

*North Carolina's Rejection of  
Medicaid Expansion:  
Politicizing the Health of our  
Communities?*

by

Yele Aluko

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***North Carolina's Rejection of  
Medicaid Expansion: Politicizing the  
Health of our Communities?***

by

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## *Introduction*

Not much is generally understood about the intricacies of the [Affordable Care Act](#). While this is a national conversation about universal healthcare as a moral imperative, we must understand that it is also a very local one to North Carolina. It is local because the implications of Medicaid Expansion as a component of Healthcare Reform impact the health of the Southern states more disproportionately.

The Patient Protection and Affordable Care Act (PPACA), commonly called the “Affordable Care Act” (ACA) or “Obamacare”, was signed into law by President Barack Obama on March 23, 2010. It represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of [Medicare and Medicaid](#) in 1965.<sup>1</sup> Medicare refers to government health insurance provided for United States citizens above the age 65, while Medicaid is government funded insurance for citizens and legal residents with income below the Federal Poverty Limit (FPL).

Why did President Obama and supporters of this Act feel its passage was necessary? To answer that question, one must first understand that the Act is designed to address several issues of which the following are paramount:

- a) The moral and philosophical question as to whether a government has the obligation to

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<sup>1</sup> 111th Congress Public Law 148. U.S. Government Printing Office. 2010.

provide universal health insurance for those that could otherwise not afford it.

- b) The inescapable reality that the escalating healthcare expenditure in the U.S. is currently almost 20% of the Gross Domestic Product, and is not sustainable.
- c) The fact that the U.S. healthcare system is characterized as the most inefficient and expensive among the 11 most westernized member nations of the Organization of Economic Cooperation and Development (OECD).
- d) The acknowledgement that the current model of reimbursement to U.S. physicians and hospitals has failed to provide healthcare value to large populations and to the nation.

The aim of the Affordable Care Act is simple: Obamacare provides Americans, both below and above the Federal Poverty Limit, with expanded access to consistent medical care, reaching the estimated 15% (or 48 million) of the U.S. population who lack it<sup>2</sup>. To achieve this, the law requires most U.S. citizens and legal residents to have health insurance, by specifically targeting those people that receive no coverage from their employers and are not covered by U.S. health programs for the poor and the elderly. It does so through distinctly different methods. Firstly, it provides Medicaid

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<sup>2</sup> Summary of the Affordable Care Act. Henry J. Kaiser Family Foundation. April 25, 2013. <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/> [Accessed October 20, 2014]

coverage through expanded eligibility criteria to millions of low-income Americans under the age of 65. Secondly, for those exceeding income eligibility for expanded Medicaid enrollment, new affordable private insurance exchanges are made available. Thirdly, the law bans insurance companies from denying health coverage to people with pre-existing health conditions. Fourthly, it allows young people to remain on their parents' health insurance plans until age 26. Furthermore, it requires businesses with more than 50 full-time employees to offer health coverage. As an incentive for enrollment, financial penalties are imposed on persons eligible for coverage that fail to obtain insurance, and on businesses that fail to provide insurance for their employees. Obamacare prioritizes preventive care, the overall quality of care, and the elimination of waste, fraud and inefficiency. It holds insurance companies accountable to lower health care costs and guarantees more choice. Ultimately the law aims to slow the growth of U.S. healthcare spending, which is the highest in the world.

We must understand that prior to Obamacare, Medicaid failed to serve several people who need care the most. These are individuals and families above the Federal Poverty Limit; single or married hard working people without dependent children earning more than \$11,670 a year and working in employment that did not provide healthcare yet not able to afford commercial insurance. This group typically burden states with unsustainable healthcare related costs since several lower income people without health coverage receive uncompensated care when sick.

## *So what exactly is Medicaid Expansion?*

Medicaid Expansion is a fundamental element of the Affordable Care Act that refers to expanded eligibility for Medicaid coverage. It does so by changing the income requirements for eligibility. It is designed to provide coverage for 19 million of the 48 million uninsured Americans that existed prior to Obamacare, creating a new Medicaid group for individuals age 19 up to 65 who:

- have income below 138% FPL,
- meet citizenship requirements,
- are not incarcerated,
- and are not entitled to Medicare<sup>3</sup>.

Medicaid Expansion provides all states with the opportunity to receive Federal funds to finance these expanded options so they can increase Medicaid eligibility for their citizens. Federal funding is set to cover 100% of Medicaid Expansion through 2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond<sup>4</sup>.

Medicaid Expansion is important because it essentially closes the insurance gap for lower income individuals by providing affordable healthcare coverage. Affordable healthcare coverage enables more consistent access to accountable healthcare delivery, and provides for

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<sup>3</sup> “How Medicaid Expansion Affects You.” [www.healthcare.gov](http://www.healthcare.gov)

increased healthcare value - defined as best clinical outcomes at reasonable cost, available not just to the privileged but to the entire population.

Numerous studies show that Medicaid has helped make millions of Americans healthier. It has done so by improving access to preventive and primary care and by protecting against serious diseases. A landmark study of the State of Oregon's Medicaid program found that compared to similar people without coverage, people with Medicaid were 40 percent less likely to suffer a decline in their health in the previous six months<sup>4</sup>. They were also more likely to use preventive care (such as cholesterol screenings), and to have regular offices or clinics where they could receive primary care and obtain diagnosis of and treatment for illnesses such as depression and diabetes. In addition, research published in the *New England Journal of Medicine* reported that expansions of Medicaid coverage for low-income adults in Arizona, Maine, and New York reduced mortality by 6.1 percent. Moreover, people with Medicaid in Oregon were 40 percent less likely than those without insurance to go into medical debt or leave other bills unpaid in order to cover medical expenses. In fact, the latest research from Oregon found that Medicaid coverage nearly eliminated catastrophic, out-of-pocket, medical expenditures.

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<sup>4</sup> B. D. Sommers, K. Baicker, and A. M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *New England Journal of Medicine*, 367 (2012):1025-1034.

## *What is value in healthcare?*

In most industries, value is defined as the receipt of goods or services that provide a desired result to the consumer, divided by the cost the consumer pays for the goods or services. In Healthcare, we could translate this as Quality of Care divided by Payment for Care. This gives us an idea for extrapolating the metric of value in healthcare. Quality can be further defined as a composite of patient outcomes, safety and experiences, while cost is further categorized as the cost to all purchasers of care.<sup>5</sup> Value in healthcare remains largely misunderstood and inconsistently measured, meaning different things within the industry, and other things when viewed through the lens of the patient.

Broadly speaking, a nation's overall health status is measured by a variety of metrics including life expectancy, infant and adult mortality; degree of smoking, alcohol consumption, physical exercise and obesity; the extent of the physician and other healthcare provider workforce, workforce diversity and its reimbursement profiles; the efficiency of care delivery within and outside the hospital setting; timely access to physician and hospital care; avoidable admissions, appropriate prescribing practices, population screening for cancer, and very importantly, the achievement of

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<sup>5</sup> M. E. Porter and T. H. Lee, "The Strategy that will fix Healthcare," *Harvard Business Review*. October 2013.  
<https://hbr.org/2013/10/the-strategy-that-will-fix-health-care/>

societal health equity.<sup>6</sup> These are metrics that define a nation's health status.

Most importantly, these metrics are expected to be delivered at reasonable costs of health expenditure and financing. It may surprise one to learn that there is an established body of data demonstrating that the U.S. Healthcare system performs worse than 10 other nations that comprise the most industrialized countries in the OECD. The Commonwealth Fund provided data in 2013 on the health systems of Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom and the U.S. by measuring national statistics on infant and adult mortality, life expectancy, access to physician appointments and several others. It found that the U.S. was last or near last in measures of health access, efficiency, and equity.<sup>7</sup>

The metric the U.S. performed best on was "effective" care, fixing problems when they occurred but fixing them expensively. It fared poorly when it came to managing administrative hassles for both doctors and

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<sup>6</sup> U.S. Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives. The Commonwealth Fund. June 2014.

<http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last>. Accessed February 17, 2015.

<sup>7</sup> The Daily Briefing. August 2013. <http://www.advisory.com/daily-briefing/2013/08/28/bloomberg-ranks-the-worlds-most-efficient-health-care-systems>. Accessed February 17, 2015.

patients, avoiding emergency room use, and reducing duplicative medical testing, all part of the score for "efficient care." Americans also had the worst equity of care between high-income and low-income patients.

In a 2013 Bloomberg ranking of nations with the most efficient health care systems, the United States ranks 46th among the 48 countries included in the study<sup>8</sup>. It should be sobering to note that, "with the exception of Mexico, Turkey, and the United States, all countries comprising the OECD had achieved universal or near-universal (at least 98.4% insured) coverage of their populations by 1990".<sup>9</sup> In 2004, the Institute of Medicine (IOM) report states: "The United States is among the few industrialized nations in the world that does not guarantee access to health care for its population"<sup>10</sup>.

For several years, the United States has had the highest per capita spending on health care of any industrialized nation. Despite these unprecedented levels of spending, harmful medical errors abound and fragmented care within and across systems continue to confound and frustrate patients and providers. Healthcare costs have

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<sup>8</sup> The Daily Briefing. August 2013. <http://www.advisory.com/daily-briefing/2013/08/28/bloomberg-ranks-the-worlds-most-efficient-health-care-systems>. Accessed February 17, 2015.

<sup>9</sup> Towards High Performing Health Systems. The OECD Health Report, 2004.

<sup>10</sup> Institute of Medicine. Committee on the Consequences of Uninsurance (January 13, 2004). *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academies Press. p. 25.

continued to escalate while up to 48 million Americans remain uninsured. Rising numbers of aging patients with chronic multiple disease contribute in a large way to the escalating healthcare costs. Furthermore, an increasing aging population with large numbers of heart and lung disease, diabetes and cancer, together constitute more complicating factors in the trend to higher costs of care.<sup>11</sup>

American patients pay two to three times more than Canadian or European patients for the same drugs. According to the World Health Organization (WHO), the United States spent more, specifically two and a half times more than the average of all OECD countries on health care per capita (\$8,608), and much more on health care as a percentage of its GDP (18.0%) in 2013. The Commonwealth Fund ranked the United States last in the quality of health care among similar countries, and it notes that U.S. care costs the most.

Achieving high value for patients must become the overarching goal of health care delivery, with value defined as health outcomes achieved per dollar spent. It must be unequivocally understood that achieving true healthcare value for the entire U.S. population is the overarching goal of Obamacare.

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<sup>11</sup> P. L. Young, L. Olsen, and J. M. McGinnis (2010), *Value in Health Care: Accounting for Cost, Quality, Safety, Outcomes, and Innovation: Workshop Summaries*. Roundtable on Evidence-Based Medicine. Institute of Medicine. The National Academies Press.

*Let's now turn to the involvement of the U.S. Supreme Court, and its Ruling on Obamacare.*

We know that all states receive Federal funds to support their Medicaid programs. In its original form, Obamacare called for the loss of ALL Medicaid funding if states failed to accept Medicaid Expansion. Congressional Republicans challenged the constitutionality of penalizing states in that manner for refusing expansion. As a result, 26 states brought suit against Obamacare in 2010. [In 2012, the U.S. Supreme Court determined that imposing the risk of loss of ALL Medicaid funding for states refusing Medicaid Expansion was unconstitutional. This gave all states the option to opt out of expansion.](#) Recall that Federal funding was set to cover 100% expansion through 2016 and more than 90% up to 2020 and beyond.

Interestingly, several states decided to opt out. In February 2014, Gov. Pat McCrory signed legislation that passed in the NC General Assembly indicating that North Carolina would not participate in the Medicaid Expansion program provided for by Obamacare. Since that time, twenty-nine states have accepted Medicaid expansion of which Arizona, Indiana, Iowa, New Jersey, New Mexico and Pennsylvania are the only Republican-led states that opted for expansion. Four Republican-led states: Tennessee, Utah and Wyoming have not made a decision for or against expansion. The remaining 19

states that have rejected expansion, including North Carolina, are all Republican-led<sup>12</sup> (see Figures 1-3).

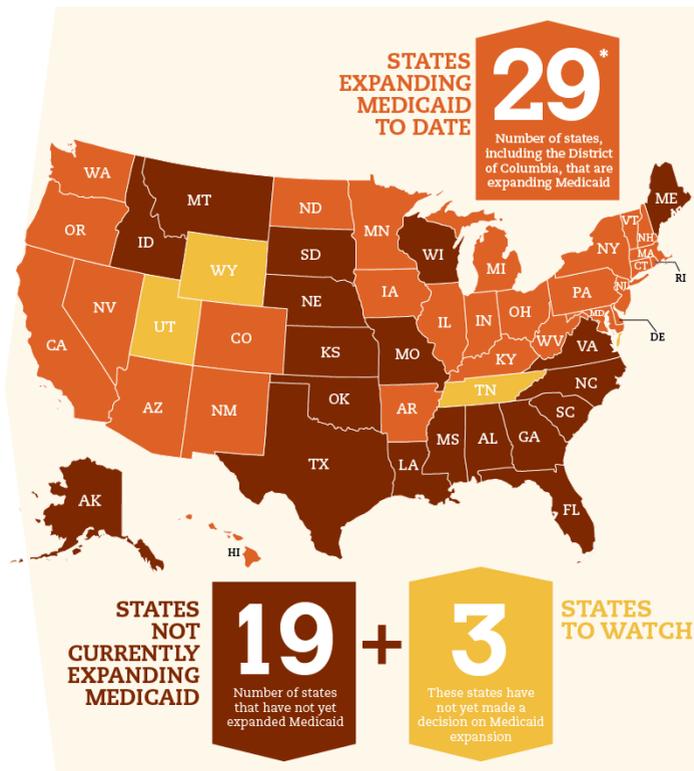


Figure 1. Status of Medicaid Expansion in Different States  
Source: Families USA [<http://familiesusa.org/product/50-state-look-medicaid-expansion>]

<sup>12</sup> “Where the States stand on Medicaid Expansion.” Daily Briefing, The Advisory Board Company, 2015.  
<http://www.advisory.com/dailybriefing/resources/primers/medicaid-map>. Accessed February 21, 2015.

# EXPANDING

Number of residents who may gain access to Medicaid, in states that will expand the program

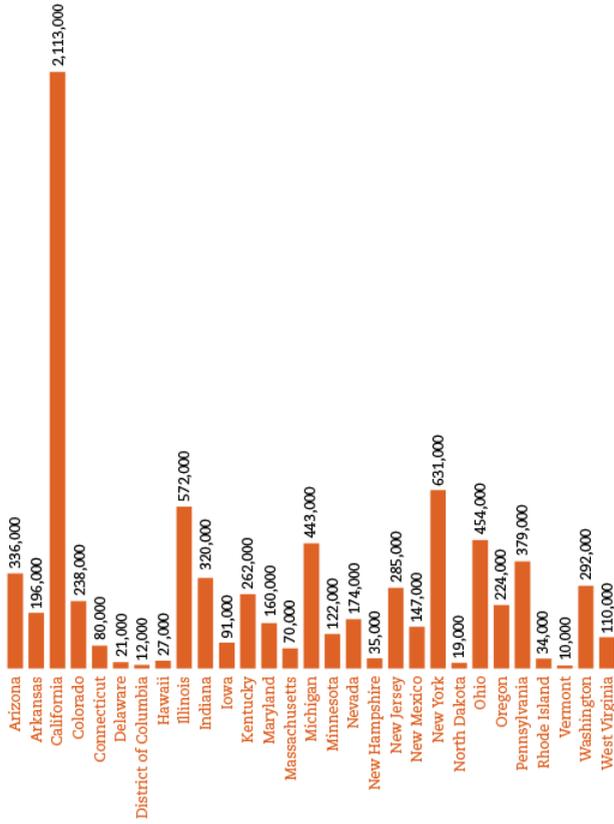


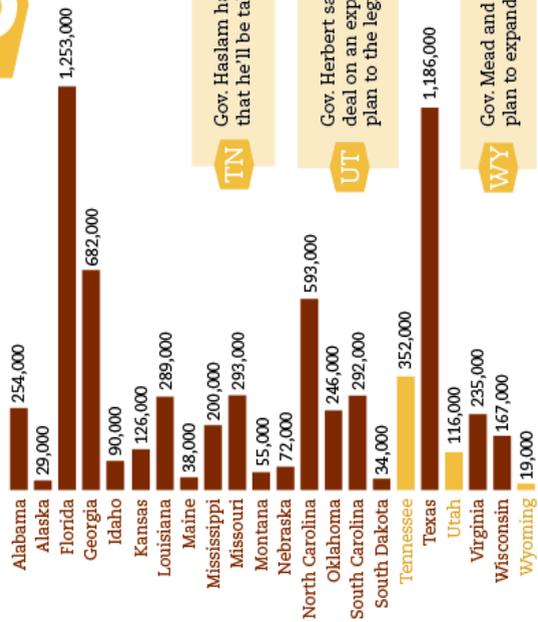
Figure 2. Number of potential beneficiaries in states expanding Medicaid.

Source: Families USA [<http://familiesusa.org/product/50-state-look-medicaid-expansion>]

# NOT YET EXPANDED

Number of residents who won't gain access to Medicaid and are likely to remain uninsured, in states that have not yet expanded Medicaid

# 3 STATES TO WATCH



**TN** Gov. Haslam has released a plan for expanding Medicaid that he'll be taking to the legislature

**UT** Gov. Herbert says he and CMS have reached a tentative deal on an expansion proposal and he'll be taking his plan to the legislature in 2015.

**WY** Gov. Meed and CMS are in discussions about a Wyoming plan to expand Medicaid.

Figure 3. Potential number of people who may remain uninsured in states that are not expanding Medicaid.  
 Source: Families USA [<http://familiesusa.org/product/50-state-look-medicaid-expansion>]

This has raised questions as to whether there is a partisan agenda to deny coverage in Republican-led states, irrespective of the need of their citizens, and the overall health of these individual states in particular and of the nation in general. In the 19 states that have not expanded Medicaid, the Urban Institute informs that 6.7 million residents are projected to remain uninsured in 2016 as a result of this choice. These states are foregoing \$423.6 billion in Federal Medicaid funds from 2013 to 2022, which will lessen economic activity and job growth. Hospitals in these 19 states are also slated to lose \$167.8 billion (31%) boost in Medicaid funding that was originally intended to offset major cuts to their Medicare and Medicaid reimbursement.

*So, what's the Record to Date on Obamacare Enrolment?*

The Congressional Budget Office projects that the law will decrease the number of uninsured people by up to 12 million by 2014 and 26 million by 2017. Early polling data from Gallup, RAND, and the Urban Institute indicate that the number of uninsured people may have already declined by up to 9 million and that the proportion of U.S. adults lacking insurance has fallen from 18% in the third quarter of 2013 to 13.4% as of May 2014.

*What then is North Carolina's Rationale for Rejecting Expansion?*

As of October 2014, North Carolina remains one of 19 Republican states, and one of 10 Southern states, that have decided to opt out of Medicaid Expansion. Why is this decision significant? What are the purported reasons behind it, and what are the implications?

Currently, North Carolina's Medicaid program sets an annual income eligibility ceiling of \$19,790 for a family of three. And this does not apply to adults without dependent children.<sup>13</sup> With Medicaid Expansion, the eligibility ceiling rises to \$27,310. Under the current program, prior to expansion, the federal government pays 66 percent of the cost, and the state pays the balance.

To quote [Governor Pat McCrory in a statement he issued on February 12, 2013:](#)

It is abundantly clear that North Carolina is not ready to expand the Medicaid system since the current system in North Carolina is broken and not ready to expand without great risk to the taxpayers and to the delivery of existing services to those in need. We must first fix and reform the current system. The potential long-term cost to the North Carolina taxpayer and needed flexibility for reform

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<sup>13</sup> U.S. Department of Health and Human Services

cannot be determined based upon the information and details provided to us by the federal government. There has been a lack of preparation within state government during the past year to build necessary and reliable systems to implement a state exchange.

While some have claimed that the Medicaid Expansion will cripple state budgets, a study by the Center on Budget and Policy Priorities shows that in reality it will cover millions of low-income people at a very modest cost to states. What is more, savings in state-funded services for the uninsured will offset part, and possibly all of that cost.

*What are the implications for North Carolina?*

The Supreme Court's decision to allow states to opt out of Medicaid Expansion, while protecting the principle of constitutional rights, is predicted to have adverse health and financial consequences for all states that do so.<sup>14</sup> Based on the data from the [Oregon Health Insurance Experiment](#), it is predicted that many low-income women will forego recommended breast and cervical

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<sup>14</sup> The role of Medicaid in State Economies and the ACA. The Kaiser Commission on Medicaid and the Uninsured Report. July 2013. The Henry J. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf>. Accessed October 0, 2014.

cancer screening; those with diabetics will forego medications, and all low-income adults will face a greater likelihood of depression, catastrophic medical expenses, and death. According to Dr. Quentin Young, national coordinator of Physicians for a National Health Program, recent estimates indicate that lack of health insurance causes close to 50,000 unnecessary deaths every year in the United States.

Disparities in access to care based on state of residence will increase. Because the federal government will pay 100 percent of increased costs associated with Medicaid expansion for the first three years (and at least 90 percent thereafter), opt-out states are also turning down billions of dollars of potential revenue, which might otherwise strengthen their local economy.

People of color make up the majority of uninsured individuals with incomes below the Medicaid expansion limit, both in states moving forward and states not moving forward with the expansion. Nearly half of all uninsured people of color under the Medicaid expansion limit reside in states that are not moving forward with the Medicaid expansion at this time.<sup>13</sup>

The South is more heavily affected than other regions in the U.S.; the share of the uninsured with incomes at or below 138% of the Federal Poverty Level living in states that are not moving forward with the expansion is smaller in the Midwest (25%), the West (8%) and the Northeast (2%), and largest in the South including North Carolina. As such, this decision to opt out of Medicaid

Expansion in North Carolina has several immediate- and long-term public health and economic implications for the state and its citizens. There are currently about 1.5 million people uninsured in North Carolina. In the short term, more than 800,000 uninsured North Carolina residents would be denied coverage under Obamacare, presenting ongoing limitations for access to healthcare and an escalating public health burden to the state. While all of NC will be impacted by this decision, our rural communities will be impacted the most. Twenty percent of the people in Western North Carolina have no form of health insurance. However, about 110,000 people in Western North Carolina would have qualified for Medicaid through the expansion<sup>15</sup>. At larger hospitals in the larger cities, there is a better payer mix than rural areas where the poverty level and unemployment rates are higher. We are now faced with the situation whereby the medical costs of the uninsured in the rural areas and small towns (most of North Carolina) will be carried by hospital emergency departments and paying patients through higher commercial insurance premiums.

In 2013, researchers from the Harvard School of Public Health found that when states expanded their Medicaid programs and gave more poor people health insurance, fewer people died. The Kaiser Family Foundation has predicted that opting to expand Medicaid would generate

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<sup>15</sup> P. Manning, "After Medicaid expansion denied in NC, advocates still pushing," Carolina Public Press, March 2013. <http://www.carolinapublicpress.org/14387/after-medicaid-expansion-denied-in-nc-advocates-still-pushing>. Accessed October 20, 2014.

state savings and revenues exceeding the cost of expansion. States, including North Carolina, could also see revenue from the broader economic effects of the Medicaid expansion, such as increased jobs and income as well as tax revenues at the state level within the health care sector and beyond due to the multiplier effect of spending. Indeed, current evidence demonstrates that states accepting Medicaid expansion have already experienced more jobs and increased economic activity. A report released by the Department of Health and Human Services projects that hospitals that have expanded Medicaid would save \$4.2 billion this year in uncompensated care costs because of the Affordable Care Act.

### *Closing Remarks*

Health care reform in the United States has a long history dating back to the 19<sup>th</sup> century. Indeed, after the Civil War, the Federal Government did establish the first system of national medical care in the South. Known as the Freedmen's Bureau, the government constructed 40 hospitals, employed over 120 physicians, and treated well over one million sick and dying former slaves. These hospitals however were short lived, lasting from 1865 to 1870. Freedmen's Hospital in Washington DC

remained in operation until the late nineteenth-century before it became part of Howard University.<sup>16</sup>

There have been many mavericks in our national history in the quest for a better health status for our people, and for our nation. Reforms have often been proposed, but have rarely been accomplished. From President Harry Truman's failed proposal on universal healthcare in 1945, to President Lyndon Johnson's signing into law both the Medicaid and Medicare programs in 1965. In 1972 President Richard Nixon signed the Social Security Amendments extending Medicare to disabled persons under 65 and to those who require kidney dialysis. There were also the failed health bills proposed by Senator Ted Kennedy through the 1970's and 1980's, and the failed 1993 President Clinton's Healthcare Plan. From President George W. Bush who signed the Medicare Modernization Act in 2003 adding outpatient prescription drug benefits to Medicare beneficiaries, to President Barack Obama and his signature Obamacare signed in 2010, no doubt the quest for better healthcare delivery has preoccupied many presidents and federal administrations.

One commonality of purpose among these leaders - Democrats and Republicans - has been a social conscience stirring within them, illuminating the obligation of a country to provide health coverage for the elderly, the poor and the disabled.

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<sup>16</sup> Jim Downs, *Sick from Freedom*. New York, Oxford University Press, 2012.

Medicaid Expansion is needed to preserve the well-being of our working class, to protect the health of North Carolinians, and to promote the growth of our economy. The General Assembly's decision to forego Medicaid Expansion has led to missed opportunities for the state of North Carolina. It has sent the wrong message to the citizens of North Carolina, Republicans and Democrats alike, and it has sent the wrong message to Washington DC.

## ABOUT THE AUTHOR

Dr. Yele Aluko is Senior Vice President at Novant Health, and Medical Director of the Novant Health Heart and Vascular Institute in Charlotte, NC. His clinical expertise and interests include complex coronary interventions, transcatheter valve replacement, and transcatheter closure of congenital cardiac septal defects. Dr. Aluko is certified by the American Board of Internal Medicine, the Canadian Board of Internal Medicine, and by the American Board of Internal Medicine in the subspecialties of cardiovascular diseases and interventional cardiology. He is a Fellow of the American College of Cardiology and the Society for Cardiovascular Angiography and Interventions. Beyond a personal commitment to excellence in the delivery of cardiovascular medicine through Novant Health's facilities, Dr. Aluko demonstrates vocal and visible commitment to both local and national advocacy efforts that address the issue of health care disparities within racial, ethnic and gender minority populations in the United States.

Dr. Aluko has also provided leadership in several professional and civic institutions in the Charlotte region and across the United States. He is a past board member of the Association of Black Cardiologists, a past president and founding member of the Association of

Nigerian Physicians in the Americas, and a founding member of the Carolinas Association for Community Health Equity. Dr. Aluko has also served on the board of the World Affairs Council of Charlotte and the Greater Carolinas chapter of the American Red Cross. He has received numerous awards for his trailblazing medical practice, advocacy for equity in healthcare, and civic leadership. He was the 2009 recipient of the Award of Excellence from the Thurgood Marshall College Fund. In 2010 he received the prestigious Richard Vinroot International Achievement Award. The Charlotte Post Foundation awarded him a Luminary Lifetime Achievement award in 2011, and he was honored with the Health Hero award by the Bobcats Sports & Entertainment Inc. in 2012.



Faces from The 6<sup>th</sup> Annual Dr. Bertha Maxwell-Roddey  
Distinguished Africana Lecture.

Above - Dr. Maxwell-Roddey flanked by Dr. Yele Aluko and Dr.  
Shirley Houston Aluko

Below – Guests of Honor and Collegiate 100 members





Audience at the 6<sup>th</sup> Annual Dr. Bertha Maxwell-Roddey Distinguished Africana Lecture. October 22, 2014

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