Health Care for the Poor: Adequacy, Availability, Affordability

By Pam Silberman

Studies show most Americans share the view that good health care should be a basic right—not a commodity for sale to the highest bidder. But is health care as readily available to those who sell hamburgers as to those who sell auto insurance or blue-chip stocks? The answer—clearly revealed in statistic after statistic concerning the health of the poor—is an emphatic no. Many low- to moderate-income citizens lack adequate health insurance, and the poor use fewer health services, even though they have more health problems than the general population. Experts believe at least part of the problem is cost and availability. What can be done to make health care more accessible and affordable to North Carolina's poor? Are there realistic hopes for reform?

"It is indefensible that we are the only industrialized country in the world, except for South Africa, without a national health care program."

—Dr. Arthur Flemming, former U.S. Secretary of Health, Education, and Welfare.

What should be the government's role in assuring adequate and affordable health care for all citizens? The federal government wrestled with this crucial question during the war on poverty in the 1960s. Instead of a comprehensive plan, Congress decided to focus on health care for the poor and the elderly, and in 1965 Medicaid and Medicare were born. In the decades that followed, more programs were implemented to aid the medically indigent. But considerable latitude was left to the states, and North Carolina has failed to fill the gaps, leaving gaping holes in the state's health-care safety net.

Experts say Medicaid covers only a third of

Pam Silberman is an attorney with the North Carolina Legal Services Resource Center specializing in health care issues. Silberman has served on the Legislative Study Commission on Indigent Health Care since 1985.

Eric Green / N.C. Poverty Project

state residents who fall under the federal poverty line, and Medicare covers less than half of the total medical expenses of the elderly. But perhaps the most onerous health-care problem facing North Carolina is that nearly one third of the state's residents are *medically indigent* — that is they either have no health insurance coverage at all or their coverage is inadequate.

Who Are the Uninsured?

Many of the medically indigent are impoverished, while others are low- to moderate-income residents who could be plunged into poverty by any major medical emergency. The ranks of the uninsured also include people who have a reasonable income by traditional measures but cannot buy insurance, either (1) because they have a pre-existing medical condition, (2) because their employers do not offer insurance at work and they cannot afford to purchase their own policy, or (3) because they have not met the required waiting period—often six months to a year—for enrolling in the group health insurance plan offered by their employer.

Most of those who lack health insurance, however, have low or moderate incomes, says Chris Conover of the Center for Health Policy Research and Education at Duke University. Conover's research has revealed that in North Carolina, as many as 1,156,000 people are uninsured at some time during a typical year.[1] Another 750,000 people have health insurance which is insufficient to meet their health care needs.[2] Three quarters of these medically indigent citizens are poor or near-poor, Conover says, and evidence abounds that inadequate health insurance is a significant barrier to getting good health care.

Why? First, it is difficult to find doctors and hospitals willing to treat non-emergency patients without a proven ability to pay, and second, the poor put off preventive medical treatment. "They are going to wait a long time before they pay $50 or $100 to go to a doctor to track down a suspicion they are not well," says Jim Bernstein, director of the Health Resources Development Section of the N.C. Department of Human Resources.

Studies have shown that even though North Carolina's uninsured are in worse health than the general population, they use 30 percent to 50 percent fewer services. (See Table 1, p. 124.) When they do seek medical treatment, they are

Table 1. Health Condition Reported by Patient Type

Health Condition	Medicaid	Uninsured	Insured
Arthritis	38%	21%	17%
High Blood Pressure	38%	20%	17%
Heart Disease	16%	7%	4%
Kidney Disease	10%	6%	5%
Diabetes	10%	4%	3%
Stroke	6%	3%	1%
Disability Which Prevents Working	15%	6%	1%

Source: "Who are the Medically Indigent?" Report to the Indigent Health Care Study Commission by C. Johnston Conover, Duke University Center for Health Policy Research and Education, chart entitled "Health Status of Adults in North Carolina," March 12, 1986, p. 28.

more likely to use a public health clinic or an emergency room.[3]

From her Waxhaw home, Dona Montgomery directs a nonprofit advocacy group called the North Carolina Alliance for Social Security Disability Recipients. Montgomery says she believes ability to pay has a significant impact on health care availability. "Many doctors require patients to pay for their services on the day the services are rendered," says Montgomery. "Other doctors refuse to treat patients who have outstanding debts. As a result, many uninsured individuals do not go to the doctor's office until it is too late." These gaps in the health care delivery system fly in the face of polls showing broad public support for access to health care for all Americans, regardless of ability to pay.[4]

Children are the most likely of any group to lack health insurance coverage, according to Conover's study. In 1985, approximately 36 percent of the uninsured in North Carolina were children under age 18.[5] The situation is far worse for low-income children. The number of uninsured poor children grew from 44.2 percent of the state's poor children in 1980 to 53.2 percent in 1985.[6] Experts warn that as the cost of health insurance rises, more and more workers may drop optional family coverage for their dependents, pushing the number of uninsured children even higher. Conversely, the elderly are the group most likely to have some health insurance coverage because of the wide availability of Medicare. Conover found only 2.5 percent of the elderly to be uninsured sometime during the year.[7]

Eric Green / N.C. Poverty Project

But Medicare coverage alone is insufficient to meet a person's health care needs, and there are 267,000 elderly or disabled North Carolina residents who have Medicare coverage as their sole source of health insurance.[8] Blacks and other minorities are more likely to lack health insurance coverage than whites, and women are more likely to be uninsured than men.[9]

More than two-thirds of the uninsured live in a family where one or more persons works, and more than half live in a family in which one or more persons is working full time. A majority of the uninsured workers work in small firms with fewer than 25 employees or are self-employed, but the reasons employees lack health insurance on the job vary with the size of the firm. Most of the uninsured workers in small firms are not offered health insurance. Small businesses often cannot afford the costs of health insurance, which may run between 30 percent and 50 percent higher than insurance costs at large firms.[10] On the other hand, most of the uninsured workers in large firms are offered health insurance but for one reason or another do not qualify for the plan. For example, the plan may have a six-month waiting period, or may exclude part-time workers or those with pre-existing medical conditions. Although many of these workers are only temporarily uninsured, they nonetheless face the risk of staggering medical costs during this period of exposure.

Recent trends indicate the number of uninsured workers will continue to grow. One reason is a 2 percent decline in employer-based coverage in the United States during the 1980s.[11] This decline is due partly to the shift in jobs from the manufacturing sector to the service sector, which traditionally provides fewer benefits. (For more on this trend, see Bill Finger, "Making the Transition to a Mixed Economy," *North Carolina Insight*, Vol. 8, No. 3-4, April 1986, pp. 3-20.) Nationally, between 1980 and 1985, employment in industries with below-average rates of health coverage grew four times as fast as employment in industries with above-average rates of coverage.[12] This situation is far worse in North Carolina, where employment in industries with below-average rates of health coverage grew seven times as fast between 1980 and 1987 as employment in industries with above-average rates of coverage.[13]

More important, however, are rising health insurance costs and the overall health of the economy. "Premium increases of 30 percent to 40 percent a year are going to get a lot of people thinking about whether they can afford health-care coverage," says Conover. "What happens in terms of trends [also] very much depends on the economy. The economy is absolutely a critical variable, and it is inherently unpredictable."

Conover says his projections show only a modest increase in the uninsured population through 1992 if the economy remains healthy,

Eric Green / N.C. Poverty Project

but an increase of as much as 85 percent in the event of a major recession.

Medicaid: Short of the Mark

Medicaid was created to provide health insurance for the nation's poor, but the program has fallen far short of its mark. On a given day, only about one-third of the people living in poverty in North Carolina qualify for Medicaid, Conover says. One reason for this is the eligibility restrictions imposed by Congress, which limited Medicaid coverage to groups known as the *categorically eligible* — children under the age of 21, pregnant women, families with dependent children, people 65 years or older, and blind or disabled persons. In order to be eligible for Medicaid, the recipient must meet these categorical restrictions, plus stringent income guidelines. Thus, individuals between ages 21 and 64, who have no dependent children and who are not disabled, cannot qualify for Medicaid, regardless of their income or medical needs.

Despite these categorical limitations, Conover says North Carolina has the flexibility to expand Medicaid to cover thousands of additional low-income people. In most states, Supplemental Security Income (SSI) recipients—low income individuals who are elderly, blind, or disabled—automatically receive Medicaid. North Carolina does *not* provide automatic coverage to all SSI recipients, thereby excluding roughly 66,500 low-income elderly, blind, and disabled citizens from Medicaid coverage.[14]

The state also excludes thousands of poor people from Medicaid coverage by setting restrictive standards on income and available resources. In order to qualify for Medicaid in North Carolina, a person may have no more than $1,500 in countable assets. For a family of four, the figure increases to only $2,450.[15]

Income limits are even more restrictive than asset limits. Aside from the categorical exceptions allowed by Congress, Medicaid coverage must be limited to those with incomes of no more than 133 percent of the Aid to Families with Dependent Children payment level in order for the state to receive a federal reimbursement of 67 percent for Medicaid expenditures.[16] This link to the AFDC payment level translates into extremely low Medicaid income criteria in North Carolina, which ranks 42nd in the nation in AFDC payment levels.[17] For example, the maximum AFDC payment for a family of one is $177 a month. Therefore, the Medicaid income limit for an individual is 133 percent of $177, or only $241 a month. (See Table 2 below).

These income limits do not automatically exclude a person from Medicaid eligibility. If categorically eligible, an individual or family may be found to be *medically needy*. In order to qualify, the individual or family must incur medi-

Table 2. Income Limits on Medicaid Coverage in North Carolina

Family Size	AFDC Maximum Payment	Medicaid Income Limit	1988 Federal Poverty Guidelines	Medically Needy Income Limit as % of Poverty Guidelines
1	$ 177	$ 242	$ 481	(50%)
2	231	308	644	(48%)
3	266	358	808	(44%)
4	291	387	971	(40%)

Table by Pam Silberman

Eric Green / N.C. Poverty Project

cal bills equaling the difference between the family's countable income and the medically needy income limit. This difference is called a deductible or *spend-down*. The effect, however, is to force people to spend any excess income and to live on incomes no greater than the Medicaid income guidelines in order to have their health care costs covered by Medicaid.

The legislature's Indigent Health Care Study Commission has recommended that the state broaden Medicaid eligibility in North Carolina to take in about 179,300 additional residents. This would be accomplished by increasing income limits from 50 percent to 75 percent of poverty for the elderly and disabled; from 100 percent to 185 percent of poverty for women and infants; and by increasing by 5 percent the income limits for all other categorically eligible recipients (now 50 percent of poverty guidelines for a family of one). The estimated cost comes to $231 million, with the state paying an additional $65 million (28 percent), local government paying $12.2 million (5 percent), and the federal government picking up the remainder (67 percent).

Such an expansion of Medicaid is strongly favored by the North Carolina Hospital Association, which argues that the number of non-paying patients at North Carolina's hospitals contributes to rising medical costs for paying patients and increased insurance costs for employers. "The North Carolina Hospital Association is working to increase the number of poor people eligible for Medicaid, even though Medicaid does not cover the cost to the hospital of treating a Medicaid patient," says William A. Pully, hospital association lobbyist. "Something is better than nothing, and nothing is what we are getting right now for treating these people. There is a lot of room to expand. We think the state should maximize participation in Medicaid." Pulley says it makes sense for the state to participate to the fullest because the federal government will provide more than a two-to-one match for state and local dollars. "North Carolina ranks 48th in the amount of *all federal funds* per capita coming to the state," says Pulley. "We're not getting our fair share."

Daphne Lyon, chief of planning in the Department of Human Resources Division of Medical Assistance, says 1986 figures, the latest available, showed North Carolina, the nation's 10th most populous state, ranked 17th in drawing *federal dollars to match Medicaid expenditures.*

But despite broad support for Medicaid expansion, whether the state will be able to find the money to pay its share this year remains a question. Revenue collections have fallen short of projections for fiscal year 1988-1989, leaving little room for the legislature to add or expand programs during the 1989 session.

Medicare Coverage Not Enough

Unlike Medicaid, Medicare is not based on a person's financial status. There is no income or resource test in the Medicare program. In order to receive Medicare coverage, a person must be at least 65 years old or have been disabled for at least two years and with some small exceptions must be receiving either Social Security retirement or disability payments.[18]

Medicare coverage alone, however, is insufficient to meet a person's health care costs. Medicare does not cover certain medical needs, such as routine physical check-ups, dental care, intermediate nursing home care, eyeglasses, or drugs. For the services Medicare does cover, a patient must pay at least $26.50 in monthly premiums and pay large deductibles and co-payments.[19] Prior to recent changes, Medicare covered only about 40 percent of a patient's total health care costs.[20]

The Hill-Burton program, created in 1946, has been another source of medical treatment for the poor. Originally set up as a system to pay for the capital costs of hospital construction, the program evolved into a system of treating the poor. In return for federal hospital construction money, local hospitals had to agree to provide a certain amount of free or reduced-charge services to low-income, uninsured individuals for a certain length of time. Thus, while the Hill-Burton free-care provisions were in operation, many low-income people had access to hospitals for necessary treatment.

Congress stopped funding the Hill-Burton program in 1977. Since that time, many North Carolina hospitals have exhausted their free-care obligations. Of the 96 hospitals with Hill-Burton free-care obligations in 1980, only 56 hospitals continue to have free-care obligations, and most of these obligations will be exhausted in the next 10 years.[21] By the end of 1990, in fact, only 37 of North Carolina's 127 general acute-care hospitals still will have Hill-Burton obligations to provide health care for the poor.[22]

Besides the free care which hospitals provide as a part of their Hill-Burton obligations, hospitals also provide a measure of free care to the uninsured and under-insured. In 1985, for example, North Carolina hospitals provided $172 million worth of free care (defined as both charity care and bad debt). Three-quarters of this free care ($124 million) was provided to the uninsured, and one-quarter ($48 million) was provided to people with insufficient health insurance coverage.[23] Pully says continued cuts at the federal level in Medicare reimbursement and increased competition for fewer paying patients in 1987 alone had pushed the amount of uncompensated care provided by North Carolina hospitals to about $780 million. This includes charity care and bad debt. The figure also includes contractual adjustments, which primarily comprise the hospitals' costs for treating Medicare and Medicaid patients, minus government reimbursement for care provided under these programs.

Similarly, physicians in private practice provided $198 million in free care, or 11.1 percent of total physician billings in 1985. About one-quarter of the physician free care, or $52 million,

Scott Dedman / Pisgah Legal Services

went to the uninsured, and the remaining $146 million went to those with inadequate health insurance coverage.[24]

While both hospitals and physicians provide a significant amount of uncompensated care to the uninsured and under-insured, these services do not address all of the needs of the medically indigent. And this source of care for the medically indigent is threatened by cost control efforts. Since charity care and bad debt are financed largely by shifting the costs onto paying patients, efforts to cut costs to private patients may also cut into the amount of free care provided to the medically indigent.[25] (For more on how hospitals care for the medically indigent, see Lori Ann Harris, "The Performance of For-Profit and Not-for-Profit Hospitals in Providing Health Care for the Medically Indigent," *Comparing the Performance of For-Profit and Not-For-Profit Hospitals in North Carolina*, N.C. Center for Public Policy Research, Raleigh, N.C., March 1989, pp. 37-80.)

In addition to Medicaid, Medicare, and the Hill-Burton programs, Congress provided funding to local communities to set up health care centers in medically under-served areas. These centers provide primary health care, such as physician and nursing services, on a sliding-scale basis to the people in their community, with fees based on ability to pay. In addition, some of the facilities offer dental care and low-cost prescriptions. None of the facilities, however, pays for the costs of hospital care for low-income individuals needing treatment.

North Carolina operates 35 clinics under this federal program, plus 46 programs under a similar state-funded rural health program. Nonetheless, "there are still 44 counties in the state that are designated health manpower shortage areas, which means that they have limited access to primary health care physicians," according to DHR's Bernstein. Bernstein says this accessibility problem hits the uninsured poor the hardest, both because they have a harder time finding physicians willing to treat them and because they often lack transportation.

The state also has a system of public health departments which provide some health services to the medically indigent. There are 87 health departments which cover all 100 counties of the state. The services offered at local health departments vary by county. For example, all of the health departments offer immunizations and all check for venereal diseases. But only seven health departments have primary health-care clinics where adults can obtain full medical screenings and treatment.[26]

♦

"The litmus test that both the biblical and republican traditions give us for assaying the health of a society is how it deals with the problem of wealth and poverty."

— Robert Bellah et al.
Habits of the Heart

♦

Are the Current Services Enough?

Despite the range of health services currently available to the poor and uninsured, statistics clearly indicate that the care afforded the medically indigent is inadequate. According to a 1983 national study, the insured receive 54 percent more walk-in care than do those without insurance coverage. "It is not the case that the uninsured manage to obtain ambulatory care comparable in amount to that obtained by the insured by relying on public clinics, teaching hospital outpatient clinics, nonprofit health centers, or the charity of private physicians. Without insurance, many simply do without care," the authors conclude. They say that "financial access to care is clearly the most important factor affecting use."[27]

Even Medicaid recipients have trouble finding doctors who are willing to accept Medicaid patients. Overall, only 53 percent of the state's primary care physicians actively participate in the Medicaid program, according to the N.C. Division of Medical Assistance. On the county level, participation varies from a high of 100 percent in Alleghany, Bertie, Camden, Franklin, Hoke, Jones, and Richmond counties, to a low of 27 percent in Dare County, a coastal county with relatively few Medicaid-eligible residents.[28] According to a 1987 study by Ralph Nader's Public Citizen Health Research Group, *North Carolina is tied with New Jersey for the nation's lowest physician participation rate in the Medicaid pro-*

gram.[29] While state officials question this finding, they agree that physician participation in the Medicaid program is a significant problem in North Carolina.

Critics say access to hospital care for the uninsured is only slightly better. "Many low-income people who need essential but non-emergency care are turned away or are discouraged from seeking hospital care because they can't pay the required pre-admission deposit or because they have outstanding unpaid hospital bills," says Montgomery of the Alliance for Social Security Disability Recipients.

A survey by the North Carolina Center for Public Policy Research found pre-admission deposits are widely used by for-profit, not-for-profit, and public hospitals across the state. Of the 75 hospitals responding to the survey, 52 percent reported using pre-admission deposits, mostly for non-emergency surgery.[30]

Pully says non-paying patients *should* be discouraged from using hospitals for care, except in emergency situations. "The hospital is the single most expensive portal of entry to the health care system," says Pully. "All efforts to discourage its use by those unable to pay should be supported, even if only those needing emergency care are admitted. The incentives should be directed toward providing adequate primary care [at doctors' offices and clinics]. Offering elective surgery to the uninsured would quickly bankrupt the system."

One national study found that the insured receive 90 percent more hospital care than do the uninsured. This differential is particularly marked in the South, where insured people receive *three times* as many days of hospital care annually as do uninsured persons.[31] Another study found that the uninsured are most often hospitalized for maternity or accident cases, and are less likely than insured patients to receive care requiring high technology.[32] In addition to the problems the uninsured face in obtaining physician and hospital care, the uninsured must overcome obstacles to obtaining ancillary care (such as medication), transportation to the medical provider, and adequate community support services that would enable the elderly to stay out of nursing homes.

Although the health care needs of the poor are well-documented, the question of how best to meet them is far from settled. In one recent study, researchers found that even when primary care clinics were accessible and heavily used, the health of the poor did not improve to the level of the general population. These researchers concluded that education level, quality of housing, nutrition, and other variables erode the health of the poor even when health care is readily available. The authors recommended treating not just the symptoms, but the social conditions that helped to spawn them.[33]

Still, it makes sense intuitively that the poor are better served by health services that give them adequate treatment than by the current stopgap approach. Sweeping programs that would wipe out social inequality are unlikely, but there is substantial room for fine-tuning the existing health-care delivery system so that it better serves the poor.

What Other States Are Doing

Those states which have acted on the indigent health care problem generally have taken one of two approaches: a comprehensive approach aimed at ensuring that every citizen has access to affordable health care, or a targeted effort to expand health care for certain subgroups of the population. Most states have chosen the latter option.

Only Massachusetts has developed a comprehensive health care plan. Beginning in 1992, Massachusetts will require all employers with six or more employees to offer health insurance to all employees who work 30 hours a week and to their dependents.[34] To cover those who cannot obtain employer-based health insurance, Massachusetts will provide health insurance to the unemployed receiving unemployment insurance; expand Medicaid to cover more pregnant women and infants; help otherwise ineligible disabled children and adults obtain the same benefits available through Medicaid; require all college students to have health insurance; and establish a state-subsidized health insurance program for those on general assistance and those who do not fall into any other program category.

Many other states are experimenting with the targeted approach. Some are attempting to broaden private sector health insurance coverage through tax incentives and other means. Others aim at expansion of public assistance programs. The National Leadership Commission on Health Care, a privately formed panel, in January 1989 proposed a national health insurance program for all of the nation's estimated 37 million uninsured.

Several states are trying to devise ways to

—continued on page 132

State's Infant Mortality Rate Among Nation's Worst

Perhaps one of the best indicators of a state's commitment to high quality health care for the poor is its infant mortality rate—and North Carolina's rate ranks among the nation's worst. The state had the sixth highest infant mortality rate in the country in 1986. More than 11 out of every 1,000 children died before they reached the age of 1.

And this problem was even more pronounced among minorities. The infant mortality rate for non-white infants was almost twice that of white infants, with an average of 16.6 minority infant deaths per 1,000 before age 1 compared to 9.3 infant deaths for whites.

National rankings have not been compiled for 1987, but state figures show the problem has worsened. The infant mortality rate increased to 12.1 deaths per 1,000 births, or 17.6 deaths for non-white infants and 9.6 deaths for white infants.

Low birth weight and premature births are the leading causes of the high infant mortality rate. Lack of prenatal care, failure to obtain adequate nutrition during pregnancy, maternal diseases, low socio-economic status, and teenage pregnancy are risk factors contributing to North Carolina's high infant mortality rate. All of these factors are more prevalent among the poor.

Access to prenatal care is a significant problem in North Carolina. Between 1980 and 1986, the number of women who received no prenatal care increased by 57 percent. Failure to procure prenatal care can have serious consequences. According to a report by the Department of Human Resources' Division of Health Services, "Women who deliver with no prenatal care are three times more likely to have a low birth-weight baby (under 5 1/2 lbs.) and seven times more likely to have a very low birth-weight baby (under 3 1/2 lbs.)." The number of women who began to receive prenatal care in their last trimester also increased.[1]

The General Assembly expanded Medicaid in October of 1987 to cover more low-income pregnant women in an effort to improve access to prenatal care. State lawmakers raised the Medicaid income guidelines from $392 a month for a family of four—less than half of the federal poverty line—to the federal poverty guidelines ($971 a month for a family of four). About 15,000 pregnant women were eligible for this expanded Medicaid coverage.

The legislature also approved Medicaid program reimbursement for care coordination services provided to Medicaid-eligible pregnant women. The move was intended to help ensure that pregnant women receiving Medicaid also obtained needed support services, such as nutritional supplements through the Women, Infants and Children program, and transportation to the medical provider. In addition, the General Assembly increased the Medicaid reimbursement rates for the basic prenatal and delivery package from $409 to $625, expanded Medicaid to cover nurse midwife services, and most recently appropriated $240,000 to help offset the malpractice insurance costs of doctors who would provide prenatal and delivery services to pregnant women in medically underserved areas. But despite these changes, low income pregnant women still have difficulty obtaining prenatal care.

The Medicaid reimbursement rate is less than one-half of what many doctors receive from private patients. (A proposal by the Indigent Care Study Commission would increase payment for the prenatal care package by 52 percent to $950.) Thus, many doctors either refuse to treat Medicaid patients, or limit the number of patients that they will see. This cutback in the private sector forces more women to use the public health sector as their source of prenatal care. "Between 1984 and 1987 there was an 8.7 percent increase in the number of live births, but a 31.5 percent increase in the number of women receiving prenatal care at state-supported prenatal clinics," says Barry Goldstein, Assistant Director of the Maternal and Child Health Section of the Division of Health Services. However, the health

— continued on page 132

encourage more employers to offer health insurance. Hawaii has the most comprehensive employer-based approach, with employers required to provide health insurance coverage to employees working at least 20 hours a week.[35] Employers are not, however, required to provide health insurance for dependents or for certain other categories of individuals, such as those receiving Medicare.

Other states have attempted to create low-cost health insurance plans which would be attractive to the many small employers who do not provide health insurance coverage. The Robert Wood Johnson Foundation of Princeton, N.J., has funded 15 different state and local initiatives to test different ways to reduce premium costs and market health insurance plans to small employers. These methods include limited benefit packages; provider discounts; managed-care systems comparable to health maintenance organizations; small employer health insurance pools; premium subsidies; increased employee cost sharing such as higher deductibles; and information and referral systems to link small employers to existing health insurance plans.[36]

In addition, 15 states have developed high-risk pools to address the needs of the medically uninsurable.[37] These plans offer health insurance to people who have been rejected by other insurance companies because of pre-existing conditions. The purpose of these pools is to spread the cost of covering the medically uninsurable among all the regulated insurance companies in the state. Most of these plans limit the premium rates to 150 percent or less of average premium rates for individuals. Two states, Wisconsin and Maine, provide premium subsidies for low-income people. Such subsidies are intended to offset the high premiums and co-payment requirements that in some states prevent low- and moderate-income people from enrolling in these high-risk plans.

Several other states have experimented with state-subsidized health insurance programs. Washington, for example, recently enacted the Health Care Access Act, which will help subsidize health insurance coverage for 30,000 people

Infant Mortality

—continued from page 131

departments are not all equipped to handle the increasing number of pregnant women. The Division of Health Services surveyed local health departments and found that in 18 counties, pregnant women have to wait more than two weeks in order to be seen by a doctor. Four counties have waiting periods of more than four weeks.

Moreover, 11 counties in the state do not offer prenatal care in their health departments: Alleghany, Ashe, Avery, Clay, Greene, Graham, Hyde, Pamlico, Pender, Polk, and Transylvania. In addition, two of the 18 high-risk clinics in the state temporarily closed down in June 1988 because they lost their obstetrical back-up. In six of the 11 counties that do not have prenatal clinics in their health departments, residents can receive maternity care from health departments in neighboring counties. Division of Health Services officials anticipate that prenatal care will be initiated or reinstituted in four of the remaining five counties in 1989.

The state recently expanded the WIC program to serve more low-income pregnant women. WIC is a nutrition education and supplement program for low-income pregnant, postpartum, and breastfeeding women, as well as infants and young children. Adequate nutrition is critical to a healthy birth. With an annual budget of $50.1 million in North Carolina, WIC reaches 108,000 people each month, approximately 44 percent of all eligible people. National studies have shown that WIC contributed to a reduction of 20 to 30 percent in fetal deaths before birth, and that women who participate in WIC have fewer premature births.[2] The Division of Health Services has taken steps to expand the WIC program by entering into an agreement with two infant formula companies (Mead Johnson and Ross Laboratories) to rebate to the state part of the cost of the formulas. As a result, WIC will reach about

under age 65 with gross family incomes at or below 200 percent of the federal poverty line. That means a family of four with a household income of up to $23,000 is eligible for the subsidized coverage. Individuals are required to pay monthly premiums based on their income levels and have nominal copayments for certain services. To contain costs, health services are controlled through health maintenance organizations.[38] Wisconsin and New York are designing similar pilot programs to test the feasibility of state-subsidized health insurance proposals.[39]

Much of the expansion of public assistance has come in the Medicaid program. Most states view Medicaid as a cost-effective means of expanding access to health care, since the federal government contributes heavily to the cost of the program. Consequently, many states have taken advantage of recent changes in federal law that allow the provision of Medicaid to more people. As of July 1988, 30 states, including North Carolina, had enacted legislation to expand Medicaid to cover children and pregnant women with family incomes equal to or below the federal poverty guidelines. An additional 10 states have increased the income eligibility guidelines even more. Congress allows states to provide Medicaid to all infants and pregnant women with household incomes of less than 185 percent of the federal poverty guidelines.[40] Further, four states have expanded Medicaid to cover more low-income aged, blind, and disabled individuals.[41]

In addition, Michigan and Massachusetts have set up state-funded public health programs to ensure access to prenatal care for all pregnant women and children.[42] Eight states have set up state-funded prescription drug programs to subsidize the cost of medication for certain low-income elderly and disabled individuals.[43]

Options Under Study in North Carolina

North Carolina currently has two legislative study commissions examining health access issues: the Indigent Health Care Study Com-

20,000 more people each month, or 51 percent of all people eligible and in need of nutritional supplements.

While these are significant efforts to ensure that pregnant women have adequate diets and access to prenatal care, they have not yet affected North Carolina's infant mortality rate. State officials expect the impact to show up in the 1989 figures, but already there are calls for more aggressive action.

The North Carolina Institute of Medicine, in a November 1988 report, recommended that the state take several steps aimed at reducing the number of premature and low-birth-weight babies. These include county-by-county plans for delivering prenatal care to low-income women through health departments and primary care physicians; expansion of Medicaid income guidelines to 185 percent of the federal poverty guidelines for young children and pregnant women; discretionary funds for counties to fill gaps in prenatal care coverage; and state-employed doctors, nurses, and midwives to provide prenatal care in counties without obstetrical services.

Dr. Sarah Morrow, an Institute board member, says the package would cost $4.7 million in the first year. But she says besides giving children a better chance at a healthy start, increasing access to prenatal care would cut down on expensive medical treatments that often wind up on the hospital bills of paying patients. "For the cost of putting five low-birth-weight infants in intensive care nurseries, you can provide prenatal care to 149 low-income women," says Morrow.

—Pam Silberman

FOOTNOTES

[1]Testimony to the Indigent Health Care Study Commission, Subcommittee on Public Assistance Options, by Richard Nugent, consultant to the Maternal and Child Health Section, Division of Health Services, N.C. Department of Human Resources, Nov. 10, 1988.

[2]"Special Information for All Providers: Food and Nutrition Services to Women and Children," N.C. Medicaid Bulletin, N.C. Department of Human Resources, July 1988, p. 6.

Eric Green / N.C. Poverty Project

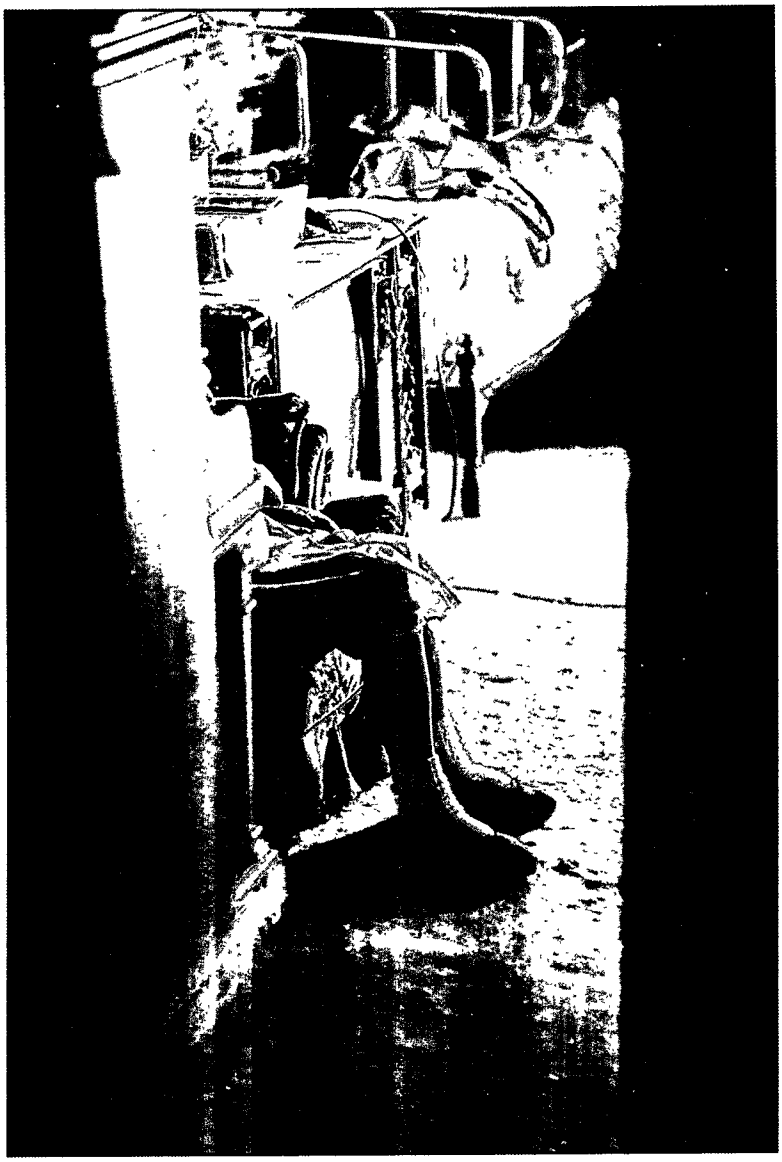
mission and the Health Insurance Trust Commission. The recommendations of these two study commissions to the 1989 session of the General Assembly include Medicaid expansion; community health demonstration programs; changes in the health insurance laws to reduce barriers to employer-sponsored health insurance coverage; and a pilot program to encourage small employers to provide health insurance.

The Indigent Health Care Study Commission recommended that the family income guidelines be increased for infants and pregnant women to 185 percent or less of the federal poverty guidelines. This would raise the income eligibility limit from the current $11,600 for a family of four to $21,460. To encourage more private physicians to treat low-income pregnant women, the commission recommended that Medicaid reimbursement for prenatal and delivery care be raised from the current $625 to $950 and that the state expand a recently enacted pilot program that offsets part of the malpractice insurance costs for obstetricians and family practitioners who agree to treat low-income pregnant women in medically under-served areas. (This is part of an effort to battle the state's high infant mortality rate. For more on this problem, see sidebar, pages 131-133.) The commission also recommended that the income guidelines be increased to cover more children, elderly, disabled, and working families. These proposals would provide Medicaid coverage to an additional 179,300 low-income individuals at a total cost of approximately $231 million, which includes the cost of administering the program as well as health services costs. The state share would be approximately $65 million, or $30 a month for each additional Medicaid recipient served, and the county share would be $13 million, or $16 a month for each new recipient.[44]

The Indigent Health Care Study Commission also recommended that the state develop a two-year demonstration project to assist communities in developing a coordinated health care delivery system for the working poor. The Health Insurance Trust Commission has endorsed this program as well. Grant funds would be made available to communities to provide primary and preventive care services and to arrange for necessary referral, hospital, and support services for the uninsured poor. This program would cost approximately $1.65 million and would provide primary care for up to 4,000 people.

In addition, the Indigent Health Care Study Commission recommended changes to the current

insurance laws to provide more coverage to employees in companies that offer health insurance. The proposed changes would prohibit companies with 20 or more employees from excluding certain employees from health coverage on the basis of their health status. The recommendations would also limit the waiting period for new employees to a 90-day maximum and would set a six-month limit on pre-existing condition exclusions. For example, a worker with diabetes would have his health costs from treatment for the disorder covered at the end of six months. The commission also recommended that pregnancy be precluded from the definition of pre-existing medical condition so that all prenatal and pregnancy-related services would be covered once the employee was eligible for coverage. These recommended changes would not, however, require companies to offer health insurance, nor would they affect self-insured health plans.



Eric Green / N.C. Poverty Project

The Health Insurance Trust Commission has asked the N.C. Life Underwriters Association to conduct a pilot marketing program in New Hanover, Brunswick, Pender, and Columbus counties. The aim is to convince small employers to participate in health plans for their employees. The association will be using a new booklet, *Group Health Plans for Small Businesses,* which contains summaries of nearly 70 policies currently available to small employers in North Carolina. The commission also recommended that the legislature approve a demonstration employer tax credit program to encourage more small employers to offer health insurance.

In addition, the Health Insurance Trust Commission asked the legislature to consider the establishment of a health insurance pool for employees with pre-existing medical conditions. The commission had first considered recommending such a pool only for employees of small businesses. The Indigent Health Care Study Commission asked that health insurance pools be considered for all of the medically uninsurable—not just employees of small businesses.

Sen. Jim Johnson Jr. (R-Cabarrus), who serves on the Indigent Health Care Study Commission, says the recommendations of the two commissions are sound and well researched, but those that will require a substantial appropriation are unlikely to be funded in the near future. "They are good recommendations, but I don't see how we're going to be able to handle them," says Johnson. "We're really strapped. We're going to have to scrape to make any adjustments in state

employee salaries."

The activities of the commissions show an interest in and commitment to improving health services to the poor. Yet even if the legislature were to adopt in full the recommendations of both commissions, the ranks of the uninsured likely would be reduced less than 20 percent.[45] Still, many would argue that the state has the responsibility to act, even if the anticipated impact is a modest one. The ranks of the medically indigent comprise disproportionate numbers of children who deserve a chance at a healthy and productive life. Minorities and the working poor also are less likely to have health insurance than the general population, and the link between this lack of insurance and inadequate health care has been well established. But there is a broader interest in mounting a vigorous attack on the problem. Unless the state acts, experts say rising health care and insurance costs will drive the numbers of the medically indigent still higher. Cost shifting by health-care providers will mean a greater burden for paying patients and for employers who offer health insurance. Through such measures as increased participation in Medicaid and inducements for smaller firms to provide health insurance, the state may be able to stem or even reverse an otherwise ominous trend toward increasing numbers of medically indigent citizens.

FOOTNOTES

[1]C. Johnston Conover, "Health Care for the Medically Indigent: Who are the Medically Indigent? and Barriers to Access," Center for Health Policy Research and Education, Duke University, presentation to Indigent Health Care Study Commission, March 12, 1986. Chart entitled "Uninsured Population," p. 3. (Hereinafter "Who are the Medically Indigent?")

[2]*Ibid.*, chart entitled "Number of Medically Indigent at Risk," p. 8. Underinsured are defined as having a 5 percent chance of spending more than 10 percent of their income on health care expenses. In addition, people who have Medicare as their sole source of health insurance are considered underinsured.

[3]*Ibid.*, chart entitled "Major Sources of Medical Care in North Carolina," p. 33.

[4]Keith Melville and John Doble, "The Public's Perspective on Social Welfare Reform," The Public Agenda Foundation, New York, N.Y., January 1988, pp. 47-48.

[5]"Who are the Medically Indigent?," chart entitled "Uninsured Population," p. 3.

[6]*Ibid.*, chart entitled "Coverage Trends Among Poor, North Carolina, 1980-1985," p. 14.

[7]*Ibid.*, chart entitled "Uninsured Population," p. 3.

[8]*Ibid.*, chart entitled "Number of Medically Indigent at Risk," p. 8.

[9]*Ibid.*, chart entitled "Demographic Characteristics of the Medically Indigent," p. 18.

[10]C. Johnston Conover, "Health Care for the Medically Indigent: What Are the Options?", Center for Health Policy Research and Education, Duke University, April 8, 1987, p. 6.

[11]Gail Wilensky, "Filling in the Gaps in Health Insurance," *Health Affairs*, Summer 1988, p. 137.

[12]"Issue Brief: A Profile of the Non-Elderly Population Without Health Insurance," Employee Benefit Research Institute, May 1987, No. 66, p. 6.

[13]C. Johnston Conover, Presentation to Healthcare Financial Management Association, Annual Meeting, May 25, 1988, Myrtle Beach, S.C.

[14]In 1974, when Congress federalized the cash assistance programs for the aged, blind, and disabled into the SSI program (Supplemental Security Income), Congress gave the states the option of providing Medicaid to all SSI recipients, or only to the aged, blind, and disabled individuals who would have received Medicaid using the state's Medicaid rules that were in effect on Jan. 1, 1972. North Carolina chose this latter option, named for Section 209(b) of P. L. 92-603, 42 U.S.C. 1396a(f). As a result, SSI recipients in North Carolina do not automatically receive Medicaid, unlike most other states.

If North Carolina provided Medicaid to all SSI recipients, 66,500 additional people would be eligible, said Wayne Stallings, Division of Medical Assistance, N.C. Department of Human Resources, Nov. 10, 1988, in his presentation to the Indigent Health Care Study Commission, Subcommittee on Public Assistance Options.

[15]Certain resources are not counted in determining Medicaid eligibility, such as the person's home, one car, and household belongings. In general, most other assets are counted in determining Medicaid eligibility.

[16]Congress broke the link between the AFDC payment levels and the Medicaid income guidelines for pregnant women, children under age 8, and the elderly and disabled, allowing states to increase the income guidelines for these groups without increasing the AFDC payment levels. Last year, the General Assembly adopted one of these options, more than doubling the income guidelines for pregnant women and children. As a result, children under the age of 2 and pregnant women who have family incomes less than the federal poverty guidelines are eligible for Medicaid.

[17]Isaac Shapiro and Robert Greenstein, "North Carolina, Holes in the Safety Nets, Poverty Programs and Policies in the States, A State Analysis," Center on Budget and Policy Priorities, Washington, D.C., 1988, p. 3.

[18]People who have chronic kidney disease and certain other limited categories of individuals also qualify for Medicare.

[19]A deduction is a fixed amount a patient must pay before his insurer begins paying for medical expenses. A co-payment is a fixed share of medical expenses which is to be paid by the patient once the deductible is met. Medicare Part A covers in-patient hospital services, skilled nursing home care, some home health services, and hospice care. In 1988, Part A had a $540 hospital deductible and an additional co-payment of 20 percent of cost for inpatient days beyond the 60th day. In addition, Medicare covered only a certain number of days in the hospital. There were similar cost sharing requirements for skilled nursing care. Under the Medicare Catastrophic Coverage Act of 1988 (P. L. 100-360 amended as 42 USC 1395 et seq.), there is one hospital deductible per year — $564 beginning Jan. 1, 1989, but no co-insurance or limit on the number of inpatient hospital days. There is a limited co-payment by the patient for the

first eight days of nursing home coverage, but no other cost sharing for nursing home care.

Medicare Part B covers doctors' services, outpatient services and diagnostic tests, rental or purchase of durable medical equipment, and certain other health services. There is currently a $75 Part B deductible each year. Part B then pays 80 percent of the "reasonable and customary charges" to the provider. The Medicare Catastrophic Coverage Act puts an upper limit on the amount of out-of-pocket expenses a beneficiary has to pay in cost sharing. Beginning Jan. 1, 1990, the upper limit will be $1,370. Once this upper limit is met (with the $75 deductible and the 20 percent co-insurance), then Medicare will pay 100 percent of the beneficiary's incurred reasonable charges.

In addition, the new Medicare Catastrophic Coverage Act phases in coverage of prescription drugs. Medicare will cover 50 percent of the actual costs of prescription drugs which are more than $600 a year, beginning in 1991. Medicare will increase its coverage to 60 percent in 1992 and to 80 percent in 1993.

[20] "The Role of Medicare in Financing the Health Care of Older Americans," American Association of Retired Persons Research Project, ICF Inc., July 1985, Table 17.

[21] "Facilities Obligated to Provide Uncompensated Services and Community Services," U.S. Department of Health and Human Services, Public Health Service, June 1980; "Directory of Facilities Obligated To Provide Uncompensated Services by State and City as of Jan. 1, 1987," U.S. Department of Health and Human Services, Public Health Service, January 1987. Updated by conversations with Bob Lindsay, Region IV, Aug. 23, 1988.

[22] Lori Ann Harris, "The Hill-Burton Act," *Comparing the Performance of For-Profit and Not-for-Profit Hospitals in North Carolina,* North Carolina Center for Public Policy Research, March 1989, p. 42.

[23] "Health Care for the Medically Indigent: Payment and Responsibility for Indigent Health Care," Duke University Center for Health Policy Research and Education, Presentation to Indigent Health Care Study Commission, April 22, 1986, chart entitled "Hospital Free Care, 1985," p. 15.

[24] *Ibid.*, chart entitled "Physician Free Care in North Carolina, 1985," p. 16.

[25] Patricia Butler, *et al.*, "State Health Insurance as Part of a National Health Program: A Report to the Executive Board, American Public Health Association," March 1988, p. 5.

[26] John Griswold, "Primary Health Care Funded Services in Local Health Departments: 1986 Survey Results," N.C. Department of Human Resources, Division of Health Services, p. 708.

[27] Karen Davis and Diane Rowland, "Uninsured and Underserved; Inequities in Health Care in the United States," *Securing Access to Health Care.* Vol. 3: Appendices, Empirical Legal and Conceptual Studies, President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, September 1982, Appendix O, p. 66.

[28] Department of Human Resources, Division of Medical Assistance, Report to Indigent Health Care Study Commission, Subcommittee on Public Assistance Options, March 31, 1988.

[29] Karen Erdman and Sidney M. Wolfe, M.D., "Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs," a publication by Ralph Nader's Public Citizen Health Research Group, 1987.

[30] Harris, *Comparing the Performance of For-Profit and Not-for-Profit Hospitals in North Carolina,* pp. 52-53.

[31] Davis and Rowland, pp. 64-65.

[32] F. Sloan, *et al., Uncompensated Hospital Care: Rights and Responsibilities,* John Hopkins University Press, 1986, pp. 29, 38.

[33] D. L. Patrick *et al.*, "Poverty and Health in Rural America," *Milbank Memorial Fund Quarterly,* Vol. 66, No. 1, 1988, pp. 128-130.

[34] Massachusetts Health Security Act, Chapter 23, signed April 21, 1988. ERISA, the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001-1381), prohibits states from directly mandating that employers provide health insurance. To get around this problem, Massachusetts developed a pay-or-play approach. Either an employer must provide health insurance coverage or the employer will be required to pay an annual tax of about $1,680 per employee into a state-administered health insurance fund. The fund will be used to provide health insurance to the uninsured.

[35] Congress amended ERISA in 1978 to exempt the Hawaii Prepaid Health Care Act. See Jane Perkins, "ERISA Preemption Affecting Indigent Health Care Coverage," *Clearinghouse Review,* April 1987, p. 1510.

[36] Presentation by Randy DeSonia, Senior Associate, Alpha Center, to the Health Insurance Trust Commission, Feb. 10, 1988.

[37] Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, Oregon, North Dakota, Tennessee, Washington, and Wisconsin all have high-risk pools. "The Risk Pool Strategy: Comprehensive Health Insurance Associations," Intergovernmental Health Policy Project, February 1988, No. 20.

[38] Health Care for the Uninsured Program, Alpha Center quarterly report, No. 3, July 1987, pp. 5-7.

[39] Intergovernmental Health Policy Project, *State Health Notes,* No. 81, April 1988, pp. 2-3.

[40] Intergovernmental Health Policy Project, *State Health Notes,* No. 87, November 1987, p. 3.

[41] National Health Law Program, *Health Advocate,* No. 158, Fall 1988, p. 19, footnote 18. New Jersey, Washington, D.C., and Rhode Island have expanded the income guidelines for the elderly, blind, and disabled to 100 percent of the federal poverty guidelines. Florida expanded coverage to those with incomes below 90 percent of the federal poverty guidelines.

[42] Telephone conversation with Kay Johnson, Children's Defense Fund, Washington, D.C., Nov. 30, 1988.

[43] Connecticut, Delaware, Illinois, Maine, Maryland, New Jersey, Pennsylvania, and Rhode Island all have prescription drug programs. Intergovernmental Health Policy Project, *State Health Notes,* No. 62, April 1986, pp. 3-5.

[44] Besides expanding Medicaid to make more people eligible, the state may want to work on smoothing the application process so that more eligible people actually get benefits. One analysis found the eligibility process to be a significant barrier to receiving Medicaid benefits. For more on this problem, see Sharon Shuptrine and Vicki Grant, "Study of the AFDC/Medicaid Eligibility Process in the Southern States," Southern Governors' Association, Washington, D.C., April 1988.

[45] Estimate based on the addition of 183,300 persons to the rolls of the insured through direct government action (Medicaid expansion and pilot primary and preventive care program for the uninsured) and on incentives to the private sector producing a modest increase in the number of health plans offered by employers.