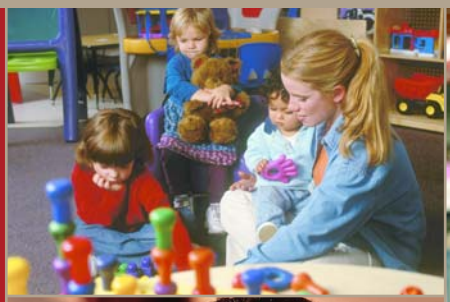







Expanding Health Insurance Coverage to More North Carolinians

North Carolina Task Force on Covering the Uninsured: April 2006

North Carolina Institute of Medicine

In collaboration with the NC Department of Health and Human Services, NC Department of Insurance, Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill

Funded by the Health Services Resource Administration, US Department of Health and Human Services

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NC IOM Task Force on Covering the Uninsured

Acknowledgements

The Task Force was a collaborative effort of the North Carolina Department of Health and Human Services (NC DHHS), the North Carolina Department of Insurance (NC DOI), the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (Sheps Center), and the North Carolina Institute of Medicine (NC IOM). The Task Force was generously funded through a one-year State Planning Grant from the Health Resources and Services Administration of the United States Department of Health and Human Services. The primary staff direction of the overall State Planning Grant Task Force work was the responsibility of Dennis Williams, Associate Director, and Anne Braswell, Senior Analyst, of the Office of the Research, Demonstrations and Rural Health Development (ORDRHD), NC DHHS.

The Task Force extends special recognition to its two Co-Chairs: Carmen Hooker Odom, Secretary, NC DHHS, and Thomas Lambeth, Senior Fellow, Z. Smith Reynolds Foundation, who helped set the agenda and gave overall direction to the Task Force. The Task Force's work and clarity of vision would not have been possible without their leadership. Pam Silberman, JD, DrPH, President and CEO of the NC Institute of Medicine, guided the work of the Task Force, facilitated one of the workgroups on public options, and was the primary author of the final Task Force report and several of the issue briefs. Sandra Greene, DrPH, Senior Research Fellow; Stephanie Poley, Project Director; and Mark Holmes, PhD, Senior Research Fellow of the Sheps Center and Vice President of the NC IOM assisted with the background research, writing and editing of the report, and facilitating the workgroup exploring private options. Kristen L. Dubay, MPP, Project Director, at the NC IOM helped organize the Task Force meetings, write sections of the reports and issue briefs, and took primary lead on editing the report. Kristie Weisner Thompson, MA, Assistant Vice President of the NC IOM also assisted with editing the report and other Task Force support. Key staff support was also provided by Adrienne Parker, Director of Administrative Operations, and Thalia Fuller, Administrative Assistant, with the NC IOM.

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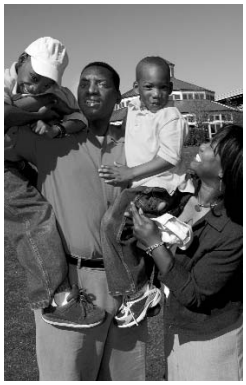

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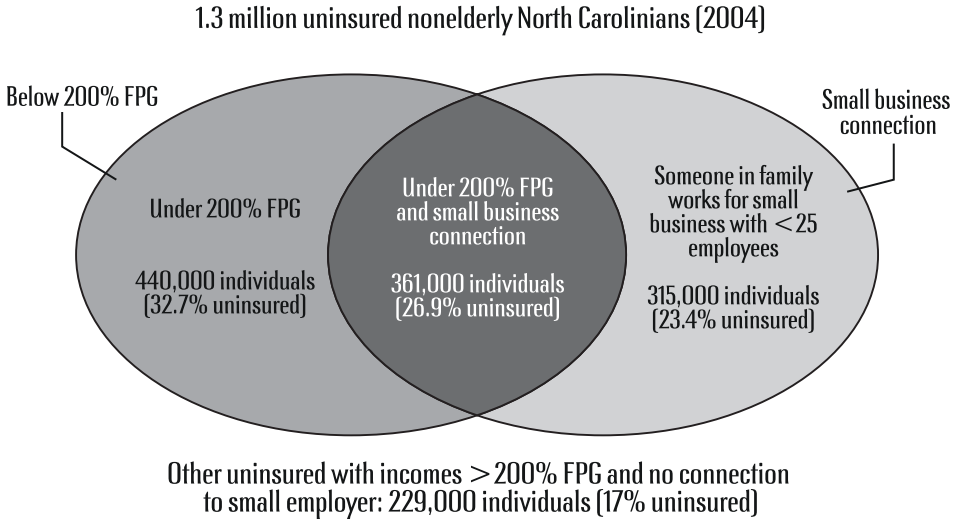
Executive Summary

Overview

More than 1.3 million nonelderly people in North Carolina lacked health insurance coverage in 2004, or more than one sixth of the state's population.[1] The percentage of the state's population without health insurance is growing more rapidly in North Carolina than in most of the rest of the country. The health of the uninsured suffers due to the lack of coverage. People who are uninsured are less likely to get preventive care or ongoing care for chronic conditions. They use fewer services and delay care, which makes them more likely to be diagnosed with a serious health condition or be hospitalized for conditions that could have been prevented if they received adequate primary care. Not only does lack of insurance coverage affect health status, it also affects the productivity of workers. People in poor health are less likely to work or may work fewer hours. Children who are sick have more difficulty learning in school. The growing number of uninsured is also creating an economic strain on the healthcare institutions that care for all North Carolinians. Ultimately, part of the cost of providing healthcare to the uninsured is borne by all residents in the form of taxes and higher insurance premiums.

In many ways, the uninsured are a microcosm of the state's population. They include workers and the unemployed; wealthy and low-income individuals; men, women, and children of all races, ethnicities, and ages. However, the two groups most likely

Chart A
Uninsured in North Carolina: Primarily Low Income or Employees of Small Firms



to lack coverage are those who have a family[a] connection to a small business with fewer than 25 employees and low-income individuals with incomes below 200% of the federal poverty guidelines. More than four fifths (83%) of the uninsured fall into one or both of these groups.[1] (see Chart A)

A common misperception is that the majority of uninsured do not work full-time. In fact, 78% of the uninsured are full-time workers or in a family with full-time workers.[1] Many of the working uninsured, particularly those who work for small firms, are not offered health insurance coverage through their jobs. On average, less than 30% of small employers with fewer than ten employees offered health insurance in North Carolina in 2002-2003, compared to 67.5% of firms with 10-24 employees, 79.3% of firms with 25-99 employees, and more than 90% of larger firms in North Carolina.[2]

Low-income individuals are also more likely to be uninsured than those with higher incomes.[1] More than one third (35.4%) of all people living at or below the federal poverty guidelines (FPG) are uninsured ($19,350 for a family of four), compared to only 8.5% of those living at 300% FPG.[3] Three fifths (60%) of the uninsured in this state have incomes below 200% FPG.

People lack health insurance coverage for a variety of reasons—but the primary reason is cost. In a statewide survey in North Carolina, more than half of the uninsured (55%) said they could not afford insurance coverage.[4] Another 23% reported that they could not obtain insurance because they were in between jobs or unemployed, a reason also connected to costs. For those with access to employer-based coverage, the average total cost in 2003 was more than $3,400/year for an employee in North Carolina, or $8,400 for a family.[5] This premium, absent any employer contribution, would constitute 36% of the gross income of a family living in poverty, or 18% of those living at 200% FPG. Even if the employee had access to employer-sponsored insurance and was only responsible for the average employee share of premium costs, this would constitute 6% of the gross income of a person living in poverty, or 12% for a family of four. Health insurance coverage is even more expensive for those who lack employer-sponsored insurance and have preexisting health problems.

Sources of Insurance Coverage

Although the number of uninsured North Carolinians is growing at a dramatic rate, the majority of North Carolinians have health insurance. Most of the nonelderly North Carolinians (61.5%) have employer-sponsored insurance (ESI). However, the proportion of individuals covered by ESI has steadily declined over the past few years. In 2000, the ESI coverage rate for all North Carolinians was nearly 68%; today it is six percentage points lower. There was a similar drop among full-time workers, from 79% in 2000 to 74% in 2004. This decrease has been concentrated primarily among small employers, while ESI coverage rates in larger firms are essentially unchanged. The increase in premium costs is the primary driver for the decline in employer-sponsored insurance.[6]

a *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. A more conservative analysis suggests that one third of the uninsured are either employees or dependents of employees of a small firm. See Appendix F for more details.

In addition to employer-sponsored insurance, approximately 6% of insured North Carolinians access coverage directly from insurance companies through nongroup policies. BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state that will voluntarily cover any individual, regardless of health status or pre-existing conditions. Other insurers may choose not to cover individuals with pre-existing health coverage, with certain limited exceptions.[b,7] However, the premium costs vary considerably in the nongroup market depending on the person's age, health status, county of residence, and health plan coverage. These premiums are often cost-prohibitive for individuals with pre-existing health problems.

Another 19% of nonelderly North Carolinians receive healthcare coverage through public programs, including Medicaid, NC Health Choice, and Medicare. Medicaid is a publicly-funded, entitlement program that provides health insurance to certain low-income individuals and families who meet specified eligibility requirements. NC Health Choice is North Carolina's State Children's Health Insurance Program (SCHIP) that provides insurance coverage to low-income uninsured children with family incomes that are too high to qualify for Medicaid, but lower than 200% FPG. Medicare is a federal program that provides health insurance to almost all older adults (age 65 or older) and to certain people under age 65 with disabilities.

Trends in Healthcare Costs

The rising costs of health insurance premiums are driving the increase in the percent of the population that is uninsured across the nation.[8] Nationally, health insurance premiums increased 65% between 2000 and 2004. This rise was more than six times greater than general inflation (9.7%) and more than five times the wage growth (12.2%).[9] The increase in premiums makes it harder for employers to offer insurance to employees and for individuals to purchase healthcare coverage. Research indicates that for every 10% increase in health insurance premiums, the number of firms that offer health insurance to their employees falls by roughly 2.5%.[10]

Most of the increase in health insurance premiums is due to the increase in the underlying costs of healthcare.[c,11,12,13,14] Healthcare costs increase for a variety of reasons, including increased costs or service utilization and changes in overall disease prevalence. Greater availability and use of technology is also a significant healthcare cost driver.[15]

When increases in healthcare costs are examined by disease category, one study shows that almost one third of the increase in national healthcare spending between 1987 and 2000 was attributable to the treatment of five major health problems: heart disease, mental disorders, pulmonary disorders, cancer, and trauma.

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b The federal Health Insurance Portability and Accountability Act (HIPAA) requires insurers to provide coverage to individuals who had 18 months of employer-sponsored or governmental health insurance and who exhausted COBRA coverage, regardless of their health status.

c The health insurance underwriting cycle can also have an effect on private health insurance premiums.

In some cases, the costs per treated case increased, while in others, the treated prevalence led the spending increase.[16] Certain lifestyle choices and lifestyle-related illnesses contribute to these healthcare problems. Smoking, heavy drinking, and obesity can lead to chronic health problems and increased healthcare costs.[17]

As a result of rising health insurance costs, many employers have shifted healthcare costs to employees through increased premiums and out-of-pocket expenses, such as deductibles and copayments. One study reported that employers increased the employee share of individual premiums by 82% between 2000 and 2005, including a 67% increase in the employees' share of family coverage.[18] One fifth of all employers are now offering high-deductible health plans, which have at least a $1,000 deductible for individual or a $2,000 deductible for family coverage. Employers have also tried to tie increased cost sharing to the services with the greatest increases in unit cost and utilization, such as hospitalizations and prescription drugs. Employers are also trying to control costs by managing high-cost claims through disease or case management programs. More than 80% of covered workers are in a plan that uses case managers to manage high-cost claims, and more than half are in plans that offer disease management.

Recommendations

The NC Institute of Medicine (NC IOM) Task Force on Covering the Uninsured was the culmination of a larger effort to examine options to expand health insurance coverage to the uninsured. The NC Department of Health and Human Services (NC DHHS) received a one-year State Planning Grant (SPG) from the Health Resources and Services Administration within the US Department of Health and Human Services to study options to expand coverage to the uninsured. The State Planning Grant effort was a collaboration of four organizations: NC DHHS, the NC Department of Insurance, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the NC IOM. These four organizations helped develop the background information about the uninsured as well as identify potential policy options the state could consider to expand coverage.

The Task Force met for approximately one year to study the problem and examine different policy options. The Task Force realized early in its deliberations that no single approach to expanding health insurance coverage would sufficiently address the problem or gain the support of all the different stakeholder groups. Therefore, the Task Force decided to take a multi-pronged approach, which includes market-based reform efforts, private-public partnerships, and public initiatives. The Task Force tried to balance the need to provide health insurance to more uninsured individuals with the necessity to restrain new health spending for employers, uninsured individuals and families, and government. Thus, many of the recommendations include limited benefit packages and/or cost sharing to ensure that, to the extent possible, uninsured individuals and families contribute toward the cost of their own care. The Task Force recommendations also encourage people to become active stewards of their own care. The recommendations include proposals to enroll individuals with complex or chronic health conditions into disease and/or case management programs, reward individuals for healthy lifestyles, and encourage the use of preventive health services.

Executive  Summary

Over the longer term, the goal for the state should be to ensure that all North Carolinians have health insurance coverage that meets their basic healthcare needs. The Task Force's recommendations, if implemented, will help expand coverage to more uninsured, but the recommendations will not ensure universal coverage. Task Force members understood that until all North Carolinians have health insurance coverage, there will be a continuing need for healthcare safety net providers who have a mission or a legal mandate to provide services to the uninsured, often at no charge or on a sliding-scale basis. Thus, one of the recommendations includes strengthening and expanding the existing healthcare safety net.

The Task Force ultimately offered 13 recommendations to expand health insurance coverage to more North Carolinians. Of these, five were considered priority recommendations, including:

1 Additional state funding to support and expand the healthcare safety net, to provide healthcare services to the uninsured;

2 Promotion of personal responsibility for leading a healthy lifestyle and the inclusion of healthy lifestyle promotion in state policies;

3 Development of a limited-benefit Medicaid expansion for low-income parents;

4 Creation of a subsidized health insurance product targeted to small employers with 25 or fewer employees, low-income sole proprietors, and low-income individuals who had not previously offered health insurance coverage; and

5 Creation of a high-risk pool for individuals with pre-existing health conditions.

The Task Force recognized that every group, including families, healthcare providers and institutions, employers, insurers and agents, and government, stands to gain by expanding health insurance coverage to the uninsured. Everyone stands to gain from a healthier and more productive workforce, and fewer bankruptcies. As more people gain insurance coverage, there will be less uncompensated care. This, in turn, will decrease the need to shift the uncompensated costs of serving the uninsured onto people with insurance coverage. This should help moderate rising healthcare costs for those with insurance.

Just as each group stands to benefit from expanding insurance coverage to the uninsured, there is a shared responsibility to contribute toward the solution. Individuals should purchase healthcare coverage when affordable coverage is available. Employers can help by offering and paying part of the costs of their employees' insurance costs. Insurers can assist by creating lower-cost products and helping subsidize some of the costs of care for high-risk individuals. Agents can help by marketing new products to small employers and uninsured individuals. Providers can help by accepting lower reimbursement rates for individuals who were previously uninsured. Government can play a role by helping to subsidize the costs of insurance for those who are low income and by supporting safety net providers.

The recommendations are listed on the following pages with "top priority" recommendations indicated by shading in the table.

Recommendations

Chapter 1: Introduction

Rec. 1.1: (Priority Recommendation)
The NC General Assembly should help support and expand the existing healthcare safety net to be able to meet more of the healthcare needs of the uninsured. (Priority Recommendation)

Chapter 4: Trends in Healthcare Costs

Rec. 4.1: (Priority Recommendation)

a) Individuals have a responsibility to understand their health needs and risks and to be better stewards of their own health. To promote healthy lifestyles:
   i) Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and they should use these resources to make healthy choices.
   ii) Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions in a manner consistent with best known evidence-based care.
   iii) Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.

b) Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.
   i) Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness-related services (such as smoking cessation) as a basic benefit.
   ii) Providers should educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.
   iii) Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e., access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.
   iv) Schools should also establish healthful policies and environments, including healthy food in cafeterias; opportunities for all youth to be active daily at school; tobacco-free policies; and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.
   v) Public health should continue and expand community-wide health awareness, promotion, nutritional information, and disease prevention activities.
   vi) Communities and governments should help support healthy communities by providing environments conducive to healthy lifestyle choices (including, but not limited to, walkways, bicycle paths, safe parks, and green spaces).

c) The NC General Assembly should adequately fund the public health system and infrastructure to provide community education and outreach related to lifestyle choices as well as health promotion and disease prevention, in accordance with the recommendations reported in the Public Health Improvement Plan developed by the NC Public Health Task Force (2004).

Rec. 4.2: The NC General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs to lower overall costs for private and public healthcare plans.

Chapter 5: Private Options to Expand Health Insurance Coverage

Rec. 5.1: The NC General Assembly should enact a Healthy North Carolina program, targeted to low-income, uninsured, working individuals, employers of firms with 25 or fewer employees, and self-employed/independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated cost-sharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs.

a) Eligibility guidelines for the Healthy North Carolina program should be as follows:
   i) Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage, or the employer has greater than a 75% participation rate among employees who do not have other coverage.
   ii) Eligibility for self-employed individuals and independent contractors is limited to those who reside in North Carolina, are low income with family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.
   iii) Individual eligibility is limited to low-income, uninsured individuals with incomes equal to or less than 250% of the federal poverty guidelines who reside in North Carolina, are employed at the time of enrollment and have been employed for a minimum of 90 days in the preceding 12 months, have no group coverage and are not eligible for employer-sponsored group coverage, were not insured within the last 12 months, and are not eligible for Medicare.

b) The NC General Assembly should appropriate sufficient ongoing funds to pay the reinsurance for products offered through Healthy North Carolina and to pay for additional tax credits for employers who contribute more than 50% of the premium cost for eligible employees or toward dependent coverage, or if the employer has greater than a 75% participation rate among employees who do not have other coverage.
   i) The reinsurance corridor should be set at a level that will result in 30% lower premiums within the Healthy North Carolina program compared to comparable coverage in the private market. Actuarial analysis should be conducted to determine the appropriate reinsurance corridor for meeting the goals of the Healthy North Carolina program.
   ii) The Healthy North Carolina program should be authorized to use program funds separately or in concert with the private industry agent community to conduct outreach and education to inform the public about the availability of the new program.
   iii) The administrators of the Healthy North Carolina program should be authorized to use program funds to pay for evaluations of the program, to include, but not be limited to: program enrollment, the relationship between premium levels and program enrollment, program cost experience, and eligibility criteria. The evaluation should also make use of surveys of covered members, participating insurers and qualifying small employers, individuals, and self-employed individuals. The findings shall be reported to the NC General Assembly on a routine basis, along with any recommendations for programmatic changes.

c) The insurers should market the program and encourage brokers and others to sell the Healthy North Carolina product by offering competitive commissions.

Recommendations continued

Rec. 5.2: The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small employer groups.

a) The study shall consider whether changes to any element of North Carolina's current small- group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.

b) The NC Department of Insurance should convene a group that includes representatives of small business, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.

c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

Rec. 5.3:

a) The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage and to initiate regional demonstration projects to pilot innovative health plans.

b) The NC General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.

Rec. 5.4: Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.

Rec. 5.5: The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or it should enact a law regarding the application of mandated benefits that would have a similar effect.

Chapter 6: Public Options

Rec. 6.1: The NC Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to, the following:

a) Increasing the number of outstationed eligibility workers.

b) Streamlining the recertification process.

Rec. 6.2: The NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including:

a) Eliminating the asset (resource) test for low-income parents.

b) Expanding the eligibility certification period from six months to 12 months.

Rec. 6.3: The NC General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover parents and pregnant women with incomes below 200% FPG with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek an 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should:
   i) Charge a sliding-fee scale premium that is based on the family's income, ranging from 0.5% for individuals with incomes equal to 100% of the federal poverty guidelines to 2% for individuals with incomes at 200% of the federal poverty guidelines. Nonsmokers or individuals who are actively participating in smoking cessation programs would be entitled to a 10% reduction on their premiums.
   ii) Develop a limited benefit package that focuses on primary care and provides $10,000 in coverage annually for inpatient hospitalizations.
   iii) Include copayments and coinsurance in the benefits package on a sliding-scale basis that encourages the use of more cost effective health interventions.
   iv) Enroll participants in Community Care of North Carolina (CCNC) and provide incentives to actively participate in disease and case management.
   v) Implement a voluntary premium assistance program, so that low-income individuals with access to employer-sponsored insurance can use Medicaid funds to pay for their share of the premium, if cost effective to the state.
b) The NC General Assembly should cover the county's share of the cost of expansion.

Rec. 6.4: The NC Division of Medical Assistance should pilot the use of an individual health risk assessment (HRA) and follow-up coaching and counseling with individual recipients in one or more of the Community Care of North Carolina (CCNC) networks to:

a) Determine the health risks of the Medicaid population.
b) Identify priorities for wellness initiatives.
c) Assess the costs of implementing a HRA program statewide or with targeted eligibility groups.
d) Assess the potential cost savings from targeted wellness initiatives.

Rec. 6.5: The NC General Assembly should enact legislation to implement a high-risk pool.

a) Eligibility for the high-risk pool should be limited to individuals who:
   i) Are ineligible for Medicaid, Medicare, or COBRA coverage, and
   ii) Are unable to purchase a policy except with a premium that is higher than that offered through the pool or have been rejected by a commercial insurer due to pre-existing health problems.
b) Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c).
   i) The NC General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.
c) Premiums should be limited to 150% of the standard risk rate.
   i) The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are

Recommendations continued

eligible for a federal premium subsidy under the Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.

ii) Nonsmokers or individuals who are actively participating in a smoking cessation program should be offered a
discount off their premium.

iii) The high-risk pool administrator should study additional ways to encourage healthy behaviors and report back to the NC General Assembly about options within one year of program operation.

d) The high-risk pool should offer participants the choice of different insurance products, including Preferred Provider Organizations (PPOs) with different levels of deductibles and cost sharing and at least one choice of a Health Savings Account (HSA).

e) The health insurance products offered through the high-risk pool should each include no less than a $1 million lifetime limit and a sliding-scale annual limit on out-of-pocket expenses of $2,000-$5,000, based on family income. These limits should be adjusted at least once every five years to reflect changes in the medical component of the Consumer Price Index.

f) The health insurance products should include disease and/or case management to help individuals with chronic and/or complex health problems manage their health conditions.

g) The high-risk pool should also be available as a guaranteed-issue policy for HIPAA-eligible individuals in the nongroup market, and to individuals who have lost health insurance coverage as a result of the Trade Adjustment Act.

h) The costs of the high-risk pool should be financed through:

i) Premiums and other cost sharing for covered individuals.

ii) State appropriations to help pay the premium subsidy for individuals with incomes below 300% of the federal poverty guidelines.

iii) An assessment on covered lives on all health insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), Third Party Administrators (TPAs), Administrative Service Organizations (ASOs).

iv) Provider reimbursement limited to the Medicare reimbursement rates.

i) North Carolina should seek federal grant funds, if available, to help support the implementation and ongoing costs of operating a high-risk pool.

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Family Size	100% FPG (Yr)	200% FPG (Yr)	300% FPG (Yr)
1	$ 9,570	$19,140	$28,710
2	$12,830	$25,660	$38,490
3	$16,090	$32,180	$48,270
4	$19,350	$38,700	$58,050
For each add'l person	$ 3,260	$6,520	$9,780

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Chapter 1 Introduction

Overview

More than 1.3 million nonelderly people in North Carolina, or more than one-sixth of the state's population, were uninsured during 2004.[a,1] Since 2000, the number of North Carolinians without health insurance coverage has increased by 300,000. Compared to most other states, North Carolina has experienced a larger increase in the percentage of nonelderly who are uninsured and a larger drop in employer-sponsored health insurance coverage. The percentage of North Carolinians without health insurance coverage increased 15% from 1999-2000 to 2003-2004 compared to a national increase of 10%.[2] The percentage of people with employer-sponsored insurance in North Carolina declined by 9% over the same time period, while nationally, the drop was 6%.

Expanding health insurance coverage to the uninsured will help improve access to needed healthcare services, so individuals can receive care in a timely, and hopefully, less costly setting.

A common misconception is that the majority of the uninsured do not work full-time. In fact, 77% of the uninsured are full-time workers or family[b] of full-time workers.[a] The two groups most likely to lack insurance coverage are those who work for small employers and low-income individuals with incomes below 200% of the federal poverty guidelines. Approximately one third of all people who work for small employers with less than 25 employees are uninsured (34%), compared to 22% of those who work for medium firms (25-99 employees), 15% of those who work for large firms (100-999 employees), or 10% of those who work for very large firms (1,000+ employees). In fact, 50% of the uninsured are workers or family of workers in small firms with 25 or fewer employees. Similarly, low-income individuals have a much greater likelihood of being uninsured than do those with higher incomes. Nearly 60% of the uninsured have incomes below 200% of the federal poverty guidelines.

People lack health insurance coverage for a variety of reasons, but the primary reason is cost. In a statewide survey in North Carolina, more than half of the uninsured (55%) said they could not afford insurance coverage.[3] Nationally, the most common reason given by employers for not offering health insurance was the high premium cost.[4]

People who are uninsured are less likely to get preventive care, and more likely to be diagnosed with a serious health condition, such as late stage cancer.[c] The uninsured

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a Data provided in this report are based on two year weighted averages of Current Population Survey data. This approach increases the accuracy of the estimates. See the Appendix F for details.

b *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. See Appendix F for more details.

c Throughout this report, comparisons between insured and uninsured individuals are made. However, the average uninsured individual may differ from the average insured individual in many other respects. Therefore, the entire difference in outcomes between the insured and uninsured is not wholly attributable to health insurance status. Additionally, it should not be interpreted that if the average uninsured individual obtained health insurance, measures of her health would be similar to the average insured individual. However, research literature concludes that lack of health insurance does adversely affect health, so it is reasonable to expect that obtaining access to health insurance would substantially improve health for uninsured individuals.

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. Obtaining needed medical care can cause families great financial difficulty. More than two fifths of the uninsured in North Carolina (41%) reported that they delayed care and 27% went without needed medical care (compared to 15% and 4%, respectively for the insured). Not only does lack of insurance coverage affect health status, it also affects the productivity of our workers. People in poor health are less likely to work or may work fewer hours. Children who are sick have more difficulty learning in school. The uninsured who do obtain care are often faced with outstanding medical bills that can lead to personal bankruptcies or adversely affect their credit rating.[5] And the growing number of uninsured is creating an economic strain on the healthcare institutions that care for all North Carolinians. Ultimately, part of the cost of providing healthcare to the uninsured is borne by all residents in the form of taxes and higher insurance premiums.

The NC Department of Health and Human Services (NC DHHS) received a one-year State Planning Grant from the Health Resources and Services Administration (HRSA) within the US Department of Health and Human Services (US DHHS) to study policy options to expand coverage to the uninsured. Four organizations helped lead this effort: the NC DHHS, the NC Department of Insurance (NC DOI), the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill (Sheps Center), and the NC Institute of Medicine (NC IOM). The NC DHHS, through the Office of the Secretary and the Office of Research, Demonstrations and Rural Health Development (ORDRHD), provided the overall leadership, direction, and coordination for the State Planning Grant. The State Center for Health Statistics within NC DHHS collected data to identify insurance coverage, access to employer-sponsored insurance, gaps in coverage, and access barriers of North Carolina residents. Staff at the Sheps Center analyzed existing data on the uninsured from national data sources and oversaw focus groups of small and large employers, insurance agents/brokers, and the uninsured. In addition, the Sheps Center contracted with Mercer Government Consulting Group to develop cost estimates of different policy options. The NC DOI assisted in identifying policy options to reduce health insurance costs and to expand coverage in the private market.

The NC IOM convened the Task Force on Covering the Uninsured to study and recommend options to expand health insurance coverage to the uninsured. The Task Force was chaired by the Honorable Carmen Hooker Odom, Secretary of the NC DHHS, and by Thomas Lambeth, Senior Fellow, Z. Smith Reynolds Foundation. It included 56 additional members, including state policy makers, legislators, county commissioners, healthcare providers, representatives of state healthcare trade associations, insurers, safety net organizations, small and large businesses, insurance agents, consumer advocates, and the faith community.

The Task Force met for approximately one year to study ways to expand health insurance to the uninsured. The Task Force examined the demographics of the uninsured, reasons for lack of coverage, and the health consequences of lacking insurance. In addition, the Task Force members heard information from focus groups of large and small employers, insurers, and the uninsured about the reasons that employers offer (or fail to offer) insurance and reasons the uninsured lack coverage, their willingness

to pay for coverage, and the trade-offs they would consider to make health insurance coverage more affordable.

Ultimately, the Task Force was charged with developing policy options to expand health insurance coverage to the uninsured. The Task Force was guided by the belief that everyone in the state stands to gain if more people have health insurance coverage. Not only will this help improve access to health services for the people who currently lack coverage, but it will also help reduce healthcare costs to those with insurance coverage and lead to a more productive workforce and healthier children. The Task Force focused its efforts on three populations most likely to lack coverage: those with low incomes (below 200% of the federal poverty guidelines), those who work for small employers, and those with significant pre-existing health problems who have difficulty affording coverage in the private, nongroup market.

The Task Force was guided by the belief that everyone in the state stands to gain if more people have health insurance coverage.

Guiding Task Force Principles

Expanding health insurance coverage to the uninsured is a complex, costly, and difficult task. Too often, past efforts to expand coverage have met with resistance from one or more organized constituency because of the costs, lack of coverage of specific services or populations, or philosophical differences about the underlying role of government and/or the private market.

The Task Force recognized the enormous role that many groups play in providing services or extending coverage to individuals who might otherwise lack health insurance coverage. Government, providers, employers, insurers, and individual families all contribute in various ways to ensure that the healthcare needs of the uninsured are met: government helps finance health insurance coverage for certain low-income individuals; providers often provide care to the uninsured on a reduced-cost basis, employers help subsidize the healthcare costs of employees who might otherwise be uninsured; and individual families help pay, and often make tremendous financial sacrifices, for needed health services. Yet, those who remain uninsured receive less care than they need, and as a result, their health suffers, and the lack of insurance has ripple effects on the economy and society as a whole. Productivity and learning decrease, and healthcare providers, who are burdened with increasing numbers of uninsured, are put in precarious financial situations that affect their ability to provide care to those with insurance coverage.

The Task Force realized early in its deliberations that no single approach to expanding health insurance coverage would sufficiently address the problem or gain the support of all the different healthcare constituencies. Therefore, the Task Force decided to take a multi-pronged approach that included market-based reform efforts, private-public partnerships, and public initiatives. The recommendations included in this report recognize that every group, including consumers, providers, employers, insurers, insurance agents, and government, has a role or responsibility to help expand health insurance coverage to the uninsured. The success of these recommendations and our ability to expand health insurance coverage to the uninsured rests on the shared support of many different groups.

Who Stands to Gain and How

1. *Individuals* have the most to gain by having health insurance coverage. As a consequence, they also have a responsibility to contribute, to the extent feasible, toward the cost of their healthcare and health insurance coverage through premiums, coinsurance, and copayments. In addition to a financial contribution, all insured individuals should be expected, and given the information and resources needed, to become active stewards of their own care. Many of the Task Force recommendations include proposals to enroll individuals with complex or chronic health conditions into disease and/or case management programs; reward individuals for healthy lifestyles; and encourage the use of preventive health services.

2. *Providers* stand to gain by having a source of coverage for some individuals for whom they were already providing coverage, but receiving minimal payments. Providers can help assist in efforts to extend health insurance coverage to the uninsured by accepting lower reimbursement rates for services (i.e., discounts off of their full charges). The costs of many of the proposed expansion options have been reduced by building in lower reimbursement rates to providers. While this would be less than they traditionally collect from commercial insurers, it will be more than they may receive from many of the low-income uninsured.

3. *Employers* stand to gain by having a healthier workforce. Most of the employers in the focus groups talked about their desire to provide health insurance coverage as a means of attracting and retaining good employees. The Task Force recognized that many employers are already providing coverage, and those who do not—particularly those with fewer than 25 employees—often lack the resources to pay for this benefit. Some of the proposals are targeted to small employers to help develop products that are more affordable, so these employers can provide coverage to their employees. Once these products are available, employers can help reduce the numbers of uninsured by offering coverage and helping to subsidize the premium costs.

4. *Insurers* will benefit by having more covered lives. There are multiple ways in which they can help expand health insurance coverage to the uninsured. First, insurers need to be partners in developing new and more affordable products. The Task Force proposed a tiered benefit product, starting with a very limited benefit design that can be offered at a lower-cost and be built up to a more comprehensive design with higher premiums. In addition, insurers can help finance losses to a high-risk pool. The Task Force has proposed that the high-risk pool be financed, in part, through assessments on covered lives for insurers, third-party administrators (TPAs), Administrative Services Organizations (ASOs), and Multiple Employer Welfare Arrangements (MEWAs).

5. *Insurance agents* will benefit from more affordable insurance options to sell, particularly to small employers. Insurance agents can assist in reducing the numbers of uninsured by marketing the new products and helping educate individuals and employers about private and public coverage options that are available.

6 *Government* also stands to benefit by producing a healthier, more competitive workforce, and healthier children more likely to succeed in school. Government at the federal, state, and local levels can assist by helping to underwrite the costs of healthcare for those who are unable to do so themselves. The public expansion options, subsidies for lower-income enrollees in the high-risk pool, and costs of the reinsurance for small employers are predicated upon some government financing. Action on the part of the NC General Assembly is needed to establish some of the products and to remove legal barriers that prevent the establishment of certain lower-cost insurance options.

Expanding health insurance coverage to the uninsured will help improve access to needed healthcare services, so individuals can receive care in a timely, and hopefully, less costly setting. Not only should this lead to improved health status of workers and children in the state, but it should help improve the financial health of many of our healthcare institutions. As more people gain insurance coverage, the need to shift the costs of providing services to the uninsured should be reduced. In the future, this should help moderate rising healthcare costs for those with insurance. Everyone stands to gain by expanding health insurance coverage to more North Carolinians.

Support for the North Carolina Healthcare Safety Net

Over the longer term, the goal for the state should be to ensure that all North Carolinians have health insurance coverage that meets their basic healthcare needs. The recommendations included in this report, if implemented, will help expand coverage to more of the uninsured, but will not ensure universal coverage. Until all North Carolinians have health insurance coverage, there will be a continuing need for healthcare safety net providers who serve the uninsured. These organizations, including Federally Qualified Health Centers (FQHCs), state-funded rural health clinics, free clinics, local health departments, hospital emergency departments and outpatient clinics, Area Health Education Centers program residency clinics, school-based or school-linked health centers, and Project Access models or other community collaborations, have a legal mandate or mission to provide services to the uninsured and often provide services at no charge or on a sliding-fee scale. Private physicians also provide care to the uninsured, albeit not always on a reduced-fee basis. Many of the pharmaceutical manufacturers provide free medications that help address the medication needs of some of the uninsured.

The NC IOM recently completed a study examining the adequacy and financial viability of these organizations in North Carolina.[6] The study found that the safety net organizations are struggling to meet the healthcare needs of the growing uninsured population in the state. An increasing demand for services, coupled with increasing healthcare costs, is causing financial strain. Despite the many different safety net organizations in the state, the existing safety net is not sufficient to meet the healthcare needs of all the uninsured. The Task Force found that only about 25% of the uninsured received primary care services from these organizations in

2004, and that the capacity to meet the healthcare needs of the uninsured varied widely across counties. The lack of affordable healthcare services leads many of the uninsured to delay care, use emergency departments for nonemergency care, or fail to fill prescriptions, all of which can lead to higher cost care when they do seek health services. Until the uninsured have health insurance coverage, the Task Force recognizes the importance of supporting and expanding the existing network of safety net providers. Therefore, the Task Force recommends:

Recommendation 1.1: The NC General Assembly should help support and expand the existing healthcare safety net to serve more of the healthcare needs of the uninsured.

Report Overview

This report is divided into seven chapters. Chapter 2 describes characteristics of North Carolina's uninsured in more detail and the consequences of being uninsured. Chapter 3 provides information about different sources of private and public insurance coverage. Chapter 4 describes some of the underlying factors that contribute to rising healthcare costs. Chapter 5 focuses on policy options to help reduce the costs of health insurance coverage, particularly for small employers. Chapter 6 describes public options to expand health insurance coverage to the low-income uninsured, as well as mechanisms to create a state subsidized high-risk pool for people with pre-existing health problems. Chapter 7 is a summary of the Task Force recommendations. The Appendices include an explanation of the 2005 Federal Poverty Guidelines, data tables on the numbers of uninsured, North Carolina county-level numbers of the uninsured, a summary of focus group results, a summary of actuarial analyses, the methodology explaining data analyses, a description of the Healthy New York program, and a list of acronyms.

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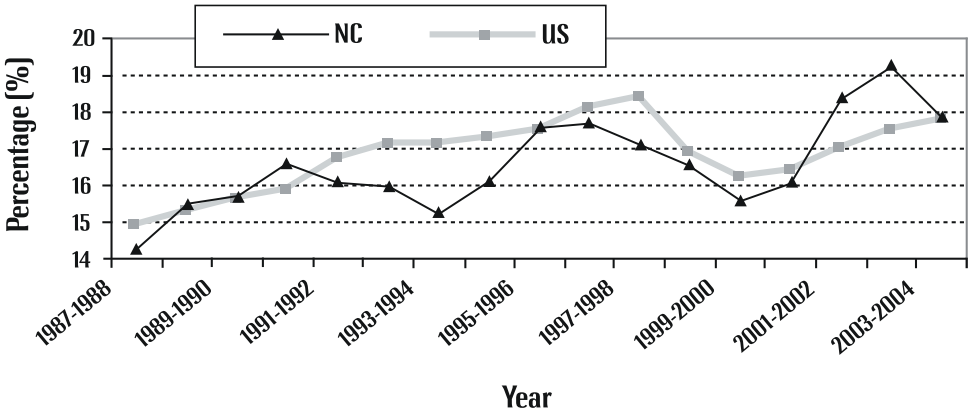
Chapter 2  The Uninsured

Between 1999-2000, and 2003-2004, the percentage of the nonelderly uninsured in North Carolina increased almost 15% (from 15.6% to 17.9%, respectively). Nationally, the percentage of nonelderly without insurance coverage increased by 10% (from 16.2% to 17.8%).[1] (see Chart 2.1) Due to this increase, there are now more than 1.3 million nonelderly people in the state who are uninsured.[2]

Most of the increase in the uninsured is due to the drop in employer-sponsored insurance. North Carolina experienced a greater loss in employer-sponsored insurance than other states.

Chart 2.1
Percent Uninsured Under Age 65 (North Carolina and National Estimates, Two-Year Averages (1987-1988 to 2003-2004)



Source: Holmes M. Analysis of US Census Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Health Historical Tables. Persons Under Age 65. HI-6. Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

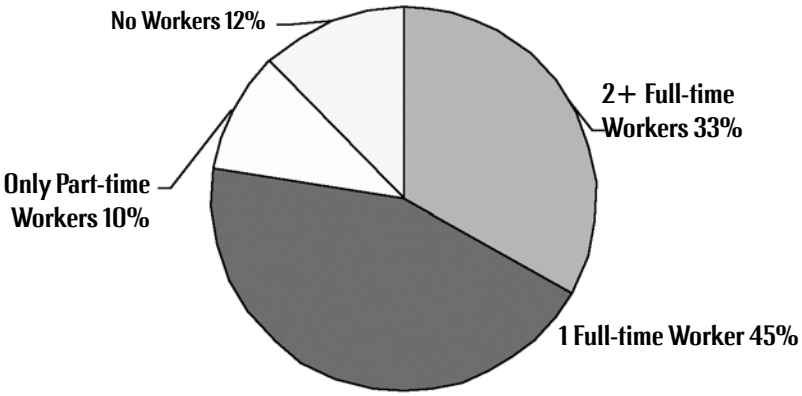
Most of the increase in the uninsured can be attributed to the drop in employer-sponsored insurance (ESI) coverage. A greater percentage of people lost employer-sponsored coverage in North Carolina in the last four years compared to the rest of the country. The percentage of people with employer-based insurance in North Carolina declined by 9%, from 67.6% (in 1999-2000) to 61.5% (2003-2004). Nationally, there was only a 6% decline in employer-sponsored insurance during the same time period, from 67.6% to 63.3%. The economic forces affecting this change and more detailed information about employer-sponsored health insurance are discussed in the following chapter. This chapter provides background on the characteristics of the uninsured, the reasons why people lack coverage, and the interaction between insurance status and health.

Characteristics of the Uninsured

More than one sixth of the state's nonelderly population lacks health insurance coverage. The uninsured, in many ways, are a microcosm of the state's population. They include workers and the unemployed; wealthy and low-income individuals; and men, women, and children of all races, ethnicities, and ages. However, certain demographic groups have a higher risk of being uninsured, including individuals who work for small employers or in certain industries, lower-income individuals, young adults, people who are racial or ethnic minorities, noncitizens, and people living in rural areas.

Most of the uninsured are workers or family[a] of workers. Most of the uninsured in the state have a connection to the workforce, with more than three fourths of the uninsured being in a family[a] with at least one full-time worker (see Chart 2.2).[1] Only 12% of the uninsured have no connection to the workforce.

Chart 2.2
Percent of the Uninsured Based on Employment Status (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

Only 12% of the uninsured have no connection to the workforce.

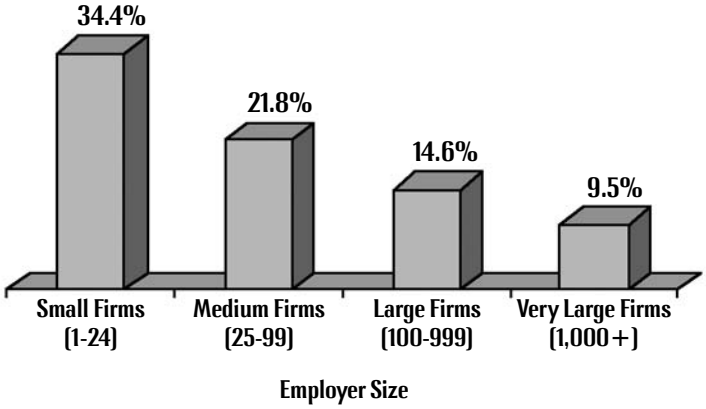
While most of the uninsured live in a family with at least one full-time worker, families with only part-time workers have the highest likelihood of being uninsured. More than one quarter of the people in households that contain only part-time workers (28%) are uninsured, compared to 19.2% of families with one full-time worker and 11.5% of those with two or more full-time workers. Families with only part-time workers have a higher likelihood of being uninsured than do families with no workers (22.5%). This is due, in part, to the fact that families with no workers are more likely to qualify for Medicare or Medicaid. (See Chapter 3 for a description of eligibility rules.)

Individuals who work for small employers or in certain industries, such as construction, manufacturing, or hospitality, are less likely to have health insurance coverage. More than half of all uninsured workers (55.5%) work for small employers with less than 25

a *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. See Appendix F for more details.

employees. Another 12.6% work for medium-size firms (25-99 employees), 12.0% work for larger firms (100-999 employees), and 19.9% work for the very largest firms (more than 1,000 employees). Not surprisingly, employees who work for the smallest firms also have the highest risk of being uninsured (Chart 2.3).[1]

Chart 2.3
Percentage of Employees Working in Different Firm Sizes Who are Uninsured (North Carolina, 2003-2004)

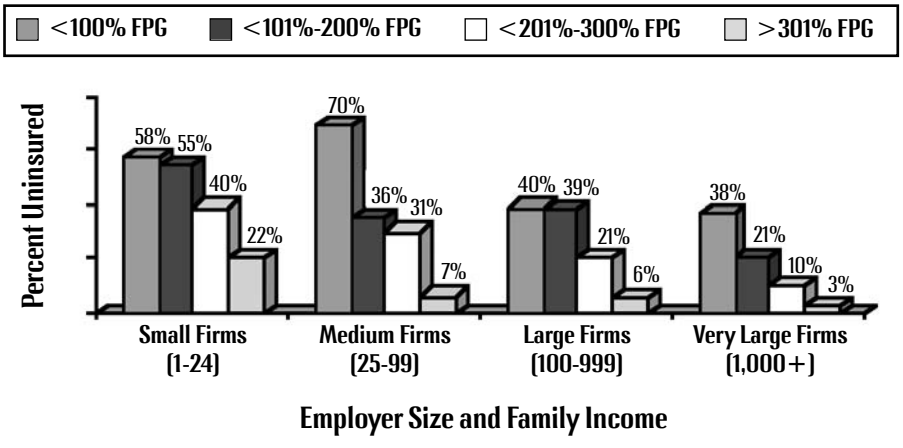


Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

More than half of uninsured workers work for small employers with 25 or fewer employees.

Low-income workers who work for small employers are more likely to be uninsured than most other workers. In general, an individual worker's risk of being uninsured is highest when he/she has low family income or works for a very small firm (with fewer than 25 employees) (see Chart 2.4).[1] As one uninsured person noted in focus

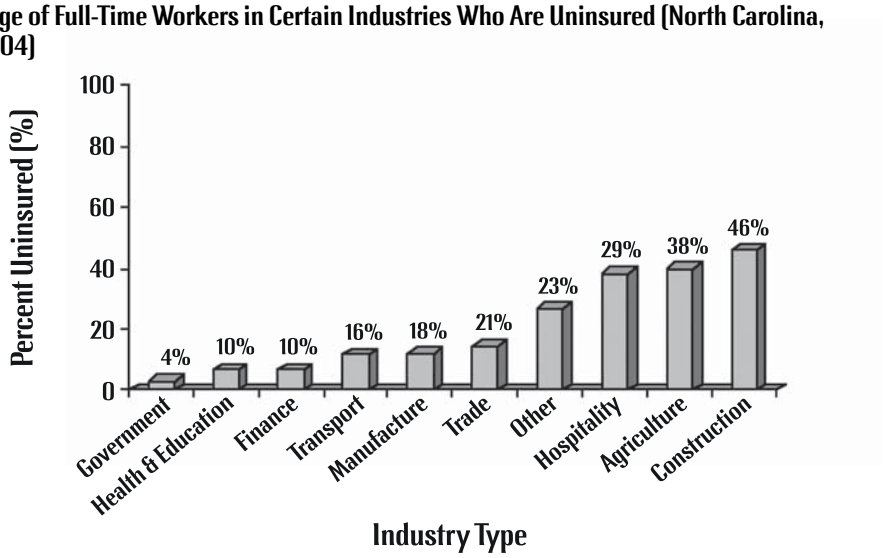
Chart 2.4
Percentage of Full-Time Workers, Working for Different Size Employers and With Different Incomes, Who are Uninsured (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

groups conducted in North Carolina, "At the grocery store I work for, they have insurance, but I can't afford it. Between my wife and me, we make too much to qualify for Medicaid, but not enough to pay for insurance." The higher the person's income or larger the firm, the less likely he/she is to be uninsured.

Chart 2.5
Percentage of Full-Time Workers in Certain Industries Who Are Uninsured (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

Approximately three fifths (60%) of the nonelderly uninsured have incomes below 200% of the federal poverty guidelines ($38,700 for a family of four).

Insurance coverage also varies by industry, with uninsured rates ranging from less than 4% for full-time government employees to almost half (46%) of those working full time in construction (see Chart 2.5).[1]

Lower-income individuals and families are the most likely to lack health insurance coverage. People with incomes less than the federal poverty guidelines (FPG) are the most likely to be uninsured (see Table 2.1).[3] (See Appendix A for FPG data.) More than one third

Table 2.1
Insurance Coverage by Poverty Status (North Carolina, 2003-2004)

Insurance Type (Percent of people less than age 65)	<100% FPG (15%)	100-200% FPG (18%)	200-300% FPG (16%)	300%+ FPG (50%)	Total (100%)
Employer	13.2%	32.3%	61.7%	80.1%	58.3%
Medicaid	35.3%	19.7%	5.8%	2.8%	11.3%
Medicare	5.8%	5.6%	3.8%	1.3%	3.2%
Private	10.4%	13.1%	10.4%	7.2%	9.3%
Uninsured	**35.4%**	**29.4%**	**18.3%**	**8.5%**	**18.0%**
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year. Percentages might not add to 100 due to rounding.

of the people living in poverty are uninsured, compared to 8.5% of those with incomes in excess of 300% FPG. Low-income people are less likely to have employer-based coverage and more likely to rely on Medicaid as their source of health insurance coverage.

Of the more than 1.3 million people in the state who lack insurance coverage, approximately 800,000 (59.6%) have incomes below 200% FPG (or $38,700 gross income per year for a family of four). Strategies to extend health insurance coverage to the low-income uninsured may need to be different than those for higher-income individuals. Low-income uninsured are less likely than higher-income uninsured to have access to employer-sponsored insurance, partly because they are slightly more likely to work in industries, such as construction or hospitality, which are less likely to offer insurance.[4] They are also less likely to work full-time and have a more sporadic employment history than those with higher incomes.[1] Further, lower-income uninsured individuals have worse health status than higher-income uninsured. For example, they are 4.5 times more likely to have diabetes, 30% more likely to have high blood pressure, 50% more likely to have high cholesterol, and almost twice as likely to report having fair or poor health than higher-income uninsured individuals.[5]

While most of the uninsured are low-income, many uninsured have higher incomes: 16.6% have incomes between 200-300% FPG, and 23.9% have incomes in excess of 300% FPG. Among those with incomes above 300% of FPG, the uninsured generally have lower self-reported health status than people with insurance coverage. For example, 36.3% of the uninsured at this income level reported having poor, fair, or good health status (versus very good or excellent health status). In contrast, only 23.8% of those with insurance coverage reported being in poor, fair, or good health status. Also, among those with incomes in excess of 300% FPG, the uninsured generally have lower family incomes than do those with insurance coverage.[b] This suggests that some of the uninsured have worse health problems, which may make health insurance coverage unaffordable in the nongroup market.[1] (See Chapter 3 for discussion of nongroup coverage.)

Table 2.2
Percent of Uninsured Population and Total Population, by Race (North Carolina, 2003-2004)

Race/Ethnicity	Percent of Total Uninsured Population	Percent of Total Population
White, Non-Latino	49%	69%
African-American, Non-Latino	23%	21%
Latino	21.5%	6%
Other Races, Non-Latino	6.5%	4%

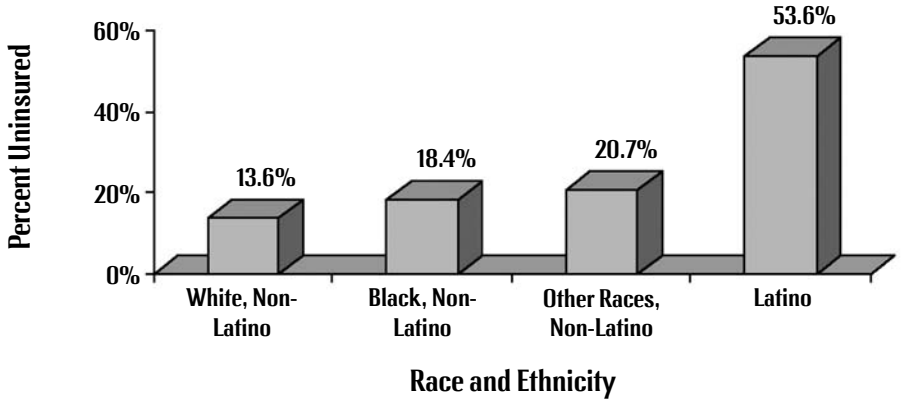
Source: Holmes M. Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year. US Census Bureau. American Community Survey, 2004 Summary Tables; 2004 General Demographic Characteristics; using American Fact Finder.

b The uninsured with incomes in excess of 300% FPG generally have lower incomes than those with insurance coverage. For example, 46% of the nonelderly uninsured individuals in families with incomes above 300% FPG have incomes closer to 300% FPG (300-400% FPG), compared to 31% of insured nonelderly individuals. Insured individuals generally have higher incomes.

Chapter 2  The Uninsured

Most of the uninsured are whites, but racial and ethnic minorities have a higher chance of being uninsured. While almost half of the uninsured are white, non-Latino (49%), they actually represent a smaller percentage of the uninsured than they do in the general population (69%).[1,6] African American non-Latinos constitute 23% of the uninsured, Latinos constitute 21.5%, and other races (non-Latino) constitute 6.5% (see Table 2.2).[1,7] While not the largest numbers of uninsured, Latinos and African Americans have a higher likelihood of being uninsured than do whites (see Chart 2.6).[1]

Chart 2.6
Percent of Individuals, by Race and Ethnicity, Who are Uninsured (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey 2004-2005 (CPS) (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

The likelihood of being uninsured also varies by nation of birth and citizenship, especially for 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 about equally as likely to be uninsured as nonwhite, non-Latinos (24.3%); however, Latinos born outside the United States are much more likely to be uninsured (39.9%), and those that are noncitizens are most likely to be uninsured (70.4%).[8] Latinos are more likely to be uninsured because they work in industries that are less likely to offer health insurance coverage (such as construction), and are less likely to work in industries that do offer insurance (such as health and education).[c] Although poor, many Latino immigrants living in North Carolina are not eligible for publicly subsidized health insurance coverage. 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 North Carolina Health Choice (State Child Health Insurance Plan), unless they become citizens or are qualified immigrants who have resided in the United States for at least five years.[9] More

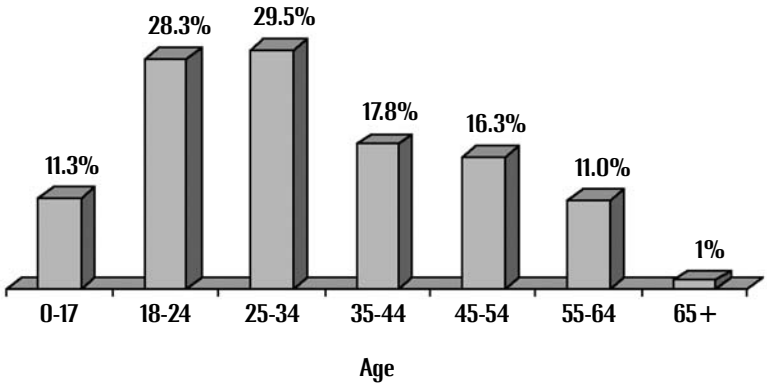
c Latinos are more likely to work in low-insurance industries. For example, 40% of full-time Latinos work for construction compared to 8% of non-Latinos full-time workers; whereas only 4% of full-time Latinos work for health and education, compared to 22% of non-Latino full-time workers.

The uninsurance rate varies across the state from a high of 28.3% in Tyrrell County to a low of 13.9% in Wake County (2004).

than half (58.3%) of the Latinos living in North Carolina are noncitizens, and many are recent immigrants who arrived in the United States within the last five years.[d,10]

Young adults are more likely than older adults to lack insurance coverage. Young adults, ages 18-34, are more likely to lack insurance coverage than any other age group (see Chart 2.7).[1] They comprise 44.8% of all the nonelderly uninsured. They are more likely to work in construction or the hospitality industry, have lower wages, and have less stable work history than older adults. This suggests that some young adults may have less access to employer-sponsored insurance and/or have less ability to pay for coverage when offered.

Chart 2.7
Percent of Individuals Who are Uninsured, by Age (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

Men are more likely to lack insurance coverage than women. Approximately one fifth of all men in this state lack coverage (20.2%), whereas only 15.8% of women lack coverage. This may be due, in part, to the fact that women are more likely to qualify for Medicaid coverage. Medicaid pays for approximately 42% of all births in the state.[11] Further, most single-parent households are headed by women. Some of these families—those with very low incomes—may qualify for public assistance and Medicaid.

The uninsurance rate varies across the state, but generally people living in rural areas have a greater likelihood of being uninsured. The uninsurance rate varies across the state and is dependent, at least in part, on the county's economic base (major industries and

d The term "noncitizen" is not synonymous with immigrants who are in the United States without documents. Individuals do not need to be citizens to reside in the United States legally. Immigrants can reside in the United States with many different types of immigration classifications, including work or student visas. Many noncitizens serve in the US military. There are no official estimates of how many Latinos are currently residing in North Carolina without documentation, but some experts estimate that between 48-54% of all foreign-born people in North Carolina are undocumented. Passel JS. Unauthorized Migrants: Numbers and Characteristics. Background Briefing Prepared for Task Force on Immigration and America's Future. Pew Hispanic Center. June 14, 2005. Available at http://pewhispanic.org/files/reports/46.pdf. Accessed December 5, 2005. Another study of Latinos estimated that 44.5% of North Carolina Latinos were undocumented in 2004. Kasarda and Johnson. The Economic Impact of the Hispanic Population on the State of North Carolina. Available at http://www.ncba.com/2006HispanicStudy.pdf. Accessed January 10, 2006

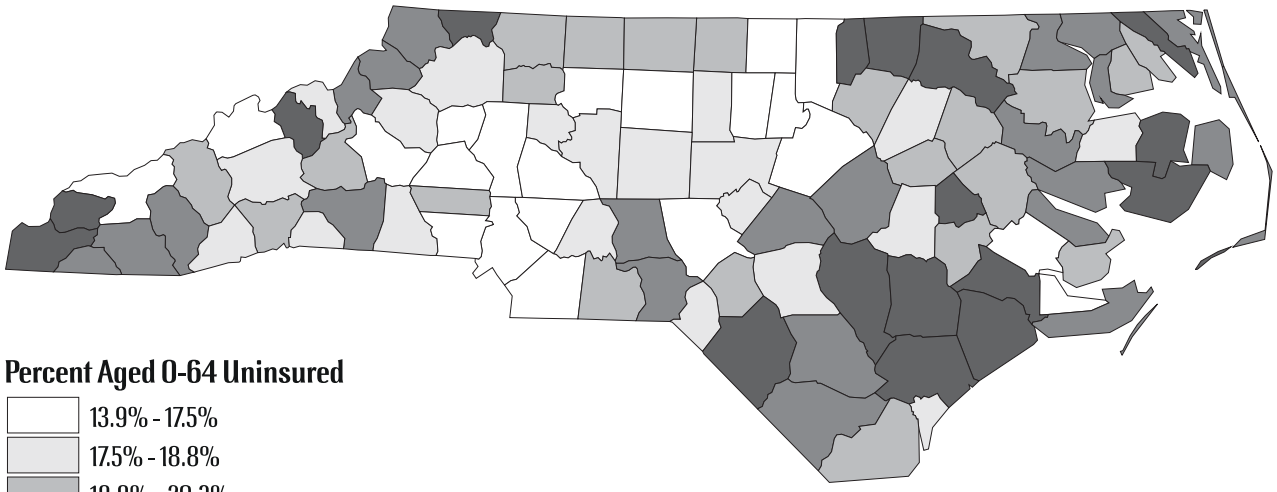
employers), the unemployment rate, and other socio-economic factors. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill used these factors to develop county-level estimates of the uninsured.[12] The uninsurance rate estimates ranged from a high of 28.3% in Tyrrell County to a low of 13.9% in Wake County in 2004.

Most of the uninsured lack coverage because of the costs.

- *The ten counties with the highest percentage of people without insurance coverage included:* Tyrrell (28.3%), Duplin (26.9%), Hyde (26.2%), Sampson (25.1%), Onslow (24.8%), Greene (24.4%), Alleghany (23.9%), Robeson (23.5%), Warren (23.4%), Camden (23.1%).
- *The ten counties with the lowest percentage of people without insurance coverage included:* Wake (13.9%), Mecklenburg (14.8%), Granville (15.0%), Swain (16.0%), Durham (16.1%), Guilford (16.2%), Orange (16.3%), Forsyth (16.3%), Union (16.4%), Cabarrus (16.5%).

See Appendix C for a complete list of county statistics on the uninsured.

Map 2.1
Percent of North Carolinians Age 0-64 Uninsured, 2004



Produced by Program on Health Econimics and Finance, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Data Source: Synthetic estimates based on Annual Social Economic Survey, US Census Bureau. (2004-2005).
Contextual Data Sources: US Census Bureau, North Carolina Employment Security Commissions, Claritas.
Full report available at http://www.shepscenter.unc.edu.

In general, people living in rural areas have a higher risk of being uninsured (21.4%) than do people living in urban areas (16.6%). Rural counties often have greater percentages of the population who are uninsured (see Map 2.1), but urban counties have greater numbers of uninsured. Approximately two thirds of the uninsured (65.7%) live in urban areas and one third live in rural areas (34.3%).

Most of the Uninsured Lack Coverage Because It Costs too Much

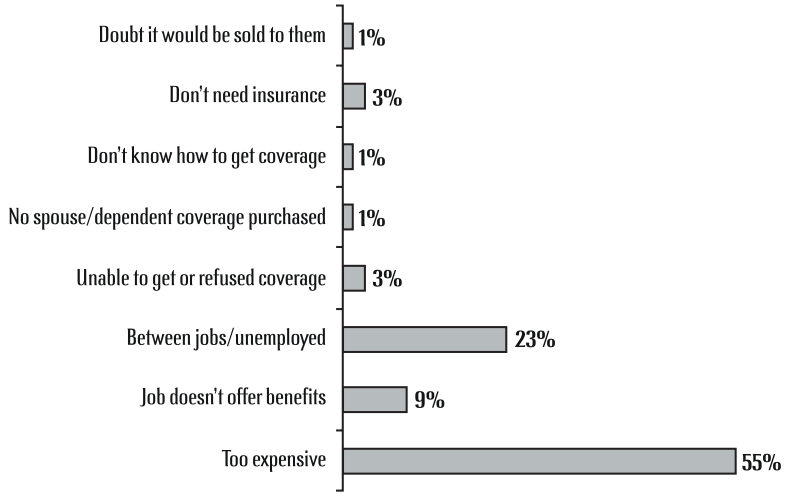
"We do surveys of why people don't take our coverage and I haven't had anyone say that 'I just don't like it.' Every single one of them said they couldn't afford it. It costs too much."

NC focus groups with employers, 2005.

People lack health insurance coverage for a variety of reasons. Some work for employers who do not offer health insurance coverage, while others may not qualify for health insurance coverage or be able to afford their share of premiums even when it is offered. Some choose not to purchase coverage when it is available. Many who are unable to purchase employer-based coverage also have difficulties affording coverage in the private, nongroup market. This is especially difficult for people with pre-existing health problems.

Most of the uninsured in North Carolina lack coverage because of the costs. In a 2005 survey of adults in the state, 55% of the uninsured reported that they lacked health insurance coverage because it was too expensive, 32% said that they did not have access to employer-sponsored insurance because either it was not offered or they were between jobs (see Chart 2.8).[13] Only 3% reported that they did not need it.

Chart 2.8
Primary Reason for Not Having Health Insurance (North Carolina, 2005)



Source: State Center for Health Statistics. Behavioral Health Risk Factor Surveillance Survey. Division of Public Health, NC Department of Health and Humans Services, Raleigh, NC. 2005. Preliminary weights.

The average total cost for employer-based coverage in North Carolina was more than $3,200 per year for an employee or $8,200 for family coverage in 2002-2003 (see Chapter 3).[14] This premium, absent any employer contribution, would constitute 36% of the gross income of an individual living in poverty for single coverage or 45% of the gross income of a family living in poverty for family coverage (2002). Individuals and families with incomes of twice the federal poverty guidelines would also have a difficult time paying the full premium costs, which would comprise 18% of gross income for single coverage, and 23% for family coverage. Even if the employee had access to employer-based insurance coverage and was only responsible for the average employee share ($558 for individual coverage or $2,200 for family coverage), this would still comprise 6% of the gross income of an individual living in poverty, or 12% of a family of four.

The cost of nongroup coverage is often even more expensive than employer-based health insurance. BlueCross BlueShield of North Carolina (BCBSNC) is the largest insurer in the nongroup market and is the only insurer in the state that will cover any individual, regardless of health status or pre-existing condition. However, the premium costs vary considerably, depending on the person's age, health status, county of residence, and chosen plan coverage (as discussed in Chapter 3). Nongroup coverage may be unaffordable to individuals unless they are young, in good health, and have higher incomes.

The Health of the Uninsured Suffers as a Result of Lacking Health Insurance Coverage

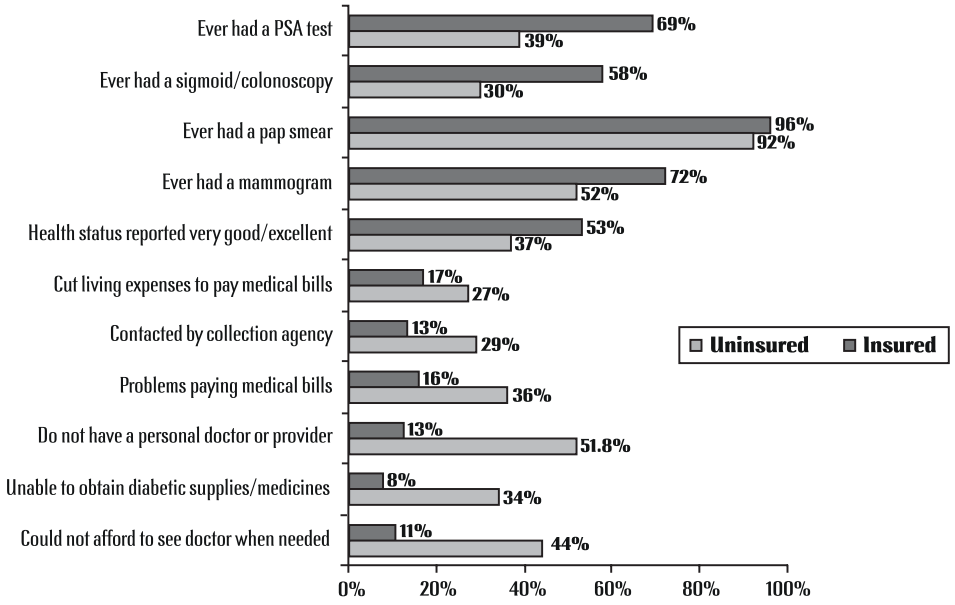
North Carolinians without health insurance are more likely to report access barriers and less likely to be able to get the healthcare services they need than people with insurance coverage.

North Carolinians without health insurance are more likely to report barriers accessing healthcare and are less likely to report getting the health services they need. The State Center for Health Statistics (SCHS), within the Division of Public Health, NC Department of Health and Human Services, conducts the Behavioral Risk Factor Surveillance Survey (BRFSS) annually, a telephone survey of 15,000 adults across the state. The survey includes questions on insurance coverage, ability to access health services, and whether respondents have ever had preventive health screenings. Uninsured North Carolinians in the 2004 BRFSS survey were more likely to report that they had no personal doctor or healthcare provider (52%) than people with insurance (13%), despite the fact that they are more likely to report being in fair or poor health (see Chart 2.9).[13] The uninsured are four times more likely to report that there were times in the last 12 months when they needed to see a doctor, but could not because of the costs (44% uninsured vs. 11% for people with insurance). Similarly, uninsured people with diabetes were more likely than those with insurance to report that there were times when they were unable to obtain either testing supplies or medicines due to the costs (49% vs. 16%, respectively). Uninsured women are less likely than insured women to report having ever had a mammogram, and of those who had a mammogram, they were less likely to report having a mammogram in the last year (45% vs. 70%, respectively). Uninsured adults who were 50 or older were less likely to report ever having a colorectal screening (sigmoidoscopy or colonoscopy), and uninsured men were less likely to have ever had a Prostate Specific Antigen (PSA) test.

In addition to experiencing difficulties obtaining needed health services, the uninsured are also more likely to report difficulties paying their medical bills, which can affect their credit rating. For example, 36% of the uninsured reported having problems paying their medical bills, compared to 16% of people with insurance coverage. Further, the uninsured are more likely than the insured to have been contacted by a collection agency in the past year as a result of unpaid medical bills (29% vs. 13%, respectively). The uninsured are also more likely than people with insurance to cut back on living expenses, such as utilities, food, clothing, housing, or transportation to pay for medical bills (27% vs. 17%, respectively).

Analyses of North Carolina hospital discharge data also show that the uninsured are about 35% more likely to be hospitalized for preventable conditions than individuals

Chart 2.9
Reported Access and Use of Selected Health Services, Access Barriers (North Carolina, 2004)*



Source: Behavioral Risk Factor Surveillance Survey, NC State Center for Health Statistics, Division of Public Health, NC DHHS, Raleigh, NC, 2004.

*All of the differences are statistically significant at $p < 0.0001$.

The uninsured delay needed healthcare services, and as a result, are more likely to be diagnosed with severe health problems. Those with chronic diseases are less likely to receive the care they need to control their conditions.

with private insurance. The uninsured are about 50% more likely to be hospitalized for asthma than those with insurance.[11]

In addition to the self-reported data in the North Carolina BRFSS, there is a rich body of research literature documenting the health consequences of being uninsured. The Institute of Medicine of the National Academies did an extensive literature review of all the research studies analyzing the health impacts of being uninsured (2002),[15] and a similar analysis was completed by Jack Hadley for the Kaiser Commission on Medicaid and the Uninsured.[16] Both analyses yielded similar results. Like the North Carolina data, national studies show that the uninsured are less likely to get preventive screenings, such as mammograms, clinical breast exams, pap smears, and colorectal or cholesterol screenings; and the uninsured, including those with chronic health conditions, are less likely to have a regular source of care.[17] However, the national studies go a step further and examine the health consequences of lacking insurance coverage. The uninsured are more likely to delay care they think they need because of the costs and are more likely to be diagnosed with severe health problems, such as late-stage cancer. Those with chronic diseases, such as diabetes, hypertension, or schizophrenia, are less likely to receive the care they need to control their conditions.[18] For example, uninsured individuals with diabetes are less likely to have regular eye or foot exams, which may prevent blindness or amputation. They also lack regular access to medications to manage health problems such as hypertension or HIV infection.

As a result of the greater difficulty the uninsured have in obtaining health services needed to control their health problems, they are more likely to end up in the hospital

Providing insurance coverage too the uninsured would increase their annual earnings by 10-30%.

for preventable health conditions.[19] Even after being admitted to the hospital, the uninsured receive fewer diagnostic and treatment services, which leads to increased risk of death.[16] The Institute of Medicine of the National Academies estimated that the uninsured have a 25% greater chance of premature death than those with insurance coverage. There are approximately 18,000 excess deaths among the nonelderly that are attributable to lack of insurance coverage.[18] The risk of dying is even higher for uninsured women with breast cancer. Their risk of dying prematurely is 30-50% higher than for women with similar characteristics who have health insurance coverage. Not only does the lack of health insurance affect health status, but it also impacts worker productivity and a child's achievement in school. The national Institute of Medicine estimated that the nation loses between $65-$130 billion every year in "health capital"[e] due to the poorer health and premature deaths of the uninsured.[20] Other estimates suggest that providing insurance coverage to the uninsured would increase their annual earnings by 10-30%.[16]

e Health capital represents the monetary value of health in future years, including the value of being alive and healthy, earning potential, and children's physical and mental development. The Coalition for American Trauma Care Washington Report. Reston, VA: The Coalition for Trauma Care. 2003. Available at http://204.3.196.9/CATC/Coalition062703.html. Accessed January 27, 2006.

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Chapter 3

Sources of Insurance Coverage

Three out of every five nonelderly people in the state are covered by employer-sponsored insurance, but the percentage of people covered by employer-sponsored insurance is declining—especially among small employers.

Although the numbers of North Carolinians without health insurance coverage have increased over the last four years, most North Carolinians have health insurance. In 2004, 61.5% of the nonelderly reported that they had employer-sponsored insurance, and 6.4% reported that they directly purchased health insurance in the nongroup market.[1] Approximately 16% of nonelderly North Carolinians are covered by Medicaid or NC Health Choice, and approximately 3% of the nonelderly have Medicare coverage.[a,b,2,3] Understanding the potential sources of coverage, possibilities of expanding coverage, and barriers to enrollment is important in developing strategies to expand coverage to the uninsured.

Employer-Sponsored Insurance

Employer-sponsored health insurance (ESI) is the primary source of health insurance coverage for nonelderly North Carolinians. In 2004, of the approximately 7.5 million North Carolinians under the age of 65, more than 61% were covered by ESI.

Even though ESI is the largest source of health insurance coverage, the proportion of individuals covered by ESI has steadily declined over the past few years. In 2000, the ESI coverage rate for all North Carolinians was nearly 68%; today it is six percentage points lower. There was a similar drop among *full-time workers*, from 79% in 2000 to 74% in 2004. This decrease has been concentrated primarily in small employers (see Chart 3.1).[2] The rate of coverage has fallen by more than one percentage point a year for *full-time workers* in firms with less than 100 employees. ESI coverage rates in larger firms are essentially unchanged over this same time frame.

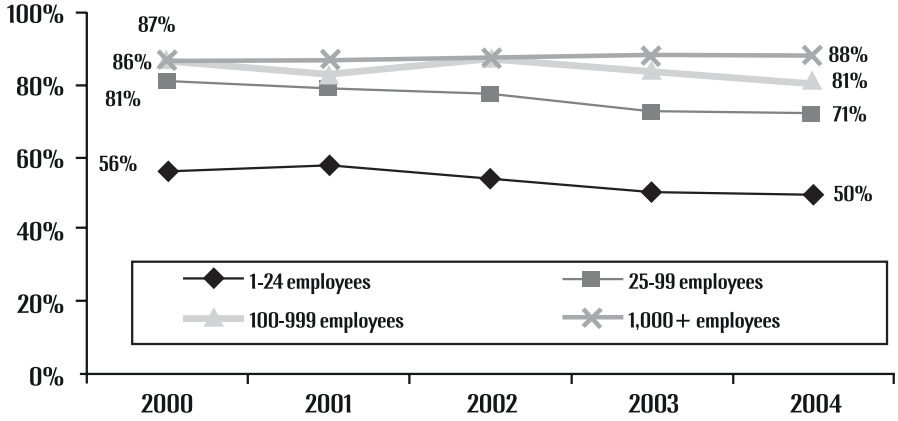
There are three factors that determine whether workers will be covered by employer-sponsored health insurance. First, an employee must work for a firm that offers insurance, or have a spouse that works for a firm with coverage. Premium costs are a major factor that employers consider in determining whether to offer health insurance coverage. Second, the employee (or spouse) must qualify for coverage. Certain individuals, such as part-time or seasonal workers, may not qualify for ESI

a Individuals can have more than one source of health insurance coverage during the year. With the exception of NC Health Choice, which is limited to uninsured children, individuals can be covered by multiple health insurance plans at the same time. For example, a working individual can receive employer-sponsored insurance and also be covered under a spouse's plan; an individual can also receive employer-sponsored insurance and Medicaid. In this latter instance, Medicaid would be the secondary payor, paying only for the services that are not covered through the employer-sponsored insurance policy. In addition, individuals can be covered by more than one plan during the year. For example, a child might be covered by NC Health Choice for part of the year and a parent's employer sponsored insurance for another part.

b The Current Population Survey historically undercounts the number of people receiving Medicaid and the State Children's Health Insurance Program benefits. Because data are available to identify the exact number of Medicaid, NC Health Choice, and Medicare enrollees, these data are reported here.

Chapter 3 Sources of Insurance Coverage

Chart 3.1
Percentage of Full-Time Workers Covered by Employer-Sponsored Insurance (North Carolina, 2000-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2000-2005 (Calendar years 1999-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2000-2005 CPS data weighted more heavily to the most recent year.

even if it is offered through the firm. Third, the employee who is offered insurance must elect coverage. One determinant of whether the employee elects coverage is whether they are or can be covered through a spouse's ESI and how the price of that coverage compares. The fact that an employee of a firm can be covered as a dependent under their spouse's ESI should be kept in mind when viewing statistics on the percent of eligible employees who are enrolled; the percent of employees who actually have coverage will be higher than the percent who are enrolled in *their* ESI. Each of these factors is discussed below.

Small employers are much less likely to offer health insurance coverage than large employers.

In North Carolina, large employers are more likely to offer coverage than small employers. Small employers (with fewer than 10 employees) are far less likely to offer health insurance coverage than other size firms (see Table 3.1).[4] On average, in 2002-2003, only 29.4% of these firms offered health insurance, compared to 67.5% of firms with 10-24 employees, 79.3% of firms with 25-99 employees, and more than 90% of larger firms in North Carolina. Overall, North Carolina employers were about equally as likely as other employers across the nation to offer health insurance coverage.

Table 3.1
Percent of Firms that Offer Health Insurance, by Size of Firm (2002-2003)

	Total	<10 employees	10-24 employees	25-99 employees	100-999 employees	1,000+ employees
NC	53.6%	29.4%	67.5%	79.3%	99.3%	98.9%
US	56.7%	36.2%	67.0%	81.7%	94.5%	98.7%

Source: Holmes M. Analysis of Medical Expenditure Panel Survey-Insurance Component. Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2002 and 2003 (Table II.A.2). Agency for Healthcare Research and Quality.

While North Carolina employers overall are about equally as likely to offer coverage as their national counterparts, North Carolina employees who work for very small firms are less likely than the national average to work in a firm that offers insurance coverage (see Table 3.2).[5] Nationally, 46.6% of employees in small firms (with fewer than 10

employees) had access to employer-sponsored insurance through their job in 2002-2003; whereas, only 36.7% of North Carolina workers in small firms work for a firm that offers insurance.

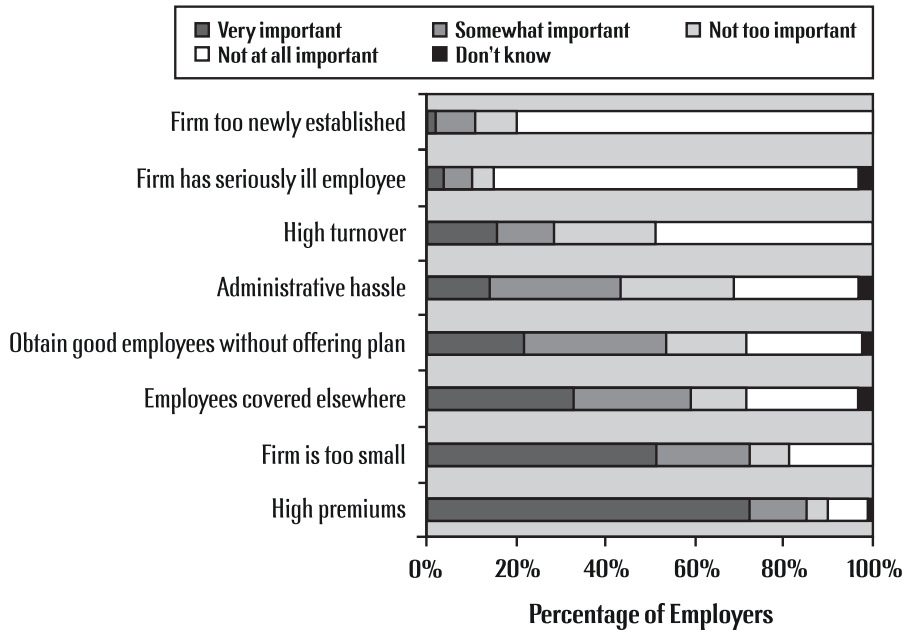
Table 3.2
Percent of Workers Who Work in Firms that Offer Employer-Sponsored Insurance (2002-2003)

	Total	<10 employees	10-24 employees	25-99 employees	100-999 employees	1,000+ employees
NC	87.3%	36.7%	67.7%	81.2%	98.8%	99.3%
US	87.6%	46.6%	71.1%	85.3%	96.2%	99.1%

Source: Holmes M. Analysis of Medical Expenditure Panel Survey-Insurance Component. Medical Expenditure Panel Survey Data (MEPS); Insurance Component, 2002, 2003 (Tables II.B.2). Agency for Healthcare Research and Quality.

The primary reason that some employers do not offer health insurance coverage is high premium costs. In a national survey of employers, 86% of employers that did not offer health insurance listed high premiums as an important reason for not offering coverage (see Chart 3.2).[6] Firm size was also an important factor: 73% noted their "firm was too small" as a reason for lack of coverage. The high cost of health insurance was also noted as a primary concern among the employers who participated in the employer focus groups conducted for this Task Force.

Chart 3.2
Reasons Employers Do Not Offer Coverage (United States, 2005)



Source: Kaiser and Health Research and Education Trust. Employer Health Benefits, 2005 Annual Survey. Chart #11.

On average, premiums for employees were approximately $3,300 per year for individual employee coverage (2002-2003) or $8,200 per year for family coverage (see Table 3.3).[7] North Carolina employees pay about the same share of premiums for individual coverage as other employees nationally, but are generally required to pay slightly more for dependent coverage.

Sources of Insurance Coverage

Table 3.3
Average Employee Premium (2002-2003)

Average premium	Total (employee share)	<10 employees (employee share)	10-24 employees (employee share)	25-99 employees (employee share)	100-999 employees (employee share)	1,000+ employees (employee share)
Employee Only						
NC	$3,289 ($558)	$3,429 ($242)	$4,154 ($626)	$3,013 ($500)	$3,512 ($546)	$3,097 ($607)
US	$3,335 ($586)	$3,700 ($452)	$3,438 ($499)	$3,300 ($600)	$3,302 ($598)	$3,280 ($615)
Family Coverage						
NC	$8,244 ($2,235)	$8,739 ($2,013)	$9,901 ($2,665)	$7,989 ($3,167)	$8,034 ($2,805)	$8,197 ($2,006)
US	$8,859 ($2,135)	$8,944 ($1,906)	$8,823 ($2,441)	$8,869 ($2,768)	$8,721 ($2,395)	$8,895 ($1,942)

Source: Holmes M. Analysis of Medical Expenditure Panel Survey-Insurance Component. Medical Expenditure Panel Survey; Insurance Component, 2002, 2003 (Tables II.C.1., II.C.2., II.D.1, II.D.2). Agency for Healthcare Research and Quality.

*Cells contain two year averages. Parentheses denotes average employee share.

North Carolina employees in all size firms are likely to enroll when they are offered health insurance coverage.

If employed in a firm that offers insurance, North Carolina employees are generally eligible for coverage and choose to enroll when offered. Employees who work for small firms are generally more likely to be eligible for insurance coverage than employees in larger firms, and are about equally likely to enroll when offered coverage (see Table 3.4).[8]

Table 3.4
Employees Eligible for Coverage, Eligible Who Are Enrolled, and Percent of All Private Sector Employees Enrolled In Firms that Offer Insurance (2002-2003)

	Total	<10 employees	10-24 employees	25-99 employees	100-999 employees	1,000+ employees
Eligible for Coverage						
NC	81.5%	87.9%	83.3%	75.1%	80.9%	82.2%
US	77.8%	81.7%	78.1%	74.5%	75.7%	78.9%
Percent of Eligible who are Enrolled in Coverage						
NC	83.4%	86.2%	79.8%	78.4%	85.5%	83.8%
US	80.7%	80.0%	77.6%	77.5%	79.7%	82.3%
Percent of All Private Sector Employees Enrolled in Coverage in Firms that Offer Insurance Coverage						
NC	68.0%	75.7%	66.4%	58.9%	69.1%	68.8%
US	62.7%	65.4%	60.6%	57.7%	60.3%	64.9%

Source: Holmes M. Analysis of Medical Expenditure Panel Survey-Insurance Component. Medical Expenditure Panel Survey; Insurance Component, 2002, 2003 (Tables, II.B.2.a, II.B.2.a(1), II.B.2.b). Agency for Healthcare Research and Quality.

For North Carolina workers who work for small firms, the problem appears to be that small employers are less likely to offer coverage. In contrast, larger firms are much more likely to offer coverage; but employees may not be eligible for that coverage. Employees in small firms are less likely to be insured because small employers are less likely to offer coverage. North Carolina employees generally are equally or more likely to have insurance coverage from their own employer than other employees nationally (see Table 3.5).[9]

Table 3.5
Percent of All Private Sector Employees Who Have Health Insurance from Their Own Employer (2002-2003)

	Total	<10 employees	10-24 employees	25-99 employees	100-999 employees	1,000+ employees
NC	59.4%	27.8%	44.9%	47.8%	68.3%	68.4%
US	54.9%	30.4%	43.0%	49.2%	58.0%	64.3%

Source: Holmes M. Analysis of Medical Expenditure Panel Survey-Insurance Component. Medical Expenditure Panel Survey; Insurance Component, 2002, 2003. Agency for Healthcare Research and Quality.

When examining employees in all firm sizes, North Carolina employees have above average coverage by ESI from their own employer as compared to the nation as a whole. Yet, ESI coverage is lower in North Carolina than the national average because North Carolina children are less likely to be covered by ESI.

Table 3.3 provides evidence that suggests North Carolina employees tend to pay slightly more for family coverage than the national average. At the same time, North Carolina median family income was lower than nationally (NC: $47,112, US: $53,692).[c,10] A recent study by Monheit and Vistnes demonstrated that roughly half of the decline nationally in dependent coverage between 1987 and 1996 was attributable to the increase in premiums for family coverage.[11] Given this relationship, one would expect that dependent coverage by employer-sponsored insurance would be slightly lower in North Carolina. Indeed, this relationship is borne out, especially with children. Only 80% of North Carolina children with at least one individual in the house with ESI had employer-sponsored insurance coverage, compared to 84% nationally.

Nongroup Coverage

According to Current Population Survey (CPS) data from 2004, North Carolinians are about equally likely to purchase nongroup coverage as their national counterparts (NC: 6.4%, US: 6.6%).[1] Individuals who purchase nongroup policies are similar to the rest of the state in terms of income, age, and employment status. However, certain groups are more likely to be covered by nongroup policies, including children and young adults 20-24 years old (particularly those working part-time). Those covered by nongroup policies also tend to be less healthy than those with group insurance.[1]

With certain limited exceptions, health insurers are not required to provide nongroup coverage to individuals with pre-existing health problems. The only exception is for people who were previously insured for at least 18 months through an employer-sponsored or governmental plan and who exhausted their COBRA continuation coverage (if applicable).[d,12] The federal Health Insurance Portability and Accountability Act (HIPAA) and state insurance laws require insurers to cover these individuals, but there is no limit on how much these individuals can be charged for their coverage.

c North Carolina was ranked low compared to other states: 41st out of the 50 states and the District of Columbia for median family income.

d The federal Health Insurance Portability and Accountability Act requires insurers to provide coverage to individuals who had 18 months of employer-sponsored or governmental health insurance, and who exhausted COBRA coverage, regardless of their health status.

BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state that will voluntarily cover *any* individual—even those who do not meet the HIPAA requirements—regardless of health status or pre-existing condition. However, the premium costs vary considerably, depending on the person's age, health status, county of residence, and health plan coverage. For example, the premium costs for a comprehensive benefit package ($250 deductible, 20% coinsurance) for a 35-year-old man could range from approximately $1,680-$15,600/year, depending on health status and county of residence.[13] The premium costs for the same policy for a 55-year-old man could range from $4,200-$36,000/year. A higher deductible plan with more cost sharing ($1,000 deductible, 30% coinsurance) would range from approximately $1,320-$12,000/year for a 35-year-old man, or between $2,880-$26,400/year for a 55-year-old man. The premium costs for women are higher, especially if a woman selects maternity coverage. For most individuals with pre-existing health problems, these premiums may be cost-prohibitive.

The cost of non-group coverage for a 35-year-old man may vary between $1,500-$15,000 per year for a comprehensive policy, depending on the person's health status. Premium prices for older individuals or women can be even higher.

Public Health Insurance Coverage

Some low-income, nonelderly individuals have access to publicly-funded insurance coverage through Medicaid, NC Health Choice, or Medicare. However, because of specific eligibility requirements (described below), they do not provide coverage to all low-income individuals.

Medicaid

Medicaid is a publicly-funded, entitlement program that provides health insurance to certain low-income individuals and families who meet specified eligibility requirements. The program costs are split between the federal, state, and county governments, with the federal government paying almost two thirds of program costs (63.4%) and the state and county paying the remainder (31.1% and 5.5%, respectively). The Medicaid program is administered through the NC Department of Health and Human Services (NC DHHS). In SFY 2004, North Carolina Medicaid program expenditures exceeded $8 billion.

To qualify for Medicaid, a person must meet specific eligibility criteria, based on categorical eligibility, income, and resources. Congress established certain categories of eligible individuals (categorical eligibility requirements) that include pregnant women, children under age 21, families with dependent children, people with disabilities, or older adults (age 65 or older). Some of these people with disabilities or older adults also qualify for Medicare ("dual eligibles").[e] Federal law also permits states to cover other individuals who would not otherwise meet the categorical eligibility requirements, such as women diagnosed with breast or cervical cancer or refugees. However, childless adults who are not disabled or elderly will not qualify for Medicaid regardless of their income. Being poor is not sufficient to qualify for Medicaid. An individual must also meet one of the categorical eligibility requirements.

e Medicare is the primary payor of Medicare-covered services for the dual eligibles (e.g., those individuals who are eligible both for Medicare and Medicaid). Medicaid is the secondary payor, and also covers Medicaid services that are not otherwise covered by Medicare (such as vision, hearing, and dental).

Sources of Insurance Coverage

In addition to categorical requirements, a person must also meet income and, sometimes, resource restrictions. Medicaid income limits vary depending on the program category (e.g., categorical eligibility) and, for children, by the age of the child.[f] For example:

- Pregnant women can have incomes no greater than 185% of the Federal Poverty Guidelines (FPG) [g]
- Children birth through age five can have family incomes no greater than 200% FPG
- Children ages 6-18 can have family incomes no greater than 100% FPG
- Families (including parents) can qualify if their income is no greater than about 37% FPG (slightly higher incomes of up to 57% of the FPG are permitted for working families)
- People with disabilities and/or people who are elderly (65 or older) can qualify if their income is no more than 100% of the FPG

Categorically eligible individuals with higher incomes may also qualify for Medicaid under a separate program category called the *medically needy program*. These individuals must incur medical bills equaling the difference between their countable income and the medically needy income limits. This is similar in some respects to a health insurance deductible; however, the amount of the "deductible" varies depending on the person's income.[h] Once the Medicaid recipient incurs medical bills equaling the Medicaid deductible, then Medicaid will pay the remaining bills.

Once an individual is deemed categorically eligible, the state also examines the individual's resources—e.g., money in the bank, other liquid assets, or real property (other than the homesite)—in determining Medicaid eligibility. The intent of the program is to save public subsidies for those most in need. Individuals who have other resources are expected to use those resources before enrolling in a public program.[i] Medicaid resource limits vary by program category.

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f The federal law establishes income eligibility thresholds, but states are free to increase the income limits for most program categories.

g The 2005 FPG is $19,350/year for a family of four. See Appendix A for the full 2005 Federal Poverty Guidelines.

h Medicaid is typically limited to individuals with incomes below the Medicaid income limits. However, some individuals with higher incomes can also qualify. Individuals who meet all the other Medicaid eligibility rules except income can qualify if they have medical bills equaling the difference between their countable income and the state's Medicaid medically needy income limits. For example: Mr. Smith is a 55-year-old man with disabilities living on $842/month in Social Security disability income. He currently meets the categorical eligibility requirements (he is disabled), and meets the resource requirements (he has no more than $2,000 in countable resources). However, his income is too high to meet the general Medicaid income limits for people with disabilities ($798/month in 2005). Mr. Smith can still qualify if he incurs medical bills equaling the difference between his income and the state's Medicaid medically needy income limits (currently $242/month for an individual). This difference is called the "spend-down" or Medicaid deductible. This spend-down is generally calculated on a six-month basis. Medicaid will pay for any additional healthcare expenses over the amount of the spend-down for the rest of the six-month period; after which Mr. Smith will have to incur new bills to meet another six-month deductible.

$842	–	Mr. Smith's monthly income
-242	–	North Carolina's Medicaid medically needy income limits
$600	–	spend-down or deductible
x 6	–	spend-down calculated on a six month basis
$3,600	–	Mr. Smith will need to incur $3,600 of medical expenses before Medicaid begins covering additional healthcare expenses.

i The Medicaid resource limits vary by eligibility category. For example, families can have no more than $3,000 in countable assets; older adults (65 or older) or people with disabilities can have no more than $2,000 (individual) or $4,000 for a couple. There are no resource restrictions for pregnant women or children.

Children are the most likely to be covered by Medicaid. As of July 2005, North Carolina's Medicaid program covered 1,138,352 individuals. Of this number, 412,470 were children, 22,850 were pregnant women, 316,143 were Temporary Assistance for Needy Families (TANF) recipients (children and caretaker relatives), 26,531 were aged, 217,882 were disabled or blind, 37,878 were under Medicare catastrophic care, and 4,598 were either in foster care, were refugees, or had breast or cervical cancer.[14]

North Carolina Health Choice

NC Health Choice (NCHC) is North Carolina's State Children's Health Insurance Program (SCHIP). Children birth through age five receive their SCHIP coverage through Medicaid; older uninsured children may qualify for NCHC if their family income is too high to qualify for Medicaid, but no more than 200% FPG. The program for older children is administered jointly between the NC DHHS and the NC Teachers' and State Employees' Comprehensive Major Medical Plan (the State Employees' Health Plan or "SEHP"). NC DHHS determines eligibility, but the benefits are administered through SEHP. Children receive comprehensive benefits that are similar to the services covered under Medicaid. However, enrollee cost-sharing is higher than in traditional Medicaid. Families with incomes in excess of 150% of FPG must pay a $50 one-time enrollment fee each year for one child or $100 for two or more children. NCHC also imposes certain copayments for different services.

Unlike Medicaid, which is an entitlement program for those who qualify, NCHC has limited funding because it is administered through a block-grant. The federal government pays 73.5% of the costs of covered services, up to a specified limit. The state pays the remaining 26.5% of NCHC costs (counties do not contribute to this program). If the program runs out of state or federal funds, it must either close the program to new enrollees or make other cuts. In fact, North Carolina was the first state in the country to impose an enrollment cap. In January 2001, the program stopped taking new applications, and 34,000 children were placed on a waiting list. Once the cap was lifted, the program began growing again, with growth around 1% per month. In December 2005, there were 134,194 children in the program.[14]

Medicare

Medicare is a federally administered and funded program that provides health insurance to almost all older adults (age 65 or older) and to certain people under age 65 with disabilities.[j] Eligibility for Medicare is not based on income and assets; instead, to qualify, an elderly or disabled individual must have worked and contributed into the Social Security system.[k] In North Carolina, there were 980,304 older adults

j Individuals cannot qualify for Medicare on the basis of a disability until they have received Social Security disability payments for 24 months. In general, in order to qualify for Social Security disability, a person must have 40 quarters of "creditable coverage," and have a physical or mental impairment that precludes a person from gainful employment and which is expected to last 12 months or end in death.

k Generally, an individual needs 40 work credits paid into the Social Security system, although they may be able to qualify with fewer work credits if they are disabled. An individual can receive up to four work credits/year. A person must have earned $920 to receive one Social Security or Medicare work credit in 2005 (or $3,680 to get the maximum of four work credits).

(age 65 or older)[15] and 225,162 people under age 65 who received Medicare on the basis of a disability in July 2003.[16] The federal government sets the program rules and pays 100% of the government's share of healthcare costs.

Without these publicly subsidized health insurance programs, many more individuals would be uninsured. Given the low-income guidelines of Medicaid and NC Health Choice, many would not be able to afford insurance in the private market.

Chapter 3  Sources of Insurance Coverage

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Chapter 4

Trends in Healthcare Costs

The increase in the percent of the population that is uninsured in both North Carolina[1] and across the nation[2] is driven by the increasing costs of health insurance premiums. Nationally, health insurance premiums increased 65% between 2000 and 2004. This rise was more than six times greater than general inflation (9.7%), and more than five times the wage growth (12.2%).[3] The increase in premiums makes it harder for employers to offer insurance to employees and for individuals to purchase healthcare coverage. Research indicates that for every 10% increase in health insurance premiums the number of firms that offer health insurance to their employees falls by roughly 2.5%.[4] As one employer noted in focus groups conducted in North Carolina in 2005, *"I want to provide it [health insurance], but I just can't because the profit margin isn't there to allow it to happen."*

The increasing cost of health insurance premiums is the number one driver of the increase in the uninsured.

Health insurance premiums are comprised of many factors, the largest of which are the medical costs covered by the plan. Most of the increase in health insurance premiums is due to the increase in the underlying costs of healthcare.[a,5,6,7,8] Healthcare costs increase for a variety of reasons, some are due to increased costs or utilization of services, and others are attributable to changes in overall disease prevalence. Each year, these factors affect overall healthcare costs in North Carolina and the rest of the country. This chapter examines trends in personal healthcare spending in North Carolina between 1990 and 2000, changes in unit costs and utilization of different services, and the effects of changes in disease prevalence and demographic changes on healthcare spending. Finally, the chapter discusses how these changes impact health insurance premiums and how employers and individuals respond to rising premium costs.

Total Personal Healthcare Spending in North Carolina (1990-2000)

Data from the Office of the Actuary of the Centers for Medicare and Medicaid Services show that North Carolinians spent $31.3 billion dollars on personal healthcare expenses in 2000.[9] Table 4.1 shows how the dollars were spent, and the increases in expenditures by service type between 1990 and 2000 (the most recent data available).

a The health insurance underwriting cycle can also have an effect on private health insurance premiums. (See page 64 for more information).

Chapter 4 Trends in Healthcare Costs

Table 4.1
Personal Healthcare Expenditures (North Carolina, 1990, 2000)

	1990	1990 % of total	2000	2000 % of total	Percent increase 1990-2000
Hospital Care	$5,905	42.8%	$12,060	38.6%	104.2%
Physician and Other Professional Services	$3,748	27.2%	$8,025	25.7%	114.1%
Dental Services	$662	4.8%	$1,508	4.8%	127.8%
Home Healthcare	$288	2.1%	$1,150	3.7%	299.3%
Prescription Drugs	$1,110	8.0%	$3,882	12.4%	249.7%
Other Nondurable Medical Products (e.g., diabetes test strips)	$546	4.0%	$679	2.2%	24.4%
Durable Medical Products (e.g., wheelchairs or walkers)	$215	1.6%	$477	1.5%	121.9%
Nursing Home Care	$1,115	8.1%	$2,524	8.1%	126.4%
Other Personal Healthcare	$208	1.5%	$979	3.1%	370.7%
Total	**$13,797**	**100.0%**	**$31,284**	**100.0%**	**126.7%**

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. North Carolina Personal Health Care Expenditures (PHCE), All Payers 1980-2000.

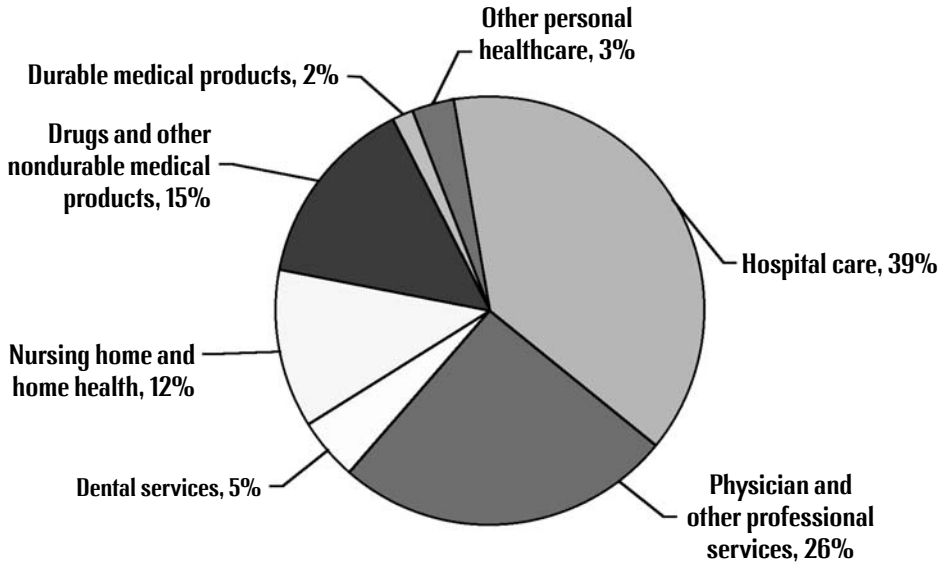
In 2000, more than one third of personal health spending in North Carolina was spent on hospital care (39%) and approximately one quarter (26%) on physicians and other professional services.[9] These expenditure rates are similar to those at the national level (36% and 29%, respectively) and accounted for more than half of the increase in total expenditures from 1990-2000. Hospital care accounted for 35% of the increase in spending, while physician and other professional services accounted for 25%. However, in recent years, prescription drugs have been one of the fastest growing components of healthcare spending. Prescription drugs accounted for 16% of the increase in overall healthcare spending between 1990 and 2000. As a result, prescription drugs constituted 12% of North Carolina personal healthcare expenditures in 2000, compared to 8% in 1990.[b] Long-term care (home health and nursing care) also constituted 12% of North Carolina personal healthcare expenditures in 2000, with spending on home healthcare increasing more than 300% since 1990.[c]

b Prescription drugs, by themselves, constituted 12.4% of personal healthcare expenditures in North Carolina in 2000, non-durable medical products accounted for another 2.2% of the state's personal healthcare expenditures. Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. United States and North Carolina Personal Health Care Expenditures (PHCE), All Payers 1980-2000.

c Long-term care expenditures, unlike most other healthcare expenses, is highly dependent on the payer. Public insurance programs, such as Medicare and Medicaid, account for a substantial portion of total spending on long-term care.

Trends in Healthcare Costs

Chart 4.1
North Carolina Personal Health Expenditures (North Carolina, 2000)



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. North Carolina Personal Health Care Expenditures (PHCE), All Payers 1980-2000.

Changes in Unit Cost and Utilization of Different Services

Expenditures for healthcare services are a function of two components: price per unit of service, and the number of units (amount of services received). Understanding whether the price or use of a service is increasing, or both, can help policymakers determine how to reduce healthcare costs. As described in more detail below, an increase in unit costs explains the rising costs of hospital inpatient care, while increased utilization explains the rising costs of hospital outpatient services and technology (particularly imaging). For prescription drugs, there has been both an increase in utilization and unit costs.[10]

Previous efforts to curb rising costs of care have focused primarily on price because it is easier to address than utilization. Providers contribute to increased utilization, as changes in technology or treatment protocols lead to increased use of certain services or procedures. Defensive medicine—or ordering unnecessary tests or procedures to prevent a potential malpractice claim—also increases utilization. Consumers' demand for services and medications also contributes to rising healthcare utilization. Controlling utilization is generally more difficult than trying to control costs because the public often views controls as restrictions on needed healthcare.[11] However, recent strategies have designed consumer cost sharing to influence patient utilization rates. By placing more financial responsibility on consumers, patients may reduce their use of unnecessary healthcare services.[12]

Trends in Healthcare Costs

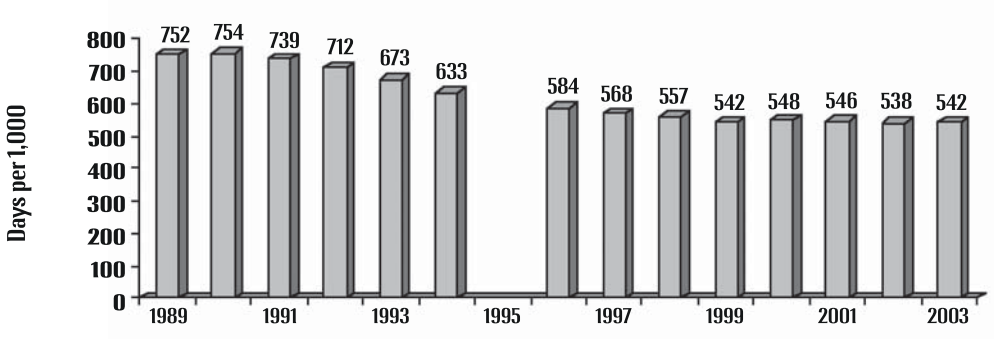
Hospital Care

Between 1990 and 2000, hospital spending increased 104% in North Carolina (see Table 4.1) and accounted for 35% of total growth in personal healthcare expenditures. Hospital spending includes that spent on both inpatient and outpatient services. National data from 2004 showed that hospital inpatient spending increased 6.2%, while hospital outpatient spending increased 11.3%.[13]

The increase in hospital services is due primarily to an increase in unit price, rather than an increase in utilization. Nationally, hospital utilization increased only 2.9% in 2004, but hospital unit cost for inpatient and outpatient services combined increased 7%.[13] On a population basis, North Carolinians are spending less time admitted as inpatients than a decade ago (see Chart 4.2). In 1989, North Carolina residents' utilization of inpatient hospital services was 752 days per 1,000 persons, compared to only 542 days per 1,000 in 2003.[14] Chart 4.2 demonstrates that most of the reductions occurred by the mid 1990s; utilization has essentially leveled off in recent years.[d,15] The most dramatic decline in utilization occurred among the elderly.

By contrast, the cost per day spent in the hospital or per admission is escalating because there are more services, treatments, and procedures provided to patients once they enter the hospital. In addition, as more nonemergent healthcare needs can be treated on an outpatient basis, inpatient utilization for those services decreases and the more intensive, higher-cost services account for a greater proportion of inpatient services, which raises costs. Further, hospital labor costs for nursing and other health professionals have increased.[16,17]

Chart 4.2
Hospital Days Per 1,000 People (North Carolina, 1989-2003)*



Sources: Admission data from Solucient, FY 1996-2003; Medical Database Commission, FY 1989-1994.

* No hospital data are available for 1995. Total admission to psychiatric, rehabilitation and substance abuse facilities (and beds) have been removed. Normal newborn admissions (DRG 391) have also been removed.

Costs for hospital outpatient care are also increasing, as the result of both higher utilization and greater unit price.[13] This increase is a reflection of more services and procedures, such as biopsies, surgeries, and chemotherapy, that are safe and

d It is important to note that the time period during which inpatient costs increased so significantly coincides with a decline in managed care. In the past, studies show that managed care was successful in suppressing spending on inpatient hospital care; particularly in lowering admissions rates and length of stay.

acceptable to be performed on an outpatient basis. In the past, some of these services would have been performed on an inpatient basis. Thus, while outpatient costs have been increasing, some of this increase in utilization helped offset the use of more expensive inpatient services. However, there is not a direct one-for-one correlation between increased use of outpatient services and decreases in inpatient utilization. Further, unit costs for outpatient care are not as well controlled as costs for inpatient care, where the use of diagnosis related groups (DRGs) or similar prospective payment methods limit charges per admission.[e]

Are New Imaging Technologies Cost Effective?

While new technology and innovation is adding to healthcare costs it is critical to understand if these additions are cost effective. Determining the cost effectiveness of medical innovations is a challenging research task that few studies have undertaken. Cutler and McClellan studied the effectiveness of new treatment regimens for five conditions: heart attacks, low-birth weight infants, depression, cataracts, and breast cancer. New and improved treatment practices, involving technology and new procedures, have evolved for these conditions in the past several decades. Cutler and McClellan's research focused on determining if these new advances proved to be cost effective. Assumptions were made on the value of survival per year, and costs of treatment were subtracted out. The results showed that new treatments for heart attacks, low-birth weight infants, depression, and cataracts were cost effective. With respect to breast cancer, however, studies showed conflicting evidence on cost effectiveness of new treatments. This type of research, while challenging to conduct, is important to drive treatment and policy decisions in a very expensive healthcare system.[19]

Technology

Greater availability and use of technology are also significant healthcare cost drivers.[18] Imaging has been one of the most significant technological advances in medical care. X-rays, introduced in 1895, were the first form of imaging. Newer forms of imaging, emerging in the late 20th century, include computed tomography (CT), magnetic resonance imaging (MRI), and positron emission tomography (PET). The current (2004) cost of a CT scan is over $1,200, an MRI is generally just under $2,000, and a PET scan costs approximately $2,300.[10]

The availability of freestanding MRI and CT scans is associated with higher utilization and spending on these services.[18] However, the use of these imaging technologies for diagnosis has generally proven to be additive rather than substitutive. A clinician may first order an x-ray or CT scan, and then order another imaging technology, such as an MRI, to confirm or further investigate a suspected malady.[18] Therefore, while a diagnosis may be more accurate, the costs associated with determining that diagnosis are increasing.[19] The latest imaging technology, PET, uses radioactive substances to examine body functions, and it is increasingly used to screen for cancer and heart disease despite professional disagreement over some specific uses of this scanning technique. Between 1970 and 1985, North Carolina had only three PET scanners in the state, located at the largest hospitals. However, since 1985, 16 more PET scanners have been approved, and now all teaching hospitals have at least one PET scanner. Moderate size hospitals are also applying for their use. This pattern of diffusion is typical for a new technology and will result in rising costs because of the wider availability of the scanners.

e Diagnostic related groups (DRGs) is a hospital payment system used by Medicare and many third-party insurers. It prospectively sets the hospital payment based on the patient's primary and secondary diagnosis, surgical procedures, age, sex, and the presence of complications.

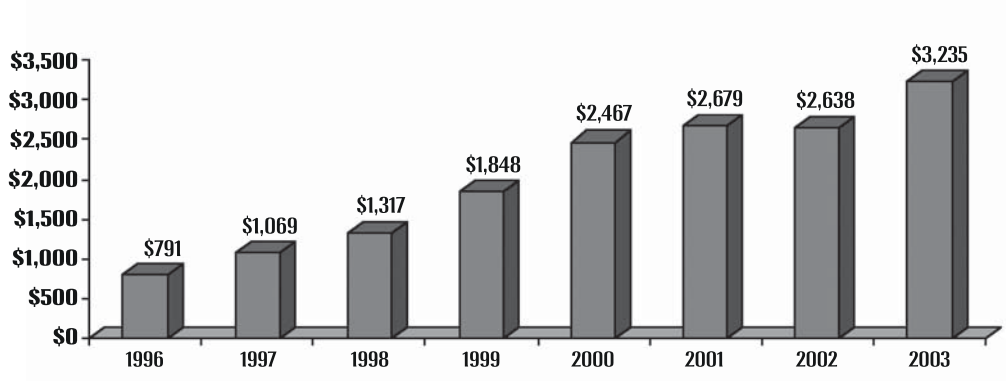
Prescription Drugs

The rising cost of prescription drugs is also a major contributor to increasing healthcare costs. In North Carolina, expenditures for prescription drugs increased 250% between 1990 and 2000 (see Table 4.1). More recent national data show that prescription drug expenditures increased 47% between 2000 and 2003.[20] Both public and private insurance programs have experienced double digit annual increases in prescription expenses.[21] This increase is due both to rising cost per prescription and an increased number of prescriptions filled.[13]

The rising costs of medications may be explained, at least in part, by the introduction of new medications into the market. The National Institute for Health Care Management (NIHCM) conducted a study of 1,035 new drug applications to the Federal Drug Administration between 1989 and 2000 and found that only 35% contained new active ingredients, while the remainder contained active ingredients already available on the market.[22] Furthermore, only 24% of the drugs offered clinical improvement. Of all the new drug applications, only 15% were both highly innovative and offered significant clinical improvement. In addition, of the $67.4 billion increase in spending on prescription drugs between 1995 and 2000, only 33% of the expenditures were spent on the pharmaceuticals that offered clinical improvements over existing prescription drugs. This raises questions about the cost effectiveness of the increased spending on pharmaceuticals.

A significant factor in the high utilization of new prescription drugs is direct-to-consumer (DTC) advertising (see Chart 4.3).[23] DTC advertising is a successful marketing tool; drugs that are heavily advertised experience a significant increase in their use.[24] Yet, there are a number of concerns about such advertising techniques. Advertisements generally contain limited information concerning side effects and promote expensive brand name drugs over generics. Patients who see these ads may exert pressure on their physicians to prescribe drugs they have seen advertised, and this may lead to use of higher cost drugs, rather than generic versions, and, in some cases, could lead to inappropriate clinical use.

Chart 4.3
Direct-to-Consumer Advertising (DTC) Spending, in Millions (United States, 1996-2003)



Source: IMS Health, Total US Promotional Spend by Type. 2004.

Malpractice

Rising malpractice premiums have been noted as a problem for some physicians in particular specialties and geographic areas. It may also negatively affect patients living in areas where physicians are no longer practicing as a result of high premiums. Malpractice also contributes to rising healthcare costs because it leads to defensive medicine. Physicians may order unnecessary tests or procedures, or avoid some high-risk patients out of fear of potential malpractice liability.[25] It is difficult to fully quantify the costs of defensive medicine, but several recent studies suggest that malpractice costs are not one of the primary contributors to the rising costs of healthcare. One study reported that only 7% of the annual increase in healthcare costs can be attributed to litigation and risk management,[26] while another showed that malpractice costs account for a very small proportion of healthcare premium costs.[27]

Changes in Disease Prevalence and North Carolina Demographics

Changes in the prevalence of certain health problems underlie some of the increased use of health services. Trends in national healthcare spending are linked to the treatment of certain health conditions. Almost one third of the change in healthcare spending between 1987 and 2000 was attributable to the treatment of five major health problems: heart disease, mental disorders, pulmonary disorders, cancer, and trauma.[28] Approximately half of the increase in health spending was attributable to 15 conditions. Increases in the overall population, costs per treated case, and treated prevalence contribute to the increase in spending (see Table 4.2).

The increase in treated prevalence was the primary factor underlying increased spending on cerebrovascular disease (60%), mental disorders (59%), pulmonary conditions (42%), and diabetes (50%).[f] In contrast, the increased cost per treated case was the primary factor underlying greater spending on trauma (169%), pneumonia (94%), infectious diseases (95%), and heart disease (69%). Overall population growth generally accounted for 20-30% of the changes in healthcare spending for any specific condition.

Certain lifestyles choices and lifestyle-related illnesses contribute to these healthcare problems. Smoking, heavy drinking, and obesity[g] can lead to chronic health problems and, as a result, increased healthcare costs.[29] The growing epidemic of obesity is a major contributor to the rising healthcare costs. Obese people have a higher risk of developing certain health problems, such as diabetes, hypertension, and heart disease. According to 2001 figures, 24% of the US population is obese, an increase of ten percentage points since 1987.[30] The increased prevalence in obesity alone accounted for 12% of the real per capita spending growth between 1987 and 2001. Sturm analyzed self-reported health risk data from a national household survey, and compared this to reported inpatient, outpatient, and prescription drug utilization. He found that obesity increased healthcare and medication costs by 36% and 77%, respectively, compared to someone with a normal weight.

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Table 4.2
Change in Nominal Healthcare Spending for the Fifteen Most Costly Medical Conditions (United States, 1987-2000)

		Percent change in spending attributable to		
Condition	Total change in spending (millions)	Increased cost per treated case	Rise in treated prevalence	Increased population
Heart disease	$26,228.50	68.6%	1.1%	30.3%
Pulmonary disorders	$24,792.00	37.5%	41.9%	20.6%
Mental disorders	$24,503.30	21.1%	59.2%	19.7%
Cancer	$17,734.30	41.9%	27.4%	30.7%
Hypertension	$15,385.80	59.8%	18.9%	21.3%
Trauma	$14,596.60	169.1%	-108.5%	39.5%
Cerebrovascular disease	$11,078.90	20.8%	60.3%	18.9%
Arthritis	$10,282.80	44.3%	31.6%	24.1%
Diabetes	$9,626.80	23.6%	49.8%	26.6%
Back problems	$9,486.40	21.7%	52.6%	25.8%
Skin disorders	$7,286.50	54.8%	22.0%	23.2%
Pneumonia	$7,203.80	93.8%	-18.4%	24.6%
Infectious disease	$6,191.60	95.2%	-17.5%	22.3%
Endocrine	$5,029.10	28.0%	43.4%	28.6%
Kidney	$3,231.40	8.8%	55.8%	35.4%

Source: Thorpe KE, Florence CS, and Joski P. Which Medical Conditions Account for the Rise in Health Care Spending? Health Affairs. Web Exclusive. August 25, 2004;W-4-437-445. Exhibit 3.

Obesity has a much greater effect on the prevalence of chronic conditions than current or past smoking and problem drinking. However, current or past smoking also increased healthcare service costs 21% and medication costs 28-30%, depending on whether the individual was a current or past smoker. Compared to obesity, which increased absolute inpatient and ambulatory care costs by $395 per year, current or ever smoking was associated with a $230 increase, and problem drinking was associated with a $150 increase.[29]

Task Force members thought that one of the best strategies to reduce overall healthcare costs was to encourage people to live healthier lifestyles. The incidence of chronic diseases, and ultimately, healthcare spending could be decreased significantly if people would stop smoking, exercise regularly, maintain a healthy weight, and reduce other risky behaviors. While this may not yield immediate savings, it will help reduce healthcare costs over a longer period of time.

f Depending on the condition, the increase in treated prevalence can be due to an increase in epidemiological prevalence of the condition (e.g., diabetes) or to the rate of treatment for a particular condition (e.g., mental health).

g In July of 2004, the US Department of Health and Human Services announced its Medicare coverage policy would treat obesity as an illness. Obesity is defined as having a body mass index (BMI, calculated as weight in kilograms divided by height in meters squared) that is 30 or more.

Trends in Healthcare Costs

People have a personal responsibility to be better stewards of their own health, but society at large can assist in that effort. Thus, the Task Force recommends:

Recommendation 4.1:

a) Individuals have a responsibility to understand their health needs and risks and to be better stewards of their own health. To promote healthy lifestyles:

   i) Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and they should use these resources to make healthy choices.

   ii) Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions in a manner consistent with best known evidence-based care.

   iii) Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.

b) Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.

   i) Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness-related services (such as smoking cessation) as a basic benefit.

   ii) Providers should educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.

   iii) Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e., access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.

   iv) Schools should also establish healthful policies and environments, including healthy food in cafeterias; opportunities for all youth to be active daily at school; tobacco-free policies; and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.

   v) Public health should continue and expand community-wide health awareness, promotion, nutritional information, and disease prevention activities.

   vi) Communities and governments should help support healthy communities by providing environments conducive to healthy lifestyle choices (including, but not limited to, walkways, bicycle paths, safe parks, and green spaces).

c) The NC General Assembly should adequately fund the public health system and infrastructure to provide community education and outreach related to lifestyle choices as well as health promotion and disease prevention, in accordance with the recommendations reported in the Public Health Improvement Plan developed by the NC Public Health Task Force (2004).

Population demographics can also affect healthcare spending. For example, adults over the age of 65 years spend more per capita on healthcare than younger individuals. Therefore, as the overall population ages, healthcare spending also increases. For example, increasing age by 20 years would increase the cost of inpatient and ambulatory care by 20% and medication costs by 105%.[29] However, the aging of the overall population is modest from one year to the next, so while it may have a long-term impact on costs, it does not significantly contribute to spending increases from year to year.

Impact of Rising Healthcare Costs on Health Insurance Premiums

The increase in the underlying healthcare costs is the primary contributor to the increase in health insurance premiums. However other factors, such as fluctuations in insurance underwriting profits[h] and rising numbers of uninsured, can also lead to increased premiums. Studies to determine the effects of the insurance underwriting profits on premiums compared premium increases of fully-insured and self-insured plans. The results found almost no effect of underwriting profits between the Springs of 2004 and 2005. However, underwriting profits grew substantially between 2003 and 2004 when premiums increased 11.2%, but medical claims expenses only rose 7.4%.[7,8]

The rising number of uninsured individuals also leads to increased costs for those with insurance coverage, as the costs of treating the uninsured are shifted to those with insurance coverage. One study found that the cost of uncompensated care received by the uninsured will be valued at over $1.3 billion in North Carolina in 2005 ($43 billion, nationally). These costs will be borne by insured individuals. The effects of these uncompensated costs in North Carolina increased 2005 premium costs for employer-sponsored insurance by $438 for individuals and $1,130 for families. This burden for uncompensated care is much higher than surrounding states where the individual costs increased by $277 in Virginia, $272 in Tennessee, $275 in Georgia, and $202 in South Carolina. It is also higher than the national average of $341 for individuals and $922 for families.[31]

One of the most closely watched measures of changing healthcare costs is the national Mercer/Foster Higgins survey of health benefit costs among public and private employers. This survey represents 600,000 employers with at least 10 employees and

h The underwriting cycle is pattern of underwriting gains and losses, reflecting insurers' strategies either to undercut premium prices to gain market share or to increase premium prices to boost profitability. The underwriting cycle led to large swings in insurance prices in the 1980s, which became more muted with the advent of managed care in the 1990s. A recent study of the health insurance underwriting cycles suggests that the swings will continue to be muted, as consolidation in the health insurance industry will lead to less price competition, and better price forecasting ability enables insurers to set premium prices closer to actual healthcare costs. Grossman JM, Ginsburg PB. As the health insurance underwriting cycle turns: What next. Health Affairs 2004;23(6):91-102.

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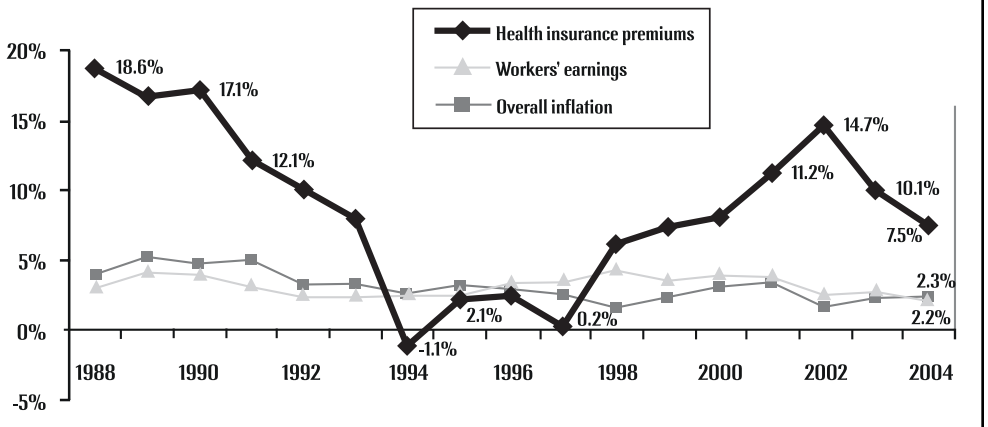
more than 90 million full- and part-time employees.[i] Chart 4.4 illustrates changes in the total cost of healthcare benefits from 1988 to 2004.[3] With the exception of a few years of modest increases during the mid 1990s, the cost of health insurance premiums substantially increased each year since the late 1980s. Healthcare inflation increased at a greater pace than the general rate of inflation. Recently, those increases have moderated and in 2004, benefit cost increases were 7.5%, down from increases of 10.1% and 14.7% in 2003 and 2002, respectively. While still significantly above inflation, it is the lowest annual increase in five years. However, there is concern that this recent moderation in benefit cost increases underestimates the true cost escalation in the healthcare system. Rather than increasing premiums, many employers have shifted some of the healthcare costs to employees through increased out-of-pocket expenses, such as deductibles and copays. Chart 4.4 does not reflect the total increase in healthcare costs because it does not include out-of-pocket expenses.

The survey also reports total health benefit cost per employee, which steadily rose over the past ten years. Cost per employee, as presented in Chart 4.5, includes both the premium paid by the employer as well as the portion paid by the employee, but it does not include changes in out-of-pocket costs.[3] Excluding out-of-pocket expenses, the total annual cost per employee in 2004 ($6,679) was nearly twice as much as in 1994 ($3,644).

Chart 4.4
Changes in Health Insurance Premiums, Inflation, and Workers Earnings (United States, 1988-2004)



Source: Mercer/Foster Higgins National Survey. (1988-2004). Wage data from: US Department of Labor. Bureau of Labor Statistics. Average Hourly Earnings of Production Workers, Seasonally Adjusted. April data 2000-2004. General inflation data from: US Department of Labor. Bureau of Labor Statistics. Consumer Price Index. All Urban Consumers. Not Seasonally Adjusted. April data 2000-2004.

i Results of another national survey conducted by the Kaiser Family Foundation (Kaiser) and Health Research and Education Trust (HRET) results in somewhat different estimates of premium increases. For example, in 2004, the Kaiser/HRET study showed an 11.2% increase from 2003. This study includes employers with three or more employees. The Mercer Foster Higgins study also includes public programs. These differences in study design help explain the different estimates of premium increases.

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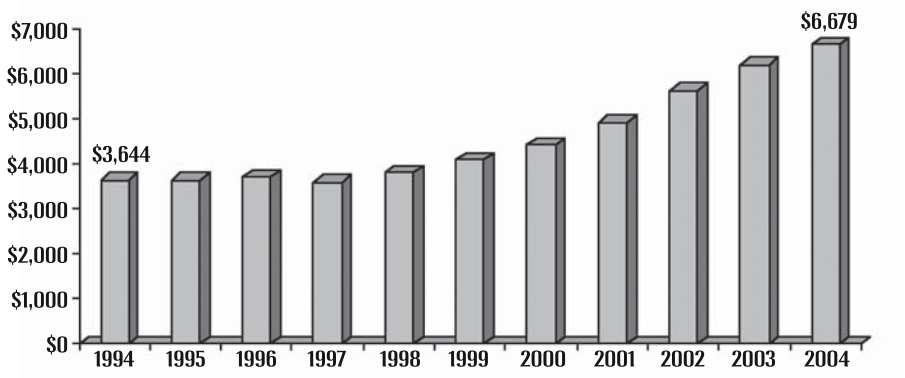
Chart 4.5
Total Health Benefit Cost per Employee (United States, 1994-2004)



Source: Mercer/Foster Higgins National Survey. (1988-2004).

Employer Reactions to Cost Increases

Employers have used different strategies to moderate the rising costs of health insurance. A survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust in 2005 reported that employers increased the employee share of individual premiums by 82% from 2000 to 2005, with a 67% increase in the employees' share of family coverage. The average inpatient deductible for a preferred provider organization (PPO) increased 85% since 2000.[j,32] Hospital-specific deductibles are also becoming more common, with half of all covered workers subject to a hospital-specific deductible. Further, 10% of workers face a separate deductible for drug coverage, and multi-tier cost sharing for prescription drugs is almost universal. The multi-tier cost-sharing policy generally requires workers to pay higher co-pays for preferred or nonpreferred brand-name drugs compared to generic drugs.[8]

One fifth of all employers are now offering high-deductible health plans, which have at least a $1,000 deductible for single coverage or $2,000 deductible for family coverage. High deductible plans can be coupled with health reimbursement accounts (HRA) or health savings accounts (HSA), which would allow employees to save earnings tax free to cover healthcare costs.[k] However, few employers are offering HRA or HSA options in conjunction with the high-deductible plans.

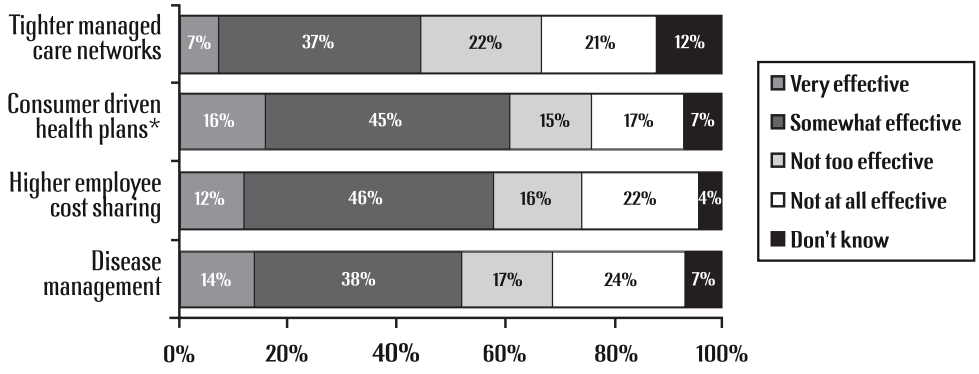
A survey of employers indicates that many believe shifting costs to the employee is an effective way to control rising health insurance premiums (see Chart 4.6).[33] Past studies suggest that higher out-of-pocket costs do deter utilization, but that individuals are equally likely to forgo necessary care and unnecessary care.[34] This is a particularly

j In many plans, certain health services are excluded from the deductible. For example, insured individuals in copayment plans generally do not have to pay a deductible for physician visits. Almost two thirds (63%) of insured workers belong to plans that exclude certain preventive services from the deductible.

k Health Reimbursement Accounts (HRA) are high-deductible policies combined with a pretax spending account. Employers may contribute to the savings account. Employees can use funds to pay for healthcare services; withdrawals are not subject to taxes or penalty if used for healthcare services. Employees may not contribute, and the funds are not portable (e.g., the employee will not have access to the funds after he or she leaves employment.) Health Savings Accounts (HSA) are similar, but both the employer and employee can contribute to the savings account with pretax dollars. Further, the savings account is portable and will follow the employee if he or she leaves employment.

Trends in Healthcare Costs

Chart 4.6
Employers Opinions on the Effectiveness of Different Cost Containment Strategies (United States, 2005)



Source: Kaiser Family Foundation and Health Research and Education Trust. Employer Health Benefits 2005 Annual Survey. Exhibit 12.5.

*Consumer Driven Health Plans include high deductible plans with a personal or health savings account.

significant problem for low-income people, who are more likely to forgo necessary care and suffer adverse health outcomes. Employers are also trying to control rising healthcare costs by managing high-cost claims. A small percentage of the population accounts for the majority of spending on healthcare. In 1996, approximately 5% of the population accounted for 55% of the spending, and 30% of the population accounted for 90% of the spending. This trend has been consistent over time.[35] (see Table 4.3)

Table 4.3
Distribution of Healthcare Spending (United States, 1996)

Expenditures	Share of total healthcare spending
Top 1%	27%
Top 2%	38%
Top 5%	55%
Top 10%	69%
Top 30%	90%

Source: Berk ML, Monheit AC. The concentration of healthcare expenditures, revisited. Health Affairs 2001;20(2):9-18.

People with chronic conditions are included in the high-cost groups, and many employers are trying to manage the high costs of chronic conditions through disease management (DM) programs. More than four fifths of covered workers (81%) are in a plan that uses case managers to manage high-cost claims. More than half (56%) of all workers with employer-sponsored health insurance are in a plan with at least one disease management program. Of those covered by disease management programs, most workers are covered by programs that manage diabetes (99%), asthma (86%), hypertension (82%), and high cholesterol (66%).[36] Fifty-two percent of employers surveyed in 2005 indicated that disease management was a very or somewhat effective strategy to control rising healthcare costs,[33]

although a review of studies examining the return on investment of disease management programs shows mixed results.[l,37]

Increased Premiums and the Impact on the Uninsured

In the 1990s, rising health insurance premiums accounted for more than half of the increase in the percent uninsured across the nation.[38] More than half (55%) of the uninsured in North Carolina reported that they lacked health insurance coverage because it was too expensive.[39] In 2005, the average annual premium in North Carolina for an individual was $4,097 and for families was $10,570.[31]

Although the charge to the Task Force was to develop options to expand health insurance coverage to the uninsured, the Task Force was cognizant of the need to reduce overall healthcare spending. Without meaningful cost containment efforts, healthcare costs will continue to increase and lead to more uninsured. The Task Force developed proposals to reduce healthcare premiums through reduced benefit packages and more consumer cost sharing. The limited benefit plans focus on primary care and preventive services in order to diagnose and treat patients in the least costly healthcare setting. Many of the proposals also include disease and case management initiatives, to help people with high-cost health conditions better manage their health. Additionally, the Task Force also wants to reward healthy lifestyles, so several of the proposals have included reduced premiums for nonsmokers and have included suggestions about how additional lifestyle incentives can be included in the programs in the future.

The Task Force members realized that additional work was needed to identify strategies to reduce healthcare spending and, ultimately, health insurance premiums. Therefore, the Task Force recommends:

Recommendation 4.2: The NC General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs to lower overall costs for private and public healthcare plans.

l A recent Cornell-Medstat study was unable to determine whether disease management programs deliver a return on investment. A review of 44 studies analyzing the economic impact of DM programs found mixed results for those targeting depression, diabetes, and asthma, which are the most common diseases targeted. However, those programs targeting congestive heart failure and multiple chronic conditions were more likely to be successful.[37]

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Chapter 5

Private Options to Increase Health Insurance Coverage

Employer-sponsored health insurance is the primary source of health insurance for North Carolinians under the age of 65. In 2005, approximately 61% (4.5 million) of nonelderly North Carolinians were covered by employer-sponsored health insurance. However, this reflects a 9% decline in the percentage of North Carolina employees covered by employer-sponsored insurance since 2000. This drop has been concentrated among small employer groups with less than 25 employees. In developing strategies to reduce the number of uninsured in our state, it is important to understand why this population has such difficulty accessing employer-sponsored health insurance and what options may improve access.

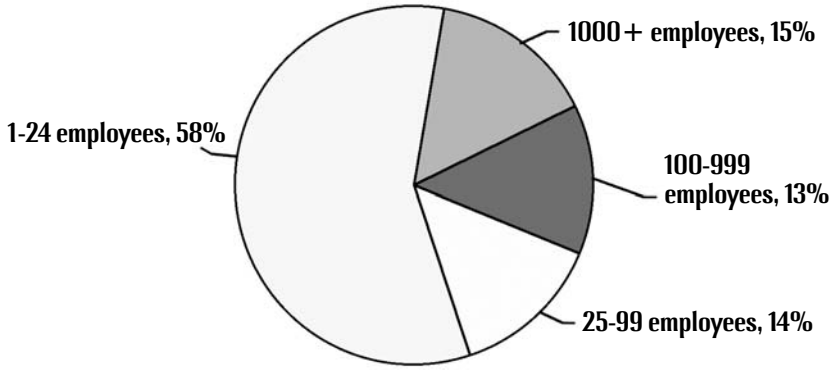
Workers in Small Firms

Employees of small firms are much less likely to have health insurance through their job than employees of large firms.

Thirty percent of the working population in North Carolina works in a small firm with fewer than 25 employees.[1] The population of full-time employees in small firms has a much lower rate of coverage under employer-sponsored insurance than full-time employees in large firms. Only 51% of full-time workers in small firms were covered by employer-sponsored insurance, compared to 89% of workers at large firms.

Although some workers can access health insurance coverage through their spouse or a public program, 34% of all full-time workers in small firms are uninsured, compared to 6% of workers in the largest firms. As a result, full-time, uninsured workers in small firms account for more than half (58%) of all uninsured, full-time workers in North Carolina (see Chart. 5.1).[1]

Chart 5.1
Uninsured Full-Time Workers by Firm Size (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey 2004-2005 (CPS) (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004-2005 CPS data weighted more heavily to the most recent year.

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North Carolina small-firm employees are less likely to be offered health insurance by their employer than nationally (see Table 5.1), but those who are offered insurance are more likely to enroll than other employees nationally.[2] There are many potential reasons why North Carolina small employers may be less likely to offer health insurance to their employees. Higher health insurance premiums could be one reason for lower offer rates. In fact, North Carolina has higher health insurance premiums for small employers than nationally. Combined data from 2002 and 2003 indicate that the average total premium for North Carolina small firms with fewer than 50 employees was $3,597 per year, compared to a national average of $3,499 (see Table 5.1). By contrast, the average premium for larger firms with at least 50 employees was lower in North Carolina ($3,206) than it was nationally ($3,286).

Table 5.1
Health Insurance Offer Rates and Average Premium Costs in Businesses with Fewer than 50 Employees (2002-2003)

State	Percent Offered Coverage	Average Premium Cost	Percent Who Are Offered Who Enroll
North Carolina	**57.2%**	**$3,597**	**67.6%**
United States	62.6%	$3,499	61.0%

Source: Holmes M. Analyses of 2002 and 2003 Medical Expenditure Panel Survey; Insurance Component, 2002, 2003 (Tables II.B.2, II.C.1, II.C.2). Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends.

Of course, there are many factors driving healthcare costs and thus health insurance premiums.[a] Evaluating the causes of higher health insurance premiums was beyond the scope of the Task Force's charge. However, the fact that the average premium for large employers is below the national average yet the average premium for small employers is above the national average leads one to question whether statewide factors are responsible for the higher small employer premiums. One would expect that factors affecting the state as a whole, such as physician practice patterns, would affect all premiums, not just those in small groups. Regardless of the exact cause, this fact demonstrates one potential cause of the financial pressures inhibiting small employers from offering health insurance coverage.

Policy Options

Healthy North Carolina

Due to the relative difficulty workers at small firms have accessing employer-sponsored health insurance, the Task Force chose to focus its energy on developing health insurance options that would encourage small employers to offer employer-sponsored insurance to their employees. The Healthy North Carolina program is one such option. A Healthy North Carolina program was discussed in Senate Commerce Committee in the 2005 Session as a Proposed Committee Substitute to Senate Bill 255 (PCS to First Edition S255-CSRD). As outlined in PCS 255, Healthy North Carolina was designed to emulate the Healthy New York (Healthy NY) program, which is a public-private

a See, for example, Chapter 4 in this report on Healthcare Cost Drivers.

partnership that utilizes government reinsurance to reduce the cost of health insurance products on the private market for uninsured individuals, small employers, and self-employed/independent contractors that meet certain eligibility requirements.[b]

The Healthy NY program has two main components (see Appendix G for full summary of the Healthy NY program).

1 The program is targeted to the types of workers considered to be most at risk of being uninsured: small businesses with fewer than 50 employees, where 30% of employees earn wages of $33,000 or less and the employer has not offered health insurance coverage in 12 months; individuals meeting income eligibility requirements who do not have health insurance, have been employed in the past 12 months, and are not eligible for public insurance or other group coverage; and sole proprietors[c] meeting income eligibility requirements who have not had health insurance for the past 12 months.

2 The state acts as a reinsurer, reimbursing private health plans for 90% of claims falling within a certain range of claims costs, from $5,000 to $75,000, called the "reinsurance corridor." This reinsurance reduces the expected medical costs to the health plan, allowing private insurers to reduce premiums for the product, compared to similar products offered in the private market.

The Healthy North Carolina program proposed in PCS to First Edition S255-CSRD was developed based upon the Healthy NY program. The proposed Healthy North Carolina program and the existing Healthy NY program differed on both of the points above. That is: (a) the Healthy North Carolina proposal did not include income eligibility criteria to target low-income individuals, and (b) the reinsurance corridor outlined was different. There were other important differences between the proposed North Carolina program and the New York program. Specifically, the benefit design proposed for North Carolina was rich, in terms of covered services and level of coverage, as compared to the existing private, small-group market, while the benefits under the New York program are pared back from the private, small-group products in that state. In addition, the proposal for North Carolina was based on a requirement that all health insurers would participate in the program, while the New York program is based solely upon health management organization (HMO) plans. These differences will impact the size of the program's premiums.

The following outlines the three categories of groups eligible to enroll in the Healthy North Carolina program as outlined in PCS 255.

1 *Small employers* qualify if they meet all the following characteristics.

- Employ fewer than 50 employees in North Carolina.
- Did not offer employer-sponsored insurance in the previous 12 months.

b In 2000, the State of New York instituted Healthy NY, a program aimed at increasing health insurance coverage for citizens of New York. Available at www.healthyny.com. Accessed January 11, 2006.

c The Healthy NY program defines sole proprietor as "the sole owner and employee of a business." This is the meaning of the phrase in this chapter, as opposed to the legal classification of a business (e.g. contrasted with "corporation" or "partnership").

- Assure that 75% of eligible employees participate.
- Contribute at least 50% of the premium.

2 *Individuals* would qualify if they meet all the following characteristics.

- Are currently employed.
- Have no group coverage and are not eligible for employer-sponsored group coverage and/or Medicare.

3 *Self-Employed/Independent Contractors* would qualify if they meet all the following characteristics.

- Are not currently insured.
- Have not been insured in the previous 12 months.
- Are not eligible for employer-sponsored coverage.

The benefit package outlined in PCS 255 is somewhat broader than the typical small group plan in North Carolina and, more significantly, provides for higher levels of coverage (through lower deductibles, copayments, and co-insurance) than products currently offered to small groups. Covered services would include hospital care, outpatient care, physician services, maternity services, preventive care, diagnostic and laboratory services, emergency care, therapeutic care, and blood and blood product coverage. Deductibles and copayments outlined in the proposal are listed in Table 5.2.

Table 5.2
Proposed Healthy North Carolina Benefit Deductibles and Copayments (PCS 255)

Inpatient hospital services	$500 copayment per hospitalization
Surgical services	Copayment of the lesser of either 20% of the cost of the service, or $200.
Outpatient surgical facility charges	$75 copayment
Emergency department services (ED)	$50 copayment, waived if hospitalized following ED visit.
Pre-natal care	$10 copayment
All other services	$20 copayment

The proposal in PCS 255 also required an annual evaluation of the program to be conducted by an independent contractor and paid for with fund monies. The evaluation would analyze program enrollment, the relationship between premium levels and program enrollment, and program cost experience. The contractor would also conduct surveys of covered members, participating insurers, and qualifying small employers, individuals, and self-employed persons.

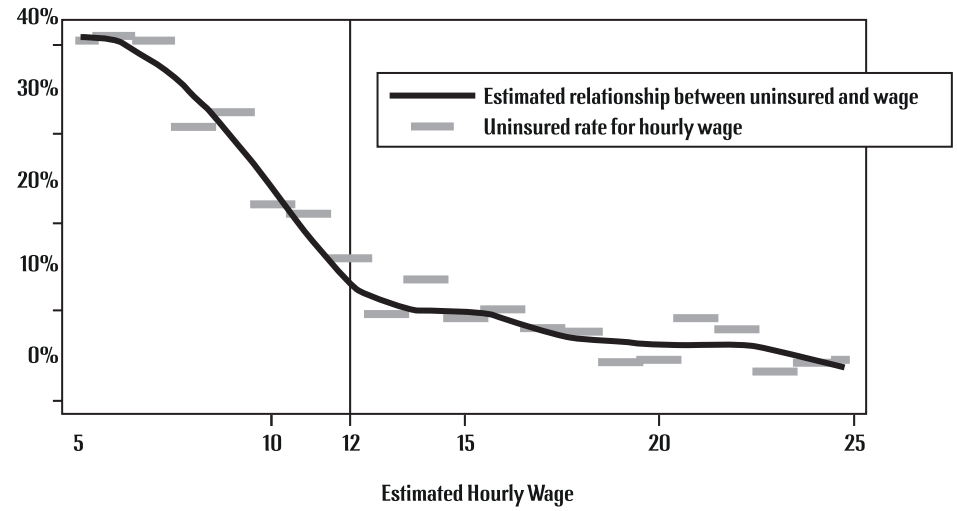
The Task Force reviewed the Healthy North Carolina proposal in PCS 255 and the Healthy NY model and felt that a number of changes could improve a Healthy North Carolina program. Some of those changes include making income eligibility standards more restrictive than outlined in PCS 255 in order to serve the population most at risk of being uninsured and make the program more financially feasible; adjusting the reinsurance corridor; aligning benefits with similar coverage available on the North Carolina private market to make the program more effective at keeping premium

costs to participants as low as possible; and introducing wellness and preventive care incentives to control costs over the long-run.

The Task Force recommended that the eligibility criteria be modified to target firms with 25 or fewer employees that employed significant numbers of low-wage workers, or low-income sole-proprietors or workers. To qualify, the firm, sole proprietor, and/or worker could not have had coverage in the last 12 months. The Task Force recommended that Healthy North Carolina initially be limited to small employers with 25 or fewer employees, as these were the employers that were least likely to offer insurance coverage. In North Carolina, only 29.4% of firms with fewer than 10 employees and 67.5% of firms with 10-24 employees offered coverage in 2002-2003.[3] In contrast, 79.3% of employers with 25-99 employees, 99.3% of employers with 100-999 employees, and 98.9% of employers with 1,000 or more employees offered coverage. Even among small employers, access to ESI is most acute in smaller firms. Of all employees of firms with less than 50 employees, more than 80% of those who were not covered by their firm's health insurance worked in a firm with fewer than 25 employees.[4]

The Task Force also recommended that the Healthy North Carolina program be limited to small employers with low-wage workers: at least 30% of the workers must be earning $12/hour or less. The Task Force picked this wage threshold because analysis of the likelihood of being uninsured suggests that $12 is an important threshold (see Chart 5.2).[1] The dark line represents the estimated relationship between the employee's wage and the likelihood of being uninsured. The gray horizontal lines are the proportion uninsured for a given wage (rounded to nearest dollar). For example, approximately 40% of full-time workers with wages between $5 and $7 are uninsured. Although the likelihood of being uninsured decreases as wages increase, the relationship is weaker at wages above $12.

Chart 5.2
Percent of Full-Time Workers Uninsured by Wage (North Carolina, 2003-2004)



Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2004-2005 (Calendar years 2003-2004). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. Full-time workers only.

The Task Force recommended that the eligibility criteria for small employers be based on the employee's hourly wages, rather than family income, since the employer would not have access to an employees' income from other sources (for example, a spouse's income). This would ease administrative burdens on the small employer. Conversely, the Task Force recommended that eligibility for sole proprietors or workers not covered through a participating small employer be limited to individuals with family incomes up to 250% FPG ($48,375 for a family of four). Using family income is a more exact method of targeting eligibility to those families that would have financial difficulty purchasing insurance at market rates. Limiting the qualifying population is valuable because it reduces the program's overall costs to the state, while targeting those most in need.

As an example, Table 5.3 provides the income eligibility requirements for individuals

Table 5.3
Income Eligibility Requirements for Healthy NY (2006)

Family Size	Annual Household Income	Monthly Household Income
1	Up to $25,125	Up to $2,094
2	Up to $33,375	Up to $2,782
3	Up to $41,625	Up to $3,469
4	Up to $48,875	Up to $4,157
5	Up to $58,125	Up to $4,844
Each additional person	Add $8,250	Add $688

Source: Healthy NY.

and sole proprietors participating in Healthy NY.[5]

The Task Force also recommended that healthcare coverage eligibility for working individuals not otherwise covered through their employer be limited to those individuals with a strong connection to the workforce. Specifically, the Task Force recommended that those qualifying for Healthy North Carolina as individuals should demonstrate 90 days of employment in the previous 12 months (possibly for multiple employers), in addition to being employed at the time of enrollment. This will help reduce the likelihood of adverse selection (see explanation below) into the plan.

To further minimize the possibility of adverse selection into the plan, the Task Force agreed with the minimum employer participation requirements as set out in PCS 255. To participate, small employers should be required to pay at least 50% of the employees' premium costs and must ensure that at least 75% of eligible employees who do not have other insurance coverage enroll in the plan. Generally, people who are less healthy and likely to incur higher healthcare costs are more likely to enroll and pay for health insurance than those who are healthier (otherwise known as "adverse selection"). Thus, low participation rates—with higher-risk individuals—will increase the average cost per eligible. For example, one study that modeled the effect of adverse selection for a new health insurance product targeted to the uninsured suggested that claims would be 2.29 times higher if only 25% of those eligible participated compared to what would be expected if all eligible people enrolled (see Table 5.4).[6] At 75% participation,

Private Options to Increase Health Insurance Coverage

Table 5.4
Percentage of High and Low Utilizers by Different Enrollment Pentration Levels and Expected Claims Costs Compared (Minnesota, 1991)

Overall Penetration (Enrollment among Eligibles)	Penetration of High Utilizers	Penetration of Low Utilizers	Expected Relative Claims Costs
25%	65%	15%	229%
50%	85%	41%	156%
75%	95%	70%	122%
100%	100%	100%	100%

Source: Bluhm WF. The Minnesota Antiselection Model. Actuarial Research Clearinghouse 199. Vol. 2. Actuarial Education and Research Fund 1991 Practitioners Award Winner.

Reinsurance in the $15,000 to $75,000 corridor might lower premiums by roughly one sixth.

the expected claims cost would be 1.22 times higher than with full participation. The Task Force recommended an additional tax subsidy for small employers who: pay more than 50% of the employees' premium costs, contribute toward the cost of dependent coverage, or have greater than a 75% participation rate among eligible employees who have no other coverage. Providing an additional tax subsidy should help reduce the costs to the employer and the employee, thus making it more likely that small firms and/or low-income employees can afford coverage.

The Task Force also emphasized the importance of ensuring that a Healthy North Carolina program would offer lower-cost premiums than what is currently available on the private market. Therefore, it was suggested that the benefits covered under Healthy North Carolina plans reflect those currently available in the North Carolina market. The benefits described above in the Healthy NY program and PCS 255 are better than what is available, on average, in the private market. Therefore, it was suggested that the benefits be reduced to keep premium costs as low as possible. However, Task Force members recommended that the plan include mental health coverage because excluding this coverage may lead to greater utilization of other health services, such as physician's services or hospitalizations.

The Task Force also recommended including well visits and preventive care incentives, such as an annual physical or a smoking cessation program. Members could be encouraged to use preventative services through deductible or co-pay reductions or a free wellness visit upon initial enrollment. To the extent that preventive care lowers healthcare utilization in more expensive settings, such as the emergency department and inpatient hospital care, enticing members to engage in preventive care will have long-run cost savings. Prescription drug coverage has also been shown to have long-run cost savings. Healthy NY has an option for prescription drug coverage and Task Force members felt that prescription drug coverage should also be available in a Healthy North Carolina plan.

In order for private insurers to invest the resources necessary to develop a Healthy North Carolina product, they must feel confident that the Healthy North Carolina program has long-term viability. If appropriations are insufficient, health plans may discount the value of the reinsurance pool and the premium decrease may be less than anticipated. Therefore, the state will need to appropriate multi-year, adequate, and ongoing funds for a Healthy North Carolina reinsurance program.

Private Options to Increase Health Insurance Coverage

For example, the state of New York allocated $89.4 million to the Healthy NY program in 2003, $49.2 million in 2004, and $22 million for the first half of 2005, allowing unexpended funds to be carried over to future years.

The key element of this plan is the effect of the reinsurance corridor on the expected medical claims borne by the private insurer. A reduction in the claims risks decreases premium costs. Estimates place the expected effect of a $5,000 to $75,000 corridor (the current Healthy NY design) at roughly 32% of claims; the expected decrease due to a $15,000 to $75,000 corridor (the PCS 255 proposal) is roughly 16% of the medical cost.[d,7] This latter number translates to roughly $600 per member per year in 2006. However, the Task Force suggested conducting further analysis of the effects of different reinsurance corridors on premium costs before finalizing a reinsurance corridor for a Healthy North Carolina program. The goal of that analysis should be to determine a reinsurance corridor that would effectively reduce premiums for a Healthy North Carolina insurance product by at least 30% compared to what enrollees would be quoted in the private market.

The Task Force also recognized the need to market the plan in order to achieve sufficient enrollment and spread risk across a large population. Thus, it recommended that funds be allocated for outreach and education and that insurers provide competitive commissions to brokers to encourage them to actively sell the Healthy North Carolina product. These provisions make it more likely that enrollment in the plan will be large enough to reduce risk within the covered population.

Recommendation 5.1:

The NC General Assembly should enact a Healthy North Carolina program, targeted to low-income, uninsured, working individuals, employers of firms with 25 or fewer employees, and self-employed/independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated cost-sharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs.

a) **Eligibility guidelines for the Healthy North Carolina program should be as follows:**

   i) **Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage,**

d These estimates were intended to convey the magnitude of the effect on the premium. A more rigorous actuarial analysis would yield more accurate estimates.

or the employer has greater than 75% participation rate among employees who do not have other coverage.

ii) Eligibility for self-employed individuals and independent contractors is limited to those who reside in North Carolina, are low income with family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.

iii) Individual eligibility is limited to low-income, uninsured individuals with incomes equal to or less than 250% of the federal poverty guidelines who reside in North Carolina, are employed at the time of enrollment and have been employed for a minimum of 90 days in the preceding 12 months, have no group coverage and are not eligible for employer-sponsored group coverage, were not insured within the last 12 months, and are not eligible for Medicare.

b) The NC General Assembly should appropriate sufficient ongoing funds to pay the reinsurance for products offered through Healthy North Carolina and to pay for additional tax credits for employers who contribute more than 50% of the premium cost for eligible employees or toward dependent coverage, or if the employer has greater than 75% participation rate among employees who do not have other coverage.

i) The reinsurance corridor should be set at a level that will result in 30% lower premiums within the Healthy North Carolina program compared to comparable coverage in the private market. Actuarial analysis should be conducted to determine the appropriate reinsurance corridor for meeting the goals of the Healthy North Carolina program.

ii) The Healthy North Carolina program should be authorized to use program funds separately or in concert with the private industry agent community to conduct outreach and education to inform the public about the availability of the new program.

iii) The administrators of the Healthy North Carolina program should be authorized to use program funds to pay for evaluations of the program, to include, but not be limited to: program enrollment, the relationship between premium levels and program enrollment, program cost experience, and eligibility criteria. The evaluation should also make use of surveys of covered members, participating insurers and qualifying small employers, individuals, and self-employed individuals. The findings shall be reported to the NC General Assembly on a routine basis, along with any recommendations for programmatic changes.

c) The insurers should market the program and encourage brokers and others to sell the Healthy North Carolina product by offering competitive commissions.

Small Group Reform

In the 1990s, North Carolina altered its methodology for setting health insurance rates for the "small-group" market, which guide the insurance rates for small-employer groups with 1-50 employees. Small-employer groups have historically been less likely to offer coverage, largely because of the premiums. Moreover, prior to the enactment of the small-group laws, many small employers were simply

Private Options to Increase Health Insurance Coverage

refused coverage by insurers who deemed them to be undesirable risks. In the 1990s, there were also huge variations in the premiums charged to small employers —even those that had similar employment characteristics to other small employers. The small-group reform of the 1990s was an effort to ensure that every small employer could purchase some form of small-group health insurance (i.e., "guaranteed issue rights") to spread the health risks of small employer groups across the entire small-group market, to reduce variations in premium rates, and to make health insurance more affordable for the average small-employer group. The federal law known as the Health Insurance Portability and Accountability Act (HIPAA), enacted in 1997, expanded the guaranteed issue rights previously adopted in North Carolina.

More than 80% of North Carolina workers who work in a firm that does not offer health insurance are governed by small-group rating laws.

The currently used rating methodology, developed in the 1990s, is called an "adjusted community rating with rate bands." The "community rate" is the statewide expected per person annual claims cost for an insurer's entire book of small-group business. The "adjusted community rate" is the differentiation in premium costs from the community rate for a particular small group, based on the small group's "case characteristics," which are defined as age, sex, family composition, and geographic location (see page 86). The rating bands are added to allow some variation from the adjusted community rate, to reflect actual or expected differences in claims experience or administrative costs at the group level. However, this variation is limited to a 20% increase from or reduction to the adjusted community rate.

The central idea behind the adjusted community rate with rate bands is to limit premium variation charged to small groups with similar characteristics and to help make insurance coverage more affordable. Thus, some small groups pay premiums lower than what they would pay if they were rated as an independent small group, while others pay higher premiums. However, there is still substantial variation among groups with differing employee characteristics. For example, the premium for a small group employer may vary widely between a firm with young, healthy employees in a geographically less expensive area and a firm with an older workforce in a geographically expensive area. Premiums may vary by as much as 1,200% for groups with different age composition, geographic location, and expected utilization.

While there is still substantial variation among small groups based on age, sex, and geographical location of the group, small-group reform laws helped reduce the variation among similarly situated groups. Effectively, small-group reform laws helped to reduce the prices that could be charged to the highest cost groups. To do this, the laws also increased the prices that could be charged to the lowest-cost groups. In a sense, the groups paying below-market premiums (highest-cost groups) are subsidized by the groups facing above-market premiums (lowest-cost groups). Overall, the effect of small-group reform laws on health insurance coverage in the small-group market is unclear.

Due to this complicated relationship, the ramifications of modifying the rating policy are difficult to predict. One theoretical approach to the relatively high uninsurance rate in small employers is to lower the rate banding to, for example, 15%. This would decrease premiums for the most expensive groups, perhaps enticing some higher-cost groups to offer employer-sponsored insurance to their employees. On the other hand, health plans would be receiving less revenue for the high cost groups (all groups

with premiums above the 15% cap would pay lower premiums). If covering these less healthy groups caused a resulting increase in claims experience, then the average claims cost (community rate) would rise, thereby increasing the rate for all groups, including the healthier ones. To make up for this revenue loss, insurers may charge higher premiums for healthy groups, which could price healthier small employers out of the market. Conversely, loosening the rate bands, say to 25%, would allow healthier groups to obtain insurance at even cheaper rates—perhaps enticing some to buy coverage—but would make insurance even more expensive for the sicker groups. As shown through these examples, it is unclear whether tightening the insurance bands would ultimately lead to an increase or decrease in coverage.

The Task Force was limited in its ability to project all the potential ramifications of changes to the rules governing rate-setting in the small-group market. In addition to small-group rating laws, there are other factors that affect the premiums charged to small employers or the willingness of small employers to offer coverage. For example, overall medical inflation impacts premium prices (see Chapter 4). There has also been a consolidation in the number of insurers selling health insurance in the small-group market, which might lead to less price competition.[e]

Recommendation 5.2: The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small-employer groups.

a) The study shall consider whether changes to any element of North Carolina's current small-group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.

b) The NC Department of Insurance should convene a group that includes representation from small businesses, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.

c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

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e In 2003, there were 32 small-group carriers (29 in 2005). The top five carriers (BlueCross BlueShield of NC, United Healthcare NC, Mega Life & Health Insurance, MAMSI Life and Health, and Wellpath Select) provided health insurance to 84.6% of the groups. BlueCross BlueShield of NC provided insurance to 45.6% of the covered groups. Small-group insurers covered over 53,000 groups or more than 547,000 lives. Burke BM. NC Department of Insurance. (March 2005). Nationwide, small-group markets have become less competitive in since 2002. See "Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004." Government Accountability Office Report GAO-06-155R. October 13, 2005. Available at http://www.gao.gov/new.items/d06155r.pdf. Accessed March 17, 2006.

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The Task Force thought it was time to review the small-group rating laws enacted in the 1990s to determine if additional changes are needed to make health insurance coverage more affordable. Due to the complicated nature of the small-group rating laws and their interaction with the other provisions of small-group reform laws, the increased consolidation in the small-group insurance industry, and the concern that small employers are dropping health insurance coverage for their workers, the Task Force recommends:

In particular, it is important to understand how these reforms have affected insurance coverage in North Carolina with respect to premiums, cost equity, rates of coverage, and availability of group insurance. Included in the review, should be consideration of the definition of small group (e.g., associations, groups of one), and evaluation should include a comparison to processes in other states and consideration of an employer's industry, size, and geographic location.

The NC Department of Insurance (NC DOI) convened a group to study the small-group laws, in accordance with the recommendations of the Task Force. The Task Force applauds the Department for moving forward on this recommendation, but recognizes that NC DOI will be able to conduct a more thorough study of the issues if it is provided ample resources. For example, the ability of NC DOI to contract with outside consultants that have data from other states will greatly increase the ability of NC DOI to perform a comprehensive analysis. Thus, the Task Force recommends that the NC General Assembly provide the funding necessary to thoroughly study small-group reform laws in North Carolina.

Health Insurance Innovations Commission

The NC General Assembly established the Health Insurance Innovations Commission (HB 1463, SB 1223, Session 2003-2004) in July of 2004 to address two key issues: access to affordable health insurance for the state's small businesses and management of high-cost/high-frequency medical conditions. The NC General Assembly recently appointed members to the Health Insurance Innovations Commission, which has a similar goal as this Task Force. Therefore, the Commission could assist with implementing Task Force recommendations, particularly as they pertain to assistance with research and evaluation of specific programmatic ideas. The Task Force recommends:

Recommendation 5.3:

a) **The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage, and to initiate regional demonstration projects to pilot innovative health plans.**

b) **The NC General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.**

Private Options to Increase Health Insurance Coverage

Tiered Benefit Plans

Compared to the national average, North Carolina employees are less likely to work in a firm that offers employer-sponsored insurance to their employees (see Table 5.1). However, North Carolina employees who are offered employer-sponsored insurance are more likely to enroll than employees nationally. One interpretation of these facts is that while employees are willing to purchase insurance, employers are reluctant to offer it. Focus group results suggested that some individuals also would like lower-cost insurance plans, and some employers choose not to offer health insurance because they don't believe their employees could afford it. The most straightforward manner to reduce health insurance plan premiums is to limit benefits. Focus group participants expressed a willingness to offer and pay for insurance products that have limited benefits and, thus, are more affordable as long as the plans offer some primary care, hospitalization, and drug coverage.[f]

One possible avenue to encourage more employers to offer health insurance to their employees is to facilitate the offering of *tiered benefit plans*. Tiered benefit plans can exist with many different designs. The most common design has two elements. First, the employer contributes all or a substantial portion of the premium for a "base plan," which provides a more limited array of benefits than conventional plans. Second, the employee has the option to purchase a plan with additional benefits from a list of plans offered by the health plan. This type of plan design provides plans with lower costs to the employer because the benefits are lower than those conventionally provided in comprehensive plans, but allows employees to purchase a richer set of benefits if they desire.

The Tier 1 plan is estimated to cost less than half of the average small employer premium in 2003.

In order to provide some estimates of the premiums that would be likely under such a design, the Task Force directed Mercer Human Resource Consulting to develop cost estimates for one possible tiered benefit design. In practice, each health plan would design their own set of benefits, so the benefit design and associated premiums would vary, but these estimates are useful for guidance.

The tiered benefit plan for which Mercer provided cost estimates is outlined in Table 5.5. There are three "tiers" to this plan. Tier 1 is the most limited benefit plan. It covers up to four physician visits per year (up to $500) with a $25 copay. After a $500 deductible, the plan covers 80% of charges for inpatient care up to $10,000 per year. Diagnostic testing (such as X-ray and laboratory) is covered at 80% up to $250 per year. Emergency room visits, after a $75 copay, are covered up to $150 per year. Prescription drugs are covered up to $1,000 per year with a three-tier copay structure. The estimated monthly premium is $150 for adults and $92 for children. Focus group participants—both employers and individuals—typically expressed a willingness to pay $50 dollars for health insurance per month. The estimated $150, divided equally between employers and individuals, implies that participants would have to pay $75 a month. If an employee pays for the health insurance premiums using pre-taxable income, the equivalent after tax price would be approximately $60, which is only slightly higher than what participants expressed they were willing to pay ($50).

f For more details, see the Appendix D Focus Group Report.

Private Options to Increase Health Insurance Coverage

Table 5.5
Tiered Benefit Plan and Estimated Premiums

	Tier 1	Tier 2	Tier 3
Physician Visits **All tiers: $25 copay**	Max 4 visits, annual max $500	Max 8 visits, annual max $1,000	No visit limit, annual max $2,000
Inpatient Hospital	All tiers: 80% coverage, $500 deductible		
Annual Benefit	$10,000	$25,000	$50,000
Diagnostic Testing **All tiers: 80% coverage**	$250/year max	$500/year max	$1,000/year max
Emergency Room	$150/year max, subject to $75 copay (copay waived if admitted)		
Prescription Drugs	3 Tier copay: $15 generic; $30 brand name when generic not available; $50 brand name when generic available.		
Annual Benefit	$1,000/year	$2,000/year	$4,000/year
Mental/Behavioral Health Services	N/A	12 office visits/year with $35/visit copay. Annual Max $1,000	24 office visits/year with $35/visit copay. Annual Max $2,000
Disease Management	N/A	Disease management services for select conditions.	
Estimated Monthly Premium			
Adult	**$150**	**$232**	**$270**
Child	**$92**	**$99**	**$107**

Tier 2 doubles the coverage for office-based physician services to eight visits and $1,000 per year and increases the maximum annual inpatient benefit to $25,000. Diagnostic and prescription drug coverage also increases. Furthermore, two additional services are covered in Tier 2. Mental and behavioral health services are covered up to $1,000 per year, and disease management programs are also offered for certain conditions. This tier has an estimated premium of $232 a month for adults, which is $82 higher than the Tier 1 premium. Tier 3 increases coverage for some services for an estimated monthly premium of $270 per adult.

There is no doubt that the benefits included in these tiers—especially Tier 1—are very limited. They do not provide catastrophic coverage and, thus, do not prevent personal bankruptcies due to severe illness or injury. For example, the average charge for a stay in a North Carolina hospital in 2003 was $13,761.[8] Given this charge, the annual Tier 1 benefit would be exhausted, and the plan member would be responsible for a balance of $3,761. Furthermore, this charge represents the average *facility* charge; patients are billed separately for physician services while admitted to the hospital.

However, as limited as this type of health plan is, it may be the only type of insurance affordable to some employee groups, thus it could be the only option that some employers would be willing to offer for their employees. Compared to the average monthly premium of $317 for employers with less than 50 employees in 2003,[9] the estimated total cost for Tier 1 represents a savings of approximately 60%. Although the tiered benefits plans have more limited benefits than conventional plans, they could provide some healthcare coverage to individuals who are currently without health insurance coverage.

Private Options to Increase Health Insurance Coverage

Currently, the only potential barrier for the effective design of tiered benefit products into the North Carolina market is the state's mandated benefit laws. The Task Force is not recommending the elimination of mandated benefits; however, some flexibility in the administration of these laws may be needed so that tiered benefit plans can be a more attractive option. Therefore, the Task Force recommends:

Recommendation 5.4: **Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.**

Recommendation 5.5: **The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in those instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or enact a law regarding the application of mandated benefits that would have a similar effect.**

One possible consequence of the introduction of tiered/limited benefit plans is that employers may drop comprehensive health insurance coverage and substitute it with tiered plans. While this could lead to an increase in the number of insured North Carolinians, it would also increase "underinsurance." Underinsurance is a term used for individuals that have health insurance coverage, but whose coverage is not comprehensive enough to make needed healthcare services for illness or injury affordable.

Current Small-Group Rating Method (per NCGS §58-50-130)

Premiums for small employer groups—those with 1-50 employees—are calculated using an "adjusted community rating with rate bands." The following four steps provide a simplified description of the premium-setting process.

Step 1: Determine the "community rate" for the company's small-group book of business.

The statewide expected per-person annual claims cost for an insurer's entire book of small-group business is known as the community rate.

Step 2: Adjust for any benefit differences based on the particular small-group plan that a small employer purchases.

For example, a small-group plan that covers prescription drugs will cost more than one that does not cover prescriptions.

Step 3: Determine the "adjusted community rate" for the specific small group, based on the group's demographics or "case characteristics."

a. Determine the age-gender-family composition of the employees to be covered by the employer. Adjust the community rate to account for these factors.

The health plan adjusts the community rate to account for the age-gender profile of the company. For example, the health plan might be underwriting a group with five employees: three males, aged 21, 25, and 58, and two females aged 32 and 54. Older employees tend to have higher medical costs; these higher costs imply an upward adjustment of the community rate. Younger employees have lower expected costs, which imply a downward adjustment.

b. Adjust the average cost per employee for geographic factors.

Even for individuals who are the same gender and age, expected claims costs can differ greatly based on where they live or work. Reasons for differences in claims cost due to geography include (but are not limited to) physician practice patterns (e.g., a tendency to hospitalize for certain conditions), consumer practice patterns (e.g., a tendency to "tough it out"), the unit cost of services (e.g., the cost of an appendectomy), and the underlying health of the population in the area (e.g., an increased rate of respiratory diseases). The average cost per employee from Step 3a. is then adjusted up or down based on geography.

Note that the resultant rate after taking into account the case characteristics, known as the adjusted community rate, can vary greatly between employer groups when there are differences in age and gender composition of each employer's workforce and/or when the employers are located in different parts of the state.

Step 4: Increase or decrease the adjusted community rate for other group-specific factors, but not by more than 20% (i.e., adjustments within the "rate bands".)

The adjusted community rate can be increased or decreased by up to 20%, based on anticipated above- or below-average administrative or claims costs. For example, a group that may have higher administrative costs, or has higher historical claims, may be banded upward. It is illegal to consider explicitly occupation or industry.

Thus, North Carolina's small-group rating is a compromise between pure community rate—where the amount of risk-spreading and subsidy from the younger/healthier/least-risky individuals to the older/less healthy/riskier individuals is maximized—and allowing rating based purely on the demographics and health status of individual groups—where the younger/healthier/least-risky individuals pay the least and the older/sicker/riskier individuals pay the most.

Private Options to Increase Health Insurance Coverage

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Chapter 6

Publicly Funded Insurance Coverage

Public Health Insurance Coverage

Some low-income nonelderly individuals have access to publicly funded insurance coverage through Medicaid or NC Health Choice. However, because of the categorical, income, and resource restrictions, these programs do not cover all low-income, uninsured individuals. In addition, some individuals who are currently eligible are not enrolled. Other low-income individuals are ineligible because of the strict eligibility rules. Because the federal government pays the largest share (63%) of the program costs for Medicaid, the Task Force explored ways to expand this coverage to more low-income, uninsured individuals. The Task Force did not recommend expansions to NC Health Choice to cover more children since the state uses its federal State Children's Health Insurance Program (SCHIP) allotment to cover existing groups of children.

Medicaid

Medicaid is a publicly funded program that provides health insurance coverage to certain low-income individuals and families. To qualify for Medicaid, a person must be the right "type" of person (categorical eligibility) and have income and resources below certain limits. Generally, Medicaid is limited to specified categories of eligible individuals, including pregnant women, children under age 21, families with dependent children, people with disabilities, or older adults (age 65 or older). In addition to categorical requirements, a person must also meet income and, sometimes, resource restrictions (described in Chapter 3). Medicaid income limits vary depending on the program category (e.g., categorical eligibility), and for children, by the age of the child. (see Chart 6.1)

a The NC General Assembly directed the Division of Medical Assistance within the NC Department of Health and Human Services to expand Medicaid to cover working disabled individuals with higher incomes than the existing Medicaid income eligibility guidelines. Individuals will be required to pay a sliding-scale premium based on the amount of their income. N.C.G.S. §108A-54.1. (Effective January 1, 2007 or 30 days after the implementation of the new Medicaid Management Information System).

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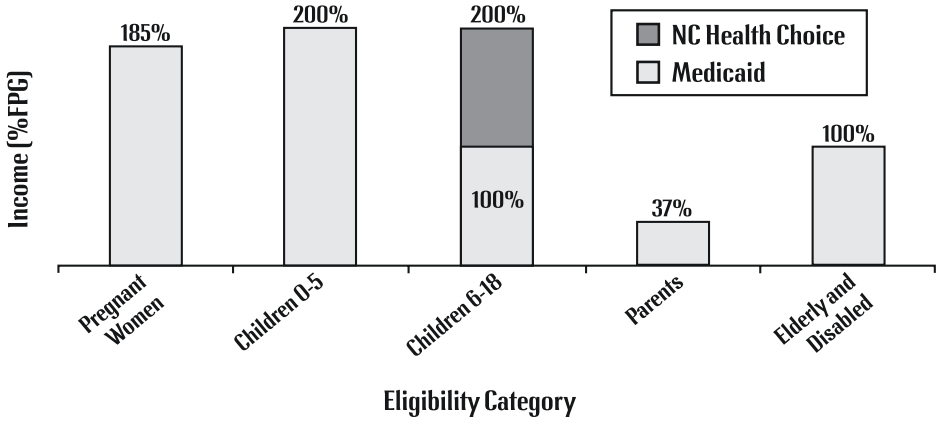
Chart 6.1
Medicaid and NC Health Choice Income Eligibility Standards as Percent of Federal Poverty Guidelines (2005)[a]



For those who qualify, Medicaid offers comprehensive health insurance coverage that is designed to be affordable to low-income people. The covered services include inpatient and outpatient hospital services; physician visits; prescription drugs; diagnostic services; mental health and substance abuse services; physical, speech, and occupational therapy; family planning; and dental, vision, hearing, and long-term care services. Medicaid reimbursement rates are well below the commercial rates, although high in comparison to other states.[1] North Carolina enjoys strong support among the provider community, with many—if not most—providers participating in Medicaid.[b] Medicaid was designed to cover low-income individuals, so federal law restricts allowable cost-sharing to nominal amounts, which are generally no more than $1-$3 for selected services.[c] With the exception of these allowable copayments, providers who participate in the Medicaid program must accept the Medicaid payment as payment-in-full.

Medicaid has helped improve the quality of care provided to Medicaid recipients and has had positive spillover effects on care provided to the uninsured and other people with insurance coverage. In North Carolina, Medicaid recipients with certain chronic or high-cost health conditions receive care coordination and disease management services through Community Care of North Carolina (CCNC). CCNC consists of community networks of primary care providers, hospitals, departments of social services, and health departments that provide disease management and case management services to help patients manage chronic or high-cost health conditions.[d] In December 2005, there

b With certain exceptions, providers are not required to accept Medicaid patients. The exceptions include community health centers, Medicare-certified rural health clinics, state-funded rural health centers, health departments, and most hospitals. These providers are required, under state or federal law, to treat Medicaid patients.

c Federal law prohibits cost sharing for certain categories of individuals, including children, pregnant women, and individuals in nursing facilities; and puts limits on the amount of cost sharing for other populations. The law also prohibits states from limiting the services covered for children. For example, states must cover dental care for children even if they choose not to cover dental services for adults (dental is an optional benefit for adults).

d Providers are paid $2.50 per member, per month to manage all of the patient's care (e.g., be available 24 hours-a-day, seven days-a-week, 365 days-a-year, coordinate referrals, etc.). Networks receive an additional $2.50 per member, per month, part of which is used to hire case managers to provide education and support services needed to help patients manage their health conditions. Each CCNC network participates in statewide disease management initiatives, based on evidence-based medical practice. In addition, local networks can develop evidence-based systems of care to address local health issues for their Medicaid population.

e The state is in the process of expanding the program to the remaining eight counties.

were 14 regional networks covering approximately 670,000 Medicaid recipients in 92 of 100 counties.[e] The initial results of this initiative have been promising, both in terms of improved clinical care and reduced health expenditures.[2] As a result, in the 2005 Legislative Session, the NC General Assembly instructed the NC Department of Health and Human Services to expand CCNC to dual eligibles (individuals who are receiving Medicaid and Medicare coverage) and to children enrolled in NC Health Choice. North Carolina has historically operated a separate SCHIP program; the services are provided through the State Employees' Health Plan, so NC Health Choice beneficiaries have not previously been enrolled in CCNC.

Public Program Options

Outreach and Simplification

Analyses of the Current Population Survey suggest that thousands of nonelderly uninsured people may meet the income eligibility criteria and qualify for Medicaid or NC Health Choice.[f,3] National studies show that many people who are eligible for public programs do not enroll.[4,5] Many of these individuals simply do not know about the programs or the eligibility criteria. Complicated application processes also deter people from applying.

To address this issue, the Task Force suggested that the Division of Medical Assistance (DMA) and the NC General Assembly take steps to increase outreach and simplification efforts to encourage participation by uninsured individuals who are currently eligible to apply for Medicaid. Other states have developed extensive outreach or simplification efforts, for example, by outstationing eligibility workers or creating public information campaigns. Other states have streamlined the eligibility determination process by expanding the eligibility time period from six months to 12 months (37 states),[g] eliminating the need to provide pay stubs or other verification of income (12 states),[h,6] or by eliminating the resource (assets) limits for low-income families (22 states).[i] These expansions would simplify the eligibility process and enable individuals who already qualify for Medicaid to enroll. For example, most low-income families do not have resources that would prevent them from qualifying, so eliminating the asset test would make it easier for the state to provide coverage to greater numbers of qualified individuals. When Louisiana eliminated the assets test for parents, it resulted in an enrollment increase of less than 3%, but the eligibility determination process was greatly simplified.[6]

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f Holmes M. Analysis of US Census. Current Population Survey (CPS) 2002-2004 (Calendar years 2001-2003). Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. 2005. The analyses show that as many as: 192,000 uninsured children under age 18, 46,000 uninsured adults with dependent children, 13,000 uninsured pregnant women, and 4,000 uninsured people with disabilities may be income eligible for Medicaid or NC Health Choice, but are not enrolled. However, this is likely to be an overestimate of people who are potentially eligible for publicly subsidized health insurance. The CPS typically undercounts people who are eligible for Medicaid. Further, non-citizens, and some individuals that have too many resources, may not qualify even if they meet other program rules.

g Thirty-seven states have implemented 12-month eligibility period for families: AL, AZ, AK, CA, CO, CT, DE, DC, FL, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MS, MO, MT, NV, NJ, NY, OR, PA, RI, SC, SD, TN, VA, WV, WI, WY.

h Twelve states have eliminated the need to provide income verification for children's programs (Medicaid or SCHIP): AL, AZ, AK, CT, GA, HI, ID, MD, MI, MT, OK, VT, WY.

i Twenty-two states have eliminated the asset test for parents: AL, AZ, CT, DE, DC, IL, KS, LA, MA, MS, MO, NJ, NM, ND, OH, PA, RI, SC, VT, VA, WI, WY.

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The NC Division of Medical Assistance has already made significant progress in simplifying the application process for children. In addition, the Division recently simplified the adult application form and changed policies to allow mail-in applications. The Task Force applauds the Department's ongoing efforts in this regard, but also identified additional areas to pursue. Based on this information, the Task Force recommends:

Recommendation 6.1: **The NC Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to, the following:**

a) Increasing the number of outstationed eligibility workers.

b) Streamlining the recertification process.

Recommendation 6.2: **The NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including:**

a) Eliminating the asset (resource) test for low-income parents.

b) Expanding the eligibility certification period from six months to 12 months.

Medicaid Expansion

The Task Force explored different options to expand Medicaid to cover more adults and children. Specifically, the Task Force explored Medicaid expansions to cover:

- Parents with incomes between 37% of the federal poverty guidelines (FPG) (current eligibility limits) and 100% FPG.
- Parents with incomes between 101-150% FPG.
- Parents with incomes between 151-200% FPG.
- Parents with incomes between 201%-300% FPG.
- Children with incomes between 200% FPG (current Medicaid or NC Health Choice eligibility limits) and 300% FPG.

Table 6.1
Covered Services under Medicaid Expansion, Full Medicaid or Medicaid "Light"

Services	Full Medicaid	Medicaid "Light" [j]
Premium	1%-4% individual 2%-8% family	0.5%-2% individual (above 100% FPG) 1%-4% family (above 100% FPG)
Inpatient Hospital (Non-Maternity, Non-Behavioral Health)	Covered (no copay)	Covered: $5,000 deductible/year or $10,000 total; 20% coinsurance ($100 hospital deductible on the $10,000 total package)

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Services	Full Medicaid	Medicaid "Light"[j]
Skilled Nursing	Covered (no copay)	Not covered
Outpatient Hospital Physical Health	Covered (no copay)	Covered, 20% coinsurance, 25 visit limit for physical, occupational, and speech therapy with prior approval by primary care provider (PCP)
Emergency Department	Covered (no copay)	Covered, $100 copay (waived if admitted), 20% coinsurance
Primary Care and Specialty Physician and Non-Physician Clinicians	Covered ($3 copay) (24 visit limit/year)[k]	Covered (sliding-scale primary care copay: $10/$20 for individuals with incomes below/above 150% FPG; specialty copay: $20/$40 for individuals with incomes below/above 150% FPG) 5 physician visit/year (PCP and specialty total)(additional wellness visit allowed, one for adults, according to periodicity schedule for children) Additional visits allowed if actively participating in CCNC and approved by PCP
Pharmacy	Covered, 6 prescriptions/ month limit ($1-$3 copay)	Covered, 6 prescriptions/month limit, waived if actively participating in CCNC case management or disease management (copays: $5 Tier 1, $30 Tier 2, $60 Tier 3)
Well Child Care	Comprehensive coverage for children; No cost sharing for children on any services	Well child visits according to periodicity schedule and immunizations only
Maternity	Covered, no cost sharing	Prenatal care only covered for women if income above 185% FPG. Not covered for dependents (<18 years old) (<185% and dependents covered by Medicaid); delivery charges already covered by Medicaid
Family Planning	Covered, no cost sharing	Contraceptives covered (5 physician visit or wellness visit limit), not included in 6 prescription limit/month
Behavioral Health Inpatient	Covered, excludes state psychiatric hospitals for individuals age 21-64	Covered, 20 day inpatient limit, subject to $5,000 deductible or $10,000 total inpatient coverage limitations (combined with non-behavioral health inpatient limitations)
Behavioral Health Outpatient	Covered, $3 copay for private psychiatrists; priorauthorization required after 8th visit (adults), 26th visit (children)	Covered, 20 day limit (prior authorization after 8th visit for adults). Copay: $20/$40, below/above 150% FPG
Behavioral Health Other for Inpatient with Prior Approval	Covered	Intensive day treatment allowed as substitute
Lab and Radiology Required for MRI and PET Scans	Covered	20% coinsurance, prior authorization

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Table 6.1 continued

Services	Full Medicaid	Medicaid "Light" [j]
Durable Medical Equipment	Covered, no cost sharing (Prosthetics/Orthotics only covered for children < 21)	$500 limit with prior approval (no limit on diabetic supplies)(does not cover glasses)
Case Management	CCNC and case managementfor other selected populations	CCNC only
Home Health and Personal Care Services	Covered, no cost sharing (personal care services limited)	Not covered
Dental	Covered, no cost sharing	Not covered
Podiatry	Covered, 24 visit limit/ year[k]	Covered, 5 physician visit limit/year Copay: $20/$40; below/above 150% FPG
Optometry	Covered, 24 visit limit/ year[k]	Covered, 5 physician visit limit/year Copay: $20/$40; below/above 150% FPG
Ambulance	Covered	$150 copay, waived if admitted; 20% coinsurance
Out-of-Pocket Maximum	None	$2,500 per individual/year on coinsurance
Annual Benefit Limits	None	$1 million/year

The Task Force worked with Mercer Government Human Services Consulting to develop cost estimates for a full Medicaid expansion to these groups with the same comprehensive service package as currently offered through Medicaid, as well as separate estimates for a more limited benefit package (see Table 6.1). The limited benefit package had more comprehensive coverage of preventive services and primary care, but limited coverage of inpatient hospitalizations. Mercer provided cost estimates for two different versions of the limited benefit package: one with a $5,000 hospital deductible and another with $10,000 total hospitalization coverage.

The Medicaid "light" package does not include nursing home care, home health services, personal care services, dental, or prenatal care for pregnant women with incomes below 185% FPG, which are already covered under traditional Medicaid. The Task Force also considered other options to reduce the costs of a limited benefit package, but funds were unavailable to obtain full actuarial estimates of these changes.[j]

j The Task Force considered additional restrictions in coverage if needed to further reduce the cost of the Medicaid expansion, however, funds were not available to develop cost estimates to determine the amount of savings that could be achieved through these benefit reductions. Some of the options that the Task Force considered included a maximum coverage limit of $10,000 on outpatient hospital services. This limit would apply to outpatient surgery, diagnostic imaging, and other outpatient services, but would not apply to emergency services, chemotherapy, or radiation therapy. Other options the Task Force considered included limiting prescription drug coverage to two prescriptions/month (contraceptives would not be subject to the two prescriptions/ month limit; and the limit could be waived if actively participating in CCNC). The Task Force also considered requiring prior authorization for outpatient behavioral health services for adults after the eighth visit; limiting inpatient behavioral health services to 20 days of coverage, and allowing individuals to substitute intensive day treatment for inpatient behavioral health services (with prior authorization). The Task Force members also suggested providing a 10% discount for nonsmokers or people actively participating in a smoking cessation course, but this discount was not included in the cost estimates provided herein.

k Medicaid visits to primary care and specialty physician and non-physician clinicians, podiatrists, and optometrists, combined, are subject to a total 24-visit annual limit.

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Table 6.2
Expected Participation Rates for Low-Income Families in Insurance Expansion, by Premium Cost

	EXPECTED PARTICIPATION RATES		
Individual Premium Cost	**<150% FPL**	**150-250% FPL**	**≥ 250% FPL**
Free	74%	79%	86%
$1	49%	56%	63%
<2% income	36%	43%	52%
2-6% income	25%	33%	39%
6-10% income	20%	28%	32%
10-14% income	16%	19%	24%
14-20% income	11%	16%	20%
20+ income	8%	11%	14%
Family Premium Cost	**<150% FPL**	**150-250% FPL**	**≥ 250% FPL**
Free	82%	88%	95%
$1	70%	80%	90%
<2% income	60%	72%	86%
2-6% income	50%	65%	78%
6-10% income	40%	55%	62%
10-14% income	32%	38%	47%
14-20% income	22%	31%	39%
20+ income	15%	22%	28%

Source: Feder, Ucello, O'Brien. The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance. The Kaiser Project on Incremental Health Reform, Kaiser Family Foundation. October 1999.

Individuals in a Medicaid expansion program would be required to contribute toward the costs of coverage, using a sliding-scale premium based on family income. The premium included for the full Medicaid package was higher than that for the more limited Medicaid package, reflecting the more comprehensive coverage and the higher costs. Past studies suggest that lower-income people are less able to pay health insurance premiums, even when set at a percentage of the family's income.[7] Thus, the Task Force designed a premium structure, with no premium for individuals with incomes below 100% FPG, and phasing up to 2% for those with incomes up to 200% (see Table 6.2). Mercer Government Human Services Consulting estimated that the premium structure would result in a 50% enrollment rate for the full Medicaid coverage and a 30% enrollment rate for the limited benefit package (see Appendix E).

If the state were to expand full Medicaid to cover all children and parents with incomes below 300% FPG, it would cover approximately 174,000 people at a cost of $354.5 million to the state and counties (see Table 6.3). The federal government would contribute $603.5 million. Expanding Medicaid to all children and parents with incomes below 300% FPG with a more limited benefit package (including $10,000 total hospital inpatient coverage) would extend coverage to approximately 104,000 people for a cost to the state and counties of $121.3 million and $206.6 million to the federal government.

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Table 6.3
Medicaid Expansion Costs and Covered Lives, FY 2006 (in millions)[l]

	PARENTS[m]				CHILDREN	TOTAL
	37% to 100% FPG	101% to 150% FPG	151% to 200% FPG	200% to 300% FPG	200% to 300% FPG	Total
Full Medicaid						
Avg. Covered Lives	62,810	37,359	29,679	23,991	19,728	173,566
State Share	**$125.3**	**$71.0**	**$52.8**	**$37.1**	**$15.7**	**$301.8**
County Share	**$21.9**	**$12.4**	**$9.2**	**$6.5**	**$2.7**	**$52.7**
Federal Share	$250.6	$141.9	$105.5	$74.1	$31.3	$603.5
Member premium	$0	$5.5	$12.2	$24.7	$11.3	$53.6
Member out-of-pocket	$3.1	$1.8	$1.4	$1.1	$0.6	$8.0
Limited Benefit $5,000 Hospital In Patient Maximum						
Avg. Covered Lives	37,686	22,415	17,807	14,394	11,837	104,139
State Share	**$41.6**	**$23.6**	**$17.4**	**$12.3**	**$5.2**	**$100.1**
County Share	**$7.3**	**$4.1**	**$3.0**	**$2.1**	**$0.9**	**$17.5**
Federal Share	$83.2	$47.3	$34.7	$24.6	$10.5	$200.2
Member premium	$0	$1.6	$3.7	$7.4	$3.4	$16.1
Member out-of-pocket[n]	$50.7	$29.4	$24.0	$19.0	$9.8	$132.9
Limited Benefit $10,000 In Patient Maximum						
Avg. Covered Lives	37,686	22,415	17,807	14,394	11,837	104,139
State Share	**$42.8**	**$24.4**	**$17.9**	**$12.8**	**$5.4**	**$103.3**
County Share	**$7.5**	**$4.3**	**$3.1**	**$2.2**	**$0.9**	**$18.0**
Federal Share	$85.7	$48.7	$35.8	$25.5	$10.9	$206.6
Member premium	$0	$1.6	$3.7	$7.4	$3.4	$16.1
Member out-of-pocket	$42.0	$24.4	$20.1	$15.9	$7.1	$109.4

Priority Expansion for Low-Income Parents

North Carolina's income eligibility rules are comparable to or higher than many other states for pregnant women, children, older adults, and people with disabilities. However, North Carolina's income eligibility rules for parents are among the lowest in the country.[o,8] North Carolina limits Medicaid to working adults with a net countable family income of less than approximately 37% FPG (or approximately 57% when considering gross income). Only 15 states have lower income eligibility limits for parents than North Carolina. As a result, the Task Force's top priority for Medicaid expansion is to cover parents and pregnant women with incomes up to 200% FPG with a limited benefits package.

l The costs in Table 6.3 include the cost of covered services only, not the state or county administrative costs in determining eligibility.

m The cost estimates do not include the additional costs of covering first-time pregnant women with incomes between 185-200% FPG.

n Approximately 21% of the members' out-of-pocket costs are attributable to the $5,000 hospital deductible.

o Only 15 states have lower income eligibility limits for parents than North Carolina: AL (19%), AR (20%), CO (39%), ID (31%), IN (29%), KS (38%), LA (20%), MD (40%), MS (35%), NE (56%), NJ (41%), OK (45%), TX (33%), VA (36%), WV (38%).

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The Task Force recommends that the limited benefit package be focused on ambulatory care, with incentives to actively participate in disease and case management services when appropriate. Inpatient hospital services would be limited to $10,000 total coverage annually.[p] Expanding Medicaid was considered one of the most cost-effective ways to provide coverage to the uninsured, since the federal government pays 63% of program costs. Further, this expansion would not be an entitlement, so the state could limit the number of people who would be covered under this option.

The primary beneficiaries of this expansion would be working adults who either are not offered health insurance through their jobs or are making wages so low they have difficulty affording coverage that may be offered. However, children also stand to benefit, as studies show that children are more likely to have health insurance coverage and to receive medical services if their parents are also covered.[9] For approximately $100 million (in state and county funds), North Carolina could expand Medicaid to cover approximately 78,000 adults. The federal government would contribute $170 million. The state would need to seek a waiver of traditional Medicaid rules in order to offer a more limited Medicaid benefit package that emphasizes primary care with limited hospital coverage and more extensive cost sharing.[q] These uninsured adults would be required to pay premiums, on a sliding-fee scale basis, along with other cost-sharing that would incentivize them to become more prudent purchasers of care. Under the Task Force's plan, members would be required to pay approximately $5.3 million in premiums and approximately $86.5 million in out-of-pocket costs (not including any amount in excess of the $10,000 hospital inpatient coverage). Enrolled individuals will be encouraged, and given the information and support needed, to better manage their own healthcare. The Medicaid expansion would also be combined with a premium assistance program to help pay the employees' premium costs for private insurance, when cost effective to the state to do so. In addition, the group feels that the state should cover the county share of service and administrative costs to avoid undue financial burden on county governments.

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p The Task Force members decided to recommend a limited benefit package with $10,000 total hospital inpatient coverage. For many individuals, this would actually provide better coverage. Many individuals have inpatient stays that cost less than $10,000. For those who do exceed the $10,000 limit, many hospitals will write-off these costs (for people below 200% FPG). In addition, hospitals have an incentive to write-off any amount above $10,000 in order to qualify for coverage under the Medicaid Disproportionate Share Hospital (DSH) payment system. Under DSH, hospitals can receive additional Medicaid payments to help offset some (but not all) of the charity care provided to uninsured individuals. Bad debt does not qualify for DSH reimbursement, thus a hospital may not be able to receive DSH payments for uncollected charges if it tries to collect the amount in excess of $10,000.

q North Carolina would need to seek a Section 1115 waiver or Health Insurance Flexibility and Accountability (HIFA) waiver to be able to offer a limited Medicaid benefit package with premiums and more substantial cost-sharing42 U.S.C. §1315. The US Department of Health and Human Services, Centers for Medicare and Medicaid Services, administers Section 1115 and HIFA waivers. Available at: http://www.cms.hhs.gov/hifa/default.asp. Accessed December 5, 2005.

Recommendation 6.3: The NC General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover parents and pregnant women with incomes below 200% FPG with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek an 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should:

   i. Charge a sliding-fee scale premium that is based on the family's income, ranging from 0.5% for individuals with incomes equal to 100% of the federal poverty guidelines to 2% for individuals with incomes at 200% of the federal poverty guidelines. Nonsmokers or individuals who are actively participating in smoking cessation programs would be entitled to a 10% reduction on their premiums.

   ii. Develop a limited benefit package that focuses on primary care and provides $10,000 in coverage annually for inpatient hospitalizations.

   iii. Include copayments and coinsurance in the benefits package on a sliding-scale basis that encourages the use of more cost effective health interventions.

   iv. Enroll participants in Community Care of North Carolina and provide incentives to actively participate in disease and case management.

   v. Implement a voluntary premium assistance program, so that low-income individuals with access to employer-sponsored insurance can use Medicaid funds to pay for their share of the premiums, if cost effective to the state.

b) The NC General Assembly should cover the county's share of the cost of expansion.

Recommendation 6.4: The NC Division of Medical Assistance should pilot the use of an individual health risk assessment (HRA) and follow-up coaching and counseling with individual recipients in one or more of the Community Care of North Carolina networks to:

a) Determine the health risks of the Medicaid population.

b) Identify priorities for wellness initiatives.

c) Assess the costs of implementing a HRA program statewide or with targeted eligibility groups.

d) Assess the potential cost savings from targeted wellness initiatives.

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r This analysis is based on BlueCross BlueShield of North Carolina's Blue Advantage plan.

Private-Public Partnerships

High-Risk Pool

BlueCross BlueShield of North Carolina (BCBSNC) is the only insurer in the state to offer health insurance in the nongroup market on a guaranteed issue basis.[r] Premiums vary, based on the age, geographic location, and health status of the individual. Individuals are placed into one of seven premium tiers, depending on their health status. Those in the highest four tiers are currently paying more than 150% of the standard rate charged to healthier individuals. In fact, individuals in the highest-risk category may be paying up to 700% of the standard rate. For example, nongroup health insurance coverage for a 35-year-old male with major health problems could cost more than $800/month (for $1,000 deductible, 30% coinsurance plan), or more than $1,800/month for a 55-year-old male. People with pre-existing health problems are most in need of health insurance to help pay for healthcare services, but the premiums needed to cover the costs of care make this coverage unaffordable.

Thirty-three states have established high-risk pools to help spread the costs of providing insurance to people with significant pre-existing health problems.[10] Two bills were introduced in the 2005 NC Legislative Session to create high-risk pools (HB 1535, SB 534), and another bill was introduced to create a study commission to examine this issue (HB 180). Research suggests that about 1% of North Carolina's population is medically uninsurable,[11] and only about 10% of these individuals would enroll. States limit the maximum premium charged to medically uninsurable individuals to make it more affordable, and some states provide a further subsidy to help lower-income individuals pay the premiums. The premiums paid do not cover the full cost of the claims incurred in these high-risk pools. Therefore, most states fund the deficits either through an assessment on the insurance companies, state appropriations, or other means.

Congress appropriated $90 million in grant funds to be distributed to the states as part of the Deficit Reduction Act of 2005 to help states offset losses incurred in qualified high-risk pools.[12] Fifteen million dollars were set aside in federal fiscal year 2006 to provide start-up funds of up to one million dollars for states that have not yet established a high-risk pool. The legislation also appropriated $75 million/year through 2010 to help offset up to half of the ongoing operational costs of state high-risk pools: 40% of the money will be distributed equally among states that operate high-risk pools, 30% based on the numbers of uninsured, and 30% based on the number of participants in the high-risk pool.

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s Twenty-seven states use an assessment on insurers to help fund the losses in the high-risk pool. Of this, 11 states provide full or partial tax credit offsets for the assessment, thereby shifting the costs back to the state (AL, AR, IN, IA, KS, MO, MT, NM, ND, SC, WY); another 11 states have no tax credit offset (AL, CT, FL, ID, IL for its HIPAA pool, KY (partial funding source), LA (only for its HIPAA pool), MN, OK, TX, WA). Seven of the states have a broad assessments on insurers, including commercial insurance carriers, stop-loss, reinsurance carriers, and Third Party Administrators (TPA's) on a per-person/per-month basis (CO, IN, MS, NH, OR, SD, and WA). Two states pay for the high-risk pool through surcharge on hospital bills (MD, WV) and six states use general revenue or other sources of funding (CA, IL, KY, LA, NE, UT).

t Seven states help subsidize the premium costs for lower-income individuals (CO, CT, MT, NM, OR, WA, WI).

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The Task Force recommends creating a high-risk pool that limits premiums to 150% of the standard risk, so that more of the people with pre-existing health problems could afford coverage. Losses would be covered through an assessment on insurers, including traditional insurance companies, Health Maintenance Organizations (HMOs), Multiple Employer Welfare Arrangements (MEWAs), third party administrators, stop-loss, and reinsurance carriers.[s,10] Providers would be paid using the Medicare payment rates, which is less than what is typically offered through commercial insurance. The NC General Assembly should also help subsidize the premium costs for lower-income individuals.[t]

Task Force members also recommended that the high-risk pool provide guaranteed coverage to HIPAA-eligible individuals in the nongroup market. These are individuals who were previously insured for at least 18 months and who have exhausted their Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage (if available). Twenty-seven other states use their high-risk pools to ensure guaranteed coverage for these individuals.[13] A study by the General Accounting Office (GAO) found that states that used their high-risk pool to ensure portability of coverage to individuals in the nongroup market after exhausting COBRA coverage offered lower rates than other states that did not have this protection.[14] Fifteen states also used their state high-risk health insurance pool to provide coverage to individuals who lost health insurance under the Trade Adjustment Act, through the Health Coverage Tax Credit program (HCTC).[13] Individuals eligible for coverage under HCTC can receive a refundable tax credit equal to 65% of the premium paid by the individual and qualifying family members. The Task Force recommends that the high-risk pool be used to provide coverage to these individuals, but that federal funds be used to subsidize the coverage before state premium subsidies are used.

In order to discourage people from waiting until they have large healthcare expenses before enrolling in the high-risk pool, the Task Force recommends that individuals who enroll without prior creditable coverage be subject to a preexisting condition exclusion of up to 12 months. However, the Task Force did not want to penalize those individuals who, as of the date that the pool first becomes operational, are high-risk, uninsured, and meet all eligibility criteria for the pool, by subjecting them to a 12-month exclusion for their pre-existing conditions. These individuals would not have had an affordable coverage option available to them when they first became uninsured. On the other hand, the Task Force recognized that the pool could immediately be faced with relatively high claims cost upon the initial enrollment of this group if they were not subject to any waiting period at all for their pre-existing conditions. As a compromise, the Task Force recommends that the high-risk pool include an open enrollment period when it first becomes operational, to allow individuals who did not previously have access to affordable coverage to enroll in the high-risk pool with a reduced exclusionary period of six months.

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u Recognizing that many individuals decline coverage due to high premium costs in Tiers 4-7, BCBSNC used the distribution of applicants for Blue Advantage for its base population estimates, rather than actual enrollees in Tiers 4-7. After determining the distribution of individuals who would fall into each of the top four tiers, BCBSNC calculated total cost projections for a high-risk pool based on the actual experience of claims costs in Tiers 4-7. These cost estimates were based on an average Blue Advantage benefit design, which is roughly equivalent to a $1,500 deductible, $25 copay, and 75% coinsurance.

BCBSNC conducted an analysis using its member claims data for the high-risk tiers (e.g., those individuals currently paying more than 150% of the standard rate).[u] Based on North Carolina data and experience, BCBSNC estimates that it would cost approximately $30 million per year, in addition to the premiums paid by the customers, to operate a high-risk pool in North Carolina. The estimates assume that 9,000 medically uninsurable people would enroll in the high-risk pool, or about 10% of the eligible population. The estimates also assume a population risk profile that closely resembles Blue Advantage applicants, healthcare utilization that is similar to those who are currently enrolled in Blue Advantage, an administrative cost to run the pool of 7.5% of claims, and provider payments based on the Medicare rates.[v] Some of these costs may be subsidized if Congress passes legislation to help subsidize state high-risk pools.

There would likely be a greater number of enrollees if the state provides an additional premium subsidy for low-income people. Data from other states suggest that enrollment could be higher (between 10-30%) if the state provides an additional subsidy to help reduce premium costs.[10] The Task Force assumed 20% participation (or 18,000 enrollees) if the state provided an additional premium subsidy.

Specifically, the Task Force recommends:

Recommendation 6.5: The NC General Assembly should enact legislation to implement a high-risk pool.

a) Eligibility for the high-risk pool should be limited to individuals who:

   i) Are ineligible for Medicaid or Medicare coverage, and

   ii) Are unable to purchase a policy except with a premium that is higher than that offered through the pool or have been rejected by a commercial insurer due to pre-existing health problems.

b) Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c).

   i) The NC General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.

c) Premiums should be limited to 150% of the standard risk rate.

   i) The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the

v BlueCross BlueShield of North Carolina estimated that the high-risk pool would cost $40 million assuming that BCBSNC paid the rates generally paid through its Preferred Provider Organization (PPO) products. Using Medicare reimbursement rates would lead to a reduction in overall costs to approximately $30 million. FitzSimon C. Personal communication. November 15, 2005.

federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.

ii) Nonsmokers or individuals who are actively participating in a smoking cessation program should be offered a discount off their premiums.

iii) The high-risk pool administrator should study additional ways to encourage healthy behaviors and report back to the NC General Assembly about options within one year of program operation.

d) The high-risk pool should offer participants the choice of different insurance products, including Preferred Provider Organizations (PPOs) with different levels of deductibles and cost sharing and at least one choice of a Health Savings Account (HSA).

e) The health insurance products offered through the high-risk pool should each include no less than a $1 million lifetime limit and a sliding-scale annual limit on out-of-pocket expenses of $2,000-$5,000, based on family income. These limits should be adjusted at least once every five years to reflect changes in the medical component of the Consumer Price Index.

f) The health insurance products should include disease and/or case management to help individuals with chronic and/or complex health problems manage their health conditions.

g) The high-risk pool should also be available as a guaranteed-issue policy for HIPAA-eligible individuals in the nongroup market and to individuals who have lost health insurance coverage as a result of the Trade Adjustment Act.

h) The costs of the high-risk pool should be financed through:

i) Premiums and other cost sharing for covered individuals.

ii) State appropriations to help pay the premium subsidy for individuals with incomes below 300% of the federal poverty guidelines.

iii) An assessment on covered lives on all health insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), Third Party Administrators (TPAs), Administrative Service Organizations (ASOs).

iv) Provider reimbursements limited to the Medicare reimbursement rates.

i) North Carolina should seek federal grant funds, if available, to help support the implementation and ongoing costs of operating a high-risk pool.

Chapter 6  Publicly Funded Insurance Coverage

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Chapter 7  Conclusion

North Carolina is in the midst of a healthcare crisis it cannot afford to ignore. More than 1.3 million nonelderly North Carolinians lacked health insurance coverage in 2004, or more than one sixth of the state's nonelderly population. Compared to most other states, North Carolina is experiencing a more rapid increase in the percentage of people without health insurance coverage and a more rapid decline in the percentage of people with employer-sponsored insurance.

The increased cost of health insurance premiums is the primary cause for the rise in the numbers of uninsured nationally and in North Carolina.[1] More than half (55%) of the uninsured in North Carolina reported that they were uninsured because health insurance was too expensive.[2] The average cost of employer-sponsored insurance (ESI) in North Carolina was more than $3,200 per year for an employee or $8,200 for family coverage in 2002-2003. Nationally, between 2000 and 2004, ESI premiums increased by 65%, much faster than the increase in general inflation (9.7%) or wage growth (12.2%).[3] As a consequence, health insurance coverage is becoming unaffordable for businesses to offer to their employees and for individuals to purchase.

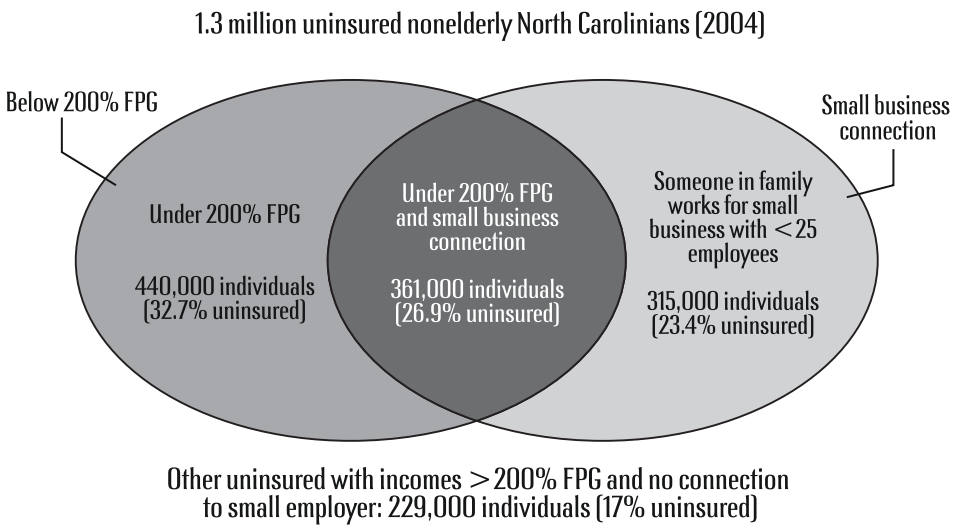
Health insurance premiums are rising because of the increase in underlying healthcare costs. There are many reasons for this increase, including that people are using more services, costs of services are increasing, and overall disease prevalence is rising. Many lifestyle choices and lifestyle-related illnesses increase the risk of chronic diseases, which leads to rising healthcare costs.

Many people are unable to afford healthcare coverage because of these increased costs. Two groups are the most likely to lack health insurance coverage: those who have a connection to a small firm and individuals with family incomes below 200% of the federal poverty guidlines (FPG) (see Chart 7.1). In fact, half (50%) of the uninsured are workers or family[a] of workers in a small firm. Three fifths (60%) of the uninsured have low incomes, (income below 200% FPG). In total, more than four fifths (83%) of the uninsured fall into one of these two groups. Individuals with pre-existing health problems also have a greater risk of being uninsured.

a *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. A more conservative analysis suggests that one third of the uninsured are either employees or dependents of employees of a small firm. See Appendix F for more details.

Chapter 7  Conclusion

Chart 7.1
Uninsured in North Carolina: Primarily Low Income or Employees of Small Firms



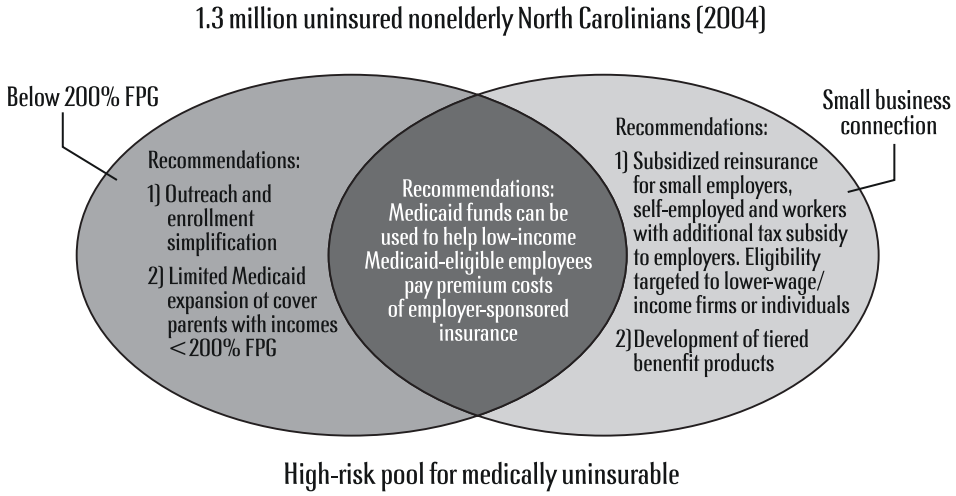
People who are uninsured have more difficulty obtaining needed health services than those with insurance coverage. Uninsured North Carolinians are less likely to have a regular doctor or get preventive health services.[4] They are more than four times more likely than people with insurance to report that there were times in the last 12 months when they needed to see a doctor but couldn't because of costs. In general, the uninsured use fewer services and delay care, which makes them more likely to be diagnosed with a serious health condition—such as late stage cancer—or be hospitalized for conditions that could have been prevented if they received adequate primary care. Further, lack of insurance coverage and uncovered healthcare costs are a major contributor to personal bankruptcies.

Not only does lack of insurance coverage affect individuals and families without insurance coverage—it affects everyone. People in poor health are less likely to work or may work fewer hours. Children who are sick have a harder time learning in school. The cost of providing care to the uninsured is also shifted to those with private health insurance coverage, leading to higher health insurance premiums in the private market. One study suggests that the increased cost of caring for the uninsured in North Carolina has led to an increase in employer-sponsored insurance—$438 per year for individuals and $1,130 for families. In addition, the growing numbers of uninsured are creating an economic strain on the healthcare institutions that care for everyone.

The NC Institute of Medicine (NC IOM) Task Force on Covering the Uninsured focused its work on expanding health insurance coverage to the two groups most likely to lack coverage—small employers, low-income families—and to those with pre-existing health conditions. The recommendations concentrate in three areas: (1) subsidies and new insurance products aimed at making health insurance more affordable to small employers, (2) a Medicaid limited benefit package for low-income adults, and (3) a high-risk pool for people with pre-existing health problems. (see Chart 7.2)

Chapter 7  Conclusion

Chart 7.2
Uninsured in North Carolina: Covering the Uninsured Task Force Primary Recommendations



The Task Force tried to balance the need to provide health insurance to more uninsured with the necessity to restrain new health spending for employers, uninsured individuals and families, and government. Thus, many of the recommendations include limited benefit packages and/or cost sharing to ensure that, to the extent possible, uninsured individuals and families contribute toward the cost of their own care. The Task Force recommendations also encourage people to become active stewards of their own care. The recommendations include proposals to enroll individuals with complex or chronic health conditions into disease and/or case management programs, reward individuals for healthy lifestyles, and encourage the use of preventive health services.

The Task Force recognized that every group, including families, healthcare providers and institutions, employers, insurers and agents, and government, stands to gain by expanding health insurance coverage to the uninsured. Everyone will benefit from a healthier and more productive workforce and fewer medically-related bankruptcies. As more people gain insurance coverage, there will be less uncompensated care. This, in turn, will decrease the need to shift the uncompensated costs of serving the uninsured onto people with insurance coverage. This should help moderate rising healthcare costs for those with insurance.

Just as each group stands to gain by expanding insurance coverage to the uninsured, there is a shared responsibility to contribute to the solution. Individuals should purchase healthcare coverage when affordable coverage is available. Employers can help by offering and paying for part of their employees' insurance costs. Insurers can assist by creating lower-cost products and helping subsidize some of the costs of care for high-risk individuals. Agents can help by marketing new products to small employers and uninsured individuals. Providers can help by accepting lower reimbursement rates for individuals who were previously uninsured. Government can play a role by helping to subsidize the costs of insurance for those who have low incomes.

Chapter 7  Conclusion

The NC IOM Task Force on Covering the Uninsured spent almost a year studying this issue, and developed 13 recommendations that could significantly increase the availability of affordable coverage to the uninsured. The recommendations are listed below, along with the groups (families, businesses, providers, insurers, or government) that are being asked to assist in implementing or financing the recommendation. Additional information about each recommendation is included within the chapters noted in the table. The table below also includes estimates of the number of people who will be covered by the proposal, as well as preliminary cost estimates of the different recommendations when fully implemented (when such data are available). A description of the source of the estimates as well as the methodology used to determine the estimates are included in the footnotes. These cost estimates assume full implementation, which will take several years to achieve. Recommendations the Task Force considers priority are indicated in the table by shading.

Recommendations

Chapter 1: Introduction

Rec. 1.1: The NC General Assembly should help support and expand the existing healthcare safety net to be able to meet more of the healthcare needs of the uninsured.

Role and Responsibility:

- Providers (provide care to the uninsured) and
- Government (NC General Assembly appropriate funding to support and expand safety net)

Chapter 4: Trends in Healthcare Costs

Rec. 4.1:

a) Individuals have a responsibility to understand their health needs and risks and to be better stewards of their own health. To promote healthy lifestyles:
   i) Individuals should be given the education, support, and resources needed to make informed healthy lifestyle choices, and they should use these resources to make healthy choices.
   ii) Individuals with chronic diseases should be provided information and access to health services in order to manage their health conditions in a manner consistent with best known evidence-based care.
   iii) Individuals who engage in risky health behaviors (such as smoking, sedentary lifestyles, or abuse of drugs or alcohol) should be expected to pay differential premiums to cover some of the increased healthcare costs of their unhealthy lifestyle choices.

b) Providers, employers, insurers, schools, and government should work together to promote healthy lifestyle choices and encourage people to participate in evidence-based wellness initiatives.
   i) Insurers should develop insurance products with financial incentives that reward healthy lifestyle behaviors and should cover wellness-related services (such as smoking cessation) as a basic benefit.
   ii) Providers should educate individual patients and, where appropriate, their family members, about the importance of lifestyle choices in maintaining optimal health; provide information and referrals to help patients engage in healthy behaviors; and provide patients with the information and skills needed to manage chronic disease conditions.
   iii) Employers should, to the extent possible, establish policies and environments that support positive behaviors (i.e., access to healthy food in vending machines and cafeterias, ensuring a tobacco-free environment, encouraging activity at work) and offer wellness programs to engage employees in health awareness and improvement programs in the workplace.

iv) Schools should also establish healthful policies and environments, including healthy food in cafeterias; opportunities for all youth to be active daily at school; tobacco-free policies; and educational opportunities to teach students the importance of healthy lifestyles to maintain optimal health.

v) Public health should continue and expand community-wide health awareness, promotion, nutritional information, and disease prevention activities.

vi) Communities and governments should help support healthy communities by providing environments conducive to healthy lifestyle choices (including, but not limited to, walkways, bicycle paths, safe parks, and green spaces).

c) The NC General Assembly should adequately fund the public health system and infrastructure to provide community education and outreach related to lifestyle choices as well as health promotion and disease prevention, in accordance with the recommendations reported in the Public Health Improvement Plan developed by the NC Public Health Task Force (2004).

Role and Responsibility:

- Families: Families should lead healthier lifestyles or pay for increased costs.
- Business: Employers should offer worksite wellness programs.
- Providers: Providers should counsel patients on the importance of healthy lifestyles.
- Insurance: Insurers should offer premium discounts for healthy lifestyles.
- Government: The NC General Assembly should appropriate funds to public health for health promotion, disease prevention; Schools should educate students about the importance of healthy lifestyles.

Rec. 4.2: The NC General Assembly should create a study commission to identify other ways to reduce the growth in healthcare costs to lower overall costs for private and public healthcare plans.

Role and Responsibility:

- Government: The NC General Assembly should fund a legislative commission to study this issue.

Chapter 5: Private Options to Expand Health Insurance Coverage

Rec. 5.1: The NC General Assembly should enact a Healthy North Carolina program, targeted to low income, uninsured, working individuals, employers of firms with 25 or fewer employees, and self-employed/ independent contractors, which offers more affordable health insurance products than what are currently available in the North Carolina marketplace. The health insurance benefits and associated cost-sharing should be closely aligned with current small-group products, with the inclusion of coverage for mental health and prescription drugs

a) Eligibility guidelines for the Healthy North Carolina program should be as follows:

i) Employer eligibility is limited to employers with 25 or fewer employees that have not provided group coverage for employees within the last 12 months. At least 30% of the employees must be low income (defined as having an hourly wage of $12 or less, indexed annually by the Medical Component of the Consumer Price Index). To qualify, at least 75% of the eligible employees who do not have other health insurance coverage must elect coverage under this plan. Qualified employers must contribute at least 50% of the premium cost for individual coverage. Qualified employers should receive an additional tax credit to help subsidize some of the premium costs paid in excess of 50% of the premium costs for the individual if: the employer contributes more than 50% of the premium cost for individual coverage, the employer contributes toward the cost of dependent coverage, or the employer has greater than a 75% participation rate among employees who do not have other coverage.

ii) Eligibility for self-employed individuals and independent contractors is limited to those who reside in North Carolina, are low income with family incomes equal to or less than 250% of the federal poverty guidelines, are not currently insured and have not been for the past 12 months, are not eligible for employer-sponsored group coverage, and are not eligible for Medicare.

Recommendations continued

iii) Individual eligibility is limited to low-income, uninsured individuals with incomes equal to or less than 250% of the federal poverty guidelines who reside in North Carolina, are employed at the time of enrollment and have been employed for a minimum of 90 days in the preceding 12 months, have no group coverage and are not eligible for employer-sponsored group coverage, were not insured within the last 12 months, and are not eligible for Medicare.

b) The NC General Assembly should appropriate sufficient ongoing funds to pay the reinsurance for products offered through Healthy North Carolina and to pay for additional tax credits for employers who contribute more than 50% of the premium cost for eligible employees or toward dependent coverage, or if the employer has greater than a 75% participation rate among employees who do not have other coverage.

i) The reinsurance corridor should be set at a level that will result in 30% lower premiums within the Healthy North Carolina program compared to comparable coverage in the private market. Actuarial analysis should be conducted to determine the appropriate reinsurance corridor for meeting the goals of the Healthy North Carolina program.

ii) The Healthy North Carolina program should be authorized to use program funds separately or in concert with the private industry agent community to conduct outreach and education to inform the public about the availability of the new program.

iii) The administrators of the Healthy North Carolina program should be authorized to use program funds to pay for evaluations of the program, to include, but not be limited to: program enrollment, the relationship between premium levels and program enrollment, program cost experience, and eligibility criteria. The evaluation should also make use of surveys of covered members, participating insurers and qualifying small employers, individuals, and self-employed individuals. The findings shall be reported to the NC General Assembly on a routine basis, along with any recommendations for programmatic changes.

c) The insurers should market the program and encourage brokers and others to sell the Healthy North Carolina product by offering competitive commissions.

Estimated uninsured covered: 33,500

Role and Responsibility:

- Families: Uninsured individuals should purchase insurance and pay premiums (cost estimate: $79 million in premium costs for employees, self-employed, and working individuals). [a] See methodology explanation at the end of the table.
- Business: Small employers should offer insurance and pay part of the premium (cost estimate: $39 million).[a]
- Insurance: Insurance companies should participate in Healthy North Carolina. Agents should actively market this product to eligible small employers, sole proprietors, and working individuals.
- Government: The NC General Assembly should provide financing for reinsurance and tax credits (cost estimate: $51 million for reinsurance. Does not include additional costs for tax credit).[a]

Rec. 5.2: The NC General Assembly should authorize and fund a study, to be conducted by the NC Department of Insurance, of the impact of small-group reform in North Carolina and potential reforms to the existing small-group reform laws that may increase healthcare coverage among small employer groups.

a) The study shall consider whether changes to any element of North Carolina's current small-group rating system, to the definition of small employers, or to how rating requirements apply to small employers of different sizes could be expected to result in increased coverage among small employers. In evaluating these questions, the experiences of other states' small-group rating systems should be considered.

b) The NC Department of Insurance should convene a group that includes representatives of small business, brokers, underwriters, and other experts who can review the data and determine whether changes are needed to existing small-group reform laws.

c) Funding for this study would enable the Department to secure data and expertise from consultants that otherwise would not be available to the Agency.

Role and Responsibility:

- Business: Small employers should participate in the study.
- Insurance: Insurers and agents should participate in the study.
- Government: The NC Department of Insurance should convene a group to study small group reform laws. The NC General Assembly should appropriate funding for the study.

Rec. 5.3:

a) The NC Institute of Medicine Covering the Uninsured Task Force supports the work of the NC Health Insurance Innovations Commission, whose statutory mandate is to investigate the problems small employers face when trying to purchase health insurance coverage and to initiate regional demonstration projects to pilot innovative health plans.

b) The NC General Assembly should appropriate funds to support the work of the Health Insurance Innovations Commission.

Role and Responsibility:

- Business: Small employers should participate in the Commission.
- Insurance: Insurers and agents should participate in the Commission.
- Government: The NC General Assembly should appropriate funding to support the Commission.

Rec. 5.4: Private insurance companies should develop and sell tiered benefit packages that offer low-cost health insurance products in North Carolina. The lowest-cost tier should offer basic healthcare coverage, which can be enhanced to include more comprehensive benefits with reduced cost sharing and higher premiums.

Estimated uninsured covered: 27,500

Role and Responsibility:

- Families: Families should purchase coverage if affordable coverage is available (estimated cost: $35 million in premiums. Does not include other out-of-pocket costs, including deductibles or other cost sharing).[b] See methodology explanation at the end of the table.
- Business: Employers should offer and help subsidize the premium costs for their employees (estimated costs: $37 million).[b]
- Insurance: Insurers should create tiered benefit products. Agents should actively market these products.

Rec. 5.5: The NC General Assembly should provide the NC Department of Insurance authority and guidelines to apply state-mandated benefit laws in a flexible manner in instances where strict application of such laws would preclude the approval of tiered health insurance benefit plans, or it should enact a law regarding the application of mandated benefits that would have a similar effect.

Role and Responsibility:

- Government: The NC General Assembly should amend existing state mandate laws for tiered benefit products. The NC Department of Insurance should administer the law.

Chapter 7  Conclusion

Recommendations continued

Chapter 6: Public Options

Rec. 6.1: The NC Division of Medical Assistance (DMA) should increase outreach and further simplify the Medicaid application and recertification process to encourage those who are currently eligible to apply and maintain their eligibility. DMA should consider, but not be limited to, the following:

a) Increasing the number of outstationed eligibility workers.

b) Streamlining the recertification process.

Estimated new eligibles: 25,500 [c] See methodology explanation at the end of the table.

Role and Responsibility:

- Government: The Division of Medical Assistance should further work to simplify the application process and do more outreach to encourage eligible individuals to apply for and maintain coverage. [c] (Estimated costs based on 10% of potential eligibles enrolling. State costs: $29.2 million, county costs: $5.2 million, federal costs: $59.5 million)

Rec. 6.2: The NC General Assembly should enact legislation to reduce administrative barriers and increase processing efficiency, including:

a) Eliminating the asset (resource) test for low-income parents.

b) Expanding the eligibility certification period from six months to 12 months.

New eligibles included in estimates for 6.1

Role and Responsibility:

- Government: The NC General Assembly should amend the Medicaid laws. [c] See methodology explanation at the end of the table.

Rec. 6.3: The NC General Assembly should expand Medicaid to cover more uninsured low-income people. First priority should be to cover parents and pregnant women with incomes below 200% of the federal poverty guidelines (FPG) with a limited benefits package.

a) The NC General Assembly should direct the NC Division of Medical Assistance to seek a 1115 waiver to develop a limited benefit package. As part of the 1115 waiver, the NC General Assembly should:
   i) Charge a sliding-fee scale premium that is based on the family's income, ranging from 0.5% for individuals with incomes equal to 100% of the federal poverty guidelines to 2% for individuals with incomes at 200% of the federal poverty guidelines. Nonsmokers or individuals who are actively participating in smoking cessation programs would be entitled to a 10% reduction on their premiums.
   ii) Develop a limited benefit package that focuses on primary care and provides $10,000 in coverage annually for inpatient hospitalization.
   iii) Include copayments and coinsurance in the benefits package on a sliding-scale basis that encourages the use of more cost effective health interventions.
   iv) Enroll participants in Community Care of North Carolina (CCNC) and provide incentives to actively participate in disease and case management.
   v) Implement a voluntary premium assistance program, so that low-income individuals with access to employer-sponsored insurance can use Medicaid funds to pay for their share of the premium, if cost effective to the state.

b) The NC General Assembly should cover the county's share of the cost of expansion.

Estimated new eligibles: 78,000

Role and Responsibility:

- Families: Families should enroll, pay premiums and cost sharing, and participate in disease management. (estimated costs: $5.3 million in premium costs, $86.5 million out-of-pocket cost sharing, not including any amount in excess of the $10,000 hospital inpatient coverage). [d] See methodology explanation at the end of the table.
- Providers: Providers will accept Medicaid rates, which are lower than commercial rates; some of the $86.5 million in cost sharing will be absorbed by providers. [d]
- Government: The NC General Assembly will appropriate funds to cover state and county share of Medicaid expansion. The NC Division of Medical Assistance should seek a waiver from the US Centers for Medicare and Medicaid Services to offer a limited benefit package. (estimated costs: $100 million in state/county costs, $170.2 million federal). [d]

Rec. 6.4: The NC Division of Medical Assistance should pilot the use of an individual health risk assessment (HRA) and follow-up coaching and counseling with individual recipients in one or more of the Community Care of North Carolina (CCNC) networks to:

a) Determine the health risks of the Medicaid population.

b) Identify priorities for wellness initiatives.

c) Assess the costs of implementing a HRA program statewide or with targeted eligibility groups.

d) Assess the potential cost savings from targeted wellness initiatives.

Role and Responsibility:

- Families: Individual enrollees will participate in wellness initiatives.
- Providers: Providers will participate in wellness initiative as part of CCNC network.
- Government: Division of Medical Assistance will develop and administer the wellness initiative through CCNC.

Rec. 6.5: The NC General Assembly should enact legislation to implement a high-risk pool.

a) Eligibility for the high-risk pool should be limited to individuals who:
   i) Are ineligible for Medicaid, Medicare, or COBRA coverage, and
   ii) Are unable to purchase a policy except with a premium that is higher than that offered through the pool or have been rejected by a commercial insurer due to pre-existing health problems.

b) Individuals who enroll in the high-risk pool shall be subject to a pre-existing condition exclusionary period of up to 12 months unless the individual had creditable prior coverage, in accordance with NCGS §58-68-20(c) .
   i) The NC General Assembly should create an open-enrollment period of six months when the program first becomes operational to allow individuals to enroll in the program with a reduced pre-existing condition exclusionary period of six months.

c) Premiums should be limited to 150% of the standard risk rate.
   i) The state should provide an additional subsidy to help individuals with incomes below 300% of the federal poverty guidelines pay for their share of the premium. The state subsidy would pay for 95% of the premium costs for individuals with incomes below 100% of the federal poverty guidelines to be phased out when a family's income reaches 300% of the federal poverty guidelines. The subsidy would be based on the lowest cost plan offered through the high-risk pool. Individuals who are eligible for a federal premium subsidy under the Trade Adjustment Act must apply for such coverage. The amount of the state subsidy will be reduced by any federal premium subsidy provided.

Recommendations continued

ii) Nonsmokers or individuals who are actively participating in a smoking cessation program should be offered a discount off their premium.

iii) The high-risk pool administrator should study additional ways to encourage healthy behaviors and report back to the NC General Assembly about options within one year of program operation.

d) The high-risk pool should offer participants the choice of different insurance products, including Preferred Provider Organizations (PPOs) with different levels of deductibles and cost sharing and at least one choice of a Health Savings Account (HSA).

e) The health insurance products offered through the high-risk pool should each include no less than a $1 million lifetime limit and a sliding-scale annual limit on out-of-pocket expenses of $2,000-$5,000, based on family income. These limits should be adjusted at least once every five years to reflect changes in the medical component of the Consumer Price Index.

f) The health insurance products should include disease and/or case management to help individuals with chronic and/or complex health problems manage their health conditions.

g) The high-risk pool should also be available as a guaranteed-issue policy for HIPAA-eligible individuals in the nongroup market, and to individuals who have lost health insurance coverage as a result of the Trade Adjustment Act.

h) The costs of the high-risk pool should be financed through:

i) Premiums and other cost sharing for covered individuals.

ii) State appropriations to help pay the premium subsidy for individuals with incomes below 300% of the federal poverty guidelines.

iii) An assessment on covered lives on all health insurers, reinsurers, Multiple Employer Welfare Arrangements (MEWAs), Third Party Administrators (TPAs), Administrative Service Organizations (ASOs).

iv) Provider reimbursement limited to the Medicare reimbursement rates.

i) North Carolina should seek federal grant funds, if available, to help support the implementation and ongoing costs of operating a high-risk pool.

Estimated new eligibles: assumes 20% of medically uninsurable or 18,000 people will enroll with additional premium subsidies [e]

Role and Responsibility:

- Families: People with pre-existing conditions should enroll and pay premiums and other out-of-pocket costs. (estimated costs: $32.4 million in premiums (assuming 9,000 enrollees and no additional premium subsidy. The costs to the families do not include other out-of-pocket costs, including deductible, copayments, or coinsurance). If an additional premium subsidy were provided, we assume 18,000 enrollees. Families would pay $31.6 million in premium costs (not including other out-of-pocket costs). The state would pay the additional premium costs).[e] See methodology explanation at the end of the table.
- Providers: Providers should accept Medicare rates in lieu of regular commercial rates. [estimated costs: $10 million (assuming 9,000 enrollees) or $20 million (assuming 18,000 enrollees)]. [e]
- Insurance: Insurers will be assessed to create a high-risk pool [estimated costs: $30 million (assuming 9,000 enrollees) or $60 million (assuming 18,000 enrollees)]. [e]
- Government: The state government would pay $33.2 million to help subsidize the premium costs for lower-income individuals with pre-existing conditions. [e]

[a] Estimates prepared by Mark Holmes, PhD. Vice President NC Institute of Medicine. Senior Research Fellow, Cecil G. Sheps Center for Health Services Research. Assumes: National 2003 MEPS estimates are used to derive the estimated number of individuals working in a firm that does not currently offer health insurance in "low-wage" firms, with Current Population Survey (CPS) analysis used to modify the MEPS "low-wage" firm definition to the definition used in Recommendation 5.1. A 30% premium reduction is assumed, along with the elasticity of demand obtained by Gruber and Lettau.[5] This generates the estimated number of employees in a firm that newly offers health insurance. We assume 60% eligibility and 70% take-up rates, consistent with current MEPS estimates. We then trend premium estimates forward four years from 2003 to 2007. We assume the employee share of the post-subsidized premium is 50% ($147.13 in 2007). Working and self-employed individuals are estimated using CPS for baseline enrollments. Demand elasticity of -.081 is obtained from "The Price Sensitivity of Demand for Nongroup Health Insurance," Congressional Budget Office, August 2005, Table 6.[6]

[b] The estimates are based on the assumption that 5% of the full-time uninsured workers would enroll, or 27,550 uninsured individuals. The Task Force estimated a low take-up rate because historically, limited benefit packages have not sold well in the market.[7] The estimates assume that about one third of the new enrollees would purchase Tier 1, Tier 2, and Tier 3. The cost estimates are based on monthly plan costs of $150 (Tier 1), $232 (Tier 2), and $270 (Tier 3), which were estimates provided by Mercer Government Consulting for a sample 3-tier benefit design. The costs assume that the employer would pay 75% of the lowest cost plan.

[c] The NC Division of Medical Assistance provided FY 2006 estimates per eligible. The October 2005 actual costs per eligible were: $197.31 for infants and children, $505.03 for parents of dependent children, $920.26 for pregnant women, and $1,272.53 for people with disabilities. The Task Force was unable to identify any data to know how many people who are currently eligible but not enrolled would apply for Medicaid and enroll if more outreach and program simplifications were implemented. The cost estimates included here are built around the assumption that 10% of the estimated numbers of people eligible but not enrolled would enroll. Analysis of 2001-2003 CPS data suggest that as many as 192,000 children, 46,000 parents of dependent children, 13,000 pregnant women, and 4,000 people with disabilities may currently qualify for Medicaid, but are not enrolled. This is probably an overestimate of potential eligibles, as the CPS data historically undercount the number of people enrolled in Medicaid and does not include information to determine resource eligibility. Holmes M. Presentation to NC IOM Covering Uninsured Task Force: Cary, NC. Apr. 2005.

[d] Mercer Government Human Services Consulting. The cost estimates were based on expanding Medicaid with a limited benefit package to parents up to 200% of the federal poverty guidelines (FPG). It did not include the costs of covering first-time pregnant women with incomes between 185-200% FPG, as this recommendation was included later in the Task Force's deliberations. The

estimates assume a 30% take-up rate among those potentially eligible for the limited benefit package. The estimates were adjusted for pent-up demand, anti-selection factors, potential health status of participants, and benefit package design. Cost estimates are trended forward to CY 2006. Estimates do not include state or county administrative costs. The Task Force recognizes that some of the out-of-pocket costs will be paid by the families and some will be absorbed by the providers as uncompensated care.

[e] BlueCross BlueShield of North Carolina (BCBSNC) estimated that the high-risk pool would cover approximately 18,000 people (approximately 20% of medically uninsurable), with losses to the pool of roughly $40 million in addition to premiums paid (of $32.4 million) This estimate was based on BCBSNC data and experience, assuming a risk profile that resembled Blue Advantage applicants, healthcare utilization similar to those who are currently enrolled in Blue Advantage, and an administrative cost to run the pool of 7.5% of claims. The estimate assumes the Blue Advantage benefit design, which is roughly equivalent to a $1,500 deductible, $25 copay, and 75% coinsurance, and BCBSNC's Preferred Provider Organization (PPO) provider reimbursement rates. Reducing provider reimbursement in the high-risk pool to Medicare rates would provide additional savings of approximately 15%, so the total losses to the pool would be $30 million. If an additional premium subsidy were provided and 18,000 people enrolled, the losses to the pool would equal $60 million.[8]

Experience from other states suggests that enrollment could be higher (between 10-30%) if the state provides an additional subsidy to help reduce the premium costs. The Task Force assumed 20% participation if the state further helped subsidize the premiums. The state subsidy estimates assume 18,000 enrollees. The percent of the state high-risk pool enrollees in each poverty category are estimated by the distribution of uninsured who specify their health as fair or poor in CPS 2003-2004. Then a sliding-scale premium subsidy was applied based on the family's income. Fourteen percent of those in fair or poor health had incomes below 100% FPG (95% subsidy), 39% had incomes between 100-200% FPG (75% subsidy), 35% had incomes between 200-300% FPG (25% subsidy), and 12% had incomes in excess of 12% (0% subsidy). If an additional premium were provided similar to these given assumptions, the enrollees would pay approximately $31.6 million, and the state would pay approximately $33.2 million.[8]

Chapter 7  Conclusion

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Appendix A | Federal Poverty Guidelines

The federal poverty guidelines are set annually by the US Department of Health and Human Services, as a means of determining eligibility for certain federal programs. They are based on the federal poverty threshold, developed by the US Census. The federal poverty guidelines vary, by size of the family. In 2005, the federal poverty guidelines were:

Table A.1
2005 Federal Poverty Guidelines (FPG)

Family Size	100% FPG	200% FPG	300% FPG
1	$ 9,570	$19,140	$28,710
2	$12,830	$25,660	$38,490
3	$16,090	$32,180	$48,270
4	$19,350	$38,700	$58,050
5	$22,610	$45,220	$67,830
6	$25,870	$51,740	$77,610
7	$29,130	$58,260	$87,390
8	$32,390	$64,780	$97,170
For each add'l person	$ 3,260	$6,520	$9,780

Source: 2005 HHS Federal Poverty Guidelines. Available online at: http://aspe.hhs.gov/poverty/05poverty.shtml (accessed May 17, 2005).

Appendix B | Data Tables

Table B.1
Coverage and Average Premiums for Employer-Sponsored Insurance (ESI), 2002-2003 Averages

Firm Size	Total	Less than 10	10-24	24-99	100-999	1,000 or more	Less than 50	50 or more
ESI Coverage								
Percent of firms that offer ESI to employees								
North Carolina	53.6%	29.4%	67.5%	79.3%	99.3%	98.9%	39.1%	96.1%
United States	56.7%	36.2%	67.0%	81.7%	94.5%	98.7%	43.9%	96.0%
Percent of workers in firm offering ESI to employees								
North Carolina	87.3%	36.7%	67.7%	81.2%	98.8%	99.3%	57.2%	97.5%
United States	87.6%	46.6%	71.1%	85.3%	96.2%	99.1%	62.6%	97.3%
Percent of employees in firm that offers, who are eligible for ESI								
North Carolina	81.5%	87.9%	83.3%	75.1%	80.9%	82.2%	84.1%	81.0%
United States	77.8%	81.7%	78.1%	74.5%	75.7%	78.9%	78.3%	77.7%
Percent of employees who are eligible that enroll								
North Carolina	83.4%	86.2%	79.8%	78.4%	85.5%	83.8%	80.3%	84.1%
United States	80.7%	80.0%	77.6%	77.5%	79.7%	82.3%	77.9%	81.4%
Overall percent of employees enrolling in ESI through their firm								
North Carolina	59.4%	27.8%	44.9%	47.8%	68.3%	68.4%	38.6%	66.4%
United States	54.9%	30.4%	43.0%	49.2%	58.0%	64.3%	38.1%	61.5%
Premiums								
Average total premium for employee coverage								
North Carolina	$3,289	$3,429	$4,154	$3,013	$3,512	$3,097	$3,597	$3,206
United States	$3,335	$3,700	$3,438	$3,300	$3,302	$3,280	$3,499	$3,286
Employee share of employee coverage								
North Carolina	$558	$242	$626	$500	$546	$607	$470	$582
United States	$586	$452	$499	$600	$598	$615	$509	$609
Firm share of employee coverage								
North Carolina	$2,731	$3,187	$3,528	$2,513	$2,966	$2,490	$3,128	$2,624
United States	$2,750	$3,248	$2,939	$2,700	$2,705	$2,666	$2,991	$2,677
Total premium for family coverage								
North Carolina	$8,244	$8,739	$9,901	$7,989	$8,034	$8,197	$8,938	$8,151
United States	$8,859	$8,944	$8,823	$8,869	$8,721	$8,895	$8,912	$8,849
Employee share of family coverage								
North Carolina	$2,235	$2,013	$2,665	$3,167	$2,805	$2,006	$2,494	$2,197
United States	$2,135	$1,906	$2,441	$2,768	$2,395	$1,942	$2,325	$2,099
Firm share of family coverage								
North Carolina	$6,010	$6,726	$7,236	$4,822	$5,229	$6,191	$6,444	$5,955
United States	$6,724	$7,038	$6,382	$6,102	$6,327	$6,953	$6,587	$6,751

Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, US DHHS, 2002-2003.

Table B.2
Coverage and Average Premiums for Employer Sponsored Insurance, 2002-2003 Averages

Characteristic	Thousands of Uninsured	Percent of the Uninsured	Risk of Being Uninsured
Total	**1,344**	**100**	**18**
Family Poverty Status			
<100%	399	29.7	35.4
100-200% FPG	401	29.9	29.4
200-300% FPG	223	16.6	18.3
300%+ FPG	321	23.9	8.5
Race/Ethnicity			
White, not Latino	659	49	13.6
Black, not Latino	309	23	18.4
Not white, black, or Latino	87	6.5	20.7
Latino	289	21.5	53.6
Labor Force Status (civilian adults only)			
Not in labor force	294	25.4	19.6
Unemployed	99	8.6	43.7
Part time	180	15.5	24.5
Full time	586	50.5	18.3
Size of Employer (full- and part-time workers)			
1-24	404	52.8	33.4
25-99	93	12.1	21.3
100-999	87	11.3	14.1
GT 1,000	127	16.5	8.3
Unknown size	56	7.3	39.2
Family Connection to Workforce[a]			
No workers	164	12.2	18.4
Only part-time workers	141	10.5	28.5
1 full-time worker	596	44.3	18.2
2+ full-time workers	444	33	15.7
Age			
0-17	243	18.1	11.3
18-24	244	18.2	28.3
25-34	358	26.6	29.5
35-44	207	15.4	17.8
45-54	189	14	16.2
55-64	103	7.7	11
Citizenship			
Citizen	1,081	80.4	15.4
Not a citizen	264	19.6	57.7

a *Family*, as used in Current Population Survey analyses throughout this report, is broadly defined and includes more individuals than those typically eligible for dependent health insurance coverage. See Appendix F for more details.

Appendix B | Data Tables

Characteristic	Thousands of Uninsured	Percent of the Uninsured	Risk of Being Uninsured
Gender			
Male	749	55.7	20.2
Female	596	44.3	15.8
Urban/Rural			
Urban	883	65.6	16.6
Rural	462	34.4	21.4
Health Status			
Excellent	418	31.1	15.2
Very Good	426	31.7	17.9
Good	362	26.9	21.6
Fair	107	7.9	22.5
Poor	33	2.4	15.4
Industry (full- and part-time workers)			
Agriculture	32	4.2	40.2
Construction	192	25.1	48
Manufacturing	70	9.2	12.7
Transportation	20	2.7	12.1
Trade	89	11.6	15.6
Health & Education	76	10	9.2
Finance	20	2.6	8.7
Government	5	0.6	2.7
Hospitality	102	13.3	33
Other	159	20.8	25.9

Percent of the Uninsured is the percent of all uninsured in that category. For exanple, 29.7% of the uninsured have family income below the poverty line. Risk of Being Uninusred is the percent individuals in that category who are uninsured. For example, 35.4% of those with incomes below the poverty line are uninsured.
Source: Holmes M. Analysis of US Census. Current Population Survey (CPS) 2003-2004 (2002-2003). Cecil G. Sheps Center for Health Services Research. The University of North Carolina at Chapel Hill. 2005.

Appendix C

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County-level Estimates of the Number of Uninsured in North Carolina

2004 Update

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Introduction

According to the United States Bureau of the Census, in 2004, 45.8 million U.S. Residents lacked health insurance for the entire year. Approximately 1.3 million of those uninsured Americans lived in North Carolina. Substantial policy interest has focused on the uninsured both nationally and, given annual increases North Carolina has experienced, it is an especially important issue in this state. The percent of North Carolina residents that lack health insurance for a full year has risen from 15.3 percent in 2000 to 17.5 percent in 2004 (Figure 1). Analysis of the rate of uninsured for small areas, such as counties, is often impossible due to data limitations. Policy interventions aimed at the uninsured are likely to be most effective at local levels. For example, a health care provider interested in providing low cost or free care for uninsured individuals might consider the rate of health insurance coverage when deciding where to offer services. The lack of small area estimates on the rate of health insurance coverage substantially limits the ability to effectively target of some possible solutions to the health insurance problem.

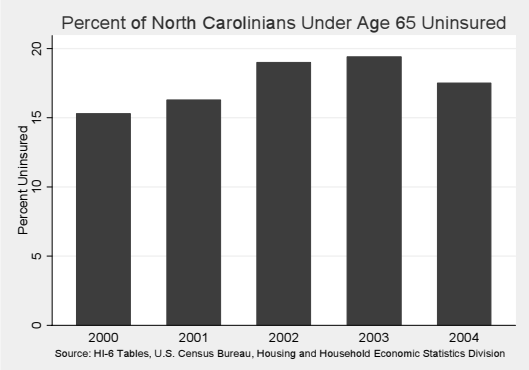

Figure 1: Percent of North Carolinians Uninsured 2000-2004

Background

To address the absence of county-level estimates of the uninsured in North Carolina, in March 2001 the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill issued a report entitled *County-Level Estimates of the Uninsured in North Carolina, 1995-1999*. That report used data from the U.S. Census Bureau's Current Population Surveys (CPS) and other data sources to estimate the number of persons under the age of 65 years who did not have health insurance in each of North Carolina's 100 counties.[1] Because the sample size of the CPS (the source for most government estimates of health insurance coverage) is insufficient to support estimates at geographic levels smaller than the state, the approach taken by this initial report was to investigate the factors that increase the likelihood of lacking health insurance coverage and then extrapolating those relationships onto data from individual counties. For example, if 20 percent of males and 10 percent of females in North Carolina are uninsured, then these rates can be applied to county level characteristics to generate an estimate of the rate of uninsured in a particular county. The authors of the initial report considered characteristics such as gender, age, race, ethnicity, poverty status, educational attainment, and employment. This report updates that analysis to provide estimates of health insurance coverage for 2004.

Because data sources and methodology differ between the annual reports produced by the Sheps Center, direct comparison of rates from the different periods is not recommended. The data used for the estimates of health insurance coverage are drawn primarily from the U. S. Census Bureau's annual survey of

[1] Most North Carolina citizens 65 or over are eligible for Medicare.

insurance coverage, which reports a statewide rate. In order to make county-level estimates of the uninsured, three years of CPS data are pooled and reported in this analysis. The three-year weighted average creates an overall statewide estimate that differs slightly from the CPS estimates for any year during that period.

Findings in Brief

This report provides county-level estimates of the number and percentage of people under the age of 65 who lack health insurance for 2004. The model used pooled data from the U.S. Census Bureau's CPS and population characteristics of each of North Carolina's 100 counties to estimate the proportion of a county's residents that lack health insurance for *all* of 2004. Calculations were made for two subsets of the population: under age 18 years and those 18 to 64 years of age. The county level estimates ranged from a low of 13.9% in Wake County to a high of 28.3% in Tyrrell County. Along with Wake County, Mecklenburg, Granville, Swain, and Durham Counties appeared in the five counties with the lowest rate of uninsured persons under 65 years in 2004. Onslow, Sampson, Hyde, and Duplin Counties joined Tyrrell County in the counties with the largest proportion of the under age 65 population uninsured in 2004. As might be expected, the counties with the largest absolute numbers of uninsured had the largest overall populations. Approximately 104,000 residents of Mecklenburg County lacked health insurance in 2004. Other counties with large numbers of residents who were uninsured were Wake, Guilford, Cumberland, and Forsyth Counties. Tyrrell County is estimated to have had the fewest uninsured in 2004 at slightly less than 1000.

Developing County-Level Estimates

The goal of this study was to develop county-level estimates of health insurance coverage. The process involved pooling data for three years of CPS statewide surveys and applying those state level estimates to individual county-level data for each of the three years. This procedure adjusts for the specific characteristics prevailing in each county for each of those years. Summing the county level estimates to a statewide number creates a slightly different overall estimate of the number of uninsured in the state from what is reported in the Census Bureau CPS estimates. This difference is then used to adjust the county-level estimates to ensure internal consistency. Because the CPS sampling is structured to create a state-level estimate, we sought to reconcile our county-level estimates with the CPS. To do this, we adjust the county-level estimates appropriately.[2] If factors increasing the risk of being uninsured have larger effects if other risk factors exist, then the approach we take will underestimate the number of uninsured. For example, it may be the case that being unemployed increases the risk of being uninsured more for those with less education. In other words, the adjustment accounts for the fact that we do not observe multiplicative effects of having multiple risk factors leading to the lack of health insurance.

Data Sources and Assumptions

The 2004 and 2005 Annual Social and Economic Supplement to the Current Population Surveys[3] contained roughly 4000 North Carolina residents each year who were under age 65 and not members of the armed forces. Like the earlier studies, several individual level characteristics were used to quantify the extent to which individual characteristics influence a person's likelihood of having health insurance coverage. The most recent data source was used to update this information, but data sources for some characteristics differed from the earlier reports. The selection of variables that are used to make the estimates was limited by the availability of corresponding county-level variables used to make predictions of the number of uninsured in each county in North Carolina. The model for respondents under age 18 included race, ethnicity, and poverty variables. Age, sex, race,

[2] Rao (*Small Area Estimation*, 2003) suggests this method to ensure consistent estimates. For further details on this and other technical or modeling questions, please contact the authors.

[3] Note that the year of the CPS refers to the previous year of data. That is, the 2005 CPS describes the 2004 circumstances of the household.

ethnicity , poverty, and income, as well as sector of employment (or lack of employment) were included in the model for persons age 18 to 64.[4] The data were gathered from several sources:

- Information on race, age, gender, and ethnicity were obtained from the U.S. Census Bureau, Population Division for 2004.
- Poverty estimates for 2002 were provided by the U.S. Census Bureau, Housing and Household Economic Statistics Division, Small Area Estimates Branch
- Data from Claritas, a marketing group, provide estimates on family income for 2003.

For adults aged 18-64, we also used the following employment characteristics.

- The North Carolina Employment Security Commission publishes information on 2004 unemployment rates as well as industry employment patterns.
- Information on employer size – a key determinant of employment sponsored insurance — was obtained for 2003 from County Business Patterns, published by the U.S. Census Bureau.

Employer size is a notable addition this year and is responsible for some notable geographic patterns. For example, Swain and Washington Counties had marked decreases in the proportion of their residents that are uninsured because large firms (who are more likely to cover employees than small firms) employ a large number of employees in the county.

Methods

Linear probability regression models were used to quantify the extent to which individual characteristics influence a person's likelihood of having health insurance coverage. Two separate models were estimated. One model estimated the effect of the characteristics on respondents under age 18, and another model examined the population between ages 18 and 64. For respondents over age 65, Medicare coverage was assumed; hence respondents over age 65 were excluded from the analysis. Members of the armed forces were also excluded. The coefficients derived from the regression were applied to county-level population data. The distribution of the population in each county across the variable categories was used to identify the characteristics of an (artificial) person who is representative of the entire population in that county. For example, if females age 25-29 represent three percent of a county's population, the representative person was assigned a value for that particular variable of 0.03. Using these values and the coefficients obtained from the regression model a probability of being uninsured was calculated for this representative person. The probability of being uninsured was then multiplied by the number of persons in that particular county to estimate the total number of uninsured. This process was repeated for every county and for each of the two population subgroups (0 – 17 years; 18 - 64 years). The estimated total number of uninsured between the ages of 0 and 64 for each county and year was obtained by adding the estimated number of uninsured across the two age groups.

We employed a new weighting technique this year. In order to put more weight on recent observations, we developed an algorithm that determined the optimal weight to place on each year's data. For the estimates presented in this report, our weights were 2004 (.766) and 2003 (.234). That is, the observations from CPS 2003 contributed to the overall estimates but the modeling put more weight on data from recent years. This allows recent developments to be captured by our models.

Results

Table 1 presents the county-specific estimates of the number and percent of children, adults, and individuals below age 65 who lacked health insurance in 2004. The estimates reveal substantial variation across counties in the percentage of the population without insurance.

For more information on the uninsured in North Carolina, visit our website at http://www.shepscenter.unc.edu

[4] For further details, consult earlier versions of this report.

Cecil G. Sheps Center for Health Services Research

Table 1: North Carolina County-Level Estimates of Uninsured, 2004

	Ages 0-17			*Ages 18-64*			*Ages 0-64*		
County Name	**Number**	**Percent**	**Rank***	**Number**	**Percent**	**Rank***	**Number**	**Percent**	**Rank***
Alamance	4,243	12.5%	58	18,192	21.3%	37	22,434	18.8%	38
Alexander	928	11.3%	21	4,409	19.8%	18	5,337	17.5%	20
Alleghany	282	13.6%	91	1,806	27.1%	91	2,088	23.9%	94
Anson	745	12.1%	44	3,453	22.4%	51	4,198	19.5%	49
Ashe	638	13.3%	82	3,882	24.6%	76	4,520	22.0%	81
Avery	454	13.4%	85	2,806	24.5%	75	3,260	22.0%	80
Beaufort	1,339	12.5%	62	6,820	24.7%	78	8,159	21.3%	76
Bertie	622	12.7%	70	2,467	21.5%	40	3,089	18.9%	41
Bladen	1,116	13.7%	93	4,727	23.3%	62	5,843	20.5%	66
Brunswick	2,063	11.7%	32	12,045	23.2%	60	14,108	20.3%	61
Buncombe	5,438	11.5%	24	27,238	20.1%	24	32,676	17.8%	24
Burke	2,612	12.3%	53	10,440	18.7%	10	13,052	17.0%	11
Cabarrus	4,013	10.6%	8	17,494	19.0%	11	21,507	16.5%	10
Caldwell	2,182	11.9%	38	9,940	20.0%	23	12,122	17.9%	25
Camden	204	10.9%	11	1,504	27.3%	93	1,709	23.1%	91
Carteret	1,352	11.1%	12	9,039	23.3%	61	10,391	20.4%	63
Caswell	629	11.8%	34	3,269	21.6%	42	3,899	19.1%	43
Catawba	4,155	11.4%	22	18,349	19.4%	14	22,504	17.2%	14
Chatham	1,550	12.2%	50	7,331	20.2%	26	8,881	18.1%	30
Cherokee	681	13.2%	80	3,888	25.6%	84	4,568	22.4%	86
Chowan	414	11.9%	36	2,095	24.9%	79	2,509	21.1%	74
Clay	201	11.6%	30	1,353	23.8%	68	1,554	20.9%	71
Cleveland	2,846	11.6%	28	12,091	20.1%	25	14,937	17.6%	21
Columbus	1,847	13.5%	88	8,475	25.6%	83	10,322	22.0%	83
Craven	2,662	11.1%	14	11,059	20.3%	27	13,721	17.5%	19
Cumberland	10,494	11.5%	25	41,988	22.0%	47	52,482	18.6%	35
Currituck	578	11.2%	15	3,505	24.3%	73	4,083	20.8%	68
Dare	753	10.8%	9	5,285	24.1%	72	6,039	20.9%	70
Davidson	4,312	11.8%	33	19,757	20.4%	29	24,069	18.0%	28
Davie	1,023	11.6%	27	4,834	20.4%	28	5,857	18.0%	27
Duplin	2,215	16.3%	100	9,940	31.4%	99	12,155	26.9%	99
Durham	6,160	10.4%	6	28,814	18.3%	6	34,974	16.1%	5
Edgecombe	1,795	12.4%	55	7,442	22.1%	49	9,236	19.2%	46
Forsyth	8,948	11.2%	17	36,781	18.3%	7	45,729	16.3%	8
Franklin	1,535	11.6%	29	8,022	23.1%	57	9,557	19.9%	53
Gaston	5,312	11.1%	13	24,174	19.8%	17	29,485	17.3%	17
Gates	324	12.1%	45	1,653	24.7%	77	1,977	21.1%	73
Graham	237	13.6%	90	1,231	25.3%	82	1,468	22.2%	85
Granville	1,488	12.0%	41	5,566	16.1%	2	7,054	15.0%	3
Greene	743	15.2%	98	3,634	27.9%	94	4,377	24.4%	95
Guilford	10,886	10.1%	4	51,839	18.6%	8	62,725	16.2%	6
Halifax	1,799	12.6%	63	9,084	27.3%	92	10,883	22.9%	90
Harnett	3,485	12.8%	71	15,492	24.0%	71	18,977	20.7%	67
Haywood	1,373	12.1%	47	7,238	21.5%	39	8,611	19.1%	44
Henderson	2,436	12.2%	51	11,842	21.5%	41	14,278	19.0%	42
Hertford	690	12.5%	57	3,566	24.5%	74	4,256	21.2%	75
Hoke	1,589	13.4%	87	5,377	21.9%	45	6,966	19.1%	45
Hyde	143	13.3%	83	1,062	30.2%	97	1,205	26.2%	98

Appendix C | County-level Estimates of the Number of Uninsured in North Carolina 2004 Update

Cecil G. Sheps Center for Health Services Research

	Ages 0-17			Ages 18-64			Ages 0-64		
County Name	**Number**	**Percent**	**Rank***	**Number**	**Percent**	**Rank***	**Number**	**Percent**	**Rank***
Iredell	3,723	10.8%	10	17,035	19.9%	21	20,758	17.3%	16
Jackson	885	12.0%	39	5,391	23.7%	67	6,275	20.9%	69
Johnston	4,411	11.8%	35	21,813	23.9%	69	26,224	20.4%	64
Jones	347	14.2%	95	1,656	26.1%	87	2,003	22.8%	88
Lee	1,695	13.1%	78	6,205	21.1%	33	7,901	18.6%	36
Lenoir	1,790	12.2%	49	8,194	23.4%	64	9,984	20.1%	57
Lincoln	2,064	12.5%	61	9,498	21.9%	46	11,561	19.3%	47
McDowell	1,264	13.0%	76	5,892	21.7%	43	7,156	19.4%	48
Macon	798	12.9%	75	4,565	25.1%	80	5,363	22.0%	82
Madison	555	12.8%	73	2,299	18.7%	9	2,853	17.1%	13
Martin	788	13.0%	77	3,782	25.6%	85	4,570	21.9%	79
Mecklenburg	19,009	9.4%	2	85,338	16.9%	3	104,347	14.8%	2
Mitchell	432	13.4%	86	1,999	20.6%	31	2,431	18.8%	39
Montgomery	1,031	15.1%	96	4,064	24.0%	70	5,095	21.4%	77
Moore	1,982	11.3%	20	9,017	19.8%	19	10,998	17.5%	18
Nash	2,578	11.3%	19	12,236	21.8%	44	14,814	18.8%	37
New Hanover	3,762	10.1%	3	23,990	21.1%	34	27,753	18.4%	31
Northampton	602	12.3%	52	2,829	22.2%	50	3,431	19.5%	51
Onslow	5,823	12.7%	66	29,740	30.6%	98	35,563	24.8%	96
Orange	2,754	10.4%	7	14,602	18.2%	5	17,356	16.3%	7
Pamlico	292	12.0%	42	1,745	22.4%	52	2,037	20.0%	55
Pasquotank	1,129	12.5%	56	5,343	23.4%	63	6,472	20.3%	60
Pender	1,265	12.6%	64	7,442	26.1%	88	8,707	22.6%	87
Perquimans	319	12.7%	69	1,600	23.1%	58	1,919	20.3%	62
Person	1,014	11.5%	23	4,508	19.5%	15	5,521	17.2%	15
Pitt	3,927	11.2%	18	20,929	22.8%	54	24,856	19.6%	52
Polk	451	12.2%	48	2,163	19.9%	22	2,615	17.9%	26
Randolph	4,315	12.8%	74	18,122	21.2%	36	22,438	18.8%	40
Richmond	1,603	13.2%	81	7,090	25.2%	81	8,693	21.6%	78
Robeson	4,911	13.5%	89	21,857	28.2%	95	26,768	23.5%	93
Rockingham	2,669	12.5%	60	12,612	22.1%	48	15,280	19.5%	50
Rowan	3,903	11.9%	37	15,768	19.0%	13	19,671	17.0%	12
Rutherford	1,900	12.7%	68	9,013	23.5%	65	10,913	20.5%	65
Sampson	2,455	15.2%	97	11,221	29.2%	96	13,676	25.1%	97
Scotland	1,184	12.0%	40	4,739	21.4%	38	5,923	18.5%	33
Stanly	1,662	11.5%	26	7,436	20.6%	30	9,098	18.0%	29
Stokes	1,239	11.7%	31	6,634	23.0%	55	7,873	19.9%	54
Surry	2,383	14.0%	94	9,878	22.6%	53	12,262	20.2%	58
Swain	405	12.8%	72	1,363	17.3%	4	1,768	16.0%	4
Transylvania	658	11.2%	16	3,557	21.0%	32	4,215	18.5%	34
Tyrrell	126	15.4%	99	863	32.3%	100	989	28.3%	100
Union	4,369	10.3%	5	18,667	19.0%	12	23,036	16.4%	9
Vance	1,542	12.7%	67	6,944	26.5%	89	8,485	22.1%	84
Wake	16,878	9.1%	1	75,788	15.8%	1	92,666	13.9%	1
Warren	572	13.2%	79	3,257	27.1%	90	3,829	23.4%	92
Washington	414	12.6%	65	1,565	19.9%	20	1,979	17.7%	22
Watauga	965	12.1%	46	6,917	23.5%	66	7,881	21.1%	72
Wayne	3,605	12.1%	43	14,922	21.1%	35	18,527	18.4%	32
Wilkes	1,877	12.4%	54	8,305	19.8%	16	10,182	17.8%	23
Wilson	2,422	12.5%	59	10,861	23.2%	59	13,283	20.1%	56
Yadkin	1,186	13.3%	84	5,287	23.0%	56	6,474	20.3%	59
Yancey	508	13.6%	92	2,867	25.9%	86	3,376	22.8%	89

Rank based on estimated percentage of residents who lack health insurance, with lower numbers implying higher rates of health insurance coverage.

Appendix D | Summary of the FGI Research Focus Group Report

Overview

As a part of the NC Department of Health and Human Services (NC DHHS) one-year State Planning Grant from the Health Resources and Services Administration (HRSA), the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill contracted with FGI Research to conduct focus groups to examine: (1) uninsured individuals' healthcare and insurance decisions; (2) employers thoughts regarding offering health insurance to their employees; and (3) perspectives from insurance agents and brokers regarding the uninsured and potential health insurance policies to serve them. The purpose of these groups was to learn: how decisions are made by individuals with regard to seeking health insurance and by employers with regard to offering health insurance, and what policy options are favored for expanding coverage by each group.

Discussion topics included factors considered in making decisions to take-up or offer health insurance, consequences of being uninsured/not offering insurance, and the willingness of both individuals and employers to pay for insurance. Other discussion included possible trade-offs in lifestyle or benefits to make insurance more affordable. Focus group participants were also presented with a number of hypothetical insurance plans and asked to offer their policy preferences.

These focus groups were conducted in a manner designed to provide a wide array of experience and opinion. However, the sample is not scientifically representative of the larger population, and the data must be approached with this in mind. Focus groups of uninsured individuals were held in Beaufort, Cabarrus, Jackson, Robeson, and Wake counties. Focus groups for employers and representatives responsible for managing their company's healthcare benefits were divided by firm size. Four groups were held with small employers (1-49 employees), two groups with medium employers (25-99), and two groups with large employers (100+). The focus groups for small employers were held in Catawba, Halifax, Pitt, and Moore counties. Medium employer groups were located in Buncombe and New Hanover counties. The large employer groups were held in Guilford and Mecklenburg counties. Participants in these groups represented diverse professions, including agriculture, hospitality, government, and construction. Focus groups for agents and brokers were held in Mecklenburg and Wake counties.

Appendix D | Summary of the FGI Research Focus Group Report

Factors in Deciding to Take-up/Offer Health Insurance

The focus groups highlighted the following as factors in deciding whether to take-up/offer health insurance: cost, retention and attraction, and coverage trends. Cost was the principal reason uninsured participants noted for not having health coverage, although the majority expressed concern about not having health insurance. About half of the employed, uninsured participants had insurance available through their employer, but felt they couldn't afford the portion they would be required to pay to participate in the plan. Employers also mentioned cost as the primary barrier to providing coverage to their employees. Participants representing businesses reported that skyrocketing yearly premium increases created difficulties for both the business and the employee.

For the businesses offering health insurance to their employees, they noted doing so to attract and retain good workers. Employers cited competition and the cost of training as important factors in their decisions. Additionally, they saw health benefits as a cost effective method of offering employees greater compensation. Other factors perceived by insurance agents, brokers, and employers as contributors to the lack of affordable health insurance included: fewer insurance companies in the state, leading to a lack of competition and rising costs; increases in required participation rates for small employers; and paying more for less coverage than five years ago.

Consequences of Being Uninsured or Not Offering Insurance

Numerous uninsured respondents reported health problems for which they were currently receiving less than adequate treatment. Many uninsured participants also noted they were not getting check-ups or other routine preventive care. Some people said this was due to the cost, others reported trouble finding doctors who would treat them without insurance coverage. Some employers noted losing good employees as a negative consequence of not offering employer-sponsored health insurance coverage.

Insurance agents, employers, and uninsured individuals all spoke of the importance of the hospital emergency departments in meeting the healthcare needs of the uninsured. While many participants recognized that the use of the emergency department for primary healthcare is a driver in rising healthcare costs, uninsured participants often viewed it as a viable healthcare choice. Other avenues that were mentioned included urgent care centers, county clinics, and doctors with sliding-scale fee systems.

Trade-Offs for Affordable Coverage

Many focus group participants recognized that trade-offs would be necessary for more people to access health insurance. Younger participants without current health problems were more likely to have an interest in a limited benefit policy than older respondents or those with current health problems. The cost of prescription medications was a recurring concern for participants. The low-wage, uninsured workers didn't see how

they could pay much more than $50 a month for health insurance. However, most were reluctant to trade amenities like cable television or cell phones to offset the price of coverage.

Generally, the employers described changing plans, restricting benefits, and/or raising deductibles in order to manage premium increases. Many participants said that their companies no longer paid any portion of the family coverage. Some respondents said that they actively discouraged employees from taking up family coverage because of the costs. Employers are shifting benefits packages around, letting go of profit-sharing plans, or postponing raises to offset the increased cost of insurance. Both employers and human resources professionals spoke of having to get creative to continue offering health insurance to their employees.

Solutions

All groups noted a need to increase government involvement in healthcare, particularly in the areas of the uninsured and rising healthcare costs. Potential government interventions mentioned in the groups included: tax credits for businesses or individuals, government-run insurance pools, subsidies toward premium expenses, and government-sponsored systems of care. Increased regulation of healthcare costs, including doctors, hospitals, pharmaceuticals, attorneys, and insurance companies, was also mentioned in all groups. In particular, respondents cited prescription drug advertising and litigation as factors in rising prices.

Education of healthcare consumers was also noted as an important need. Several uninsured participants spoke of lacking a basic understanding of health insurance and required explanations of the terms "deductible," "co-pay," and "co-insurance." Employers mentioned needing to spend a lot of time with employees reviewing their health insurance benefits and educating them on healthcare issues.

Product Preferences

At the end of each focus group, participants were asked to prioritize their preferences for five different hypothetical health insurance plans. These plans and their costs mirrored products that might be available through an insurance broker in North Carolina. The five plans discussed were a Preferred Provider Organization (PPO), a Health Savings Account (HSA), two Limited Benefit plans (LBP and LBP with high-deductible hospital option), and a Hospital-Only plan. Uninsured individuals gave lower ratings to all the plans than did other participants, as they perceived these products to be out of their price range. Employers and brokers gave the PPO the highest ratings. Many respondents thought the PPO plan was under-priced. Agents and brokers expressed a high level of interest in all the plans and suggested that variety was currently lacking in the marketplace. Small businesses also found the variety more attractive than did larger businesses. A number of participants representing small employers expressed a desire for a tiered product that would allow employees limited benefits with an opportunity to "buy up."

Appendix D | Summary of the FGI Research Focus Group Report

Conclusions

Cost is the main driver with regard to health insurance take-up by individuals and offers of insurance by employers. All parties consulted in these focus groups—agents, employers, and uninsured individuals—expressed concern about rising healthcare costs and the lack of affordable health insurance. Although employer-sponsored health insurance has been the backbone of the industry in the United States for most of the last century, employers are finding it difficult to maintain benefit levels. Thus, employees are paying more for less coverage than they did just five years ago. Small businesses are feeling the pinch more than their larger counterparts. They report having few choices when it comes to insurance offers.

The complete FGI Research Focus Group Report can be accessed online at: http://www.nciom.org/projects/uninsured/uninsured.html.

Appendix E

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Full report available at: http://www.nciom.org/projects/uninsured/uninsured.html

February 20, 2006

Evaluation of HRSA Coverage Options: Executive Summary

Cecil G. Sheps Center for Health Services Research
(at the University North Carolina-Chapel Hill)

MERCER
Government Human Services Consulting

A copy of the full Mercer Government Human Services Consulting report on Evaluation of HRSA Coverage Options can be accessed online at: http://www.nciom.org/projects/uninsured/uninsured.html.

Executive Summary

Growth in the number of Americans without health insurance coverage has become a significant policy issue across the country. North Carolina is no exception, where the uninsured population has increased from 16 percent of the non-elderly population in 1999-2000 to 18 percent of the non-elderly population in 2003-2004.[1]

To support a Heath Resources and Services Administration (HRSA) State Planning Grant to study policy options for expanding health insurance coverage in the state, the Cecil G. Sheps Center for Health Services Research at the University of North Carolina–Chapel Hill hired Mercer Government Human Resources (Mercer) to assist in option design and pricing. With direction from the Cecil G. Sheps Center for Health Services Research (at the University North Carolina-Chapel Hill) and the Task Force for Covering the Uninsured, Mercer evaluated both public sector- and private sector- sponsored options for expanding coverage. All cost projections are based on coverage for calendar year 2006.

Public Sector Options

Mercer evaluated three publicly sponsored expansion options; all were Medicaid expansions. The first option is an expansion of the current set of Medicaid covered benefits, and the remaining two are variations on a limited benefit expansion. Children in North Carolina from families with incomes up to 200 percent of FPG are currently eligible either for Medicaid or Health Choice for Children, depending on income level and age. All three expansion options were evaluated for expansion to children from 200 to 300 percent of FPG.

Medicaid currently covers non-pregnant adults with incomes up to 37 percent of the Federal Poverty Guidelines (FPG) and pregnant women with incomes up to 185 percent of FPG. All three expansions were evaluated for parents of children enrolled in Health Choice in the following income bands: 37 to 100 percent, 100 to 150 percent, 150 to 200 percent, and 200 to 300 percent.

Providing full Medicaid benefits to individuals is expensive; the benefits are comprehensive and the member cost sharing is very low. Per person monthly cost projections for adults ranged from $490 to $530, depending on FPG level. Children are less expensive, projected at $257 monthly. The full Medicaid expansion to 300 percent FPG could be expected to cover 174,000 people at a total annual cost of $1 billion. That cost would be shared between the federal government, the State, Counties, and enrollees in the form of a premium contribution.

A limited benefit expansion could provide a less expensive alternative and still provide coverage of key services to some individuals currently without health care coverage. The

[1] Holmes M. Data from the U.S. Census, Current Population Survey: 2004, 2005 (reflecting 2003, 2004 coverage). Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. 2005. The analyses are based on two-year average of 2004, 2005 CPS data weighted more heavily to the most recent year.

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limited benefit options evaluated do not include all the benefits in the regular Medicaid program, and they require significantly more cost sharing on the part of the enrollee.

Mercer evaluated two versions of a limited benefit plan, with the difference between the two being the treatment of hospital inpatient services. In the first alternative, there is a $5,000 hospital inpatient deductible that must be borne out of pocket before the benefit begins. In the second alternative, there is a $100 inpatient hospital deductible, and then 80 percent of costs are covered until the plan has paid out $10,000 in inpatient expenses.

Mercer's analysis showed that the projected costs for the two limited benefit options do not differ much from one another, but are much lower than for the full benefit expansion. Per person monthly cost projections for adults ranged from $270 to $290 for the $5,000 Inpatient Deductible option and from $275 to $300 for the $10,000 Inpatient Limit alternative.

However, this type of plan is likely to attract fewer enrollees than a full expansion. Although the premium charged is lower, many persons are likely to consider the covered benefits and the high cost sharing levels and choose not to enroll. Projections for each of these products were that they might cover approximately 104,000 individuals at a total annual cost of $334 to 344 million. Again, these costs would be shared by the federal, state, and county governments, and by the enrollees through the payment of a monthly premium contribution.

Private Sector Options

Focus groups conducted in Spring 2005 as part of the HRSA project revealed interest in tiered benefits offered to small employers, particularly in the form of limited benefit plans. This model includes a base plan of benefits and the opportunity to "buy up" to higher levels of benefits. Small employer coverage is regulated by the State, and this option might require statutory and/or regulatory changes. While this type of product would be designed and priced by the private market in North Carolina, the Task Force asked Mercer to produce cost estimates for a sample product, to provide a sense of whether this type of option might provide an attractive cost/benefit alternative that could encourage higher levels of coverage among employees of small employers.

The sample product evaluated covers a core set of services considered to be the most critical: inpatient hospital care (including professional services while admitted), physician office visits, diagnostic testing, emergency room, and prescription drugs. The base plan (Tier 1) covers a low level of these benefits (for example, up to 4 office visits annually), while employees could choose to buy one of two richer versions of the plan (Tier 2 or Tier 3). All three tiers have member cost sharing requirements that are similar to those in standard commercial health insurance products.

These very limited products are projected to be significantly less expensive than comprehensive health insurance products currently available. For instance, the sample product estimated monthly premium cost per adult ranged from $150 (Tier 1) to $270

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(Tier 3). However, despite the interest in this type of product expressed in HRSA focus groups, limited benefit plans have not historically been popular in the private health insurance market. For this reason, cost estimates were developed assuming that 40 percent or fewer eligible individuals would purchase this product.

Other private sector coverage options were considered by the Task Force but were not priced by Mercer.

Methodology

Mercer used an actuarial pricing approach to project costs for each of the policy options evaluated. This type of approach starts with base data that represents the closest possible match to the target population, covered services, and service delivery method of the option to be priced. That base data is then adjusted for expected differences between the base and the option, including differences in population, covered services, cost sharing elements, and time period.

For the public sector options evaluated, Mercer used North Carolina Medicaid data as the most reasonable available base data source. For the private sector options, North Carolina detail from a large commercial claims data set was used. The adjustments made to those data sources were based on data analysis, other internal and external research, and the judgment of Mercer's actuaries. The adjustments are appropriate for the type of analysis performed; they do, however, rely on assumptions that are selections from ranges of reasonable assumptions. The cost projections that result, and are shared above, are best interpreted as a point estimate within a range of reasonable results.

A copy of the full Mercer Government Human Services Consulting report on Evaluation of HRSA Coverage Options can be accessed online at: http://www.nciom.org/projects/uninsured/uninsured.html.

Appendix F | Methodology

This Appendix describes datasets used in analysis and outlines briefly some of the approaches taken in the statistical analysis and development of cost estimates. For more details, contact the North Carolina Institute of Medicine. For information on the details of the actuarial analyses, interested readers should consult the final report by Mercer Human Resource Consulting (Appendix E).

I. Data Sets

There were three datasets commonly used throughout this report, including the Current Population Survey, the Medical Expenditure Panel Survey, and the Behavioral Risk Factor Surveillance System. They are each described below.

A. The Current Population Survey

The Current Population Survey (CPS) is a monthly survey of about 50,000 US households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years.[1]

The CPS is the primary source of information on labor force characteristics of the US population. The sample is scientifically selected to represent the civilian noninstitutional population. Respondents are interviewed to obtain information about the employment status of each member of the household age 15 years and older. However, published data focus on those aged 16 and over. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas.[1]

The Annual Social and Economic Supplement (ASEC) is a supplement to the CPS conducted in March of each year. The ASEC is a more detailed survey of a subsample of the CPS households and contains information on employment benefits, work history, and detailed income characteristics. Most importantly for the purposes of the Task Force, the ASEC contains a number of questions on health insurance. Therefore, ASEC serves as the source of the official poverty, income, and health insurance estimates published by the Census Bureau every fall. Following the general convention used in the literature on health insurance, throughout this Task Force "CPS" is used to refer to the ASEC.

Sample ASEC questions regarding health insurance status include asking respondents, *"At any time in 2004, (were you/was anyone in this household) covered by Medicare?"*

If the respondent answers affirmatively, the interviewer asks for the names of all those covered by Medicare. This same question is asked numerous times regarding many different types of insurance plans (e.g., Medicaid, employer-sponsored insurance, nongroup coverage). Anyone in the household who was not listed, therefore, did not have any health insurance in the previous year. The CPS asks a confirmation question to double-check the accuracy:

"I have recorded that (name/you) (was/were) not covered by a health plan at any time during 2004. Is that correct?"

Through this process, the insurance status of everyone in the household—not just those 15 and over, as in the Basic CPS survey—is ascertained.

In the 2005 ASEC (referring to 2004 insurance coverage), 4,430 North Carolinians were surveyed. Of these, 4,003 were under the age of 65.

More information can be found at http://www.bls.census.gov/cps/.

B. Medical Expenditure Panel Survey

The Medical Expenditure Panel Survey (MEPS) is a comprehensive set of surveys sponsored by the Agency for Healthcare Research and Quality (AHRQ), an agency of the US Department of Health and Human Services (DHHS). The core survey is known as the Household Component and it collects information from approximately 25,000 individuals across the country. It follows each individual's healthcare utilization at five separate points over a two and a half year period. Households provide a rich set of data on their healthcare utilization and expenditures, as well as characteristics thought to influence healthcare utilization patterns, such as insurance coverage, household income, and attitudes about healthcare treatment. The data are well-suited to analyze most issues surrounding households' decisions about healthcare. A chief limitation of the Household Component for this Task Force is that it is not designed to support state-level analyses. Researchers are able to access state-specific data at the Data Center at AHRQ headquarters in Maryland, and such analysis was performed for the Task Force purposes. There were two main findings from that analysis. The first was that in nearly all respects, North Carolina is very similar to the South in general. The second is that the state-specific analyses undertaken in Maryland relied on a small sample size and therefore could not be considered very reliable. In the end, therefore, MEPS analysis *per se* guided little of the Task Force deliberations, although published research using MEPS was used fairly regularly. The chief exception was the estimates for Healthy North Carolina (see below).

As mentioned above, MEPS consists of many separate components that link to the households, including an Insurance Component. The Insurance Component (IC) is a survey of businesses, which ascertains information about employer-sponsored insurance (ESI) in the establishment. Characteristics of the establishment, such as the number of workers, industry, and average wage of the employees, are also collected. In contrast with the Household Component, the Task Force used the IC a great deal, primarily because it is the best resource for information about ESI premiums and coverage. One limitation of the data is that micro-level data are unavailable; researchers must rely

on the tables published on the AHRQ website. Furthermore, because estimates are imprecise and vary considerably from year to year, two-year averages were used.

More information can be found at http://www.meps.ahrq.gov/.

C. Behavioral Risk Factor Surveillance System

The State Center for Health Statistics, Division of Public Health, NC DHHS, conducts the Behavioral Risk Factor Surveillance System (BRFSS) annually. It is a telephone survey of 15,000 adults across North Carolina that includes questions on insurance coverage, ability to access health services, and use of preventive screenings. Questions about insurance coverage were added to the 2005 BRFSS survey for the first five months. Between January and May, 5,273 people were interviewed. Of those interviewed, 582 reported being uninsured and were asked why they lacked health insurance coverage.[2] The 2005 weights are considered preliminary until they are processed by the Centers for Disease Control. At the time this report was being printed, the 2005 weights had not been finalized. Therefore, 2004 data were used if the questions were asked in 2004. The preliminary 2005 weights were used for the State Planning Grant if no comparable questions existed in years prior to 2005, as in the case of the new questions regarding insurance coverage, access to health services, and use of preventive screenings.

More information can be found at http://www.schs.state.nc.us/SCHS/brfss/.

II. Statistical Analysis

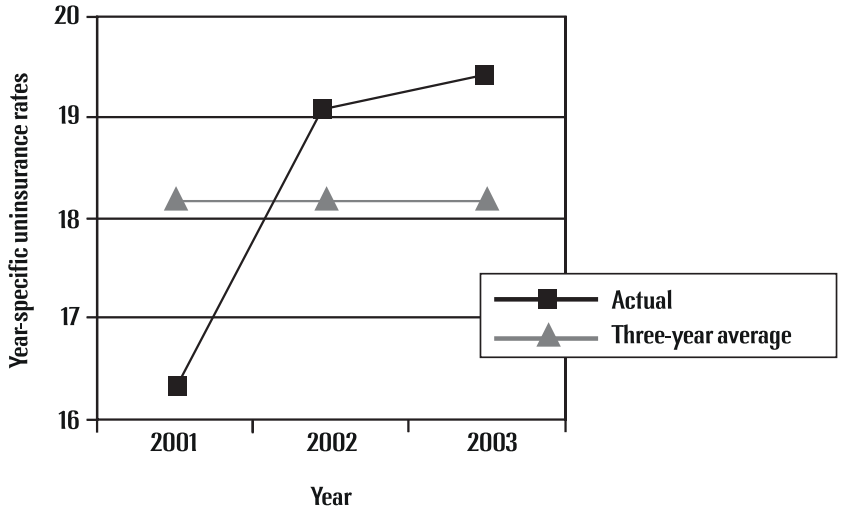
Described below are two details of analysis associated with the Current Population Survey.

A. Current Population Survey Analysis: Development of Multiple-year weights

It is common Census Bureau practice to report multiple-year averages for state-level uninsurance rates. For example, the DeNavas-Walt et al (2004) CPS report presented both two- and three-year averages.[3] We extend this technique using a slightly more sophisticated method outlined here.

At its core, using multiple-year averages is a tradeoff between precision and bias. Using multiple year data generates more precise estimates (smaller sampling error) because it uses a larger sample size. On the other hand, the bias component acknowledges that averaging over longer time periods ignores time trends in the data. For example, a three-year average (2001-2003) is best interpreted as an estimate of the 2002 uninsurance rate. Chart F.1 demonstrates this principle with year-specific estimates from the Annual Social and Economic Supplement (ASEC) and the simple three-year average. It shows that a multiple-year average does not account for a secular increase in the uninsurance rate.

Chart F.1
Effect of Multiple-Year Averaging



Our approach acknowledges the tradeoff between precision and bias by using a three-year average, but placing **greater weight on more recent years**. The weights are calculated empirically. The goal is to develop an estimation method that minimizes the average error—it balances the increased precision from greater years against the increased bias by considering more temporally distant data.

The estimation procedure utilizes a four step process.

Step 1: Generate estimates of the uninsurance rate for age-specific categories *using the most recent year of data only.*

For the approach developed here, we are considering the 2004 uninsurance rate (2005 ASEC). The age-specific uninsurance rates are unbiased, but imprecise, estimates of the actual rate. That is, there is no reason to suspect they are systematically high or low, but we know that they are likely to be imprecise estimates of the truth. These estimates are set aside and treated as the gold standard.

Step 2: Bootstrap the ASEC data for the three most recent years and generate analogous age-specific uninsurance rates for each year.

We randomly sample the ASEC data for the three previous years (2003, 2004, and 2005 here). We sample, with replacement, sample sizes similar to the size of the North Carolina ASEC. Sampling partially accounts for the survey design by sampling counties rather than individuals/families/households. That is, we randomly choose one of the counties in the ASEC and select all households within that county. This accounts for the within-county correlation in the uninsured rate.

Of course, the ASEC does not identify all counties used in the sampling frame; a large number of households have the county code suppressed. These households are randomly divided into 10 similarly sized groups and are treated as "quasi-counties."

The sampling is repeated 100 times, and after each iteration the age-specific estimates are set aside.

Step 3: Determine the optimal year-specific weights.

The goal is to find w_{2002}, w_{2003}, and w_{2004} such that

$E(ACTUAL_{2004} - [w_{2002}*UI_{2002} - w_{2003}*UI_{2003} - w_{2004}*UI_{2004}])$,

(where $ACTUAL_{2004}$ is the true, unobserved uninsured rate in North Carolina in 2004, and UI_{2004} is the 2004 estimate) is as close to 0 as possible, subject to the constraint that the weights sum to 1.

We use a simple regression method to estimate the weights. We regress

$GOLD_{2004} - UI_{2004}$ on UI_{2002} and UI_{2003}

where the $GOLD_{2003}$ is the set of gold standards obtained in Step 1. The subtraction of the 2003 estimate from the left hand side ensures the weights sum to 1, with w_{2004} defined as $1 - w_{2002} - w_{2003}$. The constant is constrained to 0.

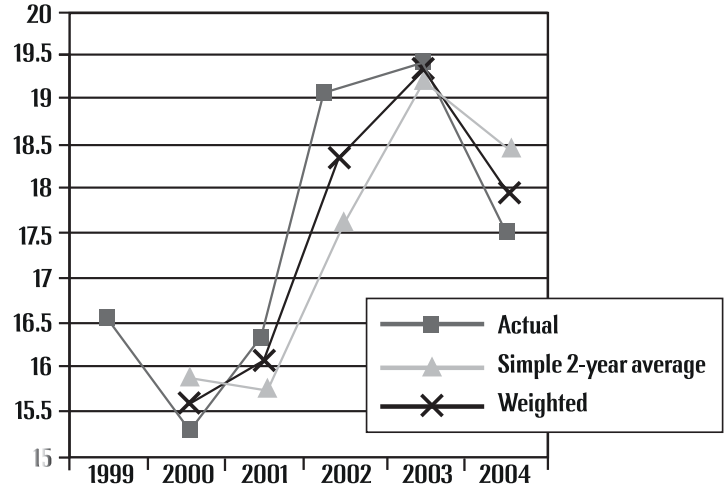
This is a simplification of the approach actually used. We wanted the weights to be independent of the "base year," so repeated this analysis from the perspective of estimating 2004, 2003, and 2002 uninsurance rates. Although we allowed a three-year average, a two-year average performed just as well empirically.

The ideal weights

Current year: 0.7659562
Previous Year: 1- 0.7659562 = 0.2340438

These weights are multiplied by the CPS weight [marsupwt].

Chart F.2
Multiple-Year Weight Estimates



The weighted estimate is much closer to the 2004 specific estimate, but is lower because it incorporates estimates from earlier years.

Source: DeNavas-Walt, Carmen, Bernadette D. Proctor, and Robert J. Mills, U.S. Census Bureau, Current Population Reports, P60-226, Income, Poverty, and Health Insurance Coverage in the United States: 2003, U.S. Government Printing Office, Washington, DC, 2004.

Step 4: Reweight to scale to 2004 population sizes.

For percentage-type metrics, this last adjustment is not necessary, but it is important for population-type metrics (number of individuals). The new weights are finally multiplied by an upweighting factor to generate weights consistent with 2004 population levels.

Continuing our empirical example, we add the multiple-year average to the original figure.

B. Current Population Survey Analysis: Definition of "Family"

The Current Population Survey defines a household as consisting of "all the persons who occupy a house, an apartment, or other group of rooms, or a room, which constitutes a housing unit…."[4]

A family is defined as "a group of two persons or more (one of whom is the householder) residing together and related by birth, marriage, or adoption. All such persons (including related subfamily members) are considered as members of one family…"[4]

So when CPS calculates family poverty, for example, it includes all members of the family—which might include grandparents, brothers, nephews, etc. This is the same definition we use for calculations using family measures, such as in the "at least two full time workers in the family" categories (Chapter 2) and the Venn diagram "family has a small business connection" (Chapter 7).

Recall that *50 percent* of the uninsured have a "small business connection," meaning that someone in the *family* (CPS definition) works for a firm with fewer than 25 employees.

Now, of course, the CPS definition of "family" is broader than that which is relevant for most insurance plans. Most plans will not allow an individual to cover her brother, or her parent, or her adult child. In that sense, when talking about the potential impact of different policy expansions, we should use the **insurance market's** view of "family"—to-wit, spouse and young children (where the definition of "children" includes natural, adopted, and step children). Call this a "traditional family."

This is non-trivial to measure in practice. There are variables that describe the relationship each person has to the householder (the person who owns/rents the home), but it is not as comprehensive as one might hope.

If 50 percent is considered an upper bound on the percent of uninsured in a family with a small business connection, it is straightforward to estimate a lower bound: define a traditional family as only those that are

- the householder
- the spouse of the householder
- the children of the householder (under 18 or under 25 and full time student)

Using this measure, about one third of the uninsured are in a family with a small business connection.

There are two examples showing how this measure is a low estimate.

The first is to design a complex family structure. For example, Grandpa is the householder, and his daughter and grandson also live in the house (daughter works in small business). Or the householder's brother and brother's daughter (householder's niece) live in the same house (and the brother works in small business). The natural inclination is to exhaust all possible situations like this. This is impractical for two reasons. The first is that it is nearly impossible to design logic that considers all possible familial structures. The second is that the relationship variable is insufficient to definitively determine whether two people are related in the traditional sense. In the first example we would know that there is a child and grandchild of the householder—it would be natural to assume that the child is the mother of the grandchild, but this is not known with certainty. In the second, we know the householder's brother and "another relative" live in the household. Thus we would not be able to link the householder's brother and niece as a traditional family.

Another example that illustrates how this measure may be a low estimate is the case where a divorced parent works for a small business but does not live in the household. Such a person is not surveyed at all, although the child would presumably have access to health insurance through the divorced parent if it was offered through his/her employer.

A more practical problem is explaining this process, and, probably more severe, that the definition of family in the Venn diagram differs for income and for connection to small business.

For this reason, we use the CPS definition of *family* (50%) but mention in footnotes that a conservative estimate is one third.

III. Cost Estimates

The following documents the methods used to develop cost estimates for the policy recommendations.

A. Recommendation 5.1 (Healthy North Carolina)

1. Impact of Reinsurance Corridors on Premiums

Although not directly included as an element of the cost estimates presented in Chapter 7, some estimates of the cost of reinsurance corridors were provided in Chapter 5. First, Medical Expenditure Panel Survey (MEPS) data from 2002 were obtained for workers ages 18-64 years old who were covered by employer-sponsored insurance in all twelve months and were employed in a firm with fewer than 50 employees in all periods of observation. The annual total expenditure by private insurers was inflated by 40.1% to 2006 using the estimates of healthcare cost increases.[5] This generates a distribution of expected medical costs to the insurer. It is straightforward to calculate the expected state cost for alternative corridors. For

example, if we know that there are $1 million in claims in the $5,000 to $10,000 corridor and there were 9,000 individuals in the plan, then the state share would be $1 million * 90% or $900,000, or $100 per enrollee. The expected state share was calculated on an annual per member basis. It was commonly represented as a percent of the expected medical claims.

We compared our estimates of the state cost of the Healthy NY corridor to estimates generated by an actuarial firm and they were within one percentage point, lending support to our approach.

Potential Limitations: MEPS is not the ideal data source for such a calculation. It would be preferred to have commercial claims data from North Carolina covering more lives than were used here. In MEPS, plan design (cost-sharing, benefits) varies in ways unknown to the analyst. That is, only the amount the plan paid is known—everything else about the plan covering the employee is unknown. The analysis was limited to employees, not dependents, and those that were insured in 2002. The claims distribution of the group covered under an expansion would likely be increased; actuaries typically assume that the newly insured have higher claims in the first year due to "pent-up demand"—medical care that is desired but not purchased until insurance is active. Estimates are based on 2002 utilization; temporal changes in utilization patterns would affect the estimates.

2. Determining the Number of Potential Eligibles

There are two approaches to determining the number of potential eligibles. The first considers those covered because their firm participates in Healthy North Carolina. The second is for working individuals and the self-employed.

a. Approach: Employees

To estimate the number of potentially eligible employees, we begin with the MEPS Insurance Component tables for 2003. Table II.B.2 presents the percent of North Carolina employees, by firm size, employed in a firm that offers health insurance. Table II.B.1 presents the number of North Carolina employees by firm size. The information in these tables can be combined to calculate the number of employees in North Carolina firms with 1-24 employees that do not offer health insurance: 332,324.

This number is then subjected to the "low wage" criterion: at least 30% of the workers must have a wage below $12 for the firm to be eligible. Although MEPS defines a "low wage" firm, it has a much more stringent definition of 50% earning less than $10. Thus, the percent of small firms qualifying under the "low-wage" qualification had to be estimated. There are no existing data sources that would be useful in estimating this number. We therefore estimate the percent of firms that would qualify by simulating firms, a not uncommon exercise in policy cost estimates. We take CPS data on firm size, industry, and wages and construct 3,000 artificial firms by randomly matching CPS respondents within firm size-industry cells. First, we compare our estimates with those of MEPS using the "50% less than $10" criterion. MEPS does not include low wage by firm size at the state level, so we cannot compare our estimates for North

Carolina directly to the national MEPS estimates. Nationally, 32 percent of firms with 1-24 employees (that are classified as either high wage or low wage) are classified as low wage. Our estimates for North Carolina are slightly higher at 39 percent, but examining all firm sizes, North Carolina firms are about three percentage points more likely to be low wage than the national rate, so the estimates are reasonable.

With our simulation method validated, we then subject the recommended "30% less than $12" criterion to the simulations. The estimated percentages of workers that would qualify, by industry and firm size, are presented in Table F.1.

Table F.1
Estimated Percent of Employees Employed by a Firm with at Least 30 Percent of Employees Earning Less than $12 an Hour

	Number of employees		
Industry	Less than 9	10-24	Total 1-24
Agriculture	97.8%	100.0%	98.1%
Construction	91.3%	99.0%	92.4%
Manufacture	64.5%	90.5%	72.0%
Transport	59.7%	85.0%	62.1%
Trade	80.2%	79.5%	80.0%
Health & Education	84.2%	100.0%	88.7%
Finance	75.8%	41.5%	69.7%
Hospitality	99.8%	100.0%	99.9%
Other	83.0%	92.5%	84.2%
Total	83.9%	91.4%	85.3%

Overall, the estimated percent of individuals in firms with 1-24 employees in North Carolina that would meet this criterion is 85.3%. We then multiply the estimated number of employees in firms not offering health insurance (332,324) by this 85.3 percent to calculate 283,472 potential eligibles.

We assume that the risk corridor will elicit a thirty percent reduction in premiums. Gruber and Lettau (2004) estimates an offer elasticity of -.537 for small firms (less than 100 employees),[6] suggesting a percent change in the offer rate of .537 * .30 = 16.1 percent increase in the offer rate. This is multiplied by the number of potential eligibles to obtain 283,472 * .161 or 45,639 newly offered employees. We assume 60% eligibility (Table II.B.2.a) and 80% take-up among those eligible (Table II.B.2.a.i), or 21,910 newly insured employees. The average contract size for Healthy NY was 1.44, 1.62 for small business enrollees. According to the CPS, in North Carolina in 2004, the number of individuals covered as a dependent on an ESI was 2,080,509. The number of individuals with an employee-only plan was 1,174,378; the number of individuals with a family plan was 1,042,385. The average contract size, therefore, is 1.94. To project estimated enrollees in Healthy North Carolina, we assume the midpoint of 1.94 and 1.62, or 1.78. Therefore, we upweight the 21,910 employees by 1.78 to get 39,000 new enrollees.

According to MEPS, the average premium for a North Carolina employee in 2003 was $3,411. The average family premium was $8,463. The total amount paid for ESI, thus, was 1,174,378 * $3,411 + 1,042,385 * $8,463 = $12,827,508,000. According to the CPS numbers presented in the preceding paragraph, 4,297,272 were covered by ESI, implying that the premium for the average covered life was $2,985.04 (total premiums divided by covered lives). This estimate is for 2003. Inflated by 7.5% three times to translate the 2003 estimates to 2006, we obtain an average premium of $3,708.31. This is the expected per member per year (PMPY) baseline premium (that is, the market price for ESI) in 2006.

The recommendation is for a reinsurance corridor generating a 30% discount to the premium. Given the $3,708.31 estimated PMPY premium, this is a $1,112.49 annual cost to the state. However, this is the cost in the "steady state" version of the program, in which every enrollee is enrolled for an entire year. Since the reinsurance is calculated on a calendar year, members who enroll later in the year are, other things equal, less likely to achieve the minimum cumulative claim amount necessary to qualify for reinsurance. Based on the Healthy NY experience, we estimate that in periods of substantial program expansion, the actual reinsurance per member may be roughly half of the steady state estimate. For example, in 2004 the estimated state cost per member enrolled in Healthy NY for the entire year was just over $1,000, while the cost per mid-year enrollment was just over $500.[7] This value is more difficult to estimate than the full-year cost; fifty percent of the full year cost is our best guess. Note, however, that the total premium net of discount should be identical under the "steady-state" cost and the "expansion." Therefore, if the "expansion" cost to the state is $550 (half of the "full-year" cost), then the employees and employers will pay more.

The recommendation is that the employer pays 75% of the employee share, with additional incentives for subsidy of family coverage and the employer paying a greater share of the employee coverage. We assume, therefore, that the employee pays 2/3 of the (expected) after-reinsurance cost. Thus, the employer pays from 2/3 of ($3,708.31 – $1,112.49) [$1,730.55] under the "steady-state" cost to 2/3 of ($3,708.31 – $550) [$1,730.55] under the "expansion" phase of the program.

Table F.2
Summary of Annual Cost Estimates per Healthy North Carolina Small Employer Member

Program Period	Steady-State	Expansion
Total Premium	$3,708.31	$3,708.31
State reinsurance payment	$1,112.49	$550.00
After reinsurance	**$2,595.82**	**$3,158.31**
Employee	$865.27	$1,052.77
Employer	$1,730.55	$2,105.54

b. Approach: Individuals and Self-Employed

Many of those that are uninsured are not eligible for Healthy North Carolina because they were offered employer-sponsored insurance (ESI) from their employer but declined coverage, presumably because they were required to contribute to the premium. Because these individuals are not eligible, we must eliminate them from

the estimate of eligible enrollees. To do so, we must adjust the estimated number of uninsured *downward* by the estimated number of workers who were offered ESI but declined coverage.

Using CPS data we estimate that there are 384,000 full-time workers with income below 250% FPG who have health insurance from their own employer. If 20% of those that are offered ESI decline coverage (MEPS, Table II.B.2.a.(1)), then the number offered ESI from their employer is 384,000 / .8 = 480,000. About 96,000 of these (480,000 – 384,000) are assumed to be offered ESI, but declined coverage. There are 350,000 full-time uninsured workers with incomes below 250% FPG and 67,000 who enroll in non-group insurance, making a total of 417,000. About 96,000 of these (480,000-384,000) are assumed to be offered but decline ESI from their employer, leaving 321,000. Take up of nongroup insurance is estimated to be 67,000 / (67,000 + 350,000), or 16%. The estimated elasticity on the take-up rate due to a 25% decrease in price of nongroup insurance is -.081.[8] This is inflated by .3/.25 to account for the larger discount to obtain an elasticity of .0972. This generates 6,500 newly enrolled workers. This is inflated by 1.44 (to account for dependents) to generate 9,360 covered lives. We assume the cost to the state is the same as the cost to the state for working employees—$550 – $1,100.

Limitations: This method depends heavily on what are known as behavioral parameters —estimates of how firms and individuals respond to changes in prices. There is no accounting for crowd-out (enrollment by those that are currently covered by health insurance). There is only a limited assessment of dependent coverage. Due to data limitations, we often assume that estimates for a large category of individuals apply to a subcategory. For example, we assume that the average premium for small groups is the same premium that a firm that is indifferent between providing coverage would receive. In other words, it is likely that the firms that would be enticed by a small decrease in the premium would face larger premiums than those that are currently offering health insurance (the fact that they are facing higher premiums is one reason they are not currently offering insurance). Our approach does not account for this fact. We also assume that the offer rate in small firms is the same as the offer rate in small firms that meet the low-wage criterion.

The variation in expected state cost under the different phases of the program is particularly important. In 2004, Healthy NY began the year with approximately 40,000 enrollees and ended with about 80,000 enrollees. The total reinsurance cost for the year was just over $31 million. It is also important to note that our predicted enrollee distribution is quite different from the experience of Healthy NY. These differences underscore the importance of the formal actuarial analysis.

B. Recommendation 5.4 Tiered Benefits

Approach: Mercer developed price estimates of $150 (Tier I), $232 (Tier II), and $270 (Tier III). There are approximately 550,000 uninsured full-time workers in North Carolina. We assume that 5% of these workers would enroll in the tiered benefit plan. This rate was considered reasonable by a group of individuals familiar with the insurance market. We assume that the workers would divide equally among the three tiers and that employers would pay 75% of cost of the lowest Tier.

Limitations: There is no evidence supporting the net take-up of 5%, nor the distribution among the Tiers. The 75% contribution by the firm is lower than the current proportion contributed by firms for small firms; this may be appropriate, however, given that these are likely to be newly offering firms (or firms that would otherwise cease offering ESI to employees).

C. Recommendation 6.1 Medicaid Outreach

Approach: Medicaid eligibility is a function of three main eligibility criteria: income, assets, and category. Although the CPS contains rich information on households, including income, the exclusion criteria used by the Division of Medical Assistance renders it difficult to conclude definitively on an individual's potential eligibility for Medicaid. Therefore, best approximations were used to develop estimates of the number of potentially eligible individuals who are not enrolled in Medicaid. For example, the number of potential eligibles qualifying as pregnant women was estimated using women who had a child under the age of 1 year living in the household with income below 185% of the FPG; individuals potentially eligible under the disabled qualification were identified as those receiving Social Security income due to a disability. For the most part, asset tests were not imposed in determining the number of potential eligibles. Due to these reasons, the numbers given are likely high estimates. Furthermore, many of these individuals who appear to be uninsured may actually be covered under Medicaid, since it is well known that CPS undercounts the number of Medicaid eligibles. For example, CPS indicates that 936,898 were *ever* covered by Medicaid or NC Health Choice in 2004, while the Division of Medical Assistance reports 1,125,624 were covered by Medicaid and an additional 121,836 were covered under NC Health Choice in December 2004. The number covered at any time in 2004 will exceed this monthly enrollment count.

The average per-beneficiary cost is lower for the outreach than might be expected because so few disabled potential eligibles—the most expensive of the four groups considered here—are estimated to be potentially eligible but not enrolled. This lowers the average per-beneficiary cost.

D. Recommendation 6.5 High-Risk Pool

Approach: BlueCross BlueShield of North Carolina estimates that 90,000 North Carolinians would be eligible for the high-risk pool and 20% of these would enroll, implying 18,000 enrollees in the pool. The recommendation includes a provision for a premium subsidy ranging from a 95% subsidy for those below 100% FPG to a 0% subsidy for those with income above 300% FPG. The distribution of high-risk pool enrollees is approximated by assuming a distribution proportional to the distribution across income for uninsured non-elderly individuals self-designating as having fair or poor health status:

Table F.3
Estimated Distribution and Average Premium Subsidy of High-Risk Pool Enrollees, by Income

Income	Distribution	Average Premium Subsidy
<100% FPG	14%	95%
100-200% FPG	39%	75%
200-300% FPG	35%	25%
>300% FPG	12%	0%

The state premium subsidy cost is estimated by multiplying the base premium ($1,800) inflated to 150% of risk ($2,700), computing the income group-specific per enrollee subsidy, and then aggregating based on the predicted distribution of members across income cells. This leaves a $1,385.10 premium subsidy per enrollee for the state. The average enrollee in the plan pays $1,314.90. The amount of the revenue generated by the assessment on insurers would equal $66 million, the difference between expected claims and the revenue.

Appendix F | Methodology

References

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Appendix G | Healthy NY

Healthy NY is a program based in New York state that was designed to encourage small employers to offer health insurance coverage to their employees, dependents, and other qualified individuals. Healthy NY is also available to eligible working uninsured individuals, including sole proprietors. Eligibility criteria for each group are summarized below. Qualifying individuals can purchase one of two standardized benefit packages offered through participating health plans. Health plans are able to offer these products at an affordable rate to residents who would likely otherwise go uninsured, because the state serves as reinsurer to the plans for Healthy NY members.

In December 2005, active enrollment in Healthy NY was 106,944. The total number of people ever enrolled in the program (January 2001 through December 2005) is 216,563.[1] Net enrollment (the number enrolled minus the number that left the program) in 2005 grew by 40%, or 30,647 members. The total number of new enrollees in 2005 was 93,387 members, a 76% increase. In the four years since inception, Healthy NY premiums have proven to be consistently lower than in the small group across the state, though savings estimates have varied by region and by year. In 2005, average premiums were approximately 27% lower for Healthy NY members compared to similar plans in the commercial market.[2]

As of December 2005, 56% of enrollees were working individuals, 26% were from small business groups, and 18% were sole proprietors. This represents a slight drop in percentages comprised by working individuals and sole proprietors compared to 2004, where they accounted for 58% and 19%, respectively. However, it reflects an increase for the small business groups, which accounted for only 23% of enrollees in 2004.[1]

Program Design

Health Plan: Persons meeting eligibility criteria for Healthy NY may enroll in one of two benefit packages (one with prescription drug coverage and one without), which are offered by all participating health maintenance organizations (HMOs) (though premiums may vary by health plan). For both packages, benefits are streamlined to cover essential health needs including: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, and emergency services. Excluded benefits include mental health services, substance abuse treatment, chiropractic care, hospice, home health, and physical therapy. Cost sharing is included in both benefit packages. As of November 2005, 81% of Healthy NY members were enrolled in the benefit package with prescription drug coverage, and 19% were enrolled in the package without. Of those enrolled in the nonprescription drug coverage, 80% were from the categories of sole proprietors and working individuals.[1]

Reinsurance: In an effort to keep premiums low, New York is acting as reinsurer with an excess-of-loss provision for all Healthy NY enrollees. The state pays 90% of all Healthy NY members' claims between $5,000 and $75,000. In calendar year 2005, claims paid by Healthy NY were estimated at $31.5 million.[1]

Eligibility Criteria

Individuals: To qualify for Healthy NY, the individual must be a New York state resident (or spouse) with some employment experience within the past 12 months for an employer that does not provide health insurance. The individual must have been uninsured for 12 months preceding application or lost insurance coverage due to a qualifying event (loss of employment, new employer, death of family member, loss of COBRA/group health plan/dependent coverage). The individual must be ineligible for public insurance (e.g., Medicaid and/or SCHIP coverage), and must meet income guidelines (see Table G.1).

Small Employers: To qualify as a small business, the business must have fewer than 50 employees, be located within New York state, and have a workforce comprised of at least 30% of employees earning wages of $34,000 per year[a] or less. The small employer must not have provided (arranged for and contributed a certain dollar amount per employee) group health insurance coverage to their employees within the last 12 months. Employers meeting these criteria are eligible to participate in Healthy NY if they can assure 50% of the eligible employees will participate (and at least one participant earns annual wages of $34,000 or less), the employer will contribute at least 50% of the premium, and that Healthy NY will be made available to all employees who are working more than 20 hours per week and earning $34,000 or less.

Sole Proprietors: To qualify as a sole proprietor, the individual must be the sole owner and only employee of a business, reside in New York state, and not have had health insurance in effect for the 12-month period preceding application or lost that coverage due to a qualifying event (same as defined for individuals). Sole proprietors have the same income guidelines as individuals (See Table G.1) and cannot be eligible for public insurance.

Table G.1
Healthy NY Income Guidelines*

Family Size	Annual Household Income**	Monthly Household Income
1	Up to $25,125	Up to $2,094
2	Up to $33,375	Up to $2,782
3	Up to $41,625	Up to $3,469
4	Up to $49,875	Up to $4,157
5	Up to $58,125	Up to $4,844
Each Additional Person	Add $8,250	Add $688

* The amounts listed are effective January 1, 2006, and pregnant women count as two people. When calculating family size, include the number of family members in the household whether they will be included on the Healthy NY policy or not.

** Approximately 250% of the 2006 Federal Poverty Guidelines determined by the US Department of Health and Human Services.

a Adjusted annually for inflation. The amount listed is effective January 1, 2006.

Appendix G | Healthy NY

References

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Summarized information was taken directly from Healthy NY program website (http://www.ins.state.ny.us/website2/hny/english/hny.htm), and Commonwealth Fund publication no. 820 (http://www.cmwf.org/publications/publicatioins_show.htm?doc_id=286904)

Appendix H | Acronyms

ASO	Administrative Service Organization
BCBSNC	Blue Cross Blue Shield of North Carolina
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CCNC	Community Care of North Carolina
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
CT	Computed Tomography
CY	Calendar Year
DHHS	Department of Health and Human Services
DM	Disease Management
DMA	Division of Medical Assistance
DOI	Department of Insurance
DRG	Diagnosis Related Group
DTC	Direct to Consumer
ED	Emergency Department
ESI	Employer-Sponsored Insurance
FDA	Food and Drug Administration
FPG	Federal Poverty Guidelines (also known as FPL, or Federal Poverty Level)
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAO	General Accounting Office
HB	House Bill
HCTC	Health Coverage Tax Credit program
HIFA	Health Insurance Flexibility and Accountability

Appendix H | Acronyms

HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
IP	In Patient
MEWA	Multiple Employer Welfare Arrangement
MRI	Magnetic Resonance Imaging
NC IOM	North Carolina Institute of Medicine
NCHC	North Carolina Health Choice
NIHCM	National Institute for Health Care Management
ORDRHD	Office of Research, Demonstrations and Rural Health Development
OT	Occupational Therapy
PCP	Primary Care Provider
PCS	Proposed Committee Substitute
PET	Positron Emission Tomography
PPO	Preferred Provider Organization
PSA	Prostate Specific Antigen
PT	Physical Therapy
SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SCHS	State Center for Health Statistics
SEHP	State Employees' Health Plan, or North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan
SFY	State Fiscal Year
TANF	Temporary Assistance for Needy Families
TPA	Third Party Administrator