NORTH CAROLINA CENTER FOR
PUBLIC POLICY RESEARCH INC.

NEWS RELEASE

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CENTER OFFERS OPTIONS FOR ADDRESSING GAPS IN HEALTH CARE COVERAGE

More than a quarter of North Carolina's population has too little health care coverage, despite massive increases in Medicaid spending in recent years, the North Carolina Center for Public Policy Research reports in the latest edition of its quarterly magazine, North Carolina Insight. The Center says it's time to do something about this expensive problem and offers a range of options for addressing it.

Insight presents an analysis of gaps in health care coverage in North Carolina, examining who is least likely to be covered and which employers are least likely to offer insurance. It presents four policy options for addressing the problem of inadequate health care coverage, a problem which afflicts 1.9 million citizens -- about 29 percent of the state's population. These options range from a state mandate of universal health coverage to doing nothing and letting the free market dictate who gets health coverage.

"It's clear that in recent years the growth in the health insurance problem has come among people who work, while the number of uninsured poor has actually dropped," says Mike McLaughlin, Insight associate editor and co-author of the article. Chris Conover of the Center for Health Policy Research and Education, also a co-author, analyzed Current Population Survey data to estimate the numbers of uninsured and underinsured for North Carolina.

Since 1985, the state has expanded Medicaid enrollment by 52 percent, and the number of uninsured poor has fallen. Still, the overall number of uninsured has not declined, which implies that every poor person now covered by Medicaid has been replaced by a person with a higher income. In the early 1980s, nearly half of the uninsured were poor and fewer than one in five were middle income or higher. Now less than one-third are poor and more than a third are middle income or higher.

The typical North Carolina family now picks up the tab for $950 in medical bills left behind by non-paying patients annually, the Center reports. About half of that amount comes in the form of state and local taxes. The rest is in hidden taxes -- the so-called cost shift in which medical bills rung up by non-paying patients get added to the bills of paying patients.

There is also a health cost for people without insurance. "People without health care coverage wind up waiting until they are sicker to seek care," says McLaughlin. "They don't seek preventive care and their health suffers. So do the wallets of those who must pay for their treatment."

On the average day, workers and their dependents make up three-quarters of the uninsured population, Insight says. Small employers -- those with fewer than 25 employees -- are much less likely to offer health insurance than larger firms. While almost all firms with 500 or more employees offer plans, only about a third of employers with 10 or fewer employees offer plans. All told, employers in small firms account for 44 percent of uninsured workers.

Cost is the most frequently cited reason that small employers do not offer plans. And while larger firms offer plans, structural barriers such as waiting periods for coverage, exclusions for pre-existing conditions, and no coverage at all for part-time workers keep some employees from participating.

Edward Green, a nursery operator in Wilkes County, is among those small business owners who might offer health insurance if it were more affordable. "I definitely would be interested if it were an attractive policy at a discounted price for the small employer," says Green, who employs up to nine workers including four family members at Green Valley Farms. "Anybody who comes to work for me, they know I don't have insurance, and that's spelled out to them up front. They're taking their chances, and that's sad, but we just can't pay it."

The legislature took some action to make insurance more affordable and available to small employers -- those who employ fewer than 26 workers and more than two -- with legislation passed during the 1991 session. The new law requires insurers who write policies for small employers to offer two types of coverage -- a stripped-down basic plan that would be exempted from some state insurance mandates, and a more elaborate plan such as that offered larger employers. Still, experience in other states suggests the new law will have limited impact on the problem of small employers' not offering health insurance.

The Center also explores the demographics of the problem of inadequate health care coverage. For example, blacks are almost twice as likely to be uninsured as whites, and children living in single-parent families are twice as likely to be uninsured as those living in two-parent households. In fact, children account for fully a fourth of the people in North Carolina without health care coverage.

Young adults ages 18 to 30 are even more likely to be uninsured than children, accounting for almost a third of the problem. At that age, they are most likely to be facing workplace eligibility barriers. They are earning less money than their older colleagues, but their health is generally better. They may be tempted to do without coverage for themselves or their families when costs are passed along to them by their employers.

Three industries account for 60 percent of the uninsured workers in North Carolina: retail trade, services, and construction. Low-wage jobs are less likely to provide health insurance, and the typical retail-trade worker earns 40 percent less than the average worker in the state. Services and construction work pay more, but the service industry includes many self-employed people who may not be able to afford coverage. And high turnover in the construction industry may prevent firms from offering coverage.

Four different groups comprise the medically indigent in North Carolina, the Center reports. They are: (1) those who are uninsured all year; (2) those who are uninsured part of the year; (3) the under-insured with private insurance; and (4) the under-insured enrolled in Medicare. All together, some 1.2 million people are uninsured at some point during the course of a year and another 700,000 are under-insured, meaning they are at substantial risk of spending more than 10 percent of their incomes on medical expenses.

People who rely solely on Medicare to pay their medical bills are considered under-insured because Medicare typically pays only 45 percent of bills for its elderly participants. Despite having some coverage, they often have higher out-of-pocket medical expenses than people without medical insurance at all. Medicaid, on the other hand, provides broad health care coverage for the poor. But not all doctors accept Medicaid patients, and many poor people

don't qualify.

The combined cost of Medicaid, direct government services, and unpaid medical bills now exceeds $3 billion in North Carolina. Facing this kind of expense, the Center says the state must examine whether to launch an all-out initiative to broaden health care coverage and must weigh how far it should go in assuring universal coverage. The Center presents four options for addressing the issue of health care coverage.

Option 1: The legislature could make incremental changes that broaden health insurance but leave it up to employers whether they offer plans and employees whether they enroll in them. This approach leaves room to broaden coverage through further Medicaid expansion, implementation of a state-operated pool for the hard-to-insure, and other incremental steps. Incentives could be offered to employers to encourage them to offer plans. At least 24 states operate high-risk insurance pools for the hard-to-insure. These operate much like North Carolina's automobile reinsurance facility. All of the pools lose money. The approach would provide more people with health care coverage than have it now and is the easiest to achieve politically, but it would still leave gaps.

Option 2: The state could adopt a "pay or play" approach of requiring employers either to play by providing health insurance or pay into a fund to provide basic coverage for the uninsured. Delaware and Ohio are considering this approach. Massachusetts has adopted it but has yet to implement it. The approach has several advantages. It provides a mechanism for funding universal health insurance, and it improves health care access for people who are uninsured or underinsured. But there are also disadvantages. Marginal businesses would suffer and the increased costs of doing business likely would be passed along to workers through reduced pay and benefits. The state must also consider the consequences for industrial recruitment and retention if it adopts such a comprehensive and costly approach and neighboring states do not.

Option 3: The state could go to a single-payer system such as that operating in Canada. Under this approach, the state would act as health care administrator under a government insurance program. Or it could contract this responsibility to a private firm. Every citizen would have health insurance. Administrative costs theoretically would be reduced because paperwork would be simplified. And a single payer would have a strong bargaining position with providers that might make cost containment more effective. But without successful cost containment, explicit rationing of health services like that begun in Oregon for Medicaid recipients might be required to bring costs under control.

Option 4: The state could do nothing and hope the problem of the uninsured and under-insured doesn't continue to mount. Under this scenario, hospitals and other care providers would continue to shift to paying patients the cost of providing health care for the medically indigent. This could continue to drive up insurance rates, forcing more employers to cancel plans or pass cost increases on to employees. More employees might drop coverage for themselves and their families.

The recent Pennsylvania Senate election showed that health care coverage has become a major political issue nationally. And a 1991 Gallup Poll found 85 percent of Americans think the nation's health care system needs reform. A legislative study commission is studying the issue of health care coverage reform and will report to the 1993 session of the General Assembly.

"The assumption has been that this is an issue that only the federal government could

handle," says Ran Coble, the Center's excecutive director. "But the best thing to do may be to encourage the states to experiment. And since North Carolina has more than a quarter of its population with little or no health insurance coverage, we think it's time this state experimented."

The N.C. Center for Public Policy Research is an independent, nonpartisan, nonprofit corporation created to study public policy issues facing North Carolina and evaluate state government programs. This research project was supported by grants from the A.J. Fletcher Foundation in Raleigh and the Kathleen Price and Joseph M. Bryan Family Foundation in Greensboro.

The Center also receives general operating support from the Z. Smith Reynolds and Mary Reynolds Babcock Foundations, both in Winston-Salem. Other funding comes from seven other foundations, 120 corporate contributors and more than 600 individual and organizational members. In addition to publishing North Carolina Insight magazine, the Center has conducted studies on disparities in funding among rich and poor school districts in North Carolina, campaign finance, mountain-area land-use management, and a comparison of the formal powers of all 50 governors.

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Copies of the issue of Insight magazine containing the research on health care coverage in North Carolina can be obtained from the Center for $12.70, plus $1.50 for postage and handling. Call (919) 832-2839, or write the N.C. Center, P.O. Box 430, Raleigh, N.C. 27602.

For more information, call Mike McLaughlin at the Center at 919-832-2839.

Table 2. North Carolina's Medically Indigent

Uninsured All Year	600,000
Uninsured Part Year	600,000
Underinsured (Private Coverage)*	400,000
Underinsured Medicare	300,000
Total	1,900,000

*The underinsured are defined as those at risk of spending more than 10 percent of their family income on medical expenses.

Source: Center for Health Policy Research and Education, Duke University

Table 3. Average Daily Uninsured in North Carolina by County, 1988

County	Number Uninsured	Percent of Population Uninsured	County Rank in % Uninsured*
Warren	3,600	21.9	100
Hyde	1,200	21.5	99
Greene	3,400	20.8	98
Bladen	6,400	20.8	97
Washington	2,900	19.6	96
Perquimans	2,100	19.0	95
Swain	2,000	19.0	94
Chowan	2,600	18.9	93
Hoke	4,600	18.9	92
Martin	5,100	18.8	91
Hertford	4,500	18.7	90
Halifax	10,500	18.5	89
Caswell	4,100	18.2	88
Pender	4,800	18.0	87
Brunswick	9,200	17.9	86
Onslow	22,700	17.8	85
Graham	1,300	17.7	84
Northampton	3,900	17.7	83
Columbus	9,300	17.6	82
Robeson	19,000	17.6	81
Sampson	8,900	17.6	80
Cherokee	3,700	17.4	79
Ashe	4,000	17.2	78
Vance	6,700	17.0	77
Wilson	11,100	17.0	76
Cumberland	44,400	17.0	75
Beaufort	7,300	16.9	74
Camden	1,000	16.9	73
Lenoir	10,100	16.7	72
Bertie	3,500	16.7	71
Jackson	4,500	16.7	70
Tyrrell	700	16.4	69
Avery	2,500	16.3	68
Pasquotank	5,000	16.2	67
Yancey	2,600	16.1	66
Franklin	5,700	16.0	65
Alleghany	1,600	16.0	64
Harnett	10,400	15.9	63
Duplin	6,600	15.8	62
Scotland	5,400	15.7	61
Madison	2,700	15.7	60
Person	4,800	15.2	59
Jones	1,500	15.2	58
Granville	5,800	14.9	57
Clay	1,100	14.9	56
Gates	1,400	14.6	55
Currituck	2,000	14.6	54
Pitt	14,700	14.5	53
Edgecombe	8,600	14.5	52
Pamlico	1,600	14.4	51
Mitchell	2,100	14.4	50
Craven	11,700	14.3	49

County	Number Uninsured	Percent of Population Uninsured	County Rank in % Uninsured*
Lee	6,000	14.2	48
Richmond	6,500	14.1	47
Anson	3,700	14.1	46
Haywood	6,700	14.0	45
Wayne	13,200	13.4	44
Carteret	6,900	13.3	43
Nash	9,700	13.2	42
Johnston	10,400	12.9	41
Rutherford	7,300	12.6	40
Macon	2,900	12.4	39
New Hanover	14,400	12.2	38
Watauga	4,200	12.1	37
Polk	1,700	11.8	36
Moore	6,900	11.8	35
Dare	2,400	11.5	34
Orange	9,900	11.3	33
Surry	6,900	11.1	32
Wilkes	6,800	11.0	31
Henderson	7,600	11.0	30
Cleveland	9,400	10.9	29
Stokes	4,000	10.9	28
Mecklenburg	50,900	10.7	27
Lincoln	5,100	10.7	26
Buncombe	18,400	10.7	25
Rockingham	9,200	10.6	24
Union	8,800	10.5	23
Yadkin	3,100	10.3	22
Guilford	33,900	10.1	21
Davidson	12,500	10.0	20
Stanly	5,100	10.0	19
Davie	2,700	9.7	18
Durham	16,600	9.7	17
Gaston	16,800	9.7	16
Transylvania	2,500	9.6	15
Montgomery	2,300	9.5	14
Forsyth	25,600	9.5	13
Iredell	8,600	9.5	12
McDowell	3,400	9.4	11
Wake	36,600	9.4	10
Randolph	9,500	9.3	9
Alamance	9,800	9.3	8
Rowan	9,700	9.2	7
Caldwell	6,500	9.2	6
Alexander	2,500	9.1	5
Catawba	10,600	9.1	4
Cabarrus	8,400	8.9	3
Burke	6,800	8.9	2
Chatham	3,200	8.7	1
Statewide Total	802,900**	Avg. 12.4	

* Ties in percentage due to rounding only. ** Based on 1988 data, adjusted to reflect the projected impact of Medicaid expansion, so statewide total does not match the figure for North Carolina in Table 1. The average daily uninsured population for 1990 was about 885,000, and the number uninsured over the course of the year totaled about 1.2 million.

Source: Duke University, Center for Health Policy Research and Education.