

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

### The growth of the current Medicaid program.

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 162,000 additional *currently* eligible individuals are expected to enroll in Medicaid in 2014-2015 due to other parts of the Affordable Care Act (ACA) not affected by the Supreme Court decision.

States throughout the country—including those planning to expand Medicaid—have actively been cutting Medicaid rates and services to balance their budgets (California, Illinois, Indiana, Maine, New York) or raising taxes to fund the current program (California).



### The cost of Medicaid expansion is between \$613 million and \$1.9 billion, 2014-2020.

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

Costs are estimated between an additional \$613 million and \$1.9 billion of state funds through 2020. 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 initial 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. The state is also responsible for 50% of the administrative costs related to expansion and must start paying that in 2014.

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.

### We need to focus first on improving the value our health care system delivers.

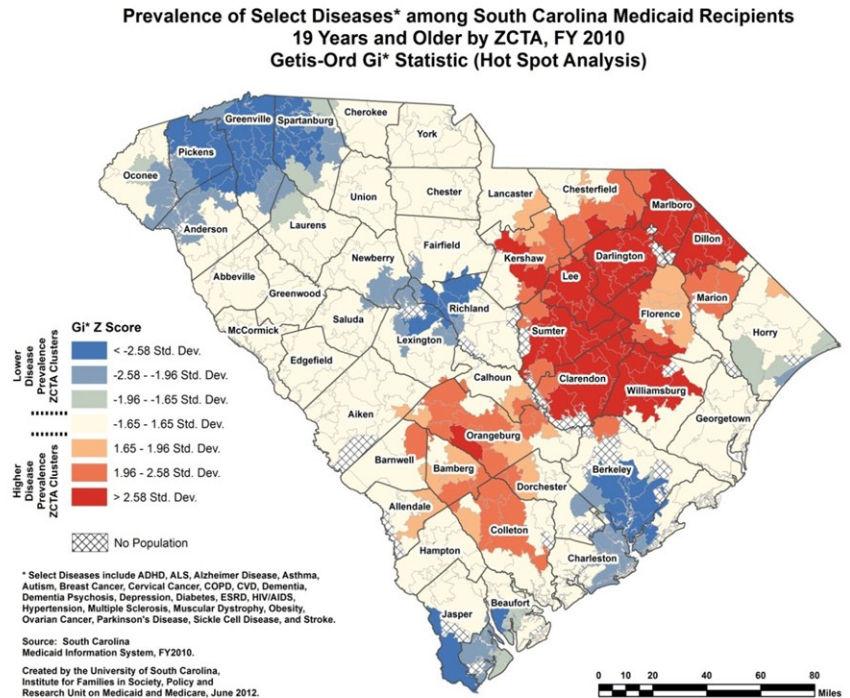
The Institute of Medicine estimates that 1/3 of national health care spending—\$765 billion in 2009 alone—is excess cost that contributes nothing to health. A few examples:

- 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 Medicaid health plans and health providers still lag far behind the nation on Medicaid quality measures. For example, in CY 2011 only 24% of adolescents received their recommended health screenings and only 46% of children received their recommended lead screenings; only 44% and 43% 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.

### Purchasing health coverage vs. purchasing health.

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 of high quality* just by having a Medicaid card. For example:

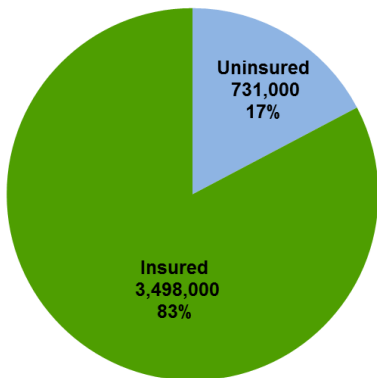
- The health of adult Medicaid beneficiaries varies widely according to geography of the state even though Medicaid is paying for health services in each case. *The red areas on this map indicate where South Carolina's health needs exist – yet the ACA Medicaid expansion puts the majority of money into areas with less need.*
- 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 (in Medicaid or the private market) would require 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. All states will be competing for new physicians. (See pie chart below.)



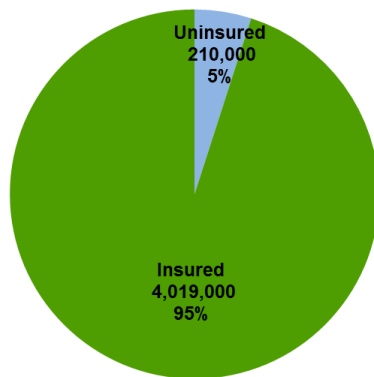
Medicaid expansion would also force the state to spend more of its limited revenue on health care services instead of improving education and creating jobs through infrastructure investments and job training programs which ultimately contribute the most to health.

### Even without expansion the number of uninsured in South Carolina will be reduced.

Pre-ACA: 2013 Uninsured



Post-ACA: 2014 Projected Uninsured



“Insured” is defined as having access to health coverage.

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

About 521,000 citizens could get coverage either because they are already eligible for Medicaid but unenrolled, or by using new tax credits to purchase health coverage through the federal insurance exchanges.

### **Hospitals are going to be paid MORE for uncompensated care – not less.**

If the number of people with access to Medicaid and affordable private insurance coverage increases by over 500,000, there is less need for Disproportionate Share Hospital (DSH) money.

National level DSH decreases should not affect South Carolina until 2017 and DSH is not expected to drop by more than 35% overall. Even then, with the large decrease in the number of uninsured, hospitals will actually end up being paid MORE for the uncompensated care they do have to deliver.

In fact, Governor Haley recently committed to pay for 100% of the uncompensated care for 19 rural hospitals in South Carolina. Right now only 57% of their uncompensated care is covered.

### **South Carolina's health care safety net for the uninsured is robust and will grow stronger.**

There are many resources in place for the current safety net, many of which receive enhanced funding through ACA to serve the state's uninsured.

- 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. While the number of uninsured drops, funding for FQHCs remains the same, leaving more funding to address the remaining uninsured.
- 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.
- These safety net programs could collectively be stronger as their funding remains, but the number of people served is significantly lower.

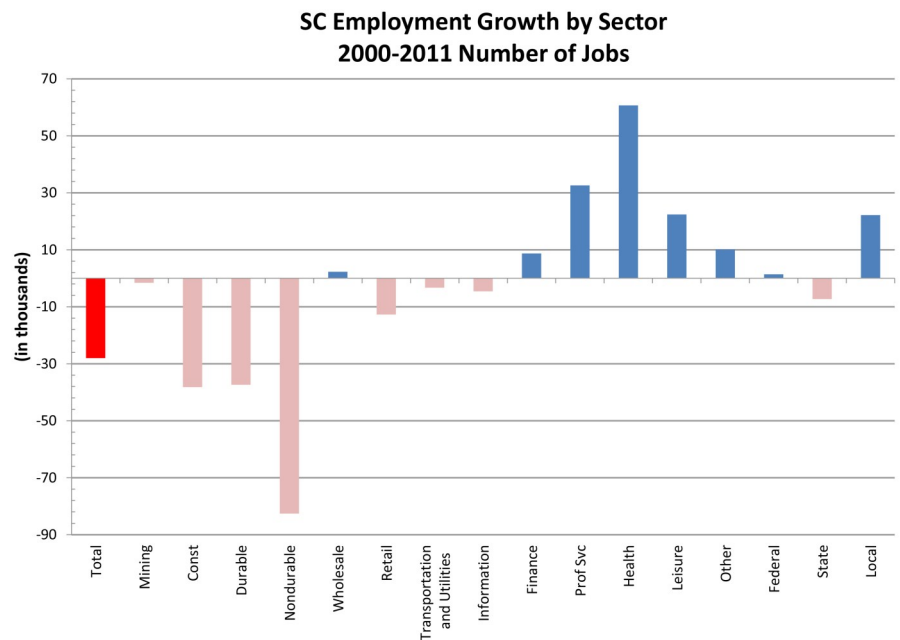
### **Health care vs. other economic and social investments.**

Health and social rehabilitation consumed 20% of South Carolina's General Fund in FY 2002. By FY 2012, this spending increased to almost 28%. Yet, in 2012 South Carolina ranked 46th in the nation in overall health.

The Institute of Medicine states that this year-after-year growth in health care spending is depressing overall economic growth as states have to spend more and more on health care. Thus, states 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.

*Continued growth in health care jobs can depress job growth in other sectors of our economy.* According to South Carolina's Board of Economic Advisors (BEA), from 2000-2011, growth in health jobs was about twice the number of the second sector

(Professional Services). The health sector grew by more than 60,000 jobs during that time, while more than half the sectors had negative job numbers growth.



Source: BEA

Even since recent spending reductions by the state Medicaid program, health jobs have grown from 153,400 in April 2011 to 160,600 in October 2012. Despite this growth, thousands of health care jobs continue to go unfilled.

In an independent peer review report on health care job growth in the United States, Georgetown University concluded that by 2020 5.6 million new health care jobs would be created in the United States **with or without Obamacare** – with 30% growth in South Carolina.

### **New taxes from ACA will return to South Carolina without Medicaid expansion.**

Several hundred billion dollars of new taxes are included in ACA, much of which **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, and may return through military, education, infrastructure and other spending.
- Tax credits through the federal exchange 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.

### **Better strategies for South Carolina.**

Debating the incremental effects of ACA nationwide is distracting legislatures and other policy makers from the fact that most current Medicaid programs are growing at an unsustainable rate. Last year alone the inflation and natural enrollment growth in South Carolina's Medicaid program was \$66 million in state funds.

South Carolina Health and Human Services is working to increase value by increasing efficacy and reducing cost per person through three major strategies: **payment reform**, **clinical integration** and **targeting hotspots and disparities**.

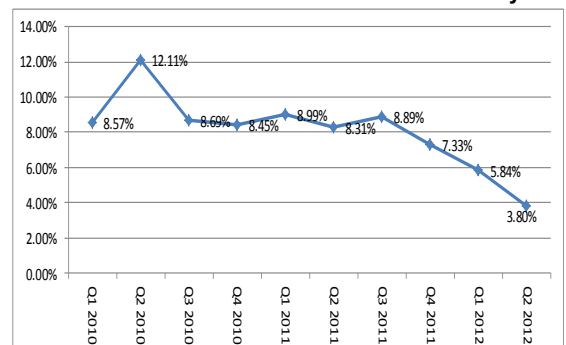
For an example of *payment reform*, South Carolina is demanding quality care for its citizens by offering financial incentives and penalties to improve quality and access.

When it comes to *clinical integration*, South Carolina is one of 15 states selected to design new coordinated care approaches for elderly individuals dually eligible for Medicare and Medicaid. The goals of the South Carolina Dual Eligible Demonstration Project (SC DuE) are to eliminate duplication of services, expand access to needed care and improve the lives of dual eligible individuals, while lowering costs.

Spending should be focused where there is the most need, *targeting hotspots and disparities*. Beginning next year, Medicaid-designated rural hospitals in South Carolina will be fully compensated through the Medicaid DSH program for their uncompensated care costs. By investing health care dollars in ways that most improve health, South Carolina provides greater resources when they are most needed without spending additional funds.

In the last year, non-medical inductions prior to 39 weeks were reduced by half as a result of SCDHHS's Birth Outcomes Initiative. Beginning in 2013, SCDHHS no longer provides reimbursement to hospitals and physicians for elective inductions or non-medically indicated deliveries prior to 39 weeks gestational age, leading to healthier babies in South Carolina. This example of *targeting disparities*, resulted in savings of \$6 million for first quarter FY 2013 alone.

**Medicaid Rates with Documented Elective Inductions  
as a Subset of the =>37 to <39 Weeks Delivery**



*For questions or more information, please contact*

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