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spotlight

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# Repair and Reform Medicaid

*Even more essential under ObamaCare*

KEY FACTS: **• North Carolina funding for Medicaid will exceed $3 billion in FY 2012.**

**• North Carolina has one of the most expensive Medicaid programs in the Southeast, spending approximately $4.6 million more per year than Virginia and $2.4 million more per year than Tennessee.**

**• Since 1990 the General Assembly has expanded eligibility for Medicaid and NC Health Choice by about 900,000 people.**

**• ObamaCare forbids reducing eligibility back to previous levels. ObamaCare will also expand enrollment from 1.3 million people to potentially over 2 million people in 2014.**

**• Medicaid already provides less access to care than private insurance. Without the ability to reduce enrollment among Medicaid recipients with higher incomes, access to care will decline for every Medicaid recipient.**

**• Without reform or tighter eligibility, the state will need to cut some services and payments to doctors. Both options will mean worse care for every person on Medicaid.**

**• Gov. Bev Perdue and the General Assembly need to push Washington for exemptions from Medicaid restrictions and greater ability to innovate with premium support and encourage patient control of their own care.**

North Carolina state Medicaid appropriations for Fiscal Year (FY) 2012 will have grown about $700 million since FY 2007 without changes.[1] Federal law will make it difficult to pay for this program and other core functions of the state, such as education. In fact, ObamaCare will make as many as 888,000 more people eligible for North Carolina Medicaid in 2014.[2]

Gov. Bev Perdue and the General Assembly need to make the case to Congress and the Obama administration of the need for greater flexibility that allows for reform. Without reform, Medicaid will provide worse care for everyone enrolled. With reform, there is a chance to restrain this drag on state finances and to improve access and care for those enrolled.

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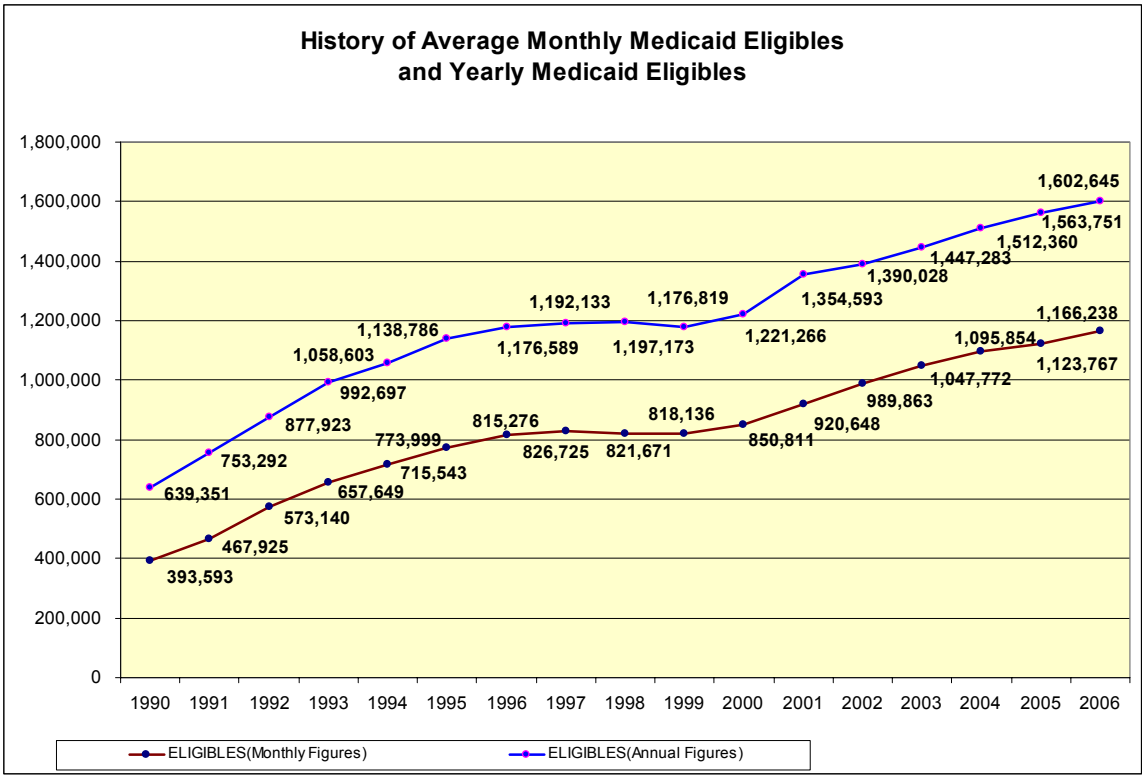
**Figure 1. History of the North Carolina Medicaid Program, FY 1970 to FY 2006**




*Source: "History of North Carolina Medicaid Program, State Fiscal Years 1970 to 2007," North Carolina Department of Health and Human Services, Division of Medical Assistance, www.ncdhhs.gov/dma/pub/historyofmedicaid.pdf*

## Enrollment Expansions and Cost Growth Since 1990

Medicaid is the largest publicly funded insurance program in the United States, with the number of average monthly eligibles in North Carolina increasing from 393,593 during FY 1990 to 1,166,238 during FY 2006.[3] Since 1990 the number of children eligible for NC Health Choice for Children, the closely related State Child Health Insurance Program (SCHIP), has increased by about 600,000 and will grow again significantly in 2014.[4] During FY 2008, the estimated 1.7 million residents receiving benefits in North Carolina cost nearly $10.2 billion in state and federal funds.

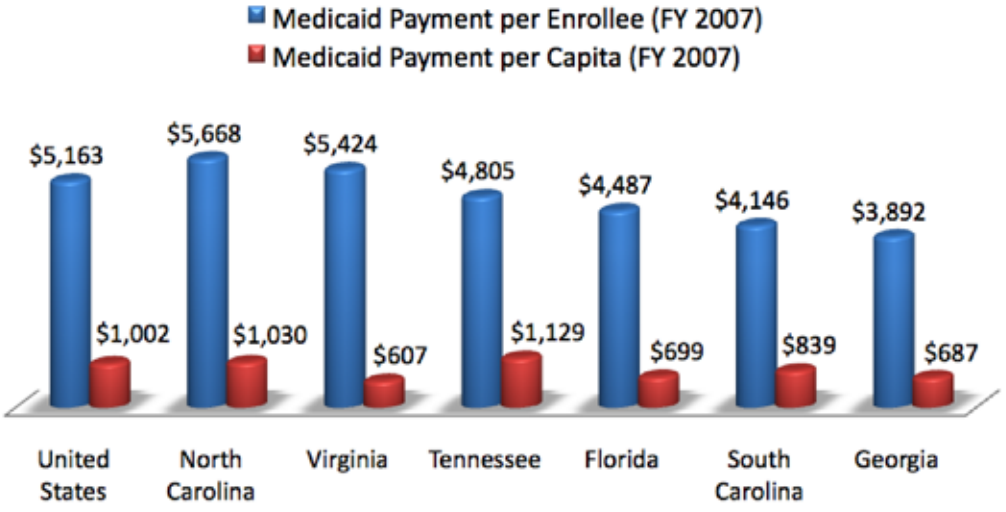
North Carolina's Medicaid spending has continued to grow rapidly, increasing 9.8 percent between 2001 and 2004 and 5.5 percent between 2004 and 2007.[5] Although recent data reflect a decline in Medicaid cost, that trend cannot continue with skyrocketing eligibility. Medicaid enrollment in North Carolina is expected to increase by 38.2 percent by 2019 as Medicaid expands to include people earning up to 138 percent of Federal Poverty Level (FPL), or $30,843 for a family of four, which is required by ObamaCare.[6]

Cost containment strategies for Medicaid have become very important to control budgets, while still encouraging improvements in health care. However, these goals are proving extremely difficult due to ObamaCare rules that forbid changes that tighten eligibility standards for all Medicaid populations.

## The State of Things

Currently North Carolina's Medicaid program uses state and federal funds to provide substandard health insurance to pregnant women, low-income children, parents of dependent children, people with disabilities, and other specified groups. It also provides long-term care and some non-Medicare services for seniors and other specified groups. To

**Figure 2. North Carolina Medicaid expenditures per enrollee and per capita are among the highest in the Southeast**




*Sources: Kaiser Family Foundation: statehealthfacts.org; state demographics; author calculations*

receive Medicaid services, an individual must demonstrate that they meet specific health coverage eligibility criteria, have U.S. citizenship, and meet certain financial requirements.

Medicaid is, after public education, the second largest program in the state's budget. North Carolina spends more on Medicaid than any other state in the Southeast and is in desperate need of Medicaid reform. Previous efforts, including implementing a preferred drug list and making greater efforts to reduce system inefficiencies, are not nearly enough to offset increasing costs or reduce the $2.4 billion deficit facing North Carolina in FY 2012, even with the gimmicks in the governor's budget.

Despite this deficit, ObamaCare will make it nearly impossible for states to make economic reductions to Medicaid due to requirements of maintaining high eligibility while imposing new costly provisions beginning in 2014.[7] Secretary of Health and Human Services Kathleen Sebelius has been all but intractable regarding state requests for flexibility of plan design and payments to providers.[8] Moreover, both Republicans and Democrats have asserted that states will need to find alternatives to the strict requirements for the individual mandate imposed by ObamaCare.[9, 10]

Fortunately for policymakers, there are some limited options available to save the state money while encouraging Medicaid recipients to regain power over their health care options. Specific steps legislators can take for improved cost containment are suggested below.

### Reform Long-Term Care

The most feasible possibility for reform is to make immediate changes to long-term care — e.g., nursing, adult, and home care — through the federal Deficit Reduction Act of 2005 and to change enrollment and coverage requirements for long-term care.[11] The Deficit Reduction Act has enabled states to have flexibility in how they align their respective Medicaid benefit packages with the rest of the market.

Long-term care has been the largest portion of North Carolina's Medicaid budget (about one-third, over $3 billion) for many years. This is because of the broad range and costly services used by enrollees such as the elderly, the dis-

abled, and the chronically ill.[12] However, less than one out of every nine dollars spent on home health care comes out of the pockets of these patients.[13] Immediate remedies include encouraging private long-term care insurance and reducing the number of people and services that are eligible for Medicaid payment. North Carolina, however, does not give much financial incentive to people to purchase long-term care insurance, even after the General Assembly restored the state income tax credit for its purchase in 2007.

North Carolina does not strongly limit services covered by providers. In this area, North Carolina could follow Florida's lead. In 2007 Florida set a fixed-payment delivery system for nursing homes to limit the services ordered through the previous fee-for-service system.[14] The fixed-payment system limits what providers can charge for services, and encourages adults to save early for their long-term care so they can access more elective services as they age. This idea is even supported by Democrats such as Sen. Ben Nelson, who conceded in a letter to constituents that private insurance is better than Medicaid.[15] Although this recommendation would most likely be the easiest to implement, there are unresolved complications as the Deficit Reduction Act, a federal law, contradicts ObamaCare, another federal law.

**Reduce Optional Services**

Another alternative for reducing the Medicaid deficit is to reduce the number of optional services it covers. This approach has been successful in other states such as Arizona, where various transplants have been categorized as discretionary.[16] The Arizona Health Care Cost Containment System has taken the stance that transplants ranging from $263,000 (kidney) to over $1 million (intestine) are too costly.[17] The Oregon Health Plan has also created a system that prioritizes optional services and creates a dividing line based on available funds in determining what will be publicly financed.[18] Although decisions for determining who should receive funding for services are tough and often lead to politically complex situations, services that are not required by the federal government are an obvious place to save state funds. North Carolina policymakers could follow suit by determining that optional services, such as end-of-life care, risky operations, and transplants are "optional" or "experimental," thereby requiring private coverage. For guidance, the John Locke Foundation identified some optional services that could be reduced in its 2011 budget proposal.[19]

**Obtain Block Grants**

Lastly, and likely most influential on the state's Medicaid system, North Carolina could attempt to secure Medicaid funding in the form of a block grant from the federal government, committing a level of federal funding without regard to the state's level of spending and without regulation of fund usage. Therefore, block grants are an effective means for allowing each state to determine how health care related funds should be spent and are currently provided to North Carolina frequently for mental health services and women and children's programs. Currently, federal payments to states are guaranteed "as-needed," meaning that the federal funds are supplied as "matched funding."[20] North Carolina, for example, receives nearly two dollars in federal funds for every dollar in state funds spent on Medicaid. A block grant, however, would allow the federal government to commit a certain amount of funding no matter what the state spends. This form of cost-sharing enables states to know exactly how much funding will be provided and for how long, removing an incentive to expand coverage.

Rhode Island led the way for Medicaid block grants with a global Medicaid waiver in 2009. Under that waiver, Rhode Island receives fixed payments from the federal government for five years.[21] Gov. Carcieri credited this waiver as the prime contributor to the state's fiscal surplus in FY 2010.[22] Based on that success, other states, including Michigan, Oklahoma, Washington, and Colorado, are exploring block grants in 2011 to regain flexibility and control over state health spending.

## Conclusion

Due to the overwhelming burden ObamaCare will place on the state of North Carolina's budget, alternatives to the current legislation must be explored. Legislators took an important first step with the introduction of Health Care Protection Act (HB2), showing that a stand against ObamaCare must be taken without hesitation. The foundation of ObamaCare is the Massachusetts health care law, which has resulted in a greater number of individuals with insurance but has also rationed health care services and greater costs for insurance and expenses for the government. North Carolina cannot afford current Medicaid costs and expansion of Medicaid, and the additional expenses laid out for 2014 and beyond will cause further harm. Moreover, the greater funding needed to expand Medicaid must come from other state sources like education. The most effective way to improve the state's budget and promote individual rights would be to repeal ObamaCare. However, in the absence of that happening in the near future policymakers should seek an immediate waiver from ObamaCare's Medicaid provisions that destroy the state's freedom to innovate.

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## End Notes

1. "Medicaid is the Fastest Growing Program in the State's Budget: Growth Will Accelerate as the State's Population Ages," North Carolina Center for Public Policy Research, Jan. 29, 2010, *www.nccppr.org/drupal/content/news/2010/01/29/271/medicaid-is-the-fastest-growing-progam-in-the-states-budget-growth-will-*.
2. John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL," Kaiser Commission on Medicaid and the Uninsured, May 2010, *www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf*.
3. "History of North Carolina Medicaid Program, State Fiscal Years 1970 to 2007," North Carolina Department of Health and Human Services, Division of Medical Assistance, *www.ncdhhs.gov/dma/pub/historyofmedicaid.pdf*.
4. Nicole Fisher, author calculations based on 2008 data from the U.S. Department of Health and Human Services and the Kaiser Commission on Medicaid and the Uninsured.
5. See Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from Centers for Medicare and Medicaid Services HCFA-64 reports, 2010, *www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=1*.
6. *Op. cit.*, note 2.
7. Nina Owcharenko, "State Medicaid Reform after Obamacare," Heritage Foundation *WebMemo* No. 3062, Nov. 16, 2010, *www.heritage.org/research/reports/2010/11/state-medicaid-reform-after-obamacare*.
8. "Sebelius outlines state flexibility and federal support available for Medicaid—Full Letter," U.S. Department of Health and Human Services, Feb. 3, 2011, *www.hhs.gov/news/press/2011pres/01/20110203c.html*.
9. Sarah Kliff, "Nelson says individual mandate 'must change,'" Politico.com, Feb. 1, 2011. *http://www.politico.com/blogs/glennthrush/0211/Nelson_says_individual_mandate_must_change_.html*.
10. "Nelson: Nebraskans want healthy and educated children, not divisive politics," press release, office of U.S. Sen. Ben Nelson, Aug. 30, 2010, *bennelson.senate.gov/press/press_releases/083010-01.cfm*.
11. "Deficit Reduction Act of 2005: Implications for Medicaid," Kaiser Commission on Medicaid and the Uninsured, February 2006, *www.kff.org/medicaid/upload/7465.pdf*.
12. Jenni Owen, Lisa J. Berlin, Aimee Wall, and Linda Attarian, editors, "Medicaid Cost Containment Strategies for North Carolina and Other States," Center for Child and Family Policy at Duke University and School of Government at the University of North Carolina at Chapel Hill, May 24, 2005, *www.familyimpactseminars.org/s_ncfis01report.pdf*.
13. Stephen Moses, "Long-Term Care Financing in North Carolina: Good Intentions, Ambitious Efforts, and Unintended Consequences," John Locke Foundation, Policy Report, January 2008, *johnlocke.org/research/show/policy%20reports/145*.
14. Michael Bond, "Florida's Medicaid Reforms: A Progress Report," James Madison Institute *Backgrounder* No. 52, August 2007, *www.jamesmadison.org/pdf/materials/587.pdf*.
15. *Op. cit.*, note 7.
16. C. David Flower, "State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage," *Minnesota Law Review* 79 (1233), May 1995.
17. Milliman, Organ Procurement and Transplant Network, "The Cost Of Organ Transplants," National Public Radio, Nov. 17, 2010, *www.npr.org/2010/11/11/131215308/arizona-budget-cuts-put-organ-transplants-at-risk*.
18. Jonathan Oberlander, Theodore Marmor, and Lawrence Jacobs, "Rationing medical care: rhetoric and reality in the Oregon Health Plan," *Canadian Medical Association Journal* 164 (11), May 29, 2001, *www.cmaj.ca/cgi/content/full/164/11/1583*.
19. Joseph Coletti, "Protecting Families and Businesses: A Plan for Fiscal Balance and Economic Growth," John Locke Foundation *Spotlight* No. 408, Feb. 21, 2011, *johnlocke.org/research/show/spotlights/259*.
20. "Medicaid and Block Grant Financing Compared," Kaiser Commission on Medicaid and the Uninsured *Policy Brief*, January 2004, *www.kff.org/medicaid/upload/Medicaid-and-Block-Grant-Financing-Compared.pdf*.
21. Gary Alexander, "Rhode Island Global Consumer Choice Compact Medical Waiver: A National Model for Medicaid Reform," December 2010, *www.galen.org/fileuploads/RIMedicaidReform.pdf*.
22. Pamela M. Prah, "Rhode Island's Medicaid Gamble," *Stateline*, May 11, 2010, *www.stateline.org/live/details/story?contentId=483799*.