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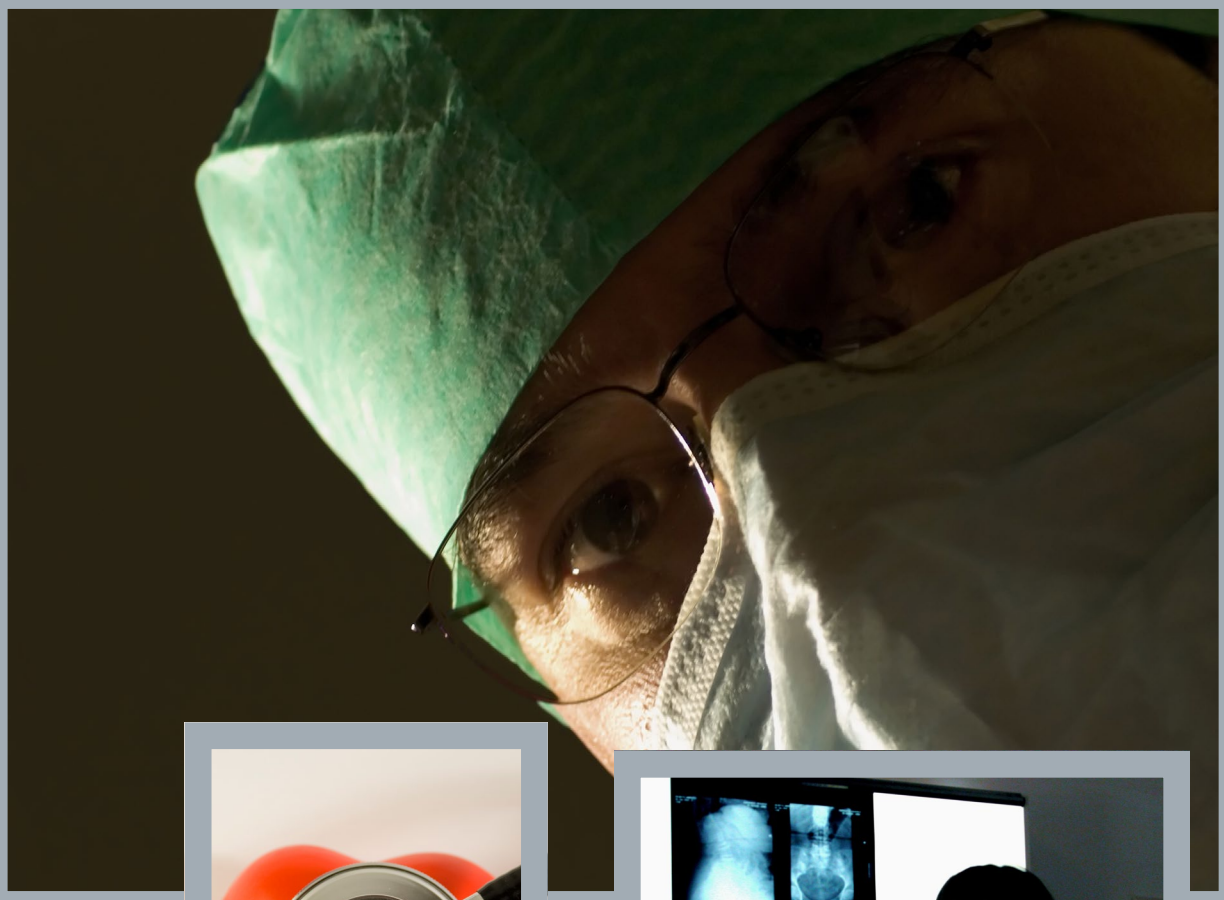

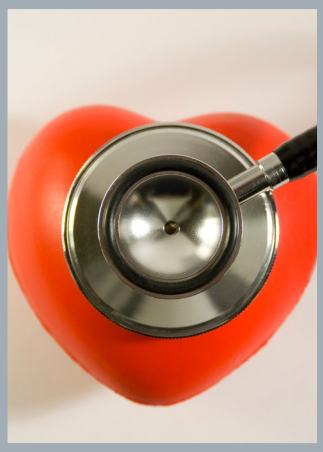

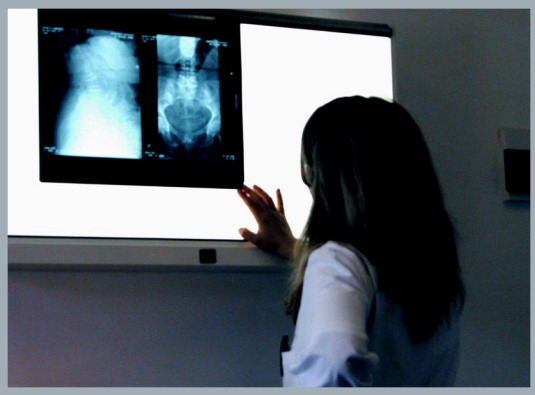

# DIAGNOSING THE PROBLEM 1985-2010

## *A Guide to North Carolina Healthcare Policy*

JOHN W. POPE CIVITAS INSTITUTE

THE CIVITAS INSTITUTE PUBLIC POLICY SERIES

# Diagnosing the Problem 1985-2010

## *A GUIDE TO NORTH CAROLINA HEALTHCARE POLICY*

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# ABOUT THE SERIES

## Civitas Institute Public Policy Series

*The purpose of the Civitas Institute Public Policy Series is to equip the legislator, as well as the layman, with the tools necessary to understand public policy in North Carolina. Toward this end, each guide does three things: defines basic terms, answers essential questions, and provides a legislative and political history regarding a particular policy area. Thus each guide consists of three distinct sections – Key Terms, Q & A, and a year-by-year timeline – that can be used to easily find specific information on a particular issue or time period. Detailed charts and graphs provide additional data for those readers interested in learning more about select topics. Overall, the guides provide a roadmap for the citizen legislator – and perhaps more importantly, the average citizen – interested in learning more about essential policy ideas and long-term trends.*

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Special thanks to all those who helped make this project a success. In particular, Max Borders and Brian Balfour collaborated on the conclusion and assisted with final edits. Thanks as well to Christie Adams for laying out the text and designing the cover.

*If you think healthcare is expensive now, wait until you see what it costs when it's free.*

P.J. O'Rourke

*Healthcare is coming back. It may be a bad dream for some.*

Senator Hillary Clinton (D-New York)

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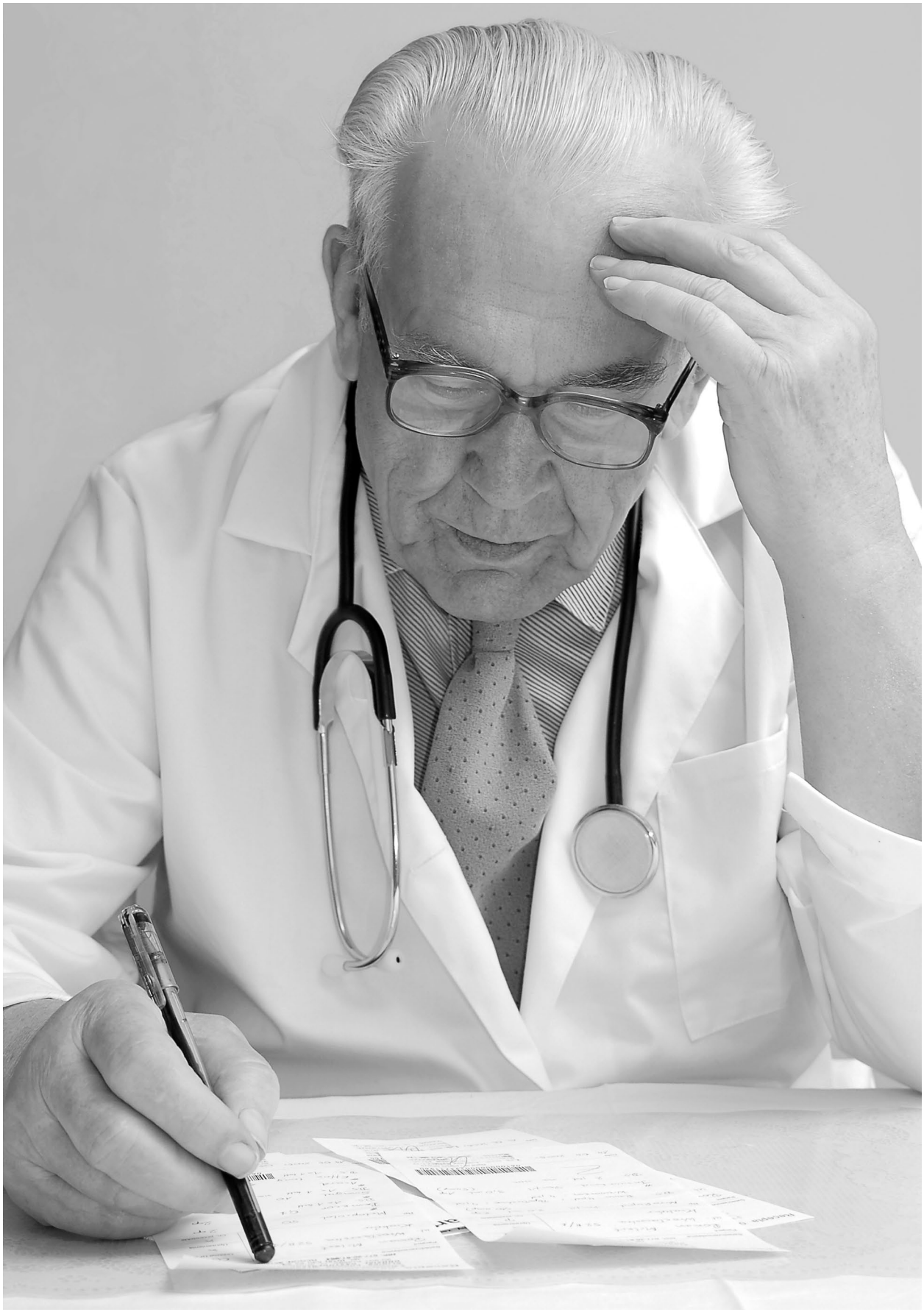


# EXECUTIVE SUMMARY

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 North Carolina spends far more on education than on healthcare. Taken together, education and healthcare consume roughly 75 percent of the state's budget. For FY2010, education spending comprised more than half of the operating budget while healthcare represented almost a quarter of the total budget. It is also true that education policy has dominated the debate over spending and taxation over the past 25 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 and the public backlash over the more recent "Obamacare" legislation.

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 second 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. As of 2010, the FPL for a family of four is $22,050; 200 percent of FPL is $44,100. Health Choice covered 122,431 children in 2010, with another 15,000 eligible children not enrolled in the program. Between 2000 and 2010, enrollment increased rapidly, rising from 104,000 to 122,431.

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 uninsurable 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." Having established a high-risk pool in 2009, 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 FY2010, 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 25 years, Medicaid spending more than doubled as a share of the Department of Health and Human Services (DHHS) budget. The FY2010 budget for the Division of Medical Assistance – which operates Medicaid – has expanded to $2.3 billion.

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. According to 2008 data from the Kaiser Family Foundation, North Carolina's average payment per Medicaid enrollee was $5,706, seven percent higher than the $5,342 national average.[1] Indeed, average annual growth rates in Medicaid spending in North Carolina between 1990 to 2001 was 14 percent, significantly outpacing the national annual average growth rate of 10.9 percent. More recently, North Carolina's average annual Medicaid spending growth rate between 2007 and 2009 of 8.2 percent easily topped the national annual average of 7.1 percent.[2]

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 significant shift 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. Following that is a timeline detailing major healthcare issues in North Carolina. In order to win the policy debate in the future, it is important to understand how we arrived at our present.

ENDNOTES:

1 State Health Facts, Kaiser Family Foundation. "North Carolina: Medicaid payments per enrollee, FY 2008." Available online at: http://www.statehealthfacts.org/profileind.jsp?ind=183&cat=4&rgn=35

2 State Health Facts, Kaiser Family Foundation. "North Carolina: Average Annual Growth in Medicaid Spending, FY 1990-2009." Available online at: http://www.statehealthfacts.org/profileind.jsp?ind=181&cat=4&rgn=35

# **key** terms

### *ACCESS*

A managed care Medicaid program administered by the Division of Medical Assistance. The Division of Medical Assistance uses Carolina ACCESS to buy preventive care and treatment from primary care physicians for Medicaid enrollees. The division also runs ACCESS II, a managed care program that provides treatment programs for such diseases as asthma and diabetes. More specifically, ACCESS links Medicaid patients with primary care providers. These providers are the gatekeepers of the Medicaid system. Under ACCESS, all Medicaid patients must see their primary care provider before they may see a specialist. It is incumbent upon the primary care provider to show fiscal restraint in deciding whether or not a patient should see a specialist. Another result of this gatekeeper system is that it prevents patients from seeing the specialist of their choice.

### *Accountable Care Organization (ACO)*

The "Affordable Care Act" or "Obamacare" creates federal accountable care organizations (ACOs) under the Medicare Shared Savings program. An ACO, in theory, is a network of healthcare providers, both doctors and hospitals, that shares responsibility for patient care. The system would tie provider reimbursement to specific metrics in an effort to reduce costs and improve quality. Providers would be jointly responsible for patient care, forcing them to cooperate and avoid unnecessary and costly tests and procedures. Under Obamacare, an ACO would manage the healthcare of at least 5,000 Medicare beneficiaries for a minimum of three years.

However, ACOs are likely to become a part of the problem in healthcare reform, rather than a viable solution. ACOs will push more and more power into the hands of fewer and fewer healthcare organizations until they likely become "too big to fail." As many hospitals prepare themselves for integrated ACO systems, many will choose to merge together and purchase doctor practices, leaving fewer independent hospitals and physicians. Such a system could undermine competition and shift the focus to quantity of medical procedures rather than quality of care. The greater the market share these large ACO systems have, the more leverage they have in the marketplace, which may ultimately drive up healthcare costs.

### *AFDC (Aid to Families with Dependent Children)*

Welfare program for needy children and their caretakers. AFDC was the backbone of the federal welfare program that ended with the welfare reform of 1996. AFDC was prone to cost inflation because it did not provide adequate incentives for enrollees to obtain suitable employment. A work incentive law of 1968 even allowed AFDC enrollees to work and earn up to 150 percent of their AFDC basic benefits without losing such benefits. The 1996 welfare reform ended AFDC and replaced it with TANF, Temporary Assistance for Needy Families.

### *Association Health Plans (AHPs)*

Also referred to as Small Business Health Plans (SBHPs), AHPs would allow business, professional or other similar associations to offer health benefits to their members. For example, an association encompassing the restaurant workers of North Carolina could use such a plan to take advantage of the buying power of a large group of healthcare consumers. Advocates of AHPs argue that they could be used to provide an affordable health insurance option, particularly for small businesses. By arranging

health insurance through an AHP, for instance, small businesses can obtain more affordable coverage by spreading risk among a larger group and leveraging greater negotiating power. Neighboring South Carolina enacted similar legislation in February 2008 that permits a group of at least 10 small businesses to join together to obtain group insurance coverage for their employees.

### *Budget Appropriation*

Money authorized by the Legislature to be spent on a particular program or line item; an unexpended appropriation is one that could have been spent, but was not; an unappropriated balance refers to cash reserves that have not been allocated for any purpose.

### *Budget Bill*

The session laws that appropriate funds for the next biennium (or fiscal year). In sections called special provisions, the budget bill enumerates the total budget appropriated to each agency, salaries of government officials and other public employees, and the legal language that specifies how agencies and other entities may or may not spend their money and report on their expenditures.

### *Coverage Mandate*

A coverage mandate is a legal requirement that dictates that all health insurance policies sold in North Carolina cover certain services, providers, and groups of people. Mandates are the result of laws passed by the General Assembly as a means of regulating the insurance market. As of 2010, North Carolina has 49 mandates, which continue to increase the price of health insurance.

### *Department of Health and Human Services (DHHS)*

The department conceives of itself as being "responsible for ensuring the health, safety and well being of all North Carolinians." This mission also entails providing human services for "fragile populations" and "helping poor North Carolinians achieve economic independence." Given the ambitious goals of DHHS, it should come as no surprise that it is the single largest executive agency, with more than 19,000 employees. The department's operating budget exceeds $14 billion. The majority of this spending is allocated to three divisions:

- Division of Medical Assistance ($9.7 billion)
- Division of Social Services ($1.2 billion)
- Division of Mental Health, Developmental Disabilities and Substance Abuse Services ($1.1 billion)

### *Disproportionate Share Reserve*

A reserve account established in 1993 (S.L. 1993-321) to hold excess payments dispersed by the Medicaid Disproportionate Share Hospital (DSH) program to hospitals that serve a "disproportionate number of low-income patients with special needs." Throughout the 1990s, federal policymakers expressed concern that many states were taking advantage of the DSH program to decrease their own contributions to Medicaid and subsidize general spending initiatives.

### *DSH (Disproportionate Share Hospitals)*

Hospitals with at least 25 percent low income patients and a higher-than-average rate of Medicaid patients. To qualify as DSH, Medicaid revenues, bad debt allowances, and charity care must comprise 20 percent or more of a hospital's total revenues. Five percent of all Medicaid expenditures in North Carolina go to DSH. In 2003, the state auditor censured the Division of Medical Assistance, a branch of the DHHS, for misappropriating millions of dollars of DSH funds. The auditor found that the division had effectively ceded

control over DSH payments to the largest Medicaid hospital provider in the state. The division also violated federal regulations by paying DSH compensation to an association of 41 public hospitals, instead of directly to the providers. In addition, the division channeled $240 million over six years to hospitals not eligible for DSH payments. In all, the state auditor found $660 million in questionable or wrongful spending: $414 million of that amount in federal funds; and $246 million in state funds.

## *ERISA*

The Employee Retirement Security Act (ERISA), passed in 1972, established new rules and regulations over employer-based retirement and healthcare benefits in the private sector. The key provision in ERISA is one exempting self-funded private health benefit plans from state insurance laws, such as coverage mandates. This provision permits multistate companies who self-insure to offer uniform health plans regardless of their employees' location. North Carolina's state employee plan, because it is also self-funded, is exempt from state mandates as well. Approximately 60 percent of North Carolina employers offering health insurance benefits are covered under ERISA regulations.

## *Executive Organization Act(s)*

The 1971 and 1973 statutes that created the Department of Human Resources (DHR) – now the Department of Health and Human Services (DHHS).

**1971.** The state Legislature passed the Executive Organization Act of 1971 to consolidate the state's numerous executive agencies and departments under broad categories. At this time, the state created the Department of Human Resources (DHR), which combined several independent departments, such as mental health and human services, under DHR.

**1973**. The 1973 Executive Organization Act solidified the bureaucratic growth of the executive branch. This act restructured DHR by creating a Board of Human Resources to advise the DHR secretary on various matters. In 1989, DHR was restructured again by transferring several departments out of DHR to other agencies, such as the Department of Environment, Health and Natural Resources. In 1997, the Department of Human Resources was renamed the Department of Health and Human Services (DHHS).[1]

## *FPL (Federal Poverty Level)*

FPL is the income threshold below which an individual or a family is defined as poor. The federal and state governments use FPL to determine income thresholds for programs such as Medicaid – eligibility for which is capped by the federal government at 133 percent of FPL. North Carolina employs a higher income cap of 200 percent of FPL, which makes approximately 100,000 more children eligible for Medicaid SCHIP than under the federal cap. This extra enrollment costs taxpayers an estimated $144 million per year. North Carolina state taxes pay 25 percent of this cost; the rest is subsidized by federal taxes.

## *Fiscal Year (FY)*

The 12-month period covered by the state budget: July 1 to June 30.

## *Florida Lawsuit*

The official case name of the Florida lawsuit is *State of Florida v. U.S. Department of Health and Human Services*. The plaintiffs include Attorneys General representing 26 states, the National Federation of Independent Business and two individuals. The Florida

lawsuit challenges the constitutionality of the individual mandate in Obamacare requiring all individuals to obtain health insurance coverage (with a few exceptions for low income individuals). It claims the mandate exceeds the federal government's power to regulate interstate commerce under the Commerce Clause. The suit also asserts that Obamacare violates the Tenth Amendment by forcing states to expand their Medicaid programs. U.S. District Court Judge Roger Vinson ruled that the individual mandate is unconstitutional and unseverable from the rest of the law, thus the entire law must be void. As of late 2011, the U.S. Eleventh Circuit Court of Appeals ruled the individual mandate should be struck, but the other provisions could remain "legally operative."

Other notable lawsuits were filed containing similar challenges to the constitutionality of Obamacare. The state of Virginia, during the 2010 Virginia General Assembly session, filed its own lawsuit, challenging the individual insurance mandate as well. U.S. District Court Judge Henry Hudson also ruled the individual mandate unconstitutional. By late 2011, the U.S. Fourth Circuit Court of Appeals found in a 3-0 decision that Virginia lacked standing because it was not injured and in a 2-1 ruling found Liberty University lacked standing because the penalty amounted to a "tax." Finally, the Thomas More Law Center also filed a lawsuit but lost in a 2-1 decision by the U.S. Circuit Court of Appeals. The U.S. Supreme Court will likely determine the constitutionality of Obamacare by the summer of 2012.

## *General Fund*

Funds general needs, as opposed to specific or restricted purposes. The General Fund accounts for about half of the state's total budgetary financing and is supplied by revenue from a wide variety of taxes and fees, as well as money from court fees, disproportionate share receipts, investment earnings and bonds, the tobacco settlement, the Highway Fund, and the Highway Trust Fund.

## *Health Benefit Exchange*

Under the "Affordable Care Act" or "Obamacare," states are required to establish a health benefit exchange by January 1, 2014. For states that fail to do so, the federal government, under the U.S. Health and Human Services (HHS) Secretary, will set up an exchange for it. In theory, the exchanges are to facilitate the purchase of "qualified" health insurance plans in a consumer marketplace. The HHS Secretary has broad discretion when implementing and regulating the rules and standards for the creation and operation of the exchanges. States must follow these rules and standards and may not make rules that conflict with the federal standards. HHS has provided little guidance, however, on key questions about what the exchanges should include and how they should be run. Instead, it essentially leaves the HHS Secretary with unchecked power to determine what is and isn't in compliance with Obamacare.

## *Healthcare*

Services and products that provide medical examinations, treatment and preventive care. Healthcare includes services such as hospital care, physician and dental services, and nursery and home care. It also includes products like prescription drugs and medical equipment. Personal healthcare consists of the treatment of individuals with specific medical conditions. Public healthcare costs are driven by public health programs and program administration.

## *Health Check*

According to the Division of Medical Assistance, "Health Check is Medicaid for children. Health Check covers complete medical and dental check-ups, and provides vision and hearing screenings and referrals for treatment." More specifically, Health Check

is North Carolina's Medicaid program for state residents aged 0 through 20. Health Check is for children in the poorest families in the state; as such, it requires no enrollment fees or copays. Primarily because of expanding eligibility, Health Check enrollment has grown steadily over the past 15 years. For FY2004-05, for example, the N.C. Department of Health and Human Services reports that 567,000 children were eligible for Medicaid, an increase of 161 percent in 10 years.[2] In 2005, 257 per 1,000 children in North Carolina were Medicaid eligible. In 1995, only 140 per 1,000 children were Medicaid eligible.

North Carolina has contributed to the growth of Health Check expenditures, in particular, by expanding the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to all North Carolinians through age 20. Since EPSDT entitles enrollees to be treated for any health problem found during screening, the state has experienced cost containment problems with the program. Moreover, while NC Health Choice has an absolute enrollment cap, Health Check is open to all eligible enrollees. In an attempt to curb expenses, North Carolina has implemented managed care and also cut physician reimbursement rates. Managed care restricts patients' rights to choose a health provider while reimbursement cuts discourage health providers from accepting Health Check patients. Neither measure focuses on eligibility, which is the primary driving force behind Health Check cost inflation.

## *Health Disparity*

A difference in health status between individuals or groups of individuals. The Office of Minority Health and Health Disparities devotes a large part of its budget to researching and attempting to reduce health disparities. In doing so, the office has adopted specific socioeconomic views regarding what a health disparity is and what causes such health disparities. In particular, the assumption is made that all people, regardless of specific lifestyle choices (for example, drug use or poor diet), ought to be equally healthy. This assumption is related to other socialist-style agendas that promise equal access to all resources (food, housing, transportation) for all people, regardless of individual choice.

## *Health Expenditures*

The sum total of all healthcare outlays. There are two primary types of health expenditures:

### Total Health Expenditures

The sum of personal health expenditures, plus government expenditures on public health programs and administration costs for health programs. In 2009, total health expenditures in the United States were $2.5 trillion, costing $8,086 per person or 17.6 percent of the nation's Gross Domestic Product. In North Carolina, total health expenditures were $44.3 billion as of 2004 (the latest year for which state-level data is available).[3]

### Personal Health Expenditures

Outlays for treatment of individuals with specific medical conditions. Personal health expenditures were an estimated 84 percent of total health expenditures in 2009. In North Carolina, the largest personal health expenditures remain hospital care and physician services.

## *Health Savings Account (HSA)*

A tax-exempt account established through a qualified trustee (e.g., a bank or insurance company) that enables a consumer to purchase healthcare. An HSA is essentially a savings account that can be used to pay for health expenses using pretax dollars. In order to qualify, the consumer must enroll in a High Deductible Health Plan (HDHP). HDHPs

cost less than traditional insurance plans but do not provide coverage until the consumer has spent at least $1,000 on health expenses (their deductible). Consumers can use pretax money deposited in an HSA to pay for HDHP and other medical expenses.

### *Healthy Start Foundation*

A private, nonprofit contractor funded by the Division of Public Health. The Healthy Start Foundation runs the First Step Campaign which educates the public on parenting. Healthy Start was established in 1990 with $5 million in seed money from pharmaceutical giant, Glaxo, Inc. Healthy Start also coordinates the Medical Home Campaign, as well as several other initiatives related to reducing infant mortality and improving children's health.

### *High-risk Pool*

Legislation (S.L. 2007-532) sponsored by Representatives Verla Insko (D-Orange) and Hugh Holliman (D-Davidson) created the "North Carolina Health Insurance Risk Pool" in 2007. The pool is a nonprofit entity that is run by a board of directors appointed by the governor and top legislative leaders. Persons eligible for enrollment include residents who have been refused health insurance coverage for health reasons; persons who can only obtain coverage under limited conditions, such as a conditional rider; those who can only obtain coverage at a rate higher than the pool rate (which is to be set at between 150 percent to 200 percent of individual standard rates); persons who qualify as federally defined eligible individuals; and persons with certain medical conditions. At the time the legislation was passed, the plan was expected to cover between 9,000 and 14,000 persons, or 1 percent of the state's uninsured population. By the end of 2010, the plan actually only covered 5,242 people."[4]

### *Long Session*

With elections held in November of each even-numbered year, the General Assembly convenes from January to July (but often even longer) of each odd-numbered year for what is called the long session. The biennial budget is crafted and adopted during the long session.

### *Managed Care*

A cost containment measure used by health insurance providers to restrict a patient's right to choose a physician or caregiver. State Medicaid agencies use managed care to funnel their enrollees to a limited number of health providers. As a result, the unit cost for providing healthcare is lower and the Medicaid agencies can cut reimbursement rates. North Carolina DHHS credits managed care and reimbursement cuts for holding down Medicaid costs.

### *Medicaid*

A national health insurance system funded jointly by the federal government and the states. Beyond certain basic thresholds, Medicaid eligibility differs from state to state. According to the Division of Medical Assistance, the program "is the largest source of funding for medical and health-related services for America's poorest people." In 1987 one out of twenty North Carolinians were enrolled in Medicaid; by 2008, this number had jumped to almost one in five.[5] As enrollment has increased, so have expenditures. In 1987, Medicaid personal health expenditures in North Carolina were $918 million. By 2009, this number had increased to $11.5 billion.[6]

### *Medicare*

A national health insurance program that primarily covers the elderly and younger citizens with certain disabilities. Unlike Medicaid, Medicare is a strictly federal program. Medicare was founded in 1965 and

opened for enrollment a year later. In 2009, Medicare spending reached $502 billion. It is expected to grow an average 6.9% per year through 2019.[7]

### *Medicare Part D*

The Medicare Part D feature was created as part of the federal Medicare Prescription Drug, Improvement, and Modernization Act passed on December 8, 2003. Part D is a voluntary, subsidized prescription drug benefit for Medicare enrollees that went into effect in January 2006. The plan is administered by the Centers for Medicare and Medicaid Services (CMS). Part D coverage typically includes a co-insurance arrangement. Seniors must pay up to the $310 deductible. After this stage, the senior makes copayments and the Part D plan pays its share until the combined amount, including the deductible, reaches $2,840. From this period up until $4,550, seniors are considered in the "Donut Hole." However, seniors will continue to get a 50 percent discount on many brand-name medications during this phase. Upon reaching $4,550, the drug plan will cover the majority of costs and seniors will make small copayments. This is known as catastrophic coverage. However, under Obamacare, seniors will be encouraged to unnecessarily choose more expensive branded products because of a fully government-subsidized insurance plan, significantly escalating the cost of treating seniors without actually and measurably increasing the quality of their care.

### *NC Health Choice for Children*

An SCHIP program that provides health insurance for children of low income families. The program covers children in families that earn too much to qualify for Health Check/ Medicaid, but whose income does not exceed 200 percent of the federal poverty level. Because the funds for NC Health Choice are set prospectively, i.e., prior to the start of each

budget year, the number of children eligible for the program is capped for each fiscal year. When the number of eligible children exceeds the enrollment cap, children are put on a waiting list. Benefits provided under NC Health Choice are equivalent to those provided under the state employees and teachers' health plan, except that NC Health Choice kids also get vision, hearing and dental coverage. NC Health Choice has been promoted as a tax-paid alternative for children without health insurance. The continued expansion of NC Health Choice, however, seems to have done little to reduce the rate of uninsured children in North Carolina. In fact, the number of uninsured children has risen since the inception of Health Choice. In 1998, 242,000 were uninsured. By 2009, that number had risen to 269,000.[8]

### *NC Kids Care*

A new SCHIP program designed to provide taxpayer subsidized insurance for children from families who earn between 200 percent and 300 percent of federal poverty level (FPL)(as of 2005, half of all families in North Carolina earned up to 300 percent of FPL). In order to enroll in NC Kids Care, children must be ineligible for any form of government sponsored health insurance, including Medicaid and Medicare. The FY2007-09 budget appropriated more than $7.3 million over two years to implement the program.

In August 2007, the Bush administration issued a new rule that requires states to cover 95 percent of low-income children (200 percent FPL) before using federal funding to cover children from families who earn more. Under this new policy, NC Health Choice would have to reach a 95 percent participation rate before the state would be eligible to receive federal funding for NC Kids Care.

### *Office of Minority Health and Health Disparities (OMHHD)*

A public health office within DHHS that researches and attempts to reduce real or perceived health disparities among minority groups. The OMHHD was established in 1992 by the North Carolina Legislature in order to eliminate health disparities, with the implication being that every racial (and socioeconomic) group should have equal health outcomes. The office defines leading health indicators that allegedly cause health disparities. Two of these indicators are poverty and median family income. Via the Minority Health Advisory Council, the OMHHD lobbies for initiatives, such as community-based syringe exchanges, that it believes will serve minority groups. The office also provides cultural diversity and interpreter training to health professionals. See also Health Disparity.

### *Public Health Expenditures*

As opposed to paying for individual healthcare, public health expenditures are used on research and to provide the public with health information. For FY2006-07, the Legislature appropriated $177 million for public health activities. According to a 2005 Public Health Improvement Plan, one of the primary goals of the state's public health policy is the elimination of health disparities. In order to implement this goal the report recommended significant spending increases for several programs, such as: increasing funding for school nurse services from $11.4 million to $48.7 million over a four-year period; expanding the state's chronic disease prevention program to $27 million; and allocating $747,000 for interpreter, language and cultural competency training for medical professionals. The report also suggested that the state assume responsibility for all Medicaid expenditures not funded by the federal government. In return, North Carolina's counties would be required to use their share of the Medicaid burden to fund public health programs.

### *SCHIP (State Children's Health Insurance Program)*

Created by the U.S. Congress in 1997 as a supplement to traditional Medicaid (§ XXI of the Social Security Act), SCHIP is a health insurance program for children in low income families. The program is jointly funded by the federal government and the states. Each state is operationally responsible for the program and can set its own eligibility rules at or above federal minimums. North Carolina exceeds federal rules for SCHIP, allowing families who earn up to 200 percent of FPL to qualify. The federal cap is 133 percent. Over the past ten years, enrollment in North Carolina's SCHIP program – NC Health Choice and Health Check – has rapidly expanded, going from 104,000 children in 2000 to 253,892 in 2010.[9]

The N.C. Department of Health and Human Services acknowledges, however, that the number of children on SCHIP is generally underestimated. Total 2010 SCHIP expenditures in North Carolina were $367 million, with the state paying 25 percent, or $91.9 million, of this amount. See also NC Health Choice for Children and Health Check.

### *Short Session*

The legislative session that convenes in even-numbered years. The session meets

from May to July (and often longer) in order to make adjustments to the biennial budget adopted during the long session.

### *Single-payer Healthcare/Insurance*

Under a single-payer healthcare system, the government, rather than individual patients or insurance companies, pays all healthcare costs. The cost of such a program can be approximated by looking at total national health expenditures, which were $2.5 trillion in 2009. The U.S. Department of Health and Human Services reports that taxpayers pay for 45 percent of these expenditures today. If Congress created a single-payer health insurance system, the additional cost to taxpayers would be in the trillions. In many countries, such as Canada, Great Britain and Sweden, universal health insurance has resulted in a lower quality of care, as well as supply shortages. Under such a program, state authorities would decide what benefits the single-payer insurance plan would provide. To guarantee that the government has full control over health resources, universal health plans not only outlaw private health insurance, but also often ban the private practice of medicine. Such a ban was a controversial feature of the 1994 "HillaryCare" plan, which would have forced all employers to provide health insurance to their employees.

### *Smart Start*

A social program whose stated goal is to "assist parents in their role as the primary caregivers and educators of young preschool children" by providing daycare services that help children enter school meeting minimum health and education preparedness standards. Unlike the federally funded Head Start program, which is open to low income 3- and 4-year-olds, Smart Start has broader eligibility and age requirements (up to age 6). While Smart Start explicitly claims it is not a childcare center, the program "helps make child care centers better through educational opportunities." Smart Start is primarily funded by the state, but local public-private partnerships have been given operational responsibility. A statewide nonprofit organization, the North Carolina Partnership for Children, exercises oversight over 79 local Smart Start partnerships, which operate in all 100 of North Carolina's counties. Under state law (cf. G.S. 143B-168.11-143.168.15), 70 percent of Smart Start funding must be used to provide direct childcare and educational services, with 30 to 50 percent being used for childcare subsidies. Each public/private partner is also required to raise at least 10 percent of its funding from private donors. For FY2010, the state allocated $188 million for Smart Start.

### *TANF (Temporary Assistance to Needy Families)*

TANF is a cash assistance and work opportunity program for low income families. Persons who qualify for TANF also qualify for Medicaid, although North Carolina has stricter eligibility rules for TANF than for Medicaid. Under the 1996 Welfare Reform Act, TANF replaced AFDC, the previous federal welfare program. TANF provides temporary cash assistance to needy families with children while encouraging adult providers to find employment. (TANF, for instance, imposes a five-year cap on welfare throughout a person's lifetime; albeit states are allowed to exempt 20 percent of their caseload from this five-year cap.) Unlike AFDC, TANF also encourages couples with children to marry and stay married. Although TANF is federally funded, each state pays administration costs of the program. Each state is also able to set eligibility requirements for TANF. In 2005, TANF cost U.S. taxpayers $14 billion. Of this, $251 million went to North Carolina, which allocated an additional $19.3 million to administer the program for 2005. Congress reauthorized TANF with the Deficit Reduction

Act of 2005 while also strengthening incentives for states to reduce TANF caseloads.

### *Universal Health Coverage/ Insurance*

Universal health coverage, as opposed to universal healthcare, makes it illegal not to have health insurance coverage, much the same way as it is illegal not to have car insurance. Unlike car insurance, the government subsidizes healthcare coverage for anyone who can't afford private insurance. Under Obamacare, individuals are required to purchase health insurance or pay a penalty. This mandate is the first time in history that individuals are required to purchase a product simply because they exist and breathe.

ENDNOTES:

1 For more information, see N.C. Department of Health and Human Services, "About the NC Department of Health and Human Services"; available from http://www.dhhs.state.nc.us/whoweare.htm.

2 These figures are for unduplicated eligibles.

3 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

4 http://www.statehealthfacts.org/profileind.jsp?ind=602&rgn=35&cat=7

5 http://www.statehealthfacts.org/profileind.jsp?sub=52&rgn=35&cat=4

6 http://www.statehealthfacts.org/profileind.jsp?ind=177&cat=4&rgn=35

7 https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_sheet.asp

8 http://www.statehealthfacts.org/chfs.jsp?rgn=35&rgn=1

9 http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=61&rgn=35

## 1 HOW DEPENDENT ARE WE? Federal Funding & North Carolina

Federal influence over state budgets increases almost every year. Today, every state is critically dependent on federal funds just to make ends meet. North Carolina is by no means an exception to this trend. According to the state's FY2006 Comprehensive Annual Financial Report, "The state receives significant financial assistance from the federal government in the form of grants and entitlements, which are generally conditioned upon compliance with terms and conditions of the grant agreements and applicable federal regulations, including the expenditure of the resources for eligible purposes."

Over the past several years, the state's dependency on federal dollars has grown at a steady pace. In FY1996, the federal government paid a quarter of every dollar of the state's total revenues. In FY2010, they contributed a full one-third of total state revenues.

Put differently: from 1996 to 2010, the state's total revenues from taxes, fees and other sources – including federal funds – increased by 139 percent; during the same period, federal funds distributed to the state of North Carolina grew by 205 percent.

The majority of federal dollars go to Medicaid and transportation – always with strings attached. In particular, states that accept federal funds must adhere to federal regulations regarding the use of this money. Take Medicaid, for example. North Carolina pays 35 percent of Medicaid expenditures,[1] with the federal government paying the remaining 65 percent. Until recently, the counties paid a small percentage as well but the county share was phased out on July 1, 2009. The state must also provide all the services that are specified by federal mandates. The result is a loss of control over who the state can and cannot cover.

Federal funding also hinders states from exercising financial independence by preventing cuts in services that a state no longer wants or can no longer afford. By being forced to subsidize these services, state expenditures become automatic – preparing the way for virtually automatic tax increases. As federal money pays for a larger and larger share of the state budget, voters and taxpayers in North Carolina have less and less say in how to run the state's business. In addition to limiting financial independence, federal dollars are also used to force certain social agendas – for instance, regarding tax-paid healthcare, abortion, or the environment – on the states.

If current trends continue, federal funding may overtake state revenue as the state's single largest revenue source in the not too distant future.

**Federal Taxes Paid vs. Federal Spending Received:**
**North Carolina, 1981-2004**

| | Total Dollars ($millions) | | Dollars Per Capita | | | | | |
|---|---|---|---|---|---|---|---|---|
| Year | Federal Taxes Paid to Washington, D.C. | Federal Spending Received | Federal Taxes Paid to Washington, D.C. | State Rank (1 is highest) | Federal Spending Received | State Rank (1 is highest) | **Federal Spending Received Per Dollar of Tax Paid** | **State Rank (1 is highest)** |
| 1981 | $11,799 | $11,189 | $1,986 | 41 | $1,884 | 48 | $0.97 | 30 |
| 1982 | $12,186 | $11,951 | $2,030 | 41 | $1,991 | 48 | $0.96 | 31 |
| 1983 | $12,158 | $12,874 | $2,005 | 40 | $2,124 | 50 | $0.90 | 35 |
| 1984 | $13,981 | $13,626 | $2,276 | 37 | $2,218 | 49 | $0.88 | 43 |
| 1985 | $15,653 | $15,005 | $2,512 | 35 | $2,408 | 50 | $0.88 | 42 |
| 1986 | $16,693 | $15,746 | $2,648 | 34 | $2,498 | 50 | $0.86 | 42 |
| 1987 | $18,623 | $16,598 | $2,918 | 35 | $2,600 | 48 | $0.90 | 40 |
| 1988 | $19,997 | $17,743 | $3,095 | 35 | $2,746 | 47 | $0.93 | 37 |
| 1989 | $22,252 | $19,106 | $3,400 | 32 | $2,920 | 48 | $0.91 | 37 |
| 1990 | $22,826 | $20,573 | $3,438 | 33 | $3,099 | 48 | $0.92 | 36 |
| 1991 | $23,630 | $23,570 | $3,499 | 33 | $3,490 | 47 | $0.95 | 33 |
| 1992 | $24,899 | $26,172 | $3,625 | 34 | $3,810 | 47 | $0.95 | 33 |
| 1993 | $26,932 | $27,352 | $3,844 | 33 | $3,904 | 48 | $0.92 | 37 |
| 1994 | $29,778 | $28,739 | $4,164 | 33 | $4,019 | 47 | $0.93 | 39 |
| 1995 | $32,233 | $30,692 | $4,412 | 33 | $4,201 | 46 | $0.95 | 36 |
| 1996 | $34,664 | $33,370 | $4,646 | 33 | $4,472 | 42 | $1.01 | 29 |
| 1997 | $38,043 | $34,592 | $4,994 | 33 | $4,541 | 39 | $1.01 | 29 |
| 1998 | $41,615 | $35,744 | $5,355 | 31 | $4,600 | 40 | $1.01 | 31 |
| 1999 | $43,870 | $37,482 | $5,543 | 32 | $4,736 | 41 | $1.02 | 31 |
| 2000 | $47,692 | $41,414 | $5,928 | 32 | $5,147 | 37 | $1.08 | 27 |
| 2001 | $46,717 | $44,602 | $5,721 | 32 | $5,462 | 37 | $1.07 | 30 |
| 2002 | $44,019 | $48,180 | $5,318 | 34 | $5,820 | 39 | $1.06 | 29 |
| 2003 | $42,190 | $51,766 | $5,080 | 34 | $6,232 | 38 | $1.08 | 26 |
| 2004 | $44,476 | $55,233 | $5,306 | 36 | $6,590 | 35 | $1.10 | 27 |

Note: During fiscal years in which the federal government runs deficits some spending is financed through borrowing. This creates implicit tax liabilities for states that must be repaid eventually. To incorporate these implicit tax liabilities into the analysis, the following adjustment was made to state tax burdens: First, the total federal tax burden is increased by the size of the federal deficit. Next, this total burden is allocated among states based on each state's proportion of the actual federal tax burden. Finally, adjusted spending-per-dollar-of-tax ratios are calculated by dividing actual expenditures by the adjusted tax figure, effectively making figures deficit neutral.

Source: Tax Foundation Special Report No. 139, "Federal Tax Burdens and Spending by State," and U.S. Census Bureau's Consolidated Federal Funds Report for 2004.



WHAT ARE THEY AND HOW MUCH DO THEY COST?

# 2 Coverage Mandates

**What Are They**?

A coverage mandate is a legal requirement that dictates all health insurance policies sold in North Carolina must cover certain services, providers, and groups of people. Mandates are the result of laws passed by the General Assembly as a means of regulating the insurance market. An insurance provider is not allowed to register an insurance plan in North Carolina unless that plan meets all of the state's coverage mandates. As a direct consequence, consumers cannot buy insurance that does not meet the state's coverage mandates. As an indirect consequence, navigating the regulatory waters of a given state becomes more difficult for insurers, which in turn raises barriers to entry into the marketplace.

Insurance buyers pay for coverage mandates through higher insurance premiums. While some mandates do not affect the price of insurance by much, others are more costly. North Carolina has 52 mandates, which together have increased the price of health insurance significantly.[2]
Overall, two forms of mandates exist, those for private health insurance carriers and those that pertain to state Medicaid programs. We focus here on private insurance mandates. As regards the private insurance market, mandates differ according to whether they apply to benefits, providers or persons:

- Benefits mandates determine what health benefits an insurance plan must cover. Some of the most common benefits mandates cover alcoholism, breast reconstruction, diabetic supplies and mammograms.
- Provider mandates force insurance buyers to pay for various specialists that many consumers will never see. Some of the more common provider mandates are for services provided by chiropractors, psychologists and optometrists.
- Person mandates dictate who must be covered by an insurance plan, in addition to the buyer himself. The most common category is coverage for newborns. Some states mandate coverage for adopted children, dependents and employees.

As of 2010, no two states required identical sets of coverage mandates, with the result that insurance providers cannot sell the same insurance policy to residents of different states. Accordingly, mandates increase costs for insurance providers, who must tailor their plans to the individual mandates applicable in each state. By preventing interstate competition, mandates contribute to higher prices for consumers, and thus also to increases in the number of uninsured persons.

In particular, mandates have a disproportionate impact on smaller businesses and individuals who purchase their own health insurance. Thanks to the Employment Retirement Income Security Act (ERISA), companies that self-insure, or provide their own health insurance plan to employees, are exempt from state mandates. Likewise, Medicaid is exempt, as is the Teachers and State Employees' Comprehensive Major Medical Plan (State Health Plan). It should be noted, though, that the State Health Plan provides much of the coverage mandated of private insurers.

As of 2010, the number of mandates imposed by each state varies considerably, from 13 in Idaho to 69 in Rhode Island. With 52 mandates, North Carolina has nine more than the national average. North Carolina is one of only 15 states that had 50 or more mandates. North Carolina's overall uninsured rate (as of 2007) was 16.6 percent. By comparison, Idaho, with the lowest amount of mandates had an uninsured rate of 14.7 percent. Florida, with 49 mandates – similar to the number in North Carolina – had an uninsured rate of 20.5 percent. This disparity is most likely due to the fact that all mandates are not equal. Some mandates have a much greater financial impact on health insurance than others. For example, a mental health parity mandate may have a greater impact on premium prices than a mandate for an inexpensive or preventative measure.

Coverage mandates are often defended under the rubric of consumer protection; the implication is that, without mandates, consumers would not be able to obtain a "necessary" level of insurance coverage. People often disagree, however, as to what types of coverage are necessary (e.g. chiropractors) with the result being that the implementation of new mandates is sometimes subject

to undue influence by special interests. One thing is clear, however: by making insurance more expensive, mandates hurt those consumers who are priced out of the market altogether.

Similarly, coverage mandates are sometimes employed as a surreptitious means of driving healthcare policies that many people do not support. In 1999, for instance, North Carolina became one of the first states to require insurance coverage for contraceptives or "family planning services." Although churches and related institutions are exempt from the mandate, the law discourages small business owners who object to contraception from offering health insurance to their employees.

Moreover, several of North Carolina's mandates are either very expensive or are relatively rare. Consider that:

- Four of the most expensive mandates cover services provided by chiropractors, dentists, psychologists and social workers. These mandates alone add an estimated 10 percent to the premium cost of health insurance.
- Six of the rarest mandates, required by 15 or fewer states, add about 3 percent to the cost of a premium: birthing centers/midwives (6 states); bone mass measurement (15); cleft palate (14); marriage therapists (13); pastoral counselors (2); and pharmacists (5).

Proponents of coverage mandates argue that such laws are necessary in order to provide insurance coverage for consumers who cannot otherwise obtain certain medical services.[3] They also argue that mandated coverage for preventative care, such as routine mammograms, saves money in the long run by facilitating the early detection of serious diseases. Early detection and intervention can prevent more costly and invasive procedures down the road. Similarly, some mandates save money by allowing patients to see a less expensive provider – a nurse practitioner, for instance, instead of a doctor.

But even without mandates in place, insurance companies are not likely to offer policies that do not include preventative care and lower-cost service providers. That means such mandates would be offered without government intervention.

Many mandates, however, are inefficient and costly, and serve special interests more than the general public. Consider the following:

- North Carolina's 52 coverage mandates require coverage for pastoral counselors, marriage therapists, drug abuse treatment, contraceptives, chiropractors, clinical trials, and cleft palate. Yet many consumers will never use these services, and some business owners would prefer not to provide coverage for them.
- Mandates are not necessarily aligned with medical research. One example is the mandated frequency of certain diagnostic tests. The U.S. Preventive Services Task Force recommends that women be screened for cervical cancer every three years for a 91 percent reduction in the incidence of invasive cervical cancer. Some states,[4] however, require annual screening, which reduces the incidence of invasive cancer by two percentage points, but costs three times as much.[5]

**2010 North Carolina's Health Insurance Mandates**

| | States | Cost | | States | Cost |
|---|---|---|---|---|---|
| **BENEFITS** | | | **PROVIDERS** | | |
| Alcoholism/Substance Abuse | 46% | 1% to 3% | Birthing Center/Midwife | 12 | <1% |
| Bones Mass Measurement | 16 | <1% | Chiropractor | 44 | <1% |
| Breast Reconstruction | 50 | <1% | Dentist | 33 | 3% to 5% |
| Cervical Cancer/HPV Screening | 31 | <1% | Marriage/Family Therapist | 17 | <1% |
| Cleft Lip and Palate | 17 | <1 % | Nurse | 11 | <1% |
| Clinical Trial (Cancer) | 28 | <1% | Nurse Practitioner | 29 | <1% |
| Colorectal Cancer Screening | 34 | <1% | Psychiatric Nurse | 18 | <1% |
| Contraceptives | 29 | 1% to 3% | Optometrist | 41 | 1% to 3% |
| Dental Anesthesia | 31 | <1% | Pastoral Counselor | 3 | <1% |
| Diabetes Self-Management | 38 | <1% | Pharmacist | 6 | <1% |
| Diabetic Supplies | 47 | <1% | Physician Assistant | 15 | <1% |
| Drug Abuse Treatment | 34 | <1% | Podiatrist | 33 | <1% |
| Emergency Room Service | 45 | <1% | Professional Counselor | 17 | <1% |
| Lymph Edema | 3 | <1% | Psychologist | 44 | 1% to 3% |
| Mammography Screening | 50 | <1% | Public or Other Facility | 19 | <1% |
| Mastectomy | 25 | <1% | Social Worker | 26 | 1% to 3% |
| Mastectomy Minimum Stay | 25 | <1% | | | |
| Maternity | 22 | 1% to 3% | **COVERED PERSONS** | | |
| Maternity Minimum Stay | 50 | <1% | Adopted Children | 44 | <1% |
| Mental Health General | 42 | 1% to 3% | Continuation Dependent | 45 | <1% |
| Mental Health Parity | 48 | 5% to 10% | Continuation Employee | 46 | <1% |
| Newborn Hearing Screening | 18 | <1% | Conversion to Non-Group Coverage | 41 | 1% to 3% |
| Off-Label Drug Use | 36 | <1% | Foster Children | 2 | <1% |
| Ovarian Cancer Screening | 7 | <1% | Disabled Dependent Adult | 42 | 1% to 3% |
| Prostate Cancer Screening | 36 | <1% | Newborn | 51 | 1% to 3% |
| TMJ Disorder | 19 | <1% | | | |
| Well Child Care | 33 | 1% to 3% | | | |

"States" = number of state with some version of this mandate (includes District of Columbia)
List of mandates is derived from Council for Affordable Health Insurance

Source: http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf

## How Much Do They Cost?

The additional cost of coverage mandates varies. Some mandates add less than 1 percent to the cost of an insurance premium. Others – such as mental health parity and prescription drug coverage – add up to 10 percent. North Carolina has recently added mental health parity to its list of mandates, while all of the other mandates are not estimated to add more than five percent to the cost of a policy. The cumulative effect of adding one mandate after another, however, can add up to a significant increase in price.

- The higher insurance costs due to coverage mandates may also affect the willingness of small businesses to purchase health insurance for their employees and of individuals to purchase insurance for themselves. Looking at states with many mandates – compared to those with few – one finds a positive correlation between the number of mandates imposed and the percentage of uninsured individuals in that state.[6] In other words, mandates can

price people out of the health insurance market, leaving them uninsured. When these individuals get emergency care, the bill is paid by taxpayers.

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, much in the same way individual consumers can buy a car that has more options than the standard model. Lawmakers might also consider the following reforms being implemented in other states:

- **Mandated offers**. Some states mandate that insurance companies offer to cover certain benefits. This guarantees that the benefits are available, but the choice of whether to pay for the coverage is made by the individual. Virginia, for example, mandates that insurers offer coverage for bone marrow transplants, child health supervision services, and treatment for morbid obesity. There is some concern, however, that mandated offers will lead to adverse selection, driving up the cost of these benefits for purchasers who do opt to include them.
- **"Mandate Light"** is a relatively new method employed by some states to ease the cost burden of state coverage mandates. As of 2006, eight states – including Arkansas, Florida, Georgia, and Kentucky – have introduced "flexible benefits" plans in which people can enroll at lower cost. The cost savings from these plans are usually reported to be less than 10 percent compared to full benefits plans, and enrollment to date has been low. If more states added mandate-light options, however, the market for these plans could become more competitive, driving down costs.
- **Analysis of impact**. At least 30 states require an analysis of the impact of existing or proposed mandates on health insurance premiums.[7] Virginia and Maryland, for example, analyze the cost of all mandates.

## 3 HOW CAN WE LOWER COST? The Uninsured

In 2005, 1.1 million, or 18 percent, of working age North Carolinians were without health insurance. (Some of these persons lacked insurance for part of the year while others were uninsured the entire year.) Additionally, 262,000 children were uninsured.

Many people do not have insurance because they cannot afford it, including those that enjoy a relatively high income; some simply choose not to buy it for other reasons. According to U.S. Census data, in 2005 almost one in five of North Carolina's 1.3 million uninsured earn more than $75,000 per year; 40 percent of uninsured individuals make more than $46,300, the median household income in North Carolina. According to the Kaiser Family Foundation, a health plan for an average family costs an average of $833 per month, or almost $10,000 a year. But in North Carolina health insurance is more expensive than in other states because of costly state regulations.

Decreasing the state's regulatory burden would not only permit more families to buy their own health insurance, but also:

- Lead to lower premiums for those who already have insurance; and
- Enable more businesses to offer health insurance to their employees.

While many people are forced to choose between higher take-home pay or health benefits, several factors frustrate this decision 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.

This is primarily because each state requires health plans to meet a complex set of coverage mandates (See Q&A #2). The more mandates, the more expensive the policy. No two states have the same set of coverage mandates. (North Carolina has 52 as of 2010). Regulatory compliance is one reason why only a limited number of insurance providers can sell health insurance in North Carolina.

For example: a family with three children in Raleigh who wants to purchase a plan with a deductible less than $3,000 and no coinsurance will only be able to choose from three plans. These plans cost up to $7,500 per year, but do not cover dental care or visits to medical offices before the deductible is met. Once dental and doctor's visits are factored in, the total cost easily reaches $10,000 per year, including the deductible.

The lack of competition among insurance providers in North Carolina also causes premiums to rise faster than inflation. Recent data shows that health insurance premiums nationwide increased at four times the rate of inflation from 2000 to 2007.

Some suggest there would be fewer people without insurance if the federal and state governments expanded Medicaid. U.S. Census data on health insurance coverage suggests the opposite. Indeed, there is an apparent inverse relation between Medicaid expansion and reduced rates of health insurance. For the past several years, Medicaid enrollment has expanded significantly in North Carolina, with the share of people on Medicaid tripling from 1987 to 2005. At the same time, the number of North Carolinians without insurance increased by one-third.

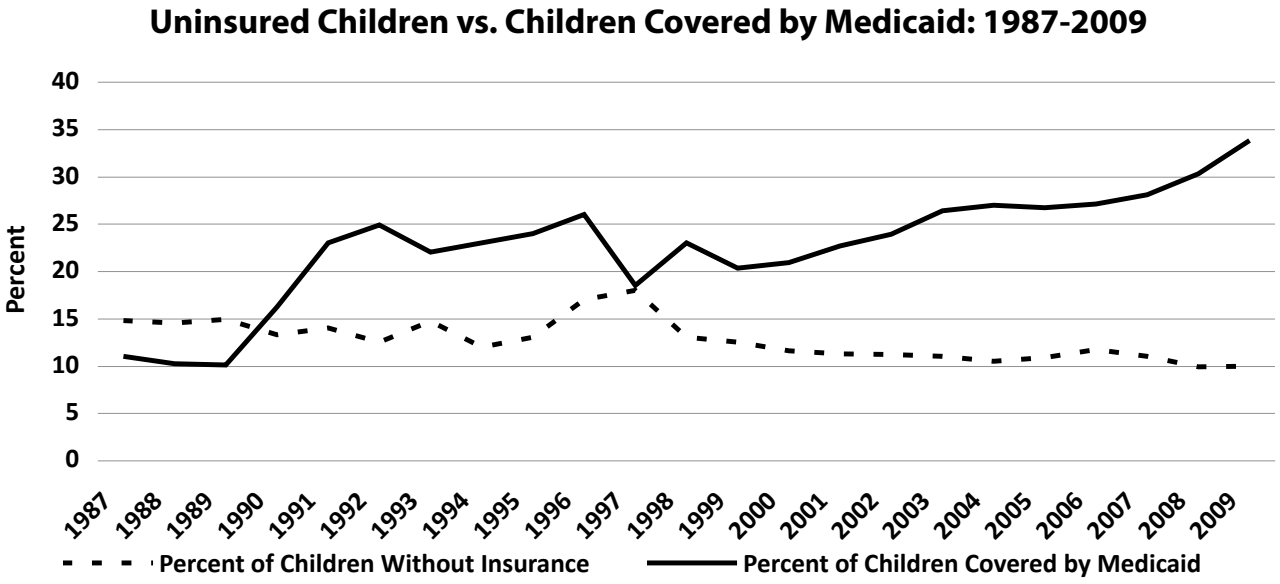
Only among children has there been a slight decline in the rate of uninsured. But this decrease has come at a steep price in the form of higher Medicaid spending. An 18 percent drop in the number of uninsured children correlates with a 147 percent increase in the number enrolled in Medicaid. That means a 1 percent decrease in the uninsured rate requires an 8 percent increase in Medicaid enrollment. Tax-paid health insurance, in other words, is a very inefficient method of reducing the rate of uninsured.

The expansion of Medicaid not only entails higher federal and state taxes, it also causes higher insurance premiums for working families. More kids on Medicaid means fewer kids on private insurance. Yet because children are considered a low risk for insurance providers, a family can almost always insure their own child cheaper with a private plan than if the child is covered by Medicaid. Take our Raleigh family as an example: their premiums would remain the same if they decided not to include their children under their policy. By contrast, adding three more kids to Medicaid would cost North Carolina taxpayers more than $4,500 per year. Thus, expanding Medicaid coverage for children is less efficient than simply permitting more families to purchase affordable health insurance coverage for themselves.

The point is that when children are offered "free" insurance through Medicaid, it drives up the premiums for their parents, who then may not be able to afford coverage at all. Moreover, since insurance providers are left with a pool of relatively high-risk buyers, they have to raise premiums for everybody. Therefore, even individuals and couples with no kids benefit if children are enrolled on their parents' own private insurance plan.

The real solution to expanding health insurance coverage in North Carolina lies in reducing costs for everyone. In particular, North Carolina should lower its number of coverage mandates. By doing so, the state would not only reduce the price of insurance sold by providers within the state, but also make it possible for families to buy insurance from states that have the same number and type of mandates. For example, families who buy health insurance in the District of Columbia only have to pay for 17 coverage mandates. Additional coverage is available but is not mandated.

If North Carolina similarly reduced its number of mandates from 52 to 17, the average family could see a roughly 25 percent reduction in their health insurance premium. If the state took the further step of permitting families to buy health insurance from other states, increased competition would push costs down even more.

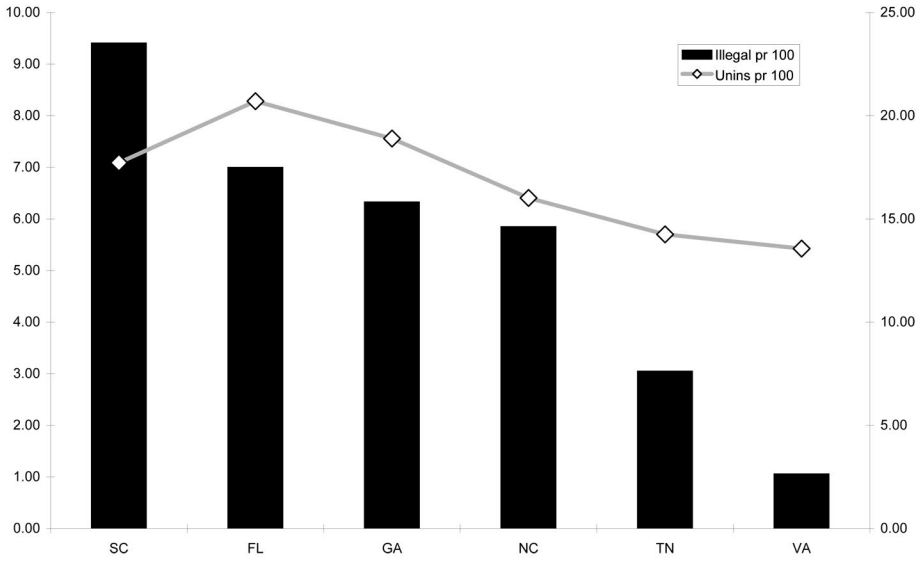


## 4 HOW MUCH DOES IT COST? Healthcare for Illegal Aliens

Recent estimates of illegal aliens in North Carolina range from 300,000 (according to the Pew Hispanic Center) to more than 1 million (as based on border apprehension counts). According to the Pew Hispanic Center, the vast majority – 78 percent – of illegal aliens are Hispanic. During the 1990s, North Carolina's Hispanic population increased 393 percent – the fastest growing of any state in the country.[8] These trends have continued into the new century, with North Carolina having the third-fastest growing Hispanic population in the United States as of 2007.

Illegal workers who pay into the federal tax system do so via payroll contributions to Social Security, Medicare and unemployment insurance. They also pay sales taxes and other taxes that go into state and local coffers. Nevertheless, most illegal aliens hold low-wage jobs that translate into low tax revenue per capita. Moreover, while many of the taxes paid by illegals are collected by the federal government, state and local governments are disproportionately responsible for providing many of the services consumed by illegals.[9]

**Uninsured and Illegal Aliens, Southeast States, 2005**




Yet even at the federal level, illegal aliens use more in services than they contribute in taxes. According to a 2004 study by the Center for Immigration Studies: "Households headed by illegal aliens imposed more than $26.3 billion in costs on the federal government in 2002 and paid only $16 billion in taxes, creating a net fiscal deficit of almost $10.4 billion, or $2,700 per illegal household." These conclusions are in line with a 1997 study by the National Research Council.[10]

As far as healthcare costs go, the Federation for American Immigration Reform (FAIR) estimated that, as of 2004, more than 3.5 million aliens were covered by Medicaid. FAIR likewise reports that "in some hospitals, as much as two-thirds of total operating costs are for uncompensated care for illegal aliens."[11] According to research by the *News & Observer*, North Carolina had more than $1.4 billion in unreimbursed hospital costs in 2003;[12] a significant share of these costs resulted from care given to uninsured illegal aliens. Of course, unrecouped costs reappear in the prices of goods and services of those who pay for their own healthcare.

The precise cost of providing healthcare to illegals is difficult to determine, however, primarily because medical professionals generally do not ask whether patients are in the United States legally.

Statistics submitted by WakeMed Faculty Physicians, an OB/GYN practice in Wake Forest, indicate that 40 percent of the babies it delivered were born to illegal aliens. Each birth cost between $6,800 and $18,000. In most cases, the tab was picked up by taxpayers through Emergency Medicaid.[13]

Indeed, 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 aliens 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 aliens also increased rapidly. Overall, state Medicaid spending for illegals more than doubled between 2000 and 2005, going from $25.8 million to $52.8 million.[14]

The RAND Corporation, a nonprofit public policy think tank, estimates that while one-fifth of illegal aliens have health insurance the cost of providing healthcare for the other 80 percent is high. Most of this cost is absorbed by hospitals that are then compensated through Medicaid. This results in higher taxes for U.S. citizens, as well as higher hospital costs for privately insured patients.

## 5 SHOULD IT BE PRIVATIZED? Vocational Rehabilitation

The Division of Vocational Rehabilitation (DVR) within the Department of Health and Human Services had a budget of $128.5 million for FY2006-07. DVR provides counseling, training, education, medical, transportation and other support services to persons with various disabilities. The aim of DVR is to help handicapped people become self-sufficient.

One of the main DVR programs is Independent Living, which assists people with disabilities in finding, establishing and maintaining the greatest possible degree of independence in their own home and daily routines. For FY2005 the Independent Living program had a budget of $17 million, which was used to serve 2,341 clients. This amounts to $7,262 per individual. In FY2006, the number of clients served dropped to 2,271 while the cost per individual increased by 4 percent.

Privatizing the Independent Living program along federal guidelines, however, would enable taxpayers to help more people at a lower cost. Since 2004, for example, the Social Security Administration has implemented a Ticket to Work program for people with disabilities. The program provides eligible individuals with a ticket that entitles the individual to vocational rehabilitation and job training, among other services, from private providers. The idea here is that private entities and employers are better suited to create the right solutions for Ticket to Work holders than is the government. Initially, 13 states participated in this program to privatize vocational rehabilitation. North Carolina was not one of those states. North Carolina has thus far not joined the Ticket to Work program, which could help lower the costs of vocational rehabilitation in the state.

## 6 WHY DO THE NUMBERS KEEP RISING?
# Uninsured Children

The number of uninsured children in North Carolina is slowly rising. While the increases are not dramatic, they are a cause for concern. In 2009, there were 276,000 children without health insurance (for all or part of the year) in North Carolina. This is a large number, but in 1997 as many as 330,000 kids were uninsured. That number was an all-time high, both in absolute numbers and as a percentage of North Carolina children (18.1 percent). By contrast, in 2009, only 11.8 percent of the state's children were uninsured. But while more children are insured today than in 1997, the number of uninsured kids dropped to 203,000 in 2000. Since then it has gone up and down, but the long-term trend is weakly upward:

**Children in North Carolina (thousands)**

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total** | 1,828 | 1,830 | 1,890 | 2,010 | 2,115 | 2,049 | 2,082 | 2,145 | 2,205 | 2,198 | 2,247 | 2,318 | 2,335 |
| **Medicaid** | 350 | 409 | 363 | 449 | 537 | 554 | 632 | 514 | 588 | 654 | 677 | 707 | 744 |
| **Private** | 1,142 | 1,211 | 1,318 | 1,370 | 1,384 | 1,224 | 1,227 | 1,405 | 1,403 | 1,131 | 1,177 | 1,223 | 1,131 |
| **Uninsured** | 330 | 242 | 227 | 203 | 230 | 261 | 249 | 220 | 262 | 307 | 272 | 216 | 276 |

**Here are the numbers given as a percentage of the total number of North Carolina children:**

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medicaid** | 19.1% | 22.3% | 19.2% | 22.3% | 25.4% | 27.0% | 30.4% | 24.0% | 26.7% | 29.8% | 30.1% | 30.5% | 31.9% |
| **Private** | 62.5% | 66.2% | 69.7% | 68.2% | 65.4% | 59.7% | 58.9% | 65.5% | 63.6% | 56.2% | 57.8% | 60.2% | 56.3% |
| **Uninsured** | 18.1% | 13.2% | 12.0% | 10.1% | 10.9% | 12.7% | 12.0% | 10.3% | 11.9% | 14.0% | 12.1% | 9.3% | 11.8% |

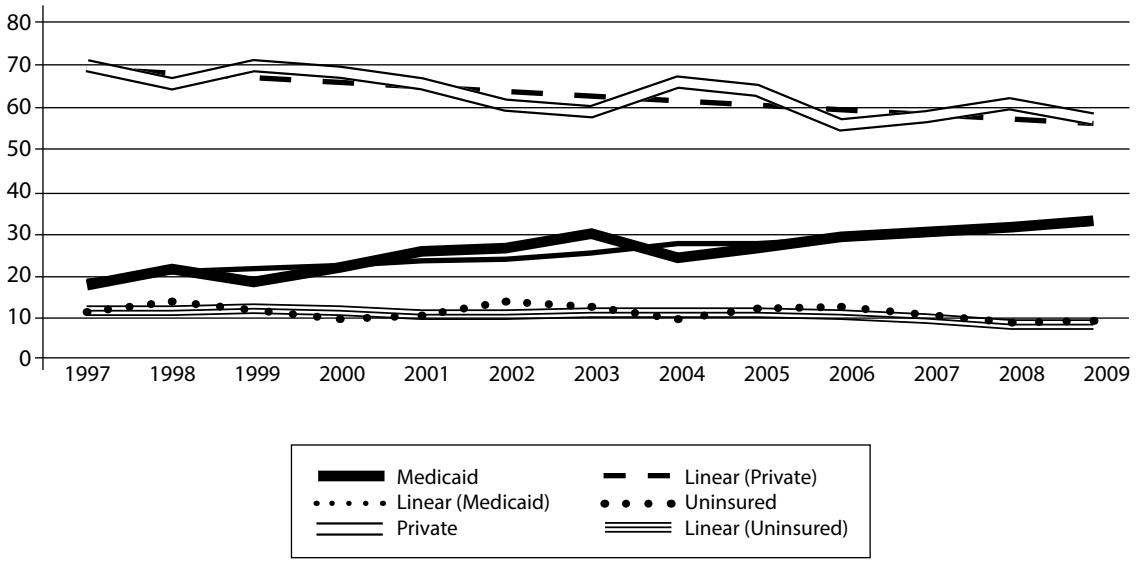
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see www.census.gov/apsd/techdoc/cps/cpsmar10.pdf[PDF].

These numbers reveal two plausible explanations as to why the number of uninsured children is slowly rising. The first explanation is the increase in health insurance premiums. While many factors are driving up healthcare costs, part of the explanation lies with coverage mandates and other government regulations that drive up the price of insurance. As prices have risen, it has become increasingly expensive for families to purchase insurance for themselves, including their children. This phenomenon has also forced small businesses to drop insurance plans or make such plans so expensive that working families cannot afford them.

The second explanation for the high number of uninsured children lies in the long-term expansion of Medicaid. As more and more children become eligible for Medicaid, there are fewer and fewer children left for private providers to insure. Since children are a relatively low risk, they are less expensive to insure. Thus when children are taken out of the pool of potential insurance consumers, the price rises for everyone, including families whose children are not eligible for Medicaid. As a result, fewer and fewer "marginal" families can afford to cover their children.

Since the expansion of Medicaid does not solve the problem of uninsured children, it is clear that more government is not a solution to the problem, but is part of the problem. A sustainable solution to the uninsured problem lies in restoring well-functioning private health insurance markets.

**Insurance Status of Children in North Carolina: 1997-2009**




WILL IT HELP BUSINESSES BUY HEALTH INSURANCE FOR THEIR EMPLOYEES?

## 7 Small Business Tax Credit

One of the problems with tax breaks is their tendency to end, as is the case with the recently passed small business health insurance tax credit (S.L. 2006-66), which expired on January 1, 2009. Most businesses think farther ahead than the next couple of years. If a tax break will allow them to take on new permanent expenditures, but the tax break is set to end in a year or two, then they will very often choose to do nothing. In this case, only a permanent tax cut may have the desired effect.

The idea of offering businesses incentives to insure their employees, however, raises a deeper question. The U.S. tax system favors employer-based insurance. For example, a recent study by the National Center for Policy Analysis shows that private individuals only pay 14 percent of total health costs out of pocket. This fact likely motivates some people to obtain healthcare services they don't really need. The tax system contributes to this overconsumption by favoring employer-based, employer-paid insurance plans. At the same time, the U.S. tax system discourages consumers from shopping around for more affordable plans. With less competition, prices (insurance premiums) inevitably become higher.

A better way to help small businesses buy coverage for their employees is to create a national health insurance market. In previous years, legislation that would permit the creation of a national market where small businesses can pool together and buy health insurance has been introduced at the national level. This could also be done at the state level. If North Carolina lifts the coverage mandates that it imposes on private health plans, and allows small businesses to buy health insurance nationally, the price of premiums will come down and each company will be able to find a plan that meets its specific needs and budget.

ANOTHER STEP TOWARDS UNIVERSAL HEALTH INSURANCE IN NORTH CAROLINA?

# 8 NC Health Choice

Possibly. NC Health Choice is a government-run, tax-paid health insurance program for children in families earning up to 200 percent of the federal poverty level (FPL). Legislation in the state budget for biennium 2008-2009 created a $7 million-plus NC Kids' Care program that expanded coverage to some 12,000 more children of families earning up to 300 percent of the poverty limit. That means families earning as much as $61,950 for a family of four – an income level that includes half of all families in North Carolina – are now eligible for state-subsidized insurance.

If the state wanted to turn NC Health Choice into a universal child health insurance program, it would have to take three steps. First, it would have to remove the income cap and make all children eligible, regardless of how much their parents earn. NC Kids' Care gets us halfway there.

Some states already apply higher income caps. Maryland, for example, has a program, similar to NC Kids Care, that employs an income cap of 300 percent of FPL. Similarly, Connecticut sets its income cap so high that half of all households in the state are eligible for taxpayer-subsidized insurance for kids. In short, the higher the income cap, the more children will enroll.

The second step toward making NC Health Choice a universal program would be to eliminate the application process. Today the statutory processing time for an application is 45 days. In turn, children eligible for NC Health Choice are enrolled one year at a time. If the application wait time, or the reenrollment process, were eliminated, more children would enroll in the program.

As part of eliminating the application process, the state would also have to eliminate the enrollment cap. Today NC Health Choice limits the number of children who can enroll based on a pre-set budget. With universal coverage, the state would no longer be able to limit enrollment numbers. As a result, however, the General Assembly would have much less control over spending for the program.

A final dimension to consider is coverage. In order to make universal coverage feasible, the state would ultimately have to make enrollment mandatory for all children. This would be tantamount to outlawing private insurance plans for children. Such models have traditionally been used in parts of Europe and are also currently in place in Canada. Likewise, President Bill Clinton's 1994 Health Security Act proposed criminalizing private healthcare.

# 9 Universal Healthcare

WHAT ARE THE MAIN DIFFERENCES BETWEEN A SINGLE-PAYER HEALTH INSURANCE SYSTEM AND MARKET-BASED HEALTH INSURANCE?

There are four key differences between a single-payer system and a market-based system.

- **Funding**. A single-payer health insurance system is funded by tax money via appropriations from the government. In a private health insurance system consumers pay for their own insurance in the form of premiums, either directly – as with car insurance – or indirectly via employee/employer contributions.
- **Coverage.** Under a single-payer system, legislators would decide what medical conditions and treatments the plan should cover. Because the government holds a monopoly, it is difficult for them to exclude contested or controversial medical procedures, such as abortion or "sex reassignment" surgery. A private health insurance market allows each insurance buyer to find and purchase the plan that best meets his needs, preferences and budgets. Consumers who think abortion is murder, for example, can choose to buy a plan that does not cover abortions.
- **Physician choice.** A single-payer system, in which the government funds the entire plan, also leads to a government monopoly over the supply of medical professionals. Under such a system, the government regulates the number of medical specialists and can also require patients to have a referral from a general practitioner (also known as a gatekeeper) before they can see a specialist. In a market system, private plans often let patients decide to see a specialist without a referral. Medical specialists will decide what insurance plans they accept based primarily on what reimbursement rates the plans offer. Insurance buyers can take into account what specialists accept a plan when they choose what plan to buy.
- **Supply constraints**. Single-payer systems in Europe and Canada tend to constrain the supply of medical services in order to rein in costs. This leads to long waiting periods, especially to see a specialist. The Canadian Supreme Court ruled in July 2005 that Canada's single-payer insurance system was unconstitutional because of such long waiting lists. A market-based system does not have these kinds of problems. To the extent that a private plan restricts access to medical specialists, it is because the plan does not pay such specialists enough. While a cheap private health insurance plan may not offer its buyers access to a full range of specialists, the free market does give the buyer opportunities to choose his own plan.

## 10 WHAT IS IT? Medicaid Swap

In an agreement included in the FY2007-08 budget (S.L. 2007-323), the state assumed the county share of Medicaid costs in a plan to be phased in over three years. Prior to the new law, North Carolina was one of only three states that required counties to pay a significant portion of the non-federal share of Medicaid funding. Effective October 1, 2007, the county share was reduced from 15 percent to 11.25 percent and then to 7.5 percent, effective July 1, 2008. The cost to the state was estimated at $86.2 million (recurring) for FY2008 and $271.2 million (recurring) for FY2009. In exchange for their Medicaid burden being lifted, counties transferred ½ cent of their 2 ½ cent sales tax revenues to the state.

Low-income, rural counties that have a high concentration of Medicaid recipients will benefit most from the swap. In these counties, foregone sales tax revenue will be much less than the Medicaid burden passed along to state taxpayers. Conversely, more urban, affluent counties, such as Wake and Mecklenburg, that have lower rates of Medicaid recipients and a growing sales tax revenue stream, will theoretically lose money from the swap. The budget, however, included a "hold harmless" provision that will use state funds to reimburse those counties that lose money under the new plan. The anticipated Medicaid burden for counties alone was expected to reach $571 million for FY2008.

## 11 HOW TO REIGN IN GROWING COSTS? Long-term Care Financing

Long-term care (LTC) consists primarily of care for the elderly in nursing homes and assisted living facilities, as well as in-home assistance. Medicaid dollars fund the vast majority of such services in North Carolina, reaching $2.7 billion in FY2005, up 45 percent from 2000. As such, long-term care spending represents the largest portion of North Carolina's Medicaid budget, consuming one-third of the program's $8.2 billion expenditures in FY2005. Similarly, according to a report by the John Locke Foundation: "Between 1980 and 2004, Medicaid expenditures for nursing home care grew from $176 million to $1.5 billion, nearly a tenfold increase. … In the same period, Medicaid home health care expenditures in the state grew from $1 million to $379 million, an annual growth rate of 17.1 percent."

One problem with long-term care is that patients who could otherwise afford such care sometimes turn to Medicaid to pay for it. Three reforms could help address this problem:

1. Lower the LTC exemption. Medicaid exempts significant amounts of wealth and assets when calculating eligibility for long-term care support. Lowering this threshold will create savings to expand the program to those who truly need it.
2. Increase efforts at Medicaid estate recovery. If the state increased the recovery rate of Medicaid expenditures to the national average, it could increase revenues by $10 million.
3. Promote and further educate citizens about the state income tax credit (S.L. 2007-323) for the purchase of private long-term care insurance.

# 12 WHAT IS IT, AND DOES IT INTRUDE ON INDIVIDUAL RIGHTS?
# The Patient Protection and Affordable Care Act (Obamacare)

The Patient Protection and Affordable Care Act is a federal statute that was signed into law on March 23, 2010 by President Barack Obama. This legislation, along with the Health Care and Education Reconciliation Act of 2010, signed into law March 30, 2010, are more commonly and collectively referred to as the "Affordable Care Act" or "Obamacare."

By 2014, Obamacare will require individuals to carry health insurance and employers with more than 50 employees to provide health insurance or pay a penalty. Catastrophic-only coverage will be limited to those under 30 or who meet the required poverty thresholds. This law marks the first time in American history that the U.S. government can force individuals and business to purchase a commodity – health insurance.

In addition, the law imposes almost a half a trillion dollars worth of new taxes, fees, and penalties on individuals and businesses. Taxes on more expensive "Cadillac" health insurance plans, combined with additional taxes on pharmaceuticals and medical supplies and expansion of qualified Medicaid enrollees, will lead to significant increases in healthcare costs for both individuals and businesses.

The new burden on businesses threatens their bottom line and hampers their ability to retain or add employees. As a result, thousands of companies, covering more than 3 million employees, requested waivers to the most intrusive provisions of Obamacare in just a year and a half following the law's passage. Unsurprisingly, the majority of waivers have come from union-backed insurance plans.

In addition, Obamacare has been challenged by lawsuits representing more than half the states. (See "Florida Lawsuit" in Key Terms). The Florida lawsuit, representing 26 states, challenges the individual mandate. It claims the mandate exceeds the federal government's power to regulate interstate commerce under the Commerce Clause. The suit also asserts that Obamacare violates the Tenth Amendment by forcing states to expand their Medicaid programs. A separate lawsuit, filed by the state of Virginia, also challenges the constitutionality of the individual mandate.

In 2010, the North Carolina legislature unsuccessfully filed a joint resolution (H1674/S1134) to protect North Carolinians from the overbearing intrusion of Obamacare's insurance mandate. In 2011, the legislature tried again with HB2, Protect Health Care Freedom Act. HB2, however, was struck down by Governor Perdue's veto pen. Instead, legislative leadership filed an amicus brief in support of the Florida lawsuit.

Ultimately, the law's constitutionality will be determined by the U.S. Supreme Court as early as mid-2012.

# 13 WHAT IS A 1915 (B)/(C) WAIVER? New Medicaid Program

The North Carolina Department of Health and Human Services (NCDHHS) began a pilot project in 2005 where Medicaid-funded services for mental health, substance abuse, and development disabilities are provided in a multi-county area on a capitation basis. In other words, the provider agrees to a fixed per patient, per month payment in return for providing treatment, regardless of the risk that cost of treatment exceeds the expected amount. Piedmont Behavioral Healthcare (PBH) was the first local management entity to operate the pilot program through the "Piedmont Cardinal Health Plan." In 2009, NCDHHS expanded the project to be phased-in statewide by submitting waiver amendment requests to the federal Centers for Medicare and Medicaid Services. These waivers include the 1915(b) Freedom of Choice waiver and the 1915(c) Innovations Home and Community Based Services waiver.

It is hoped these programs will provide a direct blow to existing mismanaged facilities. The programs would give local agencies and patients more input in treatments and funds could be better utilized and more efficiently moved where they are needed. So far, PBH has worked better under the new system, providing improved care and financial management since beginning the program. In 2011, the waiver program officially extended throughout the state with the passage of S.L. 2011-264.

ENDNOTES:

1 This percentage represents all state and local (county) contributions.

2 http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf

3 Managed Healthcare Improvement Task Force (January 2000); as cited in Helen H. Schauffler, "Politics Trumps Science, Rethinking State Mandated Benefits," *American Journal of Preventative Medicine* (19), no. 2 (August 2000): 136-137; available from http://chpps.berkeley.edu/publications/Schauffler%20papers/Politics_Trumps_Science.pdf.

4 North Carolina General Statutes direct insurers to follow the American Cancer Society guidelines, which recommend varied frequencies of screening depending on age group and past results. Younger women are screened annually.

5 Schauffler, "Politics Trumps Science."

6 Sven R Larson, "The Healthcare Choice Act: Restoring Competition in the Health Insurance Market," *Prosperitas*, Center for Freedom and Prosperity (June 2006); available from http://www.freedomandprosperity.org/Papers/hc-choice/hc-choice.pdf.

7 Bunce, *Health Insurance Mandates in the States 2007*.

8 Rick Martinez, "Immigration Hits 'Critical Mass' in NC," Carolina Journal Exclusives, *Carolina Journal Online*, (December 12, 2005); available from http://www.carolinajournal.com/exclusives/display_exclusive.html?id=2983.

9 Ibid.

10 Steven A. Camarota, "The High Cost of Cheap Labor: Illegal Immigration and the Federal Budget," Center for Immigration Studies (August 2004); available from http://www.cis.org/articles/2004/fiscalexec.html.

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

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

13 Michael Easterbrook and Jean P. Fisher, "Illegal Immigration: Healthcare," *News & Observer* (March 1, 2006), A1.

14 Ibid.

## 2009 North Carolina Immunization Rates and Requirements Before School Entry

**Diphtheria, Tetanus and Pertussis:** 5 doses; Immunization Rate: 85.9%

**Polio:** 4 doses; Immunization Rate: 92.9%

**Measles, Mumps, Rubella (given as MMR):** 2 doses; Immunization Rate: 92.9%

**Haemophilus influenzae type b (Hib):** 4 doses; Immunization Rate: 92.1%

**Hepatitis B:** 3 doses; Immunization Rate: 93.9%

**Varicella:** 1 dose; Immunization Rate: 91.9%

*As provided by G.S. 130A-156 and 130A-157, North Carolina permits medical and religious vaccine exemptions. A medical exemption may be obtained from a licensed physician who certifies that a required vaccine is or may be detrimental to a person's health. A religious exemption may be obtained by submitting a statement to a school official that confirms in writing that a person has a "bona fide" religious belief against immunization, in general, or certain immunizations (such as those cultured on aborted fetal tissue). According to the N.C. Immunization Branch: "Statements of religious objection to immunization do not need to be notarized or prepared by an attorney. They do not need to be submitted to the state for review or approval."*

SOURCE: NCDHHS, North Carolina Immunization Branch, "Immunization Rates, CDC's National Immunization Survey – 19 - 35 months," available at http://www.immunize.nc.gov/data/immunizationrates.htm; NCDHHS, North Carolina Immunization Branch, "Schools – Kindergarten," available at http://www.immunize.nc.gov/schools/kindergarten.htm.

OVERVIEW

# 1985-1989

Healthcare spending increased rapidly during the latter half of the 1980s. Between FY1985-86 and FY1989-90, Department of Human Resources (DHR) appropriations increased by 16.4 percent, with actual spending increasing by 33.4 percent. Overall, DHR spending exceeded initial appropriations by $597.6 million.

Over the latter half of the 1980s, the Division of Medical Assistance (DMA), which oversees Medicaid spending, also grew to dominate the health department's budget. In FY1986 the DMA comprised 28.9 percent of the budget. In FY1990, it reached 47 percent of the total DHR budget.

In 1987, the U.S. government implemented the country's first comprehensive, national health insurance database. Figures from that year indicate that 216,000 of North Carolina's 1.5 million children lacked health insurance for the whole year or part of the year. By 1990 the number of uninsured children had dropped to 190,000. At the same time, the number of children on Medicaid increased by 52 percent, or 84,000. In 1987, there were 162,000 children on Medicaid; in 1990, 246,000 children in North Carolina were enrolled in Medicaid.

As the number of kids on Medicaid increased, private insurance coverage for children dropped by 4.4 percent, suggesting that the expansion of taxpayer-subsidized insurance had a "crowd-out" effect on private health coverage. In other words, a negative correlation exists between the expansion of Medicaid and private insurance coverage. Between 1987 and 1990, for example, the rolls of uninsured children fell by 1 for every 3.24 children enrolled in Medicaid – which is to say that 2.24 of these children were either already insured or not counted among the uninsured. What this suggests is that many families who are obtaining public health coverage through Medicaid could, in fact, afford to purchase their own insurance on the private market.

Among working age North Carolinians, the group of uninsured grew by 14 percent to 683,000. During the same period, 55 percent more people were enrolled in Medicaid, bringing the total of Medicaid enrollees aged 18-64 to 143,000. Again, then, the increase in Medicaid spending through the Division of Medical Assistance only had a marginal impact on the rate of uninsured in North Carolina. Meanwhile, private insurance enrollment grew by a meager 2.6 percent.

## 1985

Coming in on the coattails of Governor James Martin's (R) gubernatorial victory, Republicans doubled their numbers in the General Assembly, leading to concerns among liberals that the state would reduce funding for many welfare programs. Instead, funding for several key programs increased. Commented Senator Russell Walker (D-Randolph) about the healthcare budget, "The poor did very well in the human resources area this year."

**State Abortion Fund**

In spite of resistance from a Democrat-controlled Legislature, Governor Martin and his allies succeed in placing some limitations on the State

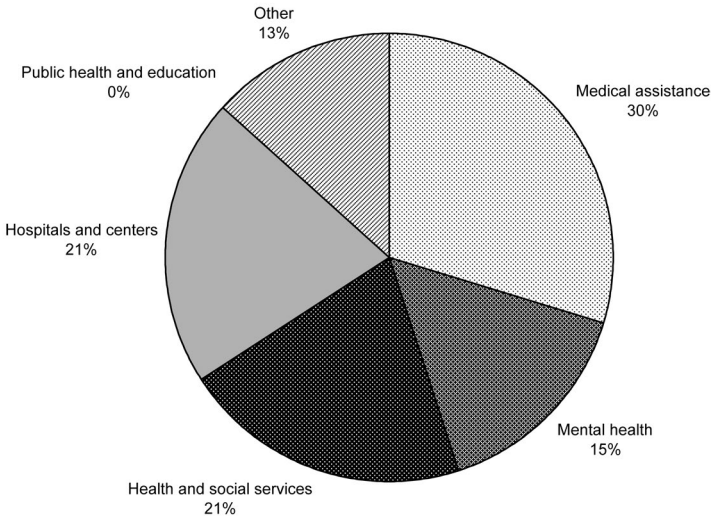
## FY 1985-86 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $703 million**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $203 million |
| Mental Health: | $105 million |
| Hospitals & Centers: | $144 million |
| Health Services: | $72 million |
| Social Services: | $71 million |

**Health & Human Services Budget: FY1985-86**




Abortion Fund. In particular, the budget bill (S.L. 1985-479) institutes a requirement that in order to be eligible for state funds a woman's health must be impaired by her pregnancy. The budget also reiterates that "the State Abortion Fund shall not be available for abortion on demand. " While funding for the program is cut from $1.4 million to $924,500, the cuts are not as large as Governor Martin hoped for. Nevertheless, the cuts lead to a 66 percent reduction in the number of state-funded abortions, which drop from 1,928 in 1984 to 598 in 1985.

**Medicaid**

The state extends coverage to all eligible pregnant women and all children in two-parent households. The move reverses a previous policy that only covered children from households in which one or both parents are either absent or unable to work.

**Other DHR Budget Highlights**

- A 10 percent increase in benefits for AFDC recipients.
- Expansion of AFDC aid to women in the third trimester of pregnancy.
- $11.3 million for an expansion of daycare services for needy families.
- $1.5 million for personal care services for the elderly.
- $684,610 for treatment for a class of mentally and emotionally disturbed children that also exhibit violent behavior – a court-ordered mandate arising from the *Willie M. v. Hunt* case.
- $500,000 for voluntary sterilization.
- Creation of an Adolescent Pregnancy Advisory Board comprised of representatives from a variety of entities, including the Statewide Family Planning Advisory Council, the Division of Social Services, the Family Planning Branch of the Division of Health Services, and Planned Parenthood. The General Assembly also mandates that the Division of Health Services establish several pilot programs aimed at reducing unintended adolescent pregnancies.

Senator Cass Ballenger (R-Catawba), in particular, is instrumental in garnering support for a measure that provides $500,000 in state funding to cover drug costs not covered by Medicaid. Defending his support for expanding state healthcare programs, Ballenger says: "We were all conservative as far as spending public money, but you've got to realize that one of the basic functions of government is to take care of those that can't help themselves. … What are you going to do – throw the AFDC mother on the street?"

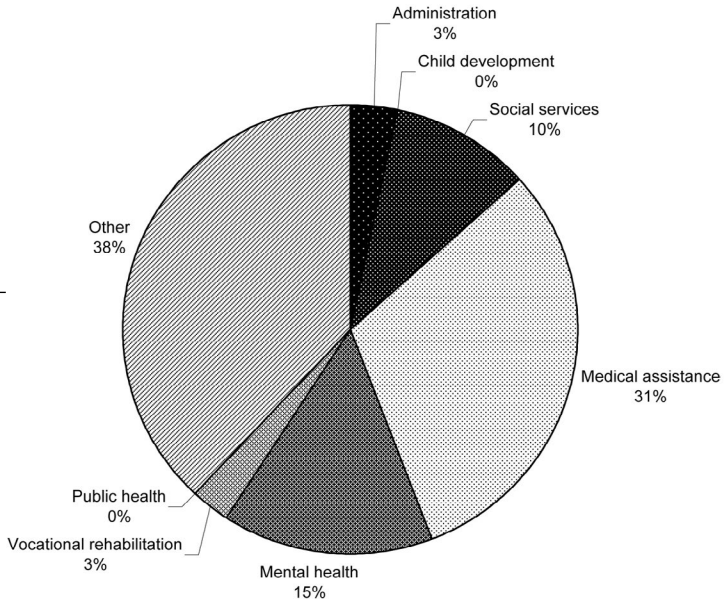
## FY 1986-87 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $729 million**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $218 million |
| Mental Health: | $106 million |
| Hospitals & Centers: | $145 million |
| Health Services: | $74 million |
| Social Services: | $71 million |

**Health & Human Services Budget: FY1986-87**




# 1986

North Carolina began to grapple with an aging population as healthcare issues affecting the elderly took center stage in 1986. In particular, a series of articles by the *Charlotte Observer* peaked interest in reforming North Carolina's nursing homes. Meanwhile, many local hospitals voiced complaints about rising operational costs.

### Nursing Homes

The *Charlotte Observer* declares a "nursing home crisis," charging that "North Carolina's system of regulating – limiting – the construction and expansion of nursing homes is plainly not working." Recalling that North Carolina placed a moratorium on the construction and expansion of nursing homes between 1981 and 1984, *Observer* editor Tom Bradbury argues that the state is not saving money by making the system more efficient, but is simply rationing healthcare. Defending the state's policy of holding down Medicaid spending on new beds, Department of Human Resources Secretary Phil Kirk responds, "We'd have 8,000 to 10,000 new beds and the taxpayers' budget would go broker than it is." Putting things into perspective, policy analyst Catherine Hawes explains: "It's a crisis in the sense that it's such a rapidly growing segment of the population, at the same time as we have enormous fiscal restraints. There's a push from one side on the budget and from the other on demographics." In fact, according to *Observer* reporter Valerie Reitman: "It cost federal, state and county government an average of $15,700 last year for a Medicaid recipient to stay in a N.C. nursing home. That's more than last year's starting salary for a N.C. teacher, more than a year's tuition at some of the nation's most prestigious colleges and more than the average N.C. factory worker's yearly wage." Owing to rising costs, Medicaid payments to nursing homes are projected to increase by 68 percent between 1981 and 1987.

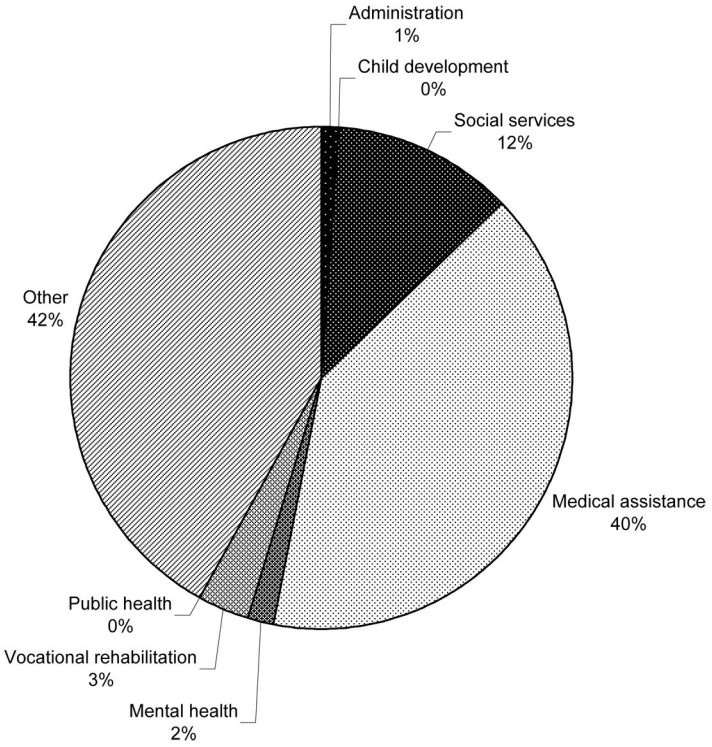
### Hospitals

In 1986, North Carolina had 135 community hospitals, most of which – 72 percent – had fewer than 200 beds. Many of the state's smaller hospitals are struggling to survive because of increasing healthcare costs. Such hospitals also have similar expenses as larger facilities, but receive less federal aid. Explains Stanly Memorial President Ken Shull: "Part is money we can't collect because the people don't have it and the rest is the difference between what our costs are and what the federal government pays us for the service. … Being outside metropolitan statistical areas means small hospitals collect 26 percent to 50 percent less than hospitals included in those areas – a severe handicap, because our costs are virtually the same." The FY1987 budget includes grants to several such small hospitals – for example, $20,000 to the Person County Hospital "to enable the hospital to better serve the health needs of all the people of the region."

**Other Highlights**

- **AFDC**: The state permits two-parent eligibility under certain conditions for children enrolled in AFDC.
- **HSAs**: Highlighting the state's dependence on federal dollars, six health systems agencies (HSAs) lose federal funding, leading to fears that the agencies will either have to obtain state funding or shut down. Comments Piedmont HSA Director Gloria Haynes: "Essentially, we are at the mercy and the whims of Congress and the state. … It's the kind of business that does not attract a lot of money otherwise. Nobody gets excited about health planning." Such agencies are responsible for conducting regional planning with the aim of reducing costs.
- **Mental Health**: Once a model system imitated by other states, North Carolina's mental healthcare system is thought to be in a state of decline. Critics claim that the state's four mental hospitals are unsafe, understaffed and underfunded.
- **Medicaid**: Effective January 1, 1986, the state begins covering annual health screens for adults enrolled in Medicaid.

**Health & Human Services Budget: FY1987-88**




# 1987

Three issues dominated the year's healthcare agenda: AIDS, the underinsured, and nursing home costs. The first two of these issues also drove the healthcare debate at the national level.

**AIDS**

In an attempt to lower the AIDS rate, North Carolina applies for a federal grant that the state wants to use to set up a program to warn the former sexual partners – sometimes numbering in the thousands – of AIDS patients. The program is expected to be both expensive and difficult to implement. Part of the funding is also to be used for general, preventive education efforts in high-risk communities, such as among minorities.

**Underinsured**

In an effort to help medically underinsured families, the General Assembly establishes the Indigent Health Care Study Commission. The commission recommends several bills to expand tax-paid health insurance for persons thought to be underinsured. Explains commission member Pam Silberman: "Under our current system we ration health care based on the ability to pay. … We're the only Western industrialized country to do that." (Other countries, of course, ration healthcare based on other mechanisms – such as lengthy waiting periods – that represent an indirect cost to consumers.)

One of the commission's recommendations is the creation of a health insurance trust for small businesses. The trust would provide subsidies to small firms that are unable to buy more expensive insurance plans tailored for big businesses. The commission also suggests expanding Medicaid. The idea is to have Medicaid cover everyone who is classified as "poor." Taken together, the bills would cost

| 1987 | |
|---|---|
| North Carolina population | 6.2 million |
| Working age (18-64) | 3.9 million |
| Children (<18) | 1.5 million |
| Per capita personal income | $14,306 |
| Compared to U.S. | 88.1 % |
| North Carolina poverty rate, all residents | 13.8 % |
| On Medicaid (all ages) | 5.3 % |
| On Medicaid (18-64) | 2.9 % |
| On Medicaid (<18) | 10.8 % |
| Uninsured, all year or part of year (all ages) | 13.3 % |
| Uninsured, all year or part of year (18-64) | 15.4 % |
| Uninsured, all year or part of year (<18) | 14.4 % |

**FY 1987-88 HEALTH & HUMAN SERVICES BUDGET**

**Total Appropriations $651 million**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $255 million |
| Hospitals & Centers: | $146 million |
| Social Services: | $73 million |
| Health Services: | $49 million |
| Vocational Rehabilitation: | $21 million |
| Mental Health: | $11 million |

taxpayers $53.4 million per year, mostly in federal funds.

As the state seeks to solve the uninsured problem by growing the government, the North Carolina Council of Churches offers insurance for children to families earning less than $12,000 per year. This private initiative emphasizes well-patient care, which prevents more serious and more costly health problems in the future.

**Nursing Homes**

Rising costs force many elderly into poverty within months of moving to a nursing home. Barbara Matula, director of the Division of Medical Assistance in the North Carolina Department of Health and Human Services, stresses, however, that there are no simple answers or solutions. It is, she acknowledges, a "tremendous problem."

**Medicaid**

In response to federal legislation, North Carolina expands enrollment thresholds for pregnant women and young children. In particular, the state emphasizes prenatal care initiatives with the intention of lowering North Carolina's high infant mortality rate. The following year, the state launches the Baby Love program.

## 1988

In addition to the national debate over welfare reform, a slowdown in tax revenue growth forced the state to look more closely at entitlement spending. The debate over how to best help the medically underinsured continued into 1988.

**FY 1988-89 HEALTH & HUMAN SERVICES BUDGET**

**Total Appropriations $689 million**

*Major Items:*

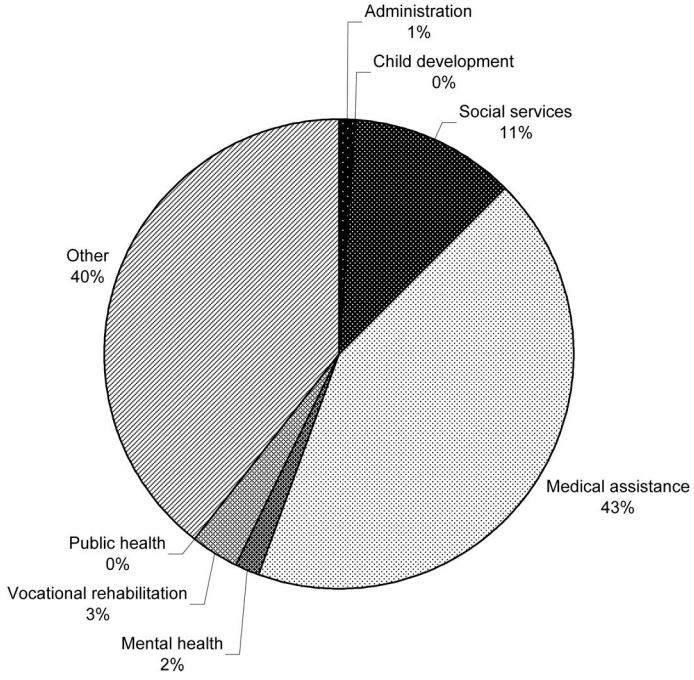
| | |
|---|---|
| Medical Assistance (Medicaid): | $289 million |
| Hospitals & Centers: | $146 million |
| Social Services: | $73 million |
| Health Services: | $49 million |
| Vocational Rehabilitation: | $21 million |
| Mental Health: | $11 million |

**Welfare Reform**

The national welfare reform debate is welcomed in North Carolina, where social services officials hope progress can be made in ending the cycle of poverty perpetuated by AFDC. Remarks Daniel Hudgins, director of the Durham County Department of Social Services, "[The welfare reform bill] provides some stronger work incentives and assures that people will be better off outside the (welfare) system than they will by remaining in the system." Hudgins also anticipates that the welfare reform bill will increase federal funding for Durham County job education services.

| 1988 | |
|---|---|
| North Carolina population | 6.3 million |
| Working age (18-64) | 4.1 million |
| Children (<18) | 1.5 million |
| Per capita personal income | $15,398 |
| Compared to U.S. | 88.8 % |
| North Carolina poverty rate, all residents | 12.6 % |
| On Medicaid (all ages) | 5.5 % |
| On Medicaid (18-64) | 3.3 % |
| On Medicaid (<18) | 10.4 % |
| Uninsured, all year or part of year (all ages) | 12.6 % |
| Uninsured, all year or part of year (18-64) | 14.3 % |
| Uninsured, all year or part of year (<18) | 13.6 % |

**Health & Human Services Budget: FY1988-89**




**Entitlement Programs**
State Senator Ken Royall (D-Durham) warns that the state's tax revenues are not growing fast enough to support entitlement programs. On a 12-month basis, revenue growth is the slowest it's been in 14 years. Cautions Royall, "If revenues don't improve, we're going to have to cut the budget." In particular, Royall notes that the state will need $90 million to fund Medicare and Medicaid programs and $65 million to provide insurance coverage for state employees. While the General Assembly approved spending hikes for 1988 based on predictions that tax revenues would grow by 6.3 percent, revenues for the year increase by only 0.8 percent. The top two gubernatorial candidates, Republican incumbent James Martin and Democrat Lieutenant Governor Bob Jordan both declare that they will rely on growing tax revenues to pay for entitlement programs. Neither candidate addresses the vulnerability of entitlement spending to economic downturns. Meanwhile, the state expands Medicaid coverage to include hospice programs. Coverage for the chronically mentally ill is also expanded.

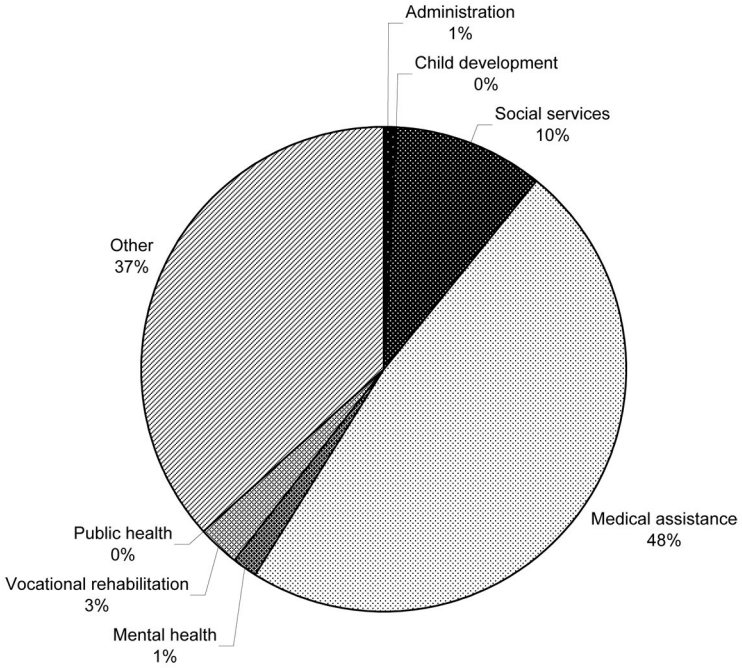
**Underinsured**
With estimated losses for uncompensated healthcare for North Carolina hospitals reaching $787 million for 1987, hospitals continue to show reluctance in admitting underinsured patients. To discourage inadequately insured patients from seeking nonemergency care, some hospitals establish administrative barriers, such as requesting preadmission deposits.

## 1989

Pregnancy and childcare issues took center stage in 1989 as new federal guidelines regarding Medicaid coverage for pregnant women and children led to several changes at the state level. In addition, the General Assembly funded an educational campaign to fight infant mortality and created the Division of Services for the Deaf and Hard of Hearing (subsequently transferred in 1999 to the Division of Education and Early Intervention).

**Medicaid**
As a result of an expansion of federal mandates and funding, the Division of Medical Assistance (DMA) budget solidifies its dominant place in the Department of Human Resources (DHR) budget. 1989 is the last calendar year in which DMA spending is below 50 percent of total DHR spending (47 cents per DHR dollar).

## Health & Human Services Budget: FY1989-90




| 1989 | |
|---|---|
| North Carolina population | 6.3 million |
| Working age (18-64) | 4.2 million |
| Children (<18) | 1.6 million |
| Per capita personal income | $16,497 |
| Compared to U.S. | 89.0 % |
| North Carolina poverty rate, all residents | 12.2 % |
| On Medicaid (all ages) | 6.0 % |
| On Medicaid (18-64) | 3.5 % |
| On Medicaid (<18) | 11.1 % |
| Uninsured, all year or part of year (all ages) | 14.1 % |
| Uninsured, all year or part of year (18-64) | 16.5 % |
| Uninsured, all year or part of year (<18) | 14.5 % |

## FY 1989-90 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $818 million**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $384 million |
| Hospitals & Centers: | $174 million |
| Social Services: | $78 million |
| Health Services: | $55 million |

- Owing to changes in federal law, the state expands Medicaid coverage for pregnant women and children. As a result, the state budget makes the following eligibility changes:
- Pregnant women with incomes up to 150 percent of federal poverty level (FPL) are covered by Medicaid.
- Infants less than one year of age from families who earn up to 150 percent of federal poverty level (FPL) are covered by Medicaid.
- Children under the age of 6 with families who earn equal to or less than federal poverty guidelines will be eligible for Medicaid beginning October 1, 1989, with 7-year-olds becoming eligible beginning October 1, 1990.
- Coverage for pregnant women is to continue for 60 days after pregnancy "without regard" to changes in income. In addition, lawmakers decide to no longer count assets as part of a pregnant woman's income.
- The state begins granting "presumptive eligibility" status to pregnant women, who then have 14 days to actually apply for Medicaid.
- In response to a 1988 federal mandate (subsequently rescinded in December 1989), the state also creates the "Medicare-Aid" program. As described by Mickey Hanula, an assistant to Insurance Commissioner Jim Long, the program is for "a class of people that have a little bit too much money to apply for Medicaid, [but] don't have enough money to pay for Medicare. So this program will be that the state will pay for Medicare for these people so if they have to be in a hospital they've got insurance."

**Other Highlights**

- **Teen Pregnancy**: The DHR budget includes $405,000 in block grant adolescent pregnancy funds that are to be used for adolescent pregnancy prevention projects. The funds are not to be used for the purchase of contraceptives and are not to be used for abortions.

- **Infant Mortality**: At 12.7 deaths per 1,000 births, preliminary statistics from the medical journal *Pediatrics* reveal that North Carolina ranks last among the states and ahead of only the District of Columbia in infant mortality rates for the year 1988. In response, the General Assembly allocates $260,000 for an Infant Mortality Prevention Campaign.
- **Prescription Drugs**: The state increases the amount paid for professional services related to filling prescriptions from $4.04 to $4.24 per month for certain medications and from $4.24 to $4.85 for others.
- **Environmental Health**: As part of the DRH budget, the state allocates $300,000 to provide "high quality environmental health programs."

OVERVIEW

# 1990-1994

The most notable change in Department of Human Resources (DHR) spending during the first half of the 1990s was a resolution of the discrepancy between appropriations and actual spending. From having spent $1.36 per dollar of appropriations in FY1989, the DHR spent 97 cents per appropriated dollar in FY1994. The rate of new spending also declined somewhat, with average annual spending hovering at about 12.5 percent a year between FY1990 and FY1994. 1991, though, also marked the first year that the Division of Medical Assistance (DMA) budget comprised more than half the appropriations for the entire health department.

The rate of uninsured also remained steady at 14 percent throughout the early 1990s. Private employer coverage also stayed at about 60 percent. Between 1990 and 1994, however, the growth rate of Medicaid enrollment (as reflected in the DMA budget) shot up from 7.7 percent in 1990 to 11 percent in 1994.

The negative correlation that emerged in the 1980s between Medicaid spending and private insurance coverage for children became even stronger during the 1990s. In 1990, 75 percent of all children were covered by private insurance; by 1994, this level had dropped to 64 percent (and has remained at this rate since then). This shift parallels a surge in the number of children on Medicaid, which went from 16.6 percent in 1990 to 24 percent in 1994. At the same time, the rate of uninsured children barely fell at all, going from 12.8 percent in 1990 to 12 percent in 1994. In fact, in terms of actual numbers, the pool of uninsured children was exactly the same (190,000) in 1994 as it was in 1990. By contrast, 133,000 kids were added to Medicaid during this period.

## 1990

The state's economy slowed down during the early 1990s, causing tax revenues to decline and demand for government entitlement programs, such as welfare and Medicaid, to increase. At the same time, the federal government launched a welfare-to-work program.

**FY 1990-91 HEALTH & HUMAN SERVICES BUDGET**

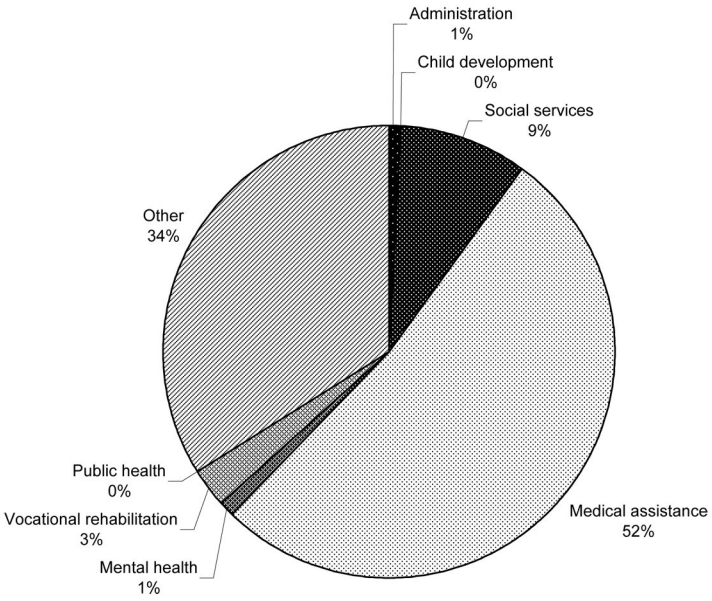
| | |
|---|---|
| **Total Appropriations** | **$883 million** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $448 million |
| Hospitals & Centers: | $173 million |
| Social Services: | $80 million |
| Health Services: | $55 million |

**Medicaid Enrollment Increases**

Due to a sharp spike in Medicaid applications, counties have increasing problems processing applications. In some instances, such as Mecklenburg County, applicants are forced to wait more than nine months before being notified of their eligibility status. Income thresholds for pregnant women and infants also increase from 100 percent to 150 percent of the federal poverty level. At the same time, the state's mounting revenue shortfall (projected at between $300 million and $500 million) leads some state legislators to begin discussing healthcare rationing. Other states – though not North Carolina – begin cutting back on certain Medicaid benefits in order to contain costs.

| 1990 | |
|---|---|
| North Carolina population | 6.39 million |
| Working age (18-64) | 4.1 million |
| Children (<18) | 1.49 million |
| Per capita personal income | $17,246 |
| Compared to U.S. | 89.5 % |
| North Carolina poverty rate, all residents | 13.0 % |
| On Medicaid (all ages) | 7.7 % |
| On Medicaid (18-64) | 4.3 % |
| On Medicaid (<18) | 16.6 % |
| Uninsured, all year or part of year (all ages) | 13.8 % |
| Uninsured, all year or part of year (18-64) | 16.7 % |
| Uninsured, all year or part of year (<18) | 12.8 % |

**Health & Human Services Budget: FY1990-91**




**Uninsured**

With a recession looming, the problem of the uninsured becomes a hot topic in the media. Some 70 percent of North Carolina's uninsured have a job and make too much to qualify for Medicaid and apparently too little to buy private insurance.

**Welfare Reform**

The federal government launches a welfare-to-work program. Starting October 1, 1990, the program is implemented in 44 North Carolina counties. Social workers are optimistic, but warn that more incentives are needed to encourage welfare recipients to obtain gainful employment.

## 1991

Rising costs, especially for "family planning services," were a controversial topic in 1991. At the same time, the number of pregnant women eligible for Medicaid increased by 16 percent during FY1991 while the number of Medicaid-eligible children increased by 55 percent.[1] Another issue of contention was low reimbursement rates for doctors who choose to work in minority communities. Anticipating a debate that will dominate discussions about Medicaid for the next two decades, North Carolina's counties continued to complain that they cannot shoulder the escalating costs of expanding Medicaid entitlements.

**FY 1991-92 HEALTH & HUMAN SERVICES BUDGET**

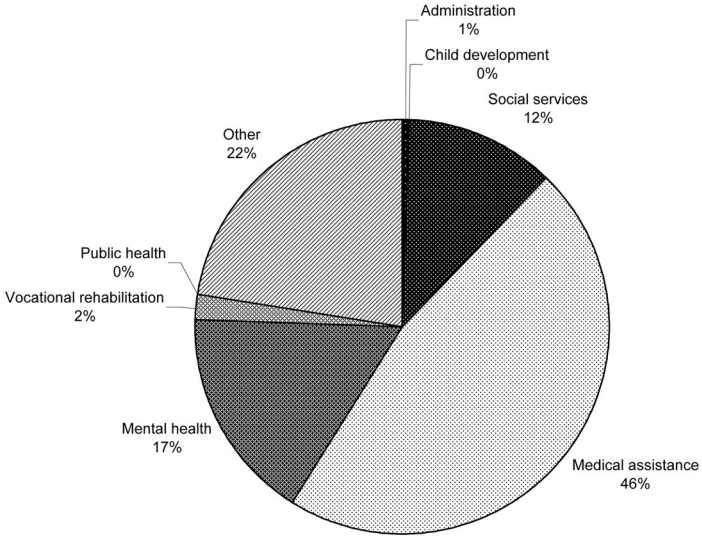
**Total Appropriations $1.14 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $523 million |
| Mental Health/D.D./Subst. Abuse: | $185 million |
| Hospitals & Centers: | $154 million |
| Social Services: | $130 million |

| 1991 | |
|---|---|
| North Carolina population | 6.64 million |
| Working age (18-64) | 4.14 million |
| Children (<18) | 1.67 million |
| Per capita personal income | $17,677 |
| Compared to U.S. | 88.9 % |
| North Carolina poverty rate, all residents | 14.4 % |
| On Medicaid (all ages) | 8.9 % |
| On Medicaid (18-64) | 5.0 % |
| On Medicaid (<18) | 18.6 % |
| Uninsured, all year or part of year (all ages) | 14.9 % |
| Uninsured, all year or part of year (18-64) | 18.2 % |
| Uninsured, all year or part of year (<18) | 13.6 % |

**Health & Human Services Budget: FY1991-92**




**Medicaid**

Carolina ACCESS is launched on a trial basis in five counties as a means of containing Medicaid costs. Essentially a gatekeeper system, ACCESS is used to buy preventive care and treatment from primary care physicians for Medicaid enrollees. A gatekeeper is a general practitioner who takes care of all nonspecialist needs of a family. Under a gatekeeper system, any patient who needs to see a specialist requires a referral from his assigned gatekeeper. A similar referral is needed for visits to the emergency room. The gatekeeper system saves costs because it restricts the supply of medical services.

**Norplant**

North Carolina decides to use Medicaid funds to offer Norplant for free to low income women at an estimated cost of $600-$1,000 per implant (insertion and removal). The contraceptive/ abortifacient, created by the Population Council and manufactured by Wyeth Pharmaceuticals, is supposed to prevent pregnancy for five years after being implanted into a woman's arm. After citizen protests that tax dollars are being used to promote abortion, Dr. Neva Abbott, a medical consultant with the Union County Health Department, confirms that Norplant prevents the implantation of already fertilized eggs. Nevertheless, the Norplant system is offered through several county health departments, as well as clinics at Duke University and UNC-Chapel Hill. Hailed as a virtual miracle drug by the media, side effects and questions over efficacy cause the device to be removed from the market in July 2002.

Even as counties are allocating money to pay for Norplant implants, the recession brings about budget cuts for county health departments. In Durham County, for instance, officials look to slash 4.3 percent from a $100 million budget. The county also anticipates an $800,000 shortfall for AFDC (Aid to Families with Dependent Children) services.

**Hospital Reimbursement**

Low hospital reimbursement rates for Medicaid patients continue to be a cause of concern in North Carolina. Under the system in place in 1991, nine high-cost hospitals in North Carolina are compensated for Medicaid patients at a higher rate than standard Medicaid rates during a limited number of days called "target days." After the target period ends, reimbursement rates drop, creating an incentive for high-cost hospitals to transfer patients to smaller, low-cost facilities. Yet doctors at such smaller hospitals are often reluctant to accept such transfers. In an attempt to resolve this problem, Governor James Martin's recommended budget proposes eliminating target days at a cost of $22.1 million, with the state paying $6.2 million,

counties $1.1 million, and the federal government the remaining $14.7 million. (The recommendation is rejected by the General Assembly.)

Even as Medicaid fees for physicians and dentists are increased by 4 percent, low reimbursement rates remain a problem in neighborhoods with large minority populations. Residents of such neighborhoods are more likely to be on Medicaid, but due to low reimbursement rates it is difficult to attract doctors to such areas. Over time, even many minority doctors tend to move out of their own neighborhoods and into more affluent areas. As with hospital reimbursement rates, this is a problem related to cost containment efforts caused by the expansion of Medicaid.

**Welfare Reform**
President George H. Bush Sr. announces a plan to transfer health and human services programs to the states. The plan meets resistance from governors, including Governor Martin of North Carolina. State and county officials are concerned that they will be left paying for entitlement programs that the federal government originally created and which the state cannot afford.

| 1992 | |
|---|---|
| North Carolina population | 6.80 million |
| Working age (18-64) | 4.24 million |
| Children (<18) | 1.71 million |
| Per capita personal income | $18,842 |
| Compared to U.S. | 90.4 % |
| North Carolina poverty rate, all residents | 15.8 % |
| On Medicaid (all ages) | 11.4 % |
| On Medicaid (18-64) | 6.3 % |
| On Medicaid (<18) | 24.7 % |
| Uninsured, all year or part of year (all ages) | 13.9 % |
| Uninsured, all year or part of year (18-64) | 18.4 % |
| Uninsured, all year or part of year (<18) | 12.2 % |

**FY 1992-93 HEALTH & HUMAN SERVICES BUDGET**

**Total Appropriations $1.41 billion**

*Major Items:*

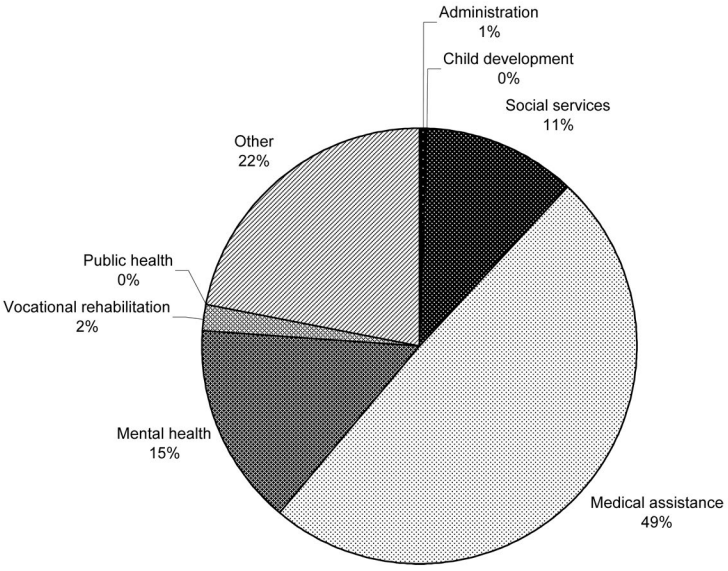
| | |
|---|---|
| Medical Assistance (Medicaid): | $602 million |
| Mental Health/D.D./Subst. Abuse: | $186 million |
| Hospitals & Centers: | $169 million |
| Social Services: | $138 million |

## 1992

As the recession deepened, more and more people enrolled in entitlement programs, such as AFDC and Medicaid. As a result, caseloads at county social services offices rapidly increased. In some counties, such as Wake and Durham, caseloads increased four to five times more than the increase in staff. As part of an ongoing effort to reign in costs, Carolina ACCESS also expanded to 12 counties and 55,705 Medicaid recipients.

**Counties Protest Federal Mandates**
North Carolina's counties, in particular, are finding their healthcare budgets squeezed by a rising number of federal mandates – healthcare mandates, and mandates in other areas as well. Such mandates force counties to provide certain services that they may not have funding for. In addition to being costly, mandates also threaten the fiscal independence of local governments. In particular, expanded eligibility for AFDC forces counties to either cut services or raise taxes (especially property taxes). "It's more of a problem now than in the last three years because we're in a recession," explains Ed Regan, a lobbyist with the N.C. County Commissioners Association. "The mandates pinch more in hard times." In protest, Gaston County declares it will not pay for the additional cost of new federal mandates (estimated at $1.7 million for FY1993). As a result, the state threatens to withhold sales tax proceeds from the county. Meanwhile, in Durham County, Social Services Director Dan Hudgins estimates that "it takes a penny on the property tax rate each year just to keep pace with the people added to the welfare rolls by the new eligibility rules."

**Health & Human Services Budget: FY1992-93**




**Family Planning Services**
As in 1991, funding for Norplant continues to be an issue for many counties. Using money provided by the Griffin Endowment, a Charlotte-based foundation, Planned Parenthood extends loans to women to help them buy the implant. Predictably, the increased availability of family planning services in North Carolina doesn't seem to lower the teenage pregnancy rate. In fact, the state sees a rapid rise – more than any other southern state – in the teenage pregnancy rate.

**Physician Shortages**
State Senator Jim Forrester (R-Gaston) introduces a bill that would give a $10,000 bonus to resident students who practice in rural areas. The proposal aims to boost the presence of physicians in counties that are not as attractive to physicians as wealthy, urban areas. In part, the bill is inspired by a 1992 report by the N.C. Hospital Association that indicates that doctors are leaving rural areas because of declining Medicaid reimbursement rates.

**Nursing Homes**
After a controversial series of articles in the *Charlotte Observer*, state officials begin to reconsider the manner in which Medicaid dollars are allocated to nursing home operators. In particular, the series is critical of large nursing homes that also provide quasi-independent pharmacy and rehabilitation services to residents. State Auditor Ed Renfrow notes that the state's current policies hurt small businesses and stifle competition. Citing a 1986 state audit of nursing homes, Renfrow comments: "You have to make sure that the transactions are all at arm's length and that it's just not another tier that's raking off money. It seemed to us at the time that the cost was not being controlled as well as it should be." According to the *Observer*, state Medicaid spending on nursing homes is at a record $590 million – a fourfold increase in 10 years.

**Universal Healthcare**
The North Carolina Institute of Medicine's (NC IOM) Health Access Forum meets with legislators to discuss what is essentially a universal healthcare plan for North Carolina. The plan resembles the "managed competition" agenda being advocated by president-elect Bill Clinton (D). The NC IOM plan would force taxpayers to pay for almost all healthcare services, primarily through a 4 percent increase in the payroll tax, a 2.8 increase in the individual income tax, and an additional 0.5 percent wage tax. Governor-elect Jim Hunt (D) is a leading member of the forum.

## 1993

The significant trends of the previous years continued into 1993, with the movement for universal healthcare gaining steam. In his State of the State address, Governor Hunt also called for $40 million to create an early childhood development program, the "North Carolina Partnership for Children," that will provide subsidized childcare and educational services for preschoolers. Finally, North Carolina's counties continued to increase taxes to pay for costly entitlement programs.

| 1993 | |
|---|---|
| North Carolina population | 6.74 million |
| Working age (18-64) | 4.26 million |
| Children (<18) | 1.59 million |
| Per capita personal income | $19,575 |
| Compared to U.S. | 91.7 % |
| North Carolina poverty rate, all residents | 14.4 % |
| On Medicaid (all ages) | 10.6 % |
| On Medicaid (18-64) | 6.6 % |
| On Medicaid (<18) | 21.5 % |
| Uninsured, all year or part of year (all ages) | 14.0 % |
| Uninsured, all year or part of year (18-64) | 16.7 % |
| Uninsured, all year or part of year (<18) | 14.0 % |

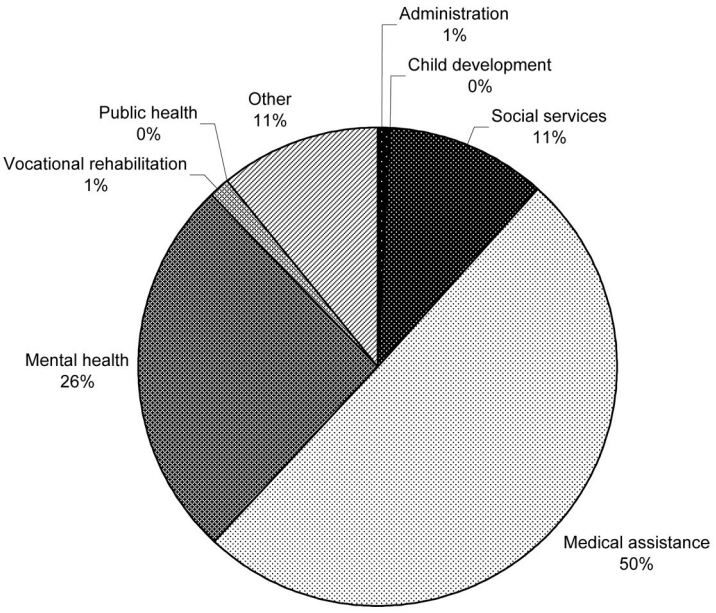
## FY 1993-94 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $1.70 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $860 million |
| Mental Health/D.D./Subst. Abuse: | $441 million |
| Social Services: | $184 million |
| Facilities Services: | $75 million |
| Youth Services: | $53 million |
| Vocational Rehabilitation: | $24 million |

**Health & Human Services Budget: FY1993-94**




### Universal Healthcare

The most significant health policy news of the year is the continued push by Governor Hunt and others for universal healthcare. To supplement the work being done by the N.C. Institute of Medicine (NC IOM), the General Assembly establishes the N.C. Health Planning Commission, chaired by Governor Hunt, to put healthcare "reform" on the "fast track." The commission will report its findings to the 1994 General Assembly with the intention of passing legislation in 1995. "We have to go back and get a good grounding of what the facts are," comments Governor Hunt. "We need to give ourselves all of next year to do this and have it ready for the 1995 session."

Ultimately, the commission recommends a program that is similar to that proposed by the NC IOM. Both plans do not aim for universal coverage, but rather a "basic benefits" model that emphasizes the euphemistically named concept of "managed competition." The plans have similar cost estimates of about $7.2 billion. In 1993 total personal health expenditures in North Carolina amounted to $18.5 billion.

### Counties Struggle Under Expanding Enrollments

North Carolina's counties continue to struggle to pay for the rising cost of entitlement programs. In Cumberland County, for example, County Commissioner John Keefe complains about having to fund wasteful federal programs. In particular, Keefe questions why the county was forced to spend $6 million on a three-year welfare-to-work program that created only 532 jobs. Reports the *Fayetteville Observer*, "The county contribution to Social Services more than tripled between 1982 and 1992, growing from $4.7 million to $15.4 million." Meanwhile, officials in Cabarrus County propose a 12 percent increase in property taxes, in part motivated by the rise in Medicaid and AFDC entitlement spending. Randolph County also increases taxes in response to new state Medicaid mandates.

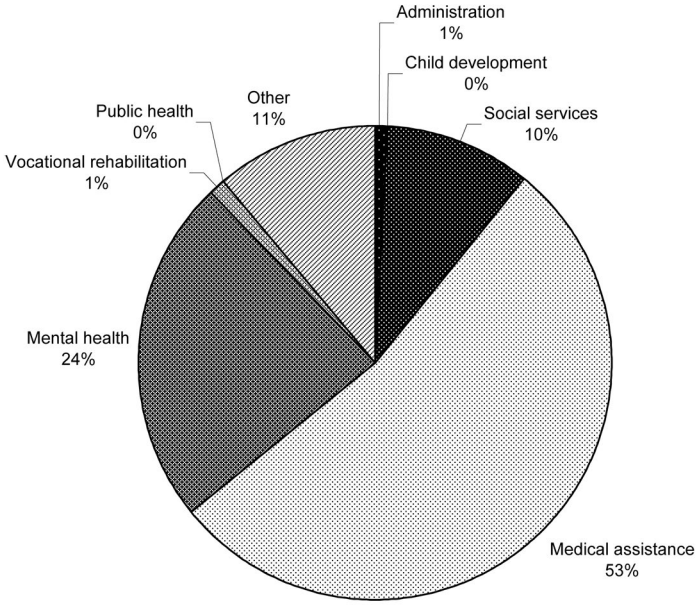
### Subsidized Childcare/Smart Start

The General Assembly consents to Governor Hunt's Smart Start daycare program,

appropriating $20 million for FY1994 and $28.4 million for FY1995 to fund the creation of 12 pilot projects under the oversight of the North Carolina Partnership for Children. Acknowledges Governor Hunt, "There's been a little controversy about this program." In particular, churches and other religious organizations oppose the program because it will use taxpayer dollars to crowd out home- and church-based childcare. Hunt defends the program, claiming that for every $1 invested in early childhood education the state will save $7 in welfare, prison and other educational costs.

The Division of Child Development is also added to the Department of Human Resources. The division is charged with providing "affordable high-quality childcare" and with helping to administer the Smart Start program.

**Health & Human Services Budget: FY1994-95**




## 1994

In 1994, healthcare again dominated the political scene, both nationally and in North Carolina. In hopes that the Clintons would be successful in pushing through nationalized healthcare, Democrat leaders in North Carolina continued to lay the groundwork for a statewide universal healthcare program. Counties also continued to labor under increasing entitlement costs. Indeed, during 1993 and 1994, the number of persons eligible for Medicaid increased by 20 percent.[2] Abortion, mental healthcare, and taxpayer-funded immunizations were also topics of debate during 1994.

**Universal Healthcare**

The failure of the "HillaryCare" nationalized health insurance program inspires a proposal from the North Carolina Health Planning Commission to create a universal health insurance plan for North Carolina. The panel, comprised of Governor Hunt and leading Democrat lawmakers, approves a list of benefits that would be provided under a statewide health insurance plan. Costs for the plan are estimated at between $11.5 billion and $19.5 billion a year. Representative Joe Mavretic (D-Edgecombe) suggests that funds are available elsewhere in the state budget. "The problem is not whether or not we can afford to do it,'" asserts Mavretic. "The problem is – and has always been – political. We haven't had the courage." By contrast, Duke University economist Chris Conover claims the plan will not finance itself, but will require new taxes: at least $1 billion in additional taxes "just to cover the 1 million uninsured."

**Medicaid**

The General Assembly creates the Health Check program in order to provide checkups, immunizations, and ongoing healthcare to Medicaid-eligible children up to age 20. The program is launched on a trial basis in 21 counties, with the aim of eventually covering some 380,000 eligible persons. Medicaid

**FY 1994-95 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$1.90 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,010 million |
| Mental Health/D.D./Subst. Abuse: | $449 million |
| Social Services: | $193 million |
| Facilities Services: | $99 million |
| Youth Services: | $54 million |
| Vocational Rehabilitation: | $24 million |

| 1994 | |
|---|---|
| North Carolina population | 6.9 million |
| Working age (18-64) | 4.4 million |
| Children (<18) | 1.6 million |
| Per capita personal income | $20,400 |
| Compared to U.S. | 93.5 % |
| North Carolina poverty rate, all residents | 14.2 % |
| On Medicaid (all ages) | 11 % |
| On Medicaid (18-64) | 6.5 % |
| On Medicaid (<18) | 23.8 % |
| Uninsured, all year or part of year (all ages) | 13.3 % |
| Uninsured, all year or part of year (18-64) | 16.3 % |
| Uninsured, all year or part of year (<18) | 11.9 % |

coverage is also extended to cover all elderly, blind, and disabled people who receive Social Security Insurance (S.L. 1994-769). The expansion covers some 100,000 new clients. In addition, the state begins to cover additional dental services for children on Medicaid. Total state Medicaid costs for the year reach $3.5 billion.

Even as Medicaid enrollment expands, the state continues to use the Carolina ACCESS program to keep costs down. Initial results indicate the program has reduced costs by $8.84 per client. In counties where Carolina ACCESS is not being used, costs rose during the same period by $16.27 per client.[3]

**Mental Health**
Reports show that mental health centers in North Carolina are not being adequately funded. Demographic changes, paired with restraints in state spending, are behind the cost crisis. A group of mental health advocates, N.C. Coalition 2001, argues that the state is receiving additional Medicaid funding because of the large share of Medicaid patients in state mental health institutions. (As of 1994, the state served some 900,000 mental health clients.) Yet much of this funding is apparently not being used to care for these patients. In spite of requesting $100 million in funding (to be taken from the state's $1.2 billion surplus), Coalition 2001 receives only $6 million. The money is to be used to fund capital needs for mental health, developmental disabilities, and substance abuse services. Part of the money may also be used to assist the nonprofit Center for Community Self-Help to establish a revolving loan fund.

**Welfare Reform**
The Southern Institute of Children and Families publishes a report that highlights a problem for many welfare recipients: once they get off welfare, they find they have to cover many bills themselves. This threshold effect is common in welfare systems. Earlier welfare reform efforts under President Reagan had not done enough to solve this problem, but there is hope that a new federal reform will do a better job. In the meantime, Governor Hunt is criticized for not doing enough to promote welfare reform – in spite of new federal waivers encouraging such reform. Hunt responds by creating a Welfare Reform Task Force, eventually applying for the waivers in August 1995.

**Abortion**
As part of the national debate over the proposed Clinton health plan, 10 states declare they will not use Medicaid dollars to fund abortion. Planned Parenthood states its intention to take these states to court. North Carolina is not among the defiant states. Rep. Mickey Michaux (D-Durham) also introduces a bill to force taxpayers to provide Norplant for free to the majority of women in the state.

**Vaccines**
Governor Hunt proposes a $10 million universal vaccine coverage plan that would provide "free" immunizations to every child in North Carolina, regardless of income. Two new vaccines – for influenza and pneumococcal – receive Medicaid coverage. The FY1995 budget also allocates $1 million to "increase childhood immunization rates in North Carolina."

According to a 1995 poll by Healthsource North Carolina Inc., nearly 80 percent agreed with the statement: "There is a healthcare crisis in America today."

SOURCE: Durham *Herald-Sun*

# 1995-1999

Department of Human Resources (DHR) spending grew at 9.7 percent per year between 1995 and 1999. Thus new spending growth decreased in comparison to the late 1990s; although, the growth rate was still much faster than the state's tax base.

Appropriations for the Division of Medical Assistance (DMA) continued to grow faster than the overall DHR budget, increasing by 37.4 percent between FY1995 and FY1999. By the end of the decade the DMA budget consumed 55 percent of the total DHR budget. During this same period, the Division of Child Development (created in 1993) also came to comprise a major part of the DHR budget. Whereas the division had a budget of $120 million in FY1996, by FY1999 its budget had doubled to $286 million.

During the late 1990s, the overall rate of uninsured North Carolinians stayed at 14.5 percent, with a slight jump from 17.5 percent to 18.2 percent for working-age persons. The uninsured rate for children also underwent an odd spike during this period. Starting out at 13 percent in 1995, the uninsured rate for children leaped to 18 percent in 1997, only to fall to 12 percent by 1999.[4] It is possible that the drop is related to the federal expansion of healthcare for children via the State Children's Health Insurance Program (SCHIP), which was established in North Carolina (effective October 1, 1998) as NC Health Choice. But given that the Medicaid totals include children covered by SCHIP we would expect to see the opposite. It is also possible that the 18 percent peak is an anomaly or simply the result of other factors that cannot be accounted for here (the economy or illegal immigration, for instance).

In any case, owing to the 1999-2001 recession, Medicaid enrollment among working-age North Carolinians increased in the late 1990s. During the same period, however, the number of children on Medicaid declined from 25.8 percent to 19.2 percent. At the same time, the share of kids on private insurance grew from 63 percent to 70 percent, reversing the trend from previous years. It is important to note, though, that the expansion of children covered by private insurance was about nine times as large, in absolute numbers, as the number of children coming off of Medicaid.

## 1995

With the "Republican Revolution" underway in the U.S. House of Representatives, Medicaid spending and welfare reform were important topics of debate in 1995. At the state level, the Republican majority in the House focused more on tax reform, welfare reform and crime, as opposed to healthcare. As the Durham *Herald-Sun* reported, "Legislators discussed health care reform this session with about the same zeal that families discuss cancer in a loved one."[5] For the most part the General Assembly merely tweaked the state's Medicaid program. "If the wiring in the house has gone bad, you don't burn down the house. You correct the wiring," explained Senator Jim Forrester (R-Gaston). For his part, Forrester proposed a bill that would expand health insurance coverage for

| 1995 | |
|---|---|
| North Carolina population | 6.95 million |
| Working age (18-64) | 4.51 million |
| Children (<18) | 1.55 million |
| Per capita personal income | $21,295 |
| Compared to U.S. | 92.3 % |
| North Carolina poverty rate, all residents | 12.6 % |
| On Medicaid (all ages) | 11.5 % |
| On Medicaid (18-64) | 6.6 % |
| On Medicaid (<18) | 25.8 % |
| Uninsured, all year or part of year (all ages) | 14.3 % |
| Uninsured, all year or part of year (18-64) | 17.5 % |
| Uninsured, all year or part of year (<18) | 13.0 % |

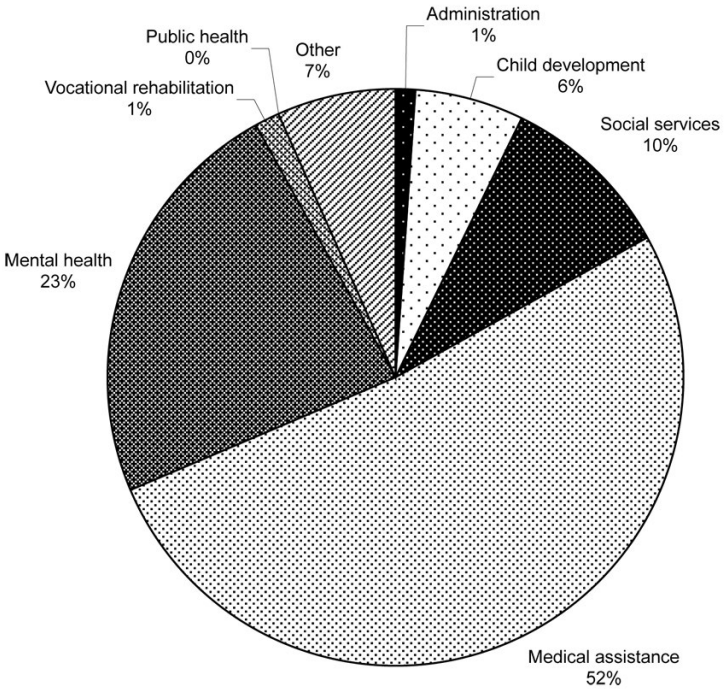
## FY 1995-96 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $2.02 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $1,045 million |
| Mental Health/D.D./Subst. Abuse: | $474 million |
| Social Services: | $197 million |
| Youth Services: | $71 million |
| Deaf and Hard of Hearing: | $26 million |
| Vocational Rehabilitation: | $26 million |

**Health & Human Services Budget: FY1995-96**




individuals who change or lose their job. Other Republicans seem to call for more fundamental change, with Lyons Gray (R-Forsyth), co-chairman of the House Finance Committee, proposing to scale down or eliminate completely the Department of Human Resources.

**Medicaid**

Given that Medicaid expenses consume more than half the DHR budget, the General Assembly again looks at strategies to lower costs. In particular, the Legislature considers recommendations from a blue ribbon task force created to analyze the effect of federal funding and mandates on state Medicaid expenditures.

Medicaid fraud was also a hot topic in 1995 as then Attorney General Mike Easley (D) seeks additional funding for the state's Medicaid fraud unit. The unit comes under intense scrutiny once it is discovered that the state's fraud efforts are resulting in a net loss. Argues Senator R. L. Clark (R-Buncombe): "We're spending more than we're taking in. We ought to abolish this program." In 1994, with a staff of 10 and a budget of $1.2 million, the unit obtained 17 convictions from fraudulent Medicaid providers.

**Abstinence Education**

Legislators abolish the state's comprehensive sex-ed curriculum and replace it with an "abstinence-until marriage" program. The new law (S.L. 1995-534) requires every Local Education Agency (LEA) to teach that abstinence is the "expected standard for all school-age children...and the only certain means of avoiding out-of-wedlock pregnancy, sexually transmitted diseases, including Acquired Immune Deficiency Syndrome (AIDS), and other associated health and emotional problems" (G.S. § 115C-81). Students may opt-out of this curriculum only with parental/guardian consent. Likewise, LEAs may "supplement" the abstinence-only curriculum with a comprehensive sex-ed program if they conduct public hearings and permit parents to review the proposed curriculum. Prior to the passage of the law, organizations such as Planned Parenthood played a leading role in teaching sex-ed in the

schools by training teachers and health department staff and leading school and after-school comprehensive sex-ed courses. Against such critics, Robin Haynes (R-Cabarrus), the bill's sponsor, defends the measure: "You can't just throw a few condoms at kids and say the problem is solved. That's a slimy way to deal with it. This is where welfare reform starts – with abstinence until marriage." Since abstinence-only education began in North Carolina (1996-2005), the state's teen (ages 15-19) pregnancy rate has declined from 89.8 to 63.1 per 1,000 – a reduction of 30 percent. During the same period, the abortion rate has dropped by 42 percent.

**Welfare Reform**

As promised in their "New Contract with the People of North Carolina," the N.C. House passes the "Public Assistance Responsibility Act." The bill would eliminate cash payments and food stamps for unwed mothers and their children and count food stamps and housing subsidies as income for eligibility purposes. Representative Cherie Berry (R-Catawba) defends the House's vote as a necessary step toward comprehensive reform: "The clock is ticking on the rising illegitimacy rate and rising cost of welfare in North Carolina. That rising rate may make America unrecognizable before we as politicians recognize the need for bold measures." In response, Representative Mickey Michaux (D-Durham) criticizes the measure as biased against blacks, who are overrepresented among welfare recipients. But as explained by the *News & Observer*, the intent of the legislation is to "change behavior by limiting benefits." Continues the *Observer*, "Families who have another child while receiving benefits can't get an increase. Men who father children out of wedlock must pay child support or perform community service."

The state begins to institute welfare reform by asking counties to allocate more resources aimed at encouraging clients to obtain employment. As a result, the number of welfare recipients obtaining employment doubles over the previous year, going from 6,098 in July 1995 to 12,893 by February 1996. Overall, the modest reforms instituted by the state result in a 6 percent reduction in the welfare rolls, compared to a 2.6 percent decline nationally.[6] Still, state welfare reform also leaves county social services departments uncertain as to what their budgets will look like in the coming fiscal year. Guilford and Rockingham counties, for example, plan to continue their welfare programs as before, including AFDC, food stamps and Medicaid.

Finally, in a move to eliminate tax-funded abortions, the General Assembly passes a bill that reduces State Abortion Fund appropriations from $1.2 million to $50,000. The budget bill (S.L. 1995-324) again limits state funding to "terminate pregnancies resulting from cases of rape or incest, or to terminate pregnancies that, in the written opinion of one doctor licensed to practice medicine in North Carolina, endanger the life of the mother." As a result of the cut in funding, the number of state-subsidized abortions falls to two over the next 18 months.

**FACTS ABOUT MEDICAID IN NORTH CAROLINA 1994-1995**

- It covered 1.1 million residents in 1994-95, or roughly one of every six people.
- Medicaid covered 45 percent of the babies born each year.
- 26.8 percent of recipients consumed 67 percent of the resources.
- Inpatient care – hospitals, nursing homes, mental retardation centers – consumed 53.4 percent of spending for services.
- 72 percent of the state's nursing home beds serve Medicaid patients.
- 14 percent of N.C. hospital charges are paid by Medicaid.
- Cost in 1994-95: $3.5 billion. Of that, $2.2 billion came from the federal government, $1.1 billion from the state, and $188 million from the counties.

SOURCE: General Assembly Fiscal Research Division, as reported by the Durham *Herald-Sun*

**Mental Health**
Mental healthcare continues to be an issue of importance to the General Assembly. To curb rising costs, the state moves to managed care within its mental health division. Managed care is a system where the insurance provider – i.e., the state – dictates where and under what conditions a patient can receive treatment. As a result, medical decisions are no longer in the hands of the patient or the patient's relatives. The General Assembly also appropriates $9 million for Coalition 2001.

# 1996

The biggest news of the year is the sweeping welfare reform that relocated the responsibility of welfare to the states. Technically, the reforms marked the end of AFDC (Aid to Families with Dependent Children). In addition, the federal government relinquished much of its responsibility for food stamp and school lunch programs.

With the election approaching, gubernatorial candidates Jim Hunt (D) and Robin Hayes (R) revealed vastly different visions of government's role in healthcare. Mr. Hayes wanted free market reform and opposed a Clinton-style socialized health model. Governor Hunt, backtracking from his previous support for a statewide universal healthcare system, also claimed to oppose "HillaryCare." Hunt, however, wanted to expand taxpayer-subsidized insurance via Medicaid.

## FY 1996-97 HEALTH & HUMAN SERVICES BUDGET

| **Total Appropriations** | **$2.15 billion** |
|---|---|
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,170 million |
| Mental Health/D.D./Subst. Abuse: | $471 million |
| Social Services: | $200 million |
| Child Development: | $120 million |
| Youth Services: | $69 million |

| 1996 | |
|---|---|
| North Carolina population | 7.26 million |
| Working age (18-64) | 4.60 million |
| Children (<18) | 1.80 million |
| Per capita personal income | $22,320 |
| Compared to U.S. | 92.3 % |
| North Carolina poverty rate, all residents | 12.2 % |
| On Medicaid (all ages) | 8.4 % |
| On Medicaid (18-64) | 4.4 % |
| On Medicaid (<18) | 18.7 % |
| Uninsured, all year or part of year (all ages) | 16.0 % |
| Uninsured, all year or part of year (18-64) | 18.3 % |
| Uninsured, all year or part of year (<18) | 17.2 % |

**Work First**
Ironically, Governor Hunt (D), who resisted genuine welfare reform throughout much of his administration, claims credit for reducing the number of welfare recipients by 10 percent through the state's "Work First" program. After receiving permission from the federal government to move forward, Hunt oversees the creation of the welfare-to-work initiative, launched in July 1996. According to a report by Sandra Babb, executive director of the Governor's Commission on Workforce Preparedness, Work First operates as follows: "Work First requires able-bodied welfare recipients who have school-aged children to participate in work, training, or community service for 30 hours per week, and get off the welfare rolls in two years or less. Additionally, Work First requires welfare recipients to take responsibility for themselves and their families by strengthening efforts to collect child support, denying additional cash benefits for children born after their parent has been in the welfare system for 10 months, and requiring parents to ensure that their children are immunized and attend school regularly."[7]

Using figures from July 1995, Governor Hunt claims Work First resulted in a 20 percent reduction in welfare caseloads in Orange County. Orange County officials attribute their success to the following three factors: "the motivation

of the individuals, the success of our staff in getting people into job training slots, and the willingness of employers to give people the opportunity to work who may have not had previous work experience." Statewide, the number of families on welfare drops by 15.4 percent. Durham County, however, only sees a 1.7 percent decline, while welfare cases actually increase in Burke County.

**Medicaid Thresholds**

As with all selective entitlement programs, Medicaid thresholds create severe marginal eligibility effects. This problem is illustrated by a story in the *Fayetteville Observer* about a Hoke County woman who receives support from her daughter to help pay for nursing home costs. The donations are not enough to live off of, but if the daughter increases her assistance the woman will no longer be eligible for Medicaid. At the same time, Congress moves to limit the ability of families to divert assets in order to qualify for Medicaid by requiring states' to file claims against the estates of deceased Medicaid recipients. Meanwhile, North Carolina's Medicaid rolls swell by 38,000 persons, reaching 1.2 million. Low income and disabled children account for much of the increase.[8]

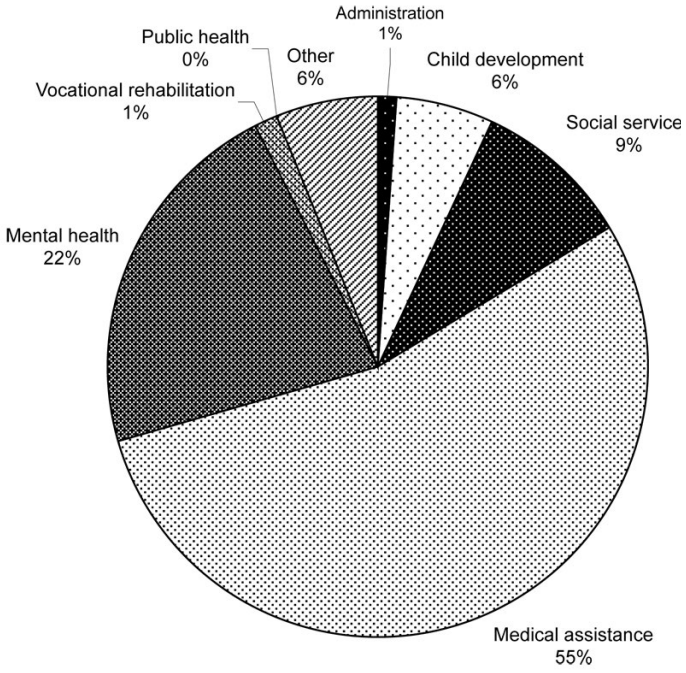
**Mental Health**

State funding for 41 local mental health programs is cut by $8.5 million. Increased federal funding, however, results in net gains for many agencies. Sally Cameron, a spokesman for Coalition 2001, urges caution in increasing state dependency on Medicaid: "We don't think there will be the large increase in federal dollars that there has been in the past. We in the coalition have said for a long time that Medicaid has been seen as a cash cow."

**Smart Start**

Governor Hunt's recommended budget calls for a $21.2 million expansion of Smart Start. House Republicans refuse to allocate funding for Smart Start growth while the Senate budget appropriates $21 million. Lawmakers finally agree to fund the initiative at $10.1 million for expansion into 11 counties. The final budget (S.L. 1996-18es2) also stipulates that funding for Smart Start shall not continue or be expanded beyond FY1997 until the 1997 General Assembly determines the program "is operating as efficiently as possible and is producing the results for which it was established."

**Health & Human Services Budget: FY1996-97**




In May, the governor also announces that Smart Start has met its fundraising goals for the year ($5.9 million in cash and in-kind donations). (In 1995 the General Assembly added a requirement, over the governor's objections, that the North Carolina Partnership for Children raise at least 10 percent of its public funding.)

The governor also declares that Blue Cross and Blue Shield of North Carolina has promised to provide free health insurance coverage for as many as 1,000 children in Smart Start counties. In fact, Blue Cross is only paying for half of these children to be insured while the state is picking up the remainder of the cost, estimated at $130,000.[9]

| 1997 | |
|---|---|
| North Carolina population | 7.35 million |
| Working age (18-64) | 4.64 million |
| Children (<18) | 1.83 million |
| Per capita personal income | $23,530 |
| Compared to U.S. | 92.9 % |
| North Carolina poverty rate, all residents | 11.4 % |
| On Medicaid (all ages) | 9.2 % |
| On Medicaid (18-64) | 6.1 % |
| On Medicaid (<18) | 19.1 % |
| Uninsured, all year or part of year (all ages) | 15.5 % |
| Uninsured, all year or part of year (18-64) | 17.4 % |
| Uninsured, all year or part of year (<18) | 18.1 % |

# 1997

Emboldened by efforts in the U.S. House to reform America's ailing welfare system, House Republicans were anxious to pass welfare reform here in North Carolina. With the state Senate having ignored similar legislation in the past, the House leadership inserted its welfare reform initiative into the $11.4 billion biennial budget. In particular, the House proposed that individual counties be permitted to create their own system for determining welfare requirements and benefits for recipients. The Senate refused to return this power to local communities, with the result that budget negotiations extended well into August. Eventually a House-Senate compromise led to an agreement that allowed counties with less than 15.5 percent total state welfare recipients to join the program.

## FY 1997-98 HEALTH & HUMAN SERVICES BUDGET

| | |
|---|---|
| **Total Appropriations** | **$2.28 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,171 million |
| Mental Health/D.D./Subst. Abuse: | $529 million |
| Social Services: | $179 million |
| Child Development: | $169 million |
| Youth Services: | $88 million |
| Office of the Secretary: | $37 million |

Another contentious issue between the House and the Senate pertained to the use of $40 million from a Medicaid reserve fund to help finance Medicaid over the coming year. The Senate proposed raiding the fund while the House urged restraint. Finally, in 1997 the Department of Human Resources had its name changed to the Department of Health and Human Services.

**Health Insurance for Children**

Congress adds a new title (XXI) to the Social Security Act, thus creating the State Children's Health Insurance Program (SCHIP). In response, Governor Hunt proposes implementing a taxpayer-subsidized health coverage program for kids from families who don't qualify for Medicaid. Initial estimates put the number of new clients at 71,000. Hunt suggests the cost of the new program will be $21.8 million a year. In addition, state health officials believe an additional 67,000 kids are eligible for, but not enrolled in, Medicaid. The cost to add these children to the Medicaid rolls is put at $11 million a year.

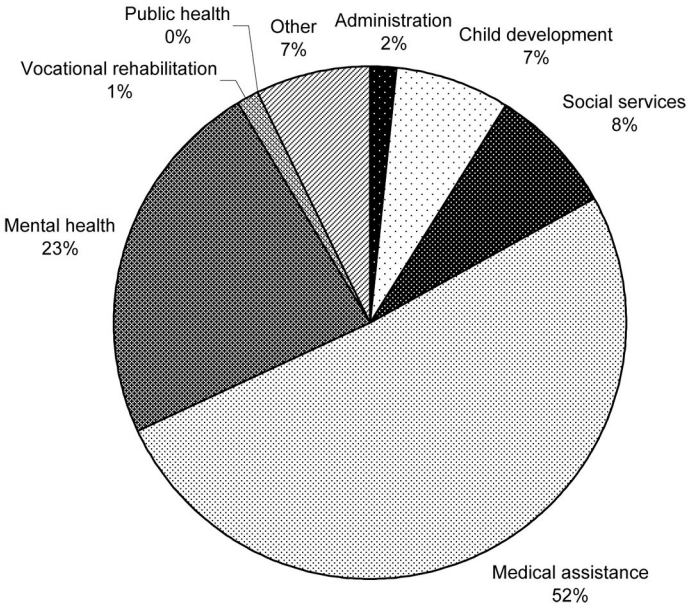
An N.C. Institute of Medicine task force likewise proposes an expanded children's healthcare plan that would cost $106 million. Federal funds would cover 70 cents of each dollar. The plan enjoys Governor Hunt's support.

Finally, even as the governor is proposing to expand Medicaid spending through SCHIP, Carolina ACCESS begins operating in 50 counties.

**Welfare Reform**

A coalition of various pro-welfare groups call for the state to abolish the Work First program. The program's critics oppose the state's two-year time limit for welfare benefits, which is stricter than the federal limit of five years. The coalition, however, seems to oppose any time limit on benefits, declaring that such a threshold is "unrealistic and punitive" and "not tolerable in a civilized and prosperous state." In response, Governor Hunt's office notes that families who are placed on the "cap clock" are leaving welfare at twice the rate than those not on the clock. Meanwhile, Republicans in the House seek to implement a welfare reform package that

**Health & Human Services Budget: FY1997-98**




| 1998 | |
|---|---|
| North Carolina population | 7.43 million |
| Working age (18-64) | 4.67 million |
| Children (<18) | 1.83 million |
| Per capita personal income | $24,743 |
| Compared to U.S. | 92.0 % |
| North Carolina poverty rate, all residents | 14.0 % |
| On Medicaid (all ages) | 9.8 % |
| On Medicaid (18-64) | 5.2 % |
| On Medicaid (<18) | 22.3 % |
| Uninsured, all year or part of year (all ages) | 15.0 % |
| Uninsured, all year or part of year (18-64) | 18.4 % |
| Uninsured, all year or part of year (<18) | 13.2 % |

would allow participating counties to develop their own program requirements and benefits. Any county can participate, but negotiations between the House and the Senate result in a pilot program that limits total enrollment to a cumulative total of no more than 15.5 percent of the state's welfare families. In spite of concerns that the Department of Health and Human Services is discouraging counties from enrolling in the initiative, 23 counties sign up for the House plan in October. The counties comprise 16 percent of the state's welfare families. The following month, six more counties ask to be included in the new welfare program. The combined 29 counties are home to 22 percent of the state's households on welfare – more than the 15.5 percent cap set by the General Assembly. As a result of the overwhelming response, the General Assembly will wait until the next session to select what counties may participate in the program.

**Smart Start**

Governor Hunt's recommended budget proposes expanding Smart Start into all 100 counties over the next two years. In May the governor declares that he "could not in good conscience sign a budget that does not provide full funding for Smart Start." While the Senate votes to give most of the funding Hunt wants for his pet program, the House balks at Hunt's $22.9 million request. Nevertheless, a House budget subcommittee later allocates $21.9 million to Smart Start, only $1 million less than Hunt's request. The final budget (S.L. 1997-443) authorizes $22.9 million for Smart Start expansion planning.

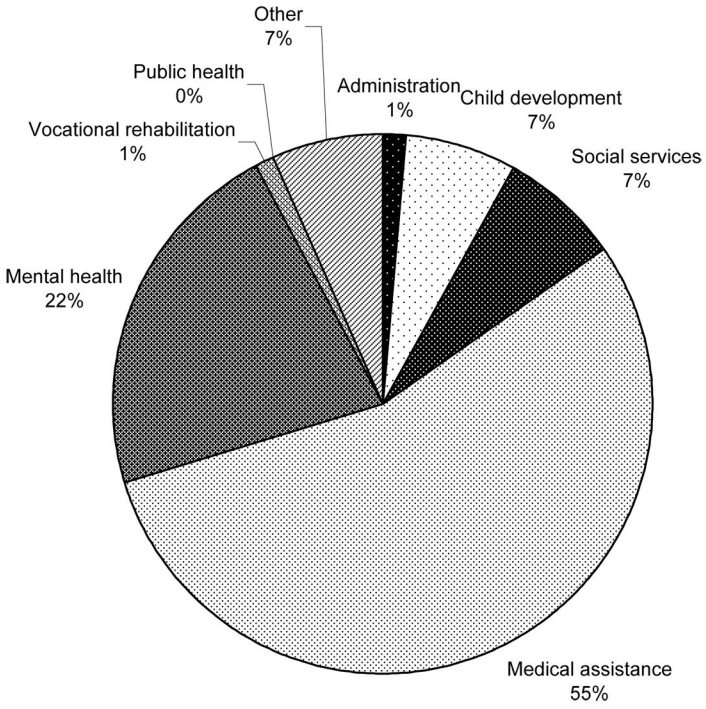
## 1998

Governor Hunt called the General Assembly back to Raleigh in March to discuss his new vision for healthcare for children. In the end, the Legislature agreed to extend taxpayer subsidized healthcare coverage to uninsured children under a program that will cost state and federal taxpayers $108 million per year, with North Carolina taxpayers contributing $28 million annually. Along with agreeing to this massive expansion of Medicaid coverage for children, the House continued its fight for welfare reform.

**NC Health Choice**

Responding to federal legislation passed the year before, the state creates NC Health Choice for Children (S.L. 1998-1es), thereby becoming eligible for an $80 million pot of federal funds

**Health & Human Services Budget: FY1998-99**




## FY 1998-99 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $2.53 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $1,386 million |
| Mental Health/D.D./Subst. Abuse: | $551 million |
| Social Services: | $184 million |
| Child Development: | $172 million |
| Youth Services: | $89 million |
| Office of the Secretary: | $33 million |

dedicated to providing health insurance for children from low income families. In return, the state budget provides $15.6 million in matching funds (for the remainder of the year). As authorized under the State Children's Health Insurance Program (SCHIP), Health Choice covers children in families that earn too much to qualify for Health Check/Medicaid, but whose income does not exceed 200 percent of the federal poverty level. Because the funds for NC Health Choice are set prospectively, i.e., prior to the start of each budget year, the number of children eligible for the program is capped for each fiscal year. Passed in May, Health Choice begins operating in October 1998, with an anticipated enrollment of 71,000 children.

In exchange for agreeing to NC Health Choice, the House pushes through a modest children's health insurance tax credit of $100 to $300 for low- and middle-income families who actually purchase health insurance for their children.

**Medicaid**

Differences between the House and the Senate reach a head during the 1998 session, with the two chambers unable to agree to a budget until October (S.L. 1998-212). The budget includes a provision that requires the Department of Health and Human Services to reduce Medicaid growth to 8 percent per year by 2001.[10]

As a harbinger of future universal healthcare debates, 1998 also features a national debate about whether or not Medicaid should cover Viagra. Two states, New York and Wisconsin, refuse to cover the drug, questioning its necessity. In Wisconsin the Department of Health and Family Services estimates such coverage would cost taxpayers $11.5 million per year. There is no similar debate in North Carolina.

**Welfare Reform**

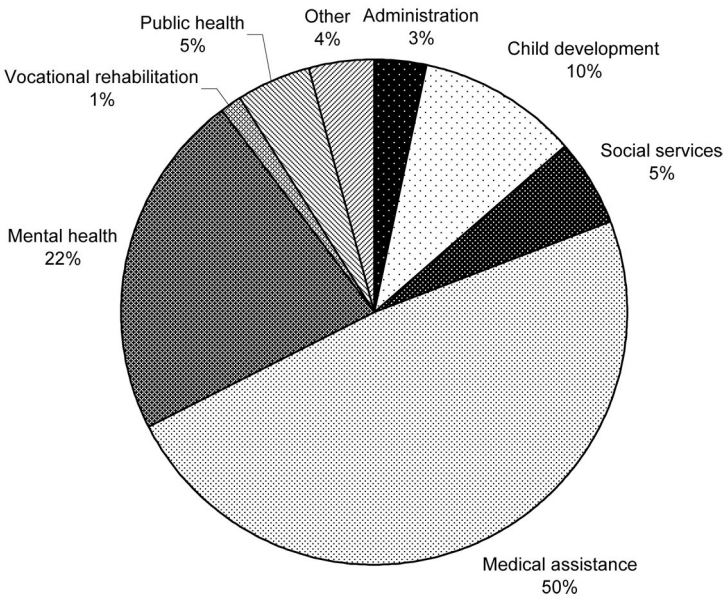
After an overwhelming number of counties sign up for the House welfare reform project, the House pushes to expand the pilot program to more counties. Ultimately, 21 counties that account for almost 9,500 families are picked to participate in the program. In addition, the General Assembly passes a measure that requires the Division of Medical Assistance to reduce the growth rate of Medicaid to 8 percent per year

**Mental Health**

Mismanagement of the state's mental healthcare system prompts federal and state auditors to levy penalties or cash infusions of up to $157 million: $75 million of these related to Medicaid. Many facilities are severely outdated. Another area of concern is the shift in funding away from the state and toward more reliance on federal dollars. Part of this entails increased dependency on Medicaid, which, in turn, has led to tighter budget caps. The following year, the state also ends its "Carolina Alternatives" mental health managed care initiative.

| 1999 | |
|---|---|
| North Carolina population | 7.77 million |
| Working age (18-64) | 4.93 million |
| Children (<18) | 1.89 million |
| Per capita personal income | $25,560 |
| Compared to U.S. | 91.5 % |
| North Carolina poverty rate, all residents | 13.8 % |
| On Medicaid (all ages) | 8.7 % |
| On Medicaid (18-64) | 4.0 % |
| On Medicaid (<18) | 19.2 % |
| Uninsured, all year or part of year (all ages) | 14.5 % |
| Uninsured, all year or part of year (18-64) | 18.2 % |
| Uninsured, all year or part of year (<18) | 12.0 % |

**Health & Human Services Budget: FY1999-00**




**1999**

In 1999, the state expanded Medicaid coverage for select populations, with the end result being that from FY1999 to FY2000 Medicaid enrollment increased by 3.6 percent. The state also added a controversial new coverage mandate for contraception and created a new health policy task force aimed at reducing "health disparities."

**FY 1999-00 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$2.78 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,349 million |
| Mental Health/D.D./Subst. Abuse: | $614 million |
| Child Development: | $286 million |
| Social Services: | $150 million |
| Public Health: | $133 million |
| Office of the Secretary: | $93 million |

**NC Health Choice/Medicaid**

Health Choice meets with uneven success in North Carolina's counties. In some counties one-third or less of eligible children have enrolled. Many counties also say they lack sufficient staff to manage the program.

Medicaid coverage expands again – this time to cover some 40,000 aged, blind and disabled persons at or below the federal poverty level (S.L. 1999-237). The budget also authorizes a study aimed at tripling the income/resources eligibility threshold for these classes of people. At the same time, the budget doubles the Medicaid continuation period for persons leaving public assistance, increasing coverage from 12 months to 24 months.[11] The state also allocates $1 million to the Healthy Carolinians program in 1999, with the intention of helping counties better address local health priorities. Finally, physician reimbursement rates for Medicaid increase from 91 percent to 100 percent.

**Other Highlights**

As an effort to reduce dependency on tax money, many hospitals create fundraising arms – an example is Carolinas HealthCare Foundation in Charlotte.

- **Children's Health**: In 1999, the Department of Health and Human Services establishes the Early Intervention and Education Division so as to help address early childhood health needs.
- **Health Disparities**: A new health policy task force is formed at the initiative of Health and Human Services Secretary David Bruton. Headed by Dr. Samuel Katz, a pediatrician with Duke University, the task force will focus on "health disparities." The group is charged with

producing a five-year plan to integrate and coordinate existing state health programs, as well as other programs, with the aim of reducing health disparities. Healthcare affordability is a leading agenda for the task force.

➤ **Contraception Mandate**: North Carolina becomes one of the first states to require insurance coverage for contraceptives or "family planning services." The new law (S.L. 1999-231) includes an exemption for "religious employers" – i.e., churches and related nonprofits. Small businesses owned by persons who conscientiously oppose contraception are not exempt.

# WHO PAYS FOR ABORTION IN NORTH CAROLINA?

## North Carolina Taxpayers Are Forced To Subsidize Abortion In Several Ways ...

### 1. FEDERAL TAX DOLLARS

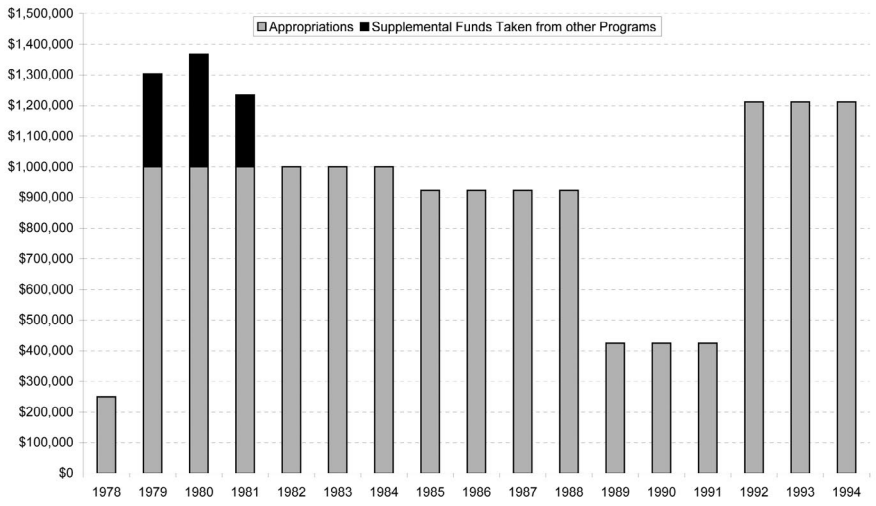
- **Medicaid**: In 1976, the United States Congress passed the Hyde Amendment that limited federal Medicaid funding for abortion to the following circumstances:
  - The woman's life is in danger due to a physical condition related to the pregnancy.
  - The pregnancy is the result of rape.
  - The pregnancy is the result of incest.

  In 1997, Medicaid funds paid for 59 abortions based on rape, 2 cases involving incest and 5 cases in which the mother's life was endangered. In 2001, $37,000 worth of federal money was spent in North Carolina to pay for six abortions; whereas in FY2004, the number of Medicaid-funded abortions was 10.
- **Title X and Other Funding**: The federal government also subsidizes abortion by funding the activities of nongovernmental organizations, such as Planned Parenthood, The Alan Guttmacher Institute, The Population Council, Advocates for Youth, and The Sexuality Information and Education Council of the United States (SEICUS). In 2001, for example, Planned Parenthood spent $162 million in federal funds domestically and another $23.4 million internationally.

### 2. STATE TAX DOLLARS

- **Medicaid:** State and local funds account for 39 cents of every Medicaid dollar spent in North Carolina. Thus, state funds are used to pay for those abortions covered under the Hyde Amendment. The state also subsidizes abortion through the State Abortion Fund, as well as various grants to nonprofits that perform abortions.

**Abortion Fund Appropriations: 1978-1994**




- **State Abortion Fund (SAF)**: In response to the limiting of federal funds for abortion via the Hyde Amendment, Governor Jim Hunt (D) and the state Legislature established the State Abortion Fund (SAF) in 1978 to provide financial assistance for poor women who might otherwise be unable to obtain an abortion. During its 17 years of active operation, the SAF spent $15.8 million in tax dollars to pay for more than 68,000 abortions. The SAF started out with a budget of $250,000 which grew to $1 million in its second year. For four straight years, Governor Hunt raided other programs to expand SAF's operations. These programs included Aid to Families with Dependent Children, mental health assistance, and funds appropriated for rest homes.

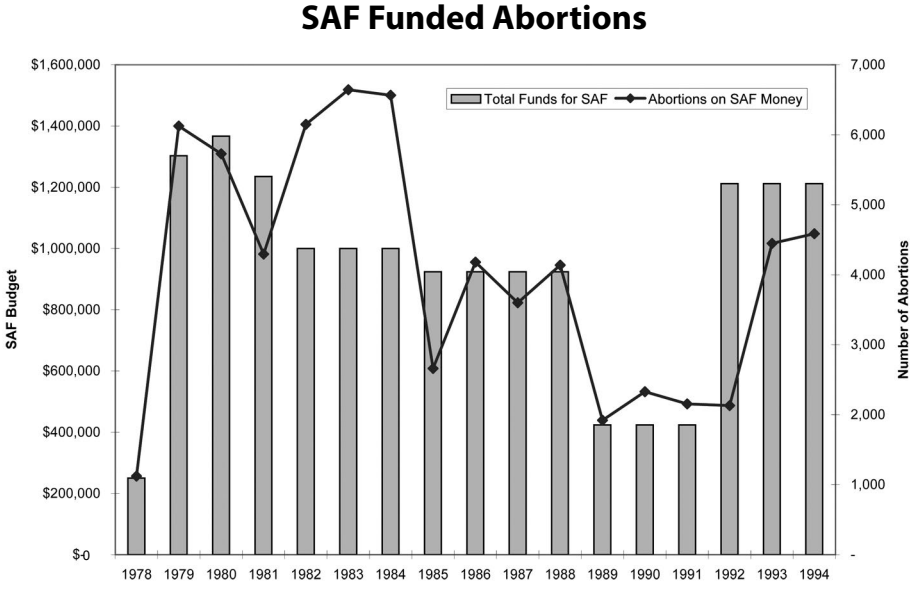
In 1980, SAF funding peaked at $1.4 million. Two years later, in 1983, the number of abortions paid for by the fund also peaked at 6,645. Under Governor Jim Martin's (R) 1985-1993 tenure, the fund's budget fell to $424,000 by fiscal year 1991. The FY1986 budget bill (S.L. 1985-479) also instituted a requirement that in order to be eligible for state funds a woman's health must be impaired by her pregnancy. The budget likewise required that "the State Abortion Fund shall not be available for abortion on demand." The reduction in funding led to a 66 percent reduction in the number of state-funded abortions, which dropped from 1,928 in 1984 to 598 in 1985.

When Hunt returned to office in 1993, SAF funding was restored to $1.2 million. The FY1994 budget also removed language specifying that the fund could not be used for abortion on demand. In addition, the new budget loosened the process by which a physician could recommend an abortion. State funding for abortions,

however, was again cut thanks to the Republican takeover of the House in the 1994 election. In 1995, the General Assembly approved legislation limiting the use of SAF funds to "cases of rape or incest, or to terminate pregnancies that, in the written opinion of one doctor licensed to practice medicine in North Carolina, endanger the life of the mother." The law also restricted appropriations for the fund to $50,000 each year. This reduction had a profound effect on state-funded abortions in North Carolina.

Due mainly to the restrictions on the use of SAF funds, the General Assembly has refrained from using any SAF money to pay for abortions since 1995. The fund still exists, though, and continues to be refunded at the $50,000 annual maximum via the biannual appropriations bill. In 2002, Planned Parenthood made a serious but failed effort to force state taxpayers to fund abortion. Already, in 1997, the North Carolina Supreme Court had ruled that indigent women do not have a right to taxpayer-funded abortions.

Predictably, the effect of cutting off state funds has reduced the number of abortions performed in North Carolina. A 2002 study published by the *Population Research and Policy Review* concluded that the 1995 SAF spending cuts reduced abortions and increased births in North Carolina.




The state also funds family planning services via the N.C. Division of Medical Assistance, a division that had overall net appropriations of $2.6 billion in FY2006-07. Such "family planning services" include voluntary sterilization, pregnancy testing, and most forms of birth control (recall that the birth control pill is also an abortifacient).

■ **North Carolina Health Choice:** The NC Health Choice program was established in 1998 with the intention of providing health insurance to children whose family income is too high to qualify for Medicaid. The program provides for services to children and teens up to their 19th birthday. Coverage under NC Health Choice provides funding for abortion, whether "therapeutic" or elective, through the first 16 weeks of pregnancy for all female subscribers or enrolled female spouses.

■ **State Funding for Nonprofits that Perform Abortions**: Each year, hundreds of millions of taxpayer dollars are allocated to various nonprofit organizations across the state. Some of the recipients of these funds are organizations that provide abortion and birth control. The most notable of these groups is Planned Parenthood – which received a total of $843,000 in 2005 and 2006 alone.

■ **State Funding and Universal Healthcare**: Under a statewide universal health insurance system, it is very likely that taxpayers would be forced to pay for both abortion and contraceptives. President Clinton's stillborn health plan contained mandatory funding of abortions. That is reason enough to expect abortion funding under a state government health monopoly. Furthermore, universal, single-payer health systems in Scandinavia provide funding for abortions, which could explain why one in four pregnancies are terminated with abortion in Sweden. These systems often serve as role models for American proponents of universal health insurance.

Another reason it is likely that a universal health system would fund abortion is that North Carolina already requires private insurance plans to cover "family planning services." It would be easy for the state to include abortion under that title. Under such a system, it would be all but impossible to ban taxpayer funding for abortion, unless *Roe v. Wade* were reversed. A national universal health insurance program, such as the 1994 "HillaryCare" system, would have similar implications.

Over the past several years, Civitas polling data has consistently shown that a majority of voters in North Carolina identify themselves as pro-life. For these people, paying taxes to fund abortion violates the inalienable right to freedom of conscience. Still others who may not identify themselves as pro-life oppose government funding for abortion for other social and fiscal reasons.

# 2000-2005

Owing to an expansion of Medicaid enrollment among working-age North Carolinians during the recession, the Medicaid share of the state budget increased significantly during this period. Historically, dependency on tax-paid entitlements does not go away once a recession ends. Thus we find that the Medicaid rolls swelled from 840,000 in 2000 to 1.06 million in 2003, with no drop off in 2004 or 2005.[12] During the same period (FY2000-2005), Medicaid spending in the state budget went from $1.35 billion to $2.44 billion.

At 6.8 percent on average per year, DHHS spending grew by 32.5 percent from 2000 to 2005. Again, the budget for the Division of Medical Assistance (DMA) was the primary driver behind this growth. Between 2000 and 2005, DMA appropriations increased by 59 percent, increasing the division's share of the DHHS budget from half to almost two-thirds.

It is noteworthy that nominal changes in appropriations for the DMA budget mirror almost to the dollar changes in the overall DHHS budget. DMA spending, however, is driven by Medicaid spending, which is dictated almost entirely by federal mandates. Thus the increase in the DMA budget suggests that the state has lost effective control over its healthcare budget (see Q&A #1).

Related to the growth in Medicaid spending is the concurrent expansion of North Carolina's SCHIP program, NC Health Choice. Between 2000 and 2005, appropriations for NC Health Choice expanded by 117 percent; albeit at $55 million this increase only represents 1.4 percent of the budget.

By the turn of the millennium, 203,000 of North Carolina's 2 million children lacked health insurance for the whole year or part of the year. By 2005 the number of uninsured children had increased to 262,000 out of 2.2 million. At the same time, 588,000 children were on Medicaid, an increase of 89,000 since 2000. 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. These changes are in line with previous trends that suggest that SCHIP is crowding out private insurance consumers. Thus although Medicaid coverage has risen steadily, the rate of uninsured children has not declined. Instead, there has been a long-term drop in the rate of privately insured children.

Among working-age North Carolinians, the group of uninsured grew by 25 percent to 1.1 million. Meanwhile, private insurance coverage for this group shrunk by 2.1 percent. The 1999-2001 recession (which really lasted until 2002 in North Carolina[13]) also brought about a significant increase in Medicaid enrollment among working age North Carolinians. Between 2000 and 2005, 59 percent more people enrolled in Medicaid, bringing the total of Medicaid clients aged 18-64 to 443,000.

In short, in spite of a 1998 directive requiring the Department of Health and Human Services to reduce Medicaid growth to 8 percent per year by 2001, Medicaid spending has increased significantly over the past several years.

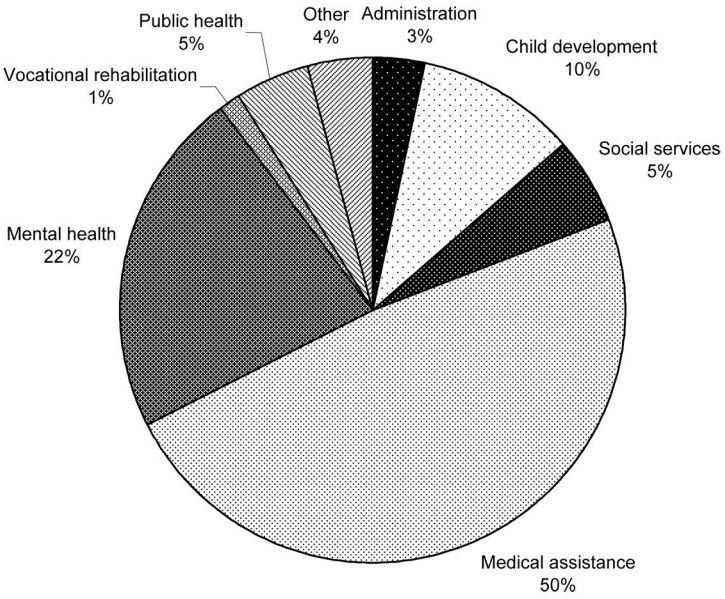
# 2000

A nationwide tobacco company lawsuit settlement sparked debate over how to spend North Carolina's share. In spite of a slowing economy, Medicaid funding was also reduced. In addition, the General Assembly passed legislation requiring the Secretary of Health and Human Services to adopt standards and goals for community health to measure the state's effectiveness in improving the health status of its citizens.

## FY 2000-01 HEALTH & HUMAN SERVICES BUDGET

| | |
|---|---|
| **Total Appropriations** | **$3.01 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,540 million |
| Mental Health/D.D./Subst. Abuse: | $608 million |
| Child Development: | $305 million |
| Social Services: | $186 million |
| Public Health: | $132 million |
| Office of the Secretary: | $90 million |

**Health & Human Services Budget: FY2000-01**




### Budget Cuts

In December 1999, the state uses a significant portion of the Medicaid reserve fund to pay for recovery efforts resulting from Hurricane Floyd. At the same time, the economy starts to slow, bringing in lower than expected tax revenues. In response, taxes are raised, but the state budget also sees some cuts. In particular, Medicaid is cut by $32 million in recurring funds while the Medicaid reserve fund is reduced by $70 million. At the same time, growing interest in NC Health Choice fuels Medicaid enrollment, as some families applying for Health Choice learn they are actually eligible for Medicaid.[14] In addition, per capita expenditures increase rapidly in 2000, going from 2.6 percent in FY1999 to 12.4 percent in 2000.

### Health and Wellness Trust Fund

In 2000, the General Assembly creates the Health and Wellness Trust Fund in anticipation of money to be distributed from the Master Settlement Agreement: the result of a national lawsuit levied against seven major tobacco product manufacturers. Each state will receive a share of the overall proceeds of $206 billion, with North Carolina acquiring $4.6 billion over the course of the next 25 years.

By law (S.L. 2000-147) 25 percent of funds received from the Master Settlement are to be placed in the Health and Wellness Trust Fund. The fund is to be used for the following three purposes: 1) "to address the health needs of vulnerable and underserved populations in North Carolina"; 2) "to fund programs and initiatives that include research, education, prevention, and treatment of health problems in North Carolina and to increase the capacity of communities to respond to the public's health needs"; and 3) "to develop a comprehensive, community-based plan with goals and objectives to improve the health and wellness of the people of North Carolina with a priority on preventing, reducing, and remedying the health effects of tobacco use and with an emphasis on reducing youth tobacco use." The legislation also establishes an 18-member commission to administer the fund; the commission is comprised of appointees made by the governor, the president pro tempore of the Senate, and the speaker of the House. Grants from the fund must be used for health efforts

| 2000 | |
|---|---|
| North Carolina population | 8.0 million |
| Working age (18-64) | 5.04 million |
| Children (<18) | 2.01 million |
| Per capita personal income | $27,068 |
| Compared to U.S. | 90.7 % |
| North Carolina poverty rate, all residents | 12.5 % |
| On Medicaid (all ages) | 12.5 % |
| On Medicaid (18-64) | 5.5 % |
| On Medicaid (<18) | 22.3 % |
| Uninsured, all year or part of year (all ages) | 13.6 % |
| Uninsured, all year or part of year (18-64) | 17.4 % |
| Uninsured, all year or part of year (<18) | 10.1 % |

and are intended to supplement, not supplant, other state expenditures for health.

Critics of the legislation suggest that the share of funds allocated to address health costs related to smoking is not enough. They are concerned that lawmakers will use the funds for unrelated items. Accordingly, House Majority Leader Philip Baddour (D-Wayne) introduces a bill that would earmark funds from the settlement for specific groups. One of those groups would be tobacco farmers. The bill dies in committee.

**State Health Standards**
The 2000 budget includes special provisions aimed at developing "state health standards." In particular, the law (S.L. 2000-67) requires the Secretary of Health and Human Services to "adopt measurable standards and goals for community health against which the State's actions to improve the health status of its citizens will be measured." The secretary is to report his findings to the governor and the General Assembly as regards progress in the following areas: 1) "how the State compares to national health measurements and established State goals for each standard"; 2) "steps taken by State and non-State entities to meet established goals"; and 3) "additional steps proposed or planned to be taken to achieve established goals."

**Prescription Drug Assistance for the Elderly**
Funding for this program was increased from $0.5 million to $1 million for FY2000-01. The Elderly Prescription Drug Assistance Program pays for outpatient prescription drugs for seniors who suffer from cardiovascular disease or diabetes and are also ineligible for full Medicaid benefits. Recipients must have annual incomes of less than 150 percent of the federal poverty level.

A special provision in the state budget establishes the Legislative Study Commission on Prescription Drug Assistance for Elderly and Disabled Persons. The purpose of this 12-member commission is to "determine the feasibility of assisting all elderly and disabled residents of North Carolina who need assistance with the purchase of prescription drugs because of lack of government-sponsored or private health insurance coverage for prescription drugs." In other words, the commission seeks to provide taxpayer-subsidized prescription coverage for all seniors in North Carolina.

## 2001

As the economy worsened, enrollment in the state's children's health insurance program exceeded expectations, causing an enrollment freeze. 2001 also saw the implementation of the governor's "More at Four" program (under the DHHS budget). In addition, the Legislature passed a "Managed Care Patients' Bill of Rights" that made it easier for aggrieved consumers to sue managed care organizations. The General Assembly also passes an ambitious mental health reform bill with the goal of partially privatizing the mental health system and moving treatment from state mental health hospitals to community providers.

**Health Choice**
The General Assembly freezes enrollment in NC Health Choice over concerns that funding will run out. The anticipated shortfall comes as a

| 2001 | |
|---|---|
| North Carolina population | 8.10 million |
| Working age (18-64) | 5.02 million |
| Children (<18) | 2.12 million |
| Per capita personal income | $27,493 |
| Compared to U.S. | 89.9 % |
| North Carolina poverty rate, all residents | 12.5 % |
| On Medicaid (all ages) | 11.6 % |
| On Medicaid (18-64) | 6.3 % |
| On Medicaid (<18) | 25.4 % |
| Uninsured, all year or part of year (all ages) | 14.4 % |
| Uninsured, all year or part of year (18-64) | 18.6 % |
| Uninsured, all year or part of year (<18) | 10.9 % |

## FY 2001-02 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $3.40 billion**

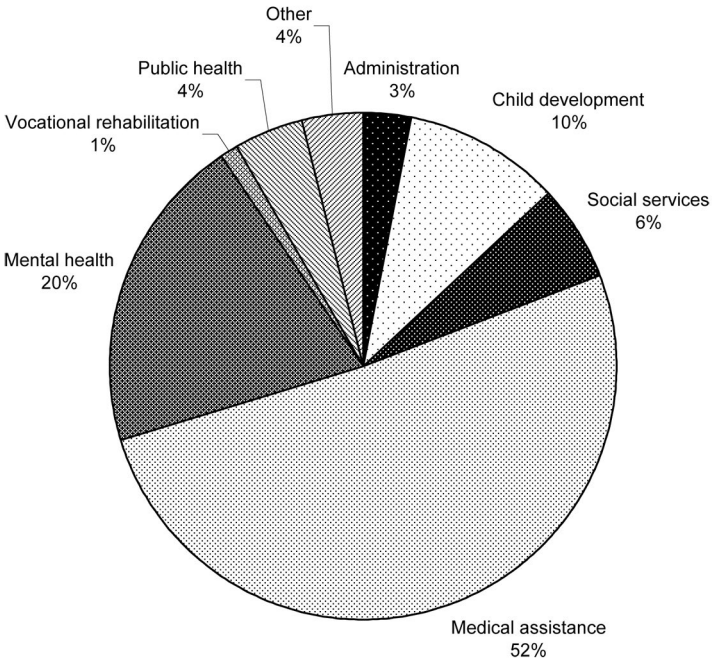
*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $1,981 million |
| Mental Health/D.D./Subst. Abuse: | $581 million |
| Child Development: | $289 million |
| Social Services: | $189 million |
| Public Health: | $109 million |
| Office of the Secretary: | $70 million |

result of enrollment growing faster than state budget projections. Under the terms of the 1997 law that launched the program, 10 states – including North Carolina – are to receive money left unspent by other states on their child health insurance programs. North Carolina's share for 2001 is $21 million. But even this infusion of federal dollars proves insufficient to cover the growing number of enrollees. Remarks June Milby, state coordinator of NC Health Choice: "We were hoping for more money than this. But the reality is, we need some additional money. We got some, and hopefully, we can use it to serve more children."

The 2001 budget (S.L. 2001-424) appropriates $20.5 million to expand the program over the next two years – in effect, doubling appropriations for NC Health Choice. Instead of capping enrollment at a specific level – 6 percent, for instance – the budget directs the Department of Health and Human Services to

**Health & Human Services Budget: FY2001-02**




"manage Program enrollment in a way that maximizes the number of children served within existing funds." In addition, the General Assembly eliminates a 60-day waiting period that required enrollees to be uninsured for at least 60 days before applying for Health Choice.

**Bioterrorism**

In response to the September-October anthrax scare following the September 11, 2001, terrorist attack, the North Carolina General Assembly enacts a number of laws related to bioterrorism. In particular, the Legislature authorizes the governor to use up to $30 million from the Savings Reserve Account to "implement defense measures against all forms of terrorism, including, but not limited to, biological, nuclear, chemical, incendiary, and explosive terrorism and to address other terrorism issues." Once used, the funds are to be paid back. The law also allocates $1.9 million to the Department of Crime Control and Public Safety to implement "terrorism defense measures" (S.L. 2001-457). Additional legislation (S.L. 2001-469) establishes a biological agents registry and creates new penalties for the "unlawful manufacture, assembly, possession, storage, transportation, sale, purchase, delivery, or acquisition of nuclear, biological, or chemical weapons of mass destruction."

**Patients' Bill of Rights**
The General Assembly passes a Managed Care Patients' Bill of Rights that makes it easier for patients to sue managed care organizations. The legislation also creates new procedures for binding arbitration related to coverage decisions. In addition, the state budget sets aside $15 million to implement the 1996 federal "Health Insurance Portability and Accountability Act." The act permits employees to retain insurance coverage even when they lose or change jobs.

**More at Four**
Governor Mike Easley (D) launches the "More at Four" program, a state-subsidized pre-kindergarten program for at-risk children. The General Assembly allocates $6.46 million for a More at Four pilot program, with the aim of ensuring "that all children have an opportunity to succeed in kindergarten" (S.L. 2001-424). The program is funded through the Department of Health and Human Services budget, but is to be developed and implemented by both the Department of Health and Human Services and the Department of Public Instruction.

**Medicaid**
Approximately 80,200 Work First enrollees are reinstated for up to four months of Medicaid benefits once it is learned that the state prematurely cut off their benefits.

**Mental Health Reform**
In an attempt to privatize the mental health system, new legislation (S.L. 2001-437) transfers many functions, such as case management, from counties to private providers. The move is part of a broad initiative aimed at shifting mental health treatment away from an institutional setting to a community-based approach. Part of the reform entails closing two of the state's mental health hospitals (Dix and Umstead) and transferring remaining patients to one new facility (Central Regional). The legislation also consolidates the state's 41 area mental health authorities into what are supposed to be about 20 local management entities (LMEs) responsible for planning and managing mental health services separately delivered by private providers. As part of the reform, legislators likewise establish a mental health trust fund, which is subsequently raided to cover the FY2001-02 General Fund budget shortfall.

## 2002

As the economic slowdown continued, the General Assembly cut several programs within the Department of Health and Human Services. Continued fears related to bioterrorism also enabled the General Assembly to pass a far-reaching health powers emergency act. Finally, both NC Health Choice and More at Four expanded rapidly in 2002.

**DHHS Budget**
The 2002 state budget (S.L. 2002-126) cuts the Department of Health and Human Services budget in several areas. The most important reductions include: 1) $6.6 million in cuts and the elimination of 12 positions within the Division of Public Health; 2) $2 million to reduce expenditures and vacant positions in Developmental Evaluation Centers (DEC); and 3) $1 million in aid-to-county funds.[15] All in all, the budget cuts $47.7 million from the DHHS budget. Still, some programs also receive increased funding, including $615,000 to reduce out-of-wedlock births; $570,000 for the Adolescent Pregnancy Prevention Program; and $250,000 for the Healthy Start Foundation.[16]

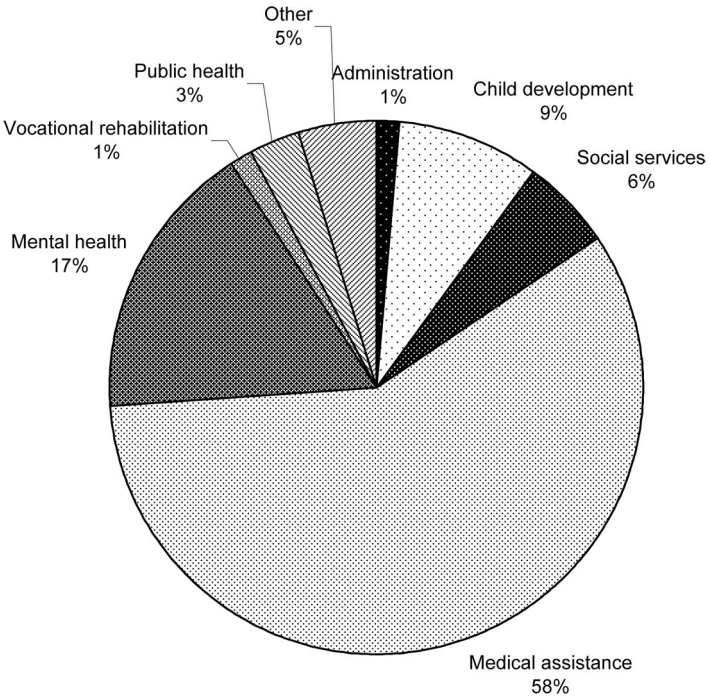
**FY 2002-03 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$3.64 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $2,219 million |
| Mental Health/D.D./Subst. Abuse: | $581 million |
| Child Development: | $289 million |
| Social Services: | $195 million |
| Public Health: | $104 million |
| Office of the Secretary: | $48 million |

| 2002 | |
|---|---|
| North Carolina population | 8.16 million |
| Working age (18-64) | 5.11 million |
| Children (<18) | 2.05 million |
| Per capita personal income | $27,510 |
| Compared to U.S. | 89.3 % |
| North Carolina poverty rate, all residents | 14.3 % |
| On Medicaid (all ages) | 11.5 % |
| On Medicaid (18-64) | 6.0 % |
| On Medicaid (<18) | 27.0 % |
| Uninsured, all year or part of year (all ages) | 16.8 % |
| Uninsured, all year or part of year (18-64) | 21.5 % |
| Uninsured, all year or part of year (<18) | 12.7 % |

State budget writers also express concern over growing Medicaid costs. Declares the budget: "The General Assembly finds that over the last two fiscal years, the cost of the Medicaid program has increased over one billion dollars ($1,000,000,000). The downturn in the economy has caused an unforeseeable increase in the number of persons eligible for the program. Even with the significant expansion funds appropriated for the increased costs, transfers of funds to meet obligations for the 2001-2002 fiscal year, and significant cost-savings measures imposed by the General Assembly and the Department of Health and Human Services, Medicaid will still need additional State funds next year to cover increased costs. The General Assembly further finds that due to the downturn in the economy and the loss of jobs in various sectors of the economy, the State must undertake various economic initiatives." These measures include transferring $38 million from the Tobacco Trust Account/Master Settlement Agreement to support General Fund appropriations for FY2003; and transferring $40 million from the Health and Wellness Trust Fund to support General Fund appropriations for FY2003. The Legislature also authorizes the use of up to $3 million from the Health and Wellness Trust Fund to institute a Senior Prescription Drug Access Program. The purpose of the program is to provide assistance to seniors and low income clients in "accessing public and private prescription drug assistance programs."

**Health & Human Services Budget: FY2002-03**




**Bioterrorism/MSEHPA**

The state moves to enact portions of the Model State Emergency Health Powers Act. Commissioned by the Centers for Disease Control (CDC), the Model State Emergency Health Powers Act (MSEHPA), was aimed at expanding executive power during public health emergencies – defined as any "potential serious threat to the public's health" – including biological attacks, virus and flu outbreaks, and even natural disasters. The law also "generally authorized PHA [public health authorities] to use every available means to control a threat to the public health during an emergency."

While North Carolina does not enact MSEHPA in its entirety, the General Assembly gives the state health director greatly expanded powers in the event of a real or suspected "public health threat" (S.L. 2002-179). These powers include: 1) requiring any person or animal to submit to examination to determine possible exposure to nuclear, biological, or chemical agents; 2) testing private property to determine the presence of nuclear, biological, or chemical agents; 3) evacuating or closing private sites

(land or building or other structure) to investigate suspected contamination; 4) quarantining people and animals that may be contaminated by a biological, chemical or nuclear agent; 5) limiting the right of family members and others to visit persons and animals under quarantine. The law defines " public health threat" as "a situation that is likely to cause an immediate risk to human life, an immediate risk of serious physical injury or illness, or an immediate risk of serious adverse health effects."

The law also gives state officials expanded access to private health records.

**Medicaid/NC Health Choice**
Thanks to the recession, Medicaid eligibles increase by 7 percent between FY2001 and FY2002. In response, the Division of Medical Assistance implements several cost containment measures. In particular, the department takes steps to reduce the use of prescription drugs. These measures include: limiting prescriptions to a 34-day supply, excepting birth control and hormone replacement therapy; increasing copays from $1 to $3; and reducing dispensing fees from $5.60 to $4.00 per prescription.

Despite cuts elsewhere in the budget, the General Assembly expands NC Health Choice by more than $20 million. This move nearly doubles its size, increasing spending from $21.7 million over the previous year to $41.8 million.

**More at Four**
The General Assembly appropriates $28 million in expansion funding for More at Four. The increase grows the program by more than four times its initial funding.

## 2003

Trends prevalent in recent years continued through 2003. NC Health Choice and Smart Start spending expanded rapidly. Rising Medicaid costs also prompted lawmakers to look to Canada for discounts on prescription drugs purchased by the state. In addition, the state passed another coverage mandate requiring insurers to cover screening for ovarian cancer and cervical cancer.

**Rising Prescription Drug Costs**
In an effort to curb Medicaid costs, North Carolina joins 12 other states that meet with five Canadian drug companies to learn how to legally purchase cheaper prescription drugs from Canada. (Earlier in the year, the city of Boston and the state of New Hampshire had already announced plans to start to purchase prescription drugs from Canadian suppliers.)

At the same time that the state is considering importing drugs from Canada, the N.C. Board of Pharmacy moves to shut down five private firms that are importing drugs from Canada for sale on the private market.

**Coverage Mandates**
The state passes a coverage mandate (S.L. 2003-223) requiring insurers to provide annual screening for women age 25 and older who are at-risk for ovarian cancer. The Legislature also adds another mandate requiring annual testing for cervical cancer. By contrast, the U.S. Preventive Services Task Force recommends women be screened for cervical cancer every three years for a 91percent reduction in the incidence of invasive cervical cancer.

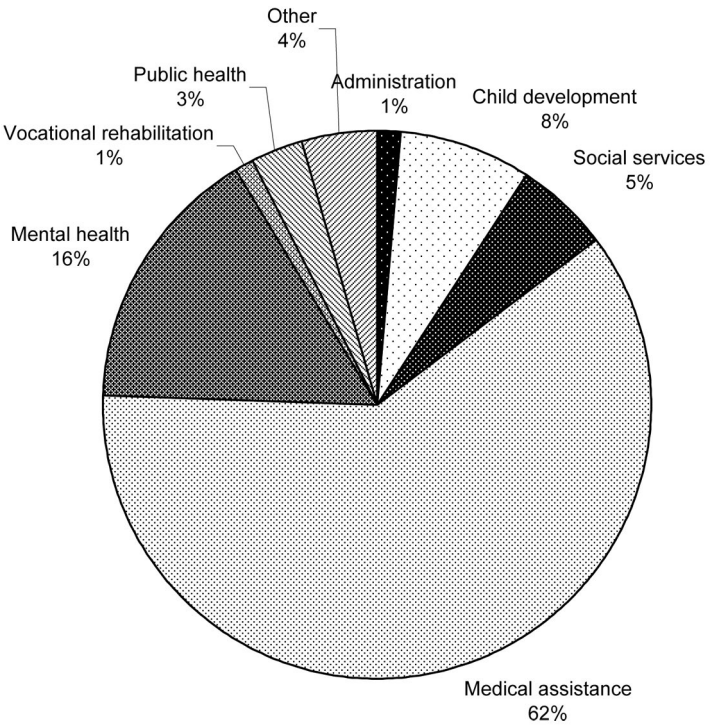
**Other Highlights**
- **NC Health Choice**: Appropriations for NC Health Choice increase by another 29 percent. Total spending climbs to nearly $54 million.

**FY 2003-04 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$3.38 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $1,987 million |
| Mental Health/D.D./Subst. Abuse: | $577 million |
| Child Development: | $259 million |
| Social Services: | $179 million |
| Public Health: | $124 million |
| Office of the Secretary: | $82 million |

| 2003 | |
|---|---|
| North Carolina population | 8.25 million |
| Working age (18-64) | 5.22 million |
| Children (<18) | 2.08 million |
| Per capita personal income | $27,919 |
| Compared to U.S. | 88.7 % |
| North Carolina poverty rate, all residents | 15.7 % |
| On Medicaid (all ages) | 12.8 % |
| On Medicaid (18-64) | 6.3 % |
| On Medicaid (<18) | 30.4 % |
| Uninsured, all year or part of year (all ages) | 17.3 % |
| Uninsured, all year or part of year (18-64) | 22.3 % |
| Uninsured, all year or part of year (<18) | 12.0 % |

**Health & Human Services Budget: FY2003-04**




- **More at Four**: In just its third year, More at Four spending jumps to $43 million – an increase of nearly 570 percent since the program's inception.
- **ACCESS II and III**: The General Assembly reduces the Medicaid budget in anticipation of savings gained from increasing enrollment in the state's three ACCESS programs. Enrollment in ACCESS II and III is expected to grow from 250,000 to 650,000. By June 2004, the program has expanded to include 13 more networks (24 counties), with an enrollment increase of 142,669 clients.[17]
- **Smoking**: New legislation bans smoking in additional areas on UNC campuses (S.L. 2003-292). These include residence halls, enclosed recreational centers and health services facilities. The law requires that universities "make a reasonable effort to provide residential smoking rooms in residence halls in proportion to student demand for those rooms."
- **Bioterrorism**: In response to controversy over the White House's proposal to mandate smallpox vaccination (cf. also S.L. 2003-169), the state passes legislation directing DHHS and local health departments to offer vaccination to first responders "who may be exposed to infectious diseases when deployed to disaster locations. The vaccinations shall include, but are not limited to, hepatitis A vaccination, hepatitis B vaccination, diphtheria-tetanus vaccination, influenza vaccination, pneumococcal vaccination, and other vaccinations when recommended by the United States Public Health Service and in accordance with Federal Emergency Management Directors Policy." Participation in the program is voluntary, except for persons "classified as having 'occupational exposure' to bloodborne pathogens."

## 2004

The year began with signs that the economy was improving. With the "temporary" sales and income tax increases still in place, tax revenues brought in a budget surplus. The final $15.9 billion budget (S.L. 2004-124) expanded NC Health Choice by $18 million and More at Four by $16 million. In January 2005, the Department of Health and Human Services (DHHS) submitted the final report from the Public Health Task Force 2004 to the General Assembly.

| 2004 | |
|---|---|
| North Carolina population | 8.43 million |
| Working age (18-64) | 5.35 million |
| Children (<18) | 2.15 million |
| Per capita personal income | $29,579 |
| Compared to U.S. | 89.4 % |
| North Carolina poverty rate, all residents | 14.6 % |
| On Medicaid (all ages) | 12.1 % |
| On Medicaid (18-64) | 7.7 % |
| On Medicaid (<18) | 24.0 % |
| Uninsured, all year or part of year (all ages) | 15.7 % |
| Uninsured, all year or part of year (18-64) | 19.8 % |
| Uninsured, all year or part of year (<18) | 10.3 % |

## FY 2004-05 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $3.86 billion**

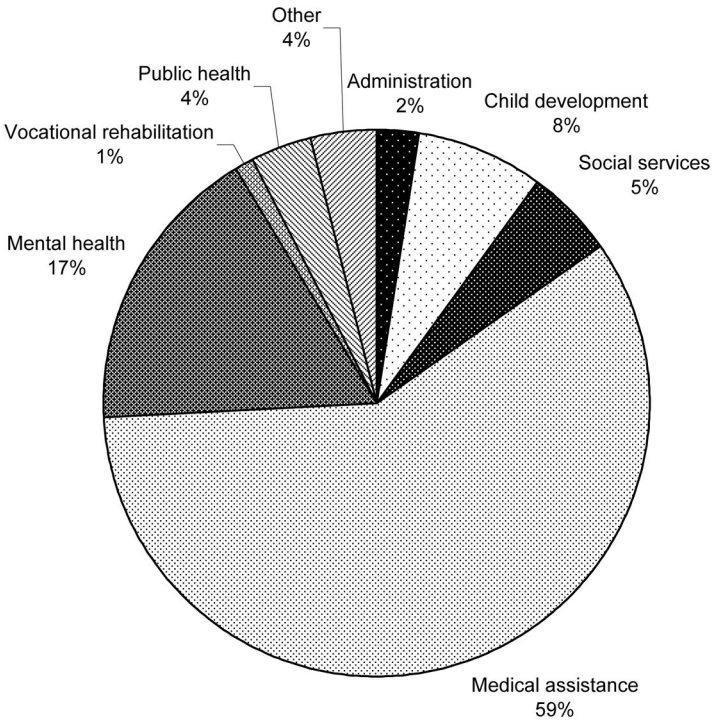
*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $2,449 million |
| Mental Health/D.D./Subst. Abuse: | $580 million |
| Child Development: | $259 million |
| Social Services: | $189 million |
| Public Health: | $123 million |
| Office of the Secretary: | $81 million |

**Public Health Task Force 2004**

Created by the General Assembly in 2003, the Public Health Task Force 2004 committee was established "to strengthen public health infrastructure, improve health outcomes, and eliminate health disparities."[18] According to the report, "North Carolina's public health infrastructure remains critically underdeveloped in a number of important areas." To address these needs, the report makes 18 recommendations. These include: 1) allocating $15 million to help local health departments improve delivery of what the report identifies as "Ten Essential Public Health Services"; 2) $2 million to create four "public health incubators"; and 3) $5.2 million to expand local public health databases. The General Assembly responds by funding several of the recommended initiatives in the FY2005 budget (S.L. 2004-124). These include: $1.1 million for the North Carolina Institute for Public Health (of UNC Chapel Hill) to oversee the development of public health incubators; and $50,000 to expand a pilot accreditation process for local health departments. A year later, the General Assembly requires all local health departments to obtain accreditation (S.L. 2005-369). (A second task force report was issued in fall 2006.)

**Health & Human Services Budget: FY2004-05**



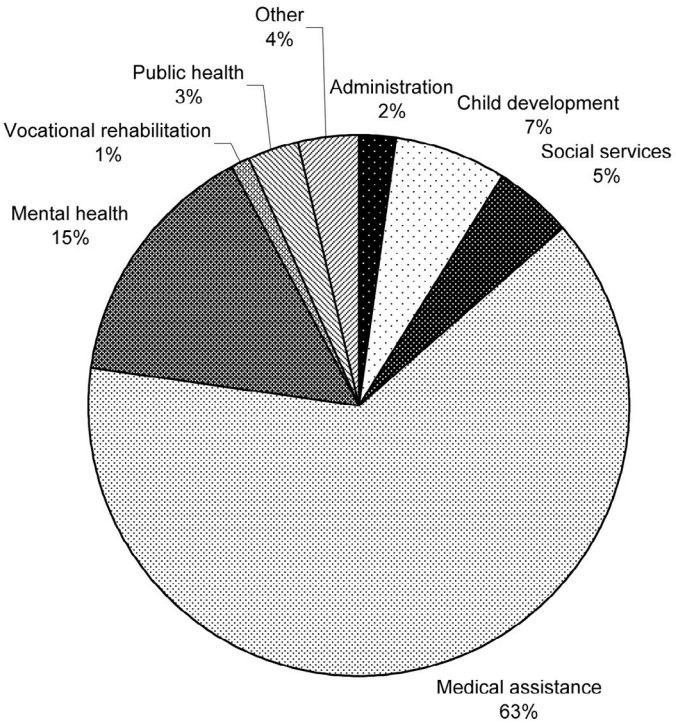

**Other Highlights**

- **NC Health Choice**: An additional $18 million allocation pushes spending for NC Health Choice to $72 million. In four short years (since FY2002), appropriations for the program have climbed 232 percent.
- **More at Four**: More at Four funding increases by $16 million, with overall spending reaching more than $58 million. This year's expansion includes funding for an additional 2,000 slots.
- **AIDS**: The General Assembly allocates more than $2.7 million to provide taxpayer-subsidized prescriptions for HIV/AIDS patients with income levels at or below 125 percent of federal poverty level. Prior to this time, the state reportedly had the

longest AIDS drug assistance waiting list in the country.[19] Earlier in the year, the A.J. Fletcher Foundation had lobbied hard to expand such assistance. According to Fletcher spokesman Chris Fitzsimon, "We want to reframe the way we think about human services issues and budget and tax issues."

- **Community Health**: The 2004 budget also appropriates $7 million in community health grants to be used to establish and maintain community health centers, rural health centers and public health departments.
- **School Nutrition**: Continuing a trend in which the Department of Education is used to expand what are typically healthcare and welfare initiatives, the General Assembly establishes the Healthful School Food Choices Pilot Program to "support the efforts of local school administrative units to provide only healthful, nutritious food choices to students." The pilot program will go into operation in eight local school administrative units.
- **Bioterrorism/Public Health Preparedness**: New legislation (S.L. 2004-80) further defines the state health director's powers to quarantine persons and animals.

**Health & Human Services Budget: FY2005-06**




## FY 2005-06 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $4.03 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $2,510 million |
| Mental Health/D.D./Subst. Abuse: | $603 million |
| Child Development: | $268 million |
| Social Services: | $189 million |
| Public Health: | $152 million |
| Office of the Secretary: | $114 million |

**Medicaid**

Driven largely by Medicaid expansion, Division of Medical Assistance spending climbs to a new high, consuming more than 63 percent of the DHHS budget. This spending draws scrutiny from the federal government, however, with the Government Accountability Office (GAO) alleging that North Carolina is using its county share program to inflate reimbursements from the federal government. By overpaying hospitals and counties with funds that are later returned, the state obtains more federal money than it should.

## 2005

With past legislation (see 1998) having failed to reign in Medicaid spending, the Senate tried to contain Medicaid costs by cutting some 65,000 clients from the rolls. As budget negotiations drifted into July, the Senate caved on the proposal, agreeing instead to fund a study of the problem. The FY2006 budget again expanded enrollment for NC Health Choice, allocating an additional $6.1 million over the previous year's spending. Likewise, More at Four spending continued to rise (S.L. 2005-276). The General Assembly also passed several important school health initiatives.

| 2005 | |
|---|---|
| North Carolina population | 8.54 million |
| Working age (18-64) | 5.33 million |
| Children (<18) | 2.21 million |
| Per capita personal income | $31,209 |
| Compared to U.S. | 90.0 % |
| North Carolina poverty rate, all residents | 13.0 % |
| On Medicaid (all ages) | 13.3 % |
| On Medicaid (18-64) | 8.3 % |
| On Medicaid (<18) | 26.7 % |
| Uninsured, all year or part of year (all ages) | 16.0 % |
| Uninsured, all year or part of year (18-64) | 20.6 % |
| Uninsured, all year or part of year (<18) | 11.9 % |

In response to skyrocketing Medicaid spending, Senate budget writers look to contain costs (about 12 percent annually) by cutting several optional state-funded benefits and lowering the income threshold for certain recipients. The savings measure would cut 65,000 people from the Medicaid rolls, most of whom (an estimated 57,000) are already on Medicare. Warns Senator Kay Hagan (D-Guilford): "The state needs ideas for holding down Medicaid expenses. If we don't, there won't be enough money to cover other items." In the end, House negotiators win back Medicaid coverage for the 65,000 clients by agreeing to a Senate proposal to continue to study the problem.

Medicaid reimbursement rates are also frozen at 2004-05 amounts in an attempt to slow Medicaid spending. The budget likewise reduces funding for personal care services by $13.7 million in FY2006 and $16.1 million in FY2007. In addition, the county Medicaid share for select mental health services is to be increased until it reaches 15 percent of the nonfederal share by FY2010 while the county share for personal care services in adult care homes is to be decreased until it reaches 15 percent of the nonfederal share by FY2010. Finally, state law explicitly exempts applicants for emergency Medicaid from having to show documentation that proves residency.

**NC Health Choice**

Even as the state moves to reduce Medicaid spending, North Carolina shifts state-subsidized insurance coverage for kids under age six from NC Health Choice to Medicaid. In return, the budget expands Health Choice enrollment for children age 6 to 18 (S.L. 2005-276). Eligibility encompasses families that are uninsured; ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance; and who earn between 100 percent and 200 percent of FPL. Enrollment for NC Health Choice is capped at 3 percent for every 6 months.

**More at Four**

The biennial budget appropriates $16.6 million in expansion funds to accommodate 3,200 more slots over the next two years. It also provides an additional $150 per slot. Total spending for More at Four reaches $74 million, more than double the amount of just three years ago.

**Health Disparities Initiative**

With the aim of reducing disparities in health status between majority and minority populations, the budget allocates $2 million in nonrecurring funds for the Community-Focused Eliminating Health Disparities Initiative. The program provides funds to community-based organizations with the aim of enabling such groups "to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to white persons. The areas of focus on health status shall be infant mortality, HIV-AIDS and sexually transmitted infections, cancer, diabetes, and homicides and motor vehicle deaths."

**School Health**

The General Assembly also passes several laws pertaining to school health. These include: 1) a measure permitting students with asthma to self-administer medication (S.L. 2005-22); 2) legislation establishing statewide nutrition standards for vending products sold in schools (S.L. 2005-253); and 3) a law directing the State Board of Education to establish nutrition standards for school meals, afterschool snacks, and other foods and beverages (S.L. 2005-457).

The infamous "Black Eye Bill" also passes as a special provision in the 2005 budget. The law requires children entering kindergarten to submit to a comprehensive eye exam.

**Cigarette Tax**

After a statewide poll shows majority support for a proposed cigarette tax increase of 5 to 50 cents over two years, Governor Easley proposes a $17 billion two-year budget that includes a 35-cent increase to the cigarette tax in 2005 and an additional 10-cent increase in 2006. In the end, the General Assembly agrees to a 1.5 cent per cigarette increase to the cigarette tax effective September 1, 2005, and an additional 1.75 cent increase per cigarette effective July 1, 2006. The state also moves to ban or limit smoking in indoor arenas (S.L. 2005-329); state correctional institutions (S.L. 2005-372); and local health department buildings and grounds (S.L. 2005-168).

ENDNOTES:

1 "History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

2 "History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

3 David Sinclair, "New Medicaid Program Earns High Grades," *Fayetteville Observer* (May 15, 1994).

4 Statistics from the Census Bureau reveal a caprice of 250,000 children in 1996 that is not reflected in more general demographic data.

5 Emery Dalesio, "N.C. Senate taking on health care reform," *Herald-Sun* (June 19, 1995), C-5.

6 "Sandra Babb and Lydia Faulkner, "The States and Social Responsibility: The North Carolina Experience," *USIA Electronic Journals* (1), no. 20 (January 1997); available from http://usinfo.state.gov/journals/itsv/0197/ijse/babbredo.htm.

7 Ibid.

8 "History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

9 Mark Stinneford, "Smart Start Meets Goal, Gets Insurance Break," *Fayetteville Observer* (May 16, 1996).

10 History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

11 Anne Dellinger, "Health," *North Carolina Legislation: 1999* (Chapel Hill: The Institute of Government, 1999); available from http://www.sog.unc.edu/pubs/nclegis/nclegis99/Chfin11.htm.

12 There was a slight decrease, however, in the enrollment for children age 18 and under in 2004; but this number increased again in 2005.

13 The state's recovery lagged one year behind the national recovery, arguably due to the tax increases passed in 2001. As a result of the higher taxes, which drained at least $1.1 billion from the economy over the course of the next two fiscal years, consumer spending declined. The renewal of the "temporary" income and sales taxes in 2003 (S.L. 2003-284) did little to reverse these trends. Thus while the national economy exceeded 4 percent in real growth in 2004, it took another year before North Carolina's economy hit 4 percent growth. From 2003 to 2005, real growth averaged 3.2 percent, two-tenths behind the national economic average of 3.4 percent for the same period. Personal per capita income also declined in relation to the national average. In 2000 North Carolina was at 90.7 percent of the national average. In 2003, the state's per capita income had fallen to 88.7 percent of the national average, only rebounding to 90 percent by 2005.

14 History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

15 "Aimee Wall, "Health," North Carolina Legislation: 2002 (Chapel Hill: The Institute of Government, 2002); available from http://www.sog.unc.edu/pubs/nclegis/nclegis2002/index.html.

16 Ibid.

17 "History of the North Carolina Medicaid Program," Division of Medical Assistance; available from http://www.dhhs.state.nc.us/dma/historyofmedicaid.pdf.

18 North Carolina Public Health, Public Health Task Force; available from http://www.ncpublichealth.com/taskforce/taskforce.htm.

19 Aimee Wall, "Health," *North Carolina Legislation: 2004* (Chapel Hill: The Institute of Government, 2004); available from http://www.sog.unc.edu/pubs/nclegis/nclegis2004/index.html.

# TIMELINE: 2006-2008

## INTRODUCTION

Two issues dominated the healthcare debate in North Carolina during the years of 2006 through 2008. The first of these is mental health reform. The second, more important, but harder to quantify, is the gradual expansion of government funded healthcare. Other healthcare policy developments include a Medicaid funding swap between the counties and the state; a push to tax and/or eliminate cigarette smoking; and incremental steps toward medical malpractice reform. These years also featured vigorous debate among healthcare professionals regarding embryonic stem cell research and participation in state executions. Finally, N.C. Medicaid spending tripled over the past 10 years, hitting $11.3 billion for FY2007-08, $3.4 billion of which was state/county expenditures.

**Mental Health**

North Carolina's mental health system is anchored by 4 state psychiatric hospitals and 25 Local Management Entities (LMEs). The system itself is administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within the Department of Health and Human Services (DHHS). Owing to comprehensive reform legislation passed in 2001 (S.L. 2001-437), the regional LMEs are responsible for planning and managing mental health services delivered separately by private providers. By all accounts, the 2001 reforms have been inadequate. Some critics, such as then-Governor Mike Easley (D), see this failure as proof that the state needs to reassert control while others argue that private providers have been hamstrung by authorization and payment delays, confusing regulatory controls, and burdensome documentation requirements.

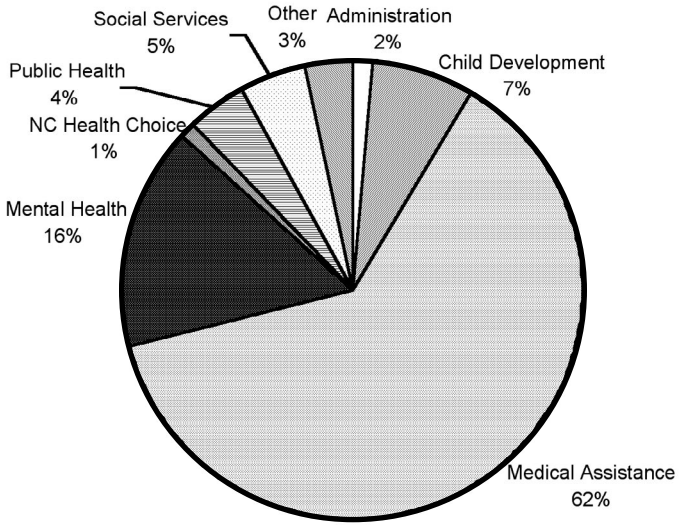
**State Funded Healthcare**

In recent years the General Assembly has inched closer to single-payer healthcare by extending insurance to children from middle-class families and by creating a state subsidized high-risk insurance pool. During the 2008 election, Governor Beverly Perdue (D) promised to expand state funded insurance even further by extending coverage to the parents of low-income children. Many observers also believe that President Barack Obama (D) will attempt to implement a single-payer healthcare system, or more likely, require universal healthcare coverage, accompanied by taxpayer funded subsidies for low- and middle-income families. All this is to say that a federal expansion of state-sponsored healthcare will likely dictate what the state of North Carolina does in the near future. At the very least, however, we can expect an Obama administration to repeal those reforms implemented by the Bush administration that have thus far prevented the unwarranted expansion of the State Children's Health Insurance Program (i.e., NC Kids Care) to children from middle-class families.

## 2006

The 2006 short session was not marked by significant health policy developments, at least as compared to the previous session (see *Diagnosing the Problem, 1985-2005: A Guide to N.C. Healthcare Policy*). That being said, the Legislature passed several laws that encroached upon private property rights and might be characterized as having furthered the "nanny state" generally. Over the objection of property owners, for example, the General Assembly required local health departments to permit, inspect and test private drinking water wells (S.L. 2006-202). Fees collected from the permitting process are to be used for local "public health purposes." The General Assembly also made it illegal to ride in the back seat of a

**Health & Human Services Budget: FY2006-07**




## FY2006-07 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations $4.23 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $2,644 million |
| NC Health Choice | $52 million |
| Mental Health/D.D/Subst. Abuse: | $663 million |
| Child Development: | $296 million |
| Social Services: | $206 million |
| Public Health: | $169 million |
| Office of the Secretary: | $64 million |

car without wearing a seat belt (S.L. 2006-140). Similarly, legislators made it illegal for persons under 18 to use a cell phone while driving (S.L. 2006-177). Finally, the General Assembly amended the infamous "Black Eye Bill" (see *Diagnosing the Problem*) by permitting kindergartners to undergo a vision screening instead of a comprehensive eye exam (S.L. 2006-240). Children who fail the vision screening are still required to undergo a full examination.

**Smoking**

As part of legislation (S.L. 2005-276) passed in 2005, the cigarette tax reaches 35 cents a pack beginning July 1, 2006. (The national average is $1.07/pack). The 2006 increase is the result of legislation (S.L. 2005-276), passed in 2005, that increased the tax from 5 cents/pack to 35 cents. The General Assembly also passes legislation (S.L. 2006-133) permitting community colleges to eliminate designated smoking areas; smoking is likewise prohibited in those buildings occupied by the General Assembly (S.L. 2006-76).

**Embryonic Stem Cell Research**

A House Select Committee on Stem Cell Research, co-chaired by Rep. Earl Jones (D-Guilford), issues a statement encouraging the General Assembly to "provide ethical guidelines for the conduct of stem cell research" in North Carolina. Jones also sponsors legislation (HB 632) that would allocate $10 million to organizations conducting stem cell research. Pro-life/family advocates oppose the measure, advocating instead for a ban on public funding for ESC research, which entails the destruction of nascent human life.

**Death Penalty**

After failing to pass legislation (HB 529) that would impose a two-year moratorium on executions in North Carolina, the General Assembly creates the N.C. Innocence Inquiry Commission (S.L. 2006-184). The commission provides another layer of oversight to review charges against persons convicted of a felony.

**Universal Healthcare**

The budget bill (S.L. 2006-66) includes a substantive special provision that directs the DHHS Secretary to "develop a plan to expand health care access for uninsured North Carolinians through the use of public/private partnerships, federal flexibility and resources, and promotion of charity care by health care providers." The result seems to come in the form of NC Kids Care, passed the following year.

**Mental Health**

- **ValueOptions**: As mandated by the Department of Health and Human Services (DHHS), mental health providers begin outsourcing Medicaid review and authorization to ValueOptions, a private, Virginia-based contractor. Just weeks into the process, providers begin to complain that the company is incompetent and taking too long

## DID YOU KNOW?

According to Families USA, healthcare premiums increased by 86 percent between 2000 and 2006 for North Carolina residents, whereas median earnings grew by only 11 percent.

to approve services. In response, ValueOptions charges that the state misled the company about the volume of requests that it would be processing. ValueOptions' five-year contract with the state is for $57.2 million.

- **Mixed Care**: The General Assembly creates a special study subcommittee to examine the practice of housing mentally ill young persons with older adults in adult-care and nursing homes. A 2004 report found that as many as 40 percent of residents in adult-care homes are mentally ill.
- **State Mental Health Hospitals**:
  - **Cherry Hospital**: The February 2006 death of Janella Williams leads to a state and federal investigation that gives Cherry Hospital of Goldsboro 30 days to fix various problems or risk losing some $10 million in annual federal funding.
  - **Dorothea Dix**: In October, the state asks the Urban Land Institute for recommendations regarding future uses of the 315-acre Dix Hill/Dorothea Dix psychiatric hospital campus, slated to close in 2008. Consultants with the institute propose selling the property for $40 million with the intention of using the space to build a public park surrounded by new government and commercial development. The project is to be paid for by issuing bonds repaid from increased property tax revenue generated by the new development.

### HEALTHCARE HIGHLIGHTS FROM THE 2006 BUDGET

- $7.1 million to the early intervention program for children from birth to age three, to support the increased number of children who have been referred to the program for services.
- $5.5 million to the universal vaccine program, to expand coverage of influenza and pertussis vaccines.
- $3.25 million to support sixty-five school nurse positions that previously had time-limited support from federal grants.
- $2 million to the Community-Based Eliminating Health Disparities Initiative. (The 2005 appropriations act, S.L. 2005-276, provided $2 million in nonrecurring funds.) The money is to be used to provide grants-in-aid to local health departments, American Indian tribes, and faith-based or community-based organizations, to improve minority health status.

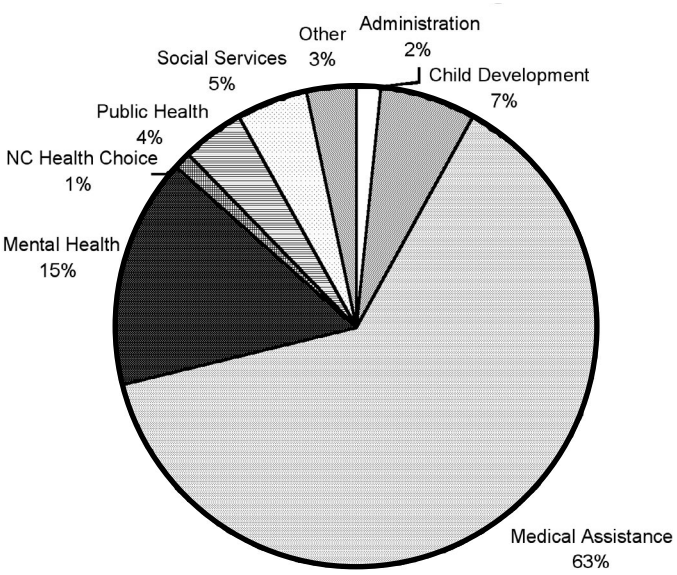
SOURCE: UNC School of Government

## 2007

2007 marked an important year in healthcare policy. After years of wrangling over the issue, the state agreed to take over the county share of Medicaid payments. The state also took significant steps toward the implementation of a universal healthcare system by passing a taxpayer funded high-risk pool, as well as a program (NC Kids Care) that extends state funded insurance to children from middle-class families. Other healthcare

highlights included the defeat of a public smoking ban, the repeal of a chiropractic provision pushed into law by then-Speaker Jim Black (D-Mecklenburg), and the passage of a mental health coverage mandate. Possibly foreshadowing future trends in children's health, legislators also introduced, but did not pass, several bills related to immunization and children's nutrition/obesity. Perhaps most important is that even as the state took on a greater share of Medicaid funding, legislators failed to address skyrocketing costs. Following an uproar over mental health community support payments, DHHS Secretary Carmen Hooker Odom resigned in May.

**Health & Human Services Budget: FY2007-08**




**FY2007-08 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$4.63 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid): | $2,920 million |
| NC Health Choice | $59 million |
| Mental Health/D.D/Subst. Abuse: | $713 million |
| Child Development: | $307 million |
| Social Services: | $217 million |
| Public Health: | $192 million |
| Office of the Secretary: | $71 million |

**Medicaid Swap**

The state assumes the county share of Medicaid costs in a plan to be phased in over three years. In exchange for their Medicaid burden being lifted, counties transfer ½ cent of their 2 ½ cent sales tax revenues to the state. Low-income, rural counties that have a high concentration of Medicaid recipients expect to benefit most from the swap. In these counties, foregone sales tax revenue will be much less than the Medicaid burden passed along to state taxpayers. Conversely, more urban, affluent counties, such as Wake and Mecklenburg, which have lower rates of Medicaid recipients and a growing sales tax revenue stream, will theoretically lose money from the swap. The budget, however, includes a "hold harmless" provision that will use state funds to reimburse those counties that lose money under the new plan.

**Universal Healthcare**

- **High-risk Pool**: The General Assembly passes legislation (S.L. 2007-532) creating a high-risk insurance pool that provides taxpayer subsidized insurance to a wide variety of enrollees, including those who can only obtain coverage at a rate higher than the pool rate (set at between 150 percent to 200 percent of individual standard rates). Premium subsidies will be provided for persons who earn up to 300 percent of federal poverty level (FPL). The pool is to be funded via premiums and fees paid by covered persons, as well as a share (estimated at $14.3 million) of the taxes paid by insurers and health maintenance organizations (HMOs) and a $1.50 annual assessment on persons insured by the state health plan. According to bill sponsor Rep. Hugh Holliman, the creation of the high-risk pool marks "the first step to having any kind of comprehensive program to insuring our people." The plan is expected to cover between 9,000 and 14,000 persons, or 1 percent of the state's uninsured population, making it one of the largest high-risk pools in the country. It is worth noting that Blue Cross Blue Shield played an active role in lobbying for the passage of this legislation, as well as NC Kids Care (see below).

- **NC Kids Care**: The FY2007-08 budget (S.L. 2007-323) extends taxpayer subsidized insurance to children from families earning up to 300 percent of FPL, which equals $61,960 for a family of four and includes roughly half of all families in North Carolina. Implementation of the new program, however, is halted owing to an August 17, 2007, federal directive requiring states to cover 95 percent of low-income children (200 percent FPL) before using federal funding to cover families earning more than 250 percent FPL. (In effect, this new rule requires the state to expand NC Health Choice before moving forward with NC Kids Care.) According to an October 2007 Civitas poll, voters are of two minds regarding universal healthcare: a slim majority (56 percent) support federally guaranteed healthcare coverage, even as 71 percent oppose taxpayer funded health insurance for middle-class families (those earning more than $41,000).

**Smoking**

Rep. Holliman (D-Davidson) again tries to ban smoking in all public places, including places of employment (HB 259). The bill fails after property rights advocates lobby for its defeat. The Legislature, however, bans smoking in all state government offices (S.L. 2007-193); in and around UNC buildings (S.L. 2007-114); and in long-term care facilities/nursing homes (S.L. 2007-459). Likewise, the General Assembly requires all cigarettes sold in North Carolina to be "fire-safe" (S.L. 2007-451). Finally, the budget bill (S.L. 2007-323) allocates $50 million annually (beginning in FY2010) for a UNC Cancer Research Fund, with funding partially derived from increasing the tobacco tax (on non-cigarette products) from 3 percent to 10 percent.

"Why do they have a problem? They perform abortions, murder babies all the time. They all of a sudden got conscience about their Hippocratic Oath. I think doctors' licenses ought to be protected if they want to participate."

–Death Row Inmate Allen Holman

**Death Penalty**

Beginning January 1, 2007, the N.C. Medical Board threatens to discipline any medical professional who monitors the administration of the death penalty. Following a federal judge's ruling that physicians must oversee (and not merely attend) all executions, the move effectively halts all executions in North Carolina. In response, the N.C. Department of Correction sues the board. Likewise, Senate Minority Leader Phil Berger (R-Guilford) files a bill (SB 114) preventing the board from disciplining any healthcare professional who assists in an execution. By contrast, Lt. Gov. Beverly Perdue (D) announces that she supports a two-year moratorium on the death penalty. By year's end, a Wake County Superior Court rules that executions are not medical procedures and so cannot be regulated by the medical board. As of December 2008, the case was still being reviewed by the state Supreme Court.

**Embryonic Stem Cell Research**

Rep. Jones again tries to pass legislation (HB 1837) that would allocate $10 million to organizations conducting stem cell research. A stripped-down version of the bill passes the House, but does not emerge from committee in the Senate. Opponents of the bill argue that ESC research is not only immoral, but has also shown little promise, as opposed to adult stem cell breakthroughs.

**Sex-ed**

Senator Linda Garrou (D-Forsyth) and Rep. Susan Fisher (D-Buncombe) sponsor legislation (SB 1182/HB 879) aimed at gutting North Carolina's abstinence-until-marriage education law and

replacing it with a comprehensive sex-ed program. The new curriculum – characterized as "abstinence-based" instead of abstinence-only–requires teachers to "provide information about the effectiveness and safety of all FDA approved contraceptive methods … including, emergency contraception," a known abortifacient. The proposed legislation fails to pass, but will almost certainly be back in 2009.

**End of Life Care**

The General Assembly passes legislation (S.L. 2007-502) that makes it easier to end the life of persons with advanced dementia, as well as unconscious persons diagnosed with an "incurable" condition. Opponents of the measure, such as the Catholic Medical Association, warn that the bill could encourage "back-door euthanasia." Likewise, House Minority Leader Rep. Paul Stam (R-Wake) argues that the standard end-of-life care form is "slanted toward non-treatment." Looking ahead to 2009, the 2008 Studies Act (S.L. 2008-181) authorizes the Joint Legislative Health Care Oversight Committee to undertake a study of Do Not Resuscitate (DNR) orders issued in the absence of a declaration for natural death.

**Medical Malpractice**

The General Assembly passes legislation (S.L. 2007-541) creating an arbitration option for personal injury or wrongful death claims arising from alleged negligence in providing healthcare. All parties must agree to enter into arbitration according to terms delineated in the law, which include a $1 million cap on damages.

**State Employee Retiree Health Benefits**

According to the state's Fiscal Research Division, as of December 31, 2005, North Carolina was liable for $23.8 billion in unfunded retiree health premium benefits. In an attempt to address this shortfall, Rep. Dale Folwell (R-Forsyth) introduces legislation (HB 1987) that would require each state agency to increase the level of payroll contributions dedicated to state retiree health benefits. Folwell's bill dies in committee.

In the wake of a scandal that includes charges that House Speaker Jim Black (D-Mecklenburg) exhorted $29,000 in bribes from chiropractors, the Legislature repealed (S.L. 2007-24) a substantive special provision that required insurance companies to charge equal copays for chiropractic services. In response, Rep. Earline Parmon (D-Forsyth) introduced a bill that would have reinstated the chiropractic coverage mandate.

**Mental Health**

- **Community Support Services**: After discovering that many providers are overcharging for community support (basic life skills) services, the state retroactively cuts rates for such claims from $61/hour to $40/hour. The cut imposes significant hardships on providers, prompting cries for DHHS Secretary Odom's resignation. In response, DHHS raises the rate to $51/hour. All in all, mental health providers are accused of overcharging the state between $120 million and $400 million for community support services. The overcharges prompt a federal audit and the deferment of $138 million in federal funding.
- **Reform of the Reform**: A report by an independent consultant hired by the Legislature suggests it will cost $2.7 billion over the next five years to fix the state's ailing mental health system. Senator Martin Nesbitt (D-Buncombe), co-chair of a legislative oversight committee on mental health, downplays this figure, arguing instead for $500 million in new spending over the next several years.

- **Coverage Mandate**: After years of lobbying by the Mental Health Association in North Carolina (MHA/NC), the General Assembly passes a mental health parity coverage mandate (S.L. 2007-268). The legislation requires insurance providers to treat mental illnesses as they would any other "physical illness generally." Subsequently, the News & Observer reports that the coverage mandate legislation was "essentially written" by Blue Cross Blue Shield.
- **DHHS Secretary Resigns**: Carmen Hooker Odom resigns in May 2007 following her mishandling of the community health services (see above) controversy. Odom claims she is leaving to become president of the Milbank Memorial Fund in New York. Dempsey Benton is appointed the new secretary (although he also steps down in December 2008).
- **State Mental Health Hospitals**:
  - **Central Regional**: The $138 million Central Regional Hospital in Butner catches fire in June, delaying the hospital's opening. In December, the new building is also cited for numerous safety violations. Transfers from Dorothea Dix and Umstead were supposed to have been completed by March 1, 2007.
  - **Broughton**: Following the death of one patient and the injury of another, Broughton Psychiatric Hospital in Morganton is decertified in August, resulting in the loss of approximately $12 million in annual Medicaid/Medicare funding.
  - **Umstead**: In March, federal investigators threaten to decertify John Umstead Hospital in Butner; the hospital passes a follow-up inspection in December.

## 2008

As might be expected in an important election year, the 2008 short session should be remembered more for what legislators failed to do than for what they actually did regarding healthcare. In spite of Governor Easley's promises to make mental health reform a priority in 2008, the General Assembly neglected to address the need for a comprehensive reevaluation of the mental health system. This is good news insofar as Governor Easley's plan would have entailed returning to the centralized system that ill-served the state prior to the 2001 shift toward semi-privatization. The General Assembly, however, did pass several significant pieces of legislation regarding mental health policy. These included ending the state's contract with ValueOptions; passing legislation requiring a county medical examiner to review all deaths at state mental health hospitals; and instituting a gun ban for persons involuntarily committed for mental health treatment.

Legislators also failed to reign in Medicaid costs. Indeed, Medicaid spending increased by 20 percent over the 2007-08 session, with NC Health Choice alone expanding by 34 percent. The General Assembly likewise refused to consider legislation (SB 1017) that would have allowed Medicaid enrollees to use Medicaid dollars to purchase private insurance. A children's health insurance tax credit also died in committee. Finally, legislators again failed to address the state's growing $24 billion unfunded liability for state retiree benefits. In related news, the State Health Plan faced a $264 million shortfall as the session came to a close, leading to the firing of plan administrator George Stokes.

**Smoking**

Continuing the trend begun in the previous session, legislators ban smoking in all state-owned or leased vehicles (S.L. 2008-149). The General Assembly also confirms the authority of community colleges to ban smoking and the use of tobacco on college property (S.L. 2008-95).

**Child Fatality Task Force**
Following a recommendation from the Child Fatality Task Force, the General Assembly passes legislation (S.L. 2008-179) requiring healthcare providers to report instances in which children are treated for recurrent illness or serious physical injury "where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma."

**Embryonic Stem Cell Research**
Although Rep. Jones' embryonic stem cell research bill (HB 1837) is still eligible for passage during the 2008 short session, Senator Walter Dalton (now Lt. Gov.) proposes a measure (SB 1965) that would allocate $16 million for stem cell research. The Catholic Diocese of Raleigh staunchly opposes the bill, which fails to emerge from committee.

**Medical Malpractice**
The N.C. Medical Society vigorously opposes a plan by the NC. Medical Board to post malpractice settlements on its website. In the end, a compromise is reached with the board agreeing to post information that pertains only to payments that exceed $25,000. More than 20 states already make such information available to the general public.

**Sex-ed**
The N.C. Commission for Public Health implements a rule change (10A NCAC 43A.0803) requiring pregnancy prevention programs (i.e., The Teen Pregnancy Prevention Initiative (TPPI)) funded by the state to teach "comprehensive sexuality education." In effect, the rule change undermines the public school system's abstinence-only curriculum and strips TPPI funding from abstinence-only programs.

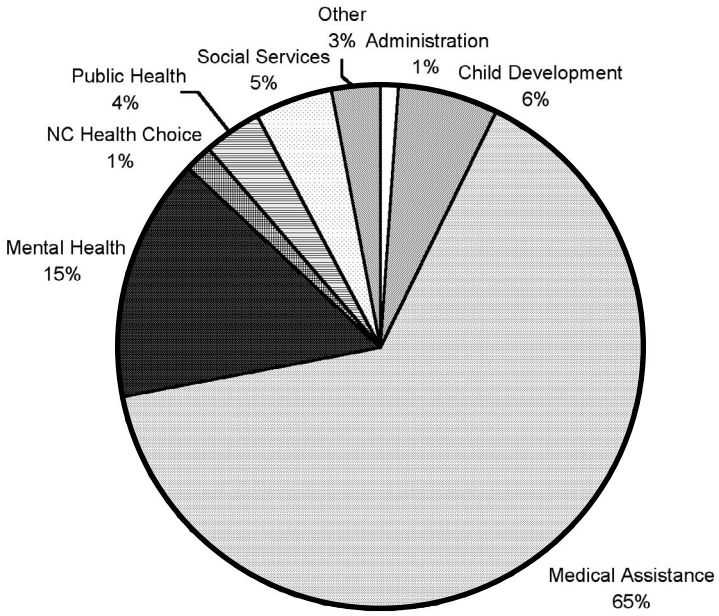
| North Carolina Health Care Indicators | 2001 | 2008 (or most recent data available) |
|---|---|---|
| Percentage of Uninsured (overall) | 14.4% (below national average of 14.6%) | 16.4% (above national average of 15.3%) |
| Percentage of Uninsured Children | 11.2% (below national average of 11.7%) | 12.1% (above national average of 11%) |
| Percentage of North Carolinians Enrolled in Medicaid | 11.6% | 13.2% |
| Percentage of North Carolina Children Enrolled in Medicaid | 25.4% | 30.1% |
| Average family insurance premium | $7,011 | $10,950 |
| NC percentage increase | 56.2% | |
| **Other State Increases:** | | |
| *South Carolina* | 46.8% | |
| *Georgia* | 47.0% | |
| *Tennessee* | 40.6% | |
| *U.S. Average Increase* | 51.6% | |
| Percentage of North Carolinians Enrolled in Private Health Coverage | 69.5% | 64.1% |
| Percentage of North Carolina Children Enrolled in Private Health Coverage | 66.2% | 58% |
| Medicaid Spending (inflation-adjusted) | $2.5 billion | $3.25 billion **30% increase** |
| Mental Health Spending (inflation-adjusted) | $720.9 million | $743 million **3% increase** |
| Medicaid Error Rate | 0.8% | 4.21% |
| Recipients of Medicaid | 28% increase | |
| Medicaid Providers - Physicians | 23% decrease | |
| Medicaid Providers - Hospitals | 61% decrease | |

**Eugenics Compensation Program**
In December, the House Select Committee on Compensation for Victims of the Eugenics Sterilization Program suggests options for compensating victims of the N.C. Eugenics Program. Begun as an expansion of the state's birth-control clinic program, the state forcibly sterilized some 7,600 persons between 1929 and 1974.

## Mental Health

- **Public Records Scandal**: After pledging to bring about mental health reform in 2008, Governor Easley is instead embroiled in a public records scandal stemming from the disposal of correspondence from former DHHS Secretary Odom. Easley goes on record as stating that he "vigorously opposed" the 2001 reforms and blames legislators and LMEs for the current crisis. The governor's proposed solution is to give the state control over the 25 existing LMEs and pull back from privatization efforts.
- **Reform of the Reform**: In April 2008, DHHS Secretary Dempsey Benton asks legislators to consider several reforms, including consolidating the state's 25 LMEs into 9 regional offices that would be responsible for patient care management. Subsequently, the FY2008-09 budget ends the state's contract with ValueOptions and returns the authorization of publicly funded mental health and other services to LMEs that serve at least 30 percent of the state's population.
- **Gun Ban**: Legislators institute a gun ban for persons involuntarily committed for mental health treatment or those deemed a danger to themselves or others (S.L. 2008-210).
- **State Mental Health Hospitals**:
  - **Central Regional**: After numerous delays, the new Central Regional Hospital opens in July 2008, but by September is already at risk of losing federal funding owing to improper Medicaid/Medicare billing procedures and improper maintenance. In September, a Wake County Superior Court delays the transfer of patients from Dix to Central Regional in light of potential violations of the Disability Rights Act. In June, the hospital's director, Patsy Christian, resigns.
  - **Cherry**: After six warnings and the death of one patient, Cherry Hospital in Goldsboro is decertified by Medicaid/Medicare in September 2008, resulting in the loss of almost $10 million in annual federal funding. The Cherry Foundation is also accused of misusing foundation funds (supplied by various pharmaceutical companies) on employee training events and trips, as opposed to therapeutic care for patients. In September, a private management firm is hired to evaluate and run the hospital.

### Health & Human Services Budget: FY2008-09




### FY2008-09 HEALTH & HUMAN SERVICES BUDGET

**Total Appropriations** **$4.91 billion**

*Major Items:*

| | |
|---|---|
| Medical Assistance (Medicaid): | $3,179 million |
| NC Health Choice | $69 million |
| Mental Health/D.D/Subst. Abuse: | $743 million |
| Child Development: | $305 million |
| Social Services: | $222 million |
| Public Health: | $189 million |
| Central Management & Support: | $53 million |

- **Broughton**: In March, the hospital wins back its Medicaid/Medicare funding only to lose a final appeal in October to retain its accreditation.
- **Additional Oversight**: In response to abuses at Broughton and Cherry, the General Assembly passes legislation (S.L. 2008-131) requiring a county medical examiner to review all deaths at state mental health hospitals.

"I don't think there's been anybody who's worked harder on healthcare issues, including choice, than me."

–Governor Beverly Perdue

## DID YOU KNOW?

"North Carolina saw in 2007 a record number of babies born and a 5 percent increase in the infant mortality rate. The state had a record 130,866 births in 2007. More than 55 percent of babies born were white, 23.4 percent were black, 16.9 percent were Hispanic, and 1.3 percent were American Indian. The infant mortality rate rose to 8.5 deaths per 1,000 live births in 2007, up from a rate of 8.1 deaths per 1,000 live births in 2006, which was the lowest rate in state history."

–Asheville Citizen Times

# TIMELINE: 2009-2010

## INTRODUCTION

Healthcare remained an important issue throughout 2009 and 2010. Medicaid spending and other government healthcare programs continued to notably increase while state revenue declined during a harsh economic time for all North Carolinians. The historic Patient Protection and Affordability Care Act, along with the Health Care and Education Reconciliation Act of 2010, together implemented the governmentally-intrusive "Obamacare." The law included numerous changes to the healthcare system that take effect over a four-year period, beginning in 2010. (For more details on "Obamacare," see the Patient Protection and Affordable Care Act entry in the Q&A section.)

The State Health Plan struggled to find adequate funding to keep the increasingly problematic program from collapsing. During 2009-2010, state employees still held on to a premium-free option and paid only modest co-pays, leaving the taxpayers on the hook for the majority of their health coverage. New legislation eliminated the 90/10 plan and pushed smoking and obese patients into the basic plan. A state audit also found that mismanagement played a significant role in the funding deficiencies though suggestions to make the system more market-based were ignored.

The legislature also enacted a new smoking ban, prohibiting smoking from restaurants, bars, and lodging establishments serving food and drinks. Some exemptions were made for private clubs and several lawsuits were filed in protest to the new law.

The North Carolina state mental health industry continued to face controversy as numerous reports pointed to financial mismanagement and patient abuse.

A new sex education program was introduced, leading to an expanded, and controversial, curriculum. The program includes information about contraceptives, sexual-contracted diseases and sexual assault though program heads promise the core concept will continue to revolve around abstinence.

## 2009

This year was marked by significant increases in government-funded healthcare programs. The 2007 legislative session established a provision transferring the counties' share of Medicaid expenses to the state in a three-year phase out plan. The final phase-out increased the state's appropriations to Medicaid by $252 million, to be paid for from the transfer of revenues from half a cent of the 2 ½ cent local sales tax to the state. The legislature also approved another health insurance mandate which further raised premiums, making North Carolina among the top states in the number of health insurance mandates. The measure required health insurers to provide coverage for the diagnosis and treatment of Lymphodema. Additionally, legislators provided $17 million in funding to increase NC Health Choice enrollment and allotted $154 million for Medicaid enrollment growth. State-funded mental health services were reduced by $40 million, and 350 positions were eliminated within the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

A significant missed opportunity, SB 725, would have allowed for the purchase of health

insurance across state lines. The bill unfortunately died in committee. There was also no initiative to enact medical malpractice reform, even though such legislation has proven to greatly ease health care costs in half the nation's states. Furthermore, there was no attempt to allow Medicaid recipients to use available funding to enroll in private health insurance, or to give people the option to have greater control over their own policies in a more consumer driven market.

## DID YOU KNOW?

According to Families USA, health care premiums increased by 96.8 percent between 2000 and 2009, while median earnings grew by only 18.4 percent.

**Smoking**
The legislature continues its smoking limitation trend in 2009. In 2007, smoking was banned in state government buildings. In 2008, the ban was extended to smoking in state vehicles. S.L. 2009-27 takes the ban even further, prohibiting smoking on private property. As of January 2, 2010, smoking is banned in restaurants, bars, and lodging establishments that serve food and drinks. Some exceptions remain for smoking rooms in lodging establishments, cigar bars, and private clubs – though the private clubs exemptions were to be challenged in 2011. The act also increases government authority to regulate smoking on local government grounds and in public places.

**Medical Marijuana**
Rep. Earl Jones sponsors the Medical Marijuana Act (HB1380) to prevent a "qualified" patient from being arrested or prosecuted, or pay any penalty for possession or use of marijuana for medical purposes. On May 2, 2009, proponents for the legalization of medical marijuana protest in Raleigh as part of the "Million Marijuana March." The legislation never makes it out of the House Health Committee.

**Salvia Divinorum**
The psychedelic Mexican herb is outlawed under Sen. Purcell's bill (SB 138) as a Schedule 1 drug in North Carolina. Schedule 1 drugs, such as heroin and LSD, have a high potential for abuse with no acceptable medical use. Salvia is a member of the mint family. Before becoming illegal, it was relatively cheap to purchase and hard to detect in drug tests. Several other states, including Ohio and California, have also banned the drug.

**Sex-ed**
The Healthy Youth Act, S.L. 2009-213 is one of the most debated bills during the 2009 session. The bill, concerning sex education in middle schools, initially seeks to provide two tracks of instruction, "abstinence only until marriage" and "abstinence-based comprehensive sexuality health education" which would provide alternatives to abstinence. The bill goes through six editions with legislators, in the end, agreeing on a one -track system. This program replaces the abstinence until marriage curriculum with a reproductive health and safety education program that explains sexually transmitted disease, contraceptive methods, and awareness of sexual assault. Parents retain the ability to keep their children out of the program.

**Death Penalty**
North Carolina becomes only the second state in the nation to allow criminal defendants to use statistical data to attempt to demonstrate racial bias as the motive for prosecutors or jurors seeking the death penalty. S.L. 2009-464 prohibits a person from being given a death sentence or executed under any judgment that was obtained on the basis of race. A defendant's claim must be raised at the pretrial conference or in a post-conviction proceeding. If race is determined a significant factor, the death sentence cannot be sought or the defendant must be resentenced to life imprisonment without parole. The act takes effect August 11, 2009 but applies retroactively.

**Federal Stimulus Money Directed to Health Care in North Carolina:**

- Child Support Enforcement Program: **$2,908,484**
- Disproportionate Share Hospitals (DSH) Allotments: **$7,224,526**
- ARRA Funding Distribution for Nutrition Services to States: **$2,768,783**
- State Adoption Assistance and Foster Care Funding: **$3,211,600**
- State/Territories Medicaid and Territories Prescription Drug Program Funding: **$904,468,803**
- Increased Demand for Community Health Care Services (IDS) Grants by States: **$8,636,285**
- ARRA, Section 317 Immunization Funding: **$5,153,105**
- Child Care and Development Fund State and Territory Allocations: **$67,543,134**
- Recovery Funding for Community Services Block Grant: **$26,243,124**
- New Access Points Community Health Care Services Grants by State/Territory: **$2,600,000**
- HRSA Recovery CIP Announcement: **$20,139,445**
- North Carolina Total: **$1,050,897,289**

Data provided by: http://transparency.cit.nih.gov/RecoveryGrants/grantstate.cfm?state=nc

**Woman's Right to Know**

Rep. Ruth Samuelson files HB 1044 which would require a 24-hour waiting period and the informed consent of a pregnant woman seeking an abortion before the procedure is performed. The legislation passes its first reading and is sent to the House Judiciary I committee but fails to make it out of committee. Similar legislation is proposed in the 2011 session with greater bi-partisan support. The Woman's Right to Know Act becomes law on July 28, 2011 as S.L. 2011-405.

**State Health Plan**

The State Health Plan marks one of the most pressing issues in the 2009 legislative session. The Plan requires an additional $1.2 billion over the next two years to keep up with projected expenses. Under the current system, enrollees pay no monthly premiums and only modest co-pays while taxpayers pick up the rest of the tab. S.L. 2009-16 attempts to patch the gap by appropriating funds, cutting some benefits, and increasing members' out of pocket costs. The legislation also eliminates the 90/10 plan option. One of the more controversial provisions is the creation of the Comprehensive Wellness Initiative. The program places participants into the basic plan if they smoke, effective July 1, 2010 or if they exceed weight limits, effective July 1, 2011. Exceptions remain in place for both categories. Additionally, the act establishes a Blue Ribbon Task Force to review the Plan's governance and financial stability.

**Medicaid Rates**

State officials reduce NC Medicaid reimbursement rates for more than 20 services in the fall. In 2009, almost two million residents receive Medicaid. The state expects to save roughly $200 million through the rate cuts. Doctors and hospitals argue the reimbursement rates for government programs, such as Medicaid, Medicare, and Tricare, are already too low. As a result, fewer and fewer doctors and hospitals will accept new Medicaid patients, reducing access to medical care for enrollees.

**Mental Health Hospitals**

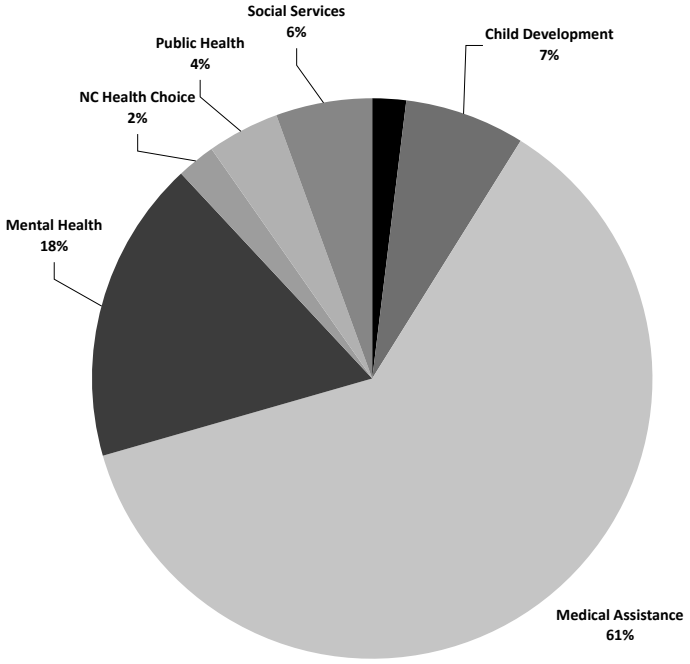
- **Albemarle Mental Health Center (AMHC):** This Eastern NC hospital announces the layoff of 80 employees and closes its 24-hour crisis unit. AMHC begins to shift its 3,000 clients from the center's own staff to private service providers as part of the new mental health reform. The hospital is also in financial trouble for overspending line items and spending funds for purposes other than what they are designated for.

- **Dominion Healthcare:** The troubled hospital, criticized for providing low-tier mental health services to patients who don't need it, closes. The state tried to shut down Dominion in 2008 but the hospital filed a lawsuit in protest. In the settlement agreement, the state agreed the facility could remain open but required it to repay $1.6 million in disputed Medicaid claims. However, the company remained closed despite the settlement agreement and has not reopened.
- **Central Regional Hospital:** The Butner hospital faces the danger of losing federal funding after an unmonitored patient attempts suicide in late February. This is the second time the new $138 million hospital, opening in 2008 and plagued with delays and cost overruns, narrowly averts federal funding losses. An early investigation found the hospital had deficiencies in patient care and reports of patient neglect and abuse by staff.
- **Dorothea Dix:** Despite its call for closure in 2008, state mental health administrators keep a number of staff and patients at the Raleigh facility. Roughly half of Dix's 200 patients move to Central Regional but the remaining patients will stay at the aging facility as a standalone psychiatric hospital. State legislators also approve $6 million in funding for Dix operations though the funding is not a recurring appropriation.
- **Mental Hospital Deaths:** A new law requires more information to be released when a patient dies at a mental hospital, substance abuse facility, or developmentally disabled center. It requires the name, gender and birth date of the deceased to be released in addition to the circumstances surrounding the death.

## DID YOU KNOW?

The North Carolina infant mortality rate reached a record low in 2009. NCDHHS reported 7.9 deaths for every 1,000 births as opposed to 8.2 deaths in 2008. The rate has improved by more than 35 percent since the late 1980s.

**Health & Human Services Budget: FY2009-10**




**FY2009 -2010 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$3.9 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid) | $2,318 million |
| NC Health Choice | $77 million |
| Mental Health/D.D./Subst. Abuse: | $664 million |
| Child Development | $257 million |
| Social Services | $208 million |
| Public Health | $161 million |
| Administration | $75 million |

**Insurance Across State Lines**
The Republican minority attempts to pass SB 725, which would allow North Carolinians to access and purchase health insurance plans authorized in other states. Such a move would lower the number of uninsured in our state and lower health insurance costs. Health insurers would face increased competition leading to greater innovation and affordable options. Under current law, citizens are restricted to purchasing only from state government-approved health providers and plans, which must include 47 coverage mandates. Opposition from BCBSNC, which enjoys a near-monopoly status in the state, helps to ensure this bill never makes it out of committee.

**Nationalized Healthcare Protests**
In August, thousands of North Carolinians gather in various cities to protest President Obama's plans for overhauling healthcare. Three healthcare proposals float around U.S. Congress in addition to the Obama administration's guidelines laying out its own plan. The healthcare debate continues to be an important issue throughout the year.

**UNC Mandated Health Insurance**
A new UNC system policy requires all students at the state's public universities to have health insurance by the beginning of the fall 2010 semester. Insurance options include allowing students to pick their own insurance, remain on their parents' dependent plans, or sign up for the UNC system campus insurance policy. Insurance is required in addition to the various student health service fees that students already pay through their tuition and fees.

**Swine Flu Outbreak**
More than a dozen deaths and roughly 300 hospitalizations occur in North Carolina as a result of the H1N1 virus in North Carolina. School children, pregnant women, the elderly, and even the legislature's staff fall victim to the swine flu. A vaccine is developed to begin to address the growing problem.

## 2010

The 2010 short legislative session was the shortest since 1994, convening on May 12 and adjourning on July 10. The budget passed before the start of the new fiscal year for the first time since 2003. Governor Perdue did not use her veto power once during this session, which is the first time since 2001 that the Governor has not vetoed a bill. This is in stark contrast to the 2011 legislative session, where Governor Perdue vetoed 15 bills, including the Protect Healthcare Freedom Act.

The November 2010 elections also marked significant changes in the legislative make-up. For the first time in 140 years, Republicans gained control of both the House and Senate. With the rise of the Tea Party movement and a shift towards fiscal responsibility and individual freedom, conservative healthcare advocates left 2010 with the hope that healthcare would be addressed with a more conservative lens in the next legislative session.

**Obamacare Enacted**
President Obama signs the Patient Protection and Affordable Care Act into law on March 23, 2010 (For more information, see Q&A "The Patient Protection and Affordable Care Act"). North Carolina's delegation is split on the issue. Senator Richard Burr (R) votes against the bill while Senator Kay Hagan (D) supports it. In the House, three conservative Democrats join all five Republicans to vote against the intrusive bill. As a result of its enactment, BCBSNC mails out refund checks to more than 215,000 policyholders. The refunds are paid from reserves on these policies because the plans will no longer be allowed in 2014 when Obamacare is fully enacted. The lack of excess reserves leaves less capital available for health insurers to protect against unforeseen expenses. Republicans also urge Attorney General Roy Cooper to join the Florida lawsuit challenging the constitutionality of Obamacare. However, Cooper believes the law is constitutional and will not pursue the lawsuit.

**Protect Healthcare Freedom Act**
NC Senate and House Republicans file joint resolutions (SB 1134/HB 1674) to consider a bill protecting North Carolinian's healthcare freedom. Conservative legislators believe the legislation will exempt North Carolinians from the liberty-restricting individual mandate of Obamacare and keep over-burdensome healthcare regulations out of the lives of individuals and businesses. The bill has no chance of passage due to the Democratic majority and the measure dies in committee. In 2011, a bill with the same title, Protect Healthcare Freedom Act, passes both the House and Senate but is vetoed by Gov. Perdue. Unfortunately, the legislature is unable to override her veto in the 2011 session.

**High Risk Pool**
North Carolina's high-risk health insurance program, Inclusive Health, participates in a new national risk pool with the federal government under new federal healthcare legislation. The high-risk pool traditionally includes people who are too sick to get coverage in the traditional market such as those with severe pre-existing conditions. The plan only covers people who have not had insurance for at least six months. NC receives $145 million in federal funding to participate.

**BCBSNC in Trouble**
Blue Cross and Blue Shield of North Carolina agrees to pay $95,000 to resolve a dispute involving 100,000 robocalls, pushing its view on the national healthcare debate. BCBSNC has to follow the state's robocall laws because it's not a tax-exempt organization and requires a live operator to clearly state who is calling and why. The settlement requires the company to create written guidelines for its employees and vendors to ensure they comply with robocall laws.

**Childhood Immunizations**
The legislature agrees to eliminate funding, through the budget bill, for the purchase of vaccines for children. The state had previously provided several vaccines to children at no cost and provided them at no cost to providers, including health departments, private practices and clinics.

## DID YOU KNOW?

For the first time in history, legislation is signed into law in 2010 that forces people to purchase a consumer commodity simply because they exist and breathe. The Affordable Care Act or Obamacare mandates individuals to purchase health insurance or pay a penalty.

**Medicaid Exceeds Budget**
NC Health and Human Services Secretary Cansler reveals that Medicaid costs will exceed the budget by approximately $250 million. North Carolina ranks ninth in the nation for Medicaid spending. This determination comes even after the legislature reduced doctor and other healthcare provider reimbursement rates last year. The Association of Home Health and Hospice is especially critical, claiming any reduced costs will lead to the elderly and disabled losing services under the Personal Care Services program.

**Death Penalty**
After a report claiming the State Bureau of Investigation crime lab used flawed laboratory work in the cases of death row inmates, death penalty opponents hold a moratorium rally. At the same time, under the new Racial Justice Act, all but a dozen death row inmates ask to have their sentences converted to a life sentence without parole. The new laws gives inmates until August 10 to challenge their trials and sentences.

**DNA Upon Arrest**
S.L. 2010-94, one of the more controversial bills approved during the legislative session, requires the collection of a DNA sample from any

individual arrested for specific offenses. The law also requires that the DNA be expunged if the individual is acquitted of the offense.

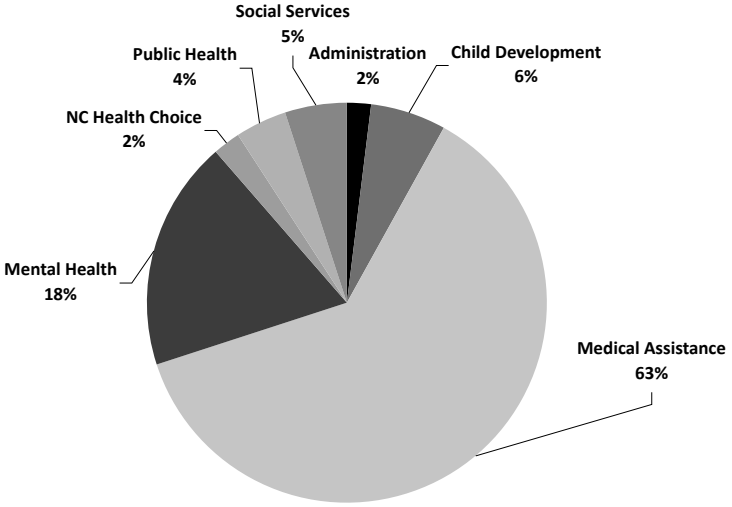
**Prisoner Medical Costs**
State auditors find North Carolina could save tens of millions of dollars annually by better controlling prisoner medical expenses and billing some inmate care to Medicaid. The cost for prisoners healthcare is, on average, 467 percent of the reimbursement rate for Medicaid and Medicare patients. Overall, prisoner health-related expenses were $231 million in the previous year.

**Sex-ed**
The new sex-education program goes into effect this school year as a result of the Healthy Youth Act of 2009. Public school ninth graders will now have access to information on contraceptives, sexually transmitted diseases and sexual assault under the new program. Abstinence will remain the focus of the curriculum.

**UNC Abortion Coverage**
The University of North Carolina allows students to remove elective abortion coverage from their university-sponsored health insurance. Students for Life of America had complained that they shouldn't be required to purchase coverage for something that runs counter to their conscience. This decision comes after the board agreed to require students on all UNC campuses to maintain health insurance beginning in the fall of 2010.

**Adult Home Care**
The state adds a four-star rating for the best adult-care homes in 2010. Additionally, the state will consider recent penalties for violations when determining a rating, making it more difficult to receive a top rating. The homes differ from the more medically intensive care facilities provided in traditional nursing homes.

**Health & Human Services Budget: FY2010-11**




**FY2010 -2011 HEALTH & HUMAN SERVICES BUDGET**

| | |
|---|---|
| **Total Appropriations** | **$3.9 billion** |
| *Major Items:* | |
| Medical Assistance (Medicaid) | $2,368 million |
| NC Health Choice | $88 million |
| Mental Health/D.D./Subst. Abuse: | $705 million |
| Child Development | $234 million |
| Social Services | $193 million |
| Public Health | $157 million |
| Administration | $71 million |

**Mental Health**

- **Mental Health Association (MHA):** The financially strapped MHA of North Carolina ends its program of providing mental health care to hundreds of people. The association is one of the largest private providers of group homes and treatment programs. It loses its accreditation this year, cutting off access to federal Medicaid reimbursements.
- **Waiting Time Lags:** A report reveals mentally ill patients remain in emergency rooms for days, unable to be admitted for psychiatric treatment. The study finds that patients who need state psychiatric treatment wait, on average,

2.6 days for admittance. State officials spend $29 million to help fund 100 new psychiatric beds in community hospitals.

- **State Mental Health Hospitals**
  - **Cherry Hospital:** Two top administrators leave the Goldsboro mental facility after struggling for the last two years to regain federal certification. The certification was taken away after a patient died resulting from his choking on his medication and who was left sitting in a chair for a day without food, water, or medical attention. Another probe concerned $355,501 in spending from a non-profit foundation for overnight staff travel to attend over 100 medical conferences, catered meals and an annual beach retreat in addition to several other reports of patient abuse from staff.
  - **Albemarle Mental Health Center (AMHC):** Several counties vote to withdraw from the troubled regional mental health agency. County commissioners in Pasquotank, Perquimans and Chowan counties vote to leave AMHC and join East Carolina Behavioral Health, which already manages several counties covered formerly by AMHC.
  - **Dorothea Dix:** State officials consider outsourcing and privatizing parts of the mental health and probation systems at the Dix facility. The plan would privatize care of 80 mental patients in a unit for patients accused of crimes, including rape and murder. These patients are either awaiting trial or have been found not guilty by reason of insanity.

**Critical Access Behavioral Health Agency (CABHA)**

The North Carolina Department of Health and Human Services approves a new category of provider agency, CABHA, meant to deliver health and substance abuse services. These new entities replace the Community Support Program. CABHAs may be for profit, not for profit, public, or private behavioral health care companies. It is hoped these programs will improve mental health services.

**Smoking Ban Lawsuits**

While complaints about establishments ignoring the smoking ban rise near a thousand, North Carolina's new smoking law brings several state lawsuits challenging its provisions. At least two suits claim the law violates equal protections guaranteed in the federal constitution and state law. Despite the ban, the American Lung Association has given North Carolina only slightly higher marks. The association gives North Carolina a "C" and three "Fs" while previously, it had received all "Fs." The report gives the state an "F" on smoke-free air because there are no statewide restrictions on smoking for most stores, recreational areas and private work sites. It also receives failing grades for its cigarette tax and spending on tobacco control programs. North Carolina gets a "C" for better smoking cessation programs for Medicaid and state employee patients.

**Hookah Bar Resistance**

Despite the new smoking ban, hookah bars across the state remain open, allowing their customers to freely smoke flavored tobacco inside. Hookahs are long pipes that heat a mixture of tobacco and flavoring and then use a tube to draw out the smoke through a water bowl. State officials and legislators argue over whether hookahs are included in the smoking ban legislation. In the process, several hookah bars go out of business. In the end, hookah bars are allowed to exist as long as they do not sell food or alcohol.

**Studies Act of 2010**
This act authorizes several existing commissions to study various topics, including numerous healthcare related areas. The Joint Legislative Health Care Oversight Committee will study and monitor the impact of revised requirements for personal care services; the Department of Health and Human Services, Division of Medical Assistance will study the feasibility of requiring Community Care of North Carolina to implement body mass index screening for children at risk of becoming obese and who are receiving Medicaid or in the North Carolina Health Choice for Children Program; and a Task Force will be appointed by the Secretary of Health and Human Services to conduct a study of alternatives to the hospitalization of frequent users of psychiatric hospitals in the state.

**State Health Plan (SHP)**
In need of an infusion of at least $572 million in the next two years, legislators grapple over what to do about the SHP as costs rise and reserves decrease. The 2010 SHP budget is $2.56 billion. The plan provides coverage to over 600,000 state employees, retirees, and dependents. A state audit finds mismanagement as the main culprit of steep losses in the plan but the true problem, the lack of understanding between benefits received and premiums paid compared to actual healthcare costs, is not addressed.

**"Children" Under 26 Remain On State Health Plan**
S.L. 2010-3 allows already enrolled dependent children under age 26 who are not eligible for employer-based coverage to remain on NC's State Health Plan. This move costs roughly $3.6 million for 2010.

**Obesity**
The number of North Carolina's obese adults increases for the third straight year. The state ranks as the tenth most obese state in the country by the Trust for America's Health and Robert Wood Johnson Foundation. Nearly 30 percent of North Carolina adults are obese according to the study. Obesity rates are highest in the South and among minority populations.

**Child Care Nutrition**
North Carolina's "nanny state" expands as legislation passes requiring even more specific nutrition standards for child care facilities. New rules specify what children can and cannot be fed, such as a ban on sugar sweetened beverages. In addition, S.L. 2010-117 recommends guidelines for increased level of physical activity at these facilities.

# 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 25 years, going from $444 billion in 1985 to almost $2.5 trillion in 2009.[1] As costs have risen, so has the rate of the uninsured, which increased to 50.7 million, an all time high, in 2010.[2]

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 need 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 25 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 52 mandates. Some estimates suggest that these mandates have increased the price of health insurance by more than 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 passage of Obamacare marked a significant nationwide step in that direction. 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, 2005

| 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**

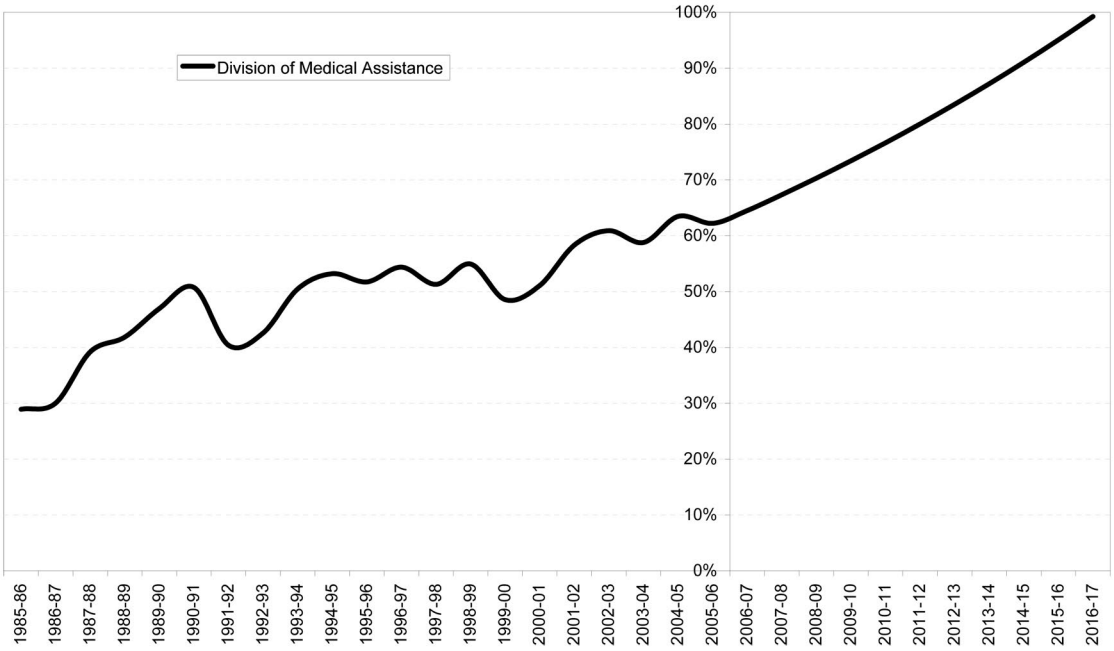
While many people are forced to choose between higher take-home pay or health benefits, several factors exacerbate this dilemma in North Carolina. Competition among health providers is limited insofar as North Carolinians are prohibited from buying out-of-state health insurance. Unlike cars, computers 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 some estimates, there are approximately 325,000 illegal immigrants in North Carolina as of 2010.[3]

## Medicaid as Share of Total DHHS Budget: 1986-2017




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 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.[4]

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."[5] According to research by the Raleigh *News & Observer*, North Carolina had more than $1.4 billion in unreimbursed hospital costs in 2003;[6] 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 exponentially increased since 1985. From 2005 to 2010 alone, spending has shot up by 33 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. According to a 2009 Fiscal Research report, North Carolina covers all but two of the optional services allowed under Medicaid, including coverage for transportation, dentures, eyeglasses, chiropractors and private duty nursing.[7] 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 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 program, for example, gives Medicaid clients control over their own personal care accounts, thus encouraging patients to take more responsibility for their healthcare decisions.[8]

  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."[9] 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 belonged 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 almost all of these options. North Carolina is among the states with the highest optional benefits coverage.

  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. North Carolina 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:

1 http://www.census.gov/compendia/statab/cats/health_nutrition/health_expenditures.html

2 http://www.kaiserhealthnews.org/Stories/2010/September/16/census-uninsured-rate-soars.aspx

3 http://www.mcclatchydc.com/2011/02/02/v-print/107914/north-carolinas-illegal-immigrant.html

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

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

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

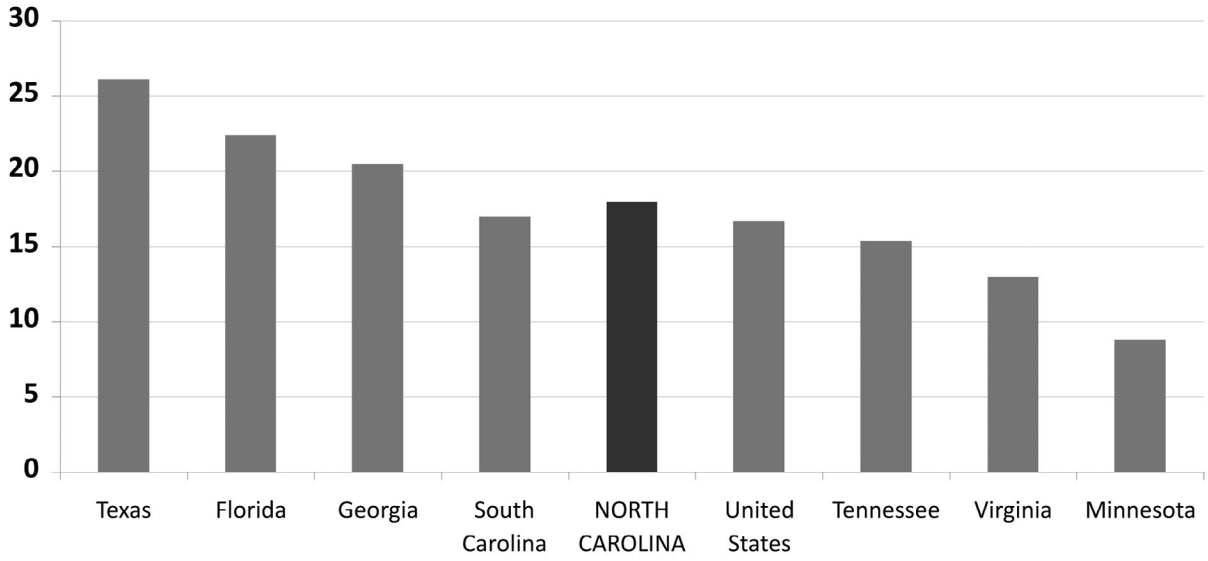
7 http://www.ncleg.net/fiscalresearch/frd_reports/FRD_Reports_PDFs/Session%20Briefings/2009%20Medicaid%20Overview.pdf

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

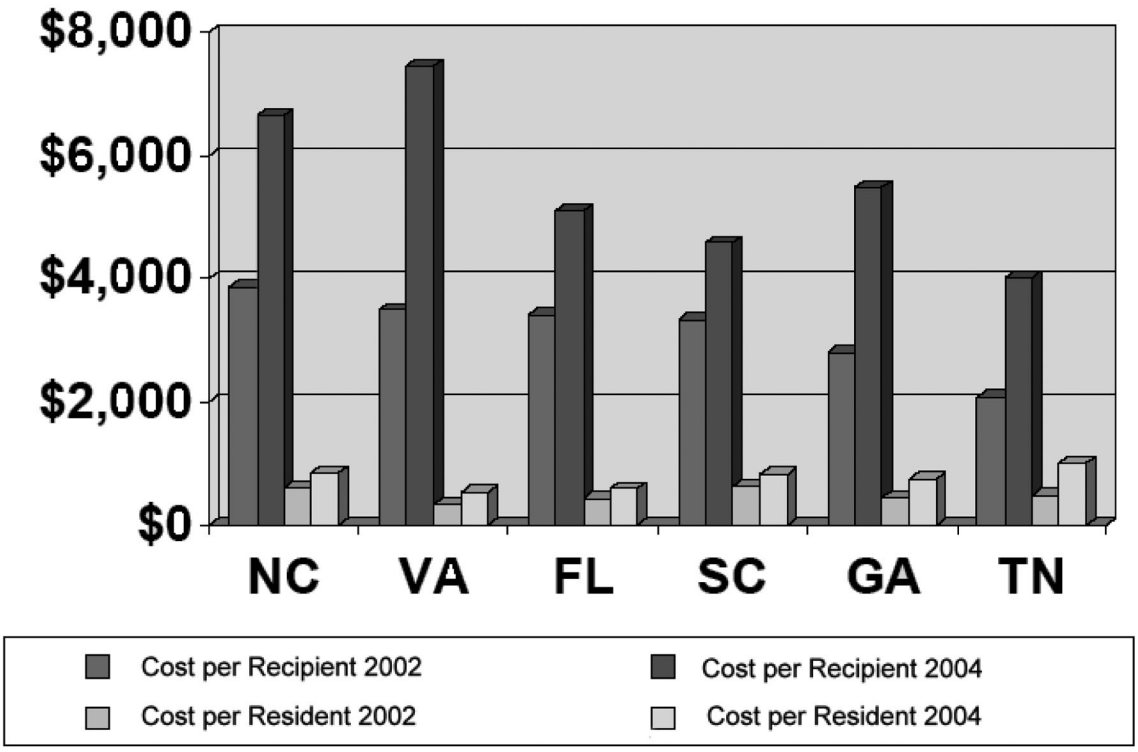
9 Jennifer Edwards, Michelle Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey," The Commonwealth Fund, *Issue Brief* (August 2002), 7; available from http://www.cmwf.org/usr_doc/edwards_erosion.pdf.

# APPENDIX

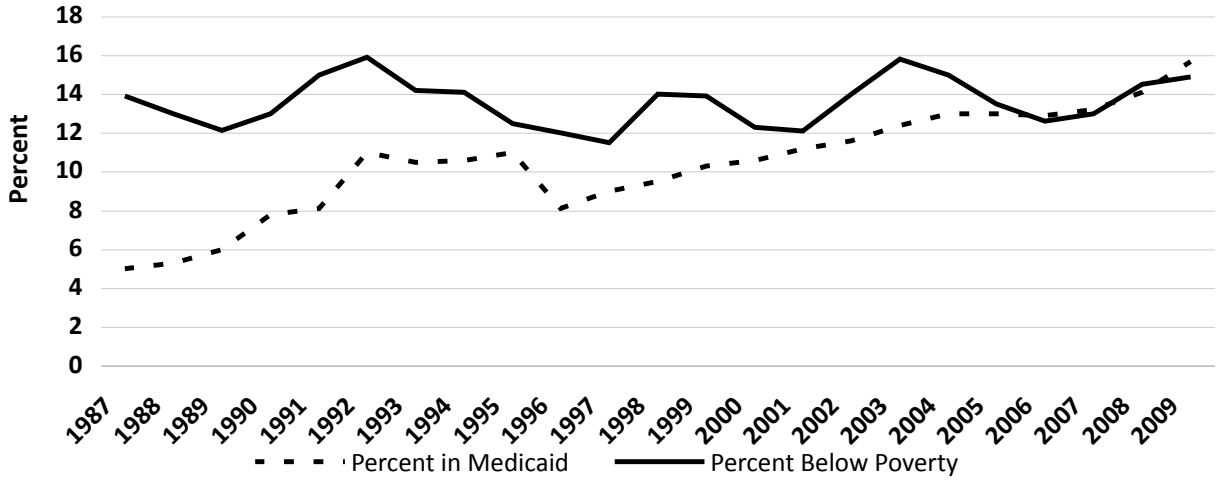
**Percentage of Residents Without Health Insurance: 2009**



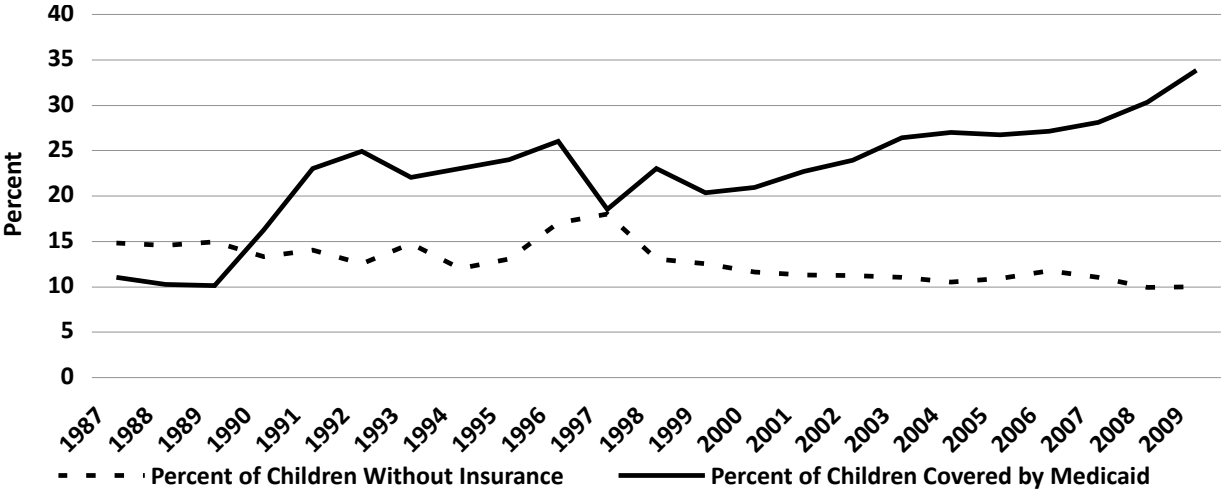

**Medicaid Cost Comparisons: Southeast States**



## Medicaid Enrollment vs. Persons Below Poverty Level: 1987-2009

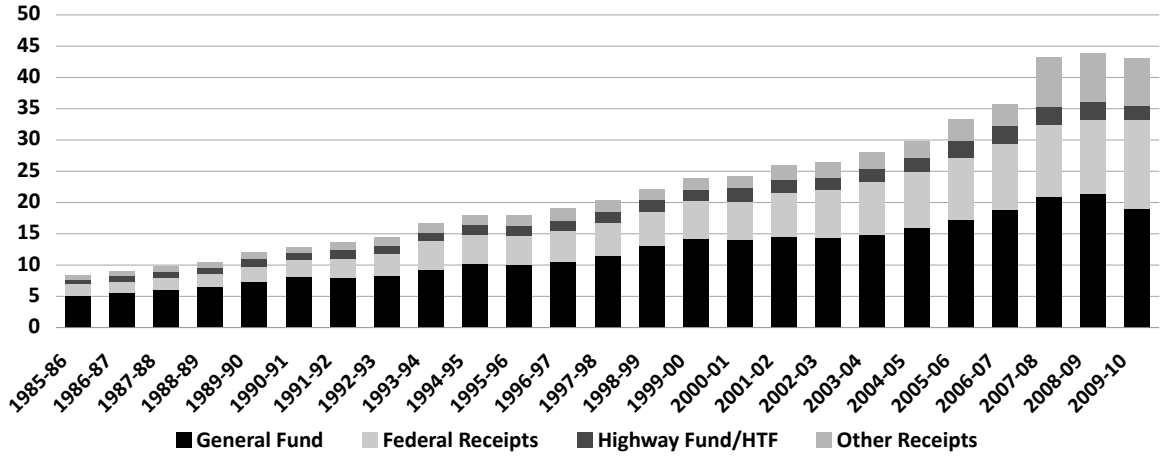



## Uninsured Children vs. Children Covered by Medicaid: 1987-2009



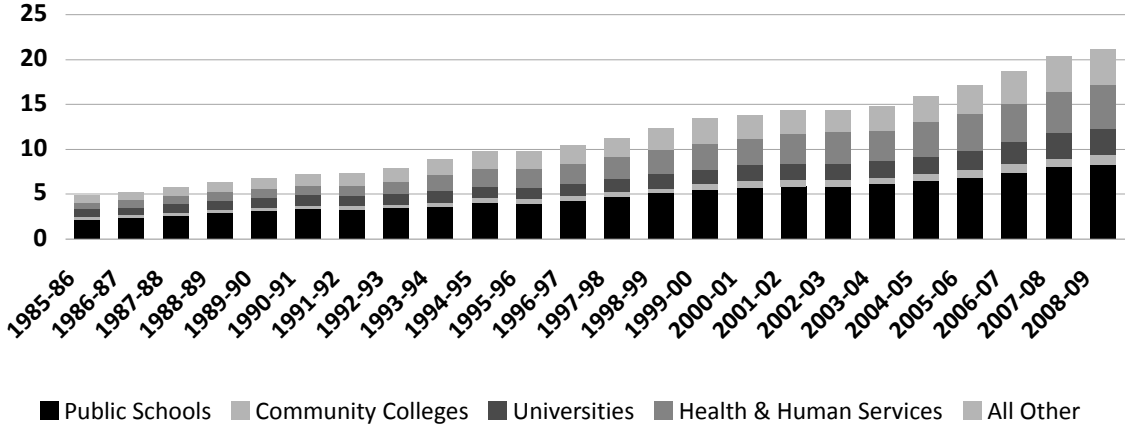
## Total State Budget By Source of Funds: 1985 - 2010

*Billions of $*




## General Fund Authorizations by Issue Area: 1985-2009

*Billions of $*



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Created by Civitas Institute, Karen Duquette. Data Source: NCDHHS, North Carolina Immunization Branch, "Immunization Rates, CDC's National Immunization Survey – 19 - 35 months," available at http://www.immunize.nc.gov/data/immunizationrates.htm; NCDHHS, North Carolina Immunization Branch, "Schools – Kindergarten," available at http://www.immunize.nc.gov/schools/kindergarten.htm.

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Created by Civitas Institute, Gary Fuquay. See "The North Carolina Department of Health and Human Services," "North Carolina Unveiled" Fall Tour (2005); available from http://www.jwpcivitasinstitute.org/newsroom/DHHS.pdf. See also: "Medicaid and Health Choice," *Agenda 2006: A Candidate's Guide to Key Issues in North Carolina Public Policy* (Raleigh: John Locke Foundation, 2006), 45; available from http://www.johnlocke.org/acrobat/JohnLocke_Agenda2006.pdf.

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**About the Civitas Institute**

The vision of the Civitas Institute is of a North Carolina whose citizens enjoy liberty and prosperity derived from limited government, personal responsibility and civic engagement.

The mission of the Civitas Institute is to facilitate the implementation of conservative policy solutions to improve the lives of all North Carolinians. Towards that end, Civitas provides research, information and training to:

- *Empower* citizens to become better civic leaders and more informed voters;
- *Educate* emerging public leaders, enabling them to be more effective in the democratic process; and
- *Inform* elected officials about citizen-based, free-market solutions to problems facing North Carolinians.

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