

HEALTH REFORM IN NORTH CAROLINA

Lessons from the Past and Prospects for the Future

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"It is the intent of the General Assembly to: develop a universal health care program to provide all North Carolina residents access to quality health care that is comprehensive and affordable."

House Bill 729, Ratified July 14, 1993

We are now entering a time when health reform has become a very popular if unresolved issue. In 2008, both presidential candidates made promises that they would bring significant change to the way we pay for and organize health care. Candidate McCain spoke of major changes in how insurance was to be regulated and health benefits taxed with the goal of ensuring that all Americans would be covered by some form of insurance or would have a safety net system available to them. Candidate Obama had a different approach to achieving many of the same goals. The campaign discussions around health reform were often accompanied by warnings to both candidates to avoid the failures of the early 1990s when President Clinton tried to push comprehensive reform.

Meanwhile, several states have been pushing ahead with reforms of their own—Massachusetts has passed a broad mandate, California considered but defeated one—however North Carolina is not among those considering comprehensive change. This may be the case because North Carolina, like the nation, thought seriously about major reform in the early 1990s but gave up on the effort, and that shift has kept us from trying again. In the current discussion of reform, especially given the focus in the presidential campaign, we ought to reflect on the past and learn from what was effective and produced genuinely positive results. When state level reformers come together today, they spend a great deal of effort looking to Massachusetts and California. But there is a lot to learn from our own experience in North Carolina.

Health reform in North Carolina in the 1990s was the product of a relatively small group of legislative leaders who tried to capture the impetus of national reform efforts to change the way health care was organized, paid for, and delivered in the state. The North Carolina Health Planning Commission was created by the General Assembly at the close of the 1993 session and passed as Chapter 529 of 1993 Session HB 729, the Jeralds-Ezzell-Fletcher Health Care Reform Act. The Commission was given a high profile as it was chaired by Governor Hunt with Speaker Dan Blue and President Pro-Tempore Marc Basnight serving as vice-chairs. The other 13 members included Lieutenant Governor Dennis Wicker, and influential members of the Assembly including Senators George Daniel, James L. Forrester, Ted Kaplan, Beverly Perdue, and Sandy Sands along with House members Dub Dickson, Karen Gottovi, Joe Mavretic, Richard Moore, and Thomas Wright. Secretaries Robin Britt of Human Resources and Jonathan Howes of Environment, Health, and Natural Resources were also members of the Commission.

The Commission was charged by law with "developing a universal health care program to provide all North Carolina residents access to quality health care that is comprehensive and affordable." The Commission was to create that plan and present it to the General Assembly in its 1995 session. There were some caveats in the bill that made the implementation of a "universal health care program" contingent upon a "national mandate for universal coverage," or appropriate waivers from the Employee Retirement Income Security Act (ERISA), Medicaid and Medicare rules, or if the General Assembly determined it could implement a program within existing law. Still, it operated under an expression of anticipated, broad scale reform of the health care system.

The mechanism for generating the plan for reform was to create 17 separate committees charged with developing specific and actionable recommendations for the General Assembly. Those committees were co-chaired by a full member of the Commission along with a member of the public or a recognized expert in state government. They were created to represent the wide range of stakeholders who would have to be called upon to ensure the passage of system-wide reform legislation.

The Health Planning Commission made a number of specific recommendations that fell into seven major categories: (1) expanding coverage to the uninsured; (2) controlling rising health care costs; (3) expanding services in rural and urban medically underserved areas; (4) changing the focus of the current health system from a curative medical system to one that focuses on keeping people healthy; (5) ensuring high quality services; (6) establishing a data and information system capable of meeting the health information needs of the future; and (7) ensuring that the health needs of at-risk populations are met. There were many specific recommendations included in the final reports of the 17 separate advisory committees that met during 1994.

The Commission delivered its final report in December of 1994, but the General Assembly it reported to had a different party in control, new leadership, and no appetite for comprehensive reform. The election of November 1994 changed the landscape for national health reform as well as reform in North Carolina. Still, the Commission was able to promote some substantive changes in North Carolina law and actually held on through 1996 in a slightly revised form as the paradoxically renamed North Carolina Health Care Reform Commission. That Commission was charged by the General Assembly in its 1995 session to become a body that would "...monitor, evaluate, address, and study a variety of issues relating to...the health care delivery system in North Carolina...with the goal of improving the health status of all North Carolina citizens."

The first commission did generate positive legislative action, but it did so with an expectation that broader changes would come eventually. A general conclusion of the Health Planning Commission was that any reform would have to be incremental. For example, they recommended that a data council should be created to coordinate the complex adoption of electronic medical records—one of many specific recommendations that did not result in action but is still discussed and relevant today.

There were recommendations that did find their way into legislation that eventually passed, including expansion of health insurance coverage for children up to 200% FPG (through Medicaid and then later, the NC Health Choice program), expansion of Medicaid coverage for the elderly and disabled up to 100% FPG, expansion of home and community based services to enable persons to remain in their home or in community-based settings, expanding portability of health insurance coverage in the group and non-group market, tort reform (including pretrial screening by a qualified expert before filing a complaint), antitrust protection for providers, and improvements for rural health access. These were largely adjustments to the existing system and not what might be called broad reform.

Despite the fact that there was little actual reform legislation passed in 1994, the extensive hearings and working sessions that resulted in the sweeping array of proposals for health system improvement was testament to the utility of this form of participatory structure for giving useful guidance for policy. When the Commission reported in the fall of 1994, it was anticipated that further changes would be made in the next session of the General Assembly. However the 1994 election changed that landscape dramatically.

The "re-established" commission had a very different structure than the original body. The 12 members of the new commission was appointed by the Speaker of the House and the President Pro-Tem of the Senate and included as co-chairs Carmen Hooker Buell, then a government affairs representative for Carolinas Medical Center, Zeno L. Edwards Jr, a state representative from Washington, North Carolina, and a dentist. The members were drawn from the House (3), the Senate (2), and major stakeholder groups in health care in the state including the North Carolina Medical Society, Blue Cross and Blue Shield of North Carolina, and the North Carolina Academy of Family Physicians.

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The Health Care Reform Commission chose to limit its meetings and the topics it would cover to a list that included primary care, children and special populations, data collection, the Department of Health, rural health, allied health issues, network issues, and long-term care. These topics were discussed in a market context as the Commission felt that their task was to provide advice and information to assist market forces to restrain increases in health care costs and improve access.

The Health Care Reform Commission submitted its final report on December 31, 1996 after receiving a six-month extension on its charter. That report included some broad recommendations, such as, "by January 1, 2000, every child in North Carolina [should] have health insurance coverage," to very specific, "state employees should be allowed to purchase group rate long-term care insurance with flex accounts." The former recommendation has not yet been achieved but led to actions that would become part of the Children's Health Insurance Program, passed in 1998. The flex program recommendation eventually became available via the State Teachers and Employees Health Plan.

Since 1996, the General Assembly has not embarked on any further broad scale legislation for health care delivery and financing but has instead tended to respond to national trends and specific state issues. As the new national administration begins to turn its attention to health financing reform, if not system restructuring, the General Assembly may find that it too wishes to address a broader set of issues in a coordinated way. What we learned from the organization and operation of the two commissions was that the broad scale involvement of over 300 citizens and leaders in the committee process could develop realistic proposals that could make it through the General Assembly. We also learned that these needed more coordination and integration. There was not enough effort put into bringing all the specific parts together. We also developed good baseline information about the problems that still face us: information systems were key in 1993 and remain so in 2009 we still are faced with a need to develop and make use of electronic health records and other forms of health information technology. We learned that changes in health insurance regulation, especially those that affected networks of providers, must be coordinated with the realities of the delivery system. We also learned that we must shore up resources in prevention and primary care to make our health system effective. Many of the hearings and testimony in the summer of 1993 and through 1994 will be germane and instructive in the coming months if North Carolina chooses to embark on a broad scale improvement of our health system. **NCMJ**