

**North Carolina Institute of Medicine  
Task Force on Covering the Uninsured  
February 24, 2005  
NC Hospital Association  
Cary, NC**

**Meeting Summary**

*Members:* Carmen Hooker Odom, Tom Lambeth, Millie Brown, Sonya Bruton, Pearl Burris-Floyd, Allen Dobson, Alan Feezor, Charles Frock, Bill Ray Hall, Ann Holton, Rep. Verla Insko, Connie Majure-Rhett, John McMillan, John Mills, David Moore, Barbara Morales Burke, Aaron Nelson, Peg O'Connell, William Pully, Sen. William Purcell, Rep. Karen Ray, Lynette Rivenbark Tolson, James Roberson, Jack Rodman, Randy Rust, Adam Searing, Sen. A.B. Swindell, Charles Willson, Leslie Winner, Doug Yarborough

*Steering Committee:* Anne Braswell, Sandra Greene, Mark Holmes, Stephanie Poley, Dennis Williams

*Staff:* Pam Silberman, Matt Canedy, Kristen Dubay, Thalia Fuller, Jaime Jenkins, Adrienne Parker, Kristie Weisner Thompson

*Guests:* Walker Armfield, Tom Bacon, Nam Douglass, Dennis Harrington, Alan Hirsch, Kathy Holladay, Ben Money, Maureen O'Connor, Andrea Radford, Eric Russman, Kevin Schulman, Jeff Smith, Jeff Spade, Roland Stephen, JoAnn Tarnowski, Phil Telfer, Tonja Williams, Cathy Wright

**WELCOME**

**Tom Lambeth**

*Task Force Co-Chair*

Tom Lambeth welcomed everyone to the meeting by speaking about the great challenge facing the state because of the impact lack of health insurance has on so many of its citizens. There are more than 1.4 million non-elderly North Carolinians who are uninsured. This accounts for approximately one out of every five people in our state. That has an impact on the lives of those people, which is important, but it also has an impact on educational achievement. Health's impact on young children's educational achievement also negatively impacts North Carolina's economic development. In the coming weeks, it will be important that the Task Force look at statistics, ideas, and background information to develop options for expanding coverage to more of the uninsured. Ideally, everyone in the state would have access to affordable healthcare coverage. However, the difficult challenge in the reality of political and budgetary constraints and the challenges to the state and federal budget are well understood.

North Carolina has been impacted by poverty in the past 50 years. The difference with the poor in North Carolina now compared with the year 1965 is that there is now a global

economy with more competition. The global economy had led to job dislocation which in turn leads to greater numbers of uninsured. This exacerbates a difficult situation. This Task Force endeavors to better understand and develop options for how to meet the challenge in this state. Mr. Lambeth noted that he and Secretary Carmen Hooker Odom will be the co-chairs for this Task Force.

## **STATE PLANNING GRANT OVERVIEW**

**Pam Silberman, JD, DrPH**

Vice President

NC Institute of Medicine

Pam Silberman thanked the Task Force members and guests for attending and the North Carolina Hospital Association for providing space for the meeting. Dr. Silberman noted that health insurance coverage is the point through which so many people access healthcare. Without it, many people do not get the healthcare they need. She explained how the Covering the Uninsured Task force fits into a larger Health Resources and Services Administration (HRSA) grant. The Task Force is the culmination of a lot of work that has preceded it. The NC Department of Health and Human Services (DHHS) applied to US DHHS for a HRSA grant to try to develop policy options to expand healthcare coverage to the uninsured. Dennis Williams, a senior health policy analyst at NC DHHS, is the project officer. This grant is a collaborative effort of the NC Office of Research, Demonstrations and Rural Health Development, State Center for Health Statistics, Cecil G. Sheps Center for Health Services Research (Sheps Center) at The University of North Carolina at Chapel Hill, NC Department of Insurance, and NC Institute of Medicine.

The primary data collection will be done by the State Center for Health Statistics and the secondary data analysis will be done by researchers at the Sheps Center. Most of the numbers on the uninsured come from The Current Population Survey (CPS), which is conducted by the US Department of Census. Mark Holmes will talk more later about who are the uninsured and what is known about their demographic composition. Data from the Medical Expenditure Panel Survey (MEPS) can also be used to determine the length of time individuals are uninsured, the availability of employer-sponsored insurance, and other reasons people are uninsured.

Dr. Silberman explained that the Task Force will also be looking at hospital discharge data to identify numbers of people without a payer source to know if they could have gotten better care up front. In terms of primary data collection, the State Center for Health statistics added questions to the NC Behavioral Risk Factor Surveillance System. The types of questions added include the source of health insurance coverage, gaps in coverage in the last 12 months, reasons that the uninsured did not have health insurance, the availability of employer-sponsored health insurance, and access barriers.

The Sheps Center will also be working with FGI Research to conduct focus groups with three groups: employers, insurance agents, and the uninsured. The focus groups will

explore the reasons why employers do or don't offer insurance or limitations in coverage; reasons why the uninsured lack coverage; and how different insurance options and prices affect willingness to purchase coverage. The Sheps Center will also work with Mercer to identify cost containment strategies, different policy options and how much they would cost.

The Task Force will meet monthly. It is not clear if the meetings will go through October, but they will end sometime in early fall. The plan is to examine the data on the uninsured, consider different policy options (including what other states have done) and develop a series of policy options that can provide a guideline for the Task Force recommendations.

The tentative Task Force work schedule is as follows:

February 24: Overview of the Uninsured

March 18: Background information on healthcare costs and coverage options

April 22: Initial discussion of public health insurance options

May 20: Initial discussion of private health insurance options (focusing on employers)

June 24: Initial discussion of small employer health insurance options (focusing on small employers)

July – early fall: Further discussion and refinement of options to expand health insurance coverage (we will talk about non-group coverage and people with existing health conditions).

Report Dissemination. The North Carolina Institute of Medicine (NC IOM) will produce a report, generally ranging between 100 and 200 pages, which includes the Task Force recommendations and data on the uninsured. The NC IOM will also produce a shorter, more readable document for legislators and policy makers and has discussed producing a series of shorter issue briefs. A variety of products for different groups and fact sheets geared for different audiences will also be available. The NC IOM will devote one issue of the NC Medical Journal, which is distributed to more than 22,000 people in North Carolina, to the topic of the uninsured. Finally, the NC IOM will hold three regional meetings across the state to publicly disseminate the Task Force findings and policy option and get feedback on the ideas.

North Carolina is one of seven states that got HRSA grant funding for this year. Most of the other states received money in previous years. Therefore, this Task Force has the benefit of learning from what other states have done. All of the states are experiencing budget constraints, so rather than looking at universal coverage, most states are examining incremental options to expand health insurance coverage to the uninsured. As the Task Force continues, the policy options chosen by other states will be examined.

## **OVERVIEW OF THE UNINSURED IN NORTH CAROLINA**

**Mark Holmes, PhD**

Research Fellow

Cecil G. Sheps Center for Health Services Research

University of North Carolina at Chapel Hill

### **Methods**

The US Bureau of the Census's Current Population Survey (CPS) collects information from about 4,000 North Carolina residents every March. For the estimates here, a weighted average of 2003, 2002, and 2001 data is calculated with more weight put on the latest years. Insurance status is defined for the year *prior* to the survey. CPS 2004, for example, refers to the insurance status in 2003.

Respondents are asked, "At any time in 2003, was anyone in this household covered by Medicaid?" If so, "Who was that?" Respondents are also asked about numerous health insurance plans (Medicare, CHAMPUS, employer-based, etc.) If the respondent answers "no" to all, then they are asked a verification question. The interviewer would say, "I have recorded that (you) were not covered by a health plan at any time in 2003. Is that correct?" If the respondent agrees, then they are classified as uninsured. "*Uninsured*" is therefore defined as "*uninsured for the entire year.*" Most researchers, however, think these estimates are more indicative of "point-in-time" estimates.

In most of the results presented here, we combine the last three years and place more weight on the recent surveys. "One-year" estimates are less precise and "multi-year" estimates are less responsive to trends. Respondents age 65 or over were not included. People over age 65 only make up about 1% of the uninsured at this point.

We define five types of coverage for those under age 65: (1) Medicare (disabled), (2) Medicaid and SCHIP (NC Health Choice), (3) employer-based; (4) private, non-employer sponsored insurance, and (5) uninsured.

### **Overview of the Results**

The uninsured rate of individuals below age 65 has grown over last three years. Those most at risk of being uninsured are between 20 and 30 years old, poor, living in a rural area, unemployed, a race other than white, Latino, not a US citizen, or employed at a small firm. Most uninsured, however, are connected to the workforce.

### **The Rate of Uninsured**

In 2003 (the latest year available), approximately 19.4% of North Carolinians below the age of 65 were uninsured. Considering *all* individuals (including those age 65 and over), it yields an uninsured rate of 17.3%. This translates to 1.42 million individuals. After smoothing the data over three years, a slightly lower estimate of 18.9% is yielded.

*Q: Are there different definitions for uninsured?*

*A: Yes, and this is the reason you see different numbers of uninsured. For example, some studies look at people who are uninsured for the entire year; others examine a person's*

*insurance status on a particular number. Each study collects their data somewhat differently. However, most estimates are based on CPS data.*

There was a secular decline in employer-based coverage as well as an increase in the rate of those enrolled in Medicaid and those without insurance. Families who are in greater poverty are more likely to be uninsured and less likely to have employer-based coverage.

**Table 1. Insurance Coverage by Poverty Status**

<b>Insurance Type</b> (Percent of <65)	<b>&lt;100% FPL</b> (15%)	<b>100-200% FPL</b> (20%)	<b>200-300% FPL</b> (17%)	<b>300%+ FPL</b> (48%)	<b>Total</b>
Employer	12.7%	30.5%	61.3%	80.8%	57.0%
Medicaid	36.6%	19.6%	8.2%	2.0%	11.9%
Medicare	6.6%	6.3%	3.4%	1.4%	3.5%
Private	8.5%	12.1%	10.8%	6.6%	8.7%
Uninsured	35.6%	31.6%	16.3%	9.2%	18.9%
Total	100%	100%	100%	100%	100%

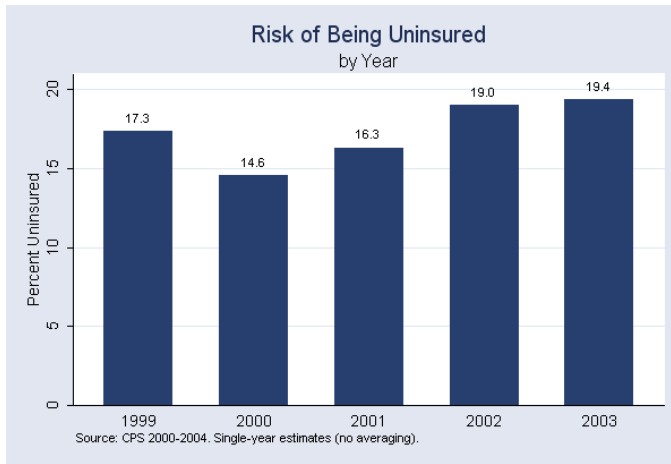
The Federal Poverty Limits (FPL) for a family of four in 2003 was \$18,400. In Table 1, percentages in parentheses denote the proportion of North Carolinians in each poverty category. For example, 15% of North Carolinians live below the poverty guideline. Note: Percentages add to 100 within the columns. For example, 12.7% of those below the poverty guidelines have employer-based coverage.

Nearly half of (46.2%) of the uninsured are unemployed, but nearly just as many are employed—28% work part-time, and 18% work full-time. About twenty-three percent of the uninsured are not in the labor force. (Children were excluded from this analysis.) Full-time workers are the least likely to be uninsured and the most likely to have employer-based coverage. Some of the people who are not working may be covered by a spouse’s employer-based plan.

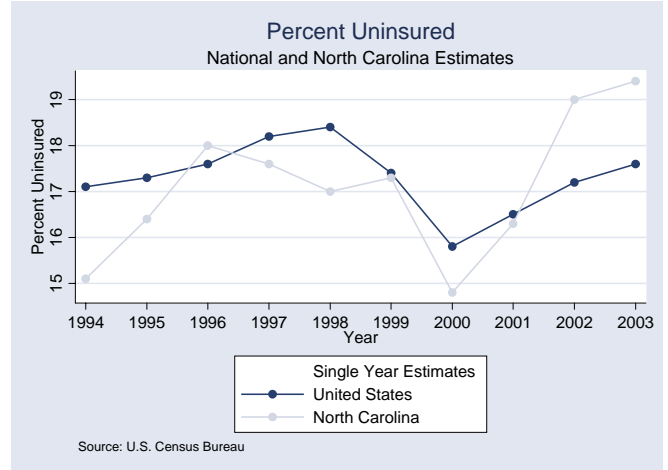
Families with two full-time workers are the least likely to be uninsured. Only 11.5% of these families are uninsured. Almost one-fifth of families (19.8% ) with one full-time worker is uninsured. Families with full-time workers tend to have employer-based coverage. In contrast, 30.2% of families with only part-time workers, and 25.1% of families with no workers were uninsured.

The rate of uninsured has increased over the last four years (See Figure 1). The poor economy and premium increases are likely large causes of this increase. Figure 2 shows estimates of the uninsured in both the United States and North Carolina for 1994-2003. Note that in 2002 and 2003, North Carolina exceeded the US average.

**Figure 1. Risk of Being Uninsured**



**Figure 2. Percent Uninsured in US and NC**



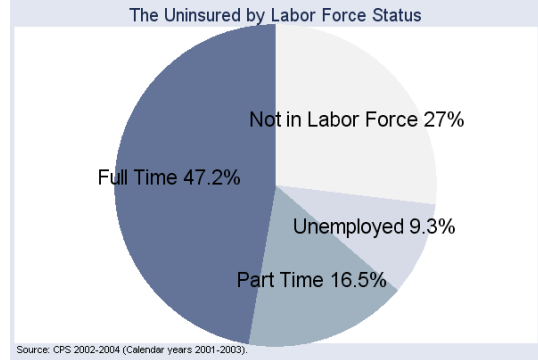
The age groups most likely to be uninsured are the 20-29 year olds, although nearly all ages have a more than ten percent risk of being uninsured.

**The Risk of Being Uninsured and Employment Status**

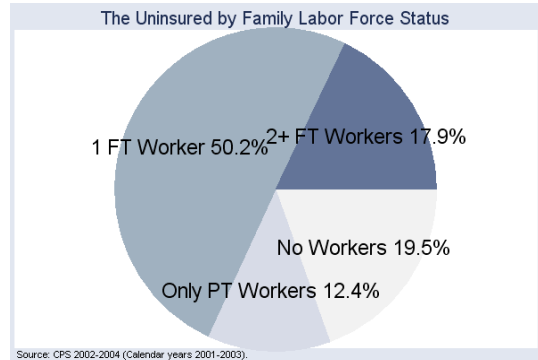
The unemployed are the most at-risk of being uninsured, with an uninsured rate of over 45% (46.2%) (See Figure 1). Thus, the *risk* of being uninsured is highest for unemployed workers, but most uninsured adults are employed. Most of the uninsured work either full-time (47.2%) or part-time (16.5%) (See Figure 3).

Individuals in a family with no full-time workers are more likely to be uninsured. One quarter (25.1%) of the families with no one in the work force is uninsured; 30.2% of the families with only part-time workers are uninsured; and 11.5% of families with two or more full-time employees are uninsured. The difference between the percentage of uninsured among families with no workers in the work force and those with only part-time workers is partly due to Medicare being more common form of insurance coverage for the families with no workers.

**Figure 3. Uninsured by Labor Force Status**



**Figure 4. The Uninsured by Family Labor Force Status**



Most of the uninsured are in families with some connection to the workforce. Families with two or more full-time workers comprise nearly 20% of all uninsured, and families with one full-time worker comprise over half (50.2%) of all uninsured. Together, over two-thirds of uninsured are in a family with at least one full-time worker (See Figure 4).

### The Risk of Being Uninsured and Poverty

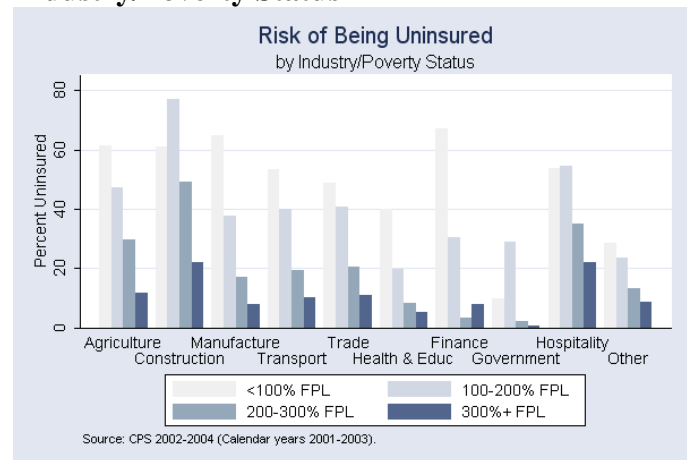
Individuals with lower incomes (as measured by poverty) are more likely to be uninsured than more affluent individuals. However, even individuals above 300% FPL have nearly a 10% risk of being uninsured. Nearly two-thirds of uninsured North Carolinians have family incomes below twice the poverty line (less than 200% FPL). Perhaps more surprisingly, nearly one-quarter of the uninsured have incomes above three times the poverty line.

Based on self-reported health status, the relatively affluent uninsured (e.g., those with incomes greater than 300% of the federal poverty guidelines). Having poorer health status leads to higher insurance premiums (at least in the non-group market). This suggests that at least some of these individuals may have difficulty affording health insurance. They may not be choosing to go without insurance coverage because they don't believe they need it.

### Risk of Being Uninsured based on Industry, Race, Ethnicity, Place of Birth, Community, Size of Employer

The industry of the worker (or the industry in which the individual most recently worked) also relates to the rate insurance coverage. Agriculture, construction, and hospitality tend to have higher rates of uninsured. Note that poverty status is related to the rate of uninsured even within industry (See Figure 5).

**Figure 5. Risk of Being Uninsured by Industry/Poverty Status**



The rate of uninsured varies by race and ethnicity. Non-Latinos of races other than white have higher rates of uninsured (20%) than non-Latino Whites (14%). Latinos have an even higher rate of uninsured (55.7%). (See Figure 6) The rate of uninsured varies by nation of birth and citizenship, especially for Latinos. More than 45% of Latino citizens born outside the US are uninsured, and almost 70% of Latino non-citizens are uninsured. One quarter of Latinos born in the US are uninsured.

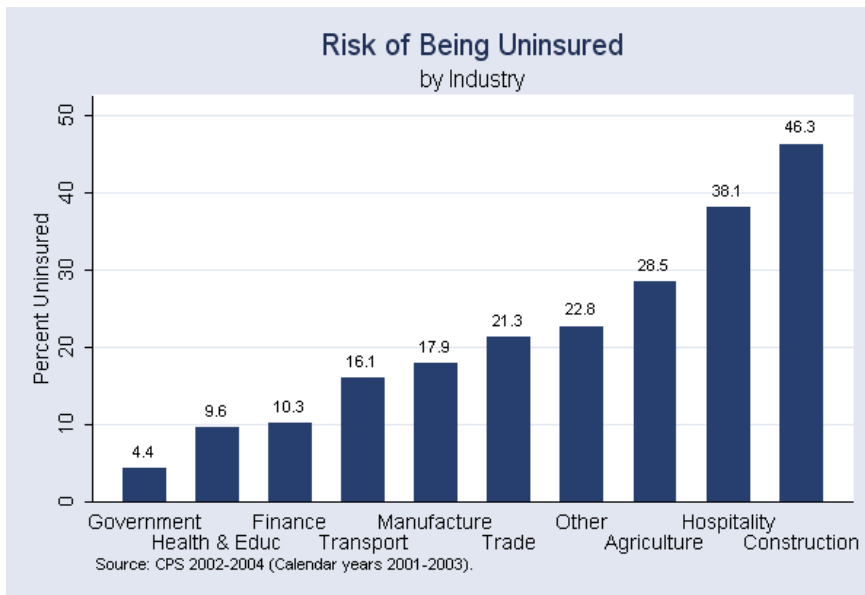
The risk of being uninsured also varies by the size of the company by which workers are employed. The smaller the firm, the more likely a worker is to be uninsured. Nearly 35% of people who work for firms with less than 25 people are uninsured, and 24% of people

who work for firms with 25-99 people are uninsured. This likely reflects higher health insurance premiums for smaller firms. Over half (51.1%) of uninsured workers are employed at a business employing fewer than 25 employees.

Rural residents are more likely to be uninsured (24% versus 17%), but there are more urban uninsured (67.3%) than rural uninsured (32.7%), because there are more people living in urban areas in North Carolina than in rural areas.

Uninsured rates by industry vary widely, from 4.4% in government to nearly 50% in construction. Figure 6 represents part- and full-time workers (full-time results similar).

**Figure 6. Risk of Being Uninsured by Industry**



### Poverty and Small Business

There are two groups of people who comprise a disproportionate number of uninsured: low-income individuals and those who work for small employers. In North Carolina, an estimated 62% of the families with an uninsured member has an income of less than 200% FPL, but families in this income range comprises only 34% of all families in the state. Similarly, 47.7% of families with at least one uninsured person has at least one person who works for a small employer (fewer than 25 employees), compared to 36.3% in the general population. More than one quarter (26.3%) of uninsured families have both an income below 200% FPL and at least one member working for a small employer. Only 16% of the uninsured population is made up of families with incomes greater than 200% FPL and who have no family members who work for small employers. This gives you a strong sense of what we are talking about. If we can figure out how to insure families with incomes below 200% FPL and/or with family members who work for a small employer, then we will have covered 5/6th of the problem.

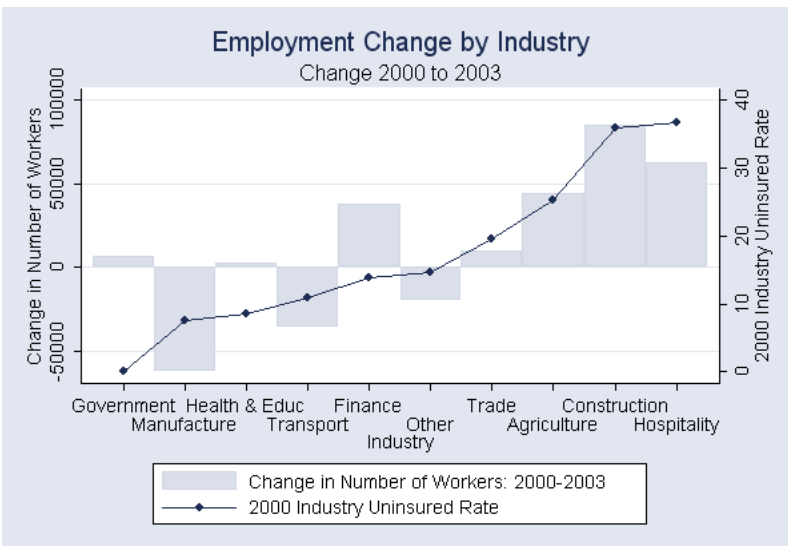
## Dynamics

We can separate two ideas: (1) Changes in the statewide uninsured rate are due to differing demographic characteristics, from (2) Changes in the statewide uninsured rate are due to differing uninsured rates for each characteristic. This may help us understand the dynamics of the statewide uninsured rate

*Industry Effects:* Conventional wisdom says the changing North Carolina economy is responsible for a large portion of the increase in uninsured from 2000-2003. However, what if NC workers in 2003 had the same distribution across industries as North Carolina workers in 2000?

Figure 7 contains two pieces of information. The left axis, represented by bars, indicates the change in the number of full-time and part-time NC workers from 2000 to 2003. For example, there are over 500,000 fewer manufacturing workers in 2003 than in 2000. The right axis, represented by the line, indicates the percent of full-time and part-time workers in that industry in 2000 who were uninsured. Note that the three industries that have gained the most jobs (agriculture, construction, and hospitality) also have the highest percent of uninsured.

**Figure 7. Employment Change by Industry**



Notwithstanding the evidence presented in the Figure 7, changes in the economy between 2000 and 2003—such as a decrease in the number of manufacturing jobs and an increase in the number of hospitality and construction jobs—account for only a 1 percentage point increase in the percent of NC adults who are uninsured. However,

the changing rates of uninsured within industries are responsible for a 4.7 percentage point increase between 2000 and 2003. This suggests that more employers are dropping coverage.

Although workers in some fields experienced a slight decline in the uninsured rate, the transportation, manufacturing, construction, and 'other' industries experienced an increase in the rate of uninsured of over five percentage points.

Similarly, changes in the uninsured rate within each poverty grouping are more responsible for the increase than changes in distribution across poverty groupings. The

bulk of the change was felt in the 100-200 % FPL group: the uninsured rate increased from 16.2 to 19.9%.

Approximately 18-19% of North Carolinians between the ages of 0 and 64 had no health insurance for the entirety of 2003. Considering the *risk* of being uninsured for a given characteristic may yield different policy conclusions than considering the *characteristics* of the uninsured. For example, the unemployed are more likely to be uninsured, but relatively few uninsured are unemployed. The increase in the statewide uninsured rate is due somewhat to changes in demographic structure, but more due to changes in the uninsured rates within the demographic.

The Sheps Center has also developed county level estimates of the uninsured. It will be available shortly on the Sheps Center website: (<http://www.shepscenter.unc.edu>). Click <What's New> for county-level estimates. The 2003 estimates not posted yet, but will be soon. The Kaiser Family Foundation also has an analysis of national trends (<http://www.kff.org>). The US Census Bureau web site posts results of national surveys (<http://www.census.gov/hhes/www/hlthins.html>).

### Comments and Questions

*Q: How did you define rural?*

*A: It is based on the CPS definition. For definitions see <http://www.census.gov/population/www/cps/cpsdef.html>*

*Q: Why didn't you do an analysis of populations in rural and urban communities?*

*A: We don't usually hear that rate is changing because people are leaving rural areas. It would be interesting to look at it and to see if the rural-urban gap has changed over time.*

*Q: A lot of people think the system is wedded to reimbursement rates that differ in rural and urban areas.*

*A: This is not an area I am familiar with.*

*Q: Are there gender differences?*

*A: Men are more likely to be uninsured, but there is not that much of a difference. Women tend to have more public insurance than men (men tend to have more private).*

*Q: Do the data include migrant information?*

*A: Yes, but it's a small number. CPS is sensitive about asking about citizenship. The Latino question comes up a lot and not something we have looked at as much because the numbers are so small.*

*Q: Size of companies. Is there a way to measure companies who employ fewer than 10 and also 10 to 25 employees? There are thousand of one- and two-person companies.*

*A: This is a fair point.*

## HOW BEING UNINSURED IMPACTS HEALTH STATUS

**Kevin Schulman, MD**

Professor of Medicine

Director, Center for Clinical and Genetic Economics

Duke University

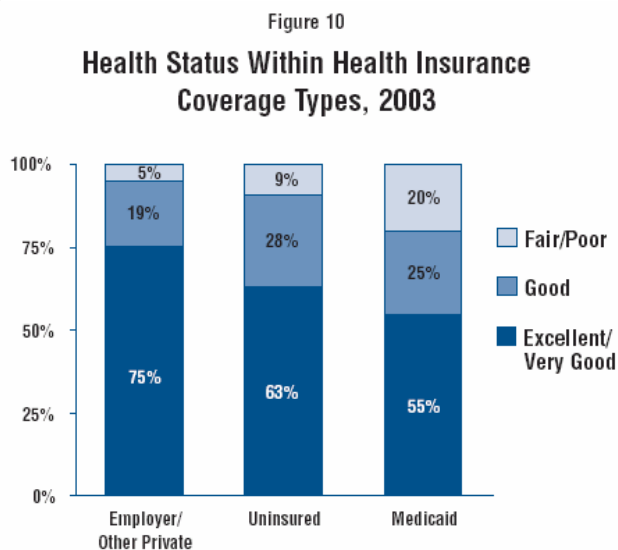
### Relationship between Health Insurance and Health Status

What difference does it make if people are uninsured or insured? Dr. Schulman's presentation highlights studies that show that being uninsured affects health status. As the cost of healthcare grows, there is an increase in the number of uninsured. Healthcare becomes too expensive for employers to provide it for their employees. For example, at Duke University, a family of four pays about \$10,000 per year for health insurance. If you are making \$20,000 a year, it is difficult to choose to spend \$10,000 on health insurance versus other necessities. So, the expense of healthcare premiums is one of the factors driving the increase in the number of the uninsured.

### Health Status by Insurance Group

Surveys that ask people to rate their own health can be a fairly reliable measure of health status. Among people with private insurance, about 75% say their health status is excellent or good. For the uninsured, the rate is only 63% and for Medicaid populations, only 55%. However, it is notable that many people on Medicaid have to be sick to qualify, so it is not surprising that Medicaid recipients have lower self-reported health status.

**Figure 1.**



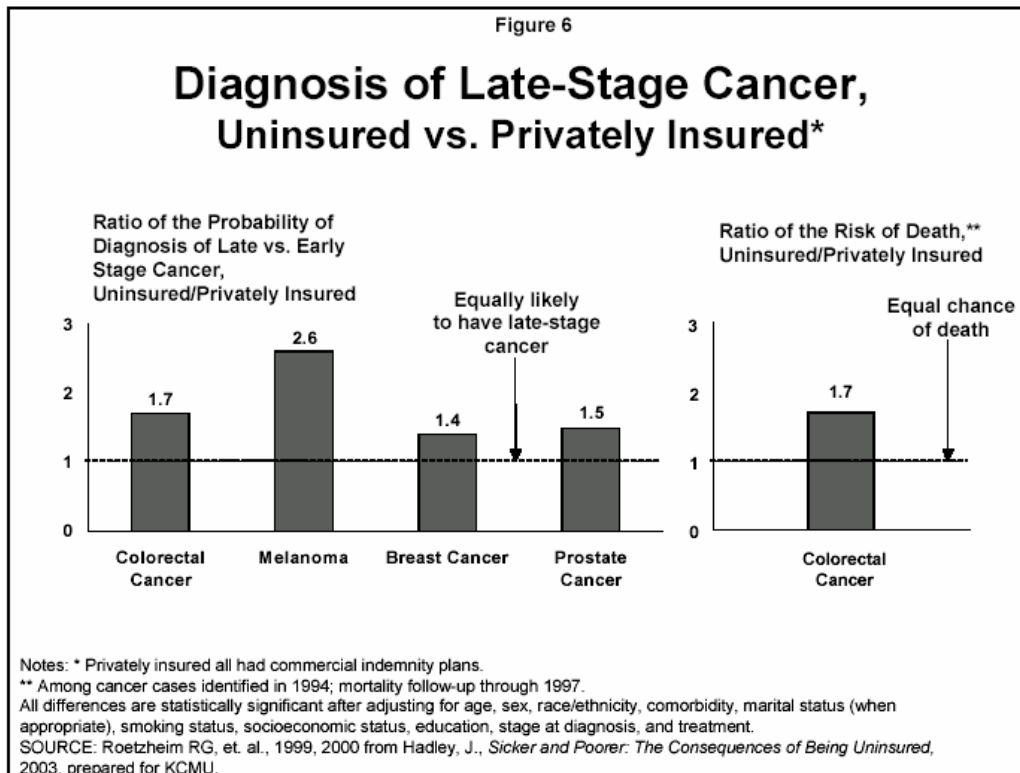
Medicaid also includes S-CHIP, other state programs, Medicare, and military-related coverage.  
Data may not total 100% due to rounding.  
KCMU/Urban Institute 2004

## Uninsured Impact on Health

The uninsured are more likely to report access barriers obtaining needed health services; less likely to get preventive screenings or care for ongoing chronic conditions; more likely to be diagnosed with severe health conditions (e.g., late stage cancers); more likely to be hospitalized for preventable conditions; and less likely to receive major health interventions.

How do we prove that insurance has an impact on health status? What is the model? Individuals without health insurance may not come in for screening visits, or at the first symptom of a problem. When a patient comes in at the last possible moment, how does that hurt her health status? One example of the effects of delayed care can be illustrated by the difference between cancer patients with late-stage versus early-stage cancer. The horizontal line in Figure 3 (below) is the point at which the uninsured and privately insured are equally likely to be diagnosed with early or late-stage cancer. The figure illustrates how those without insurance are much more likely to be diagnosed with late-stage cancer and are more likely to die from colorectal cancer than those with insurance.

Figure 2.



Age, poverty level, and region of residence also each differentially affect the likelihood of being uninsured. North Carolina's uninsurance rates of 19.0% put the state in the top half of the country compared to a national average of 17.2%. North Carolina's uninsured rate is also higher than the southeast region average of 17.1%.

A report by Jack Hadley outlines the cost of healthcare for the uninsured and determined that the uninsured do receive some care. But this does not mean that they receive appropriate healthcare. The variety of places the uninsured receive care include the emergency department, free clinics, community health centers, and private physicians' offices. On average, the uninsured receive about half as much care as the insured. In 2001, the estimated total expenditures on healthcare for the uninsured were about \$100 billion. One quarter of that amount was paid out-of-pocket by the uninsured. Private and public insurance paid approximately 40% for those who were uninsured part of the year and 35%, or \$35 billion, was provided in uncompensated care.

*Q: When you say the uninsured received half as much care, do you mean half as much time in the physicians' offices?*

*A: No, the reference is to half as much care based on the dollar value provided.*

*Q: How is uncompensated care valued? If it is valued at list price, it is going to overestimate the amount of care provided to the uninsured who are paying out-of-pocket.*

*A: Dr. Schulman said he would check the data on this.*

*Q: Of the \$35 million in total expenditures for the uninsured, isn't that a cost shifted to private sector insurance?*

*A: Yes. It is paid for by someone. Except for whatever monies are paid for directly, the rest of these monies are paid for by other people.*

### **Barriers to Care**

The uninsured also experience difficulties obtaining care. According to a national survey,<sup>1</sup> uninsured patients reported the following barriers to healthcare: 47% reported they postponed seeking care because of cost, 35% needed care, but didn't get it, 37% didn't fill prescriptions, 36% had problems paying medical bills, and 23% were contacted by a collection agency about medical bills. These problems are not limited to the uninsured; some people with insurance also report similar barriers (15% postponed care due to costs, 9% didn't get care they needed, 13% didn't fill prescriptions, 16% had problems paying medical bills, and 8% were contacted by a collection agency). However, the uninsured are more likely to report these barriers. People without insurance coverage are much more likely to report costs as a major barrier to care; whereas, people with insurance coverage are more likely to report health system problems (such as waiting times to obtain an appointment) as the cause of their access barriers.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires all hospitals to stabilize patients who seek emergency services, regardless of their ability to pay. EMTALA, however, does not help provide uninsured patients with full primary or specialty care.

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<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured. The Uninsured and Their Access to Health Care. Fact Sheet. December 2003.

A study by Berk and Monheit shows that most healthcare expenditures are concentrated in a small percentage of the people with major health problems. This holds true for both the insured and uninsured populations: nationally, the top 5% of privately insured healthcare utilizers account for approximately 51% of all healthcare expenditures, and the top 5% of utilizers among the uninsured account for 60% of healthcare expenditures spent on the uninsured. While health expenditures are similarly concentrated in groups of privately insured and the uninsured; the actual amount spent for people with insurance versus those who are uninsured varies widely. The top 5% of the privately insured use, on average, \$17,871 of health care expenses, but the top 5% of uninsured individuals only accounts for \$6,651 of healthcare expenditures. (Table 2).

**Table 1: Concentration of Health Expenditures (Insured vs. Uninsured)**

	<b>Private Insurance</b> (% Spending)	<b>Private Insurance</b> (Avg. Spent)	<b>Uninsured</b> (% Spending)	<b>Uninsured</b> (Avg. Spent)
<b>Top 5 %</b>	51%	\$17,871	60%	\$6,651
<b>Top 10 %</b>	65%	\$11,319	75%	\$4,134
<b>Top 30 %</b>	87%	\$5,090	94%	\$1,732
<b>Top 50 %</b>	95%	\$3,340	99%	\$1,098

### **Uninsured Receive Fewer Services**

Jack Hadley conducted a meta-analysis of all the published literature that examined whether being uninsured affects use of health services or health outcomes. In this report, for the Kaiser Commission on Medicaid and the Uninsured, he noted that the uninsured are less likely than the insured to get certain preventive services, including foot exams (36% versus 60%), dilated eye exams (56% versus 73%), cholesterol screenings (60% versus 82%), hypertension screenings (80% versus 94%), Pap tests in the past three years (80% versus 94%), and mammography in past two years (68% versus 89%).

Some of the uninsured delay care and end up in the hospital with conditions that could have been prevented if treated with timely primary care. Evidence from Massachusetts and Maryland shows that the uninsured were more likely to seek treatment for medically preventable conditions in hospital emergency departments. In doing so, their care becomes much more expensive to treat than it should have been had they received care sooner.

The uninsured also receive fewer therapeutic services. The uninsured are less likely to get specific surgical or medical services and more likely to have an adverse outcome. For trauma-related care, the uninsured are more than 30% less likely to receive a surgical procedure and almost 40% less likely to have physical therapy. The uninsured are also twice as likely to experience in-hospital mortality, even after accounting for severity of condition, risk of death at admission, and hospital procedures. Data from 1987 illustrate that within each of the following age groups, the hospital mortality risk for the uninsured is greater compared to the privately insured patients: Ages 0-17 (50% greater risk), ages 18-34 (30% greater risk), ages 35-49 (40% greater risk), and ages 50-64 (20% greater risk).

Overall, studies suggest that if the uninsured were continuously insured, they would experience a 10-15% reduction in premature mortality, and their improved health status would lead to increased annual earnings (of 10-30%) for adults, and increased educational attainment among children.

**Durham: A One County Case Study**

Dr. Shulman was involved in a study of Durham residents that collected data on insurance coverage, access to care, self-reported health status, their last visit to a healthcare provider, access barriers, and patient perceptions of their likelihood of having their health hurt because of a disease. As in the rest of the state, racial and ethnic minorities are less likely to have health insurance coverage: 91% of whites, 77% of blacks, and 32% of Latinos reporting to have health insurance. There were also racial and ethnic differences in where people received care: the differences within the Hispanic communities were the most striking.

**Table 2: Durham Survey: Source of care**

Where do you usually go for care?	Total (%)	White (%)	Black (%)	Hispanic (%)
Private Doctor	38	48	32	10
Duke Doctor	32	37	32	21
Durham Regional	5	4	8	4
Lincoln Community	8	1	10	44

The uninsured were less likely than the insured to report being in excellent or good health (41% compared to 58%); were more likely to report being very concerned that their health would be hurt by disease (40% vs. 24%); were less likely to have visited a doctor in the last year (67% vs. 85%); and were more likely to report not getting a prescription filled because of costs (58% vs. 14%). People were

**The Underinsured**

Aside from the millions without any health insurance coverage, we also have a problem with underinsurance. The only way to make access more available is to shift the costs onto the insured (e.g., larger co-pays and deductibles). As a result, the privately insured can afford fewer healthcare services. For example, the high-end health insurance plan at Duke University has a maximum out-of-pocket deductible for a family of four of \$6,000, but the drug out-of-pocket expenditures don't count toward that deductible. This means that families may have to spend thousands of dollars in out-of-pocket costs before the insurer pays 100% of the costs. These out-of-pocket costs can create real access barriers.

Data on the insurance effect of prescription expenditures among insured and uninsured elderly are very telling. When an individual has insurance, she doesn't have to pay the whole cost. Therefore, individuals are likely to purchase more healthcare when they are insured than when they are not because they are using someone else's money. We would

expect the differential to be even greater among people who are in poor health—e.g., those with insurance are more likely to spend money to address their healthcare needs than those who are uninsured. But there is no “insurance effect” for Medicare recipients on spending for prescription drugs as health status deteriorates. In other words, the difference in spending on prescription drugs for Medicare recipients between those with prescription drug coverage and those without coverage does not dramatically increase as their health status worsens. This is related to underinsurance. The Medigap policies do not provide sufficient coverage. If an individual reaches her insurance cap, which is easy to do, she is basically uninsured again. So her “behavior” with insurance is much like her behavior would be if she had no insurance because she has limited coverage.

**Table 3.**

**TABLE 4.** Expected Effect of Prescription Drug Insurance\*

Prediction	Overall	Uninsured <sup>†</sup>	Insured <sup>‡</sup>	Insurance Effect (95% CI)
Overall (\$)	689	574	757	183 (163–202)
By health status (\$)				
Excellent	342	218	419	201 (172–231)
Very good	502	411	558	148 (102–193)
Good	738	626	807	180 (149–211)
Fair/poor	1022	887	1094	207 (168–246)

\*Predictions are based on the 2-part regression model shown in Table 3.  
<sup>†</sup>Estimates assume no prescription drug insurance for the entire population.  
<sup>‡</sup>Estimates assume prescription drug insurance for the entire population.  
 CI = confidence interval.

High cost sharing can create access barriers for the uninsured. Another Medicare example can help illustrate this. In Durham County, 22% of the hospital discharges of Medicare recipients were for ambulatory sensitive conditions—such as uncontrolled diabetes or pneumonia—or conditions that should have been preventable if the person had been able to receive timely and adequate primary care. This may be due to the Medicare cost sharing. Medicare recipients have to pay coinsurance every time they go to the doctor; and without supplemental coverage, they also have to pay for prescriptions out-of-pocket. As a result, some Medicare recipients delay care, resulting in ambulatory sensitive admissions.

Some people argue that cost-sharing helps people make better health care choices. The idea is that if people have to pay more, they will make wiser choices (change their behavior). If this were the case, research should indicate that as people pay more for medication, they would use less of the more expensive, brand name medication. Table 4 outlines a study on drug utilization after cost-sharing policy changes. It analyzes use of ACE inhibitors (used to treat congestive heart failure and high blood pressure), proton-pump inhibitors (used for the prevention and treatment of acid-related conditions such as ulcers, gastroesophageal reflux disease, etc.), and statins (used to lower cholesterol levels). One would expect the study to show that an increase in cost-sharing would result in a decrease in use of proton-pump inhibitors first, since it seems to be the least essential medication. To some extent that does happen, but it is also evident that 20% of patients stopped taking their statins and 20% stopped taking their ACE inhibitors. Therefore, this study indicates that increased cost-sharing doesn’t make patients better consumers.

Inappropriate use of medication was reduced by 20%, but appropriate use was also reduced by 20%. So, some of the programs being put into place could negatively impact the population's health over time.

**Table 4.**

**Table 5. Drug Utilization after Policy Changes among Enrollees Who Used Tier-3 Drugs before the Changes.\***

Drug Class	Continued Use of Tier-3 Drug			Switched to Drug of Lower Tier			Discontinued Use of All Drugs in Class		
	Intervention Group	Comparison Group	P Value	Intervention Group	Comparison Group	P Value	Intervention Group	Comparison Group	P Value
	no./total no. (%)			no./total no. (%)			no./total no. (%)		
<b>Employer 1</b>									
ACE inhibitors	238/563 (42.3)	421/471 (89.4)	<0.001	234/563 (41.6)	20/471 (4.2)	<0.001	91/563 (16.2)	30/471 (6.4)	<0.001
Proton-pump inhibitors	108/328 (32.9)	219/275 (79.6)	<0.001	115/328 (35.1)	4/275 (1.5)	<0.001	105/328 (32.0)	52/275 (18.9)	<0.001
Statins	26/89 (29.2)	75/104 (72.1)	<0.001	44/89 (49.4)	18/104 (17.3)	<0.001	19/89 (21.3)	11/104 (10.6)	0.04
<b>Employer 2</b>									
ACE inhibitors	79/156 (50.6)	154/222 (69.4)	<0.001	64/156 (41.0)	33/222 (14.9)	<0.001	13/156 (8.3)	35/222 (15.8)	0.03
Proton-pump inhibitors	44/68 (64.7)	111/141 (78.7)	0.03	12/68 (17.6)	3/141 (2.1)	<0.001	12/68 (17.6)	27/141 (19.1)	0.79
Statins	14/33 (42.4)	22/25 (88.0)	<0.001	16/33 (48.5)	2/25 (8.0)	<0.001	3/33 (9.1)	1/25 (4.0)	0.45

\* For each class, the analysis includes only the enrollees who filled at least two 30-day prescriptions for tier-3 drugs only in the class in question during the 6 months before the adoption of a three-tier formulary (i.e., a small number of enrollees who had used drugs from multiple tiers before the policy changes were excluded). The rates of continued use of a tier-3 drug, switching to a drug of a lower tier, and discontinuation of use of all drugs in the class apply to the six months after the policy changes. If an enrollee switched to a different drug in tier 3, this was counted as continued use of a tier-3 drug. ACE denotes angiotensin-converting enzyme.

High medical expenses can also lead people into bankruptcy. A recent study of people filing for bankruptcy showed that about 40% of bankruptcies in the United States are related to a health condition. Some result from direct medical expenses and other bankruptcies result from a medical condition that prevents an individual from working. Bankruptcy does not just happen to people who are paying out-of-pocket for medical expenses. Those privately insured and on Medicaid and Medicare also go bankrupt. Sometimes individuals covered at the time of illness lose insurance and have a gap in coverage.

It is becoming increasingly challenging for the uninsured to pay out-of-pocket because the list price of treatment is unfathomable. Hospitals have been asked to lower treatment costs for people without insurance. However, there are barriers which prevent hospitals' from lowering their costs to the uninsured. Both the government (through Medicare) and Blue Cross Blue Shield of North Carolina require the lowest rates be given to them. So, if a healthcare provider offers a lower rate to the uninsured, the provider may need to offer the same rate to government and some third-party payers.

In conclusion, access to insurance is associated with improved health outcomes and health processes. Access to insurance is a bigger problem in North Carolina than it is nationally, especially among minority groups. Underinsurance is also likely to increase among the privately insured due to cost-sharing and rapidly rising healthcare costs.

## Comments and Questions

*Q: Are we going to be dealing with the underinsured in this Task Force? The term underinsured assumes that the proper level of insurance was in place traditionally. The coverage design is more dependent on the income of those individuals. The sad sign is that we have a one-size-fits-all plan in the workplace.*

*A: It is partly up to the Task Force whether we deal with the underinsured, but the HRSA grant, which is funding the Task Force, focuses on the uninsured, rather than the underinsured.*

*Q: In terms of quality of care, do you have any sense that providers treat the uninsured in a different, more cost effective and possibly lower quality manner?*

*A: We do offer both insured and uninsured remedies that are lower cost, even though the cure rate could be better with something more expensive. I think of healthcare as more of a system now, especially with a chronic or complicated problem. A physician must determine how to connect a patient with the specialty services needed. If they don't have insurance, I tell them to try to get an appointment with a certain specialist. So, it is not an individual level activity anymore. Our system is not all that friendly for anyone, so having to go through an extra set of hoops is even more challenging. I think of this as a cascade. To get good healthcare, you have to navigate five or ten different hoops. The most vulnerable are the ones who are going to have the hardest time navigating those hoops. It is evident that people know to go to the hospital in the case of a trauma incident, and the uninsured and privately insured are less likely to have differences in trauma, but the uninsured are still less likely to get procedures that the insured receive.*

## **IMPROVING PATHWAYS TO INCREASING COVERAGE: INFORMATION SUPPORT TO THE TASK FORCE ON COVERING THE UNINSURED**

**Sandra Greene, DrPH**

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The previous presentations explained a lot about who the uninsured are and the consequences of being uninsured. As the Task Force thinks of policy options and solutions, it is important to provide the research so that decisions are information-driven and based on fact. Dr. Greene provided more information on the background information that is being collected to support the work of the Task Force and the partners that the researchers at the Cecil G. Sheps Center for Health Services Research are working with to get this information.

There are specific groups of people without health insurance. In order to determine what additional information about the uninsured would be helpful, researchers will be trying to find out: What do they want? What do they need? What are they willing to buy? What can they afford? It cannot be assumed that we know what these groups want, can afford, or will pay with respect to health insurance coverage. In addition, there is some

information from employers that could be helpful. Some employers offer insurance, some do not. What are the factors employers consider into what they pay or what they do not? What are employers willing to pay? Brokers and insurance agents also have a wealth of information, so it will be important to derive information from them. It would be good to ask them if there are products we don't have in the market place that could benefit the uninsured populations and what types of products they think they could sell. This may help the Task Force determine if there are different kinds of policies that should be developed that could be more attractive for specific subgroups of populations.

For the research, it was determined that information should be collected from the following groups: the uninsured, employers that offer health insurance, employers that don't offer health insurance, and brokers and agents who market health insurance. To gather this information, researchers at the Sheps Center will conduct 15 focus groups throughout North Carolina, each of which will have between eight and 12 individuals. Eight of the focus groups will be with employers. Some will be with those that offer insurance, other with those that do not. Two focus groups will include large employers, two with medium sized employers, and two with small employers. Two focus groups will meet with insurance agents/brokers and five with uninsured individuals. The Sheps Center has contracted with FGI to do this work. They have experience with focus groups and familiarity with healthcare topics and health insurance.

The tentative focus group sites include: uninsured individuals in the Triangle area, west in Cabarrus and Mecklenberg Counties, far west in Watauga County, south in Robeson County, and east in Beaufort and Hyde Counties. The large employer focus groups will be in Mecklenberg County and Guilford/Forsyth Counties. The medium size employer focus groups will be in Buncombe County and New Hanover County. The small employer groups will be in Moore, Pitt, Halifax and Catawba Counties. And, finally, the brokers and agents will be in two areas: Raleigh and surrounding rural counties and Charlotte and surrounding rural counties.

The overall discussion topics for the focus groups will include offering or obtaining health insurance, consequences of being uninsured, trade-offs, willingness to pay, and policy preferences. Participants will be presented with public and private options and various insurance benefit packages to discuss.

The questions for employers will include:

- On what basis are decisions made concerning the offering of health insurance to employees?
- How important is health insurance for attracting and retaining employees?
- What trade-offs would your company be willing to make in order to afford coverage?
- What solutions do you prefer to expand coverage to the uninsured?

The questions for uninsured individuals will include:

- What are the most important factors in deciding whether to get health insurance?
- What are the primary reasons that you do not have health insurance?
- How much would you be willing to pay for your health insurance premiums?

- What trade-offs are you willing to make in order to afford coverage?

The questions for Agents/Brokers will include:

- In your opinion, on what basis are decisions made concerning health insurance by employers and individuals?
- What trends are you seeing in employer-sponsored health care?
- In your opinion, are there regulatory requirements that have a counterproductive effect on the offering of (employer-sponsored) health insurance?
- What trade-offs do you think are reasonable/feasible for a company to make in order to make insurance more accessible?

FGI has the locations of the focus groups and are very busy preparing for them. They intend to start them in the middle of March and will continue through the end of May. FGI will compile and analyze the data in June and present the results in July.

### **Critical Information for Assessing Insurance Expansion Options**

There are two types of information that are essential for assessing ways to expand health insurance options- what people want and how much it would cost. The cost data is being completed by Mercer Human Services Government Consulting. Mercer has experience working with 40 states, many of whom had State Planning Grants. Mercer has access to Medicaid data in North Carolina and private employer insurance data for the southeast. They will assist in pricing different benefit packages and determining the cost of covering subpopulations of the uninsured. Jeff Smith will lead the Mercer team.

Mercer will be listening to the Task Force discussions of public and private options to see which ones the group may favor and like to price. There are a number of variables to consider that the Task Force will have to decide upon before the pricing process can take place. Those variables include: Who will be covered? What are their demographics and health status? What services should be offered? What kind of delivery system will be used? How will it be paid for? Mercer will help us think through those decisions, so that they can more accurately price the options.

Once the actuaries from Mercer know the options the Task Force wants to consider, they will model the costs of different benefit programs to help us understand the cost implications. These will tell us the cost of coverage for individuals, families, and groups of the uninsured. During the cost determination process, Mercer will use utilization and cost patterns from North Carolina and they will also model changes in cost that would incur if underlying variables are modified.

Unlike the FGI work, Mercer will provide information more frequently, in pieces. The Task Force will start hearing from Jeff and others in March when they do a review of other states' planning grant activities. The schedule for their presentations is as follows:

- March: Review of other states' planning grant activities
- April: Description of 2-3 *public* options and their costs
- May: Description of 2-3 *private* options and their costs
- June: Refinement of costs estimates

August: Final report

### **Sheps Project Team**

The project team at the Sheps Center working on this project include: Sandra Greene, the principal investigator; Mark Holmes, an economist; and Stephanie Poley, the project manager and analyst. The project team is pleased to be a part of this and would like to hear your ideas during the Task Force process. If Task Force members or guests have any input or ideas, suggested questions to pose to the focus groups, the project team would be happy to entertain them.

### **Comments and Questions**

*Comment: 90% of employers have fewer than 15 employees. You may want to ask employers about their interest in joining groups to get better prices. There are other states that make it easier for employers to join groups for a group rate, rather than individual rates.*

*Q: In the questions for the uninsured individuals, finding out where they are accessing care now would be important information. How are you going to pick the focus group members?*

*A: With the employers, we will be buying a sample of employers by company size for the specific areas we are looking at and we will do a random sample of calling and speaking with the person who makes the decision about purchasing insurance. For the uninsured individuals, we will get a sample population of phone numbers and we will call them until we reach uninsured families who, if they qualify, will be invited to come to the focus group.*

*Q: Is there any way to work on the demographics of the focus groups?*

*A: Through random sampling, you get a good list that usually covers the general demographics of the population. We will also use good screening questions. In addition, we are offering incentives such as child care, food, and small monetary compensation.*

*Q: With the uninsured, I think you need to ask them if they had a choice, what they would have to give up in exchange for health insurance. Because what you are willing to give up and what you have to give up are very different things.*

*Q: I don't know if we are going to consider tax deductibility, but in looking at your questions for the employer and individuals, it may help separate some of the hubris at the federal level. It would be interesting to know if tax deductibility would be of interest to uninsured individuals. Also, from a small employer standpoint, what sorts of additional tax enhancements might get them to offer health insurance?*

*Comment: There was a study in the Library of Congress that talked about comparison pricing factors in small group and large group, which dealt with retentions of risk and other issues. I don't know if that has been revisited, but that would be very interesting.*

*Q: Can the Mercer data be broken down by industry type so that we can get a look at the differences between them?*

*Q: On the question of why people are uninsured, some people might be uninsured by some choice of what is worth to them. Is it lack of knowledge, lack of money to buy it, a preexisting condition, or some other reason? It would be good to really find the reason why people are uninsured.*

*A: The extent to which we know, data indicates that about 19% of the uninsured have health insurance available in some way, but don't get it because they don't know about it or for some other reason.*

*Comment: For public health insurance, you can determine how many children who qualify for SCHIP do not access it. The children's eligibility is known because they go by income guidelines. It is more difficult for those who are not children. For example, to qualify for public coverage as a non-elderly adult, you have to be disabled, or have dependent children. There is no easy way to know whether a person meets the disability standards. It's also not easy to determine eligibility for parents, because the income eligibility criteria vary by family size.*

*Q: Do employers feel a responsibility to offer health insurance or would they prefer not to offer it? It might be good to have some sort of measurement.*

*Q: How were the locations chosen? Is the random sampling county specific or will you be drawing over a multiple county area?*

*A: Most will be drawn over a multiple county area. Some of the sites were chosen based on rates of insurance. We wanted to make sure the sites were geographically diverse, have enough employers to get people to a focus group, and have a good location to hold the focus group.*

*Q: Did you look at proximity to medical centers? I think you would have some rural North Carolina who may say you have not gotten far away from the urban areas and medical centers.*

*Comment: There are fifteen focus groups, with about 150 people. A lot of people might look at the focus group locations and think that they are focused on urban North Carolina. I don't know the budget you have, but it is worth being careful how you draw the size of the sample so it is reflective of the population you are talking about.*

*A: Most of the uninsured live in urban areas, so that is one of the reasons the sites are more focused there. Plus, we were trying to keep the cost down, which is why it is less rural.*

*Comment: I don't think the cost to hold a focus group is great. It is extremely important to hold some of them in rural areas. If you aren't going west of Buncombe County, people will be aware that policy makers are not concerned with those rural areas. Of all 15 focus groups, only two sit in rural areas. That is somewhat alarming.*

*Q: We have discussed the business community. Is this Task Force going to look at the state supplying healthcare?*

*A: Sure. Whatever you want to consider is possible. All options are on the table.*

*Comment: Most people will not travel very far to attend a focus group. So they will be cross county and we will invite people, but people won't really go more than a half hour drive in order to attend something like this.*

*Comment: I don't see a focus group in the rural agricultural areas.*

*Q: Is there any way to develop a more standardized question/answer survey that you can get out to local churches?*

*A: There are a number of states that are spending almost all of their HRSA grant money on a survey, but they don't have any money left for analysis and other work. We had to choose between getting the cost data and the state data and other analyses the Task Force will need to make informed policy choices. You can't get quantitative data from focus groups. You can get qualitative data. We decided to do some focus groups. We will try to spread it out and get some more varied rural area and smaller employer sites for the focus groups. HRSA was no longer encouraging states to go the route of getting a lot of data, rather than doing other policy related work.*

*Comment: There are geographic variations in attitudes across North Carolina. That is why geography is very important. It may bring up some issues that we might over look if we didn't diversify.*

*Q: In terms of health insurance, do you want catastrophic, or do you really want something that will pay for the primary or preventative services that will keep you healthy?*

*Comment: There were a group of us trying to talk about health assurance policies and health insurance. There may be different ends of the spectrum that people have.*

*Q: One component that we seem to be missing is what it costs the taxpayer for people to stay uninsured. You can't force people to go get healthcare, but if people want it and it will save us money in the long run, can we spend some time on that? The Emerging Issues forum showed us there is a downward spiral- as the health care costs rise there are fewer people with insurance. If more and more people are uninsured, the tax payer will have to pick up the cost for an increasing number of people.*

*Comment: There is no perfect plan. There could be really bad components of any plan, but we have to move on and see how each idea could be better than what we have now.*