

EXECUTIVE SUMMARY

If there is any one area in which conservatives have failed to stem the growth of big government, it is healthcare. Of course, it is true that the state spends far more on education than on healthcare. Taken together, education and healthcare consume 81.2 percent of the state's budget. For FY2006, education spending comprised 56.7 percent of the operating budget while healthcare comprised 24.5 percent. It is also true that education policy has dominated the debate over spending and taxation over the past 20 years. In 1984, James Martin (R) was elected governor by running on a platform that combined fiscal discipline with education reform. Governor Jim Hunt (D) likewise sought to secure his legacy as an education governor by launching and continually expanding Smart Start. Governor Mike Easley (D) followed a similar path by establishing and expanding his More at Four daycare program. Ironically, however, neither Smart Start nor More at Four are really education programs. Smart Start is funded under the Department of Health and Human Services budget, and until 2006, More at Four was as well.

Governor Hunt and Governor Easley's success in convincing the people of North Carolina that these state-funded healthcare programs are really educational programs is instructive. First, Americans are much more comfortable with a taxpayer-funded and government-run educational system than they are with a taxpayer-funded and government-run healthcare system. To begin with, this is because most parents need help in educating their own children. This is not to disparage homeschooling in any way, but only to recognize that the education of children, especially adolescents, requires resources that often exceed the normal family's grasp – both in terms of time and knowledge.

Childcare, however, is a basic responsibility of every parent. That the state should seek to take over this responsibility is worrisome. Similarly, Americans are uncomfortable with nationalized healthcare because healthcare is a much more private matter than education. As the ongoing debate over abortion suggests, healthcare choices pertain to a realm of privacy that the government has no right to invade. After all, healthcare is about taking care of one's own body, and there is no thing more intimate to a person than his body. This phenomenon accounts for the American public's visceral rejection of the 1994 "HillaryCare" universal health coverage plan.

In short, universal healthcare is not an idea that sits well with Americans – not only because it requires a certain overcoming of a natural sense of privacy – but also because Americans, have traditionally held deep-seated suspicions of government. The proponents of government-controlled healthcare recognize both these facts. Thus, they have pursued a piecemeal approach to what they call "healthcare

reform," a strategy calculated not to offend the sensibilities of ordinary Americans who might be comfortable with big government, but will not accede to a government monopoly over healthcare.

Second, the road to a statewide healthcare system is through North Carolina's children. More particularly, this road is going through the State Children's Health Insurance Program (SCHIP), which in North Carolina operates as NC Health Choice and Health Check. SCHIP refers to a federal initiative created in 1997 – during President Bill Clinton's first term – that provides health insurance to children from low income families. The program is jointly funded by the federal government and the states, with each state able to set its own eligibility rules at or above federal minimums.

In effect, SCHIP reveals precisely how the Left intends to bring about universal healthcare in the United States. First, make children the center of the debate; second, federalize the process by bringing it down to the state level. In North Carolina, this strategy has worked remarkably well. In 1998 the state not only accepted \$80 million in federal funds to create its own SCHIP program, it expanded the federal eligibility threshold from 133 percent of the federal poverty level (FPL) to 200 percent of FPL. Currently, the FPL for a family of four is \$20,650; 200 percent of FPL is \$41,300. Today, Health Choice covers some 74,000 children, with another 38,000 eligible children not enrolled in the program. Between 2000 and 2005, enrollment in both NC Health Choice and Health Check rapidly expanded, going from 104,000 to 196,000. Nevertheless, attempts are currently being made to expand the program to even more children by increasing the threshold for Health Choice to 300 percent of FPL (\$61,950).

Finally, it is clear that conservatives in North Carolina don't know what to do about any of this. Indeed, many Democrats have become so emboldened in their quest for universal healthcare that they are openly acknowledging this goal, as well as the steps they intend to take to get there. During the 2007 long session, for example, Representative Hugh Holliman (D-Davidson) frankly stated that he conceived of his bill (HB 265) to create a high-risk pool for North Carolina as a major step toward universal health coverage. Stated Holliman before the House Health Committee: "We still have 1.4 million uninsured people in this state and the first step to having any kind of comprehensive program to insuring our people is this bill." Likewise, as reported by Mark Binker of the *Greensboro News & Record*: "Holliman says that the high risk pool is a first step toward universal coverage in the state. There are lots of schemes that could be used to make sure all 8 million-plus North Carolinians have some sort of health insurance. But the first step, according to Holliman, is dealing with this un-insurable group." Similarly, Representative Verla Insko (D-Orange) has spoken openly about the need to use a piecemeal approach to impose a universal healthcare system on the state, acknowledging that the "creation of a high-risk insurance pool is a first step toward universal health care for North Carolinians." After the high-risk pool is established, the next move will be to expand NC Health Choice to cover all children; next, the parents of low income children will be enrolled; finally, everyone else.

As this history of healthcare in North Carolina shows, the odds are that Representatives Holliman and Insko will get their wish. Between FY1985 and FY2005, total appropriations for North Carolina's health and human services budget went from \$703.1 million to \$3.9 billion: a 448 percent increase. Of course, much of this growth is being driven by federal mandates – in particular, through Medicaid. Over the last 20 years, Medicaid spending more than doubled as a share of the Department of Health and Human Services (DHHS) budget. For FY1985, Medicaid outlays were 28 percent of the DHHS budget; for FY2005, they were 63 percent. Over the last five years alone, the budget for the Division of Medical Assistance – which operates Medicaid – increased 59 percent.

Still, the federal government is not entirely to blame. North Carolina's Medicaid program is one of the most generous in the country, with the state among the top five in terms of providing nonmandated benefits. Between FY2004 and FY2005, combined state and federal Medicaid funding in North Carolina grew by 23.2 percent – an increase surpassed by only four states. The national average was 12.7 percent. Indeed, according to the latest data available from the Kaiser Family Foundation, total Medicaid spending per North Carolina enrollee was \$13,449 (FY2003) – almost twice the U.S. average of \$7,898 per enrollee.

If conservatives are to have any chance of winning the healthcare debate in North Carolina they first have to realize exactly what is at stake. The move to a universal healthcare system is not simply another expansion of big government; it marks a fundamental shift from a republican, free-market regime to a socialist-style state in which the government has control over the production and distribution of a substantial part of the economy. If conservatives lose this battle, they will have lost the war for the soul of this nation. In order to win this war, however, conservatives need to reframe the discussion. With this end in mind, we want to use the space that remains here to clarify a few terms essential to the debate over healthcare reform.

Healthcare Reform = Free-market Healthcare Reform

If the Left has heretofore been hesitant to admit that their ultimate goal is a universal healthcare system, conservatives need to make it clear to the American people what the liberal version of healthcare “reform” really is. Liberals do not want to reform the U.S. healthcare system; they want to abolish it.

Regardless of what it's called, or how it's done, universal healthcare is going to cause the same problems in North Carolina that it has caused throughout the rest of the world: high costs, declining quality and increased waiting periods. True healthcare reform – as we will detail in the Conclusion – entails using the free market to make quality healthcare readily available for everyone by meeting every need and every budget.

Universal Healthcare = Socialized Medicine

When people like U.S. Senator Hillary Clinton (D-N.Y.) and Representative Verla Insko (D-Orange) talk about “universal healthcare” what they really mean is a govern-

ment-controlled, taxpayer-financed healthcare system – i.e., socialized medicine. Under its most extreme form (Great Britain and Spain), medical professionals, much like school teachers, are employed by the state. In other cases (Canada, Sweden, Australia), doctors remain in “private” practice, but are paid directly by the government.

Single-payer Healthcare = Universal Healthcare = Socialized Medicine

Under a single-payer program, the government, rather than patients or insurance companies, pays all healthcare costs. Where does this money come from? Taxpayers.

Universal Health Coverage = Universal Healthcare (Lite)

Universal health coverage, as opposed to universal healthcare, makes it illegal not to have health insurance coverage, much the same way it is illegal not to have car insurance. Massachusetts recently implemented such a program in which the state will employ subsidies and price controls to ensure that everyone can afford to buy insurance. In the end, the Massachusetts model will differ little from other socialist style systems (e.g., the Canadian system).

Socialized Medicine = High Taxes

Universal healthcare does not mean free healthcare. Individual taxpayers have to pay for universal healthcare. The key question here is whether the government can provide better and less expensive healthcare than the free market. If it can, then taxpayers will want the government to monopolize this care; if it cannot, taxpayers will want to buy their own healthcare.

The Kaiser Family Foundation estimates that a health plan for an average family costs an average of \$833 per month. How much would such a plan cost in taxes if North Carolina implemented a state monopoly over healthcare?

We can begin to answer this question by looking at how much personal healthcare currently costs in North Carolina. In 2005, North Carolinians spent \$53 billion on personal healthcare, as defined by actual payments to medical providers for health services and products, including prescription drugs. The additional cost to provide health insurance for the state’s 1.3 million uninsured would be \$8.3 billion, raising total health expenses to \$61.3 billion. Basing our calculations on the state’s current tax structure, we can assume that the majority of the revenue to pay this bill is going to be derived from the sales tax and the individual income tax. Under a true single-payer model, no federal funds would be available for either Medicare or Medicaid. Thus North Carolina’s 5.3 million working-age taxpayers would be primarily responsible for shouldering the burden of socialized medicine. At best, the tax increase would be \$958.33 per working-age adult, per month, or \$1,917 in healthcare taxes per month for a family with two parents.

In addition, taxpayers would have to continue to pay taxes to support other state services, such as public education, transportation and public safety – not to mention federal taxes. Yet according to the U.S. Census Bureau, the pretax median income for

a family with three children in North Carolina is \$4,360 per month. How is this family going to pay almost \$2,000 in healthcare taxes – on top of all the other taxes?

Advocates of universal healthcare argue that the cost of the program will be much less than \$24,000 a year per family. The primary rationale for this is that a single-payer program will be more efficient – less paperwork, less hassle, less expense. Thus projections for a single-payer model that almost passed in California (SB 840) included an 8 percent savings in administrative costs. Independent research, however, suggests the opposite. According to a 2003 study by the European Central Bank, socialized healthcare systems in other countries are typically 12 percent less efficient than even the overregulated U.S. system. The result for North Carolina would be a \$7.4 billion increase in annual healthcare costs – over and above the \$61.3 billion mentioned above. That raises the health tax for our family of five to \$2,160 per month.

The only way to avoid this \$68.7 billion price tag is to institute price controls: a move that would reduce supply, drive physicians out of the state and diminish the overall quality of healthcare in North Carolina.

All in all, universal healthcare would cause state taxes as a share of personal income to increase from 3.4 percent to 30.1 percent.

Socialized Medicine = A Disaster for North Carolina's Med-tech Economy

Although the fact that California wants to try it is enough to doom any single-payer healthcare program in North Carolina, it is important to understand just what such a program would entail:

- ▶ Outlawing private health insurance and giving state bureaucrats the exclusive right to set reimbursement rates for physicians, clinics and hospitals. This would create supply shortages and create a black market healthcare system.
- ▶ Transforming the state into the sole buyer of medical drugs and medical equipment. This would hamper cost containment and invite corruption.
- ▶ Destroying professional freedom for medical professionals. Under the California model, the government would determine how many medical professionals could work in the state.

Most important, every universal healthcare program, by necessity, must cap health spending. Under SB 840, this cap was set at the state's Gross Domestic Product (GDP) plus population growth.

This cap may not sound low, but it is a disaster waiting to happen. Take investments in medical technology and pharmaceuticals. Data from the Bureau of Economic Analysis shows that U.S. health providers increase investments in medical technology by 7 percent per year. Such increases are necessary if new technology is ever

to make its way into our hospitals and clinics. If applied to the United States as a whole, say in 1960, the cumulative effect of the SB 840 cap would have lowered current technological standards in U.S. hospitals to 1982 levels.

The Med-tech Spending chart looks at the impact an SB 840 type cap would have on North Carolina if the state had introduced universal healthcare in 1994. That year, North Carolina's health sector spent \$2.4 billion on med-tech. A decade later, spending increased to \$7.9 billion, an average increase of 12.5 percent per year.

Let us now introduce an SB 840 budget cap that restricts med-tech spending growth to the sum of nominal state GDP growth and population growth. Together, this growth adds up to 8.2 percent annually between 1995 and 2004.

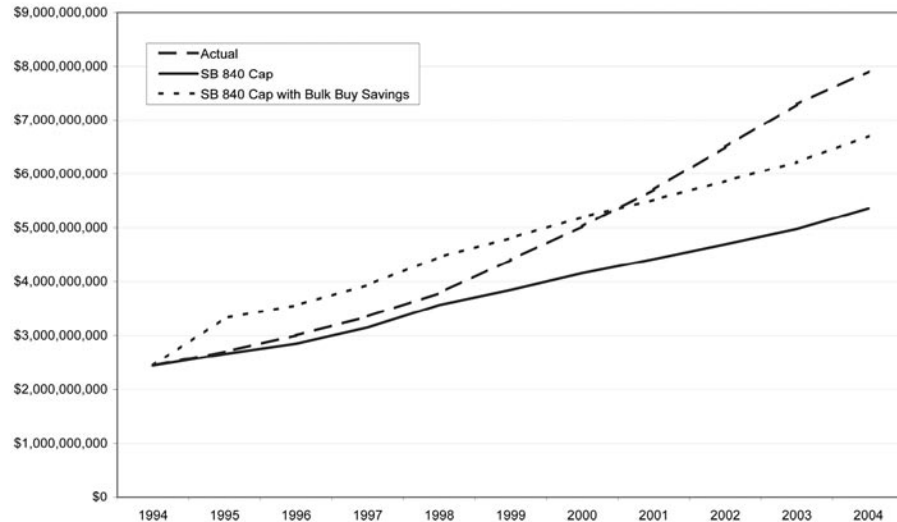
To comply with this budget cap,

North Carolina would have had to reduce med-tech spending by \$40 million in the first year alone. By 2004, the capped med-tech budget would be \$2.5 billion behind actual spending – a whopping 32 percent loss.

The authors of SB 840 claim California can reduce med-tech costs by 25 percent through bulk buys. Unrealistic as it is, let us give them the benefit of the doubt and import those savings to our North Carolina experiment. As our chart indicates, with bulk buy savings, med-tech spending would actually increase by \$500-\$600 million per year for the first four years. In the sixth year, however, North Carolina would have to start cutting med-tech spending. For FY2004, the loss would be \$1.2 billion and rise quickly thereafter.

In short, the cost of medical technology in North Carolina has been increasing faster than state GDP plus population. Such growth is inevitable if we want to enjoy the fruits of high-quality medical technology and the economic benefits such growth can bring. The only alternative is to restrict access to med-tech, or buy subpar equipment and medical drugs. But it is unlikely that people will put up with yester-tech medicine, especially when they are paying 30 percent of their income in taxes for what is supposed to be topnotch healthcare.

Med-tech Spending in North Carolina: SB 840 Cap



Socialized Medicine = Long Waiting Periods

In addition to limiting investment in new medical technology, restricting access to doctors is a classic way to keep costs down under a universal healthcare system. Looking at the experience of other countries that have instituted socialized medicine, it is certain that under a "HillaryCare" system, such as California's SB 840, long waiting periods for even necessary treatments would become routine.

In Canada, waiting times for medical treatments have become so severe that in June 2005 the Canadian Supreme Court ruled that the universal health system in Quebec violated citizens' rights to "life and personal security, inviolability and freedom." Canadians are waiting so long before they can see a doctor that their health, even their lives, are in jeopardy. Thus the court ordered an end to the government healthcare monopoly.

As reported by the Vancouver-based Frasier Institute, waiting times for even routine procedures are very long:

- ▶ Need an MRI? Prepare to wait almost 18 weeks.
- ▶ Need to see an eye doctor? Wait three months for an appointment and then another three months for treatment.
- ▶ Want to see an orthopedist? A September 1 referral will get you in to see the doctor three days before Christmas. You can look forward to surgery on June 8 the next year.

Predictably, such waiting lists have the greatest impact on the hard-working middle class families who actually pay the taxes that keep the system afloat. Canadians with money go to the few remaining private clinics or to hospitals in the United States.

In Sweden, the waiting periods are downright inhumane:

- ▶ Is your baby sick? He'll have to wait four months just to see a pediatrician. If you need to see an ear-nose-throat specialist, prepare to wait two more months.
- ▶ Feeling depressed or suicidal? In Gothenburg, Sweden's second-largest city, a teenager waiting for a psychiatrist will have to hold out for a full year just for his first appointment.

For patients that need surgery, the total waiting easily adds up to one year. Even hospital emergency rooms make Swedes wait, as in the case of a three-year old boy who recently died at a prominent Swedish university hospital. Because of health spending caps and budget cuts, the child, who had a basic stomach infection, was left unattended for hours.

The United States does not have a waiting problem, according to the Paris-based Organisation for Economic Co-operation and Development (OECD). But countries with socialized healthcare do. In 2001, the OECD reported that 38 percent of British elective surgery patients had to wait more than four months. Spanish patients in need of orthopedic surgery had to wait more than a year on average. The same applied to women waiting for a hysterectomy. Patients waiting for hip replacement in Australia, Denmark, England, Finland, Netherlands, Norway and Spain wait for 15-35 weeks. For cataract surgery, the waiting time in Australia, England, Finland and Sweden is 25-32 weeks.

Just as with med-tech spending, long waiting periods are caused by budget caps. Budget caps, in turn, are necessary to prevent taxes from going out of control. Thus the legislator who wants universal health insurance is caught between rationing supply and taxing the life out of middle class families.

If a state monopoly over healthcare is no longer sounding very good, what about a Massachusetts-style universal health coverage system? As signed by Governor Mitt Romney (R) in April 2006, the Massachusetts plan includes an “individual mandate” requiring every individual in the state to purchase health insurance by July 2007. Those who can’t afford insurance (approximately 100,000) will be insured through Medicaid; another 200,000 will receive state subsidies to help pay premiums. To help keep insurance costs low for everyone else, the state will regulate the insurance market (a classic example of one government regulation causing another). A state run “connector” will match insurance buyers with insurance providers – second guessing the market – and determine what premiums providers can charge.

State actuaries make the completely unsubstantiated claim that premiums will hover around \$200 per month per average family, far below the \$833 average estimated by Kaiser. Some sources also claim that the cost to taxpayers will be about \$1 billion annually, 78 percent of which would be covered by federal dollars. But our own preliminary analysis of the Massachusetts’ plan estimates the cost will be at least \$2.4 billion.

As costs rise, expect premiums to rise as well. Once that happens, the state will either have to increase the state subsidy or fine individuals who can’t afford the higher premiums. But according to the Massachusetts law, a resident can escape the uninsured penalty if “no affordable coverage is available.” To avoid endless court battles over what “affordable” actually means, the state will likely choose to force taxpayers to pick up the bill. At that point, Massachusetts will have the Canadian problem. Residents will see taxes go up and ask for a cap on health costs. The state will have to ration supply – or disband the individual mandate altogether.

The Free Market = Universal Healthcare

Proponents of government-run healthcare mistakenly believe that high quality healthcare is cheap. It never is. Cost and quality go hand in hand. Only a free market can assure the highest quality at the lowest price.

And while the current U.S. system is far from perfect, squeezed as it is between tax-paid healthcare and government regulations, it is a good foundation on which to improve on. In the end, the key to expanding health insurance coverage in North Carolina lies in reducing the cost of health insurance for everyone. Socialized medicine will not only increase these costs, but will result in lower quality healthcare and lengthy waiting periods. By adopting a free-market approach to healthcare reform, North Carolina can help people improve their lives while at the same time making them less dependent – not more dependent – on the government.

Health & Human Services Budget: FY2007

