WHY MEDICAID EXPANSION IS WRONG FOR NORTH CAROLINA

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Medicaid Expansion in North Carolina

Expansion DOES NOT mean access to healthcare

North Carolina has added more than **1,000,000** new enrollees to its Medicaid program from 2003 to 2018.

But the number of physicians accepting Medicaid has dropped by **1,300**

Medicaid expansion would add at least another **630,000 patients** despite the overcrowding.

Expansion DOES mean job losses and budget increases

94,000
Estimated number of jobs lost with Medicaid expansion, as Medicaid eligibility discourages work.
Source: Foundation for Government Accountability

$3.5 billion
the federal share for Medicaid expansion.

$335 million
North Carolina's share for Medicaid expansion.

Expansion crowds out care for the most vulnerable

Medicaid expansion means **able-bodied** adults will now compete with the most **needy** patients for a **short supply** of doctors.

And more **federal government dollars** favor the new, healthier patients.

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COVERAGE DOES NOT EQUAL ACCESS TO CARE

The Left would lead you to believe that Medicaid expansion would provide low-income North Carolinians with top-notch medical care, create tens of thousands of jobs, and magically be paid for by "someone else."

The reality is quite the opposite. Medicaid expansion would actually:

- Condemn low-income citizens to an already over-crowded system with little to no access to actual medical care
- Subject those enrolled to poorer health results
- Crowd out Medicaid resources for the most needy in favor of childless, healthy adults
- Cost North Carolina thousands of jobs
- Come with a hefty price tag for North Carolina, and increase the national debt
- Trap more people in poverty
- Make healthcare more expensive for everybody

WHAT THE LEFT WANTS

One of the long-held goals of the Left in North Carolina has been to expand Medicaid as provided for in Obamacare. Medicaid is a government program jointly funded by federal and state governments that pays for the medical bills of enrollees, which consist primarily of low-income households, pregnant women and people with disabilities.

Two bills, introduced during the 2017 legislative session, HB 5 and SB 3 – both entitled Medicaid Expansion/ Healthcare Jobs Initiative – constituted the latest effort to make this goal law.

The basic provisions of these bills include expanding the state's Medicaid program to everyone under age 65 not currently eligible for Medicaid earning up to 133 percent of the federal poverty level. The bulk of the expense of expansion would be paid for by the federal government, with most of the state's cost supposedly to be paid for by a hospital tax.

Expanding Medicaid would have disastrous consequences for those it purports to help, and the state of overall healthcare in North Carolina.

COVERAGE DOES NOT MEAN ACCESS TO CARE

According to estimates provided in the legislation, Medicaid expansion would add another 630,000 people onto the already over-crowded program by 2019. The goal of expanding Medicaid to hundreds of thousands of North Carolina citizens is sold as a compassionate way to provide access to medical care for low-income families. The reality, however, is that new enrollees would struggle to find access to doctors and the care they need.

Medicaid rolls in North Carolina have ballooned from about 1 million in 2003 to roughly 2.1 million today. Adding another 630,000 would push the program over 2.7 million enrollees and mark more than 1.7 million new Medicaid patients in just fifteen years.

All this would take place when the number of physicians accepting Medicaid patients is dwindling. There are currently 1,300 fewer North Carolina physicians listed as Medicaid providers in fiscal year 2018 than there were in fiscal year 2003.

Imagine now adding the equivalent of the entire population of Durham and Cumberland counties combined to a group of people already fighting over a shrinking pool of doctors. That's what Medicaid expansion would do.

Making matters worse, a 2012 article in Health Affairs found that one-fourth of North Carolina's physicians will not take new Medicaid patients.

In short, the dwindling supply of doctors is already struggling to meet the demand of the growing ranks of Medicaid enrollees. Expansion would only make things far worse.

The doctor shortage is especially acute in rural areas, where the concentration of Medicaid enrollees is even heavier, making for even lower doctor to population ratios.

This is not politics or ideology – this is simple math. Medicaid expansion in North Carolina would not provide access to medical care to the new enrollees, it would simply give them a Medicaid card with little to no hope of actually seeing a doctor when they are sick.

For example, this 2014 USA Today article looked at the impact in Reno from Nevada's Medicaid expansion. Nevada was one of 26 states to expand Medicaid in 2014, and the article notes that "many new enrollees have been frustrated by the lack of providers willing to see them," and that "(p)hysicians and clinics that treat the poor say they've been overwhelmed by new patients." As Chuck Duarte, the state's former Medicaid chief and director of the region's largest community health center, noted, "We are struggling to keep up with demand for care."

Research also shows that Medicaid patients – especially children – have far longer wait times to see a doctor or specialist and are more likely to be turned away for treatment by physicians. Trouble finding a regular physician leads Medicaid patients to utilize the highly expensive emergency room for non-emergent care at a higher rate than the uninsured. As one Reno Medicaid enrollee noted in the USA Today article: "I love it on Medicaid because now I can go the emergency room when I need to and don't have to worry about the bill."

An Asheville Citizen-Times report reviewed the RAND Corporation study showing that emergency room visits are on the rise. The article continued:

"It's often hard for patients on Medicaid-managed care plans to get appointments with primary care providers, with median waits of two weeks, though more than a quarter waited a month or more, leaving them with few options besides the ER, according to the American College of Emergency Physicians. The group also pointed to the nationwide physician shortage."

"America has severe primary care physician shortages, and many physicians will not accept Medicaid patients because Medicaid pays so inadequately," said its president, Dr. Michael Gerardi. "Just because people have health insurance does not mean they have access to timely medical care." (emphasis added)

If the radical Left gets its way and as many as 630,000 more people are stuffed onto North Carolina's Medicaid rolls, a big question remains unanswered: Who will these people see to get care? Medicaid enrollees already struggle to access care in a timely manner. Imagine how much worse the problem will be when 630,000 more people are added to the program.

The bottom line is this: those advocating for Medicaid expansion want to condemn low-income people into an already overcrowded system that is simply incapable of providing adequate medical care. That's not compassionate – that's cruel.

MEDICAID PROVIDES POOR HEALTH RESULTS

Due in no small part to the extremely poor access to care, health outcomes for Medicaid enrollees are subpar.

As Steve Anderson, the Kansas budget director from 2010 to 2013 and former board member in the hospital industry pointed out in this article, "Any discussion of Medicaid should begin with its track record on patient health. On that score, Medicaid is an abject failure."

"Medicaid recipients consistently fare poorly on medical access and outcomes. Their access to doctors and specialists is significantly lower than those with private insurance. Their death rate in hospitals following surgery is twice as high. And children on Medicaid have much longer waits to see doctors, along with a higher chance of being turned away by health care providers."

Moreover, a 2011 groundbreaking study in Oregon showed Medicaid enrollees don't experience any better health outcomes than the uninsured, and often times experience even worse outcomes.

The study examined Medicaid expansion in Oregon, comparing outcomes for people who received coverage versus a control group that did not have health insurance. It found some limited benefits of Medicaid enrollment, like reduced rates of depression. But in terms of overall health outcomes, there was no difference between the Medicaid group and the control group in terms of blood pressure, cholesterol, diabetes, or obesity – all indicators that should have improved over the span of the study.

If the goal of Medicaid is providing better health care to the poor, the evidence suggests it is failing miserably, and the failure comes with a huge price tag.

EXPANSION CROWDS OUT CARE FOR THE MOST VULNERABLE

A 2012 study by the Urban Institute examined the demographic makeup of the uninsured that would be newly eligible for Medicaid under Obamacare's expansion. Nationally, about 4 of every 5 newly eligible for Medicaid would be a working age adult with no dependent children. In North Carolina, that figure is more than 3 of every 4 newly adults.

Furthermore, according to the Obama administration's own Department of Justice, nearly 1 in 3 of those who become newly eligible for Obamacare's Medicaid expansion would have had previous time served in prison or jail.

In other words, the majority of people who would be covered under Medicaid expansion in North Carolina would be healthy, childless adults of working age or ex-cons.

This new group is who would be competing for care – from a diminishing supply of doctors — with the traditional Medicaid population of poor children, pregnant women and the disabled.

And because the federal government would pay for a higher percentage of the cost of the newly eligible under expansion compared to the traditional Medicaid population, states would favor directing resources to the newly eligible population over the most vulnerable populations.

[i] Figure taken from Medicaid Annual Reports for FY 2003 and FY 2016. Available online at: https://files.nc.gov/ncdma/documents/Reports/Annual-Reports/Medicaid-Annual-Report-SFY-2003.pdf

https://files.nc.gov/ncdma/documents/files/Medicaid-Annual-Report-State-Fiscal-Year-2016.pdf

MEDICAID EXPANSION: CRUEL, NOT COMPASSIONATE; PART 2

EXPANSION WOULD COST TENS OF THOUSANDS OF JOBS, DRIVE UP HEALTHCARE COSTS AND TRAP MORE IN POVERTY

In Part 1 of this article, we explored several of the negative consequences should North Carolina expand Medicaid per Obamacare. Part 2 will discuss still more damage that expansion could impose on the state, and conclude with several alternative policies and options that would better provide affordable coverage and care for low-income North Carolinians.

EXPANSION COSTS NORTH CAROLINA TENS OF THOUSANDS OF JOBS

Desperate because their past attempts to expand Medicaid have failed, liberal progressives a few years ago began advancing the "Medicaid expansion will create jobs" canard to try to broaden support for expansion of this costly entitlement.

Supporters were emboldened largely by two studies. One report, produced by George Washington University researchers, declared that North Carolina could create 43,000 jobs in five years under Medicaid expansion. That study was largely echoed by a January 2013 study produced by the North Carolina Institute of Medicine (NCIOM) that came to similar conclusions.

Small problem: The assumptions built into the studies claiming Medicaid expansion would create jobs don't square with reality. And in fact, credible research and logic show that expansion would cost North Carolina tens of thousands of jobs.

The job growth claims in the studies are based on the state's "drawing down" additional federal funds due to Medicaid expansion. As the GWU report describes, "Since most of the cost of a Medicaid expansion would be borne by the federal government, expansion would result in billions of dollars in additional federal funding flowing into North Carolina. These funds will initially be paid to health care providers, such as hospitals, clinics or pharmacies, as health care payments for Medicaid services."

This income received by health care providers is then spent on suppliers (such as medicine, medical supplies, etc.) and in their community on goods and services such as groceries, clothes and movies. The increased economic activity, according to the theory, would create more jobs.

We'll leave aside for now the negative impacts from our already deeply indebted federal government having to borrow billions more to fund the Medicaid expansion.

The fatal flaw in these studies is the methodology. In order to "draw down" federal Medicaid dollars, actual medical services need to be provided to Medicaid patients. It is only when doctors actually treat Medicaid patients that the federal government pays those providers for the services.

And this is where the methodology fails. As noted previously in Part 1, North Carolina's Medicaid system is already overcrowded, with a drastically increasing number of patients chasing fewer doctors.

There is simply no capacity for doctors and other providers to treat an additional 630,000 Medicaid patients. And if you think this massive shift of patients into the Medicaid program will attract more doctors to become Medicaid providers, think again. Across the state, there is a general doctor shortage, and thus doctors currently not seeing Medicaid patients are already at their limits and thus would not have the capacity to take on Medicaid patients.

Indeed, a 2011 survey by the Association of American Medical Colleges found that only 15 states have fewer primary care physicians per capita than North Carolina.

As reported in 2014 by WRAL, "A survey this year by The Physicians Foundation found that 81 percent of doctors describe themselves as either over-extended or at full capacity, and 44 percent said they planned to cut back on the number of patients they see, retire, work part-time or close their practice to new patients."

Such extreme supply constraints tell us that if North Carolina were to expand Medicaid, the newly enrolled would have great difficulty actually seeing a doctor. Coverage will not equal access.

If a new enrollee in the already overcrowded Medicaid program doesn't have access to care, then there will be no services provided. With no service provided, no federal dollars are "drawn down" to Medicaid providers. Many Medicaid patients will either not be able to receive services, or be relegated to the emergency room – and ER's are not ready to handle the influx of patients either (more on that below). The whole premise behind the studies purporting to show job creation is unsupportable.

But that's not all. Research, and common sense, tell us that expanding Medicaid will also reduce participation in the workforce, resulting in a net loss of jobs.

Studies by the National Bureau of Economic Research, the Congressional Budget Office, and university economists all find that expanding Medicaid eligibility discourages work and is associated with a decrease of jobs. Based partly on this research, the Foundation for Government Accountability estimates Medicaid expansion could cost North Carolina up to 94,000 jobs.

Academic research on states that have expanded Medicaid finds Medicaid expansion causing decreases in employment as well.

MEDICAID EXPANSION IS UNAFFORDABLE

Funding for the newly eligible Medicaid enrollees under expansion would be provided 100 percent by the federal government in the first three years, and phased down to 90 percent thereafter.

According to language in SB 3 and HB 5, the price tag for North Carolina's proposed Medicaid expansion would be steep.

By FY 2018-19, the federal share for expansion is projected to be $3.5 billion per year, with the state portion amounting to $335 million.

But if the recent past is any indicator, the actual costs will be far higher than that. As reported in October 2017 at Ohio Watchdog:

"What the administration doesn't tell us is that Medicaid costs are clearly much higher than initially projected because the administration only expected 447,000 enrollees by 2020. By contrast, the latest enrollment numbers from the Ohio Department of Medicaid stands at 708,000, or 58 percent over what Ohioans were told during the initial debate over expansion."

Similarly, expansion enrollment exceeded projections by 322 percent in California, by 276 percent in New York, and by 134 percent in Kentucky.

The state portion of expansion, according to the proposed legislation, would mostly be paid for by a hospital tax – a cost most likely passed along to patients.

Furthermore, there is no guarantee the federal government will cover its end of the costs as promised. With the national debt and unfunded liabilities exceeding $100 trillion, the wisdom of relying on federal funds is questionable. Indeed, any additional federal funds required to pay for North Carolina's Medicaid expansion will necessarily add to the national debt.

Add to that the uncertainty over federal funding for Medicaid in federal budget proposals, and the reliance on such substantial federal support for expansion is on shaky ground at best. Even a small drop in federal support could impose substantial additional financial pressure on the state budget.

MEDICAID EXPANSION STRENGTHENS THE POVERTY TRAP

Like so many government welfare programs, Medicaid expansion would serve to steepen the "welfare cliff." This is an effect whereby – on the margins – people face losing valuable government benefits if they choose work. Accepting work, or more hours, or even a promotion, would actually make them financially worse off.

The net impact is more people deciding not to work for fear of losing the benefits, causing higher unemployment. Moreover, some people may choose not to pursue higher paying jobs that they may otherwise be qualified for because the higher income would render them ineligible for government benefits that are more valuable than the pay raise.

Such perverse incentives serve to trap people in poverty. When confronted with a decision that makes them financially worse off, many rationally choose against work or a higher paying job. Unfortunately, the longer they remain unemployed or opt to forgo a higher paying job due to these short-term decisions, the more difficult their prospects are for future career advancement.

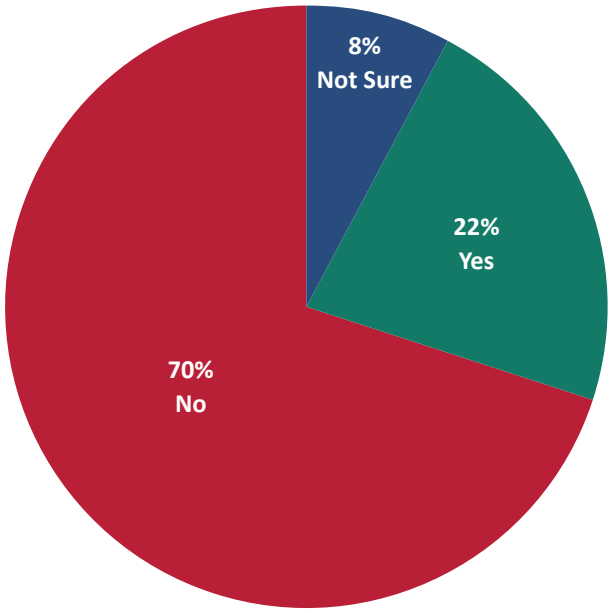
MEDICAID EXPANSION DRIVES UP HEALTHCARE COSTS

Supporters of Medicaid expansion have argued that expanding Medicaid coverage would help save money because the formerly uninsured would no longer go to the emergency room for non-emergency situations. But the Oregon study (first referenced in Part 1 of this article) concluded that Medicaid participants were actually more likely than non-insured people to go to the emergency room. Over the course of the study, there was a 40 percent increase in visits to the emergency room, and a 25 to 35 percent increase in total spending on enrollees.

Moreover, a study published earlier this year in the Annals of Emergency Medicine journal concluded that emergency room "use per 1,000 population, increased by 2.5 visits more in Medicaid expansion states than in non-expansion states," and that increases in such visits were largest for "states with the largest changes in Medicaid enrollment."

Unfortunately, ER's are not prepared for this new influx of Medicaid patients. A 2015 survey by the American College of Emergency Physicians found that "70% of member physicians believe their emergency department is not adequately prepared for potentially substantial increases in patient volume."

If visits were to increase, is your emergency department adequately prepared for potentially significant increases in patient volume?



Source: The American College of Emergency Physicians, 2015.

New Medicaid patients are more likely to go to the ER than even the uninsured. Because they can't find a primary care physician that will see them, Medicaid enrollees have no other options to seek care. And because someone else is paying most of the bill, Medicaid enrollees are insulated from the ER's high costs, unlike the uninsured. Greater use of the more expensive ER drives up overall healthcare costs.

Also, Medicaid underpays doctors. Providers have to increase their rates on privately insured patients to remain profitable. As private insurance plans become more expensive, more people become uninsured, driving more and more of them to Medicaid. It's a vicious cycle.

THE CONSERVATIVE ALTERNATIVE

Medicaid expansion is untenable. It generates negative effects on those it claims to help, drives up healthcare costs for all North Carolinians, and ultimately makes healthcare unaffordable.

So, what are preferable alternatives to ensure low-income North Carolinians have access to affordable medical care?

- *Reform Medicaid to provide more and better options.* Fortunately, state legislation passed in 2015 will do just that. The plan would change Medicaid from a fee-for-service program to one in which insurance companies are paid on a capitated per-person basis. Companies compete for Medicaid enrollees and offer differing coverage options, providing patients with more choice than the current one-size-fits all program. Another advantage is that risk of cost overruns would be shifted from the taxpayer to the insurance companies. Provider networks would also be formed, to ensure more complete, patient-centered care. The plan follows similar reforms in Florida, Louisiana and Kansas. The Foundation for Government Accountability reports that Florida's reforms resulted in $1 billion annual savings, with Louisiana enjoying savings of 3.5 percent and Kansas 5 percent. North Carolina's DHHS projects about $400 million in savings in the first five years of implementation.

- *Revise long-term care options to curb costs*. Long-term care is one of the largest cost drivers of North Carolina's Medicaid system. Nursing facility care for the elderly costs the Medicaid program nearly $1 billion per year, virtually the same amount as total inpatient costs and only behind prescription drugs and physician payments as the largest Medicaid expenditure. Ways to curb long-term costs include:

    - Lower the exemption threshold. Medicaid exempts significant amounts of wealth and assets when calculating eligibility. Doing so would ensure that asset-rich people don't crowd out care from the most needy.

    - Educate citizens about the state income tax credit for the purchase of private long-term care insurance. Reenacted in 2007, this credit amounts to 15 percent of the premium costs of long-term care. The credit may not exceed $350 and applies to married couples earning less than $100,000, or single filers earning less than $60,000. The current credit could be improved by increasing it to 20 percent (as in New York), or increasing the maximum amount allowed to $500 (as in Maryland). Increasing the tax credit would be a more affordable option than paying for future long-term care costs.

- *Create "flexible benefits" insurance* – i.e., customized plans that offer families coverage that best suits their needs. Low-income residents who don't qualify or prefer not to enroll in Medicaid need affordable insurance options. In the health insurance industry, state governments each have a set of services that insurance providers must include in all plans. These state mandates are in addition to the services required by Obamacare. North Carolina imposes 56 such mandates, more than all but 15 states in the country. Mandates add to the already skyrocketing cost of health insurance. North Carolina could pass legislation to allow for flexible plans that allow customers to select coverages that best meet their individual needs. Such options could put health insurance premiums once again within reach of many more North Carolinians. Basic, catastrophic insurance plans would be especially attractive to young people with few health needs. Drawing in more young, healthy people into the state's health insurance pool would help drive down premiums for everyone.

- *Permit families to purchase less expensive, out-of-state health insurance plans*. Another reason health insurance is so expensive in North Carolina is because the state does not permit families and individuals to purchase out-of-state health insurance. Allowing access to out-of-state plans will not only enable more North Carolinians to purchase insurance, but also lead to lower prices for in-state plans because the expanded market would end the state's insurance monopoly. Unfortunately, because of minimum coverage requirements under Obamacare, there is less price variance on health insurance between states. However, these changes would still offer some premium relief that would certainly grow if Obamacare is repealed.

PROFESSOR ARGUES FOR MEDICAID EXPANSION, FAILS MISERABLY

Recently the N&O published an article attempting to explain why NC should embrace Medicaid expansion, based on experiences from other states. The article fails, miserably.

The article's author, a law professor at Wake Forest University, makes the claim that "The strong balance of objective evidence indicates that actual costs to states **so far** from expanding Medicaid are negligible or minor."

His "evidence"?

A study that finds "there were no significant increases in spending from state funds as a result of the expansion."

Small problem, though. The study referenced only examines Medicaid spending from 2010-2015, and federal dollars covered 100% of the cost of the new expansion enrollees thru 2016. The reason there was no significant state spending so far on Medicaid is because the feds covered all the costs during the time period examined. The study actually finds that "the expansion led to an 11.7 percent increase in overall spending on Medicaid, which was accompanied by a 12.2 percent increase in spending from federal funds."

Of course the study found no significant increases in state spending on Medicaid expansion, **because the states were not required to pay for it yet.**

The article also readily admits that many expansion states have enrolled more people than they initially expected. But the author later goes on to object to claims that "each and every state that opted into ObamaCare expansion is facing a surge in Medicaid enrollment far higher than ever anticipated," and declares "officials or agencies from Indiana, North Dakota, and Ohio have flatly stated (and documented) that expansion enrollment, or overall enrollment, has either fallen short of, or not substantially exceeded, expectations."

So they admit that many states have seen enrollment higher than expectations, but that NC shouldn't be concerned because some states have seen enrollment fall short of, or not substantially exceed, expectations.

Even more interesting, when you click the "North Dakota" link provided by the article's author, you find this:

"As has been the case in many states, the cost of expanding Medicaid has been higher than expected in North Dakota…Originally, the North Dakota Department of Human Services modeled their expansion plans on projections that the state would pay $2.9 million in Medicaid expansion costs during the first half of 2017. But by 2015, that projection stood at $8.2 million. Dalrymple's final budget projected $30.5 million in state spending on Medicaid expansion from 2017 – 2019."

The author of an article claiming "evidence indicates that actual costs to states so far from expanding Medicaid are negligible or minor" actually links to an article that says the case in "many states" is that "the cost of expanding Medicaid has been higher than expected."

Medicaid expansion advocates are so desperate, they will resort to gross distortions of the truth and can't even cite sources without contradicting their own claims.

WHEN THEY LEARN THE DETAILS, VOTERS REJECT MEDICAID EXPANSION.

Medicaid expansion is a hot topic. Gov. Roy Cooper has made it one of his top talking points, and even some legislative Republicans are on board with the idea.

Expanding Medicaid into the states is a major component of government-run healthcare. It is something 14 states (including NC) have refused to do thus far.

On the surface, Medicaid expansion appears to be a popular idea with North Carolinians. But the more people learn about what Medicaid expansion actually means for our state, the less popular the idea is.

In a November 2018 Civitas Institute statewide poll, 61 percent of respondents said they favor Medicaid expansion when asked the question without any supplemental information.

A 2012 study by the Urban Institute, however, examined the demographic makeup of the currently uninsured that would be newly eligible for Medicaid under expansion. In North Carolina, 77.7 percent of those eligible under expansion would be able bodied, working-age, childless adults.

When informed about this fact, 52 percent of respondents in the Civitas poll said they would be *less likely* to support expansion given this knowledge.

The same decline in support was found when respondents were told: "Expanding Medicaid in North Carolina would likely add five hundred thousand new individuals to the program and would cost state taxpayers more than $340 million per year." Fifty percent of respondents stated they were less likely to support expansion.

Moreover, Medicaid expansion is paid for in large part by cutting more than $700 billion from seniors' Medicare benefits, according to Congressional Budget Office estimates. Knowing that expanding Medicaid to able-bodied, childless working age adults comes at the expense of Medicare benefits for senior citizens predictably hits a sour note with voters. A 2014 Foundation for Government Accountability poll of North Carolina voters revealed that an overwhelming 68 percent of voters said they are less *likely* to support Medicaid expansion in light of this knowledge.

Furthermore, according to the Obama administration's own Department of Justice, nearly 1 in 3 of those who become newly eligible for Medicaid expansion would have had previous time served in prison or jail. Unsurprisingly, the thought of extending Medicaid to childless ex-cons at the risk of crowding out coverage for more needy families does not sit well with voters. Indeed, FGA's poll also showed that 57 percent of respondents are less likely to support Medicaid expansion when given this knowledge, compared to just 17 percent of respondents who said they would be more likely to support.

Lastly, we know that as the Medicaid budget grows, the less money there is left in the state budget for other priorities, such as public education and public safety. Some refer to this as the "Pac-Man" effect. When voters were reminded of this fact in the FGA poll, a whopping 67 percent of respondents said they are less likely to support Medicaid expansion in NC.

In short, the more voters learn about Medicaid expansion, the more they oppose it. Gov. Cooper and legislative leaders should listen.

ONE MORE TIME: MEDICAID COVERAGE DOES NOT EQUAL ACCESS TO CARE

The Asheville Citizen-Times reports on a study from the RAND Corporation showing that emergency room visits are on the rise:

Visits to hospital emergency rooms are on the rise in the Carolinas and around the country, with experts pointing to the physician shortage and Obamacare as possible reasons.

One in five Americans goes to the ER at least once a year, according to RAND Corp., an independent, nonprofit think tank.

Nationwide, three quarters of ER doctors said that patient volumes increased in the past year, according to a new survey from the American College of Emergency Physicians.

….

It's often hard for patients on Medicaid-managed care plans to get appointments with primary care providers, with median waits of two weeks, though more than a quarter waited a month or more, leaving them with few options besides the ER, according to the American College of Emergency Physicians. The group also pointed to the nationwide physician shortage.

"America has severe primary care physician shortages, and many physicians will not accept Medicaid patients because Medicaid pays so inadequately," said its president, Dr. Michael Gerardi. "Just because people have health insurance does not mean they have access to timely medical care." *(emphasis added)*

We have often pointed out that coverage does not mean access to care. Progressive liberals advocating for Medicaid expansion never want to address this fact. Medicaid in NC is already overcrowded, with far too many patients chasing too few doctors.

North Carolina's Medicaid program has added more than 600,000 people in the last dozen years. At the same time, the number of NC physicians treating Medicaid patients has fallen. Expansion, by some estimates, would add another 400,000 to 630,000 to the Medicaid rolls. That would mean 'more than' a million new Medicaid enrollees since 2001 – competing for access to a shrinking number of doctors.

If the radical Left gets its way and more than half a million additional people are stuffed onto NC's Medicaid rolls: who will these people see to get care? Medicaid enrollees already struggle to access care in a timely manner, just imagine how bad the problem will be with 630,000 more people in the program.

Progressives and Liberals want to wish this problem away, and never answer the question.

ALTERNATIVES TO MEDICAID EXPANSION

- Expanding Medicaid would be a disaster for North Carolina
- Stopping expansion is not enough, however, alternatives must be offered
- NC legislators must work to expand access and reduce the costs of healthcare

There is mounting pressure on North Carolina legislators to expand the state's Medicaid program, as provided for in Obamacare. Conservatives in the legislature have resisted this temptation for several years. A pro-expansion Democratic Governor, combined with a growing coalition of Democrats and Republicans, however, make the threat of Medicaid expansion very real for 2019.

Expansion would have disastrous consequences for North Carolina. Adding hundreds of thousands of new enrollees to the already overcrowded Medicaid rolls at a time when fewer doctors are accepting Medicaid patients would severely restrict access for the neediest. The increased costs would intensify funding for other budget priorities like education and public safety. More complete arguments to resist Medicaid expansion can be found here.

But that is only part of the issue. Other reforms to our healthcare system are also needed.

Due to continued government interference in the healthcare market, insurance premiums in North Carolina continue to climb higher and higher. Too many lack reasonable access to care. Our state needs to take positive action to ensure all North Carolinians have access to affordable healthcare.

Solving this problem requires policies that create a sustainable, affordable healthcare system without reducing quality or limiting choice.

North Carolina can make insurance more affordable by giving consumers more choices. Eliminating supply restrictions like CON laws and scope of practice restrictions that drive up prices and restrict access, while encouraging cost-saving services like telemedicine and direct primary care can help to bring costs down. More freedom, and less government control, is the answer.

The Civitas Institute urges legislators to consider the following policies to help reform North Carolina healthcare:

- *Eliminate Expensive and/or Unnecessary Insurance Coverage Mandates.* While the federal government requires states to include a certain number of coverage mandates in their insurance policies, states have discretion over many more. Coverage mandates require all insurance plans to include coverage of certain services or providers, whether or not the consumer wants or needs them. North Carolina currently has at least a dozen state optional mandates, costing an estimated $218 million. Our state imposes the second-most total coverage mandates in the Southeast.

  Mandates should be re-evaluated for elimination, and legislators should strongly oppose adding mandates in the future. Legislators should also work to ensure consumers are able to choose which coverages they want included in their plan.

- *Allow for Association Health Plans*. In June of 2018, the Trump administration gave authorization to allow professional associations to offer insurance coverage to their members. These plans allow the associations to avoid Obamacare's numerous and expensive mandates.

Association Health Plans (AHPs) allow the self-employed and workers in small businesses not offering coverage to buy in to a group plan offered by the association, even across state lines. Group coverage is typically more affordable than insurance on the individual market, meaning this measure could provide more affordable insurance options to tens, if not hundreds, of thousands of North Carolinians.

The benefits of AHPs can be significant. According to news reports, "the Nebraska Farm Bureau and (health insurance provider) Medica announced they were teaming up to offer a menu of association health plans in 2019 for individual farmers, ranchers and small agriculture-related businesses." The plans are expected to deliver a premium savings of up to 25 percent.

Allowing for and promoting AHPs in North Carolina could generate significant premium cost savings for health insurance consumers, especially farmers and small business employees.

- *Allow Consumers to Purchase Health Insurance from the U.S. Territories*. A 2014 ruling from DHHS exempted the U.S. Territories from many expensive Obamacare health insurance mandates, enabling the territories to offer less expensive, and more flexible, insurance options.

  North Carolina could provide an exemption to enable North Carolinians to purchase insurance offered by the territories.

- *Allow Private, Prepaid Agreements Between Doctors and Consumers.* Direct primary care (DPC) is a growing medical care delivery mechanism in North Carolina. It involves patients paying a low monthly fee for virtually unlimited access for primary care services from their chosen physician. DPC doctors also frequently dispense prescription medications at wholesale costs.

  This arrangement allows providers to avoid the hassle and cost of insurance billing, and generates tremendous savings for patients. While already growing in North Carolina, state legislators could facilitate the further growth of this practice by passing legislation clarifying that direct care providers shall not be classified as insurance providers, ensuring they can avoid costly compliance measures. Twenty-three states have already passed such legislation.

- *Don't Hinder Telemedicine Growth.* Telemedicine is the practice of patients connecting with doctors via electronic means – these days largely by video consultation or smart phone apps.

  Such services significantly increase patient convenience, and expand access to healthcare epecially in rural areas that are experiencing doctor shortages to access a doctor they may otherwise need to drive hours to see. Telemedicine can also encourage more frequent preventative updates and monitoring of patients' condition, at a low cost.

  Telemedicine services are growing rapidly in North Carolina, and state government should resist legislation that would impede growth. One possible impediment would be the implementation of a "parity law" for telemedicine.

  A parity law requires insurance providers to bill services rendered via telemedicine at the same rate those services would cost for an in-person visit.

Adding a parity law to telemedicine would subject these services to greater government oversight, increase insurance premiums and shield patients from the actual cost of telemedicine care. All these factors would harm patients and likely slow telemedicine innovation.

- *Eliminate Certificate of Need Laws.* Certificate of Need laws (CON) require medical care providers to get permission from the state before expanding facilities, introducing new procedures or purchasing new equipment.

  CON laws restrict the amount of medical care options available for patients, limit competition and drive up costs. Placing strict constraints on the supply of any good or service will inevitably drive up its costs.

  CON laws are outdated and need to be repealed.

- *Scope of Practice.* Rural North Carolina is suffering from an acute shortage of health care providers. In a January 2018 meeting of the Committee on Access to Healthcare in Rural North Carolina, experts revealed that in North Carolina, 20 counties do not have a pediatrician; 26 counties do not have an OB-GYN; and 32 are without a psychiatrist. Moreover, 70 of 80 rural counties in NC are currently designated "medical deserts" for their lack of primary care availability.

  Curent North Carolina law restricts the scope of care that registered nurse practitioners, advanced practice registered nurses, and physician assistants can provide, while also requiring a certain level of supervision by a licensed physician.

  With so few licensed physicians choosing to practice in rural areas, laws restricting the ability of highly-trained medical care providers to provide much-needed care are devastating to rural populations.

  Freeing healthcare practitioners to perform many of the basic evaluation and treatment functions — currently limited to physicians — can drastically improve rural populations' access to needed care.

  Legislation to expand scope of practice for registered nurses and other physician assistants can not only expand access to care for rural patients, but also help to lower healthcare prices and create thousands of jobs as well.

  When Arizona removed the physician supervision of nurse practitioners, the number of nurse practitioners serving rural areas jumped by 73 percent within five years. North Carolina can do the same for nearly 15,000 advanced practice nurses and physician assistants.

  A similar approach could also be taken for dental therapists and allow them to perform certain duties instead of requiring a licensed dentist.

  Additionally, North Carolina could expand scope of practice for pharmacists to allow them to prescribe certain low-risk prescription drugs, enabling patients to avoid the costlier trip to a physician.

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