

CONCLUSION

New Choices: Making a Good System Better

Is America's healthcare system broken? Sometimes, it might seem so. After all, national health expenditures have skyrocketed over the past 20 years, going from \$255 billion in 1980 to \$1.9 trillion in 2004. As costs have risen, so has the rate of uninsured, which increased by almost 5 million over the past 10 years. Yet Civitas polling reveals that the majority of voters (71 percent) in North Carolina are happy with the quality of healthcare they are receiving. Similarly, international studies (see the Executive Summary) have repeatedly shown that the U.S. healthcare system is more efficient and technologically advanced than its European counterparts. It seems, then, that the system is not so much as broken, as in need of renovation – and innovation.

Still, it remains true that rising healthcare costs are forcing lawmakers to begin to look for new solutions. These solutions must entail more than just expanding Medicaid, but will have to provide consumers of all income levels with more choices when it comes to healthcare. In particular, we are going to see a transition away from a managed-care model to a more consumer-oriented approach. That, at least, is how the debate is being framed and will continue to be framed over the next few years. When it comes to healthcare ... consumer choice matters.

Yet, as this history of healthcare in North Carolina reveals, over the last 20 years the private healthcare market has been crowded out by a variety of state programs. Consider the expansion of state-subsidized insurance for children via Medicaid and NC Health Choice, North Carolina's State Children's Health Insurance Program (SCHIP). As enrollment in these programs has increased, the rate of uninsured children has not dropped. Instead, there has been a long-term decline in the rate of privately insured kids.

At the turn of the millennium 203,000 of North Carolina's 2 million children (10 percent) lacked health insurance for at least part of the year. By 2005 the rate of uninsured children had increased to 262,000 out of 2.2 million (12 percent). Similarly, from 2000 to 2005, the number of children on Medicaid/SCHIP increased by 89,000 to reach 588,000. But while the number of children on Medicaid increased by 31 percent and the number of uninsured children increased by 29 percent, the number of children covered under private plans only increased by 2.4 percent between 2000 and 2005. Again, these numbers suggest that state-funded insurance is crowding out private insurance.

In addition to NC Health Choice, Health Check, Medicaid, Medicare and other taxpayer-funded insurance programs, the state has made private insurance more costly by increasing the number of coverage mandates. Today, North Carolina has 46 mandates, which together have increased the price of health insurance by an estimated 41 percent. At the very least, a correlation exists between coverage mandates and the rate of uninsured. At worst, the state's programs are actually making the uninsured problem worse by introducing unintended consequences in the private health insurance market.

But while there are countless areas in which the state's healthcare policies might be improved, it is important to stay focused on the real problem at hand – namely, the gradual attempt to implement a single-payer, or universal, health coverage program. The idea of a universal healthcare system seems to be based on the presumption that the free market cannot provide adequate healthcare for everyone. Yet given the number of mandates and regulations that burden the healthcare market, it is fair to say that a free market approach to healthcare has yet to be tried in North Carolina.

Individual Plan Premiums By State

| State | Avg Monthly Premium | Avg Age | Percent Uninsured |
|-------|---------------------|---------|-------------------|
| AK* | \$ 157 | 30.1 | 17.0% |
| AL* | \$ 180 | 28.0 | 13.5% |
| AR | \$ 123 | 33.0 | 16.4% |
| AZ | \$ 122 | 29.6 | 17.1% |
| CA | \$ 130 | 29.8 | 18.7% |
| CO | \$ 124 | 30.3 | 17.0% |
| CT | \$ 161 | 34.4 | 11.6% |
| DC | \$ 191 | 31.1 | 13.3% |
| DE* | \$ 150 | 32.1 | 14.5% |
| FL | \$ 162 | 30.8 | 19.9% |
| GA | \$ 134 | 31.0 | 17.4% |
| IA* | \$ 100 | 31.0 | 9.5% |
| ID* | \$ 140 | 36.0 | 15.4% |
| IL | \$ 130 | 30.4 | 14.0% |
| IN | \$ 125 | 30.1 | 14.2% |
| KS | \$ 120 | 29.1 | 11.1% |
| KY | \$ 122 | 29.8 | 14.3% |
| LA* | \$ 178 | 28.1 | 17.2% |
| MD | \$ 175 | 29.8 | 14.6% |
| MI | \$ 98 | 29.8 | 11.6% |
| MN | \$ 154 | 32.1 | 8.9% |
| MO | \$ 108 | 28.6 | 12.6% |
| MS* | \$ 142 | 33.0 | 17.1% |
| MT* | \$ 135 | 30.0 | 19.1% |
| NC | \$ 200 | 30.8 | 15.7% |
| ND* | \$ 198 | 37.3 | 11.2% |
| NE | \$ 108 | 27.4 | 11.4% |
| NJ | \$ 245 | 33.1 | 15.3% |
| NM | \$ 145 | 33.8 | 21.0% |
| NV | \$ 156 | 31.9 | 18.5% |
| NY | \$ 379 | 40.3 | 14.2% |
| OH | \$ 128 | 30.0 | 11.4% |
| OK* | \$ 129 | 32.3 | 19.9% |
| OR | \$ 157 | 30.3 | 16.5% |
| PA | \$ 153 | 28.8 | 11.9% |
| SC | \$ 141 | 31.5 | 14.7% |
| SD* | \$ 123 | 27.1 | 12.0% |
| TN | \$ 128 | 29.8 | 14.1% |
| TX | \$ 121 | 29.2 | 25.0% |
| UT | \$ 102 | 28.7 | 14.1% |
| VA | \$ 149 | 30.5 | 14.4% |
| WA | \$ 218 | 33.8 | 13.0% |
| WI | \$ 124 | 31.3 | 10.4% |
| WY* | \$ 107 | 25.4 | 14.0% |

NOTE: Of the sample of 80,000, states denoted with an *asterisk do not have a sufficient number of policies to determine the average monthly premium at an 80% confidence level for those particular states.
 Due to the nature of reporting from carriers for Tennessee, the average monthly premium for Tennessee was projected from the average monthly premium for BOTH individual and Family Plans (combined) and not just Individual Plans.
 States where eHealthInsurance Services, Inc. did not sell Major Medical Plans at the time of the data analysis are: Hawaii, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont and West Virginia.
 Data source of "Percentage Uninsured" is U.S. Census Bureau; Current Population Survey, 2005 Annual Social and Economic Supplement, July 19, 2005.

SOURCE: eHealthInsurance

In order to begin to understand just how the market might be able to resolve the healthcare cost crisis, as well as the problem of the uninsured, the remainder of this Conclusion provides a brief overview of free market healthcare alternatives that would both save money and permit more people to pay for their own healthcare.

Encourage Alternatives to Employer-based Insurance

Thanks largely to federal tax incentives, health insurance in the United States is generally provided through employers. If North Carolina is limited in what it can do here, the state can lobby for change and make it easier for consumers to purchase their own insurance. In this respect, health savings accounts (HSAs) and corresponding high-deductible health plans (HDHPs) may provide a better alternative to traditional insurance coverage. Contributions to such accounts are not subject to income tax. In return, such accounts can only be used to pay for qualified medical expenses. Preliminary studies of HSAs indicate that health savings account holders are often more conscious of their healthcare spending habits. In fact, HSA holders tend to invest more in preventative care, which generally makes for less costly medical bills in the long-run.

Another option for both employers and employees is the health reimbursement arrangement, otherwise known as a health reimbursement account (HRA). HRAs are employer-owned accounts that allow employees to be reimbursed for eligible out-of-pocket expenses (copays, coinsurance and deductibles) from a pool of funds set aside by their employer. Unlike an HSA, money placed in an HRA must be used within a specific time period. Employers contribute a

predetermined dollar amount for each employee, and the employee has a set amount of time to use the funds. HRAs are typically tied to an HDHP, which means lower health insurance premiums for both employees and employers.

Reduce or Eliminate Coverage Mandates

A coverage mandate is a state regulation that dictates what benefits a health insurance policy must cover. Insurance buyers pay for such mandates through higher insurance premiums. The more mandates, the higher the premium. Coverage mandates are often defended as consumer protection, with the implication being that without the mandates, consumers would not be able to obtain a “necessary” level of insurance coverage. People often disagree, however, as to what coverage is actually necessary – e.g., for chiropractors or for contraception – with the result being that the implementation of new mandates is sometimes subject to undue influence by special interests.

A better alternative to coverage mandates is to deregulate the insurance market so that consumers can choose for themselves what type of coverage they think is necessary, just as, in the same way, individual consumers can buy a car that has more options than the standard model. Some states have taken a middle way by requiring that insurance companies offer certain types of coverage; other states permit mandate-light options. Creating a one-size-fits-all system of healthcare through coverage mandates is like requiring everyone to buy an SUV – whether or not the consumer needs or wants one.

Allow Interstate Competition

While many people are forced to choose between higher take-home pay or health benefits, several factors exacerbate this dilemma in North Carolina. Competition among health providers is limited insofar as North Carolinians are prohibited from buying out-of-state health insurance. Unlike cars, computers or almost any other item, people in North Carolina cannot look to Virginia, South Carolina or anywhere else to purchase a health plan.

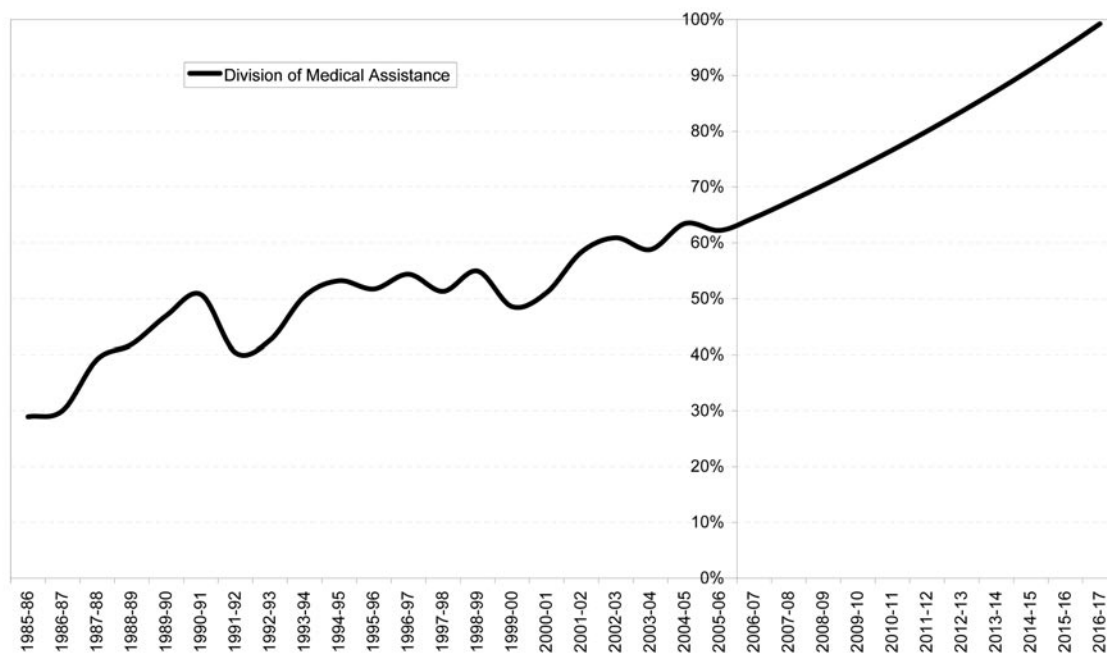
Primarily this is because each state requires health plans to meet a complex set of coverage mandates. If the state were to take steps to open up the insurance market to insurers in other states, the price of insurance might very well go down.

Discourage Illegal Immigration

Along with the “Gray Revolution” currently underway in the United States, illegal immigration is also contributing to increased healthcare costs. As discussed in the Q&A section, North Carolina has the eighth fastest growing Hispanic population in the United States. According to estimates by the Pew Center, approximately 65 percent – some 330,000 persons – of North Carolina’s Hispanic population is illegal.

Companies that use illegal labor often do not provide such employees with healthcare benefits. This means the bulk of illegal workers who become ill or get injured on the job are likely to obtain treatment through Emergency Medicaid and other similar services. In this way, these

Medicaid as Share of Total DHHS Budget: 1986-2017



companies unfairly benefit from a default healthcare subsidy, the bill for which is laid at the feet of U.S. taxpayers.

The precise cost of providing healthcare to illegals is difficult to determine. A recent study (March 2007) in the *Journal of the American Medical Association* found that between 2001 and 2004 total spending on Emergency Medicaid services for illegal immigrants in North Carolina increased by 28 percent. In 2004, 82 percent of this spending was for childbirth and complications related to pregnancy. Spending for elderly illegal immigrants has also increased rapidly. Overall, state Medicaid spending for illegal immigrants more than doubled between 2000 and 2005, going from \$25.8 million to \$52.8 million.¹

The Federation for American Immigration Reform (FAIR) also estimated that, as of 2004, more than 3.5 million immigrants were covered by Medicaid. FAIR likewise reported that “in some hospitals, as much as two-thirds of total operating costs are for uncompensated care for illegal aliens.”² According to research by the *Raleigh News & Observer*, North Carolina had more than \$1.4 billion in unreimbursed hospital costs in 2003;³ a significant share of these costs resulted from care given to uninsured illegal aliens. Of course, unrecouped costs reappear in the price of goods and services sold to those who pay for their own healthcare.

Reform Medicaid

Finally, and most important in the short-term, is the reform of the state’s Medicaid system. Total Medicaid spending in North Carolina has nearly tripled since 1995. Since 2000 alone, spending has shot up by 96 percent. The Fiscal Research Division of the North Carolina General Assembly estimates that each 1 percent increase in Medicaid expenditures equals an additional \$29 million in General Fund appropriations. Thus even if Medicaid spending were to grow by only 30 percent, the additional cost to taxpayers would be \$870 million over four years.

But the Fiscal Research Division also found that 56 percent of the state's Medicaid expenditures in 2004 were dedicated to optional services. North Carolina currently covers 33 of 38 such optional services, including coverage for transportation, dentures, eyeglasses, chiropractors and private duty nursing. Indeed, a 2001 report by The Lewin Group went so far as to characterize the state's Medicaid program as a "Cadillac" system that sacrifices cost containment to access.

Clearly, comprehensive reform of the state's Medicaid system is necessary; yet, as this 20-year study has shown, such reform is unlikely. In the meantime, what steps can state lawmakers take to curb the growth of Medicaid?

► **Premium Assistance.** Following the lead of states like Florida and South Carolina, North Carolina could permit Medicaid beneficiaries to choose their own coverage, including certain forms of private coverage. A Florida proposal, for example, would give Medicaid clients control over their own personal care accounts, thus encouraging patients to take more responsibility for their healthcare decisions.⁴

A similar premium assistance program would permit North Carolina to use existing Medicaid and SCHIP resources to help low income individuals and families purchase private health insurance. Indeed, according to a Commonwealth Fund survey, "65 percent of adults would prefer private coverage."⁵ State and federal healthcare tax credits for low income families might also help more people obtain access to healthcare through the purchase of private health insurance.

► **Grow the State's Economy.** Fiscal Research Division research also shows that the number of Medicaid enrollees is closely related to the performance of the economy. In times of economic growth, enrollment slows or even declines. In times of recession, enrollment inevitably picks up. In addition, poor counties have higher rates of Medicaid recipients. Economic growth and job creation are thus key ingredients to reducing the number of people who turn to Medicaid.

► **Limit Eligibility.** Expanding eligibility requirements significantly increases Medicaid enrollment, as happened following eligibility expansions in 1987 and 2000. As of 2006, 45 percent of North Carolina Medicaid recipients belong to eligibility groups added since 1987.

► **Set Priorities.** Should tax dollars continue to fund the high number of recently eligible Medicaid recipients, or should they be used, for instance, to finance new schools and roads?

► **Make Room for Private Insurance.** Rather than insuring more children overall, Medicaid expansion in North Carolina has for the most part merely shifted kids from private to public insurance. The number of children enrolled in Medicaid went from 10.8 percent in 1987 to 26.7 percent in 2005. Meanwhile, children covered by private plans dropped from 75.8 percent to 63.6 percent. This means that three-fourths of the increase in Medicaid child recipients came from the ranks of the privately insured. Researchers at the Robert Wood Johnson Foundation, a New Jersey-based healthcare advocacy organization, surveyed 22 leading studies on this issue and likewise concluded that such crowd out "seems inevitable."

► **Reduce Optional Services.** The federal government requires that Medicaid cover certain services. In addition, individual states can provide expanded benefits from a menu of 38 optional services. As mentioned above, North Carolina's Medicaid program includes 33 of these options. Only eight states in the U.S provide more benefits for their Medicaid enrollees. Neighboring South Carolina covers 25, and Virginia covers 30.

North Carolina's decision to extend coverage to the "medically needy" is a prime example of how optional services are fueling rising Medicaid costs. This program extends services primarily to people with too much income to be eligible for standard Medicaid coverage. Fifteen states (including South Carolina) do not cover this group of people at all. By contrast, North Carolina is quite generous in this area – state spending per "medically needy" enrollee is 70 percent higher than the U.S. average.

If it sometimes seems as if essential decisions regarding healthcare are confined to federal policymakers, the truth is that the federal government is looking to the states for new ideas and innovations. For example, healthcare experts are waiting to see whether the Massachusetts "connector" model (see Executive Summary) will succeed. In California, Governor Arnold Schwarzenegger (R) is lobbying for employer mandates. Meanwhile, Illinois is moving towards a single-payer model and Tennessee is moving away from Governor Phil Bredesen's (D) beleaguered TennCare program. North Carolina likewise has an opportunity to be a leader in healthcare reform. Accepting this call means making every effort to create a robust and competitive healthcare market in which greater access and personal responsibility for every North Carolinian is the goal.

ENDNOTES:

¹Christina Headrick, "Farm worker protection meets stiff resistance," *News & Observer* (April 29, 2003), A1.

²Federation for American Immigration Reform, "The Sinking Lifeboat," Executive Summary (Feb. 2004); available from http://www.fairus.org/site/PageServer?pagename=research_researchba61.

³Headrick, "Farm worker protection meets stiff resistance."

⁴Jeb Bush, "Florida Medicaid Modernization Proposal," State of Florida (January 11, 2005); available from <http://partnersintransition.org/Documents/policypaper.pdf>.

⁵Jennifer Edwards, Michelle Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey," The Commonwealth Fund, *Issue Brief* (August 2002), 7; available from http://www.cmwf.org/usr_doc/edwards_erosion.pdf.