Chapter Two

The Uninsured in North Carolina

Over the last four years (2000-2003), North Carolina experienced an increase in the number and percentage of non-elderly uninsured, which was more than double the rate of increase nationally.[i] During that period, the percentage of the state's population under age 65 who lacked insurance coverage increased from 15.3% to 19.4% (or a 4.1 percentage point increase), whereas at the national level, the percentage of uninsured increased from 16.1% to 17.6% (a 1.5 percentage point increase). Most of the increase in the uninsured is attributable to the decline in employer-sponsored insurance. Between 2000-2003, the percentage of North Carolina's non-elderly population with employer-based coverage declined from 67.4% to 58.5%, an 8.9 percentage point difference. There was also a drop in employer-based insurance at the national level, but this decline was less than half the decline experienced in North Carolina. Nationally, 67.7% of the non-elderly population had employer-sponsored insurance in 2000. This declined to 63.8% by 2003, a 3.9 percentage point drop in employer-based coverage.[1]

The number of uninsured would have been even larger in North Carolina had there not been an increase in the percentage of people covered by Medicaid and who purchased non-group insurance. The percentage of the state's non-elderly population covered by Medicaid grew 2.8 percentage points (compared to 2.1 percentage points nationally), while the percentage of people with non-group private coverage grew 2.4 percentage points (compared to a 0.1 percentage point increase nationally).

Certain groups have higher risks of being uninsured than others. Family income (e.g., poverty status); race, ethnicity, and country of origin; age; employment status and, if employed, the industry and firm size; and geographic location all factor into a person's likelihood of being uninsured. As a general rule, low-income families, those who are non-white or non-citizens, 20-30 year olds, unemployed, or those working for small firms or certain industries (e.g., construction, hospitality, or agriculture) are more likely to lack insurance coverage. The rising cost of health insurance also affects the ability of individuals and families to afford coverage. Obtaining needed medical care can cause great financial difficulty to families. Individuals without coverage are more likely to delay or forgo needed care. When they do seek care, they are generally sicker than the insured population and experience worse health outcomes. Each of these factors is discussed in more detail below.

Low-income families are more likely to be uninsured: North Carolina residents have been more deeply affected by the downturn in the economy than people in other states. The sluggish economy has led to increases in the state's poverty rates. North Carolina experienced the fourth largest increase in the percentage of the population with incomes below 100% of the federal poverty guidelines (FPG). Between 2001-2002 and 2002-2003 this percentage grew from 13.4% of the state's population (2001-2002) to 15.0% of the state's population (2002-2003).[2] Not surprisingly, those living in poverty have a greater chance of being uninsured and are less likely to have employer-based coverage than individuals with higher incomes (Table 2.1). More than one-third of the people living in poverty (35.6%) are uninsured as are 31.6% of the near poor (incomes between 100-200% FPG).

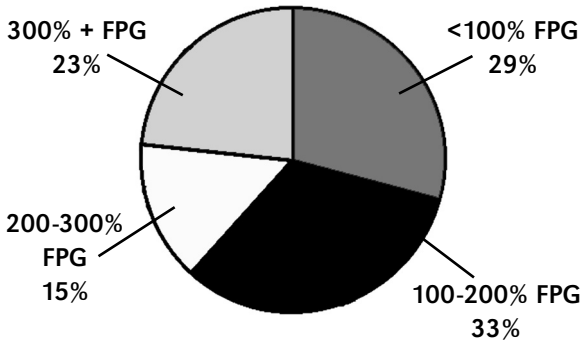
Overall, 62% of all uninsured have incomes below 200% of the federal poverty guidelines (see Chart 2.1 on page 22).

i Because most older adults, age 65 or older, have Medicare, the discussion of the uninsured is limited to non-elderly individuals (younger than age 65). Only about 1% of individuals age 65 or older lacked any type of health insurance coverage.

Table 2.1.[3,ii]
Insurance Coverage by Poverty Status—Under Age 65 North Carolina Population (2001-2003)

Insurance Type	<100% FPG	100-200% FPG	200-300% FPG	300% + FPG	Total
Employer	12.7%	30.5%	61.3%	80.8%	57.0%
Medicaid	36.6%	19.6%	8.2%	2.0%	11.9%
Medicare	6.6%	6.3%	3.4%	1.4%	3.5%
Private (non-group)	8.5%	12.1%	10.8%	6.6%	8.7%
Uninsured	35.6%	31.6%	16.3%	9.2%	18.9%
Total	100%	100%	100%	100%	100%

Chart 2.1.[4,ii]
Poverty Status of Uninsured—Under Age 65 North Carolina Population (2001-2003)



Racial and ethnic minorities and non-citizens are more likely to be uninsured than whites: One out of every five African American, non-Latinos under the age of 65 (19.9%), and 55.7% of the Latinos were uninsured, compared to only 14% of white, non-Latinos. North Carolina Latinos are more likely to be recent immigrants who were born outside of the United States, thus, they are disproportionately likely to be uninsured. Latinos born in the United States are similar in percentage uninsured to non-Latino, non-whites (24.9%); however, Latinos born outside the United States are much more likely to be uninsured (45.1%), and those that are non-citizens are most likely to be uninsured (68.4%). Latinos are more likely to be uninsured because they work in low-wage jobs, in industries that do not offer health insurance coverage (construction, hospitality), and because they are not eligible for publicly-subsidized coverage. More than half (58.3%) of the Latinos living in North Carolina are immigrants, and many are recent immigrants who arrived in the United States within the last five years. Federal immigration laws, passed in 1996, made it more difficult for Latinos and other recent immigrants to qualify for certain federally-funded programs, including Medicaid and NC Health Choice (SCHIP).[5]

Young adults are more likely to lack insurance coverage: Insurance status also varies by age, with older adults most likely to be insured. Only 1% of individuals 65 or older are uninsured, compared to 36.2% of young adults age 20-24, or 33.2% of adults age 25-29. Aside from the elderly, those least likely to be uninsured are children under age five (9.8%), or adults between the ages of 55-59 (9.9%). National studies suggest that the reason young adults are more likely to lack insurance coverage is that they are more likely to work in low-wage jobs or not-qualify for employer-sponsored insurance.[6]

Individuals working for small firms or in certain industries are more likely to be uninsured: Most of the uninsured are in families with some connection to the workforce. Families with two or more full-time workers comprise 17.9% of all uninsured, and families with one full-time worker comprise another 50.2% of all uninsured. Together, over

ii The 2004 data was weighted more heavily. Survey data reports insurance status as of the year prior to the date of the survey. In 2003, the federal poverty guidelines for a family of four was $18,400. Analysis using a weighted average from the 2002, 2003, and 2004 Current Population Survey of the US Census Bureau.

two-thirds of uninsured are in a family with at least one full-time worker. Another 12.4% of the uninsured are in a family where someone works part-time. Less than one-fifth of all uninsured (19.5%) have no connection to the workforce.

However, having a connection to the workforce—even a full-time job—does not guarantee health insurance coverage. For example, most of the uninsured *adults* are employed, with 47.2% being employed full-time and 16.5% employed part-time. The likelihood of having health insurance coverage depends, in part, on the size of the employer and the type of industry. North Carolina employees working for small companies (those employing fewer than 25 employees) have a much higher risk of being uninsured (34.2%) compared to those working for very large employers with 1,000 or more employees (11.2%). Nonetheless, approximately one-quarter of the uninsured (23%) works for very large employers. The industry of employment also affects insurance coverage. Agriculture, construction and hospitality industries are less likely to offer health insurance coverage than government, health and education, or finance jobs.

Coverage varies across geographic areas of the state, with people in rural areas more likely to be uninsured: Rural residents are more likely than urban residents to be uninsured (24% vs. 17%, respectively), but because there are more people living in urban areas, a larger percentage of the overall uninsured live in urban areas.

The Cecil G. Sheps Center for Health Services Research (Sheps Center) at the University of North Carolina at Chapel Hill (UNC-CH) developed county-level estimates of the number of uninsured individuals under age 65.[iii] Socioeconomic factors, such as race, ethnicity, age, sex, poverty, educational attainment, employment sector, and employment status of the county population, were used in developing estimates of the uninsured. The county-level estimates ranged from a low of 16.5% (Dare County) to a high of 27.0% (Duplin County) in 2003.[7] (See Chapter 4 and Appendix B for county-level estimates of the uninsured).

The rising cost of health insurance, coupled with the downturn in the economy, has made it more difficult for people to afford coverage: Nationally, health insurance premiums rose 11.2% between 2003-2004, far faster than the 2.2% increase in workers' hourly wages. North Carolina employees are generally required to pay a greater amount for health insurance premiums than other employees nationally; despite the fact that North Carolina's median income is lower than the national average.[iv,8] On average, NC employees paid $575 for single coverage and $2,110 for family coverage in 2002, compared to national average employee costs of $565 and $1,987, respectively.[9] This creates very real problems related to affordability of coverage.

Lack of health insurance affects access to care: The uninsured have much greater difficulties accessing health services. Two recent studies of low-income uninsured children in North Carolina shed light on the access barriers experienced by uninsured lower-income families. In 2001, North Carolina froze enrollment in the NC Health Choice program (North Carolina's State Children's Health Insurance Program). The Sheps Center conducted six focus groups with parents of children who were placed on the waiting list during the enrollment cap.[10] Few parents were able to afford coverage for their children so most children on the waiting list were uninsured during the freeze. Parents reported delaying needed care or using the emergency room to obtain needed services. Even when they were able to obtain care for their children, it was often at great financial cost. Parents reported juggling payments, incurring late fees, and receiving calls from creditors. Many had outstanding health bills they were trying to pay months after services were provided. Another study examined changes in access to health services for children newly enrolled in NC Health Choice. It found that children who were previously uninsured were significantly less likely to report having a regular doctor or receiving a check-up and significantly more likely to report unmet medical

iii Because most surveys (such as the Current Population Survey) are not large enough to support *direct* estimates of small areas (that is, estimates computed directly from survey responses) with ample precision, Sheps Center staff used small area estimation methods to develop *indirect* estimates of the rate of uninsured at the county level. Sheps Center staff used socioeconomic characteristics of the county, including race, ethnicity, age, sex, poverty, educational attainment, employment sector, and employment status of the county population to develop estimates of the uninsured.

iv In 2003, North Carolina's median household income was $38,234. The median US household income was $43,564.

needs than those with insurance coverage.[11]

As reported in Chapter 1, Behavioral Risk Factor Surveillance System (BRFSS) data also provide some information about ability to obtain healthcare services among NC uninsured adults.[12] Approximately 15% of respondents reported in 2003 that in the last 12 months there was a time when they needed to see a doctor but could not because of the cost. The uninsured were far more likely to report access barriers (41.2%) than were people with insurance coverage (9.5%). Similarly 35.2% of uninsured diabetics reported that there were times in the past 12 months when they were unable to obtain testing supplies and diabetes medicines due to costs (compared to 8.8% of people with insurance). The uninsured are far more likely than those with insurance to report that they have no person whom they consider to be their personal doctor or regular healthcare provider (50.7% compared to 12.4%, respectively).

More recent data on the costs of healthcare are available from a state-supplement to the BRFSS. The NC Department of Health and Human Services added questions to the 2004 BRFSS asking about adequacy of insurance coverage and out-of-pocket expenses. Preliminary data are available from 3,300 adult respondents contacted during the first three months of the 2004 BRFSS survey (January-March).[v] Of these respondents, 21% of all respondents (44% of the uninsured vs. 17% of those with insurance) reported that someone in the household had problems paying medical bills; and 18% (36% of uninsured vs. 15% of the insured) reported being contacted by a collection agency to pay past medical bills. Twenty-nine percent of the uninsured and 18% of the insured reported that they had to cut back on living expenses, including food, clothing, utilities, housing, and/or transportation, to pay for needed healthcare costs.[13]

Latinos and other immigrant populations have additional access problems related to language and cultural barriers. People who come from other countries are accustomed to different healthcare systems, financing mechanisms, and types of healthcare providers. They may also have different understandings of what affects health. These varying cultural beliefs and healthcare expectations can create barriers to the effective use of the US healthcare system. These barriers are then compounded for approximately half of all Latinos in North Carolina who report that they are unable to speak English very well.

Lack of health insurance affects health: National studies have shown that lack of health insurance affects a person's health status.[14] The uninsured receive less preventive care (e.g., they are less likely to have had a recent mammogram, Pap smear, prostate exam, or colon cancer screening). As a result, numerous studies have shown that the uninsured are more likely to be diagnosed with late-stage cancer, including late-stage melanoma, colorectal, breast, prostate, and cervical cancer. The chances of surviving cancer are much lower when the disease is diagnosed at a later stage of progression. Preventive screenings for elevated cholesterol and hypertension are also less common among the uninsured. Further, uninsured individuals with chronic illnesses are less likely to receive the care needed to manage their health conditions.[15]

Studies have shown that the uninsured are less likely to receive major interventions than those with insurance after being admitted to the hospital. A national study of 330,000 patients with myocardial infarction (heart attack) showed that uninsured patients were less likely to receive cardiac catheterization and revascularization procedures than those with insurance. This may be due, at least in part, to differences in the hospital where patients go to seek care. Treatment differences between people based on insurance status have also been found in people with diabetes, kidney disease, liver disease, pneumonia, and cystic fibrosis. Medical care also has been found to differ for trauma patients.

The uninsured use fewer services and delay care, which makes them more likely to be hospitalized for conditions that could have been prevented if they received adequate primary care. Middle-aged people who were continuously uninsured over a four-year time period were 60% more likely to have a major health decline (including death) than those with continuous insurance coverage. Other studies also show that the uninsured are approximately 25% more likely to die prematurely than people with insurance coverage. The Institute of Medicine of the National Academies found that there were 18,000 excess deaths among people younger than age 65 due to lack of health

v These data are unweighted and do not represent the state as a whole. Weighted data for the entire year (2004) will be available in April, 2005.

insurance coverage.[16] This is similar to the number of people who die prematurely due to diabetes or stroke within the same age group.

Not only does lack of insurance coverage affect health status, it also can indirectly affect labor force participation. People in poor health are less likely to work, or may work fewer hours, and as a result, their annual earnings from work are generally less than people in better health. Some studies suggest that poor health reduced annual earnings by 15-30%, and that poor health affects educational attainment.[17]

As will be evident in the following chapters, high uninsurance rates in communities can also have a spillover effect on healthcare institutions, including those providing services to people with insurance coverage. Hospitals and other healthcare organizations that serve a high proportion of uninsured patients have less ability to cover their costs.[18] This financial stress not only affects care for the uninsured, but also the ability to provide care to the larger community.

The Task Force recognized that the primary barrier the uninsured face in obtaining needed health services is lack of insurance coverage. Therefore, the Task Force recommends:

Rec. 2.1: The NC General Assembly should take steps to make health insurance coverage more affordable and to expand health insurance coverage to more uninsured individuals.

Ideally, everyone in North Carolina and in the nation should have affordable health insurance coverage that meets their basic healthcare needs. Providing such coverage would reduce the need for safety net providers; although providers who are experienced in addressing the education, transportation, and other non-financial barriers of low-income or underserved populations will always be needed.

Until the uninsured have coverage, the Task Force recognized the importance of supporting and expanding existing safety net capacity to be able to meet more of the healthcare needs of the uninsured.

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