# Chapter One Introduction

Between 2000 and 2003, North Carolina's uninsured population experienced one of the largest percentage increases in the country. Approximately 1.4 million people in North Carolina under the age of 65 are uninsured, a growth of more than 300,000 people (31%) since 2000.[1,2] One-year estimates from the Current Population Survey suggest that almost one out of every five non-elderly persons in the state (19.4%) lacked health insurance coverage in 2003. North Carolina has been harder hit than many states due to the loss of manufacturing and textile jobs that resulted from trade relocation. The rising cost of health insurance, coupled with the downturn in the economy, is making it more difficult for people to afford coverage.

Lack of insurance coverage creates great barriers obtaining needed health services. Individuals without coverage are less likely to have a regular source of care. In North Carolina, 51% of the uninsured reported that they had no one whom they consider to be their personal physician or healthcare provider in 2003. In contrast, only 12% of people with insurance coverage had no regular source of care. The uninsured are also more likely to delay or forgo needed care and are less likely to receive preventive care. When they do seek care, they are generally sicker than the insured population and experience poorer health outcomes.

Most of the uninsured in North Carolina (62%) have incomes less than 200% of the federal poverty guidelines.[3] This makes it challenging for the uninsured to pay for their healthcare needs out of pocket. Difficulty paying for needed healthcare is not limited to the uninsured, but the effects on this population are more acute. Approximately 15% of North Carolinians reported in 2003 that there was a time in the last 12 months when they needed to see a healthcare provider but could not because of the cost.[4] The uninsured were far more likely to report access barriers (41.2%), than were people with insurance coverage (9.5%).

In some parts of the state, the uninsured can access safety net organizations for some or all of their healthcare needs. Safety net organizations are defined as:

> "Providers that organize and deliver a significant level of healthcare and other health-related services to uninsured, Medicaid, and other vulnerable populations."[5]
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> Core safety net providers "have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."[5]

In North Carolina, the safety net consists of federally qualified health centers (e.g., community and migrant health centers), state-funded rural health centers, local health departments, free clinics, Project Access or Healthy Community Access Programs, school-based or school-linked health centers, hospitals, and other organizations that have a central goal of providing care to patients regardless of their ability to pay. (A list of safety net organizations by county is included in Appendix A.) In addition, private physicians often provide care to the uninsured; albeit not always on a sliding scale basis. While some safety net resources exist in most communities, they are not always sufficient in meeting the healthcare needs of the uninsured. Some communities have multiple safety net organizations, but the system of care is fragmented. Others have a basic capacity to provide primary care services, but cannot meet the need for specialty consults or referrals, prescription medications, or more complex care. Still other communities lack even the capacity to meet the basic primary care needs of the uninsured.

Existing safety net organizations are experiencing an increased demand for their services without a corresponding increase in revenues to meet this need. The state and federal funding sources available to meet the healthcare needs of the uninsured are not keeping pace with the growing needs. The increased numbers of uninsured and inability to raise revenues from third party payers or other sources is creating significant

financial strains for many of these organizations. Without these institutions, the capacity to provide healthcare services for the uninsured and other underserved groups would be seriously undermined.

The NC Institute of Medicine Healthcare Safety Net Task Force was established to examine the adequacy of the existing safety net structure. The Task Force was chaired by the Honorable Carmen Hooker Odom, Secretary for the NC Department of Health and Human Services, and Sherwood Smith, JD, Chairman Emeritus of Progress Energy, and included 46 other members, including representatives of safety net organizations and provider associations, state and local elected officials and agency staff, non-profits and advocacy organizations (See page 3 for full list of Healthcare Safety Net Task Force and Steering Committee members). The goal of the Task Force was to develop a plan to better coordinate and integrate existing safety net institutions, identify communities with inadequate systems to care for the uninsured and underinsured, ascertain possible funding sources (nationally and locally) that can be used to expand care to the uninsured, and ultimately to expand and strengthen the capacity of healthcare providers and safety net institutions to care for underserved populations.

This report is divided into eight chapters. Chapter 2 describes characteristics of the uninsured in the state in more detail and the consequences of being uninsured. Chapter 3 provides an overview of the existing safety net system, including a description of the different types of safety net organizations, their locations, the services provided, the types of patients served, and financing. Chapter 4 identifies areas in the state with the greatest unmet needs and proposes a set of recommendations for how these needs can be addressed. Chapter 5 describes the existing ways to help the uninsured or people with inadequate coverage to obtain affordable medications (including pharmacy assistance programs and the 340B Drug Pricing Program) and includes recommendations on how the availability of affordable medications can be expanded to more low-income uninsured or underinsured patients. Chapter 6 begins with a description of some of the barriers preventing efforts to better coordinate safety net resources and concludes with a series of recommendations based on best-practices and strategies to promote collaboration and integration among organizations. Chapter 7 focuses specifically on financing options, with a more detailed description of how existing safety net organizations are financed and recommendations of options to expand financial support to enable these organizations to provide additional care to the uninsured. Chapter 8 is a summary of the Task Force recommendations.

**References**


1 Historical Health Insurance Tables, Table HI-6. Health Insurance Coverage Status and Type of Coverage by State—People Under 65: 1987 to 2003. Washington, DC: US Census Bureau, Current Population Survey, 1988 to 2004 Annual Social and Economic Supplements, Last revised September 2004. (Accessed September 21, 2004, at: http://www.census.gov/hhes/hlthins/historic/hihistt6.html). This report focuses on the non-elderly uninsured, as most older adults (65 or older) have Medicare or other health insurance coverage. In North Carolina, only 1% of older adults are uninsured.

2 Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2003. Washington, DC: US Census Bureau. Current Population Survey, 2004 Annual Social and Economic Supplement, Last revised September, 2004. (Accessed September 21, 2004, at http://ferret.bls.census.gov/macro/032004/ health/h05_000.htm).

3 200% of federal poverty guidelines in 2004 amounted to $18,620 for a single person and $47,140 for a family of four.

4 2003 BRFSS Survey Results: North Carolina. NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS).

5 Lewin ME, Altman S, eds. America's Health Care Safety Net: Intact but Endangered. Washington, DC: Institute of Medicine, 2000.