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Health Policy for Low-Income People in North Carolina

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North Carolina resembles the national average in the magnitude of its uninsured and underinsured problem and the health status of its population. The state has a strong and diverse economy and a lower-than-average poverty rate, but it continues to lag behind the United States in per capita income. Although bipartisan consensus on expanded Medicaid eligibility resulted in rapid enrollment growth over the past decade, recent efforts to expand coverage to children through a Medicaid look-alike program generated an unusual amount of partisan bickering that suggests future expansion efforts may be difficult. The sheer size of the Medicaid budget has induced the state to accelerate its efforts to enroll eligibles in capitated managed care plans.

By FY 1996, the state's Medicaid program covered almost* triple *the number of eligibles it had 10 years earlier...

State Characteristics

Sociodemographic Profile

North Carolina, located on the south-central Atlantic seaboard, is the nation's 11th-largest state, with a population of 7.4 million in 1997. State residents are older than the U.S. average (see table 1), reflecting the state's popularity among retirees. The share of the population that is black is three-fourths larger than the U.S. average. The state's Hispanic share is only one-sixth as large as the nation's (although growing rapidly), but its proportion of non-Hispanic whites nearly matches the national average. The proportion of the population living in rural areas is more than 50 percent higher than the U.S. average. Population growth is nearly double the U.S. rate, largely because of North Carolina's status as a retirement mecca, the mushrooming of high-tech employment opportunities in the Research Triangle, and Charlotte's importance as a financial center.

Economic Profile

Even though it trails the overall United States in per capita income and ranks 37th in high school graduation rates,[1] North Carolina is one of the nation's leading growth states, with a strong, increasingly diversified economy. This strength is reflected in a higher-than-average fraction of the total population that is employed, a lower-than-average unemployment rate among those in the labor force, and a poverty rate that compares favorably with the U.S. average. (Before the 1982 recession, North Carolina's poverty rate generally exceeded the national average by one-third, but since then it has mirrored the national rate.[2]) In the past three decades, North Carolina has moved from being a largely agriculturally oriented state to the most manufacturing-intensive state in the country.[3]

Health Profile

North Carolina ranked 27th in a composite measure of overall health in 1997, an improvement over its 30th place ranking in 1990.[4] In

Table 1
State Characteristics

	North Carolina	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	6,730	260,202
Percent under 18 (1994–95)[a]	22.1%	26.8%
Percent 65+ (1994–95)[a]	13.4%	12.1%
Percent Hispanic (1994–95)[a]	1.6%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	21.6%	12.5%
Percent Non-Hispanic White (1994–95)[a]	73.7%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	3.1%	4.2%
Percent Noncitizen Immigrant (1996)[b]	2.1%	6.4%
Percent Nonmetropolitan (1994–95)[a]	34.1%	21.8%
Population Growth (1995–96)[c]	1.7%	0.9%
Economic		
Per Capita Income (1996)[d]	$22,205	$24,426
Percent Change in Per Capita Personal Income (1995–96)[d]	4.8%	4.6%
Percent Change in Personal Income (1995–96)[d]	6.6%	5.6%
Employment Rate (1997)[e, f]	66.1%	63.8%
Unemployment Rate (1997)[f]	3.6%	4.9%
Percent below Poverty (1994)[g]	13.3%	14.3%
Percent Children below Poverty (1994)[g]	20.1%	21.7%
Health		
Vaccination Coverage of Children Ages 19 to 35 Months (1996)[h,i]	77.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995)[j]	8.7%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1996)[k]	9.2	7.2
Premature Death Rate (Years Lost per 1,000) (1995)[l]	51.3	46.7
Violent Crimes per 100,000 (1996)[m]	588.1	634.1
AIDS Cases Reported per 100,000 (1996)[n]	12.2	25.2
Political		
Governor's Affiliation (1998)[o]	D	
Party Control of Senate (Upper) (1997)[p]	30D-20R	
Party Control of House (Lower) (1997)[p]	59D-61R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. CPS three-year average (March 1995–March 1997, where 1996 is the center year) edited by the Urban Institute to correct for misreporting of citizenship.
c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, DC, 1997. 1995 population as of April 1. 1996 population as of July 1.
d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.
e. U.S. Department of Labor. *State and Regional Unemployment, 1997 Annual Averages.* USDL 98-78. Washington, DC, February 27, 1998.
f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.
g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.
h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report* 46(29). Hyattsville, MD, July 25, 1997.
i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.
j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report* 45(11), supp. Hyattsville, MD: National Center for Health Statistics, 1997.
k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report* 45(12). Hyattsville, MD: Public Health Service, 1997.
l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1. Estimates of the Population of States: Annual Time Series, July 1, 1990, to July 1, 1996) as the denominator.
m. U.S. Department of Justice, FBI. *Crime in the United States, 1996.* September 28, 1997.
n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report* 8(2), 1996.
o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998.* January 15, 1997.
p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update.* D indicates Democrat and R indicates Republican.

part, the ranking reflects a greater concentration of black persons, who, on a number of measures, have poorer health status than white persons. An illustration of this is the infant mortality rate: North Carolina fared only 5 to 6 percent worse than the nation in 1995 when controlling for race,[5] but it averaged 21 percent worse overall because of its higher share of births to black women relative to the U.S. average.[6]

Premature mortality is about 10 percent higher in North Carolina compared with the U.S. average (see table 1), reflecting in part the higher infant mortality rate and higher risk of death due to stroke, diabetes, and alcohol.[7] North Carolina has a *lower* rate of death due to heart disease, less violent crime, and fewer AIDS cases compared with the United States as a whole. Although North Carolina generally has seen improvements in health status that mirror national trends during the past decade, there are also some disconcerting trends. For example, from 1985 to 1995, the teen death rate due to accidents, homicides, and suicides rose from 11 percent higher than the national average to 23 percent higher.[8]

Politics and Budgetary Policy

North Carolina's politics have traditionally been dominated by Democrats, but Republicans have gradually gained a nearly equal number of seats in the state legislature. Generally, North Carolina has mixed progressive and tradition-minded views, a situation that has produced polarized, increasingly party-line politics.[9] In contrast, there has been somewhat more bipartisan harmony in the state's approach to health policy, with progressive instincts tempered by conservative fiscal policies. In the past three decades, governors have championed economic development, education, roads, and children, but none have made health a focal point for their policy initiatives.

North Carolina's current governor, Jim Hunt (D), is the nation's most experienced (1976–1984, 1992–present)[10] and one of the most popular in the state's history, but he is nearing the end of his final term (in 2000). Reflecting a mistrust stemming from colonial days, North Carolina has one of the nation's politically weakest governors, although this situation was partially modified in 1996 by voter approval of gubernatorial

veto authority. The North Carolina General Assembly is intended to be a part-time citizens' legislature. It meets every year but alternates between "long" sessions (which typically run from January until at least July) and "short" sessions (which typically do not start until May).

Although the governorship has changed parties five times since 1970, the General Assembly historically has been dominated by Democrats. In 1994, however, for the first time, Republicans seized control of the House and fell only one seat shy of holding as many seats as the Democrats in the Senate. For 15 years, significant continuity in health policy has resulted from the extended tenures of the state health director, state Medicaid director, deputy director of the Department of Insurance, and director of the Office of Rural Health. Their long tenures, spanning Republican and Democratic administrations alike, are a reflection of general bipartisan agreement on many health policy issues, especially those affecting low-income people.

North Carolina's state government is expected to collect $11.2 billion in taxes for FY 1998, with overall expenditures (including federal receipts) of $19.9 billion.[11] North Carolina relies on personal and corporate income taxes for nearly half of all general revenues, and one-quarter comes from a general sales tax.[12] North Carolina has higher taxes than other states in the South, but between 1990 and 1996, as a result of changes in the tax code, the state experienced the second-largest reduction in tax collections as a percentage of base-year collections among all states in the country.[13] The state also has limited its use of debt, with a per capita total in FY 1995 that was the fourth lowest in the country. Consequently, it was one of only six states in 1996 to earn the top bond rating from all three major rating services.[14] State government employment (full-time equivalents per 10,000 population) in North Carolina (159) was nearly identical to the U.S. average (151) in 1995, as was local government employment (389 versus 385). Between 1990 and 1995, state government employment grew twice as fast in North Carolina compared with the U.S. average, and local government employment expanded 50 percent more rapidly than elsewhere.[15]

The Health Care Market

North Carolina was somewhat late in experiencing significant managed care activity because of its rural nature, resistance by providers, and relatively low employee benefit costs (which held down interest in seeking savings through managed care). However, by 1998 there were 19 full-service health maintenance organizations (HMOs) serving 1.5 million North Carolinians, nearly double the number enrolled only two years earlier.[16] Nearly two-thirds of members belong to an HMO owned by or affiliated with national insurance companies or HMO plans. Notwithstanding very rapid growth in the past few years, HMO penetration in 1996 (12.3 percent) was only half the national average (24.0 percent).[17] Moreover, there is almost no Medicare HMO activity in the state.

North Carolina has seen significant changes in hospital ownership in recent years. Between 1983 and 1997, the state experienced 24 hospital conversions, of which only 6 entailed conversions to for-profit status (3 of these involved facilities that were previously publicly owned). The remaining conversions were public (county) to not-for-profit status (10), health authority to not-for-profit (1), and public/not-for-profit to district/health authority (7).[18] As part of a nationwide restructuring and divestiture of one-third of its facilities, Columbia-HCA recently sold four of its five North Carolina facilities to a nonprofit consortium and is looking for a buyer for the fifth. This reduction in for-profit presence in the state is substantial, given that only 13 of North Carolina's 119 nonfederal short-stay hospitals were for-profit in 1997.

Currently, much of the merger and acquisition activity in the state is being driven by several large local health systems, most of which are hub-and-spoke networks designed to ensure market share for a tertiary care center at the hub. Such networks expect to gain improved leverage with managed care organizations and enhanced ability to compete once Medicaid managed care and Medicare managed care become more widespread.

Fierce competition among HMOs has helped North Carolina's large employers hold their average health care cost per employee to 10 percent below the average for the South and 21 percent below the national average. Moreover, in 1997, average costs declined by 1.7 percent in North Carolina, compared with a 4.7 percent increase in the South overall.[19] Back-to-back losses for many North Carolina HMOs in 1996 and 1997 are likely to result in average premium increases of 4 to 8 percent in 1998, and as high as 16 percent for some plans.[20] Losses also are likely to lead to efforts to reduce payments to physicians and other providers, along with a possible reduction in the number of plans operating.[21] A 1996 Milliman and Robertson study showed that North Carolina had the highest physician reimbursement rates from commercial insurance in 21 states studied (with the average private fee equaling 140 percent of the average Medicare fee, compared with 107 percent in Virginia and 122 percent in Georgia).[22] Already, there have been several very visible clashes between physician groups and health plans, and turmoil in the overall health care market in North Carolina is likely to continue for the foreseeable future.

Health Insurance Coverage

More than 820,000 North Carolinians lacked health insurance in 1994–95.[23] In addressing the problem of the uninsured, the state expanded Medicaid eligibility beginning in the late 1980s, was among the first to enact small-group health insurance reforms, and recently enacted a Children's Health Insurance Program (CHIP) targeted at 71,000 uninsured children.

Detailed Insurance Trends

North Carolina has had an uninsured rate comparable to the national average for at least two decades. Figures for 1994–95 show North Carolina with a slightly lower—but statistically insignificant—uninsured rate than the U.S. rate (14.1 percent versus 15.5 percent) (see table 2). The state also mirrors the national distribution of insurance coverage types for adults and children.

For those below 200 percent of the federal poverty level (FPL), the risk of being without coverage is slightly lower in North Carolina than it is nationwide. For this subset of the population, Medicaid coverage and employer-based cov-

Table 2
Health Insurance Coverage

Health Insurance 1994–95	North Carolina	United States
Nonelderly Population		
Percent Uninsured[a]	14.1 %	15.5 %
Percent Medicaid[a]	11.5	12.2
Percent Employer-Sponsored[a]	67.2	66.1
Percent Other Health Insurance[a, b]	7.1	6.2
19–64 Population		
Percent Uninsured[a]	16.1	17.9
Percent Medicaid[a]	6.6	7.1
Percent Employer-Sponsored[a]	68.9	67.8
Percent Other Health Insurance[a, b]	8.4	7.2
0–18 Population		
Percent Uninsured[a]	9.0	10.4
Percent Medicaid[a]	24.8	23.1
Percent Employer-Sponsored[a]	62.7	62.5
Percent Other Health Insurance[a, b]	3.5	4.0
<200 Percent of the Federal Poverty Level—Nonelderly Population		
Percent Uninsured[a]	22.5	25.3
Percent Medicaid[a]	34.4	34.1
Percent Employer-Sponsored[a]	34.9	33.9
Percent Other Health Insurance[a, b]	8.2	6.7

a. Two-year concatenated March Current Population Survey files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.
b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

erage rates are nearly identical to the national averages. The reason Medicaid coverage is lower than average for the general population but virtually identical to the U.S. average for the low-income population is that the state has a lower poverty rate. Thus the state, proportionately, has a pool of potential enrollees smaller than the national average. The similarity in Medicaid coverage of the poor between North Carolina and the nation suggests that North Carolina's eligibility rules are about average.

Medicaid Eligibility

North Carolina was one of the last states to initiate a Medicaid program (in 1970). Moreover, the state historically has maintained stricter eligibility standards for Medicaid compared to many states—including its neighbor Tennessee—although its standards have been more generous than other states in the region, such as South Carolina. When Congress "broke the link" between welfare standards and Medicaid in the Omnibus Budget Reconciliation Acts of 1986 and 1987, North Carolina expanded coverage to pregnant women and infants to 185 percent of the FPL (133 percent is mandatory). And although Congress mandated phased-in coverage for children ages 6 to 18 below the FPL, in the early 1990s North Carolina opted to cover immediately all children through age 18 instead of waiting until the year 2002. The state also covers nearly all optional groups, including the medically needy, although the eligibility threshold is low.[24]

In contrast to its relative generosity in the above areas, the state always has had low eligibility standards for Aid to Families with Dependent Children (AFDC)—now Temporary Assistance for Needy Families (TANF)—a program that automatically qualifies the recipient for Medicaid coverage. North Carolina's tight AFDC eligibility standards initially constrained it from raising medically needy standards to cover more eligibles. (By federal rules, medically needy standards cannot exceed 133 percent of the AFDC payment standard.) In 1996, the state's AFDC payment standard was only 25 percent of the FPL, so the maximum allowable medically needy standard was 34 percent of the FPL. Under TANF rules, North Carolina is permitted to increase its medically needy income standard by the increase in the medical consumer price index, but to date, North Carolina has not opted to do so.[25] As of 1996, North Carolina's medically needy income standard continues to be about one-third lower than the national average, and the asset limit is roughly 40 percent lower; this disparity will grow over time unless the state adjusts its medically needy standard with inflation. Another illustration of the state's stringency is that until January 1, 1995, North Carolina was one of only 12 states (often referred to as 209(b) states) opting to use stricter Medicaid eligibility standards for Supplemental Security Income (SSI) recipients.

Largely as a result of the eligibility expansions for children and pregnant women adopted beginning in the late 1980s, growth in Medicaid eligibles has been considerable. Between FY 1988 (the first year of major expansions) and FY 1997, total Medicaid enrollment climbed without interruption from 481,000 to 1,192,000—an annual growth rate of 10.6 percent.[26] With the initiation of welfare reform (Work First) and an improved economy, Medicaid enrollment of women and children began to fall as AFDC/TANF rolls shrank. From FY 1994 to FY 1997, North Carolina's AFDC/TANF eligibles declined by 26.9 percent, compared with 23.2 percent nationally.[27] The impact of these declines on *total* Medicaid enrollment, however, has been modest. This is because the state's removal of 209(b) restrictions on SSI eligibility and other expansion initiatives offset the dramatic drop (nearly 120,000 between FY 1995 and FY 1998) in eligibles from families receiving AFDC/TANF.[28] From FY 1997 to FY 1998, annual Medicaid enrollment grew by only 5,050 (0.4 percent).

Other Public Insurance Programs

The state has never had a state-only public health insurance program, nor does it have a General Assistance pro-

gram to help with payment of medical bills. A variety of county programs and private-sector efforts provide direct services to indigent patients, and general county subsidies to (usually county-owned) hospitals help offset their uncompensated care losses (discussed in the section on the health care safety net). The Blue Cross and Blue Shield of North Carolina Caring Program for Children was established in 1987 using private contributions to subsidize outpatient care for uninsured near-poor children ineligible for Medicaid. This program had always been relatively small but in recent years had begun to receive state appropriations ($1.05 million in 1997) to help cover uninsured children ineligible for Medicaid up to 185 percent of the FPL. The program expired October 1, 1998, because all 8,000 children enrolled are now eligible for the new CHIP.

North Carolina has never had a state high-risk pool. In 1987 Blue Cross and Blue Shield of North Carolina initiated its own high-risk pool (SNAP, or Special Needs Assessment Plan) to serve as a plan of last resort for those otherwise unable to obtain private coverage because of high risk. This plan covers several thousand people, thereby dissipating pressure to create a separate state high-risk pool. SNAP receives no state funding or subsidies from other insurers.

In 1993, a new statute created a State Health Plan Purchasing Alliance Board to promote the development of voluntary purchasing alliances as a mechanism to provide more affordable insurance for the self-employed and those in small businesses with under 50 employees. As of September 1, 1998, 2,112 persons were covered through alliances, of whom 60 percent previously had been uninsured.[29]

Private Health Insurance Reforms

In 1991, North Carolina became the second state in the country (behind Connecticut) to enact small-group reform, including limits on preexisting condition exclusions, guaranteed issue, and guaranteed renewal. The 1991 reforms, targeting groups of 2 to 49, also included alternative rating limits recommended by the National Association of Insurance Commissioners. These "rating bands" allowed age, gender, number of family members, geographic area, and industry to be used as rating factors and allowed premium variations for claims experience, health status, and duration of coverage, but prevented insurers from varying their prices more than 35 percent above or below the midpoint for small groups with similar benefits and case characteristics (that is, a range of 2:1).[30] Subsequent reforms in 1993 established modified community rating with adjustments permitted for demographic factors only, effective January 1, 1995, for new groups and phased in over several years for renewal groups. These changes turned out to be so restrictive that further amendments (effective as of June 1995) returned to the old experience rating system with narrower rating bands (±20 percent for any reason, including claims experience, health status, and duration of coverage).[31]

The enactment of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996

Table 3
Medicaid Expenditures
by Eligibility Group and Type of Service,
North Carolina and United States
(Expenditures in Millions)

	North Carolina				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Total	**$4,367.2**	**28.0%**	**16.1%**	**8.5%**	**$160,968.6**	**27.1%**	**9.7%**	**2.3%**
Benefits								
Benefits by Service	3,872.8	22.4	17.2	11.9	140,290.1	18.8	10.9	5.4
Acute Care	2,395.4	27.5	20.5	12.9	84,666.5	22.3	12.8	6.6
Long-Term Care	1,477.4	16.6	12.7	10.2	55,623.6	14.6	8.2	3.5
Benefits by Group	3,872.8	22.4	17.2	11.9	140,290.1	18.8	10.9	5.4
Elderly	1,188.0	18.0	15.4	13.1	42,418.5	16.7	8.4	3.7
Acute Care	350.3	14.1	17.0	23.5	11,229.3	18.9	12.7	8.6
Long-Term Care	837.7	19.5	14.8	9.3	31,189.2	16.0	7.1	2.1
Blind and Disabled	1,525.5	18.8	17.7	33.6	56,601.3	17.6	13.3	8.6
Acute Care	920.0	24.4	23.7	43.3	33,880.1	22.9	15.8	10.7
Long-Term Care	605.5	14.2	11.4	21.1	22,721.2	11.9	10.1	5.7
Adults	554.5	33.0	19.3	–4.7	16,956.6	21.4	9.1	0.7
Children	604.8	29.1	17.8	–12.1	24,313.8	23.8	11.4	4.4
Disproportionate Share Hospital	362.8	125.8	8.9	–15.5	15,102.6	263.4	2.0	–19.6
Administration	131.6	12.8	13.8	–1.5	5,575.9	9.8	12.8	2.3

Source: The Urban Institute, 1997. Based on Health Care Financing Administration (HCFA) 2082 and HCFA 64 data.

standardized various health insurance reforms across all states. To comply with HIPAA, North Carolina enacted further amendments in 1997, but these required very modest changes on the small-group side. Specifically, HIPAA (a) redefined group size to include groups of 2 to 50 rather than 2 to 49;[32] (b) limited preexisting conditions exclusions to conditions treated or diagnosed for up to 6 months before enrollment rather than 12; (c) credited prior waiting periods if the gap between new and previous coverage is less than 63 days rather than 60; (d) extended guaranteed issue to all group products rather than just selected ones; and (e) enacted federal fallback provisions regarding group-to-individual portability, to be enforced by the state.[33] As required, the state also implemented guaranteed renewability in the individual market, as North Carolina previously had not enacted any individual market reforms.

Medicaid Expenditures

Because of the enormous increase in eligibles since 1988, as well as increases in expenditures per enrollee, Medicaid spending in North Carolina grew at an annual average rate of 18.6 percent between 1990 and 1996 (versus 13.9 percent nationally), reaching a level of $4.4 billion by the end of that period (see table 3). Between 1990 and 1995, Medicaid eligibles grew by 13.9 percent per year, the eighth-highest rate of increase in the country and well above the national average (7.9 percent).[34] By FY 1996, the state's Medicaid program covered almost *triple* the number of eligibles it had 10 years earlier, yet the Medicaid share of state spending (19 percent) was still slightly *lower* than the U.S. average (20.2 percent).[35] North Carolina is about 8 percent above the national average, however, when adjusted for the fact that the state requires counties to cover 15 percent of the nonfederal share.[36] North Carolina is one of only 14 states requiring local funding of at least some portion of Medicaid.

With few exceptions, North Carolina's Medicaid spending growth was greater than the rate of growth in national Medicaid spending from 1990 to 1996, whether one looks at benefits by service (acute care versus long-term care) or by major eligibility group. A notable exception to this general pattern is that, from 1995 to 1996, total Medicaid spending for adults and children *declined* in North Carolina (in part reflecting reductions in AFDC attributed to welfare reform and a robust economy) while rising nationally.

Most of North Carolina's higher-than-average growth in Medicaid spending is a result of rapid expansions in eligibility. In contrast, spending per enrollee during the 1990–96 period grew only slightly faster in North Carolina (6.8 percent per year) than in the United States (6.0 percent per year). For the elderly and disabled, per enrollee expenditures grew more slowly in North Carolina than in the United States in the early 1990s and more rapidly than in the United States between 1992 and 1996 (see table 4). For adults and children, growth rates in per enrollee spending exceeded the national averages from 1992 to 1995 but declined to well below the U.S. averages from 1995 to 1996. Per enrollee expenditures in 1996 were 4 percent (blind and disabled), 7 percent (children), and 29 percent (elderly) lower than the U.S. averages, but spending for adults was 27 percent higher. An important reason for the latter is that,

Table 4
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	North Carolina				United States			
		Average Annual Growth				Average Annual Growth		
	1996	1990–92	1992–95	1995–96	1996	1990–92	1992–95	1995–96
Elderly								
Total expenditures on benefits (millions)	$1,188.0	18.0%	15.4%	13.1	$42,418.5	16.7%	8.4%	3.7%
Enrollment (thousands)	161.8	9.2	8.1	3.0	4,103.2	5.1	2.9	0.0
Expenditures per enrollee	$7,343	8.1	6.8	9.8	$10,338	11.0	5.4	3.7
Blind and Disabled								
Total expenditures on benefits (millions)	$1,525.5	18.8	17.7	33.6	$56,601.3	17.6	13.3	8.6
Enrollment (thousands)	188.3	13.0	17.1	23.4	6,698.2	9.8	9.3	5.2
Expenditures per enrollee	$8,104	5.2	0.5	8.2	$8,450	7.1	3.7	3.2
Adults								
Total expenditures on benefits (millions)	$554.5	33.0	19.3	–4.7	$16,956.6	21.4	9.1	0.7
Enrollment (thousands)	238.5	19.7	4.1	–4.7	9,225.0	11.4	5.0	–4.1
Expenditures per enrollee	$2,325	11.2	14.6	0.1	$1,838	8.9	4.0	5.0
Children								
Total expenditures on benefits (millions)	$604.8	29.1	17.8	–12.1	$24,313.8	23.8	11.4	4.6
Enrollment (thousands)	569.2	20.8	8.9	0.0	21,270.5	13.1	4.8	–1.6
Expenditures per enrollee	$1,063	6.8	8.1	–12.1	$1,143	9.5	6.3	6.3

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

because of the state's generous eligibility rules for pregnant women (185 percent of the FPL versus the federal minimum standard of 133 percent) but restrictive standards for AFDC eligibility (25 percent of the FPL versus the national average of 40 percent),[37] a higher proportion of North Carolina's adult eligibles are pregnant women compared to elsewhere.

The Health Care Safety Net

North Carolina is one of a handful of states that does not statutorily assign to any level of government the responsibility for indigent care. Although the state has been a leader in maintaining a broad and generally effective safety net of providers for the low-income population in rural areas, those not fortunate enough to live in areas served by these providers have no legal means to guarantee the availability of care. Statewide, the safety net includes 170 federally qualified health centers and rural health clinics,[38] 120 of which receive federal grants or state assistance. These centers have helped recruit primary care physicians to underserved areas. Some of these also have specialized missions, with target populations such as migrant farmworkers. A total of 87 local health departments provide maternal and child health services and in some cases adult health services. A nine-center Area Health Education Center program (the most extensive of its kind in the nation) provides residency training in major teaching and regional hospitals throughout the state, and there is an extensive companion network of family practice residency programs, which are an important source of uncompensated care for indigent patients.

State officials have expressed concern that part of this fragile safety net is in danger of being unraveled, as urban managed care plans seeking primary care providers have begun to offer lucrative incentives enticing providers away from rural counties.[39] To date there is no empirical evidence of this having an impact.[40] Part of the reason may be that North Carolina's Medicaid fees are relatively generous, which has made practice in an impoverished area more feasible. In 1993, the state's Medicaid fee for physician office visits amounted to 98 percent of comparable fees paid by Medicare.[41] This fee was substantially higher than the fee in the neighboring states of South Carolina (72 percent), Tennessee (86 percent), and Virginia (69 percent), reflecting a concerted effort in the early 1990s to improve physician payments to induce greater participation, particularly in underserved areas.

North Carolina relies much more than most states on public hospitals, with the public share of community hospital beds (35.7 percent) more than double the national average in 1995.[42] These public hospitals account for 32 percent of the short-stay hospitals in the state and include 1 state-owned teaching hospital at the University of North Carolina (UNC) at Chapel Hill, 18 city- or county-owned hospitals, and 12 hospital district or authority facilities. The state teaching hospital has an open-door policy for all state residents and, as a consequence, is an important referral facility for indigent patients from a wide geographic area. In 1997, it provided $32 million in indigent care. Historically, the state has provided an appropriation to the hospital sufficient to cover both its indigent care costs and teaching costs. These appropriations totaled $44.9 million in 1996 but were cut to $25.7 million in 1997 because of the hospital's healthy financial reserves and subsequently were raised to $36.4 million for 1998.[43] In 1997, 12 of the state's 100 counties made appropriations totaling $25.1 million to hospitals, most of which was used to cover indigent care costs.[44]

Public appropriations cover only a small portion of hospital uncompensated care, which in 1996 amounted to 5.6 percent of hospital spending in North Carolina—roughly 10 percent above the U.S. average.[45] This amounts to approximately $500 million.[46] No current data are available on the cost of public programs providing medical services to low-income patients, but a conservative extrapolation from a 1990 estimate (assuming 3 percent annual growth) suggests the cost may now exceed $800 million.[47] A similar extrapolation of estimated nonhospital uncompensated care costs amounts to $800 million as well. Thus, in addition to the billions of dollars spent through Medicaid, at least $2 billion more in medical services is provided to the medically indigent through the state's extensive safety net.

Current State Health Policy Issues

Medicaid Managed Care

North Carolina's approach to Medicaid managed care has been cautious. It is one of 31 states that in 1997 did not have an approved Section 1115 waiver to adopt managed care on a broad scale. Medicaid managed care enrollment in 1996 was 37.2 percent, only slightly lower than the national average (40.1 percent).[48] However, most of this enrollment was in primary care case management rather than full-risk capitation arrangements. To date, the single largest Medicaid managed care effort has been the Carolina ACCESS program, which began under a Section 1915(b) waiver in five counties in April 1991. Modeled after a similar program in Kentucky, ACCESS requires Medicaid eligibles to choose a participating primary care provider (PCP). The PCP is paid a monthly case management fee ($3.00 for each of the first 250 enrollees; $2.50 for each additional enrollee) to serve as a 24-hour "gatekeeper" for medical services, which continue to be reimbursed on a fee-for-service basis. Because of its success, Carolina ACCESS was expanded to 41 counties by July 1996 and now is being implemented statewide, with expected completion by the end of 1998.

Until recently, the state's only experience with full-risk HMO contracts in the Medicaid program was an arrangement with Kaiser Permanente, beginning in 1986, to provide voluntary coverage in Mecklenburg County (Charlotte) and three other counties. About 5,000 Medicaid enrollees elected to enroll. Beginning on July 1, 1996, a Section 1915(b) waiver was used to mandate managed care enrollment throughout Mecklenburg County for roughly 35,000 Medicaid eligibles (families with dependent children and pregnant women). Eligible persons must choose among four HMOs and a federally qualified health center that continues to operate as a PCP under the ACCESS model. In 1997, the mandatory groups were expanded to include the blind and disabled.

Under a separate Section 1915(b) waiver, 10 area mental health agencies (covering 32 counties) have been pro-

viding inpatient and outpatient mental health and substance abuse services to children from birth to age 17 on a fully capitated basis since January 1, 1996.[49] A waiver modification has been filed to expand this pilot project statewide to include both child and adult services. This waiver request is pending.

In other major urban areas, the state has begun to require selected Medicaid eligibles to choose between enrollment in an HMO and the Carolina ACCESS plan. Others (including pregnant women and certain categories of aged, blind, and disabled) may voluntarily enroll in an HMO or remain in fee-for-service. This initiative began in November 1997 in Gaston County, was implemented in the Triangle (Raleigh, Durham, and Chapel Hill) in February 1998 and in the Triad (Greensboro, High Point, and Winston-Salem) in August 1998, and will be rolled out elsewhere as feasible. In rural counties, the state is pursuing local community-sponsored networks to serve Medicaid patients, building on the expertise of traditional providers such as community health centers and local health departments.

Children's Health Insurance Program

Following an unanticipated partisan battle pitting the Hunt administration and the Democratic-controlled Senate against conservatives in the Republican-led House who wished to see a more market-oriented approach to expanding coverage, North Carolina succeeded in enacting CHIP, effective October 1, 1998. A newly appointed secretary for human resources, trained as a pediatrician and with a strong interest in children, was a key player in the efforts to win passage of CHIP in the face of strong opposition by those favoring tax credits or vouchers as the means to expand coverage.

The enacted plan creates a non-Medicaid program for children from birth to age 18 with incomes too high to qualify for Medicaid but less than 200 percent of the FPL. The benefits package is nearly identical to Medicaid (including dental, vision, and hearing services) but requires an enrollment fee for some families ($50 per child up to a maximum of $100 per family) and copayments for services for some families as permitted by federal law. As part of the political compromise necessary to enact CHIP, the legislation also provides that parents with incomes between 200 and 225 percent of the FPL can qualify for a tax credit of $300 if they pay for private insurance coverage for their children, while those with higher incomes (up to a family income of $100,000) can qualify for a credit of $100. The tax credit portion of the CHIP initiative does not draw down federal matching funds.

CHIP is targeted at 71,000 eligible children and is expected to cost the state $28 million (plus $80 million in federal funds). The tax credit could benefit up to 405,000 families and is projected to cost $64.5 million annually in state funds. In addition, outreach efforts will target 68,000 children currently eligible for Medicaid but not enrolled.

Other Health Policy Changes Arising from the Balanced Budget Act of 1997

The Balanced Budget Act included several important changes to the Medicaid program. These included tighter limits on the disproportionate share hospital (DSH) program and repeal of the Boren amendment. At its peak (FY 1995), DSH accounted for 10.7 percent of Medicaid spending in North Carolina. By FY 1997, DSH had declined by more than one-fifth and accounted for only 7.2 percent of spending.[50] The new DSH restrictions will have relatively little impact in North Carolina. North Carolina's state contribution to DSH is funded principally through intergovernmental transfers from the state-owned UNC Hospitals and state mental hospitals. At least 75 of the state's 118 nonfederal short-stay hospitals receive DSH supplements ranging from 2.5 percent to 19 percent of standard Medicaid reimbursement.

At this time, it is uncertain how North Carolina will respond to repeal of the Boren amendment. North Carolina's Medicaid payment-to-cost ratio (89.8 percent) for hospitals was lower than the national average in 1996 (94.9 percent) but was roughly at the median.[51] The state has a good relationship with the hospital industry (which has been instrumental in pushing Medicaid expansions through the General Assembly), so further tightening of payments is unlikely. North Carolina is one of only a few states never to be sued by nursing homes under the Boren amendment, and it is not likely to abandon its current payment methods even though the Boren amendment has been repealed.

Conclusion

As of 1994–95, one of seven nonelderly North Carolinians lacked health insurance, a somewhat lower proportion than the national average. The state's prosperous economy in recent years has permitted it to afford a sizable expansion of Medicaid over the past decade. Enrollment expansions have placed ever-increasing demands on the state's budget and have, in turn, led the state to adopt capitated Medicaid managed care reforms, although somewhat later than many states. The state's recently enacted CHIP may help up to 71,000 uninsured children, with outreach efforts adding 68,000 more to the Medicaid rolls in the best case. However, there is an underlying trend, driven by a number of factors, of a steadily increasing uninsurance rate in both North Carolina and the nation, despite a fairly robust economy.[52] What will happen in the decade ahead, especially in the face of an economic downturn, remains to be seen.

Notes

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3. North Carolina Economic Development Board. *Making North Carolina a High Performance State*. http://www.commerce.state.nc.us/commerce/econbd/economic.html.

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6. KIDS COUNT Data Online [Profile for NC]. http://www.aecf.org. May 26, 1998.

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13. NC General Assembly, Division of Fiscal Research analysis of data from National Conference of State Legislatures.

14. Table 489. *Statistical Abstract of the United States: 1997.* U.S. Bureau of the Census.

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18. Duke University, Center for Health Policy, Law, and Management. *A Guide for Communities Considering Hospital Conversion in the Carolinas.* Durham, NC: Center for Health Policy, Law, and Management, May 1998.

19. William Mercer Companies, Inc., survey results reported in *Triangle Business Journal.* January 23, 1998.

20. Joel Obermayer. "Insurers to Impose Massive Rate Hikes." *News and Observer (Raleigh),* July 1, 1998: 1A.

21. Joel Obermayer. "Competition, Rising Costs Batter HMOs." *News and Observer (Raleigh),* March 11, 1998: 1A.

22. Steve Roblee. "HMOs, Doctors Angle in Appeals to Public." *Triangle Business Journal.* August 14, 1998: 4.

23. Calculated from Current Population Survey data in tables 1 and 2.

24. The medically needy program is an optional eligibility category under Medicaid that allows persons with incomes just above the Aid to Families with Dependent Children level to qualify for Medicaid. Persons can "spend down" to medically needy eligibility if their medical expenses are sufficiently large, as commonly occurs among nursing home residents.

25. Personal communication with Pam Silberman, Cecil B. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, September 1, 1998.

26. Figures through FY 1996 reported in North Carolina Division of Medical Assistance (NC DMA). http://www.dhr.state.nc.us/DHR/DMA/97tab8.txt. September 4, 1998. FY 1998 figures are unpublished estimates provided by Patsy Slaughter, NC DMA.

27. Total AFDC/TANF, Average Monthly Number of Recipients, FY 1994–97, data provided by the Urban Institute.

28. NC DMA. http://www.dhr.state.nc.us/DHR/DMA/97tab8.txt. September 4, 1998. FY 1998 figures are unpublished estimates provided by Patsy Slaughter, NC DMA.

29. Figures obtained from State Health Plan Purchasing Alliance Board.

30. Intergovernmental Health Policy Project. *Community Rating: States' Experience.* Washington, DC: George Washington University, Intergovernmental Health Policy Project, July 29, 1994.

31. S.S. Laudicina et al. *State Legislative Health Care and Insurance Issues, 1995 Survey of Plans.* Chicago: Blue Cross Blue Shield Association, December 1995.

32. Note that HIPAA itself only required reforms to be extended to groups of 2 to 50.

33. These include (a) guaranteed issue of at least two products to HIPAA eligibles, (b) guaranteed renewal, and (c) no waiting periods for preexisting conditions.

34. Table 14 in Peter Long and David Liska. *State Facts: Health Needs and Medicaid Financing.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, February 1998.

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43. Catherine Clabby. "UNC Hospitals' Needs Evaluated." *News and Observer (Raleigh),* April 4, 1998: 1B.

44. Analysis of data from Annual Financial Information Reports, FY 1997, obtained from Department of the State Treasurer. http://www.treasurer.state.nc.us/Treasurer/lgc/afirdown.htm.

45. Chart A-10. Private Payer Payment-to-Cost Ratios, by State, 1996. *Health Care Spending and the Medicare Program: A Data Book.* Washington, DC: Medicare Payment Advisory Commission, July 1998.

46. Total hospital spending in 1996 is estimated at $8.9 billion, based on estimated per capita hospital spending in North Carolina for 1995, inflated to 1996 (see "Projected Personal Health Spending, North Carolina and United States, 1995–2030" in Appendix F, North Carolina Health Planning Commission, *Annual Report,* 1996), times total population.

47. Unpublished estimates by the author show that the total cost of direct service medical programs for North Carolina's medically indigent amounted to $683 million in 1990.

48. AARP. *Reforming the Health Care System: State Profiles 1997.*

49. North Carolina Department of Health and Human Services. "Carolina Alternatives." *Community-Based Mental Health and Substance Abuse Services.* http://www.dhr.state.nc.us/DHR/DMH/caralt.

50. NC DMA. http://www.dhr.state.nc.us/DHR/DMA/97tab6.txt.

51. Chart A-9. Aggregate Payment-to-Cost Ratios, by State, 1996. *Health Care Spending and the Medicare Program: A Data Book,* 1998.

52. The Congressional Budget Office (CBO) projects an annual increase in the national number of uninsured of 0.9 percent betweeen 1997 and 2007. *The Economic and Budget Outlook: Fiscal Years 1998–2007.* Washington, DC: CBO, January 1997. There is no reason to suppose that North Carolina's uninsured will grow any more quickly or slowly than this.

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