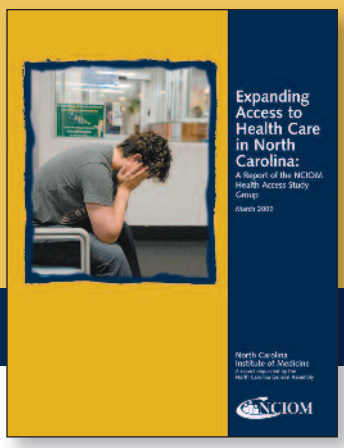


Issue Brief

# Health Care Access

## Expanding Access to Health Care in North Carolina

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### Lack of Health Insurance is the Leading Barrier to Accessing Health Care

More than 1.5 million, or 18.9%, of non-elderly North Carolinians lacked health insurance in 2006-2007.[a] The uninsured in North Carolina are four times more likely than people with insurance coverage to report that they did not seek necessary medical care because of costs or that they had no usual source of care.[1] As a result, the uninsured are less likely to get preventive screenings or to receive ongoing care for chronic conditions. They are also more likely to be diagnosed with severe health conditions and to die prematurely.[2]

North Carolina has experienced much more rapid growth in the percent uninsured than the nation. Between 1999 and 2007, the percent of uninsured individuals in North Carolina grew by 29%, compared to 12% nationally. The uninsurance rate in North Carolina grew faster than the rest of the country's because North Carolinians lost employer-sponsored insurance (ESI) at almost twice the rate as the nation (12.5% decrease vs. 6.8% nationally). Unlike in other states, public coverage in North Carolina did not expand significantly to cover the growing number of uninsured. In addition, the number of uninsured in North Carolina is likely to have increased dramatically with the recent downturn in the economy as more people have lost their jobs and/or have had to switch to lower paying jobs not offering health insurance. Although current uninsured data are not available, estimates using unemployment rates to calculate the growth in the percent of uninsured in North Carolina since 2007 show an increase of 3.1 percentage points, or 322,000 people.[b] Therefore, since 2007 the total number of North Carolinians lacking coverage has grown to approximately 1.8 million.

The uninsured are a diverse group that includes people from all income levels, age groups, geographic regions, and racial and ethnic populations. However, most of the uninsured (79%) fall into one or more of three groups:

- Children in families with incomes below 200% of the federal poverty guidelines (FPG) (14%),[c]
- Adults with incomes below 200% FPG (46%), and/or
- People with a family connection to a small employer with less than 25 employees (36%).

Lack of coverage has a negative effect on both the uninsured and society at large. Many uninsured forego or delay care and end up in the hospital emergency department for their health care. The cost of care that the uninsured are unable to pay is shifted to other paying populations. In North Carolina, individuals with health insurance pay, on average, an additional $438 and families pay an additional $1,130 per year on health insurance premiums to help cover the cost of uncompensated care for the uninsured.[3] While there are safety net providers with a mission to treat the uninsured, these providers do not have the resources to treat all of the uninsured in the state.

In response to growing access barriers, the North Carolina General Assembly directed the North Carolina Institute of Medicine (NCIOM) to convene a study group to examine and recommend options to expand access to appropriate and affordable health care in North Carolina. The Study Group was co-chaired by Representative Hugh Holliman; Senator Tony Rand; and L. Allen Dobson, MD, FAAFP, Vice President, Clinical Practice Management, Carolinas HealthCare System; and had 36 additional members. The Study Group was charged with presenting its final report to the 2009 North Carolina General Assembly. This fact sheet summarizes the Study Group's findings and priority recommendations (in italics). A copy of the full report detailing the work and all of the recommendations is available on the NCIOM's website, http://www.nciom.org.

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a Unless otherwise noted, data on the uninsured are based on North Carolina Institute of Medicine analysis of the Current Population Survey's Annual Social and Economic Supplement, published by the US Census Bureau.

b Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill and North Carolina Institute of Medicine calculations using Current Population Survey and US Bureau of Labor Statistics trends. Analysis is available on the North Carolina Institute of Medicine's website, www.nciom.org.

c 200% of the federal poverty guidelines is equal to $42,400/year for a family of four in 2008.

## North Carolina Cannot Afford to Cover All the Uninsured Without Also Implementing Strategies to Reduce Escalating Health Care Costs

While the Study Group's work focused on expanding access to care, the Study Group also recognized the need to examine cost, quality, and overall population health to ensure access to affordable health care. Health insurance premiums in the United States have increased dramatically—growing 119% between 1999 and 2008.[4] In comparison, general inflation has only been 29% and wages have increased by 34%. The rise in premiums has been driven by increases in underlying medical costs, including the high cost and utilization of medical technology and prescription drugs, growth in the prevalence of chronic illnesses, and uncompensated care for the uninsured.[5,6] More work is needed to identify strategies for North Carolina to rein in rising health care costs, enhance health care quality, and improve population health. *Therefore, the Study Group recommended that the Health Access Study Group continue to meet to examine options to reduce health care costs, improve quality and population health, and explore additional coverage options.* These issues are interrelated, as the state will not be able to fully address costs without also ensuring that everyone has health insurance. *The Study Group recommended that ultimately everyone should have coverage. Thus, the North Carolina General Assembly should require individuals to purchase health insurance once the state ensures that people have access to affordable coverage.*

## Most Uninsured Children Are Eligible for, but Not Enrolled in, Medicaid or NC Health Choice

Approximately 20% of all the non-elderly uninsured in North Carolina are children. Medicaid and NC Health Choice, the State Children's Health Insurance Program (SCHIP), cover children in families with incomes up to 200% FPG. Approximately three-in-five uninsured children in North Carolina (186,000 children) are currently eligible for, but not enrolled in, these programs. Many are not enrolled because their parents do not understand the program rules. Others are deterred from enrolling or re-enrolling because of the burdensome enrollment process. *The Study Group recommended that North Carolina expand its outreach efforts and simplify enrollment and recertification procedures to make it easier for enrollment of eligible low-income children in Medicaid or NC Health Choice.* During its 2007 Session, the North Carolina General Assembly created NC Kids' Care, a publicly-subsidized health insurance program to cover uninsured children in families with incomes between 200%-250% FPG. Implementation of the new program was delayed until Congress reauthorized SCHIP. When implemented, it will expand coverage to another 9% of uninsured children. Expanding Kids' Care to 300% FPG would cover an additional 5% of uninsured children. *To further expand coverage to uninsured children, the Study Group recommended that the North Carolina General Assembly implement NC Kids' Care and remove the enrollment growth cap on NC Health Choice.*[d]

## Nearly Half of the Uninsured Are Low-Income, Non-Elderly Adults

Unlike children, the majority of uninsured adults are not currently eligible for public programs. This is because Medicaid can only cover certain "categories" of low-income adults: those that meet certain resource limits and fall into one of the allowable coverage categories (e.g. pregnant women, adults who are parents of dependent children under age 19, adults who are disabled, or adults who are at least 65 years old). Most other childless, non-elderly, non-disabled adults cannot qualify for Medicaid regardless of how poor they are. To cover all low-income adults, federal categorical restrictions would need to be eliminated or North Carolina would need to obtain a waiver of federal Medicaid laws.

The Study Group recognized the difficulties of seeking additional state funds to expand Medicaid in the midst of a challenging fiscal environment. Medicaid enrollment typically grows during a recession as more people lose their jobs and health insurance coverage. Therefore, the federal government can assist North Carolina in maintaining current eligibility limits, and in expanding coverage by providing increased fiscal relief to the states. *The Study Group supports the Recovery and Reinvestment Act of 2009 (Pub L No. 111-005) that provides fiscal relief to the states to help pay for increasing Medicaid enrollment.*

While the state can expand coverage to low-income parents up to 200% FPG (from its current threshold of approximately 50% FPG) without a federal waiver, *the Study Group supports changes to federal Medicaid laws that would give states the authority to expand coverage to all low-income adults without categorical restrictions.* Until that time, the Study Group recommended that North Carolina seek a Medicaid Section (§) 1115 waiver to cover *all* low-income adults. In addition

d Over the last seven years, the North Carolina General Assembly established enrollment growth caps for the NC Health Choice program (6% in 2008) because the amount of the federal State Children's Health Insurance Program block grant allocated to North Carolina was not sufficient to cover all eligibles.

to covering more adults, a waiver provides other advantages. Under a Medicaid §1115 waiver, states can offer a limited benefit package, and if necessary, limit expansion to a certain number of enrollees (i.e. limit the cost of expansion). North Carolina could further reduce the cost of expansion by enrolling new Medicaid recipients into Community Care of North Carolina (CCNC)[e] and using Medicaid funds to leverage an enrollee's existing access to ESI. *The Study Group recommended that the North Carolina General Assembly direct the Division of Medical Assistance to seek a Medicaid §1115 waiver to cover more low-income adults and enroll participants in a low-cost insurance product utilizing the CCNC model.* In the interim, North Carolina can begin to expand coverage to a very high-risk, high-cost subset of the uninsured. A small subset of women have high-risk births, and absent any intervention, are likely to have high-cost, high-risk births during subsequent pregnancies. *Therefore, the Study Group recommended that the North Carolina General Assembly expand Medicaid to provide interconceptional care for up to two years for any woman who has a high-risk birth. Coverage would be limited to women who have incomes of up to 185% FPG.*

## Small Employers Are Much Less Likely to Offer Health Insurance Than Larger Firms

Almost all large employers offer health insurance coverage to employees. However, only 65% of North Carolina workers at firms with fewer than 50 employees, and less than 50% of workers at firms with fewer than 10 employees, were offered ESI in 2006.[7] This is due, in part, to higher premiums faced by small employers. In North Carolina in 2005-2006, firms with fewer than 50 employees paid, on average, $313 more for premiums than firms with 50 or more employees.[7] The Study Group examined several strategies for reducing the number of low-income uninsured workers in small firms, including modifying small group rating laws to eliminate groups of one from the small group market and using public subsidies to lower the cost of health insurance for small employers.

## Strengthening the Safety Net

Safety net organizations in North Carolina provide free or reduced-cost care to low-income, uninsured people. Most of these organizations provide preventive and/or primary care, although some offer access to pharmacy, dental, hospital, or other services. While many such organizations exist across the state, they do not have the capacity to care for the growing number of uninsured. Since 2005, the North Carolina General Assembly has provided funding to expand the availability of safety net services. However, most of the state's appropriations have been limited to non-recurring funds. Safety net organizations need recurring funding in order to hire staff and expand their capacity to serve growing numbers of uninsured. Additionally, funds are needed to create broader community collaborative networks of care for the uninsured. *Therefore, the Study Group recommended that the North Carolina General Assembly appropriate recurring funds to expand the safety net infrastructure (Community Health Center Grants program) and to support community collaborations of care for the uninsured (HealthNet).*

## North Carolina Must Ensure There Are Sufficient Numbers of Health Care Professionals to Meet the Needs of the State

North Carolina is likely to experience a shortage of physicians, nurse practitioners, and physician assistants in the next 10-20 years.[f,8] This shortage is due to the combination of an increased demand for services and a decline in the number of practicing professionals.[8] North Carolina is expected to experience even more severe shortages within certain types of specialties, including primary care, general surgery, psychiatry, and professionals who deliver babies. In addition, there is already a maldistribution of providers across the state and a shortage of minority health professionals. The maldistribution problem is likely to be exacerbated as the overall supply of providers declines. The state needs to retain and strengthen programs and policies currently in place, such as CCNC and Medicaid reimbursement levels, to ensure that there are sufficient numbers of providers practicing in underserved areas. *In order to maintain and expand access to health care services for low-income and underserved populations, the Study Group recommended that the North Carolina General Assembly continue to support CCNC, continue Medicaid reimbursement levels at 95% of Medicare rates, and increase the payment for primary care practitioners practicing in health professional shortage areas. The North Carolina General Assembly should fund technical assistance and financial incentives to practices and providers (including primary care physicians, physician assistants, nurse practitioners, certified nurse midwives, psychiatrists, psychiatric physician assistants, psychiatric nurse practitioners, general surgeons, and dentists) in underserved areas and specialties.*

e Community Care of North Carolina (CCNC) is a medical home model for the state Medicaid population. The 14 CCNC Networks, consisting of community health care professionals and health organizations, manage the care of the enrolled population. Evaluations have shown the program to lower costs and increase quality.

f Due to time constraints, the Study Group was only able to examine the supply of physicians, nurse practitioners, and physician assistants.

## An Immediate, Stepwise Approach

Residents of our state face many challenges in accessing high-quality, affordable health care. Those without health insurance face some of the most daunting challenges, but even those with coverage are facing an increasing number of barriers to accessing health care services. Rising health care costs affect everyone, regardless of insurance status. Further, the expected decline in health professionals portends even worse health access problems in the future. Addressing these issues will require a multifaceted approach incorporating public and private coverage strategies, increased support for the health care safety net, and investments in the health professional workforce. Ultimately, everyone stands to benefit from improved health care access, and likewise, everyone has a role to play in designing and implementing solutions. Although solutions are not always easy or inexpensive, a deliberate, stepwise approach—beginning immediately—will be more successful than waiting until the system collapses.

### References


1 North Carolina State Center for Health Statistics, North Carolina Department of Health and Human Services. Behavioral Risk Factor Surveillance System, 2007. http://www.schs.state.nc.us/SCHS/brfss/2007/. Published June 2, 2008. Accessed January 5, 2009.

2 Families USA. Dying for coverage in North Carolina. http://www.familiesusa.org/assets/pdfs/dying-for-coverage/north-carolina.pdf. Published April 2008. Accessed November 25, 2008.

3 Families USA. Paying a premium: the added cost of care for the uninsured. http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf. Published June 2005. Accessed January 27, 2009.

4 Claxton G, DiJulio B, Finder B, et al.; The Kaiser Family Foundation and Health Research and Education Trust. Employer health benefits 2008 annual survey. http://ehbs.kff.org/pdf/7790.pdf. Published September 24, 2008. Accessed December 12, 2008.

5 Bodenheimer T. High and rising health care costs. Part 2: technologic innovation. *Ann Intern Med.* 2005;142(11):932-937.

6 Thorpe KE, Florence CS, Howard DH, Joski P. The rising prevalence of treated disease: effects on private health insurance spending. *Health Aff.* 2005;24:317-325.

7 Agency for Healthcare Research and Quality, US Department of Health and Human Services. Medical Expenditure Panel Survey, 2006. http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&year=2006&tableSeries=-1&tableSubSeries=CDE&searchText=&searchMethod=1&Action=Search. Accessed January 15, 2009.

8 Ricketts,TC. Practitioner supply and health care access in North Carolina. Presented to: the North Carolina Institute of Medicine Health Access Study Group; October 21, 2008; Morrisville, NC. Accessed December 12, 2008.



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A copy of the full report, including the complete recommendations, is available on the North Carolina Institute of Medicine's website, http://www.nciom.org.


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