



## Medicaid Expansion under the Affordable Care Act: SC Considerations

### **The current Medicaid program continues to grow.**

Even without expansion, the current Medicaid program is projected to need an additional \$2.4 billion of state funds between 2014 and 2020. Next year alone, the 2014 Executive Budget proposes \$156 million in new state funds for Medicaid.

Even without accepting expansion about 169,000 additional currently eligible individuals are expected to enroll in Medicaid in 2014-2015 due to other parts of the Affordable Care Act not affected by the Supreme Court decision.

States throughout the country—including those supposedly expanding—have actively been cutting Medicaid rates and services to balance their budget (California, Illinois, New York) or raising taxes to fund the current program (California). [See attachment, 1: Headlines from Other States.](#)

### **Medicaid expansion is not free.**

The best estimate is that 344,000 newly eligible people would enroll in Medicaid under expansion.

Costs are estimated between an additional \$613 million and \$1.9 billion of state funds. The range reflects the significant uncertainty in future increases in physician payments as well as the total participation in the program. For example, if employers drop coverage in larger numbers than projected, the cost will be at the higher end of the range.

Once the “teaser” rate of 100% federal funding for the first three years expires and is reduced to 90% in 2020, the annual cost to the state increases. Then, \$200 million or more state funds would be needed *each year* for Medicaid, above natural enrollment/inflation growth costs.

This all assumes the federal government will keep its promise of a 90% match. The federal government continues to debate budget cuts of trillions of dollars and both Medicare and Medicaid are on the table to be cut. Cuts to Medicare affect the state’s budget because when Medicare rates drop, there is pressure to raise Medicaid rates – especially for nursing homes. *The hospital association is already arguing we must expand because of the cuts to Medicare they agreed to under ACA. More is on the way.*

Connecticut took the option to expand early under ACA and it has already produced a deficit:

*“The state’s \$365 million budget deficit dates, in part, to two years ago when Connecticut became the first state to expand medical coverage to low-income adults as an early adopter of federal health care reform...Lawmakers discovered this week that it was a lot of state money when new figures showed that 61 percent of a \$365 million budget deficit is attributable to the state’s Medicaid population for the fiscal year that will end next June 30. The state’s Medicaid bill is more than 25 percent of Connecticut’s annual budget.”*

- Expanded Medical Coverage Large Part of State Shortfall  
Matthew Sturdevant, *The Hartford Courant*, November 19, 2012

### **We are not receiving our money's worth for our current health care spending.**

The Institute of Medicine estimates that 1/3 of national health care spending—\$750 billion in 2009 alone—is excess cost that contributes nothing to health. A few examples:

- A recent Centers for Disease Control and Prevention (CDC) study found that over 53% of the 67 million adults in the US diagnosed with high blood pressure did not have it under control. *89% of these individuals with out of control blood pressure identified having a regular source of care and 85% of them have health insurance.*
- While performance has steadily improved, South Carolina health plans and health providers still lag far behind the nation on Medicaid quality measures. For example, in CY2011 only 24 percent of adolescents received their recommended health screenings and only 46 percent of children received their recommended lead screenings; only 44 and 43 percent of women on Medicaid received their respective recommended breast and cervical cancer screenings; and for adults with diabetes South Carolina fell into the bottom 25<sup>th</sup> percentile of performance on four major diabetes care measures.

### **Medicaid Expansion is not the right solution to solve South Carolina's current health problems.**

Health is not the same as health services or health insurance. 80-90% of health is determined by income, education, personal choices, environment and social supports system. The remaining is solved by health services which are not guaranteed to be accessible or high quality just by having a Medicaid card. For example:

- The health of adult Medicaid beneficiaries varies widely according to geography of the state even though Medicaid is paying for health services in each case. *See attachment, 2: Diseases Among SC Medicaid Recipients Map.*
- In many states with overly generous benefits or eligibility limits—like California—the Medicaid budget is managed by lower physician rates which result in fewer physicians willing to see Medicaid patients even though they are “covered.”
- The projected expansion of about 521,000 citizens is equivalent to 200-300 full time physicians in South Carolina, yet most of the state is a physician shortage area and there is little in the ACA to increase physician capacity.

Even though these large health disparities exist in South Carolina—primarily between the more metropolitan and more rural areas of the state—the Affordable Care Act would send the vast majority of the money into the metropolitan areas that are healthier and less money into the rural areas that are less healthy.

Expansion would also the force the state to spend more of its limited revenue on health care services instead of improving education, creating jobs through infrastructure investments and training programs which ultimately contribute the most to health.

### **South Carolina's uninsured rate will be reduced by 71%, even without Medicaid expansion.**

Even without the Medicaid expansion, the state's rate of uninsured will still be reduced by 71%, dropping from a best estimate of 731,000 to 210,000. **95% of South Carolinians will have health coverage.**

About 521,000 citizens will get coverage either because they are already eligible for Medicaid but unenrolled, or by using premium assistance to purchase health coverage through the federal insurance exchanges. *See attachment, 3: Reduction in SC's Uninsured Without Medicaid Expansion.*

### **Federal payments to hospitals to care for the uninsured will not disappear.**

In fact, the Governor's 2014 Executive Budget actually increases the amount of reimbursement hospitals would receive for the uninsured.

No national DSH payment reductions under ACA even begin until 2017.

However, while the number of uninsured South Carolinians is expected to decrease 71% even without the Medicaid expansion, the current cap on national Disproportionate Share (DSH) hospital payments for the uninsured only drops 35% by 2020. This leaves hospitals in South Carolina fully compensated for their delivery of care to the uninsured beginning in 2015 under current policy. [See attachment, 4: Estimated SC DSH Reductions, 2014-2020.](#)

### **South Carolina's health care safety net for the uninsured will remain strong and will even expand.**

Many resources exist to serve the state's uninsured and receive enhanced funding through ACA.

- South Carolina's Federally Qualified Health Centers (FQHCs) serve about 130,000 uninsured (40% of FQHC's patients), spending almost \$200 million annually for these services. As the number of uninsured drop, funding for FQHCs remains the same.
- ACA sets aside \$11 billion in capital funds for FQHCs, and more than \$60 million in ACA funds have come to South Carolina FQHCs already.
- DHEC's county public health clinics serve about 170,000 uninsured (40% of clinics' patients), providing about \$111 million in services annually.
- Beyond these, private drug companies and other programs like Welvista offer free or low cost medication programs to the uninsured. **These and other resources will still be available** to serve the state's reduced uninsured population, even without the Medicaid expansion.

### **South Carolina employers, families and government already spend too much on health care – why is the hospital association arguing that even more health care jobs is the solution?**

In 1980 12.5% of every dollar in the United States was spent on health care, in 2010 that increased to 17.9% of every dollar. We spend twice as much as the average developed country on health care yet have lower life expectancy.

The Institute of Medicine states that this year-after-year growth in health care spending is depressing overall economic growth as employers have to spend more and more on health care; and that states increasingly have to forgo investments in education, infrastructure and public safety as more and more of each state tax dollar must go towards Medicaid and state employee health benefits

The evidence is clear – the continued growth in health care jobs is depressing job growth in other sectors of our economy. According to South Carolina's BEA, from 2000-2011, growth in health jobs was more than twice the number than the second sector (Professional Services). The health sector grew by almost 70,000 jobs during that time, while more than half the sectors had negative job numbers growth.

The hospital association argued under a similar 2011 economic impact analysis by the same USC professor that several thousand jobs would be lost if Medicaid cuts were implemented. In fact, the cuts were implemented, health jobs grew from 153,400 in April 2011 to 160,600 in October 2012, and thousands of health care jobs continue to go unfilled.

Now a second analysis paid for by the SCHA by the same professor argues not that if we cut we will lose jobs, but rather if we don't expand we won't gain jobs. The study suffers from critical limitations:

- Computer models don't reflect actual labor market conditions (such as our physician shortage);
- It presumes that the unemployed won't find jobs in other sectors if not in health care.
- It double counts the economic effects by not considering that significant money— such as DSH—already is in the system for the uninsured.
- It presumes that the health care sector is operating at maximum efficiency when it is not. For example, the Greenville Hospital System has performed analysis that shows their total service area has almost twice the number of hospital beds of an efficiently operating system – they are actually planning for a smaller system, not a larger system.

### **Much of ACA's billions in new taxes will still return to South Carolina.**

Several hundred billion dollars of new taxes are included in ACA. **The majority of our federal tax dollars will return to South Carolina**, even without the optional Medicaid expansion:

- An additional 0.9% Medicare tax on high-income earners goes to the Medicare Trust Fund and will return to the state since there are no changes to Medicare enrollment.
- An additional 3.8% investment income tax on high-income earners goes to the Federal Treasury and is not dedicated to health care spending, returning portions to the state possibly through military, education and infrastructure spending.
- Federal exchange subsidies and the current federal Medicaid match of 70% will support the 521,000 uninsured South Carolinians who get coverage through the federal exchange or growth in the existing Medicaid program.

### **South Carolina must first focus on improving the value we get for our health care spending.**

South Carolina Medicaid is successfully lowering costs and improving outcomes through provider and health plan payment reform, clinical integration of services and focusing on areas and populations in greatest need (hotspots).

Sufficient money exists in the system to meet the health needs of South Carolina's population if health care providers can deliver better value by lowering health care costs and improving outcomes. Lower health care costs lead to lower premiums. With lower premiums fewer employers will drop coverage and individuals will spend less money out-of-pocket and be more likely to afford care. The state can also extend care to needy populations with the same amount of money if the cost of that care is lower.

Spending should be focused where there is the most need – for example improving birth outcomes where there are significant disparities between black and White women or focusing on geographies which suffer from poor health due to a mix of circumstances such as provider shortages or low education attainment.