

# Senate Medical Affairs ACA Subcommittee First Update

South Carolina  
Department of Health and Human Services

January 24, 2013

Many estimates are preliminary projections as of January 2013 and not considered final.  
These estimates may change as more state and federal data and guidance becomes available.

# Triple Aim

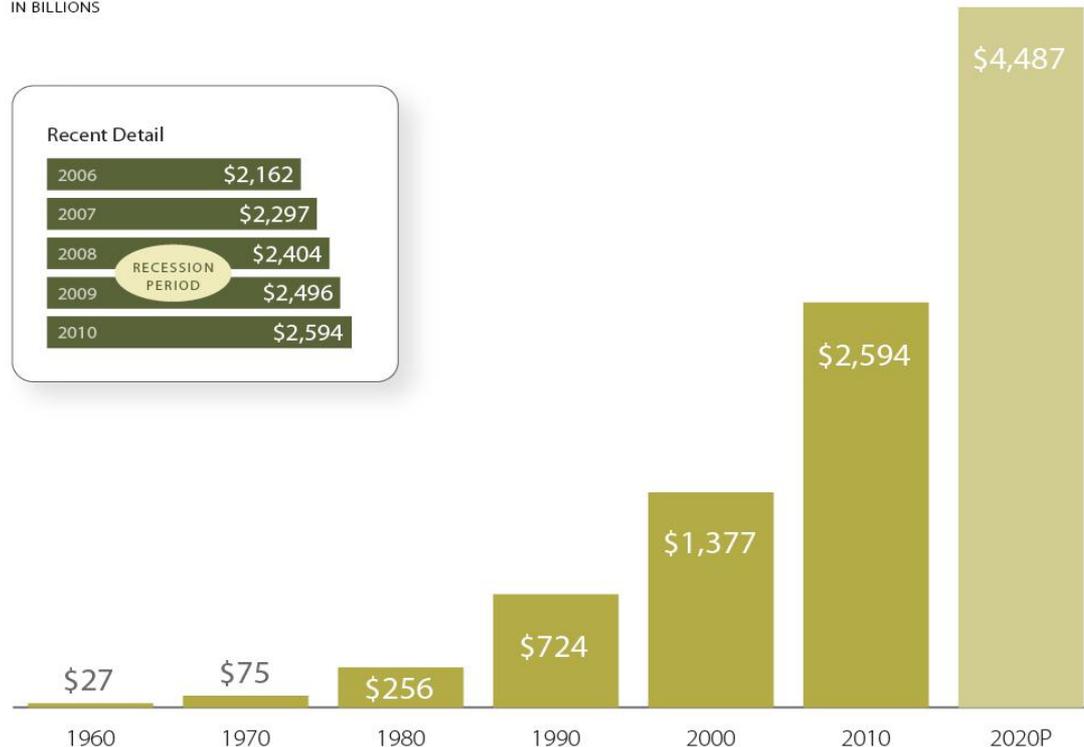
- Reduce the per capita cost of health care
- Improve the health of populations
- Improve the patient experience (quality and satisfaction)

# Constant Health Spending Growth

## Health Spending

United States, 1960 to 2020, selected years

IN BILLIONS



Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

*Total health care spending in the United States has nearly doubled or more every decade since 1960*

*In 2009, 2010 and 2011 health care spending grew 3.9% each year (record lows)*

*In each of those years real GDP grew -3.1%, 2.4% and 1.8%*

# There is Enough Money in the System

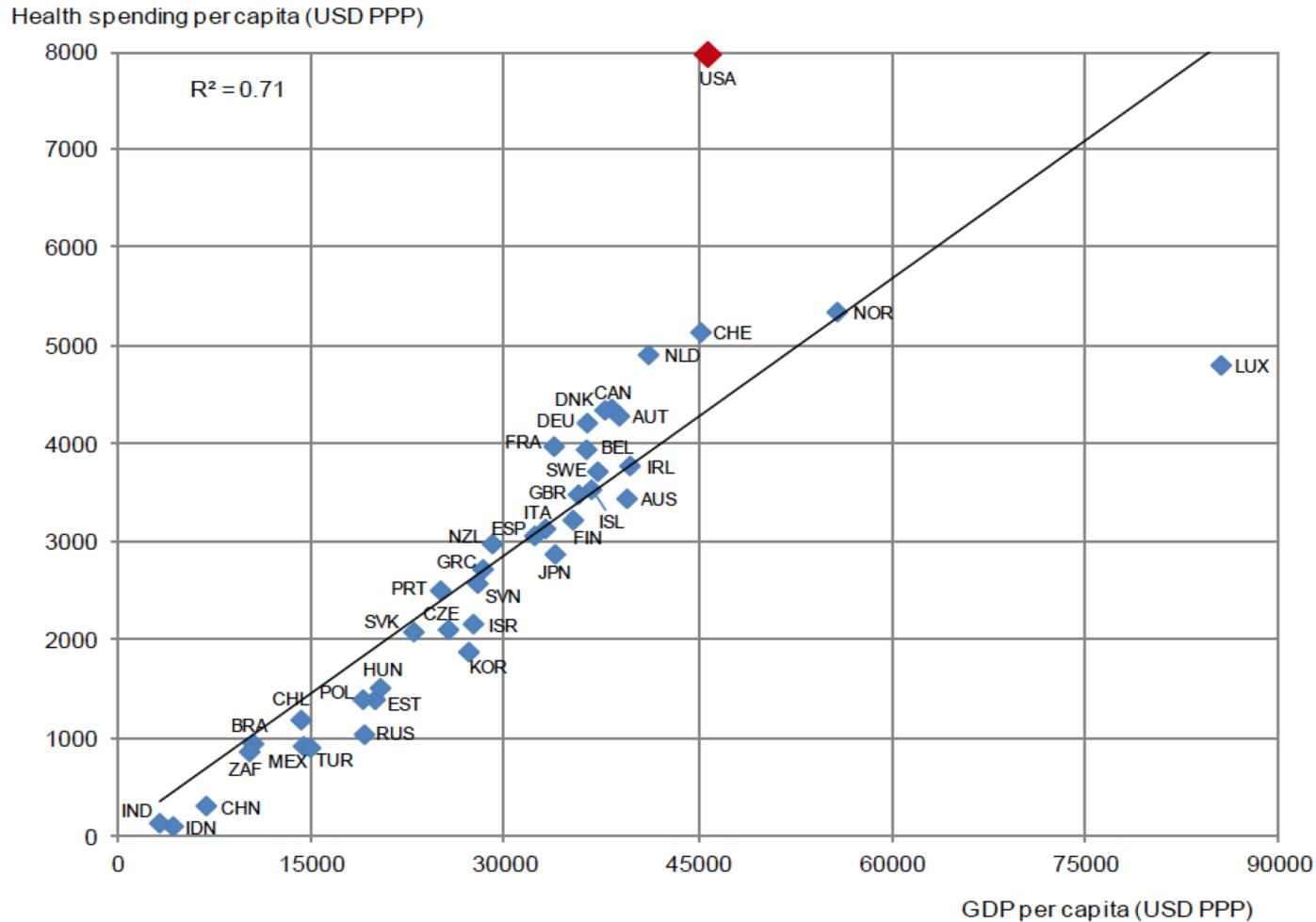
## Health Spending Per Capita and as a share of GDP Selected Developed Countries, 2010



Notes: US spending per capita as reported by OECD differs from CMS figures reported elsewhere in this report. Health spending refers to National Health Expenditures.

Source: Organization for Economic Cooperation and Development, *OECD Health Data 2012*, June 2012, [www.oecd.org](http://www.oecd.org).

**Chart 3: Total health expenditure per capita and GDP per capita, 2009 (or nearest year)**



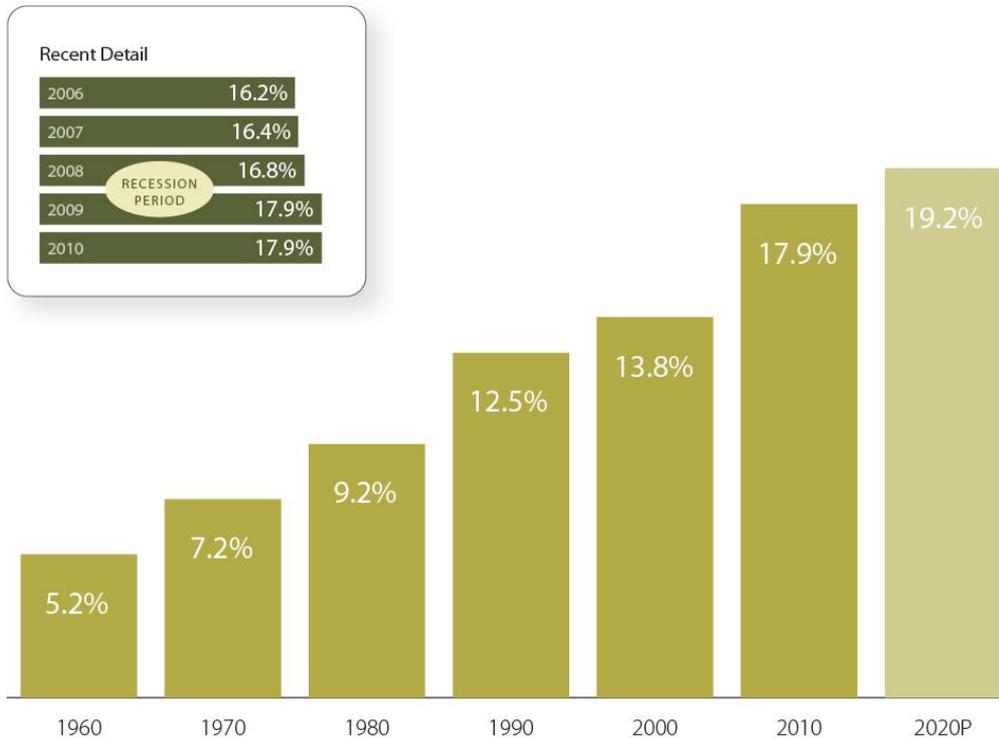
Source: OECD Health Data 2011.

# US Health Spending as a Share of GDP Grows Under ACA

*A larger portion of paychecks, payrolls and government budgets are going to health care every year*

*ACA continues growth through EHB mandates in the private market, subsidies and expansion with little cost control*

*Institute of Medicine estimates 1/3 of all health care spending is excess cost*



Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act. 2010 figure reflects a 4.2% increase in GDP and a 3.9% increase in national health spending. CMS projects national health spending will also have accounted for 17.9% of GDP in 2011 and 2012.  
 Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

# \$765B Excess Cost in 2009

- \$100B more than the entire US defense budget
- Sufficient to fully pay health insurance premiums for 150,000,000 people
- 1.5 times the total 2004 national infrastructure investment including roads, railroads, aviation, drinking water, telecommunications and other structures

*The Institute of Medicine's  
Six Domains of Excess Cost:*

*Unnecessary services  
(\$210B)*

*Administrative waste and  
duplication (\$190B)*

*Inefficient services (\$130B)*

*Prices that are too high  
(\$105B)*

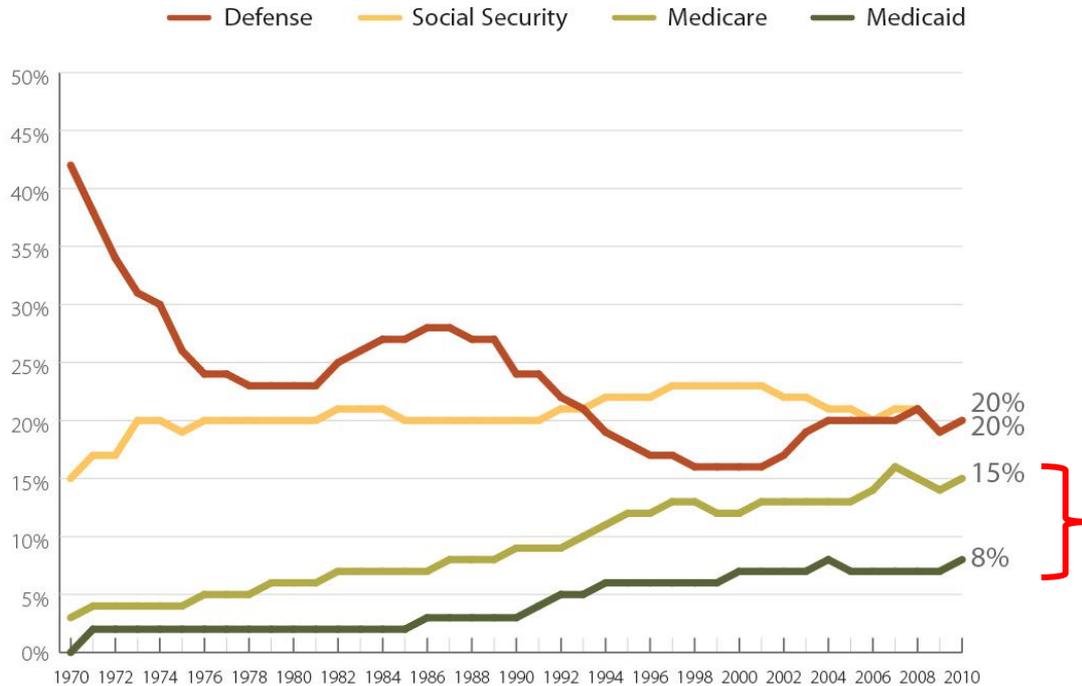
*Fraud (\$75B)*

*Missed prevention  
opportunities (\$55B)*

\*For the full Institute of Medicine report, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, visit the National Academies Press [website](#).

# Major Programs as a Share of the Federal Budget

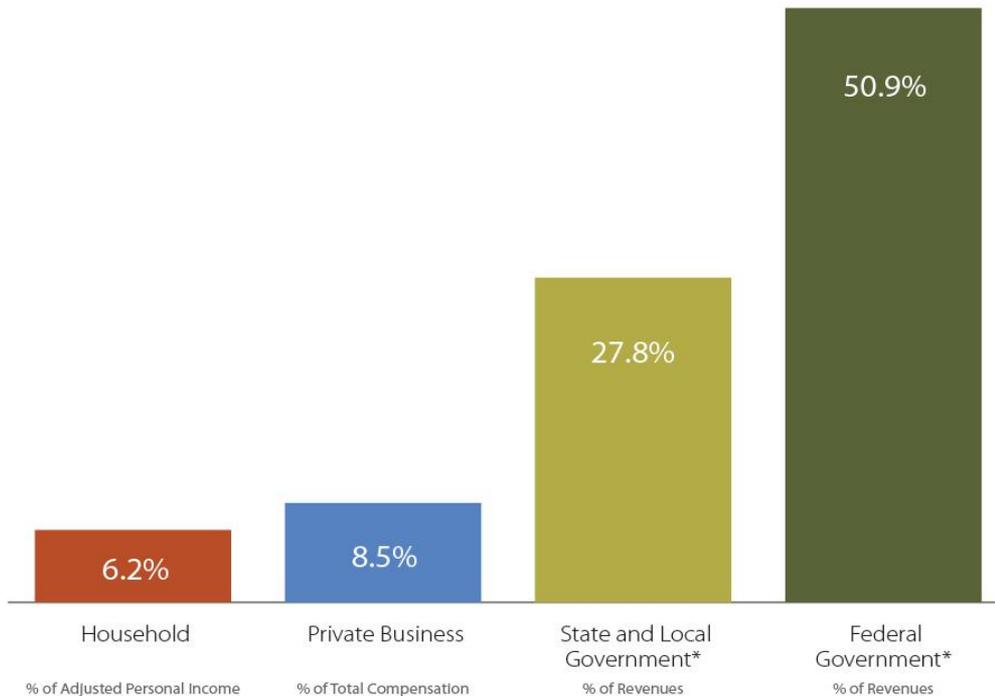
*Health care spending on Medicaid and Medicare now consumes 23% of the federal budget*



Notes: Spending shares computed as percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion of Medicaid).  
 Sources: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 to 2020*, January 31, 2012, Appendix F, "Historical Budget Data," [www.cbo.gov](http://www.cbo.gov).

# Major Programs as a Share of the Federal Revenue

## Health Care's Consumption of Contributor Resources United States, 2010



*50.9% of federal revenues for Medicaid and Medicare compared to 23% of the federal budget*

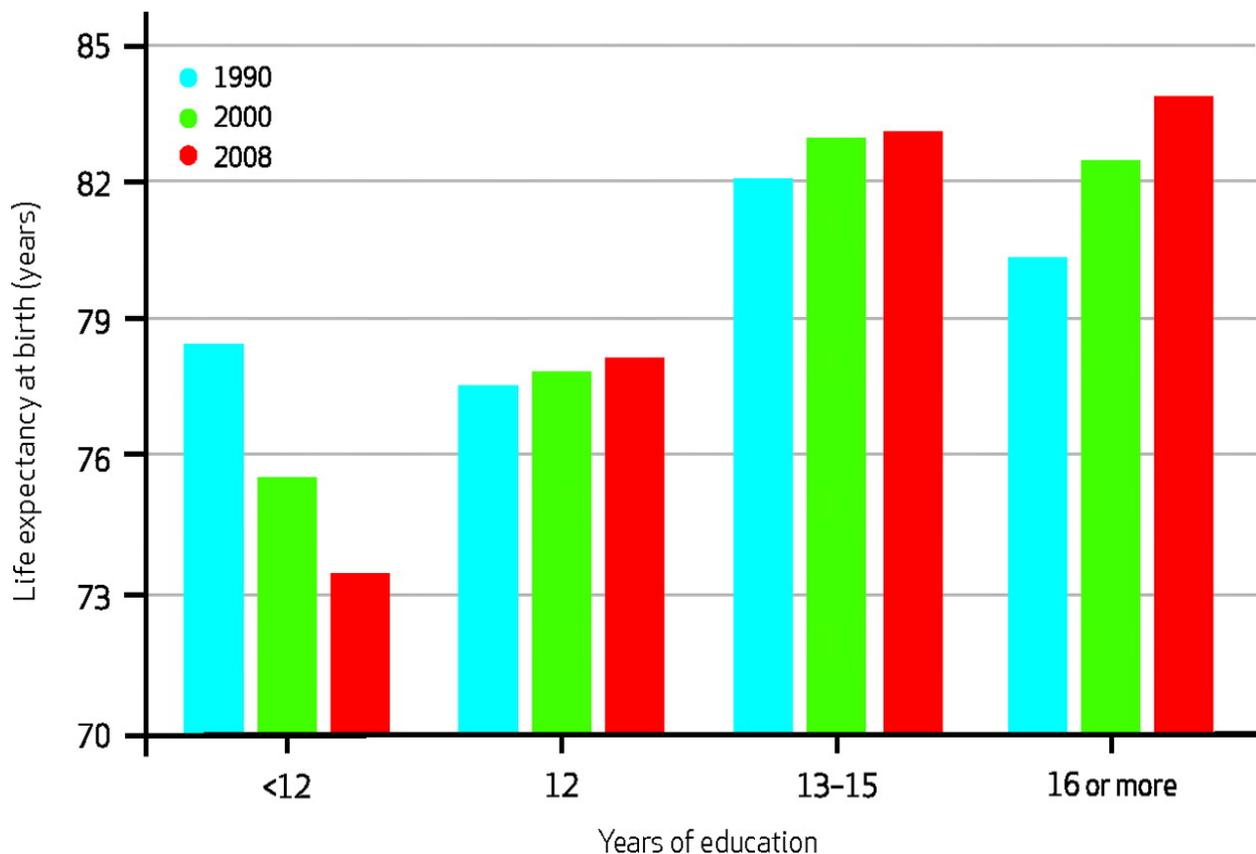
*The fine print: “due to borrowing, federal government revenues are less than outlays”*

*Even under ACA the federal government is still borrowing to pay for its health care promises*

\*Government revenues are receipts minus contributions for government social insurance; due to borrowing, federal government revenues are less than outlays.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

# US is Falling Behind in Life Expectancy

## Life Expectancy for White Women by Years of Education



*In 1950 US life expectancy ranked 12<sup>th</sup> at 68.9 years*

*In 2009 the US ranked 28<sup>th</sup> at 79.2 years*

*South Carolina ranked 42<sup>nd</sup> in US in 2007 at 76.6 years*

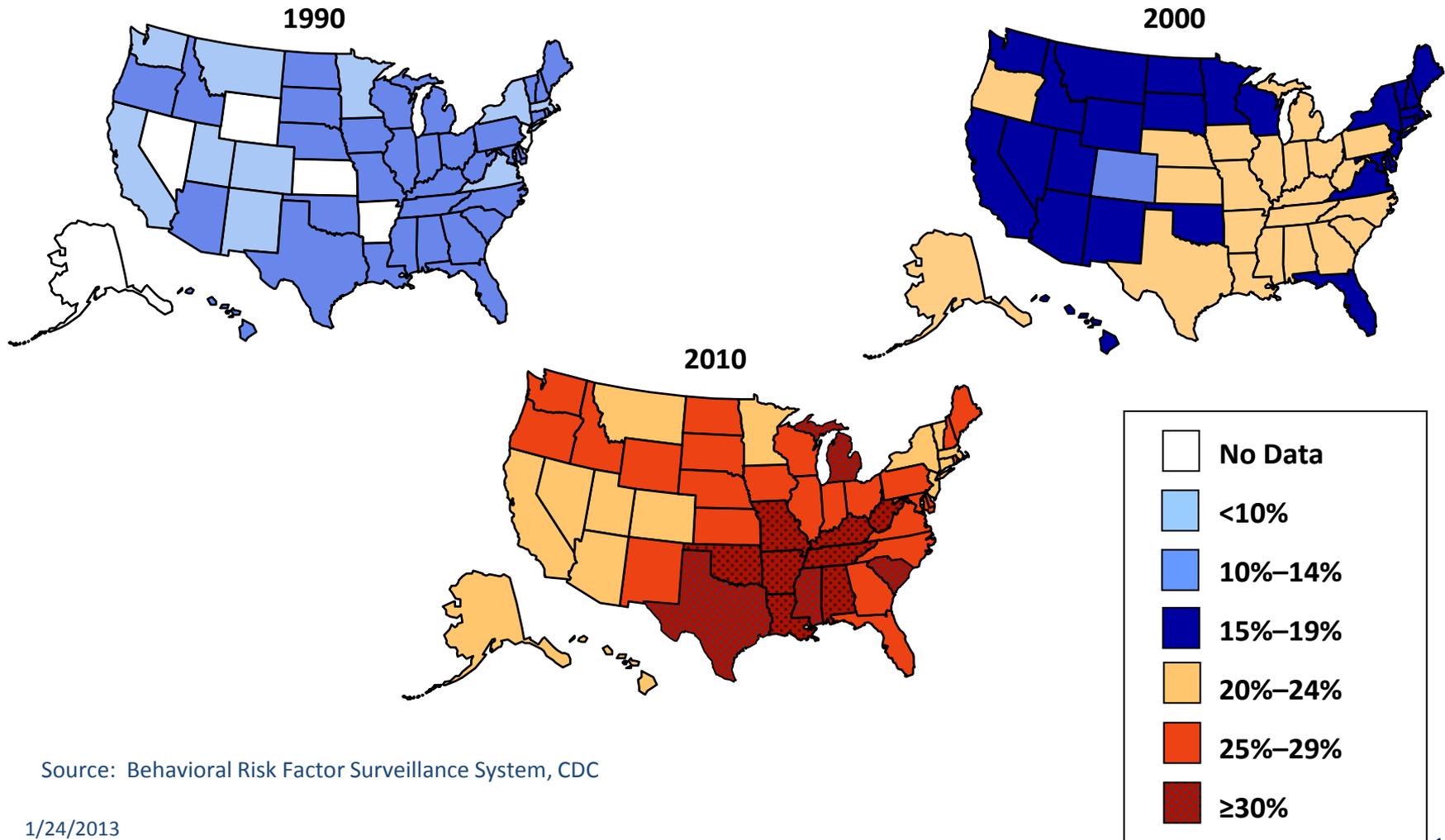
*Disturbing disparities exist, and for certain groups life expectancy has actually fallen in the past two decades*

Source: Health Affairs, August 2012

# Obesity Trends\* Among US Adults

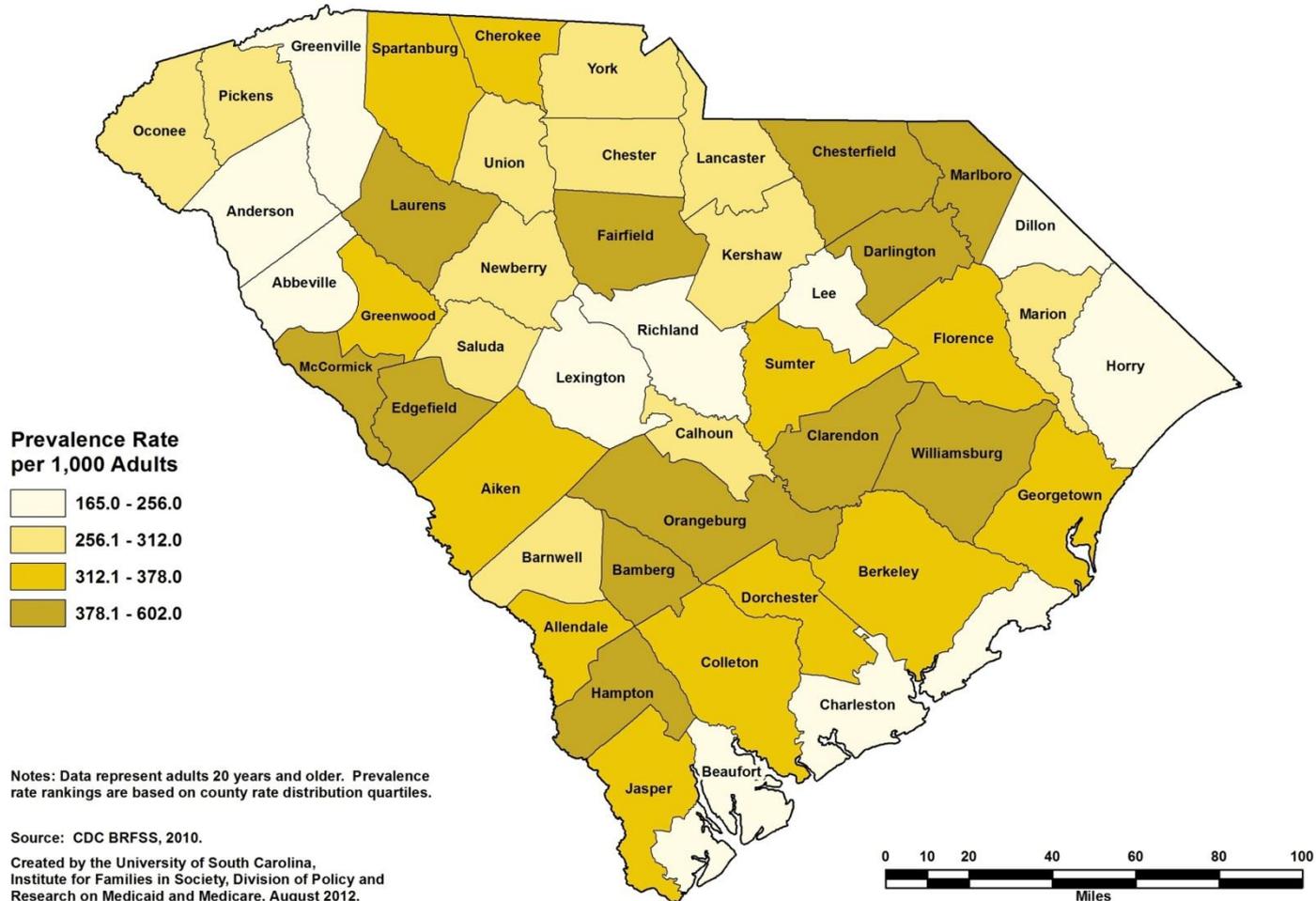
**BRFSS, 1990, 2000, 2010**

(\*BMI  $\geq 30$ , or about 30 lbs. overweight for 5'4" person)

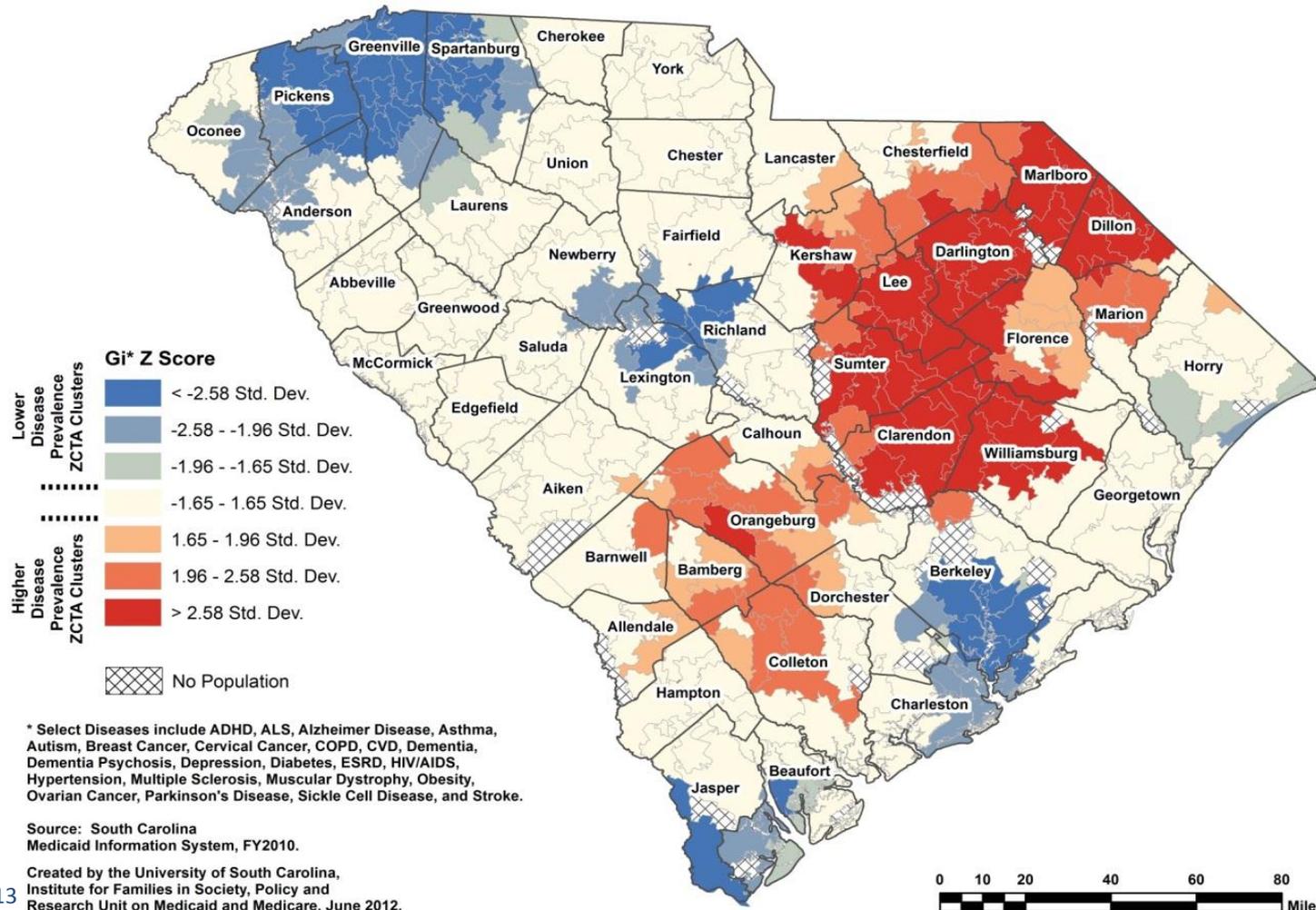


Source: Behavioral Risk Factor Surveillance System, CDC

## Prevalence of Obesity Among All South Carolina Adults by County



## Prevalence of Select Diseases\* among South Carolina Medicaid Recipients 19 Years and Older by ZCTA, FY 2010 Getis-Ord Gi\* Statistic (Hot Spot Analysis)



# ACA Overview and Impact

# SC ACA Timeline

- 2013
  - Temp bump in Primary Care Payments
  - January: State exchanges certified
  - Qualified Health Plans certified
  - October: Exchanges begin enrollment for Medicaid and qualified health plans for Jan '14
  - New Medicaid Application in place
- 2014
  - Individual Mandate/penalty/tax begins
  - Advance premium tax credits begin
  - Optional Medicaid Expansion
  - MAGI for eligibility determination, exchanges, streamlined enrollment
  - New rating rules for private insurance

*These are high-level program deadlines required by the statute that the public and many stakeholders will generally be aware of*

# Medicaid Expansion in SC: 513,000 New Enrollees by 2015

*Without Medicaid  
Expansion:*

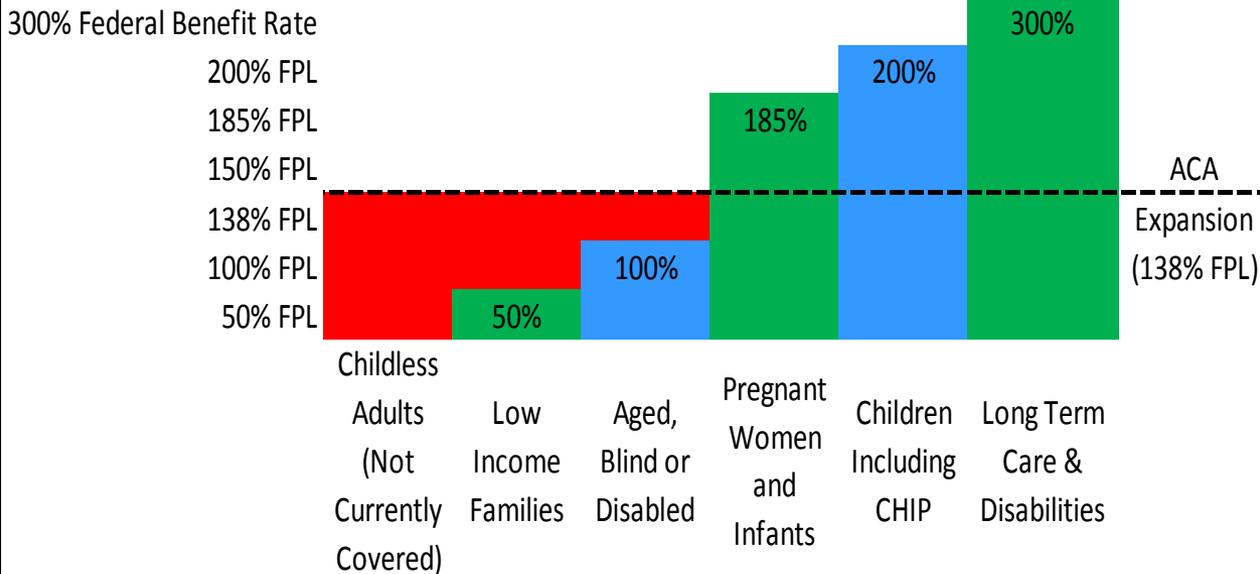
**101,000** may drop private  
insurance

**162,000** currently eligible  
but unenrolled will join  
Medicaid.

*With Medicaid Expansion:*  
**193,000** could drop private  
insurance to go on  
Medicaid

**344,000** people will  
become newly eligible for  
Medicaid

SC Medicaid Program Federal Poverty Levels (FPL)



# Medicaid Expansion in SC: 1.7M Enrollees by 2020



## *Without Medicaid Expansion:*

**101,000** may drop private insurance

**162,000** currently eligible but unenrolled will join Medicaid.

## *With Medicaid Expansion:*

**193,000** could drop private insurance to go on Medicaid

**344,000** people will become newly eligible for Medicaid

### Projected Enrollment Growth

Population	FY 2013	SFY 2014	FY 2020
<b>Current Programs</b>			
Medicaid	938,000	985,000	1,077,000
CHIP	70,000	74,000	80,000
<b>Total Current Programs</b>	<b>1,008,000</b>	<b>1,059,000</b>	<b>1,157,000</b>
<b>After ACA - 67% Average Participation</b>			
<b>Expansion Population (Newly Eligible)</b>			
Uninsured Parents/Childless Adults		252,000	267,000
Currently Insured Parents/Childless Adults		92,000	98,000
SSI		7,000	8,000
<b>Eligible but Unenrolled in Medicaid*</b>			
Currently Insured Children/Parents		101,000	107,000
Uninsured Children		13,000	14,000
Uninsured Parents		48,000	51,000
<b>Total Expansion from ACA Participants</b>		<b>513,000</b>	<b>545,000</b>
<b>Total Medicaid Population After ACA</b>	<b>1,008,000</b>	<b>1,572,000</b>	<b>1,702,000</b>

\* Estimates indicate that 162,000 people currently eligible but unenrolled will enroll in Medicaid even without the Medicaid expansion

Source: Milliman ACA Impact Analysis

# Current Medicaid Needs \$2.4B More 2014-2020

## Expanding Costs an Additional \$613M to \$1.9B



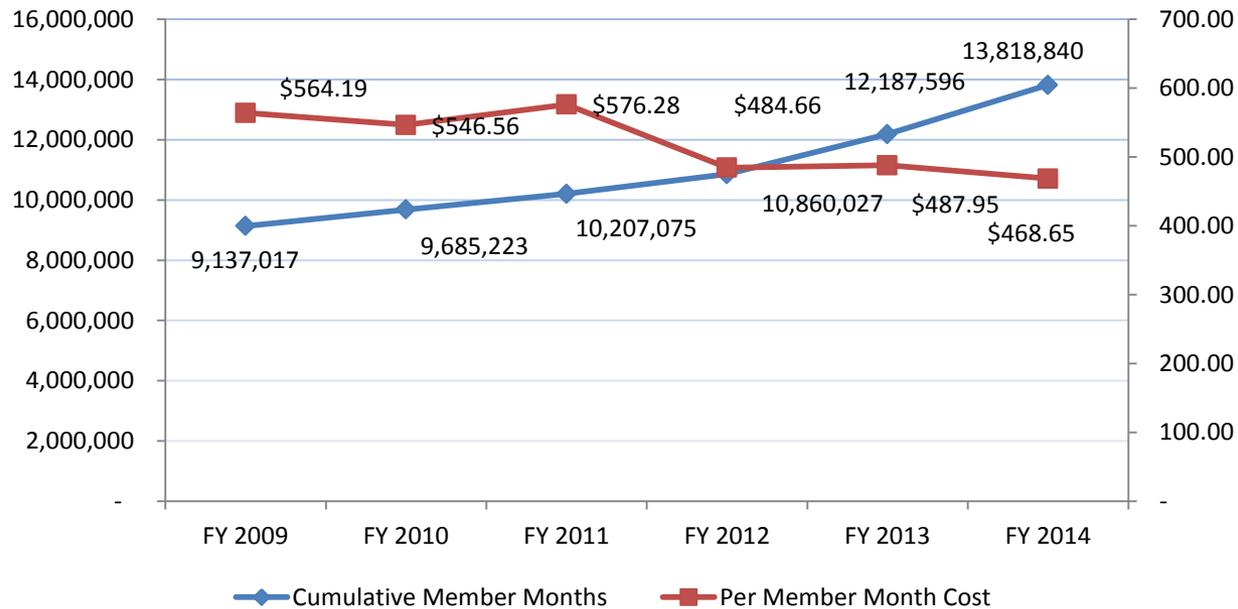
November 2012 Medicaid Expansion Projections SFY 2014 to 2020 (in \$ millions) - State Expenditures			
Category	Without Expansion – Welcome Mat Effect (Best Estimate Participation)	With Expansion to 138% FPL (Best Estimate Participation)	With Expansion to 138% FPL (100% Participation)
<b>Pre-ACA : Expected Program Growth</b>	<b>\$2,071.3</b>	<b>\$2,071.3</b>	<b>\$2,071.3</b>
ACA Impact to Current Program			
Pharmacy Rebate Savings – MCO	(\$477.3)	(\$477.3)	(\$477.3)
DSH Payment Reduction	(\$166.6)	(\$166.6)	(\$166.6)
CHIP Program – Enhanced FMAP	(\$128.6)	(\$128.6)	(\$189.9)
ACA Impact - Currently Eligible			
Eligible but Not Enrolled - Uninsured	\$520.5	\$520.5	\$746.6
Eligible but Not Enrolled - Currently Insured	\$476.4	\$476.4	\$790.3
CHIP Program – Enhanced FMAP	(\$66.3)	(\$66.3)	(\$97.9)
ACA Impact - Expansion Population			
Expansion Population - Uninsured	\$0.0	\$330.3	\$407.9
Expansion Population - Currently Insured	\$0.0	\$120.6	\$215.2
SSI Eligible	\$0.0	\$14.8	\$14.8
Health Insurer Assessment Fee	\$138.0	\$149.7	\$164.4
Physician Fee Schedule Change	\$3.5	\$3.5	\$3.6
Expenditure Shift from Other State Agencies	\$0.0	\$3.5	\$4.8
Administrative Expenses	\$61.1	\$193.4	\$285.5
<b>Sub-total</b>	<b>\$360.7</b>	<b>\$973.9</b>	<b>\$1,701.4</b>
Non-Medicaid Other State Agency Offsets	\$0.0	(\$43.7)	(\$61.4)
Sensitivity - Increase Physician Reimbursement to 100% Medicare	\$0.0	\$620.8	\$665.1
<b>Sub-total</b>	<b>\$360.7</b>	<b>\$1,551.0</b>	<b>\$2,305.1</b>
<b>Post-ACA : Expected Program Growth</b>	<b>\$2,432.0</b>	<b>\$3,622.3</b>	<b>\$4,376.4</b>

Source: Milliman ACA Impact Analysis

1/24/2013

# Budget Driver History

Comparison of Cumulative Member Months to Costs



*Cumulative member months are currently projected to grow 46% from FY 2009 to budgeted FY 2014*

*PMPM is currently projected to decline 14% from FY 2009 to budgeted FY 2014*

*Enrollment growth is our major cost driver*

Source: Milliman Spring 2012 Forecast and Department budget documents

# SC Medicaid Total Expenditures

*The Medicaid expenditures have grown 38.21% from FY2007 to FY2014.*

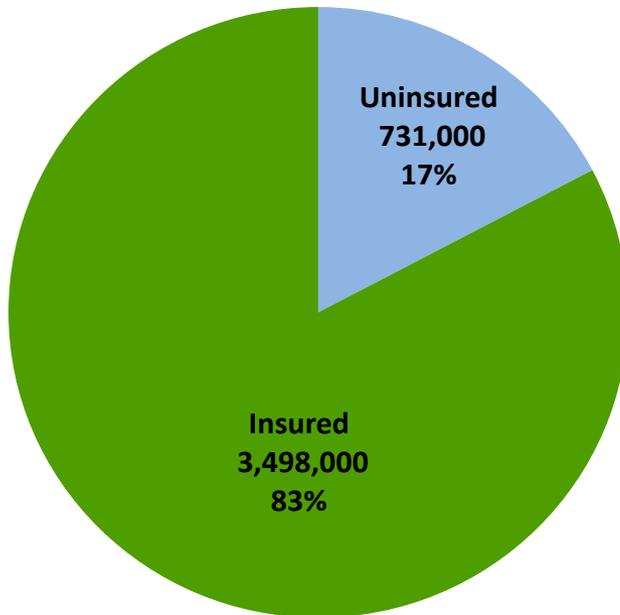
**Total Expended**



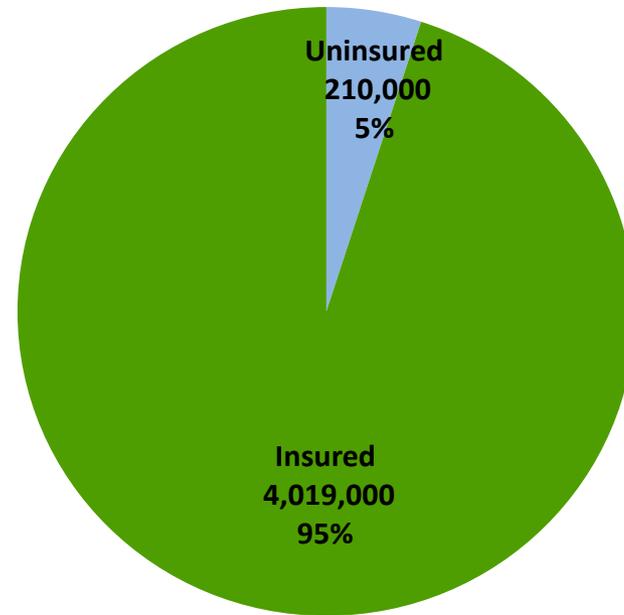
\* 2007-2012 are actual expenditures, 2013 and 2014 are projected expenditures.

# ACA Impact on SC Access to Affordable Health Insurance Coverage

Pre-ACA: 2013 Uninsured



Post-ACA: 2015 Uninsured



## By 2015

*Over half a million people will gain access to affordable health insurance coverage as defined under the new health care law*

*The system will have a difficult time absorbing this growth – it may require between 250-300 full-time physician equivalents*

# Income Profile of the Uninsured in SC

FPL	<100% FPL	100% FPL to 138% FPL	139% FPL to 200% FPL	201% FPL to 399% FPL	>400% FPL
<b>2012 Annual Income - Family of 4</b>	<\$23,050	\$23,051 to \$31,809	\$31,810 to \$46,100	\$46,101 to \$69,150	>\$69,150
<b>Uninsured</b>	284,000	106,000	131,000	127,000	83,000
<b>% of Uninsured</b>	39%	15%	18%	17%	11%

\* Source: 2011 American Communities Survey, projected to 2014

# How Will the Market Change with ACA's Optional Medicaid Expansion?

*Significant growth will occur in the number of insured adults in both the Medicaid and private market*

***71% (521,000) of SC's uninsured are projected to gain access to affordable health insurance even without Medicaid expansion***

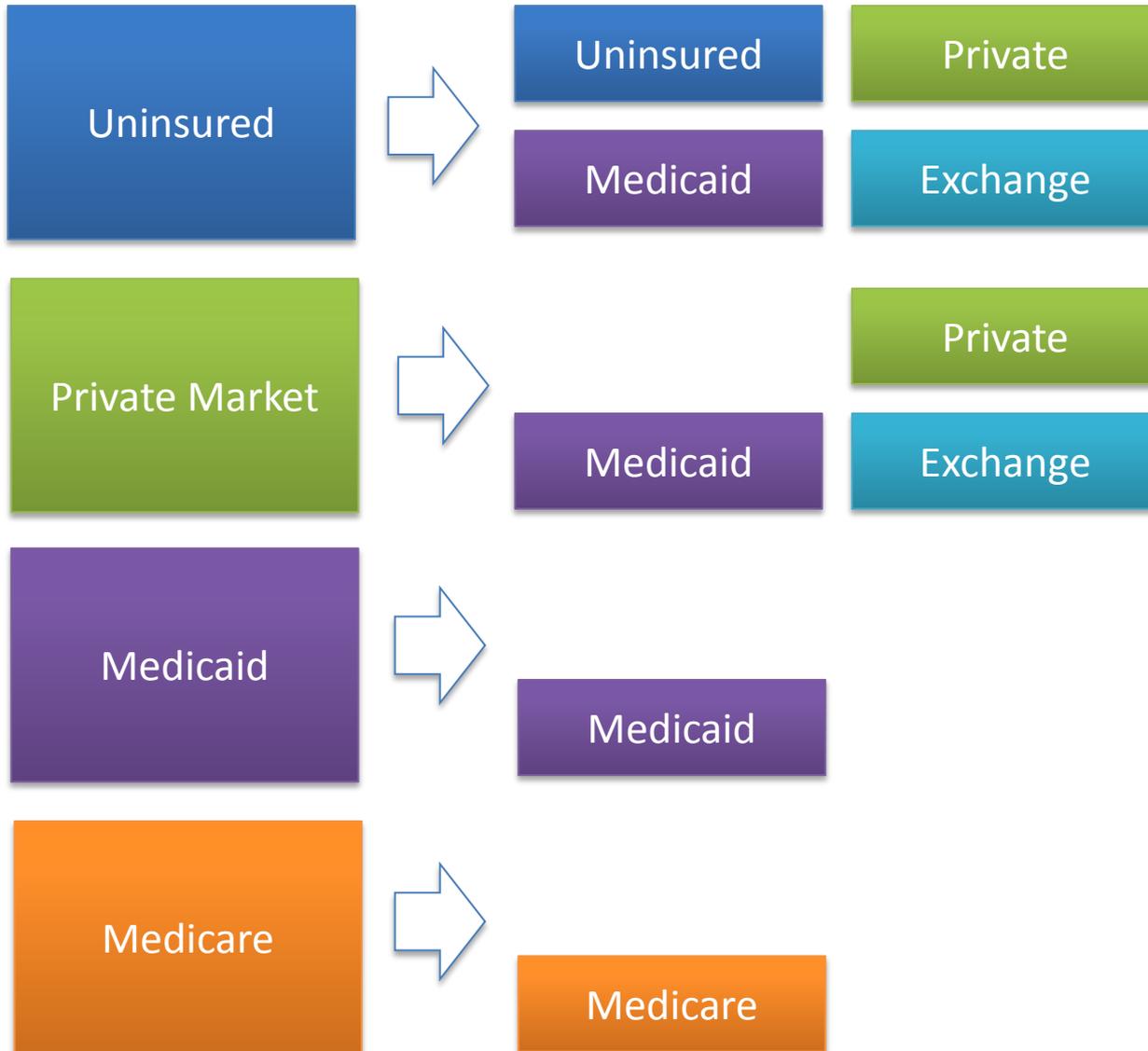
*This will inject significant new revenue into the health care system*

Category	Current Market	2014 No Expansion	2014 With Expansion
Uninsured	731,000	210,000	42,000
Medicaid	1,059,000	1,228,000	1,572,000
Private Market	2,439,000	2,358,000	2,266,000
Exchange	0	433,000	349,000
Medicare (Non-Duals)	657,000	657,000	657,000
<b>Total</b>	<b>4,886,000</b>	<b>4,886,000</b>	<b>4,886,000</b>

\* Non-citizens are not included in population numbers above

Source: 2011 American Communities Survey, projected to 2014

# How Will Payments Change After ACA?

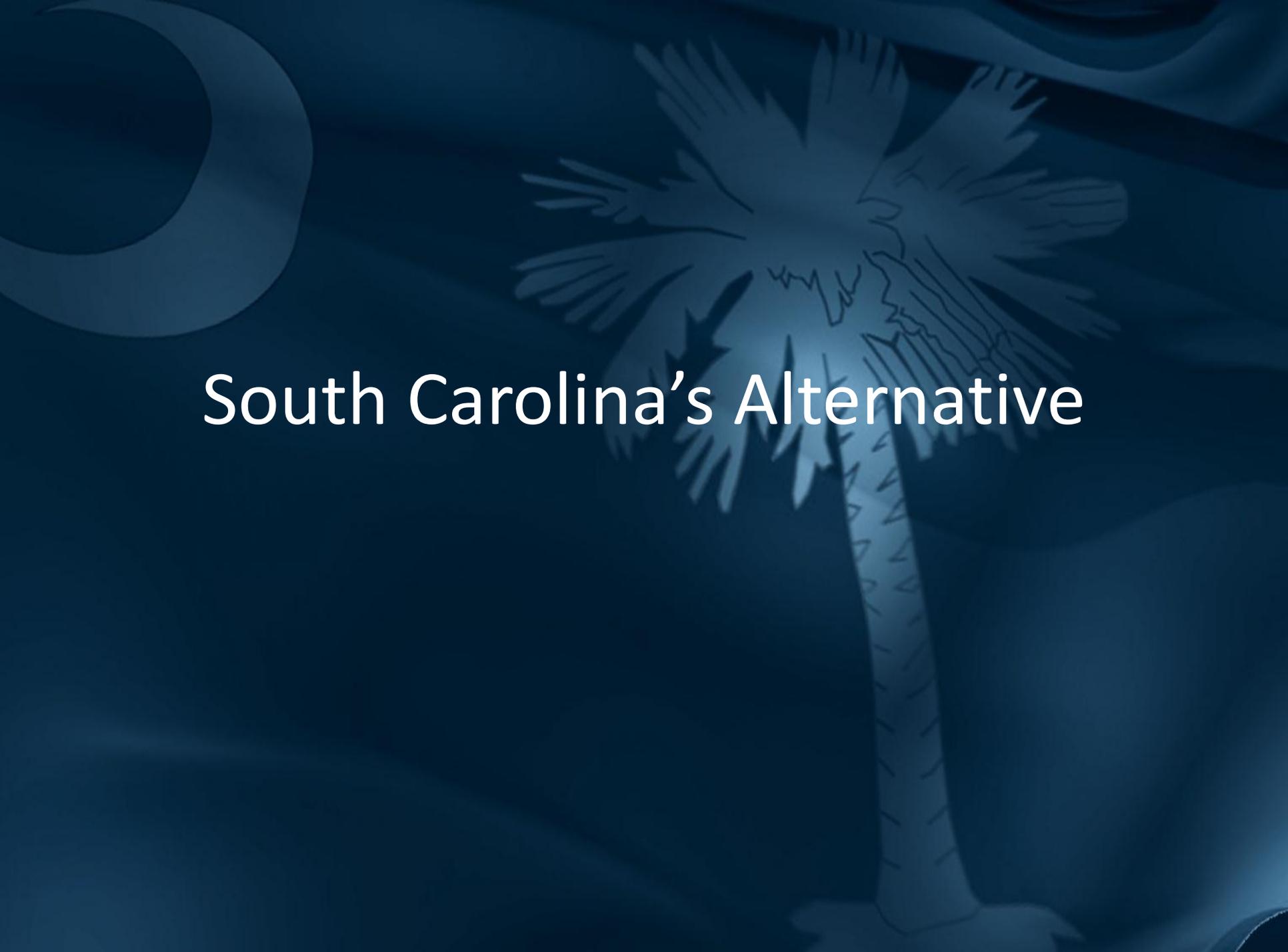


*Even without Medicaid expansion, the ACA will result in massive changes to the payor mix in SC*

*For example, the uninsured will gain insurance through Medicaid, federal exchanges or private market insurance*

*Hospitals are concerned about the net effect on their bottom line. Some changes pay more, some pay less*

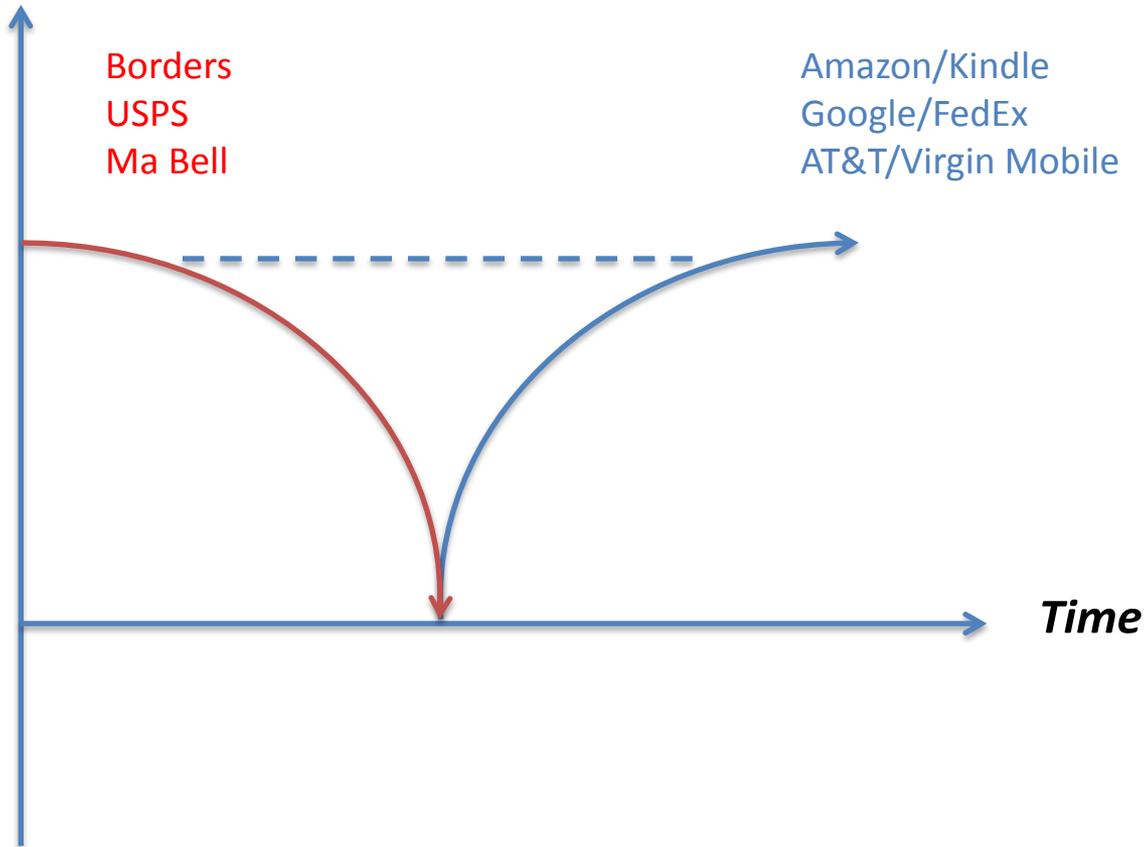
*Understanding changes in the private market is critical to the Medicaid budget*

The background is a dark blue gradient. On the left, there is a large, light blue circular shape with a darker blue center. On the right, there is a stylized palm tree with a textured trunk and a crown of fronds. The text "South Carolina's Alternative" is centered in white.

# South Carolina's Alternative

# Health Care Business Model Must Change

**Value**



*Business models have life cycles*

*Inpatient treatment is giving way to ambulatory treatment*

*Stand-alone providers are giving way to integrated services*

*How does the system bridge the gap without losing full value of the fixed investments?*

# SCDHHS Strategic Pillars

## Payment Reform

- MCO Incentives & Withholds
- Payor-Provider Partnerships
- Catalyst for Payment Reform
- Value Based Insurance Design

## Clinical Integration

- Dual Eligible Project
- Patient Centered Medical Homes
- Behavioral Health
- Telemedicine/Monitoring

## Hotspots & Disparities

- Birth Outcomes Initiative
- Express Lane Eligibility
- Foster Care Coordination
- Convenient Care Clinics
- Community Health Workers

*Improve value by lowering costs and improving outcomes:*

*Increased investment in education, infrastructure and economic growth*

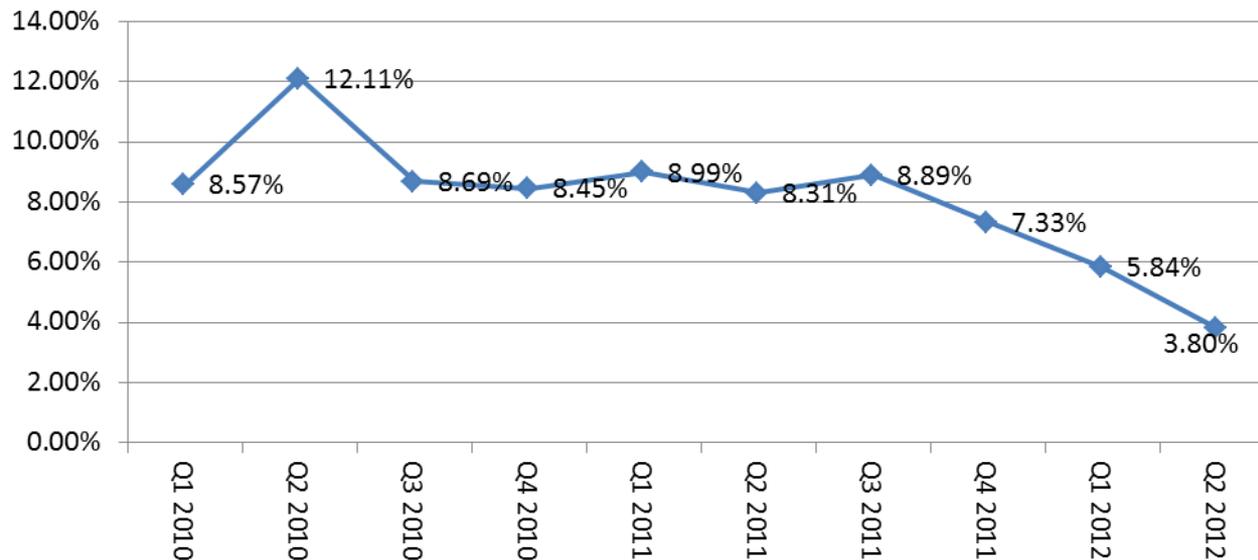
*Shift of spending to more productive health and health care services*

*Increased coverage/treatment of vulnerable populations*

*An emphasis on public health*

# Hotspots & Disparities: Birth Outcomes Initiative

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



*In July 2011, SCDHHS implemented a series of birth outcome initiatives to reduce the number of elective inductions and cesarean deliveries, as well as NICU hospital stays*

*SC is one of the first states in the nation to no longer pay for early elective deliveries; last year these harmful deliveries were reduced by half*

**Milliman estimates savings of \$6M for first quarter FY 2013**

# Governor's Investment in Rural Hospitals



	Rural Area Designation					
	CAH	Isolated	Small	Large + HPSA	Large W/O HPSA	Large - TLB of 90 Or Less
Number of Facilities	5	2	6	3	11	3
Total Number of Beds (HFY 2011)	125	90	302	315	1,835	229
Percent Change 2008-2011	-18.30%	-19.49%	-24.49%	-12.49%	-8.85%	-15.71%
# Losing Bed Days 2008 - 2011	4	2	5	3	9	3
2011 Total Occupancy Rate	18.49%	48.01%	31.74%	28.46%	50.68%	37.51%
2011 Percentage of Medicaid Days	8.25%	16.47%	21.01%	20.49%	19.77%	24.52%
4 Year Cumulative Profit (Loss) \$	(\$7,141,295)	(\$31,459,033)	\$34,363,582	(\$33,767,551)	\$381,308,641	\$9,983,161
# Operating at a Loss 2008 - 2011	4	2	4	2	0	1
# Operating at a Loss 2011	2	2	3	2	2	1

# A Path Forward

- Continue working on improving value in the health system
- Manage and measure mandated Medicaid and private market enrollment growth under ACA
- Set performance expectations for the health system to improve value
- Invest in health hotpots
- Apply for flexibility in 2017 when ACA waivers are available

***The amount of implementation risk is significant***

***Just expanding coverage does not mean meaningful connection will be made between providers and patients***

***Projection risk is very high***

***A conservative budget approach is imperative***

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Additional Slides

# DSH Payments for Uncompensated Care

- DSH pays hospitals for the cost of uncompensated care (UCC). This year SCDHHS will pay \$461.5M in DSH which covers about 57% of UCC.
- Even without Medicaid expansion the number of uninsured will decrease as coverage from federal health insurance exchanges and Medicaid grows, ***so not as much DSH will be needed in the future.***
- DSH is just one type of hospital payment. If a limit is placed on how much federal money can be spent on DSH, the state can simply shift its matching dollars to other types of hospital payments.

*Federal reductions under ACA do not begin until 2017*

*The executive budget for SFY 2014 doesn't reduce DSH payments*

*This results in extra payments to hospitals and provides transition funds the hospitals requested*

*The Governor has committed to reimbursing rural hospitals 100% of uncompensated care*

# The Taxes Leaving SC Argument is Overstated

- Several hundred billion dollars of new taxes were passed to fund the ACA
- Some argue that none of this will return if we don't expand. This is untrue:
  - An additional 0.9% Medicare tax on high-income earners (\$200k single/\$250 married) will go to the Medicare trust fund and **will return** since there are no changes to Medicare enrollment
  - An additional 3.8% investment income tax on high income earners (\$200k single/\$250k married) goes into the federal treasury. It may be used to reduce federal deficits or **return to SC** through military spending, education, infrastructure, etc., not exclusively health care
  - 71% (521,000) of SC's uninsured are projected to gain access to affordable health insurance coverage under federal exchanges and through growth in the current Medicaid program. These populations will be generously subsidized through federal tax credits or our current FMAP **so the revenue will return**

*Even with these taxes, federal spending will still run a deficit. The CBO only projects a shrinking of the federal deficit due to ACA – not an elimination*

*The CMS actuary believes it is unlikely that the Medicare reimbursement reductions will happen as planned, requiring cuts elsewhere (like Medicaid)*

*The federal government looks ready to raise taxes even further in next few months to help pay for deficits – not spending*

# SCHA Jobs Report

- Harvard economist Katherine Baicker – who has conducted studies showing Medicaid improves health – also writes in an article ***The Health Care Jobs Fallacy***:
  - “...this focus on health care jobs is misguided.”
  - “Salaries for health care jobs are not manufactured out of thin air – they are produced by someone paying higher taxes, a patient paying more for health care, or an employee taking home lower wages...”
  - “Additional health care jobs leave Americans with less money to devote to college tuition and mortgage payments, and the US government with less money to perform all other governmental functions.”

***USC performed a similar analysis in 2011. SCHA argued Medicaid cuts would cost several thousand jobs***

***After the cuts health-care jobs in SC increased several thousand from 153,400 in April ‘12 to 160,600 in Oct. ‘12 (DEW)***

***Georgetown University projects health care jobs will grow by 5.6M with or without ACA***

# SCHA Jobs Report

- Impact analysis generally ignores constraints on the labor market (such as physician and nurse shortages). Their job growth is theoretical.
- Impact analysis ignores the fact that jobs created in the analysis could have been created elsewhere, and in fact compete, in other sectors (such as transportation).
- Impact analysis assumes that the market under analysis is operating at the desirable efficiency, which health care clearly is not.

*The report double counted several hundred million dollars of annual spending on the uninsured, considering “out of scope”*

*The report did no sensitivity analysis, considering it “out of scope”*

*The report considered labor constraints in SC “out of scope”*

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End