PUTTING A FACE ON MEDICAID EXPANSION IN NORTH CAROLINA

Legend

Gene Nichol, Heather Hunt and Matthew Norchi

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Acknowledgments

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More Information

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Sonya Taylor, a 55-year-old mother and grandmother, lives in Ahoskie, North Carolina. She hails from a family of sharecroppers. “It was instilled in me at a very young age, if you want to eat, you have to work,” she says. Ms. Taylor has worked full time her whole life, as a bookkeeper or manager for a variety of retailers. But in 2011, she was forced to endure a six-hour fusion operation for scoliosis. Two metal rods and five plates were inserted in her back. Losing insurance coverage after the surgery, she had to forgo physical therapy treatments because she couldn’t afford them. Ms. Taylor also has long had a broken plate in her mouth, inhibiting her ability to smile. As she says, “it’s hard to have confidence in yourself when you have no teeth in the front of your mouth.”

Sonya’s family has a long, worrisome history of cancer. In the past few years, she’s had troubling symptoms in her gastrointestinal tract, bowel and intestines. But she now has no access to screenings because she doesn’t have insurance and can’t afford to pay for the procedures. She and most of her family are situated in North Carolina’s large Medicaid coverage gap. Her kids’ father was diagnosed with cancer in September, 2015. He wasn’t eligible for health care coverage until he was terminal. He passed away in February, 2016. “I live in fear,” she says. “My kids deal with the constant worry that they’re going to lose their mother. I feel like I’m fighting for my life and the state of North Carolina could care less.”

“If I woke up tomorrow and got an email telling me I qualified for some type of insurance, it would change my life. It would be such a godsend to me and my family. It’s disheartening now, because my kids see I have to fight for every bit of medical care I get. I’ve got grandkids. I want to see them grow up.”

—Sonya Taylor, Hertford County, North Carolina

Introduction

North Carolina is one of nineteen states, mostly southern, that have so far refused to accept the expansion of Medicaid under the provisions of the federal Patient Protection and Affordable Care Act (ACA).1 The massive health reform law, as interpreted by the United States Supreme Court,2 gives states the option of extending Medicaid coverage to those living below 138% of the Federal Poverty Level (FPL) ($33,534 for a family of four in 2016). Under the ACA framework, from 2014 through 2016, the federal government provides 100% of the funding for expansion; from 2017 through 2020, the rate drops gradually to 90%, where it will remain. The 2016 (non-expansion) Medicaid matching rate for North Carolina is about 2:1, meaning that state pays approximately 34% of the tab while the federal government covers 66%.3
In 2013, the North Carolina General Assembly passed, and Governor Pat McCrory signed, legislation prohibiting the state from accepting Medicaid expansion. The decision to reject expansion has not been officially revisited. In its wake, hundreds of thousands of low-income North Carolinians have been denied health care benefits who would otherwise have been eligible to receive them. The determination to refuse the largely federally funded expansion of health insurance coverage, for good or ill, is surely one of the most consequential in North Carolina history. This report considers its impact on the state and the lives of those denied the proffered coverage.

Much powerful work has been done, in North Carolina and around the nation, to explore the economic, social, demographic, hospital-based, health-outcome driven, and systematic consequences of our state’s rejection of Medicaid expansion. Kaiser Family Foundation studies, a massive Cone Health Foundation/Kate B. Reynolds Charitable Trust report, Harvard and Georgetown analyses, and thoughtful reports by our colleagues at Wake Forest University are probing and compelling examples.

We draw, initially, on such studies here. But our purpose and methodology is fundamentally distinct from these efforts. In the first section, we will briefly outline the key results of these formal and overarching reports. They demonstrate, broadly speaking, that by continuing to reject Medicaid expansion, North Carolina pays very substantial costs, not only in lost federal health care funding, but also in employment, tax revenues, support for hospitals’ uncompensated care, system-wide health care infrastructure expense, rural and urban economic development, and, most important, the mental and physical well-being of North Carolina residents. The medical, emotional, economic, social, financial, humane and developmental case for Medicaid expansion made in these studies is unambiguous. They also reveal that in the longer course, accepting Medicaid expansion likely would not only save lives by the thousands, but state expenditures by the millions. It is not a close case.

But the principal thrust of this study, set forth here in the decidedly more expansive second section, moves past the (admittedly crucial) assembled data to explore, largely through narrative testimony, the actual, daily-lived and experienced impact of restricted Medicaid coverage on the lives and health of various low-income North Carolinians. We do so mainly through extended interviews with patients caught in the noted Medicaid gap and an array of doctors who make it no small part of their lives’ work to serve them. We have found these discussions to be both wrenching and compelling. Often, they put flesh, blood and substance on the empirical data. They indicate, even if imperfectly, the stunning human cost of North Carolina’s rejection of expanded federal support for Medicaid coverage for poor Tar Heels. Turning away the expanded medical coverage is no mere demographic or ideological matter. It touches, dramatically and unforgivingly, the fabric, character, dignity and humanity of North Carolina life.
I. Overview of Medicaid Expansion

The ACA and Medicaid Expansion

The Patient Protection and Affordable Care Act (ACA) changed the health care landscape in the United States. U.S. citizens and lawfully present residents with incomes between 100-400% of the Federal Poverty Level (FPL)\(^1\) became eligible for significant income-based tax credit subsidies to enroll in private health insurance offered through either a state-created exchange or a federal exchange.\(^2\) These exchanges operate as online marketplaces to allow applicants to shop for different insurance plans offered by private insurance companies. Additionally, the legislation called for the mandatory state expansion of Medicaid to those below 138% of FPL. The U.S. Supreme Court, however, struck down the mandatory nature of the Medicaid provision in *National Federation of Independent Business v. Sebelius*.\(^3\) States are now free, therefore, to either accept Medicaid expansion or to reject it.

North Carolina is one of a minority of states refusing to expand Medicaid.\(^4\) The reasons given for non-expansion are hard to pin down but appear to evince skepticism toward Medicaid, President Obama and the federal government generally.\(^5\) The Speaker of the North Carolina House of Representatives, Tim Moore, explained, “Expanding Medicaid is not the right decision. We’re grappling with trying to control Medicaid spending we already have. Creating more expense doesn’t seem the prudent course.” Senate President Phil Berger agreed. “Nothing has changed to address the multitude of concerns with Medicaid expansion. We cannot afford our current Medicaid system, much less an expanded one.”\(^6\) Governor Pat McCrory has occasionally appeared more amenable to expansion, claiming, “I’m also trying to figure out what to do with Medicaid and whether to expand that or not, because the feds are offering all this money, and yet I’ve got to be concerned with the bureaucracy that could be grown because of that.”\(^7\) Still, the governor has not pressed or demanded expansion. In September 2015, Gov. McCrory signed legislation to overhaul traditional (non-expanded) Medicaid in North Carolina by privatizing statewide health insurance plans.\(^8\) No step was taken, however, toward expansion.

The Medicaid “Coverage Gap”

The most serious consequence of North Carolina’s rejection of expansion is the creation of the Medicaid “coverage gap.” Under the ACA, persons living between 100-400% of FPL are eligible to receive subsidies to help purchase health insurance through an exchange. The ACA envisioned that those living at or below 138% of FPL would be covered by Medicaid expansion. As a result of these overlapping parameters, Tar Heels who make between 100-138% of FPL are eligible for subsidies or Medicaid, if it is expanded.\(^9\) Those under 100% of FPL were assumed by the ACA to be covered by the expansion of Medicaid, so no provision for subsidies was made for this income group.\(^10\)
Medicaid expansion was a crucial component of the ACA because in its current unexpanded state, Medicaid in North Carolina covers only a few targeted populations that meet income and assets eligibility requirements. These are generally elderly and disabled poor adults, and qualifying low-income pregnant women, children, and parents. No matter how little they earn, childless adults (who are not over 65 or disabled) are ineligible for Medicaid in North Carolina. Thus, the Medicaid coverage gap refers, fundamentally, to the unavailability of insurance options for those at or below 100% of FPL. Those living between 100 and 138% of FPL, however, are also considered to be effectively in the gap because, although they qualify for subsidies, many have a hard time affording food and rent, never mind the costs of health care, and would be better served under expanded Medicaid.

The Kaiser Family Foundation estimates that there are 244,000 North Carolinians earning below 100% of FPL who would have qualified for Medicaid under the ACA. Kaiser finds, also, that including those between 100-138% of FPL raises the number of uninsured adults eligible for Medicaid expansion in North Carolina to 463,000. Table 1 describes those in North Carolina’s coverage gap. Almost 70% of those without insurance live in a family with someone who works, while over 50% of those in the gap work themselves. Whites comprise the majority of those in the coverage gap (52%), while over half are 35 years or older.

<table>
<thead>
<tr>
<th>TABLE 1. Demographics of Individuals In North Carolina’s Coverage Gap</th>
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<tr>
<td><strong>Characteristic</strong></td>
</tr>
<tr>
<td>Age group</td>
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<tr>
<td>19-24 years</td>
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<tr>
<td>25-34 years</td>
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<tr>
<td>35-54 years</td>
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<td>55-64 years</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
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<tr>
<td>Race/Ethnicity</td>
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<tr>
<td>White</td>
</tr>
<tr>
<td>People of Color</td>
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<tr>
<td>Parental Status</td>
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<tr>
<td>With dependent children</td>
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<tr>
<td>Without dependent children</td>
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<tr>
<td>Individual Employment Status</td>
</tr>
<tr>
<td>Employed</td>
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<tr>
<td>Unemployed</td>
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<tr>
<td>Family’s Employment Status</td>
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<tr>
<td>At least 1 family member working full time</td>
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<tr>
<td>At least 1 family member working part time</td>
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<tr>
<td>No one working in the family*</td>
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*Percentage adds to 101 percent due to rounding.

The lack of adequate health care kills hundreds of people in North Carolina annually and debilitates many more. Researchers from Harvard University published a study reporting North
Carolina’s refusal to expand Medicaid likely results in 455 to 1,145 deaths annually. University of North Carolina medical school professor Charles van der Horst has estimated the number of preventable deaths per year as a result of non-expansion to be between one and two thousand. The Harvard study concluded that if North Carolina accepted Medicaid, there would be:

- **45,571** fewer cases of untreated depression
- **27,044** more diabetics using diabetes medications.
- **12,051** more women age 50-64 having had a mammogram in the past 12 months
- **27,840** more women age 21-64 having had a pap smear in the past 12 months
- **14,776** fewer persons facing catastrophic medical expenditures.

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**Economic Impacts of Non-Expansion in North Carolina**

Medicaid expansion would provide a significant economic stimulus to North Carolina through increased revenue, job creation and diminished state costs. Because the state did not expand Medicaid in 2014, it has already forfeited billions of dollars and thousands of jobs. Still, huge economic payoffs for expansion can be achieved, even if belatedly, for the decades ahead.

Expansion will result in impressive increases in state revenue. In a report funded by the Cone Health Foundation and Kate B. Reynolds Charitable Trust (“Cone report”), researchers concluded that North Carolina has already lost an estimated $6.02 billion in federal funds. It stands to lose an additional $21 billion in federal funds between 2016 and 2020 if it continues to refuse expansion. State and local governments also lose tax revenue that Medicaid expansion would generate through new business activity and jobs. In 2014 and 2015, the state would have gained an additional $228 million in revenue; counties would have seen an extra $40 million. If Medicaid is not expanded, cumulative state tax revenue for 2016 through 2020 will be $862 million less than it would have been had expansion occurred. County tax revenue will be reduced by $161 million.

An array of independent and nonpartisan experts have estimated that had North Carolina expanded Medicaid in 2016, it would have generated between 20,000 and 40,000 new jobs by 2020. The Cone report estimated that almost 30,000 jobs have already been lost in 2014 and 2015 and, if the state continues to refuse expansion, 43,000 jobs in total will be forfeited by 2020. Roughly half of these jobs would be in the health care sector, with the remainder in fields such as construction, retail, service and government (Table 2). Employment benefits would be felt throughout all one hundred counties and—critically for the large swaths of the state outside metropolitan regions—would be the same for both rural and urban counties.
TABLE 2. Estimated Number of Jobs Created in North Carolina if Medicaid Is Expanded by 2016

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<tbody>
<tr>
<td>Ambulatory Health Care Services</td>
<td>9,849</td>
<td>15,650</td>
<td>16,385</td>
<td>17,129</td>
<td>18,339</td>
</tr>
<tr>
<td>Hospitals</td>
<td>2,675</td>
<td>4,243</td>
<td>4,438</td>
<td>4,634</td>
<td>4,954</td>
</tr>
<tr>
<td>Construction</td>
<td>1,712</td>
<td>3,473</td>
<td>4,377</td>
<td>4,806</td>
<td>5,017</td>
</tr>
<tr>
<td>Retail &amp; Wholesale Trade</td>
<td>1,412</td>
<td>2,288</td>
<td>2,439</td>
<td>2,523</td>
<td>2,623</td>
</tr>
<tr>
<td>Food Services &amp; Drinking Places</td>
<td>484</td>
<td>833</td>
<td>957</td>
<td>1,062</td>
<td>1,175</td>
</tr>
<tr>
<td>Professional, Scientific &amp; Technical Services</td>
<td>597</td>
<td>996</td>
<td>1,093</td>
<td>1,159</td>
<td>1,233</td>
</tr>
<tr>
<td>Social Assistance</td>
<td>268</td>
<td>443</td>
<td>487</td>
<td>527</td>
<td>578</td>
</tr>
<tr>
<td>State &amp; Local Government</td>
<td>1,891</td>
<td>3,125</td>
<td>3,413</td>
<td>3,623</td>
<td>3,862</td>
</tr>
<tr>
<td>All Other Sectors</td>
<td>3,282</td>
<td>5,195</td>
<td>5,375</td>
<td>5,421</td>
<td>5,535</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22,170</strong></td>
<td><strong>36,245</strong></td>
<td><strong>38,964</strong></td>
<td><strong>40,886</strong></td>
<td><strong>43,314</strong></td>
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</table>

**SOURCE:** Ku et al., The Economic and Employment Costs of Not Expanding Medicaid in North Carolina

Expansion would also reduce the cost of uncompensated care for hospitals.\(^{34}\) Under expansion, state-owned hospitals (the University of North Carolina hospital system, for example) would receive Medicaid payments for thousands of patients who would otherwise be unable to pay. Experts estimate that a third of uncompensated care costs for state-owned hospitals in North Carolina could be avoided with Medicaid expansion, resulting in approximately $250 million in savings between 2016 and 2020.\(^{35}\) The state would save an additional $934 million through averted costs to mental health programs covered under Medicaid.\(^{36}\)

Because the costs of expansion are borne almost entirely by the federal government for the first few years, North Carolina could see net gains from Medicaid expansion.\(^{37}\) That may change in 2020, when the federal matching rate drops to 90%. According to the Cone report, the direct cost of expansion to the state in 2020 will be approximately $604 million.\(^{38}\) Most, if not this entire sum, however, would be offset by the financial benefits of expansion.\(^{39}\) One conservative estimate has calculated that North Carolina could gain financial benefits of $556 million, compared to the cost of $604 million (Figure 2).\(^{40}\)

**FIGURE 1. Medicaid Expansion Costs vs. Benefits in 2020 (in millions)**

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**Reduced Costs for Existing Government-funded Health Programs**

**Reduced Uncompensated Care for State Hospitals**

**Increased State and County Tax Revenue**
Evidence from Other States

Medicaid expansion has had a profoundly positive effect in states that have chosen to expand. This effect was underscored by a study comparing access to health care, utilization and self-reported health status in three states in the southern United States: Arkansas, Kentucky, and Texas.\textsuperscript{41} Arkansas and Kentucky each adopted its own version of Medicaid expansion; Texas declined to expand.\textsuperscript{42} Researchers surveyed working age U.S. citizens with incomes below 138% of FPL between 2013 and 2015 in these three states. They found that Arkansas and Kentucky experienced sharp declines in rates of the uninsured, while the drop in Texas was substantially smaller. Arkansas’s uninsured rate dropped from 41.8% to 14.2%, Kentucky’s dropped from 40.2% to 8.6%, while Texas’s only fell from 38.5% to 31.8%.\textsuperscript{43} Other studies, surveying the effects of Medicaid expansion on a national scale, have noted similar improvements in health care coverage for expansion states.\textsuperscript{44}

The three state study looked at expansion in its earliest days. Nonetheless, significant changes in access to care were already underway. Expansion was associated with a notable increase in the likelihood of having a personal physician (12.1 percentage points), an increased likelihood of a checkup (16.1 percentage points), and a decreased reliance on the emergency department as a usual location of care (-6.1 percentage points).\textsuperscript{45} A U.S. Department of Health and Human Services (DHHS) literature review concluded that community health centers in expansion states experienced a 46% increase in visit rates, compared to a 12% increase in non-expansion states.\textsuperscript{46} Further, the DHHS review found that use of preventative health services increased 41% in expansion states, while non-expansion states experienced no change.\textsuperscript{47} Medicaid prescription rates increased 25.4% in expansion states, but only 2.8% in non-expansion states.\textsuperscript{48} Simon, Soni, and Cawley report that Medicaid expansion was associated with a 20% increase in the probability of visiting a dentist, a 16% increase in receiving a mammogram, and a 14% increase in receiving a clinical breast exam.\textsuperscript{49}

Medicaid expansion also removes financial barriers to care for patients. The DHHS review found that the overwhelming majority (78%) of post-expansion Medicaid enrollees that visited a doctor would not have been able to afford their care if expansion had not occurred.\textsuperscript{50} Additionally, the review found that the percentage of low-income adults reporting problems paying medical bills declined by 10.5 percentage points (34.7% pre-expansion to 24.2% post-expansion).\textsuperscript{51} The three state study concluded that by 2015 there had been an 18.2 percentage point reduction in patient-reported, cost-related barriers to care, as well as an 11.6 percentage point decline in patients skipping prescription medications for financial reasons and a 14% decline in difficulty with medical bills.\textsuperscript{52} Finally, Simon, et al. found that expansion was associated with an 8% reduction in work absences due to health issues.\textsuperscript{53}
II. Putting a Face on the Rejection of Medicaid Expansion in North Carolina: The Words of Doctors and Patients

Data, demographics and economics tell only part of a story. They can remain distant and bloodless. They can miss the intense and distinctly personal, and often familial, wounds that result from restricted health care coverage—leaving mothers, fathers, sisters, brothers, struggling souls, left out, in the shadows of an advanced and often seemingly miraculous medical system. Denied health care, close up, can prove more wrenching than a budget sheet or cost calculation reveals. This report, then, turns from the demographics and economics of Medicaid expansion to the narratives of North Carolina doctors and patients, and those who seek, unsuccessfully, to become patients. It outlines the often crushing impact on the lives of low-income Tar Heels of exclusion from health care coverage.

The stories depict the terrible price frequently paid by suffering and vulnerable members of our community. They speak of avoidable and treatable diseases that inflict brutal and unnecessary harms. Ignored symptoms, canceled or unfilled medications, barred specialists and devices, foregone therapies; unavailable tests and screenings such as mammograms, colonoscopies, sonograms and stress tests; missed treatments for diabetes, asthma, blood pressure and arthritis—all of which can cause untold suffering and result in overwhelming emergency room costs. The narratives speak of essential humane services denied, too often, to those who work hard, sacrifice, attempt to care for their families and friends, and otherwise serve their communities. They illuminate gaps in a health care system that are seemingly thought acceptable only because most of us don’t actually know they exist.

A small but illustrative sampling follows.

Dr. Stephen Luking – “Watching My Patients Pay A Terrible Price”

Steve Luking is a family physician who has practiced medicine for over thirty years, almost all of it in Rockingham County, North Carolina. Dr. Luking and his brother, Scott, run a broad family practice, serving about 6,000 patients. When we spoke, he indicated his youngest patient was three days old, the oldest 102. He often cares for four generations of a single family. About 35% of Luking’s practice is pediatrics. Most of the poor kids, thankfully, are on Medicaid. Many of their parents, though, are not. Uninsured adults make up about 10% of the people he sees. He says, in his decades working in Rockingham County, he has come to understand why nearly every industrialized country (except the United States) provides a basic level of health care for all of its citizens.
For more than thirty years, I have watched my patients with no insurance pay a terrible price. I’ve seen women die of invasive breast cancer and cervical cancer when they couldn’t afford mammograms and preventative checkups. I’ve hospitalized patients who stopped their medicines so they could pay other bills. I’ve spoken to the next of kin in funeral homes about symptoms regretfully ignored by those afraid of the cost of evaluation. You name just about any cancer or serious disease, and I can tell you about uninsured patients who delayed coming to see me, often with disastrous results. The slow death by invasive colon cancer in the patient who could not afford a colonoscopy, the diabetic who could not pay for insulin and the resulting dialysis, the families left bankrupt and depressed after a serious illness, and on and on. Despite what people say, the emergency room doesn’t provide the care these folks need. When was the last time someone received a pap smear or a screening colonoscopy in an emergency room?

Dr. Luking speaks of particular patients and their unyielding challenges:

I think of the caring, middle-aged man I saw recently in my office. He once had good insurance and a full-time job at a factory but had to quit his job and come home when his mother suffered a devastating illness. Otherwise, she would have been forced into a nursing home. I had placed him on several medicines for health issues. When I asked him if he had done his blood work, he started to cry. He told me he now had no insurance. The folks at social services had told him he wasn’t earning enough to qualify for insurance subsidies [under the ACA]. He now works for minimum wage 25 hours per week and told me he has been skipping medicines in order to make ends meet.

Another patient I saw last month is a woman in her thirties. I diagnosed her with rheumatoid arthritis last year. She came back to see me because she could not afford visits to her specialist. She also had stopped her costly immunosuppressant medicines, yet these meds are her only hope to avoid the gnarled hands and deformed joints that will inevitably come her way. She, too, didn’t qualify for insurance support at her low wage. She was advised at the government center that her only hope was to quit her job and go on permanent disability.

Last week (September, 2016), Luking saw a child, one of his regular patients, who came in, late in the day, struggling with a variety of ear infection-related issues. It was hard for Luking not to notice, though, that the child’s mother seemed to be in even worse shape. She indicated, under his probing, that she, too, had been ill for several days. He asked if she had seen her doctor. The mother explained that she didn’t have a physician. She was uninsured, though she had been working for over ten years for one of the county’s largest businesses. For many years, she had only been able to get 26 hours a week, though she constantly requested more work. The same was true, she said, of most of her friends at the store. She had tried to get Medicaid but was
told she didn’t qualify and she was unable to receive subsidies under the ACA. So she knew seeing a doctor was out of the question. Luking indicated he sees patients in similar circumstances about a half dozen times a week. Another comes to his office, once a year, essentially to continue her limited medications. Though her family has a strong history of cancer, she, in her early fifties, has never had a mammogram or any other screening test because she can’t afford them. Luking worries that her effective exclusion from the medical system will eventually prove tragic for both her and her family.

Dr. Luking has come to have a particularized vision of the low-income community he is so frequently called upon to serve. For him, there is little echo of the stereotypes that often mark our political discourse. His patients, more frequently, inspire and transform:

Twenty years ago in the middle of the night after an emergency C-section, the obstetrician at Annie Penn Hospital [in Reidsville] handed me a newborn infant in need of resuscitation. I did my job, though I was taken aback by the swollen head twice the normal size of a healthy newborn. Since that night, I have seen that child as a patient hundreds of times in the office and hospital. Through dozens of hospitalizations, some of which I seriously thought may be his last, I have watched a pure kind of love emanating from his mother that defies description. My patient cannot walk, or see, or talk. His feeding tube, brain shunt and permanent tracheostomy, along with fifteen medications, sustain his bodily functions. But his mother sustains his soul.

Always at his bedside, she has sacrificed her life to the loving attention of a severely compromised son. With the help of home nurses, she has cared for him at home. I consider her a saint. Her husband works as a farm laborer; her life’s work is a labor of selfless love. Together they earn less than the threshold for insurance coverage and would qualify for insurance coverage in most other states. She has skimped on her own health care. Her husband last year developed potentially ominous symptoms but declined a referral from the emergency room to a specialist because he already has outstanding medical bills.

“They aren’t ‘takers’ looking for a handout. These working poor are our cousins and our neighbors. They sit with us in the pews on Sunday, their children and grandchildren go to school with ours. Some have watched well-paying jobs fly to Mexico or China. Some, through personal or family circumstances earn meager wages. Some have employers who craftily maintain them under ‘temp’ status or keep their hours worked under 30 hours per week to avoid insurance obligations. Some have reached their God-given potential. Who are we to pass judgment? The fact is that near-poverty has left them all uninsurable without Medicaid. Some in Rockingham County will surely die—if they haven’t already—because of the decision to reject Medicaid.” – Dr. Stephen Luking

Dr. Steve Luking “works one day, one patient, at a time,” trying to serve the people and community he has grown to deeply love. He became so distressed about the impact on his patients of North Carolina’s decision to refuse Medicaid expansion that a few months ago he
wrote a powerful letter to his senator, Phil Berger, and Gov. McCrory, outlining the devastating effects he sees daily in his practice. The letter was eventually published in the Greensboro, Reidsville and Eden newspapers. Neither leader ever replied.

**Dr. Pradeep Arumugham – “She Would Be Alive Today If We Accepted Medicaid Expansion”**

Dr. Arumugham is a heart specialist in Kinston, North Carolina. Kinston, and Lenoir County where Kinston is located, are among the state’s poorest places. He has had big city options but prefers the quiet, friendlier life of eastern North Carolina. He has a thriving practice that includes a selfless and potent commitment to impoverished residents who are uninsured and can’t pay the fare. They are, he explains, typically hard-working folks who struggle economically—waiters, maintenance workers, cooks, laborers, retail employees. He also says, as a heart doctor, he tries to see his poorest patients on a monthly basis because “they tend to be at greater risk of dying.”

The failure to expand Medicaid, he reports, has had a devastating impact on his low-income, uninsured patients. The most wrenching of those consequences occurred last year when one of his patients, who made about $10,000 a year working in a local diner, faced severe danger of heart failure from a troubling genetic abnormality. Dr. Arumugham had treated her initially in the emergency room at Lenoir Memorial Hospital. He was able to stabilize her and send her home, but her heart remained very weak. She was in her early sixties. Her sister had died from the same malady. She needed a defibrillator, which for an uninsured patient could cost over $80,000. She couldn’t get coverage on the open market because she didn’t have enough money. She couldn’t qualify for subsidies under the ACA because she was too poor.

Dr. Arumugham saw her for several months but he was unable to secure a defibrillator. As a result, the waitress died. “We could have saved her,” he says. “I treated her for free and the medicines she needed weren’t that expensive, but we couldn’t get the device she needed.” She would “be alive today if we had accepted the Medicaid expansion.” That’s the “simple fact.”

Arumugham speaks of another patient, Shelton, a truck driver with serious heart disease. His heart function had dropped to about 35%, so it wasn’t possible, any longer, to drive a truck professionally. He lost his job and his health insurance. He has attempted to get disability benefits, but has been unsuccessful. He can’t walk for more than a few minutes without becoming exhausted. He needs a pacemaker, which, of course, he can’t afford. The trucker’s son is autistic, so his wife can’t work, needing to care for him at home. Dr. Arumugham believes Shelton’s advanced problems could have been avoided with earlier, proper treatment. Now the
doctor and the patient fear for his future—and that of his wife and son. And, of course, with Medicaid expansion, he could be fully treated.

Charles, 64, worked for years repairing tractors. He had a heart attack in 2007, eventually resulting in bypass surgery. Then he had a stroke in 2011. Charles needs a specialist to receive catheterization, but that would cost thousands of dollars that he cannot afford. Thus his health, and perhaps even his survival, are threatened. In over 30 other states, he would qualify for federally funded Medicaid. Sandra, 53, the manager of a local bingo hall, makes less than $10,000 a year. She has asthma and has repeatedly been forced to go to the emergency room, and sometimes, while there, has been placed on a ventilator. She spends many of her scarce dollars on inhalers and medicines. Medicaid expansion would notably relieve her plight.

Dr. Arumugham knows that much of the political leadership in Raleigh is adamant in opposition to expansion. He says, “I wish they would come to Kinston and meet my patients.”

“We’re only saying, you are sick, or you are injured, and we are going to try to fix you. Why is that seen as something radical or extraordinary, or as something a human being doesn’t deserve?”

“Every day, every single day, I see the way we allow these people to suffer, just because they don’t have money and we won’t let them have insurance,” he says. “I know people say, ‘I’m against giving them money they don’t deserve,’ as if they were being handed some kind of generous disability check,” the idealistic doctor reports. But that’s not what is happening, he says. “We’re only saying, you are sick, or you are injured, and we are going to try to fix you. Why is that seen as something radical or extraordinary, or as something a human being doesn’t deserve?”

Dr. Evan Ashkin – “Rationing By ‘Wallet Biopsy’ – A Doctor’s Excruciating Balance”

Evan Ashkin is a doctor of family medicine at the University of North Carolina School of Medicine. He serves patients at Prospect Hill Community Health Center in southern Caswell County (among other clinics), where a majority of the North Carolinians he sees are Spanish speaking and poor. Almost half are farmers (black, white and Latino). A quarter are on Medicaid, thirty percent get Medicare, and forty percent are uninsured.

Ashkin notes his patients don’t fit the often common stereotype of lazy freeloaders looking to game the system and get a free handout. “That viewpoint is possible only if you have never worked with anyone in this patient population.” These are people who “are simply in excruciating circumstances, in intense distress arising from circumstances beyond their control.” They are waiters, gardeners, farm hands, motel workers, dishwashers, day laborers, retail employees, housekeepers, and, ironically, home health care workers. Families with young
kids, part-time students trying to work and finish community college. Maybe policymakers ought to come down here and meet them.

“Poor folks pay a terrible cost for not having health care coverage—it takes a terrible human toll,” Dr. Ashkin explains. When you can’t get care, your health suffers markedly. “When your health is poor, you frequently become poorer, you are more likely to become, or to stay unemployed, your family is more apt to suffer, there is more harm to kids and to their communities,” he notes. And, of course, there is more harm to North Carolina. “Right now we are paying a terrible cost as a state by not expanding Medicaid and broadening health care coverage,” he says. It is “morally indefensible.”

Ashkin helps oversee a special clinical track for young doctors who come to the medical school at UNC explicitly to learn to work in these distressed and marginalized communities. “The students come here wanting to serve, we take them to these clinics so they can learn to do this kind of health care work, to make the kind of excruciating decisions poverty doctors have to make.” They know what they are getting into, he says, “they are brave souls.” They learn a sad, trying and unacceptable reality. “They have to be trained to deal with it.”

Ashkin describes the untenable choices that restricting Medicaid triggers. A man comes in with chest pains, but he’s uninsured. Do we give him the stress test we would offer if he could pay? The clinic can’t afford to continually pay for expensive procedures. So maybe the patient gets the test, maybe not. What if the doctor guesses wrong and he has a heart attack? “We say we couldn’t stand to have a two-tier health system or to have rationing,” Ashkin notes. “But this is rationing, it’s just rationing via ‘the wallet biopsy,’ the worst possible basis to allocate care.” It is “gigantically immoral, the worst criterion.” He tries to be ethical, “but why should a doctor be making such decisions?” Why is a doctor exercising “this excruciating balance?”

One of Ashkin’s patients is undocumented, having lived here seven years after fleeing violent abuse in Mexico. She was in significant distress early in a pregnancy—bleeding, badly in need of an ultrasound, presenting the serious possibility of an ectopic pregnancy. Because of constraints on public funding for her care, even if Medicaid is expanded, the clinic is hard pressed to provide a needed ultrasound. And, if it provides an ultrasound now, the clinic may not be able to provide important scans later in the pregnancy, essential to protect both the mom and the baby. The baby, of course, will be a citizen, as is his sibling—suggesting how artificial non-citizen funding restrictions can be. “So I have to help the mother through this

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wrenching choice—a choice that no mother should ever be required to make,” Ashkin says. “No one but a poor person would ever have to make such a choice; we want to avoid an early sonogram but if we guess wrong, it might prove disastrous.” Ashkin thinks of what he calls the “brother-sister test”: “Would I think it tolerable that my sister had to make such a choice?” But we force this dilemma on a “hugely vulnerable population—pregnant women, uninsured, sometimes the parent of a citizen, who isn’t one herself.” He and his medical colleagues make decisions like that, he says, every day.

And because of the cabining restrictions, Ashkin says large numbers of his patients roll in and out of Medicaid. If they have Medicaid, but then get a job, they could lose coverage. Or if they lose their job, or they go bankrupt, their Medicaid status changes back. But a patient who has asthma needs an inhaler, insurance or not. When he goes off Medicaid, he can no longer afford it. Or a patient needs blood tests, or diabetes medicine, or heart pills or high blood pressure medicine. Then, because the patient gets sicker, Ashkin notes, she, perhaps, loses her job. As a result, she goes back on Medicaid. Then she gets the inhaler or the insulin or the blood pressure medicine, but “permanent damage has occurred” in the meantime. “I hear these stories every week,” Dr. Ashkin says. They represent “an immensely destructive way to practice medicine.” A way that is also “hugely inefficient—people get sicker, the family suffers, the community suffers, the tax base suffers.” Every month, Ashkin “sees patients who get much worse outcomes, and who later trigger much higher emergency room costs, because they move in and out of Medicaid.” With expansion, he says, that wouldn’t happen.

Another of Ashkin’s uninsured patients, in his late forties, has multiple sclerosis. He couldn’t qualify for Medicaid because he makes a little too much money. But he doesn’t make nearly enough to be able to afford his MS medications, which combat the disease effectively, but are pricey. So he had to go off his medication for over a year, while trying to get accepted into a charitable care program. If he gets accepted, he will have suffered “real and permanent damage in the interim.” Similarly, a young guy Ashkin sees, out of prison for a year and a half, had diabetes. Ironically, of course, he had good health care while he was incarcerated. Having had no medical care since he was released, he developed advanced diabetic foot disease. Because he had no health insurance coverage, when “he finally came in to see us he’d lost a tremendous amount of weight, was throwing up all the time, and, eventually, may require amputation.” He had to be admitted to UNC for dialysis and the installation of a feeding tube. The hospital, Dr. Ashkin reports, will eventually have to spend over $100,000 on his care—because it was impossible to come up with a relative few dollars earlier. It is, sadly, “a very, very typical story.” By Dr. Ashkin’s lights, “it’s a bizarre way to allocate health care.”

“I believe that health care is a human right. I also believe that on a purely economic basis the argument to extend Medicaid is unassailable. Locally, regionally, statewide. We are doing ourselves a huge disservice. Ideology is overcoming rational, common sense decision-making. And it is taking a hideous toll on some of the most vulnerable people in North Carolina.” – Dr. Evan Ashkin
Dr. Julius Mallette – A “False Economy Courts Disaster” and Makes Impossible a “Civilized Medical System”

Dr. Mallette has been the chief medical officer at Kinston Community Health Center for seven years. He also has a private practice as an OB/GYN in Lenoir County. Mallette explains that community health centers in North Carolina work to fill the gap for those without either private insurance or Medicaid. The Kinston Community Health Center charges patients on an income-based sliding scale, capped at 125% of the Federal Poverty Level (or a little over $30,000 a year for a family of four in 2016). A lot of folks in Kinston, he says, can’t meet the sliding scale, modest as it is. He estimates that about 10% of patients have to be turned away because they can’t pay the fee.

But specialist needs are as large problem for the poor and uninsured as not being able to get into the door of the Center in the first place. As Dr. Mallette describes:

We have a great screening process, figuring out what patients need. But referrals to specialists, which are often critical, are problematic for our non-Medicaid patients. First, there may be large transportation costs from Kinston to East Carolina [University] or other larger medical centers. Many of our patients can’t pay to get to the referral. Then, there is the specialist’s fee. They typically demand several hundred dollars up front, so our patients accept a suggested referral but often don’t go because they can’t afford it without insurance. So they aren’t able to get the specialized heart or obesity or diabetes or dermatology or dental treatment they need. We can tell them the treatment that would help them, but we can’t secure it because the patients can’t afford the programs or the specialists needed. If you are uninsured and obese, with the challenges from it, we can’t get you into a program of treatment. And then, of course, the obesity ties into a lot of other chronic conditions. So, for a lot of our patients, if we can’t get them Medicaid, we can’t fully treat them.

Even with small referrals like dermatology, ninety percent of our folks can’t afford the up-front fee, so they end up getting diseases in their systems and, eventually, needing hospital care. Most of our self-pay patients know they can’t actually use the referrals. Some folks in their fifties just sort of give up, knowing they won’t actually have access to health care, so they don’t think they are ever going to get well. Our reach and effectiveness would be much, much wider if we expanded Medicaid.

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Then there are all the other services that the Center has difficulty providing poor, uninsured patients. “Women need mammograms, but if our patients aren’t on Medicaid, they can’t get them.” Blood pressure medicines “are very effective,” Dr. Mallette notes, “but our patients can’t afford them if they aren’t on Medicaid.” Even if some could get help with half the medicine or screening costs, it would often be enough to make the difference, he says. So they go without essential medications, and, too frequently, “we see them later in the emergency room after they’ve had a stroke or a heart attack.” Then, of course, the cost to the health care system will be $90,000 or $100,000. “It’s a false economy,” he sighs.

Diabetes medications, he notes, are expensive for uninsured patients. With insurance, the patient might incur only a $5 co-pay. But without insurance, the “meds may cost $500.” They ask, “do I pay my rent or do I pay for my diabetes medicine?” Then, he says, shaking his head, “we see them later in the intensive care unit which costs everyone four or five thousand bucks, but it’s all because they didn’t get diabetes medicine in the first place.”

Yesterday, Dr. Mallette notes, one of his patients finally cleared for traditional Medicaid. Last year, he says, she went to the emergency room six times, costing the system a whole lot more than it was supposedly saving by turning her away.

“It would be a huge benefit in Kinston,” Dr. Mallette argues, if Medicaid were expanded. There is still a “big mindset here” that “I won’t go to the hospital unless I’m at death’s door.” That costs everyone in the long course, he notes. “I practiced in South Africa when I was younger and you really saw it there.” Pregnant women would wait weeks or months to see a doctor, often leading to disaster. It means, “you can’t really have a civilized medical system,” he says. “We are courting disaster and we are not living up to our ideals.”

Running a rural community health center, and thinking about the almost 500,000 people excluded from Medicaid, Dr. Mallette is certain that “expansion would not be a financial burden but would instead prove to be of tremendous fiscal benefit, as the federal tax dollars we already pay would return to support our rural and urban hospitals, create thousands of jobs that we need and promote a healthier workforce and community.” It would also help us, Mallette observes, actually have the kind of health system we all say we believe in.

Dr. Charles van der Horst – “A Powerful, Direct and Devastating Impact on My Patients”

Dr. Charles van der Horst, an internationally renowned AIDS researcher and recently retired professor at the University of North Carolina School of Medicine, has worked and volunteered for years at clinics in Raleigh and the Triangle to serve low-income, uninsured Tar Heels. The patients he sees there are largely young and working poor: “those who build our houses, feed
us, sew our clothes, teach our youngest children, serve our burgers, answer our phones and take care of our elderly parents.” Because of our refusal to accept Medicaid expansion, he explains, his patients often have little to assist them in avoiding the ravages of life-threatening, chronic diseases.

When we met, like the scientist he is, van der Horst brought the numbers. Among the roughly 450,000 North Carolinians in the Medicaid gap, two-thirds live in families where at least one family member works. These working but poor families, van der Horst notes, are our neighbors. Almost 60,000 are construction workers, 56,000 work in food service, 46,000 are in retail, 43,000 are cleaning and maintenance folks, 36,000 are textile and laundry workers, 34,000 are bus and taxi drivers. Stunningly perhaps, 16,000 work in health care.56 For them, he explains, the evidence is clear:

For people without insurance, or who have high deductibles, they go to the doctor much less often. We know that if people have insurance, they do see doctors and they enjoy an understandably greater peace of mind. For people who don’t have insurance, they just don’t go to a physician, or go only when they can’t manage otherwise. But even young healthy people need to go to the doctor for preventative screenings—cholesterol, diabetes, blood pressure, mammograms, colonoscopies—or for vaccines, or smoking cessation treatments. Diseases can be prevented outright if the symptoms are caught in time. We have set standards in place that decrease disease, and we’ve had a major impact on disease through preventative treatments.

But that doesn’t happen if people aren’t screened. It is bad for those people and it’s bad for all of us. If you are diagnosed with HIV, and get on a treatment regime, you’ll have a normal life expectancy. You’ll work, you’ll pay taxes. If you aren’t screened and diagnosed, you’ll have repeated hospitalizations, a reduced work life and life expectancy. Undiagnosed and untreated hypertension results in strokes, kidney failure and dialysis, which cost lots and lots of money to treat. Privately insured people end up paying 10% more in premiums because hospitals have to jack up costs in order to cover the expenses of treating the uninsured.

To illustrate, Dr. van der Horst mentions a recent patient he’d been treating at a clinic. An older man, a tax-paying farmer, came in with symptoms of liver disease. Eventually, they learned his liver was riddled with cancer due to metastatic esophageal cancer. He had no insurance and did not seek treatment. “He died in a week,” van der Horst says. If he had health insurance, his life could have been saved; these were treatable conditions. Plus, he would have had a notably better quality of life as he struggled with illness. “People don’t get care because they feel like they have no choices,” he said.

Another patient worked for years for a local bank that consolidated and moved operations to Charlotte during the recession. She lost her job because, given family obligations, she couldn’t move. She looked, unsuccessfully, for decent substitute employment for many months. In the
meantime, she became ill and started “letting things go.” Her teeth were very bad and, working in customer service, no one seemed willing to hire her—as she said, “her smile not being so good.” Having lost employment and health care coverage, she had also run out of her blood pressure medicine. Effects on her hypertension were substantial. Dr. van der Horst recalls that, as she explained her plight, she sobbed in his arms. He indicates that pattern isn’t uncommon. In seeing a half dozen or so patients on an afternoon visit, one or two would likely burst into tears. In part, he thought, they cried because someone was listening and trying to help, but mainly they were just beaten down by the crush of poverty. Having health care coverage, he notes, would pointedly improve the quality, and optimism, of life.

One young man van der Horst was seeing had worked for a number of years in a stable, full-time job with health care coverage. He had severe hypertension that required treatment with four different medications—but which had, in turn, successfully controlled his high blood pressure. Then he developed a complication that affected his balance. He was adamant to keep working: “he’s a good guy who works hard and enjoys working because he wants to contribute to society.” With the new disability, though, he was unable to secure full-time work. In quick succession he lost his job, his health insurance, and had run out of his blood pressure medicine. His blood pressure soared and he started to develop kidney damage. Through the work of the volunteer clinic, they were able to get his blood pressure back under control. But if the forecast proves wrong and he develops kidney failure, he’ll need dialysis, which will cost $75,000 a year or more. “For the want of four inexpensive medications,” he states, “the health care system may be on the hook for hundreds of thousands.”

Dr. van der Horst, sadly, could go on and on. The “decision to reject Medicaid expansion has a powerful, direct and devastating impact on my patients, leading to avoidable costs, unnecessary deaths, and intolerable cruelty,” he concludes.

**Kinston Community Health Center – Patients and Staff**

Daphne Betts-Hemby is the chief financial officer of the Kinston Community Health Center. She is quick to explain how much better the Center would be able to serve its “particular population if we could get Medicaid expansion.” The Center operates on a generous, sliding scale fee basis in its effort to serve uninsured, low-income patients. But “a lot of folks can’t meet the co-pay and even more don’t bother to come in because they don’t think they’ll be able to afford it.” And these are often the folks “who need health care coverage the most.” They have chronic diseases, but they “can’t get their hypertension medicine until it’s too late.” It’s “cheaper to get an oil change on a regular basis than to wait until you have to replace the engine.” She knows for some, a $50 or $100 co-pay would not be a major barrier to treatment or referral. But “$50 is a lot of money for some of our people, it’s like asking for $10,000.”
Other staff members ratify that conclusion. “Sometimes we can provide the diagnosis, but the uninsured can’t afford the treatment, so they stop coming back,” one explains. “Others give up because they think a doctor won’t see them unless they are about to die and then it’ll be too late,” another adds. The “community need in Kinston is intense, and growing, the failure to expand Medicaid is killing our folks every day.” Felicia Daniels, another staff member, says a lot of people “make too much money to meet our criteria, but not enough to pay for health care, so we’re forced to leave people without the service they need. ... We will see a lady with a lump in her breast, but, because there’s no insurance, we can’t order the mammogram, then she’ll end up having to have her breast removed because she couldn’t get Medicaid.”

Ginn, a patient in her forties, explains: “I don’t like to go to the emergency room, they only give you the least care they possibly can so that they can turn you loose, they only consider the most desperate issues.” And, she adds, “I can’t miss work because then I won’t get paid, so I have to decide whether my health or my family comes first. For me, it’s always my family.”

Kent, a Center patient in his thirties, works full-time in the construction industry, but his diabetes sometimes limits his work hours. “It takes every penny I bring in during the week to manage my household and have something to eat.” As a result of neuropathy, he suffers from stabbing pains in his feet. The Center doctors referred him to a specialist in Greenville, but the doctor “wanted $195 before he would even take” an appointment. “I’m in the Medicaid gap and I don’t have enough money to pay for a specialist,” he says. It takes “all I’ve got to pay for housing and food and gas and heat, and health care ain’t cheap.” Even with diabetes, he says, “you’ve got to eat.”

Kent lives in fear that the Center won’t be able to help with his neuropathy medication. “If they can’t, I’ll be one of those people in the scooter at Walmart, and I want to work,” he notes. “I’ve also had to put my dental problems on hold, because I can’t afford to take care of my diabetes as it is. My teeth are in bad shape but it’s been so long since I’ve seen a dentist, I’m scared to find out how bad things are.”

Chris, a young woman from Kinston who is another patient at the Center, is diabetic as well. As a childless adult, she can’t qualify for Medicaid, even though she makes less than the federal poverty guidelines. Her diabetes has led to a cascade of related health challenges. Still, she has worked almost her entire adult life at various retail and food service operations. Most of her employers haven’t offered health benefits. Despite that, she managed to graduate from Pitt Community College with a focus in biotechnology, hoping to become a lab technician. But she has been unemployed for over a year and has difficulty standing on her feet for significant periods of time. She has developed severe Carpal Tunnel Syndrome and her pain, she reports, is “constant.” And she lives in fear she won’t be able to continue to afford the limited medications she
now receives. When we asked her how often she thinks about her health care dilemmas, she answered, “every few hours. I’m just waiting for death to come and take me, but I wish I didn’t have to be in such pain while I’m waiting.”

Conclusion

Careful studies have long indicated that North Carolina’s decision to reject Medicaid expansion is an extraordinarily costly one. Not only does the state forgo tens of billions of federal health care dollars, hundreds of millions of state and local dollars in tax revenue, tens of thousands of jobs, hundreds of millions of savings for uncompensated hospital care, but, more directly, 463,000 low income Tar Heels would receive needed health care coverage under expansion. As a result of rejecting expansion, huge numbers of poor residents will be denied routine medications for treatable conditions such as diabetes, high blood pressure, depression. They will not receive essential tests and screenings—for mammograms, colonoscopies, sonograms, and the like—essential to maintaining reasonable health. Accordingly, as many as 1,145 deaths may occur prematurely and many thousands more will suffer needlessly, triggering soaring and disproportionate medical costs for emergency procedures.

Still, these somber data don’t reflect fully the tragedy of rejecting Medicaid expansion on the lives, families and conditions of low income Tar Heels. As Dr. Evan Ashkin explains:

Poor folks pay a terrible cost for not having health care coverage—it takes a terrible human toll. When you can’t get care, your health suffers markedly. When your health is poor, you frequently become poorer, you are more likely to become, or to stay unemployed, your family is more apt to suffer, there is more harm to kids and to their communities. And, of course, there is more harm to North Carolina. Right now we are paying a terrible cost as a state by not expanding Medicaid and broadening health care coverage. It is morally indefensible.

As the Reverend Martin Luther King, Jr. said in a speech to the Medical Committee for Human Rights in 1966: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”
Endnotes

4 An Act (1) To Clarify the State’s Intent not to Operate a State-Run or “Partnership” Health Benefit Exchange, (2) To Provide That Future Medicaid Eligibility Determinations Will Be Made by the State Rather Than the Federally Facilitated Exchange, and (3) To Reject the Affordable Care Act’s Optional Medicaid Expansion, Sess. Law 2013-5 (2013).
8 See Adam Searing & Jack Hoadley, GEORGETOWN UNIV. HEALTH POLICY INST., BEYOND THE REDUCTION IN UNCOMPENSATED CARE: MEDICAID EXPANSION IS HAVING A POSITIVE IMPACT ON SAFETY NET HOSPITALS AND CLINICS (June 2016).
12 132 S. Ct. 2566 (2012). Under the ACA, if states declined to expand Medicaid, they would lose all of their federal Medicaid funds. However, the Supreme Court held that this was “unconstitutionally coercive,” and struck that nature of the provision.
15 Mark Binker, Supreme Court ruling brings Medicaid expansion for NC into focus, WRAL (June 25, 2015), http://www.wral.com/supreme-court-ruling-brings-medicaid-expansion-for-nc-into-focus/14737591/.
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18 In the first year of expansion, those in the 100-138% of FPL income group can either keep their subsidized coverage or enroll in Medicaid. However, when they re-enroll the following year, they are routed to Medicaid if their income is still at or below 138% of FPL.


20 See HALL & SHOAF, supra note 9 at 1.

21 See GARFIELD & DAMICO, supra note 5 at 8.

22 Id. at 7.

23 See Dickman et al., supra note 7.


25 Dickman et al., supra note 7.

26 KU, ET AL., supra note 6 at 9.

27 Id. at 11.

28 Id. at 9.

29 Id. at 11.

30 See HALL & SHOAF, supra note 9 at 4.

31 KU, ET AL., supra note 6 at 11

32 HALL & SHOAF, supra note 9 at 4. Additionally, the study notes that health care positions are highly valued by communities, as they pay significantly more than minimum wage jobs, with many being professional-level positions.

33 KU, ET AL., supra note 6 at 14.

34 Id. at 16.

35 Id.

36 Id.

37 Id. at 15.

38 Id.

39 See HALL & SHOAF, supra note 9 at 6-7.

40 KU, ET AL., supra note 6 at 15.

41 Sommers, et al., supra note 7.

42 Kentucky implemented traditional Medicaid expansion, while Arkansas adopted an alternative plan in which the state uses Medicaid funds to purchase private insurance for newly eligible adults in the marketplace.

43 Sommers, et al., supra note 7 at 1503.


45 Sommers, et al., supra note 7 at 1506.

46 U.S. DEP’T OF HEALTH AND HUMAN SERVICES, supra note 43 at 5.

47 Id. at 6.

48 Id. at 6.


50 U.S. DEP’T OF HEALTH AND HUMAN SERVICES, supra note 43 at 8.
51 Id.
52 Sommers, et al., supra note 7 at 1503.
53 Simon, et al., supra note 46 at 20.
54 Stephen Luking, Please Expand Medicaid, NEWS AND RECORD (April 17, 2016), http://www.greensboro.com/opinion/columns/luking-please-expand-medicaid/article_de8f7c35-5846-5e6c-a259-2d3771ea14c2.html