Spreading the Risk and Beating the Spread: The Role of Insurance in Assuring Adequate Health Care

by Chris Conover and Mike McLaughlin

North Carolina has seen unprecedented Medicaid expansion in recent years, and yet the problem of the uninsured and underinsured continues unabated. Nearly 29 percent of the state's 6.6 million citizens now face the threat of being unable to pay for medical care because they have too little health care coverage. This article examines why sweeping segments of the state's population have little or no coverage and the consequences for the health care system and for the economy.

North Carolina's system of health care coverage is in some ways like a quilt —the patchwork made up of the hundreds of private providers and the public system, Medicare and Medicaid. The image of a quilt is a comfort in the face of accident or illness. At least there is the assurance that the bills will be covered, even if we lose our health.

But this quilt has great gaping holes in it, and the moths are feeding. The sense of security it provides may well be false. Consider these facts:

■ Of North Carolina's 6.6 million citizens, 1.9 million have too little health care coverage—most of them working people.[1] Of these, 1.2 million have no health coverage at some point during the course of the year and 700,000 have too little coverage. These are the medically indigent—people who in the event of accident or illness may not be able to pay for their medical care.

■ Even those who are insured have no assurance that they will always have affordable insurance or that the insurance they do have will pay for treatment doctors recommend as the best hope for recovery from an illness.

■ Businesses confronted with rising health insurance costs are shifting more of the cost to

Chris Conover, research associate at the Duke University Center for Health Policy Research and Education, conducted research on the medically indigent problem for this article. Mike McLaughlin is associate editor of North Carolina Insight.

employees, who increasingly are giving up their own insurance or forgoing family coverage.

What kinds of problems does this lack of coverage cause, and what is to be done about it? Is there a state solution, or must the problem of inadequate health care coverage be addressed at the national level? These vexing questions are at the heart of the health care reform movement, and practical answers are not easy to come by. But the first step toward a solution is to establish the scope of the problem. Who are the medically indigent, and why do we have so many of these people?

Who Are the Medically Indigent?

One sizable component of the medically indigent population is *people who do not pay for care during the year.* Of the 4.7 million North Carolinians who visited a doctor in 1990, for example, nearly 700,000 left behind unpaid bills.[2] More than 100,000 of these were charity cases for which doctors expected to receive no reimbursement. The rest were financial hardship cases in which doctors agreed to accept reduced charges, bills that were paid in part, and bad debt. The numbers do not include the 438,000 Medicaid recipients who visited the doctor in 1990 or negotiated price reductions that reflect a volume discount, such as preferred provider arrangements.[3]

Hospitals also absorbed a healthy share of non-paying patients. Some 150,000 of 800,000 patients left behind unpaid bills in 1990, and hospitals had to write off the entire stay of 80,000 of these patients.[4] Again, the numbers exclude 140,000 hospital patients covered by Medicaid.

Besides those who can't pay their bills, there are thousands of others—most of whom are poor—whose finances are severely strained by medical expenses.[5] Extrapolating from national data, more than 350,000 people in North Carolina live in families that spend more than 15 percent of their income on health care. Of these, more than 200,000 spend 25 percent of their income or more on health care.[6] Federal poverty guidelines are written assuming that medical expenses absorb 4 to 6 percent of a family's annual income.[7]

But these figures, while alarming, probably understate the magnitude of the health coverage problem. "A lot of people can't go to a physician when they get sick," says Dr. Thad Wester, deputy state health director. "The economically compromised often postpone health care."

A better measure of the medically indigent adds those who would have left behind a medical bill if they had gotten sick, and those who failed to get medical care even though they needed it. These can be called *the medically indigent at risk*—people who are at relatively high risk of being unable to pay their medical bills.

All but the extremely wealthy face some risk of being unable to pay their medical bills. For example, even the best insurance will not pay for experimental treatments, which can bankrupt a typical family. But the uninsured and under-insured face the greatest risk, with the under-insured defined as those with enough holes in their plans that they could easily end up spending more than 10 percent of family income on medical expenses.

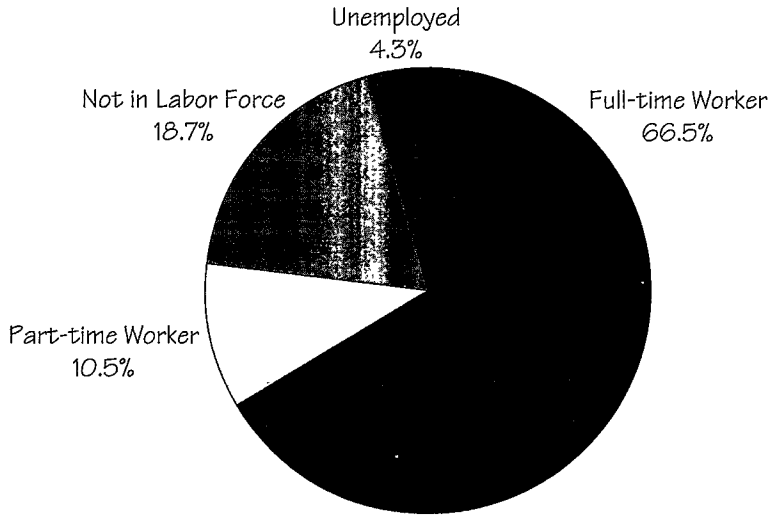
Including both the uninsured and under-insured, there are nearly 2 million people in North Carolina who are medically indigent. These include four different groups: 1) the uninsured all year; 2) the uninsured part of the year; 3) the under-insured with private insurers; and 4) the under-insured enrolled in Medicare. In North Carolina, the ***uninsured*** comprise nearly two-thirds of those at risk, with 1.2 million people uninsured at some point over the course of the year and 885,000 uninsured on any given day.[8] Half of these uninsured have had no health coverage for the entire year and more than 240,000 have not had health coverage for nearly three years.[9]

Of the ***under-insured,*** some 400,000 have private coverage and roughly 300,000 rely exclusively on Medicare to pay their medical bills.[10] These people are considered to have inadequate coverage because Medicare typically pays only 45 percent of medical bills for its elderly participants.[11] Unless a participant has a policy to fill the gaps, the patient may be unable to pay the remaining bills. Because Medicare participants typically are in poorer health than the younger uninsured, they often have higher out-of-pocket medical costs.[12]

"I firmly believe that if the whole materia medica could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes."

— Oliver Wendell Holmes

Figure 1. Workers and Their Dependents as a Proportion of the Uninsured



Data prepared by Duke University Center for Health Policy Research and Education
Source: Current Population Survey, 1988-1990

"Medicare has, I think, failed to do what it is designed to do—meet the health care needs of the elderly and disabled," says Barbara Matula, director of the N.C. Division of Medical Assistance in the Department of Human Resources. The elderly can get many of their remaining medical expenses covered by Medicaid, which is funded by the state—if they are poor enough. A working elderly or disabled person making more than $241 per month isn't eligible without spending excess income on medical bills first. "We are clearly the reinsurers for them," says Matula.

Medicaid recipients are medically indigent by definition. Unless they meet strict guidelines on income and assets, they aren't allowed to participate. Nearly 29 percent of the state's 6.6 million citizens can be considered medically indigent when Medicaid recipients are added in with the rest of the state's uninsured and under-insured.

But though Medicaid is designed to provide health coverage for the poor, it doesn't cover all of them. Estimates are that 48 percent of North Carolina's poor are covered by Medicaid at some point during the year, with about a third of these participants enrolled all year. About 30 percent of the poor can never qualify for Medicaid because of federal eligibility restrictions.[13] Medicaid is targeted at single-parent families, two-parent families with an unemployed breadwinner, pregnant women, children, the disabled, and the elderly.

In recent years, the growth in the insurance problem has come among people who work, while the number of uninsured poor has actually dropped.

People who do not fit these categories need not apply.

In addition, there are people who are technically eligible for Medicaid but decline to participate. National studies estimate that only 76 percent of those eligible participate in Medicaid.[14] If this is true for North Carolina, about one in six poor people are passing up health care coverage for which they could qualify.

The poor and near-poor make up a sizable segment of the medically indigent at risk, representing 40 percent of the uninsured and 52 percent of the under-insured. Still, it is clear that poor people aren't the only ones with too little health care coverage. In fact, 40 percent of the uninsured and more than 25 percent of the under-insured have incomes above 200 percent of poverty.[15] *In recent years, the growth in the insurance problem has come among people who work, while the number of uninsured poor has actually dropped.* (Figure 1, page 23, shows the proportion of the uninsured who are workers and their dependents.)

Table 1. Percent of Population Uninsured in Each State, 1988

	Percent Uninsured	Number Uninsured	State Rank in % Uninsured*
New Mexico	22.8	345,509	50
Arkansas	21.8	519,163	49
Texas	21.4	3,621,720	48
Florida	18.4	2,199,960	47
Oklahoma	18.0	592,995	46
Mississippi	17.9	472,365	45
Arizona	17.7	608,444	44
Nevada	17.3	172,097	43
Louisiana	17.3	778,919	42
California	17.2	4,737,675	41
Idaho	16.4	165,419	40
Montana	15.9	129,258	39
Alaska	15.8	85,903	38
Alabama	15.1	615,680	37
Kentucky	14.9	555,113	36
South Dakota	14.7	104,051	35
Oregon	14.6	397,160	34
Tennessee	14.2	687,400	33
North Carolina	**13.8**	**883,308**	**32**
Indiana	13.6	751,116	31
Colorado	13.0	428,555	30
West Virginia	12.9	245,160	29
Washington	12.8	579,781	28
Georgia	12.6	788,513	27
South Carolina	11.9	406,552	26
Utah	11.7	198,706	25

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.

Workers Dropping Health Insurance?

Why this shift in the uninsured population? Part of the problem is workers forgoing health insurance for themselves or for their families. Faced with rising costs, many employers are cutting benefits or passing more of the cost of health insurance to their employees. Some of these employees are electing to drop coverage. "[More than] a third of those without health insurance are earning twice the poverty level," says Allen Feezor,

	Percent Uninsured	Number Uninsured	State Rank in %Uninsured*
New York	11.5	2,049,755	24
Wyoming	10.9	54,968	23
Virginia	10.8	637,029	22
Nebraska	10.5	168,268	21
Missouri	10.5	533,342	20
Kansas	10.4	257,374	19
Delaware	10.2	65,178	18
Illinois	10.1	1,164,471	17
New Hampshire	9.9	105,203	16
Ohio	9.6	1,031,230	15
Maryland	9.5	430,254	14
Vermont	9.2	50,256	13
New Jersey	8.3	638,403	12
Michigan	8.2	756,414	11
Hawaii	8.1	87,669	10
Pennsylvania	8.0	949,608	9
Iowa	7.9	222,017	8
Maine	7.8	92,123	7
Wisconsin	7.6	361,781	6
North Dakota	7.5	50,447	5
Massachusetts	7.3	424,868	4
Rhode Island	7.2	71,051	3
Minnesota	6.6	282,003	2
Connecticut	5.8	186,011	1

* States are ranked according to the percentage of their citizens without health insurance, with 1 being the state with the lowest number of uninsured (Connecticut). Ties in percentages are due to rounding only.

Source: Lewin/ICF Health & Sciences International Co., 1090 Vermont Ave. N.W., Suite 700, Washington, D.C. 20005, (202) 842-2800.

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deputy commissioner of the North Carolina Department of Insurance. "And 10 percent are earning above $30,000 and still will not purchase health insurance. They spend the money on something else."

Most of these uninsured workers are young, and many forgo dependent coverage. They trust that they can pay the bills out of pocket, and Medicaid is the insurer of last resort for their children.

But the problem is far broader than people passing up health insurance. National figures show that the vast majority of workers who are offered health insurance accept the coverage being offered. Only about 10 percent of all workers refuse coverage and half of those refuse because they have coverage elsewhere.

On the average day, 465,000 workers are without health care coverage in North Carolina. When dependents are included, they make up about three-fourths of the uninsured population on a given day. Two-thirds of these uninsured workers are without coverage because they were not offered a plan.[16] Another sixth were ineligible for the employer plan either because they were part-time or seasonal employees or because they had to complete a waiting period to qualify for coverage. The remaining sixth declined coverage even though they had no other source of insurance.

Not surprisingly, workers who earn the least are the ones least likely to get coverage through their employer. Fully one-fourth of workers earning less than $5,000 a year are uninsured, compared to one in 20 workers earning $50,000 or more. And most of those workers with the lowest earnings who *are* insured get their coverage from someone besides their employer. Only one in eight workers with the lowest earnings get coverage through their job, compared to nearly 80 percent of the highest-paid workers.

Part of this may be explained by the fact that health insurance is a very expensive benefit. For example, the cost of the State Employees Health Plan is $1,600 a year for individual coverage and $4,200 for family coverage. A minimum-wage employee who works full-time all year earns only $8,840.[17] Giving this employee individual coverage comparable to that offered by the state would cost as much as an 18 percent wage increase, while family coverage would be worth 48 percent of the employee's wage. And an employee earning the minimum wage typically is in no position to help shoulder the burden of health insurance costs.

Of course many of these employees work part-time and may look to other sources of coverage besides the employer. Low-wage workers may be covered by Medicaid, by a spouse's policy, or they may be dependents covered by their parents. Only one in 10 full-time workers is uninsured, while part-time workers and full-time workers who are employed less than a full year account for more than half of all uninsured workers.

Besides being the lowest paid, uninsured workers also tend to be less educated. Only half of those with less than an eighth-grade education get coverage through their employers, and nearly a fourth of these workers are left without coverage, even though they are *more* likely to qualify for other coverage such as Medicaid.

Employers Who Don't Offer Coverage

Among employers, small businesses are the least likely to offer coverage. Indeed, a recent national survey showed that virtually all large firms with more than 500 employees now offer health insurance.[18] Even among middle-sized employers with 25 to 99 employees, the chances are 19 out of 20 that they will offer a health insurance plan. The big drop-off comes at the threshold of fewer than 25 employees. Three-fourths of employers with 10 to 24 employees offer plans, while only a third of those with less than 10 employees provide health insurance.

Employers often cite cost when asked why they do not provide health insurance.[19] They either have concerns about current or future health care costs or they feel that profits are too low or unstable to justify offering a plan. For the most part, health insurance seems to be available for small firms if they are willing to pay a high enough price.

"Many smaller firms are either start-up enterprises or are operating on very thin profit margins and cannot afford to provide all the employee benefit programs that larger or more successful employers can afford," says Randy Ferguson, an executive vice-president with Jefferson-Pilot Life Insurance Company in Greensboro.

Ferguson says an over-abundance of state-mandated benefits makes health plans unaffordable for many small businesses. "Various studies have

Jack Betts

shown that many smaller employers could afford to sponsor and would like to offer their employees a basic, bare-bones health care benefit plan but cannot do so due to various state-mandated regulations. Such regulations mandate liberal benefits that, while on the surface appear desirable, greatly increase the cost of the plans."

Feezor, the deputy insurance commissioner, says that mandated benefits increase health insurance costs in North Carolina by about 5 percent—far less than in some other states. And some of these mandates are essential to basic coverage, Feezor says. For example, North Carolina is among 49 states that mandate coverage of newborn babies.[20] "That is necessary," says Feezor. "It would be irresponsible to write insurance coverage without it." North Carolina does not mandate mental health coverage, which drives up the cost of care in many states, Feezor says.

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Insurance companies also charge small firms higher administrative costs than they charge larger firms. The very smallest firms may have to pay as much as 40 cents per benefit dollar for administrative costs, while firms with more than 10,000 workers—such as Duke Power Company and Sara Lee Corporation—pay only 7 cents per benefit dollar.[21]

The main reasons for this are economies of scale and the higher risks associated with serving small employers. "They're always going to be having to pay a little more," says Feezor of small employers. "If in one case I can cover 1,000 employees, and the other five, where am I going to spend my time?" With larger employers, Feezor says, insurance companies also gain access to larger markets for such products as life insurance and annuities, which are more profitable than health insurance.

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."

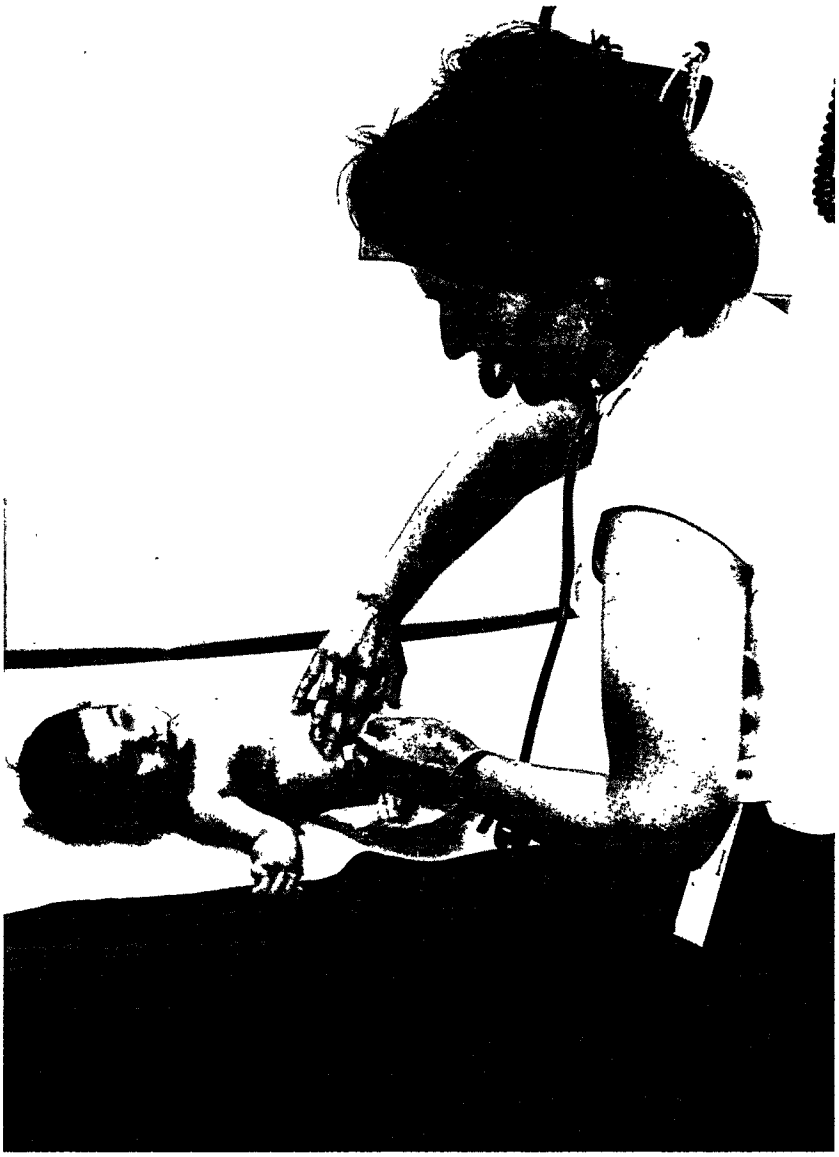
But before he would purchase *any* policy, Green says he would have to get his business on a stronger financial footing and would have to have workers he wanted to insure. He starts his workers at $3.50 an hour and some of them stay no more than three months. Green says he also would want to consider whether the policy were worth purchasing. "I'm afraid if they made it affordable, it would be a cheap little policy—a gimmick," he says.

Bob Greene operates a country store in the Wilkes County community of Clingman. Greene says he employs mostly high school students in part-time positions—so they aren't much concerned about health insurance. He did, however, lose one employee who went back to a low-wage position at a bank so she could be insured. "If I had employees who were more than part-time, or some I knew were going to stay with me, I wouldn't have a problem offering it to them," says Greene.

A growing problem for small firms is insurance company underwriting that excludes a particular worker or even an entire firm from coverage because of a single worker's medical condition. "They [insurance companies] are driven by competition, which drives out the marginally insurable people," says Wester. "They want healthy people free of overt disease." Adds Matula, "The people with the greatest risks and the highest needs are least apt to have insurance."

All told, employees in small firms account for 44 percent of uninsured workers. Most of these employees work for companies that do not offer health plans, so the key to getting coverage for small-firm workers is enticing more employers to offer plans.

In larger firms the situation is the reverse. Plans are available, but there are structural eligibility barriers that keep some employees from participating. The two biggest barriers are waiting periods required for enrolling a new employee in a plan and policies that exclude part-time and seasonal workers. A federal law known as COBRA



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gives some relief from waiting periods after a job change.[22] It requires that workers be given the option of keeping their old coverage and paying premiums out of pocket until the waiting period for enrolling in a new plan ends. Still, this transitional coverage is expensive, and many workers forgo it.

Another barrier is the practice of excluding medical expenses for pre-existing health conditions from coverage. The key to getting coverage for uninsured workers in large firms is to find a way to reduce structural eligibility barriers.

Whether a worker is offered health insurance is influenced not only by the size of the employer but by the type. Three industries, in fact, 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.[23] 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.

But size and type of employer isn't the only indicator of whether a person is likely to do without coverage. Other demographic characteristics appear to play a role. For instance, blacks are

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more likely to have no health care coverage than whites. One out of five blacks has no coverage, compared to only one out of every nine whites—despite the fact that blacks are four times more likely to qualify for Medicaid than whites. Hispanics and Native Americans also are less likely to have coverage than whites. (See Figure 2 for a breakdown of the uninsured by race.)

Family status also appears to be important. Nearly 80 percent of children living with two parents are covered by one of the parents. Only 11 percent have no coverage. The rest are covered by Medicaid or some other government or charitable program. Children in single-family homes are twice as likely to have no coverage, and they have a much greater reliance on Medicaid.

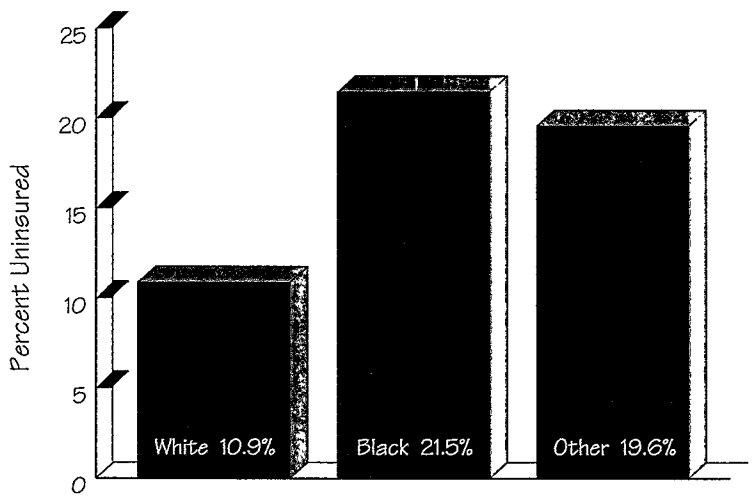
Single adults also are much less likely to have health care coverage than those who are married. They do not have the option of being covered under a spouse's policy.

And much of the uninsured problem seems to be centered on children and young adults ages 18–30. In North Carolina, the chance of being uninsured is 14 percent among children under 18. They account for fully a fourth of the uninsured. (See Figure 3, page 32, for an age breakdown of the uninsured.)

Young adults, however, face the greatest risk of being uninsured, accounting for nearly a third of the problem. They may be just starting out in the work force and unable to afford coverage if their employers don't provide it, or they may be under a mandatory waiting period before enrolling in their employer-sponsored plan. They also switch jobs more frequently than older workers, and when health insurance is presented as a costly option, they are more willing to risk doing without.

Whether one lives in a rural or urban area also makes a difference. (See Table 3, page 36 for a county-by-county breakdown of the average daily uninsured population in North Carolina.) Isolated areas with high unemployment and little manufacturing have high numbers of people without health

Figure 2. The Uninsured as a Percentage of Each Racial Group



Data prepared by Duke University Center for Health Policy Research and Education
Source: Current Population Survey, 1988-1990

Table 2. North Carolina's Medically Indigent

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

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

Source: Duke University Center for Health Policy Research and Education

care coverage. This ties in with a range of problems with rural health care. Fewer paying patients and low reimbursement rates for Medicaid and Medicare patients make it even harder to attract physicians to rural areas that already are suffering health manpower shortages, says Jim Bernstein, director of the state Office of Rural Health and Resource Development in the Department of Human Resources.

"Everything piggybacks and complicates the problem," Bernstein says. "The end result is a poor delivery system, with less access for patients and more patients waiting for services. Statistics show the health outcome in rural areas is not as good as in urban areas, and we're a rural state, so it's something we need to pay particular attention to."

The impacts of this widespread lack of health coverage fall into two broad categories. One could be labeled health and the other economics.

The Health Impact of Too Little Insurance

Study after study has shown that people without health care coverage tend to get less care than those who are covered by some type of plan and that they wait until they are sicker before seeking care.[24] "I know of very few doctors who would refuse someone in need," says Wester, the deputy state health director. Nevertheless, he acknowledges that people without health care coverage are not welcomed into the health care system with open arms. "Poor people do not like to be berated. They would like to be able to pay for their care, and they wind up not going."

The medically indigent have more chronic health conditions than the general population, as well as greater numbers of disabilities and more mental illness.[25] They use 30 to 65 percent fewer services than the privately insured,[26] face greater access barriers,[27] and defer preventive and acute care.[28]

They are less likely to have a regular source of care, and thus more likely to rely on the hospital emergency room, which is expensive.[29] Studies also indicate they are hospitalized more frequently for conditions that are preventable through access to regular care.[30] The bottom line is that the medically indigent are more likely to have worse health than the general population, at least in part because of their lack of health care coverage.

Of course the ultimate indicator of poor health is premature death. The *Atlanta Constitution-Journal*—in a computer analysis of more than

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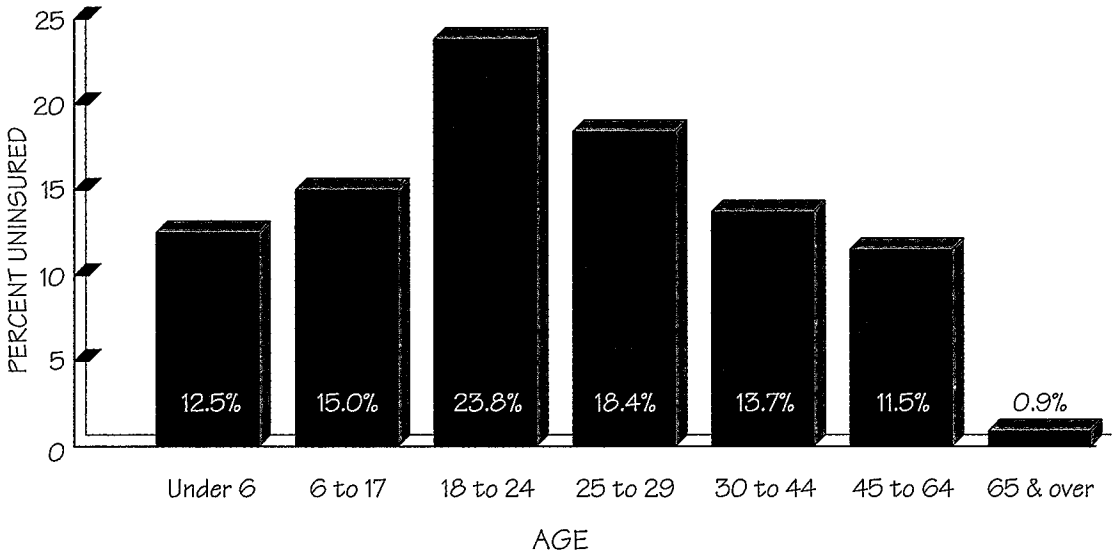
Figure 3. The Uninsured as a Percentage of Each Age Group



Data prepared by Duke University Center for Health Policy Research and Education
Source: Current Population Survey, 1988-1990

530,000 deaths in 1987 in 12 Southern states—found 22,000 deaths to be caused by diseases that were easily treated or preventable. Race and income were the strongest predictors of premature deaths, and the problem was particularly acute in rural areas.[31]

The Economic Impact of Too Little Health Insurance

But if a lack of adequate health care coverage takes its toll on the medically indigent, it also has an impact on the North Carolina economy. State spending on Medicaid and direct government medical services, plus the cost of unpaid doctor visits and hospital stays, has reached $3.3 billion a year, twice what it was five years ago.

The typical North Carolina family of four now picks up the tab for about $950 in unpaid medical care. About half 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. These costs are pushed still higher by the tendency among people without health care coverage to overuse the emergency room and end up hospitalized when it might have been medically avoidable.

Is There a Solution?

Clearly the problem of the medically indigent is one that needs to be addressed. The problem is helping to drive increased medical costs, and there is the human cost of poor health for those who do without health care coverage. On the national level, debate has focused on a national health insurance system such as that operating in Canada, an employer-based system in which employers offer a health plan or pay a penalty to help cover the uninsured, or some hybrid. But what can be done at the state level?

A handful of states are moving toward universal coverage, with one option a "pay-or-play" employer-based system.[32] Under this system, employers either play by providing coverage for their employees or pay into a state fund which is used to provide insurance for uninsured workers. Other states, including North Carolina, so far are taking a less comprehensive approach. The Health Insurance Association of America, a national

trade group, is pressing states to implement this kind of reform focusing on broadening existing coverage.

The group proposes that states make changes to make health insurance more available and affordable for small business. The states would help cover other gaps by creating high-risk pools for the hard-to-insure and by Medicaid expansion. The North Carolina General Assembly enacted the small business proposal in the 1991 session.[33]

Developed with the cooperation of small business and the insurance industry, the legislation requires insurers and health maintenance organizations writing health insurance for businesses with less than 26 and more than two employees to offer at least two types of policies. The first of these is a stripped-down version that covers only essential services and would thus be more affordable. This basic plan is exempted from state mandates, with a special committee determining which services are essential and must be provided. Feezor says the basic plan is likely to feature higher co-payments and deductibles and to cover shorter hospital stays than standard insurance.

The second type of policy is more comprehensive—similar to that currently being offered by small and medium-size employers. The nonprofit provider Blue Cross and Blue Shield of North Carolina unveiled its stripped-down coverage, called **BasiCare**, at a September 1991 news conference. The company is marketing BasiCare to individuals and small business groups, with prices

Glossary of Health Care Terms

Co-payment — The payment a patient is required to make, in addition to any private insurance coverage or government assistance program, to obtain health care service.

Coverage — A system that pays for health care, and which includes private insurance companies, employer-financed plans, government transfer programs such as Medicare and Medicaid, and the like.

Deductible — An up-front payment a patient must make on a health service before an insurer has any liability to pay.

Diagnostic Related Groups — A system of classifying patients according to the type of disease, and which is used in determining hospital payments for the Medicare system.

Health Maintenance Organization — An organized system which provides an agreed-upon set of comprehensive health services to a voluntarily enrolled population in exchange for a predetermined, fixed, and periodic payment.

Medicaid — Popular name for government program that provides medical assistance for the poor, and which is funded by the federal, state, and county governments.

Medicare — Popular name for government program that provides two kinds of health insurance for the aging—hospitalization and institutional care, and physician's care and other health services—funded under the Social Security System.

Preferred Provider Organization — An alternative to HMOs, the PPO can provide health care through an organization of doctors, hospitals, employers, and insurance companies who agree to contracts to provide certain health services to PPO members at reduced rates.

Premiums — The amount of money that insurance subscribers must pay to maintain their health insurance policies.

Prospective Payment System — A prospective system of payment using Diagnostic Related Groups (DRGs) for Medicare payments to hospitals as established by Title VI of the 1983 Social Security Amendments.

Third-Party Payer — An institution, organization, or entity that pays the health care bill for a patient. Most often, a third-party payer is either the government or an insurance company. The three parties are the patient, the provider, and the payer.

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beginning at $41.67 a month for a 22-year-old single male.

The new law controls the rate of increase insurers and health maintenance organizations can charge small employers from year to year and narrows the difference in rates insurance companies and health maintenance organizations can charge competing firms of similar size and type. It also sets up a reinsurance pool for high-risk businesses that insurers and health maintenance organizations don't want to cover.

Industry officials view the new law as an important first step toward making health insurance more broadly available in North Carolina. "Clearly, complying with this law will be costly," says Ferguson of Jefferson-Pilot. "However, the law demonstrates that health insurers are committed to contributing to the solution of the health care access problem."

It appears unlikely that small business operators will flock to the new basic plans. Feezor says a similar program operating in Virginia has been slow to catch on; both Green, the Wilkes County nursery operator, and Greene, the grocer, seemed skeptical that such a plan would meet their needs. Still, it's a start.

Other significant changes have come through private efforts. For example, Blue Cross and Blue Shield has developed a program called **ACCESS** to cover the hard-to-insure. The program was implemented after several failed legislative efforts to establish a state high-risk pool for insuring people with severe medical conditions. It offers basic coverage for all comers—if they can afford the premiums.

The company will charge as much as 175 percent of normal rates—and still expects to lose money on the program.[34] Under one plan, Blue Cross and Blue Shield charges $387 a month for individuals and $964.38 a month for a subscriber and three family members, with a $500 deductible. Another plan carries a $1,000 deductible with payments of $349 a month for individuals and $991.65 for a family of four. Losses are to be paid from the company's reserve fund.

The firm also has developed the **N.C. Caring Program for Children** in cooperation with the North Carolina Council of Churches. Under this program, sponsors agree to donate $240 a year to pay insurance premiums for uninsured children from low-income families.[35]

The Health Access Forum, a panel of doctors, government officials, academics, and industry officials appointed by the North Carolina Institute of Medicine, also is studying how to address the problem of the medically indigent.

The institute, which examines pressing health care problems, has secured a $424,000 grant from the Kate B. Reynolds Charitable Trust to pay for this attempt at consensus-building. The Health Access Forum will produce a package of recommendations for public and private actions by 1992.

The legislature also has created a study commission to "study the issues involved in designing a program to ensure that all citizens of the state have access to affordable health insurance that provides coverage for basic health needs."[36] The commission—which reports to the 1993 session of the General Assembly—is to study a range of health insurance issues, and at least two ways to broaden coverage: (1) an employer-based insurance system that depends on a state pool to cover the jobless and uses tax incentives to encourage employers to offer coverage; and (2) a single-payer, government insurance system such as that operating in Canada.

The commission also will look at health care cost containment, an issue so serious that some people believe a voluntary insurance system will never succeed. "The real problem—both for individuals and apparently for our society at large—is that today's cost of health care exceeds what most individuals are willing to pay and exceeds what society collectively is willing to pay via third-party coverage," says Feezor. "It is more expensive than we are willing to spend relative to other needs and desires."

Medical care cost increases are running double and triple the annual increase in the Consumer Price Index. Health insurance costs reflect these increases. "The costs are so disproportionate that any voluntary paying method is going to fail at some point," says Feezor. An involuntary system heavily subsidized by employers, the government, or both may be the only way to ensure 100 percent insurance coverage, he says.

Feezor believes some small employers will enroll in the stripped-down health insurance plans that emerge from the 1991 legislation, but most will continue to plead a lack of affordability. "Unless there is a tax credit or a penalty, I'm not sure a voluntary effort will make a substantial difference," he says. As for the ACCESS program—the high-risk pool for the hard to insure offered by Blue Cross and Blue Shield—Feezor believes no more than 6 to 12 percent of the medically uninsurable people in North Carolina will be able to afford the premiums.

Rep. Judy Hunt (D-Watauga) led an unsuccessful 1989 effort to establish such a pool, and the private program is modeled on her legislation. Hunt says she will be watching carefully to see whether ACCESS satisfies the need for an insurance program for people with severe medical conditions. But Hunt is skeptical of the projected rates. "Most people think they are exorbitant," she says.

Kathy Higgins, a Blue Cross and Blue Shield spokeswoman, says the program was designed to make health insurance available to those who can't get it for health reasons. "It doesn't address the cost issue," she says. "It's for those who can afford it and would never have the chance to have insurance otherwise."

Affordability also becomes a problem for further Medicaid expansion. The state's share of Medicaid expenses has been rising at a rate of 17 percent a year since 1985, and the state budget is under severe strain. That makes further expansion hard to accomplish, and Medicaid reaches only the categorically eligible poor and near-poor. The federal Health Care Financing Administration closed one option for Medicaid expansion with a ruling in September 1991 disallowing the use of provider taxes and donations to draw federal Medicaid funds for the states.[37]

The big legislative push for health coverage reform likely will come in the 1993 session, after the Health Access Forum has released its proposal and the legislative study commission has made its report. Silberman says the legislature is likely to consider one of two plans: (1) a pay-or-play system such as the one passed in Massachusetts but stalled by budget difficulties, or (2) a single-payer system such as that operating in Canada in which the government serves as health plan administrator or turns the job over to a private contractor.

The Canadian plan, says Silberman, might make cost containment more effective because it would eliminate cost-shifting. "It's a big shell game," she says. With only one payer, there would be no one to shift costs to. Still, the pay-or-play concept might prove more politically palatable. The government would not be holding all the cards, and

— continued on page 38

There are some remedies worse than the disease.

— PUBLILIUS SYRUS

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.

insurance companies could keep writing coverage for their best customers.

Other experts believe there will be less comprehensive options on the table. Feezor says so far he hasn't seen the kind of leadership that would be required to achieve a broad-based solution, and so he expects more of a piecemeal approach. "What has been noticeably absent is a major elected official of sufficient stature, stamina, and intellect to lead the debate in this area," Feezor says.

> ***"What has been noticeably absent is a major elected official of sufficient stature, stamina, and intellect to lead the debate in this area."***
>
> — ALLEN FEEZOR
> N.C. DEPARTMENT OF INSURANCE

Bernstein asks, "How realistic is it to even discuss North Carolina adopting a Canadian-style plan? I can't see how the General Assembly can even begin to consider this for many reasons, most importantly cost." Bernstein says costly mandated health care coverage—whether modeled on the Canadian system or on pay-or-play—could hurt industrial recruitment.

Phil Kirk, president of North Carolina Citizens for Business and Industry—a statewide chamber of commerce—agrees that cost must weigh heavily in any legislative package broadening health care coverage. "Any insurance plan the legislature looks at, cost certainly has to be figured into the equation," says Kirk. "Many small businesses particularly want to provide health insurance but can't afford it. It might be a difference between some of the smaller ones making a profit or closing their door."

And Kirk says some North Carolina industries such as textile firms are competing in a global market against third world countries with low salaries and few, if any, fringe benefits. Excessive health plan costs could hurt their competitiveness. "Most United States companies want to provide good fringe benefits," says Kirk, "but they have to consider the bottom line."

Yet no one disputes that the legislature will be returning to the issue of broadening health care coverage in the near future. "I think you'll see something in the next year or two—if not universal health insurance, at least something that will cover a major percentage of those people who are now uncovered," says Rep. Nick Jeralds (D-Cumberland), a leading advocate of health insurance reform. "In the 1993 session we will probably introduce some type of model plan. To what degree we can sell all the players who will be involved, we aren't certain."

Sen. Betsy Cochrane (R-Davie) agrees that health care coverage reform will be high on the General Assembly's agenda for the 1993 session. "It's going to take a joint effort of the business community working with insurers and the government," says Cochrane. "This three-pronged approach is the only chance we have to come up with some answers." Cochrane says the three groups working together could "come pretty close to covering most people." She says she doesn't think North Carolinians are ready for a Canadian-style system that doesn't pay for some procedures and requires some waiting for others.

Still, it's clear there is increasing disenchantment with the system as it exists now. A 1991 Gallup Poll found 85 percent of Americans think the nation's health care system needs reform.[38] The rising cost of care and how to pay for that care seem to be the main concerns. And the cries for reform are likely to grow louder as employers shift more and more of the cost of insurance coverage to workers—or drop it altogether.

Options

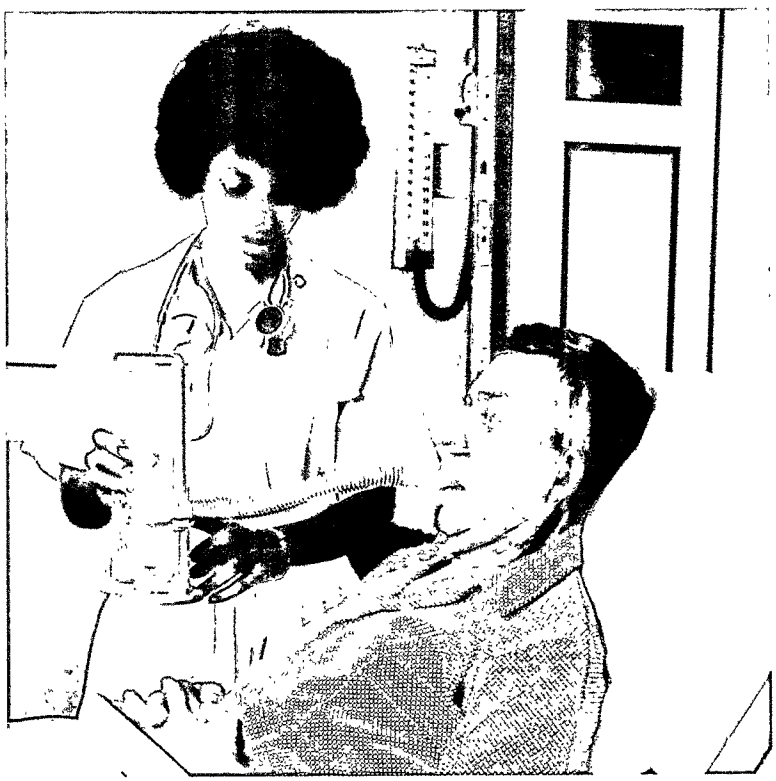
With 1.2 million North Carolina citizens doing without health coverage over the course of a year and another 700,000 dangerously undercovered, the time is approaching for major reforms. The Center has identified at least three broad options that would expand insurance coverage. Within these options are a number of incremental steps that would help chip away at the problem. There also is the option of doing nothing, which raises a fundamental policy question. Is health care a right of all North Carolinians, or is it just another economic good that should be left to market forces? If it's an economic good, then the major options are numbers one and four below. If health care is a right, then options two and three are preferable.

Option 1: The legislature could make incremental changes that broaden health care coverage but leave it up to employers whether they offer plans and employees whether they enroll in them. This approach leaves room to broaden coverage for the poor through Medicaid expansion. Medicaid expansion to the limit allowed by the federal government has been endorsed by a number of groups, including the North Carolina Hospital Association and the N.C. Medical Society. Despite the cost, expansion makes sense as a match for federal funds; the federal government pays $1.99 for every $1 in state and local funds spent on Medicaid. The question is whether it is wise to leave money on the table that could be used to help finance health care for the medically indigent.

The state also may want to examine whether it wants to help high-risk citizens who are not impoverished yet cannot afford to enroll in the private ACCESS program. At least 24 states operate high-risk pools, most of which work along the same lines as North Carolina's automobile reinsurance facility.[39] States with high-risk pools are California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maine, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. Wisconsin subsidizes premiums by up to one-third for those who cannot afford to pay. Maine also subsidizes some pool participants, and it allows some very small employers to cede high risk employees to the pool, thus reducing premiums charged for remaining employees.

All of the pools lose money, despite charging premiums that exceed the market average. Insurance companies doing business in the states typically share the losses among themselves, although some states support their pools with tax revenues. Yet the North Carolina Department of Insurance estimates that as many as 100,000 people need such a pool in North Carolina. Only a small percentage of these can afford above-market-price premiums.

The state might explore carefully tailored tax credits or subsidies to persuade more employers to offer health insurance. Many of North Carolina's 465,000 uninsured workers are employed by small businesses that may not be able to afford coverage. Tax credits could be used to persuade such employers to offer insurance, and the credits could be phased out over time. Even with tax credits, however, the increase in small employers offering health insurance may be modest. Michigan tried



Duke Medical Center

picking up a third of the tab for small employers who agreed to offer health insurance for the first time. Over a two-year period, only 15 percent of these employers took the state up on its offer. It remains to be seen whether a permanent program would have better results than Michigan's pilot study.

This approach, then, involves three sub-options: (1) Medicaid expansion, (2) creation of a state high-risk pool, and (3) incentives to encourage employers to offer health insurance. Each of these steps would take a bite out of the uninsured problem. And because the approach is incremental and does not represent drastic change, it may be the easiest to achieve politically. Yet its greatest strength is also its greatest weakness. With optional insurance, there will always be those who opt not to offer or purchase insurance, which shifts the burden of paying for care to someone else.

Option 2: The state could adopt the "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. Under this approach, insurance is not optional. The disadvantage is that employers who do not currently provide health insurance would be hit with an expensive new tax. That would be difficult to enact legislatively and would add to the cost of doing business. And cost is an oft-cited reason small business operators do not offer insurance. If they can't afford insurance, how can they afford the tax? An additional worry is that if North Carolina adopts such a program and neighboring states don't, industrial recruitment could be hurt. Still, the approach would have the advantage of covering more people than the incremental approach, and it would apply across the board in the business community.

The financing mechanism would give the state a means of insuring people who are unemployed and ineligible for Medicaid. Citizens insured through the fund could be billed on an ability-to-

Michelle Ramos-O'Hare, 7 years old, of Raleigh, at a rally for better health care at the State Capitol on Oct. 8, 1991.

Karen Tam

pay basis, providing an additional source of revenue, and the legislature likely would have to appropriate additional tax revenue to keep the fund solvent. Massachusetts is the only state which has enacted the pay or play approach, although Oregon will go to pay-or-play if small employers do not meet targets set in a tax credit program. Hawaii simply requires employers to provide health insurance and has done so since 1974. There is no "pay" option. Budget woes have stalled implementation in Massachusetts, and a hostile new governor wants to abandon the approach altogether.[40] Cost estimates for implementation have run as high as $1 billion, but the payoff would be coverage for the state's 400,000 uninsured.[41]

Delaware and Ohio are seriously considering pay-or-play, and other states are experimenting with less comprehensive reforms, says John Luehrs, the health care expert for the National Governors' Association. Luehrs says he sees three big advantages to pay or play: (1) it provides a mechanism for funding universal health insurance based on the existing system of public and private providers; (2) it improves health coverage for people who are uninsured or under-insured; and (3) it brightens the prospects for successful cost containment. Major disadvantages, says Luehrs, are that marginal businesses would suffer and that the increased costs likely would be passed along to workers through reduced pay or benefits.

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 huge government insurance program. Or it could contract this responsibility out to a private provider. The advantages are many. Every citizen would have health insurance—including the state's 300,000 children who currently do without. With a single payer, paperwork should be simplified, resulting in lower administrative costs. And a single payer would be in a stronger bargaining position with health care providers. Employers would have rid themselves of a direct expense that keeps growing every year—the cost of providing health care for workers.

But unless cost containment efforts were effective, the system could get extremely expensive and require major tax increases. And successful cost containment may require *explicit* rationing, rather than *implicit* rationing by ability to pay. That raises a whole new set of questions. Lesser steps along the road to a single-payer system might contribute to cost containment by lowering administrative expenses. For example, Luehrs suggests a single claim form, which would require only "a consensus among payers about data needed to pay a claim."

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 their policies or pass along more health insurance costs to employees. More employees might drop coverage for themselves or their families, leading to more health complications and higher medical bills, and the vicious cycle would simply feed on itself.

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Each of these options demands difficult choices, but the problem of the medically indigent isn't going to go away. Affordable health insurance—once a problem of the poor and the jobless—is becoming a middle-class issue. More than a third of the state's uninsured now are middle-income or higher, and the trend is toward still more middle-income citizens without health insurance. That makes reforms more likely, and the longer those reforms are deferred, the more drastic they are likely to be.

"The problem is so big and so serious, I think we are just getting our toes in the water," says Rep. Judy Hunt. Sooner or later, legislators are going to have to take the plunge.

FOOTNOTES

[1] Christopher J. Conover, "Health Care for the Medically Indigent of North Carolina: Number and Characteristics of Those 'At Risk'," presentation to Health Access Forum sponsored by the North Carolina Institute of Medicine, June 17, 1991.

[2] *Ibid.*, p. 1.

[3] *Ibid.*

[4] *Ibid.*

[5] Throughout this article, all references to the poor or poverty levels are based on federal poverty guidelines. The *poor* are those with income below 100 percent of the poverty level, which is $13,400 a year for a family of four. The *near-poor* have incomes between 101 and 125 percent of poverty, while *other low-income* families include everyone between 126 and 200 percent of poverty. Those at 201 to 400 percent are considered to be *middle income* and the rest are considered *high income* families.

[6] Conover, pp. 1–2.

[7] U.S. Bureau of the Census, Technical Paper 52, *Estimates of Poverty Including the Value of Noncash Benefits: 1983*, U.S. Government Printing Office, Washington, D.C.,

August 1984, p. B15.

[8] Conover, p. 3.

[9] *Ibid.*

[10] *Ibid.*

[11] In 1987, Medicare covered $2,391 of the $5,360 in average personal health care spending by the elderly. Waldo *et al.*, "Health Expenditures by Age Group, 1977 and 1987," *Health Finance Review,* Vol. 10, No. 4 (Summer 1989), p. 118.

[12] E. Howell *et al.*, "Out-of-Pocket Health Expenses for Medicaid Recipients and Low-Income Persons, 1980," *National Medical Care Utilization and Expenditure Survey,* Series B, Descriptive Report No. 4, DHHS Pub. No. 85-20204, Office of Research and Demonstrations, Health Care Financing Administration, U.S. Government Printing Office, Washington, D.C., August 1985, pp. 21–22.

[13] Conover, p. 6.

[14] J. Holahan and S.R. Zedlewski, *Insuring Low-Income Americans: Is Medicaid the Answer?* (revised), The Urban Institute, Washington, D.C., July 1990, p. 3.

[15] All figures obtained from Center for Health Policy Research and Education analysis of 1988–90 Current Population Survey data for North Carolina.

[16] Data from May 1988 Current Population Survey, reported in U.S. Congress, Congressional Budget Office, *Rising Health Care Costs: Causes, Implications, and Strategies,* Washington, D.C.: Congressional Budget Office, April 1991, p. 75.

[17] The current minimum wage is $4.25 an hour. A worker earning the minimum wage for 40 hours a week, 52 weeks a year would earn $8,840.

[18] Conover, p. 19.

[19] *Ibid.*

[20] G.S. 58-51-30.

[21] *Ibid.*, p. 20.

[22] Congressional Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, 29 USC 1161.

[23] In 1989, average weekly earnings in retail trade were $216.51, compared to $366.10 for all privately employed workers in North Carolina. Employment Security Commission of North Carolina, *Employment and Wages in North Carolina, 1989,* 1990, p. 23.

[24] For more on how the lack of insurance affects decisions to seek health care, see Pam Silberman, "Health Care for the

Health Care at the Margins: Three Families without Insurance

by Susan Dente Ross

Here are the stories of three North Carolina families without private health insurance. Gene Richards of Durham is the breadwinner for a family of four, but in a good month he earns only $900. Using a combination of charity care and installment payments, his wife Carolyn struggles to finance health care for a child with special needs. Mary Hedgepeth of Rocky Mount wants to work, but her health problems frighten off would-be employers. Her Social Security disability payments make her ineligible for Medicaid, so she forgoes care and juggles bills to make ends meet. Nancy Smith is a single parent who depends solely on Medicaid to provide health care for herself and her family. So far the Smiths' care has been adequate, but it's never been tested by a long-term health crisis. In none of these cases has care been denied due to lack of insurance, yet they illustrate how inadequate insurance can have an impact on health.

Susan Dente Ross is a free-lance writer and a journalism instructor at Lynchburg College in Lynchburg, Va.