

Executive

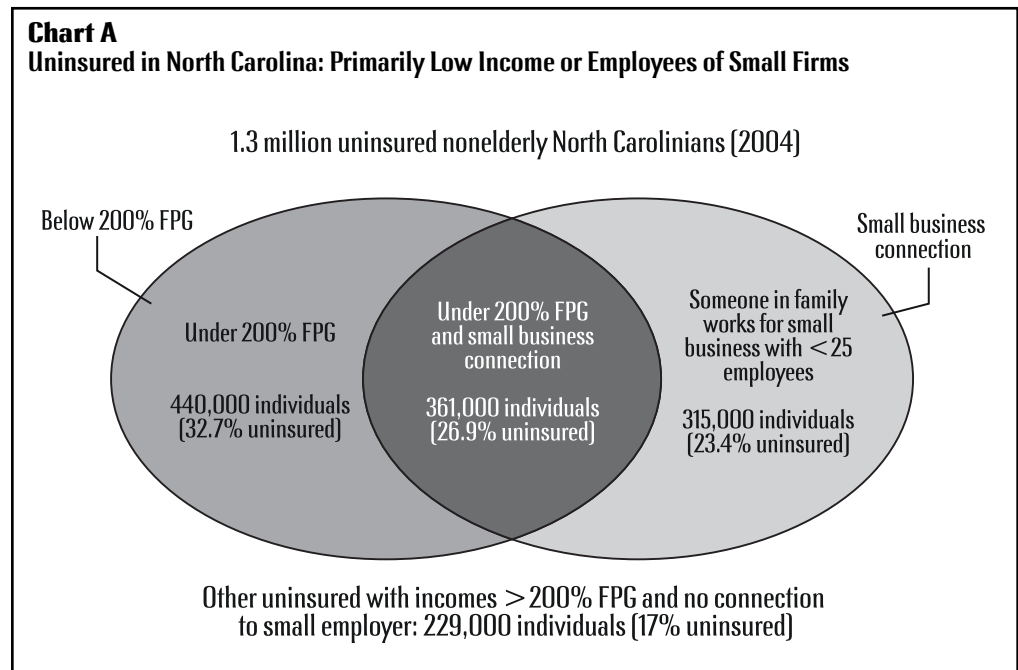


Summary

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





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.

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.



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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