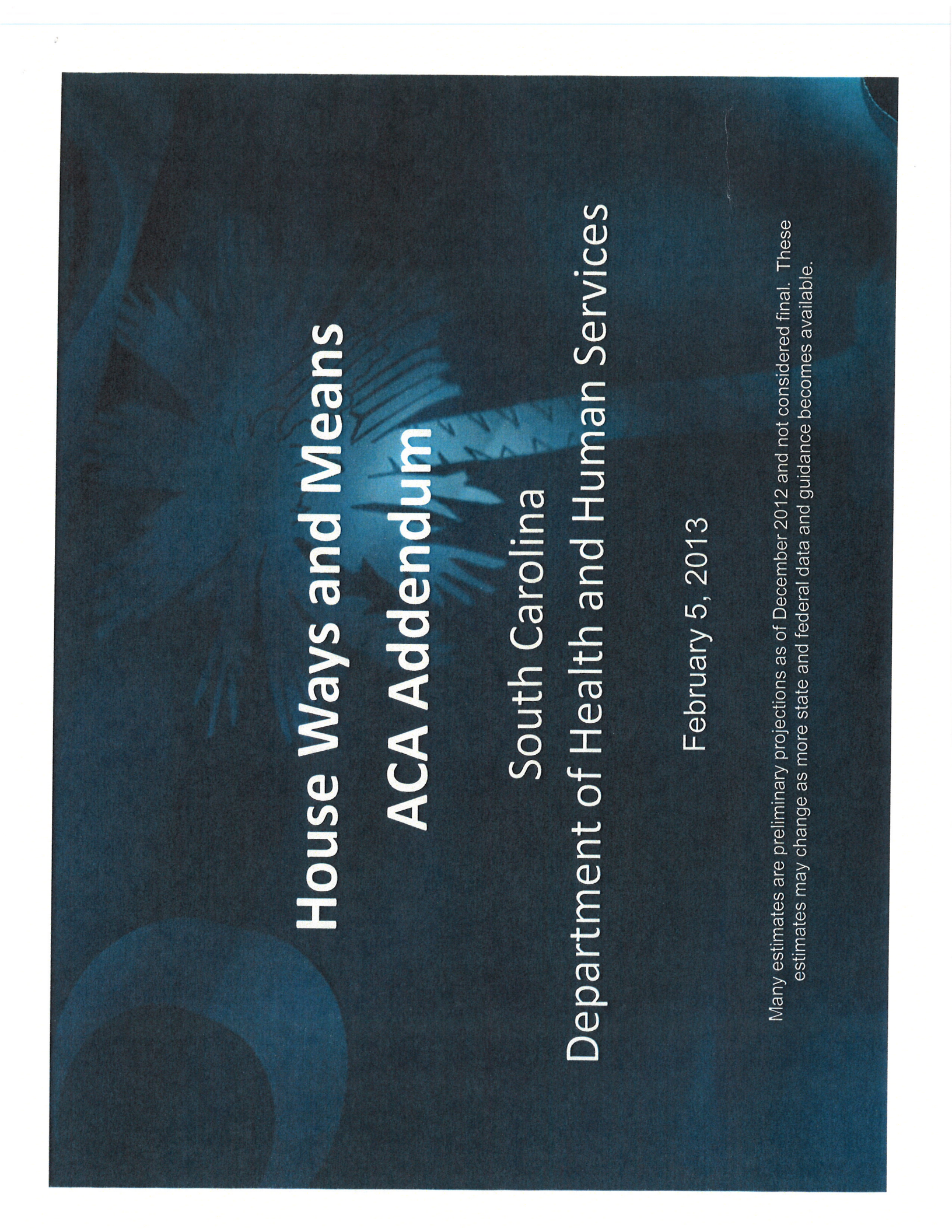




House Ways and Means ACA Addendum

South Carolina Department of Health and Human Services

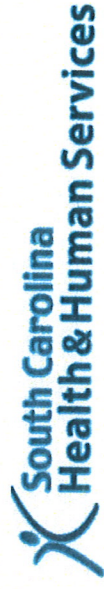
February 5, 2013

Many estimates are preliminary projections as of December 2012 and not considered final. These estimates may change as more state and federal data and guidance becomes available.

Triple Aim

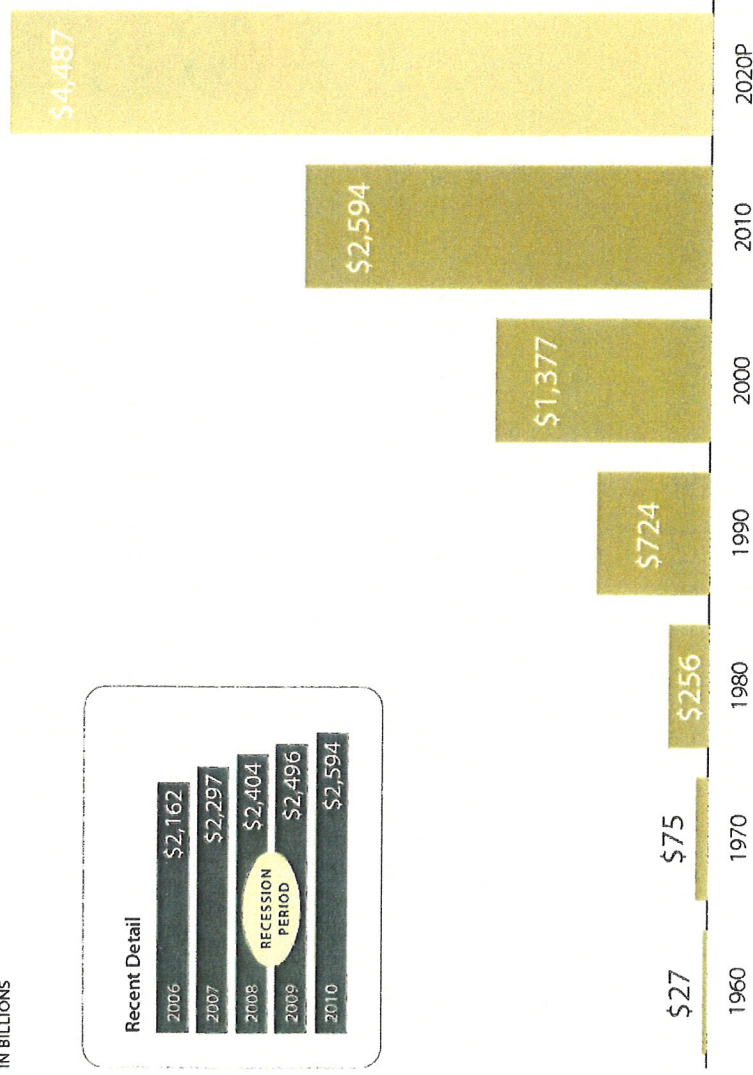
- Reduce the per capita cost of health care
- Improve the health of populations
- Improve the patient experience (quality and satisfaction)

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.

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2/5/2013

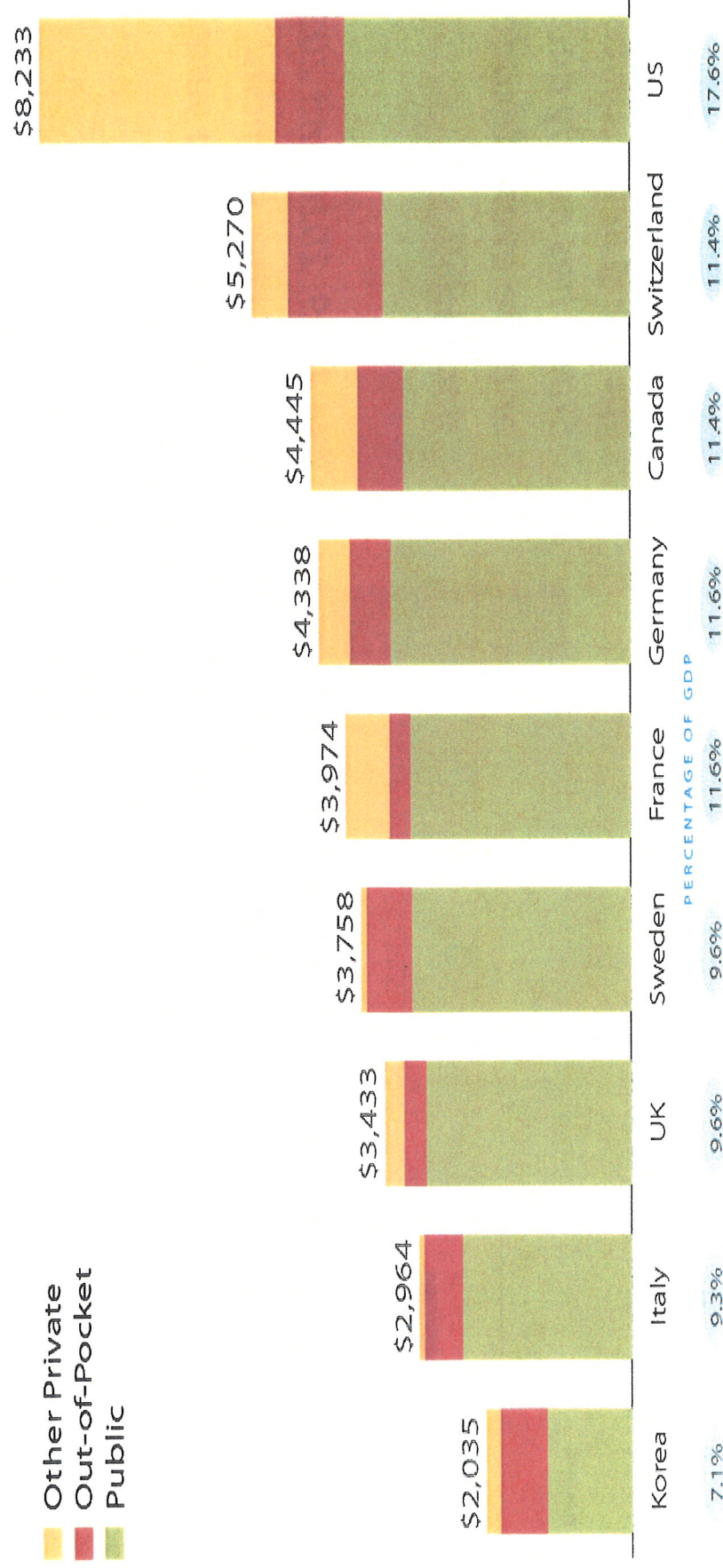
Total health care spending in the United States has nearly doubled or more every decade since 1960.

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%

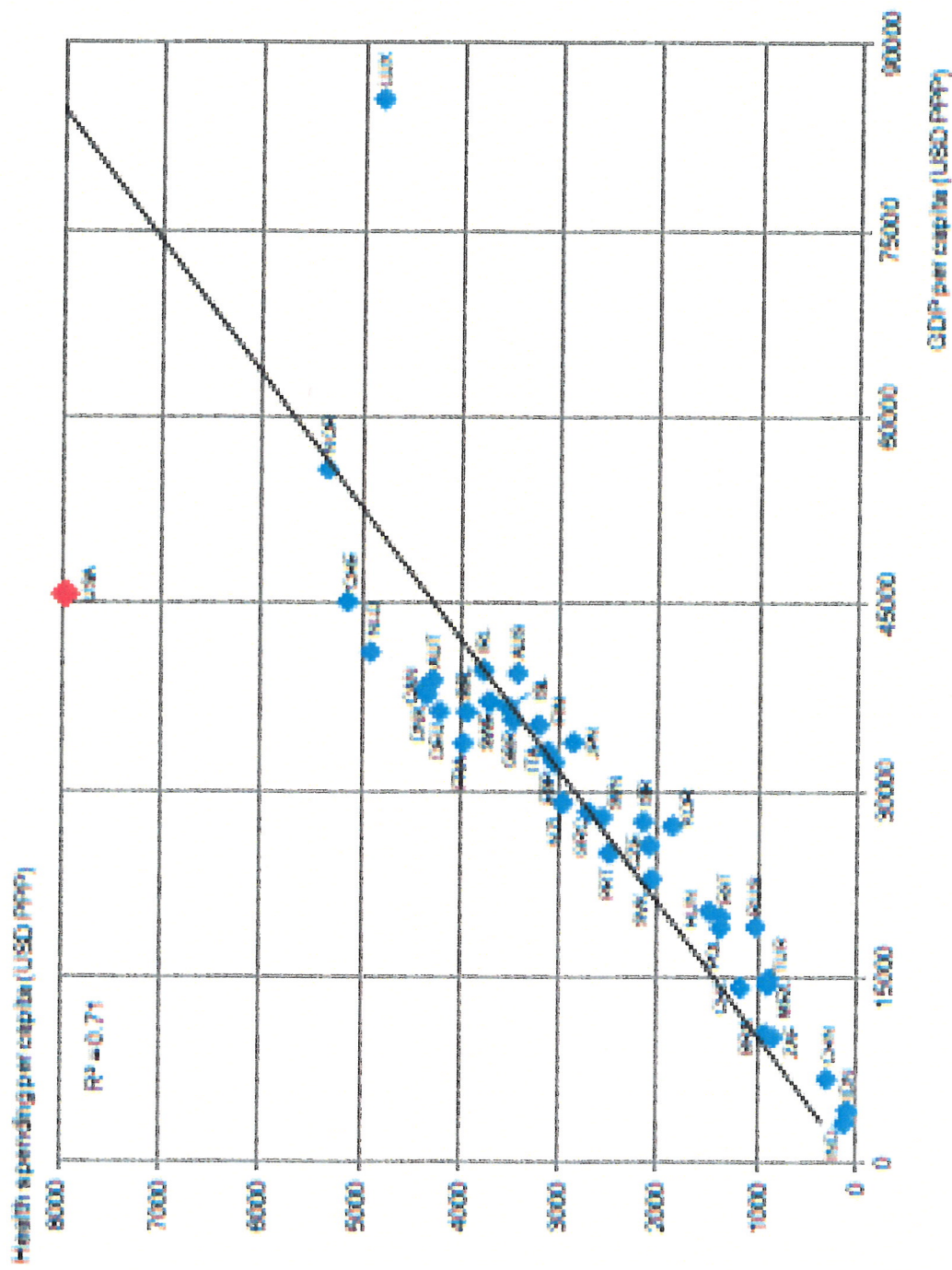
There is enough money in the system

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.

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

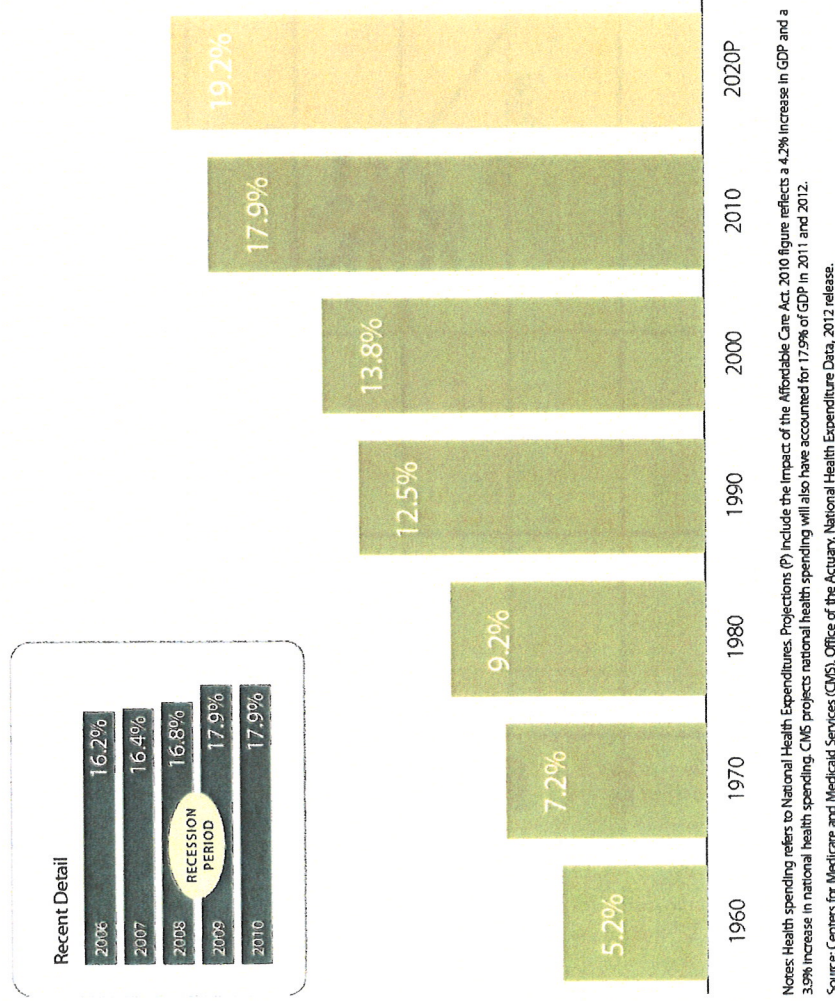
Grows under ACA



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



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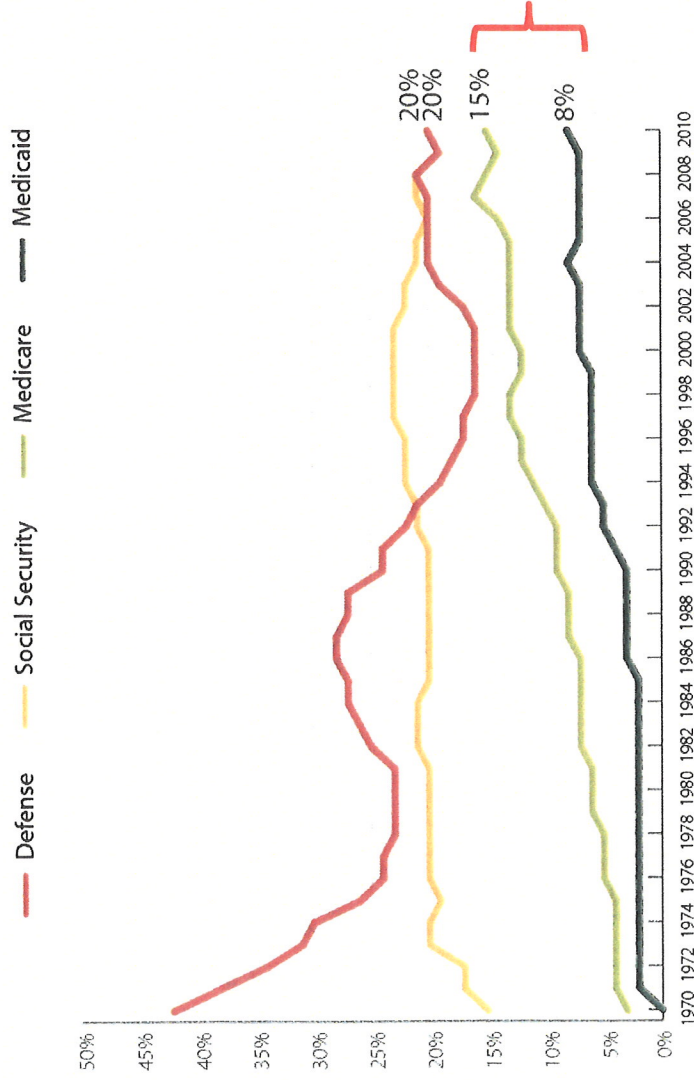
\$765 billion excess cost in 2009

- \$100 billion 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 (\$210 billion)*
- *Administrative waste and duplication (\$190 billion)*
- *Inefficient services (\$130 billion)*
- *Prices that are too high (\$105 billion)*
- *Fraud (\$75 billion)*
- *Missed prevention opportunities (\$55 billion)*

Major Programs as a Share of the Federal Budget

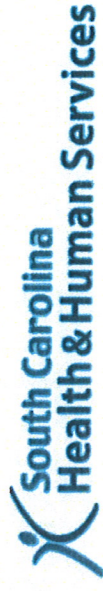


Health care spending on Medicaid and Medicare now consumes 23% of the federal budget

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.

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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

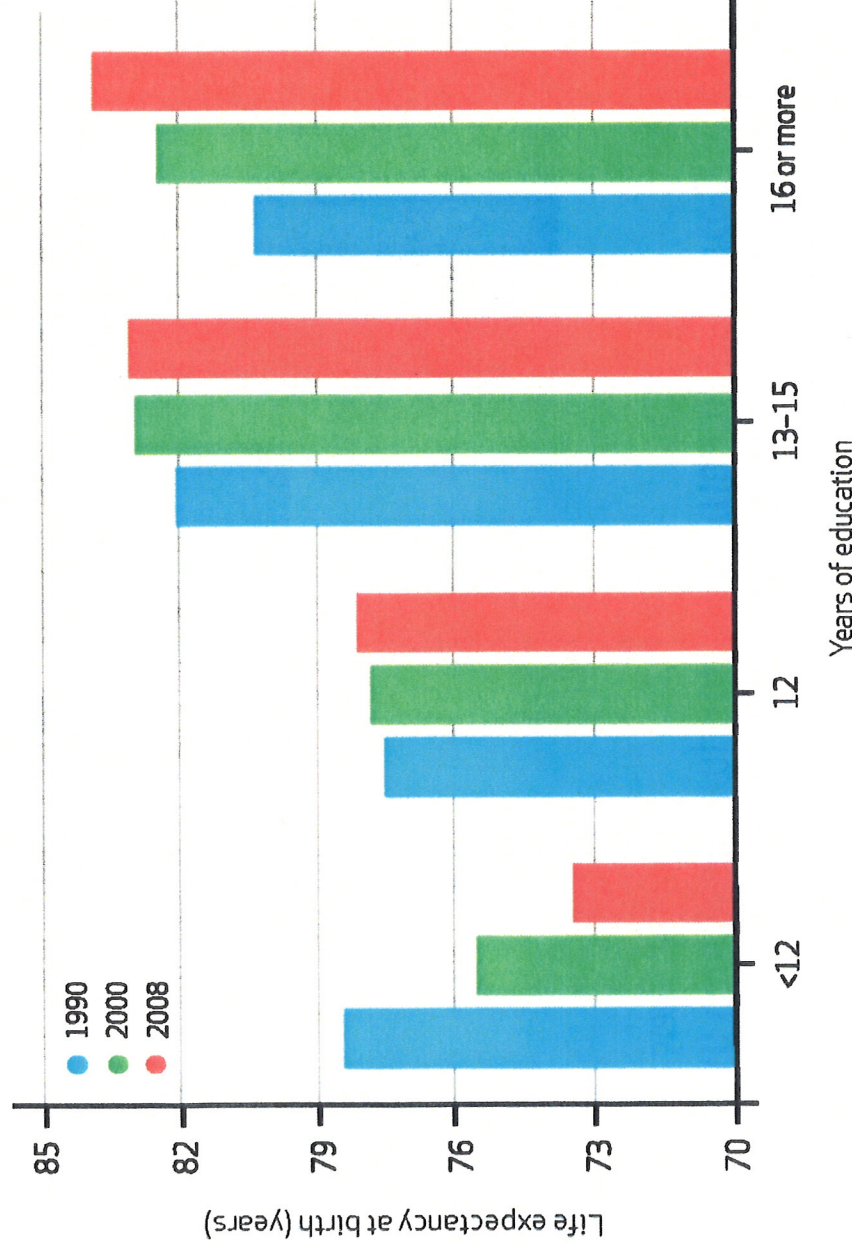
*Government revenues are receipts minus contributions for government social insurance; due to borrowing, federal government revenues are less than outlays.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

US is Falling Behind in Life Expectancy



In 1950 US life expectancy ranked 12th at 68.9 years

Life expectancy for white women by years of education



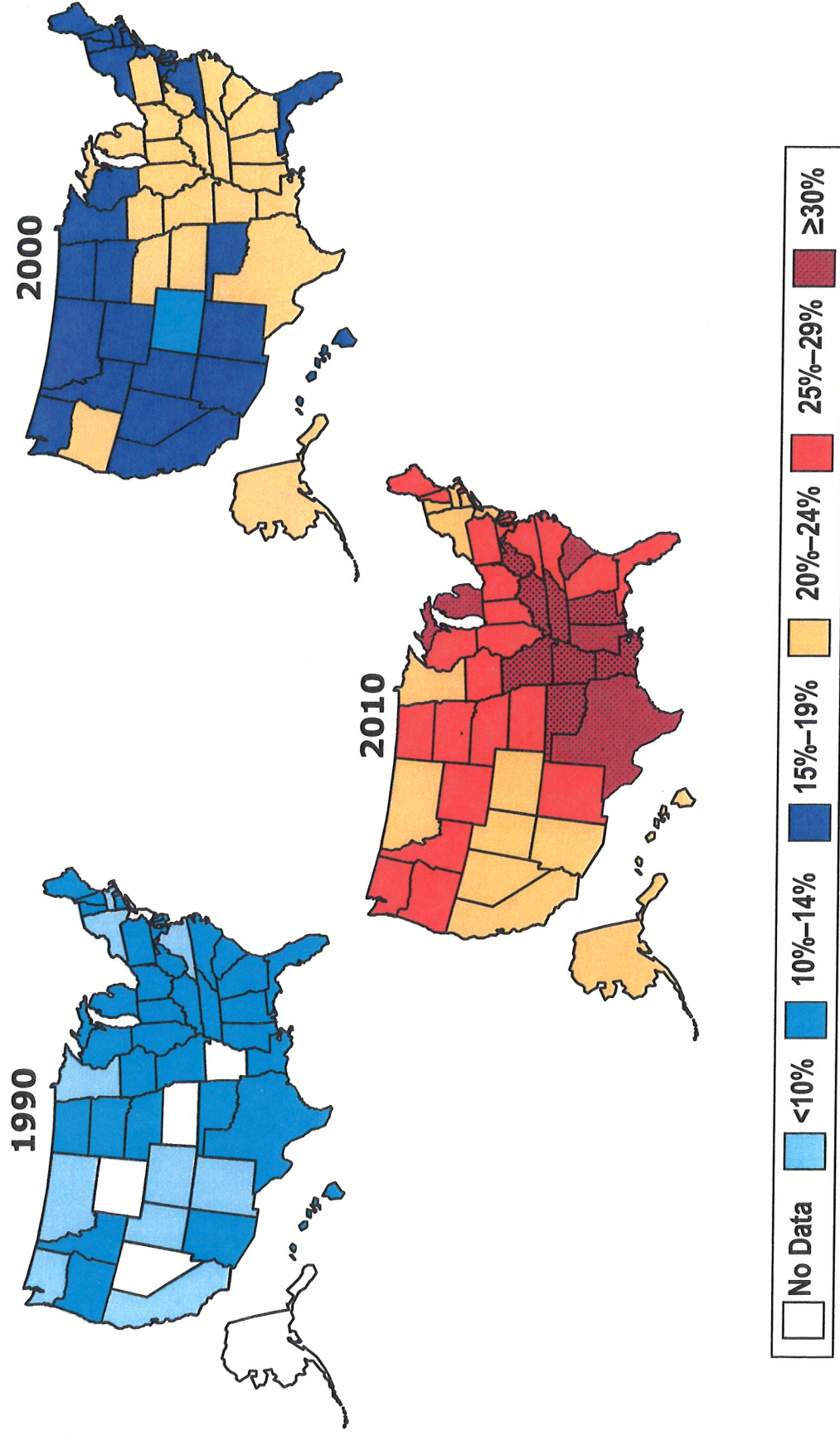
In 2009 the US ranked 28th at 79.2 years

South Carolina ranked 42nd in US in 2007 at 76.6 years

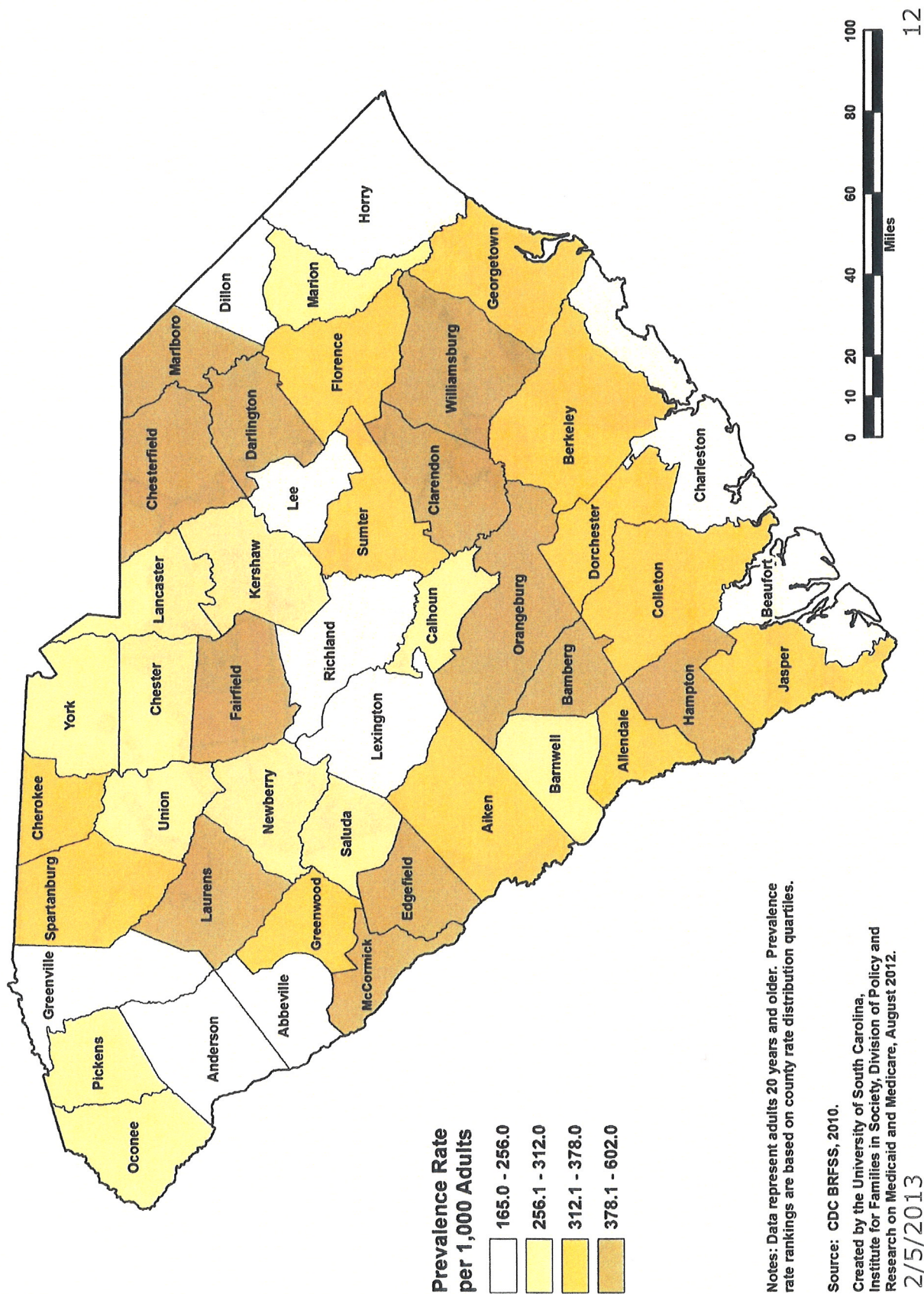
Disturbing disparities exist and for certain groups life expectancy has actually fallen in the past 2 decades

Obesity Trends* Among U.S. Adults BRFSS, 1990, 2000, 2010

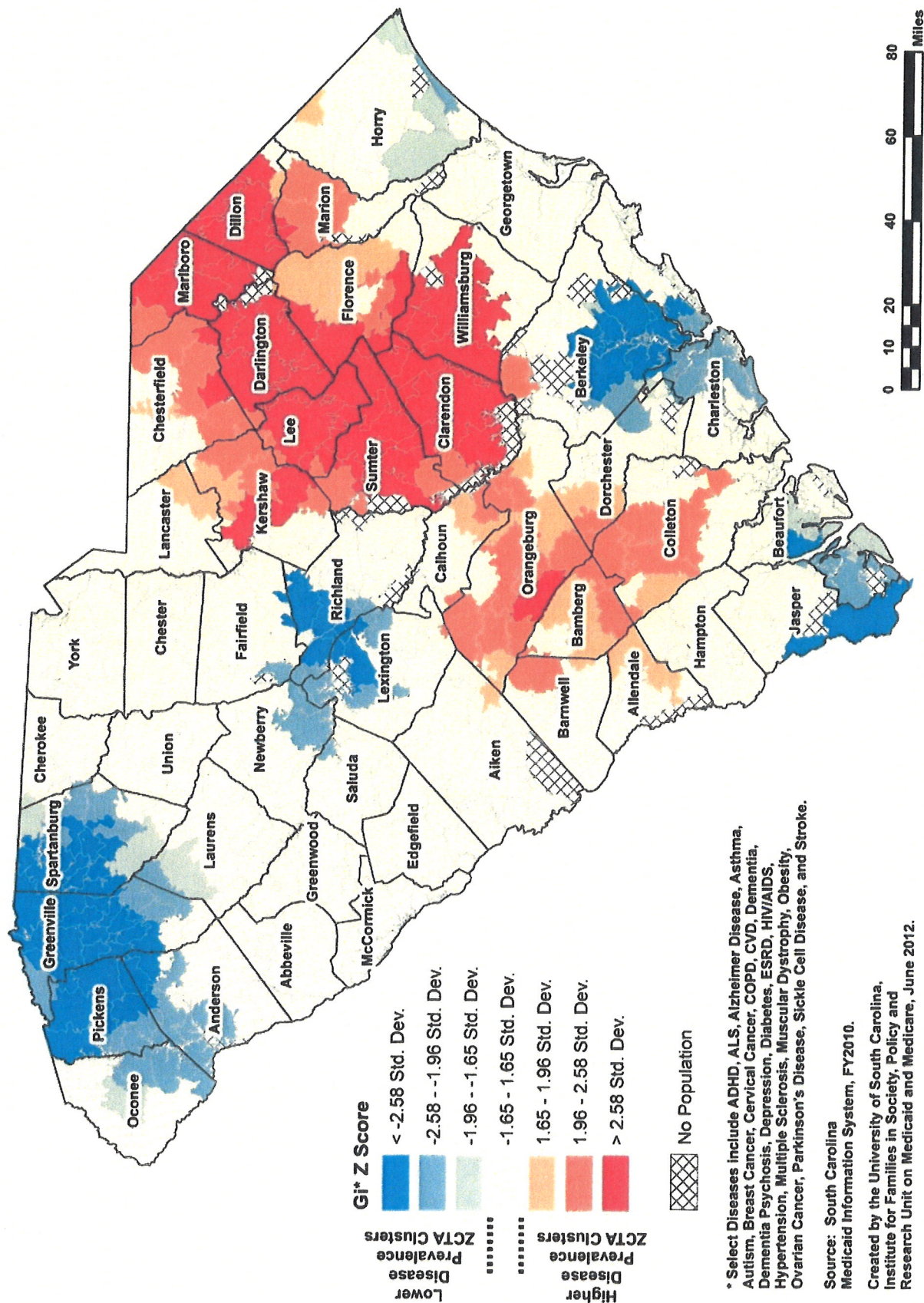
(*BMI ≥ 30 , or about 30 lbs. overweight for 5'4" person)



Prevalence of Obesity Among All South Carolina Adults by County

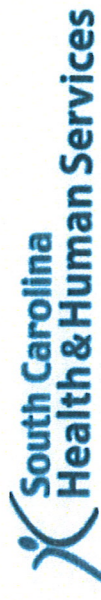


Prevalence of Select Diseases* among South Carolina Medicaid Recipients 19 Years and Older by ZCTA, FY 2010 Getis-Ord Gi* Statistic (Hot Spot Analysis)



ACA Overview and Impact

S.C. 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 ACA that the public
and many stakeholders will
generally be aware of*

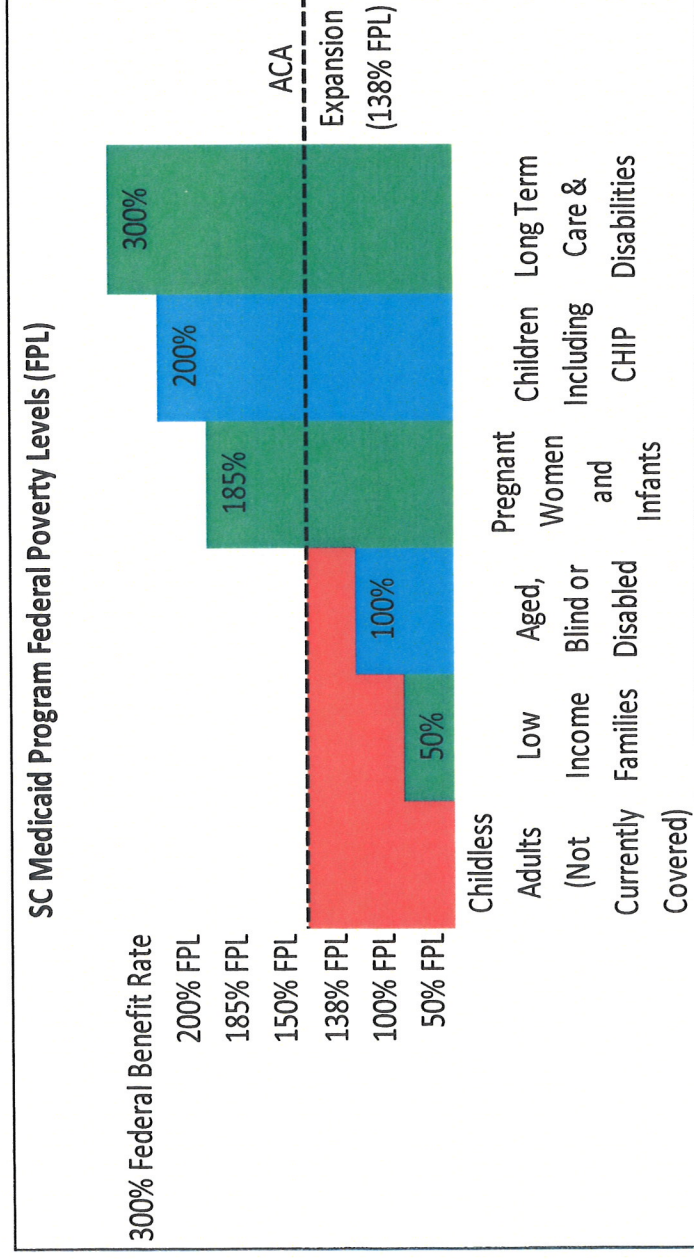
Medicaid Expansion in SC: 513,000 New Enrollees by 2015

Without Medicaid expansion:

- 101,000 may drop private insurance
- 162,000 currently eligible but unenrolled will join Medicaid (Welcome Mat effect)

With Medicaid Expansion:

- 193,000 could drop private insurance to go on Medicaid
- 344,000 people will become newly eligible for Medicaid



Medicaid Expansion in SC: 1.7 Million 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
Current Programs			
Medicaid	938,000	985,000	1,077,000
CHIP	70,000	74,000	80,000
Total Current Programs	1,008,000	1,059,000	1,157,000
After ACA - 67% Average Participation			
Expansion Population (Newly Eligible)			
Uninsured Parents/Childless Adults		252,000	267,000
Currently Insured Parents/Childless Adults		92,000	98,000
SSI		7,000	8,000
Eligible but Unenrolled in Medicaid*			
Currently Insured Children/Parents		101,000	107,000
Uninsured Children		13,000	14,000
Uninsured Parents		48,000	51,000
Total Expansion from ACA Participants		513,000	545,000
Total Medicaid Population After ACA	1,008,000	1,572,000	1,702,000

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

Source: Milliman ACA Impact Analysis

2/5/2013

Current Medicaid needs \$2.4B more 2014-2020 Expanding costs an additional \$613M to \$1.9B

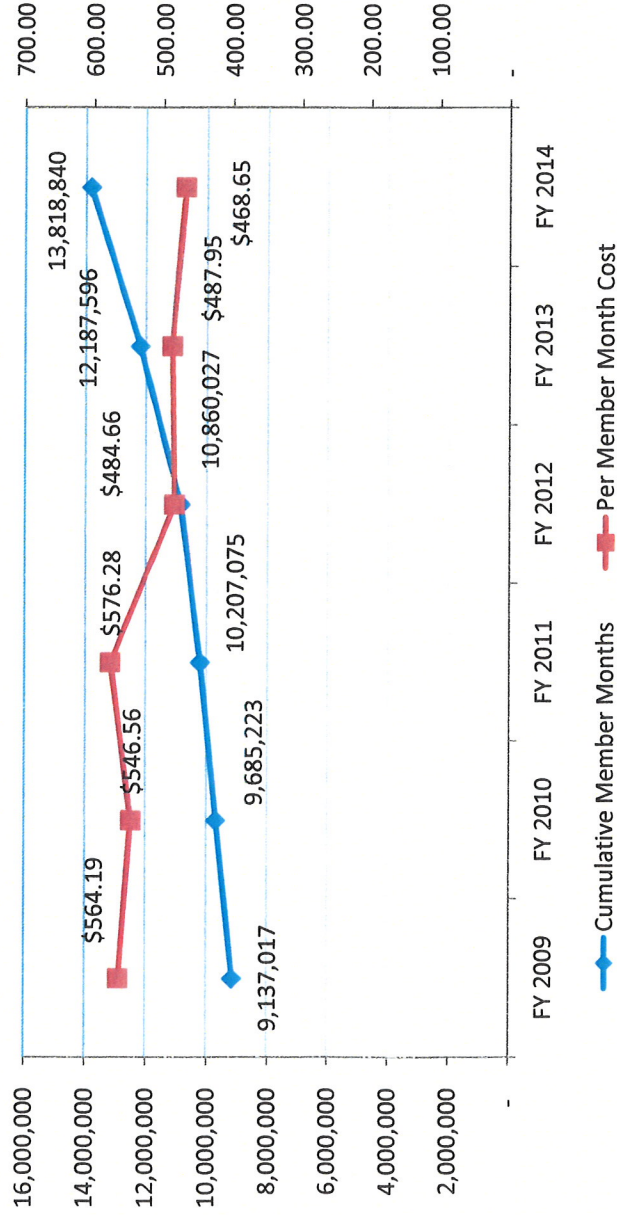


November 2012 Medicaid Expansion Projections SFY 2014 to 2020 (in \$ millions) - State Expenditures					
Category	Without Expansion - Woodwork Effect (Best Estimate Participation)	Partial Expansion to 100% FPL (Best Estimate Participation)	Full Expansion to 138% FPL (Best Estimate Participation)	Full Expansion to 138% FPL (100% Participation)	
Pre-ACA : Expected Program Growth	\$2,071.3	\$2,071.3	\$2,071.3		\$2,071.3
ACA Impact to Current Program					
Pharmacy Rebate Savings – MCO	(\$477.3)	(\$477.3)	(\$477.3)		(\$477.3)
DSH Payment Reduction	(\$166.6)	(\$166.6)	(\$166.6)		(\$166.6)
CHIP Program – Enhanced FMAP	(\$128.6)	(\$128.6)	(\$128.6)		(\$189.9)
ACA Impact - Currently Eligible					
Eligible but Not Enrolled - Uninsured	\$520.5	\$520.5	\$520.5		\$746.6
Eligible but Not Enrolled - Currently Insured	\$476.4	\$476.4	\$476.4		\$790.3
CHIP Program – Enhanced FMAP	(\$66.3)	(\$66.3)	(\$66.3)		(\$97.9)
ACA Impact - Expansion Population					
Expansion Population - Uninsured	\$0.0	\$220.4	\$330.3		\$407.9
Expansion Population - Currently Insured	\$0.0	\$55.0	\$120.6		\$215.2
SSI Eligible	\$0.0	\$14.8	\$14.8		\$14.8
Health Insurer Assessment Fee	\$138.0	\$145.5	\$149.7		\$164.4
Physician Fee Schedule Change	\$3.5	\$3.5	\$3.5		\$3.6
Expenditure Shift from Other State Agencies	\$0.0	\$2.1	\$3.5		\$4.8
Administrative Expenses	\$61.1	\$142.9	\$193.4		\$285.5
Sub-total	\$360.7	\$742.3	\$973.9		\$1,701.4
Non-Medicaid Other State Agency Offsets	\$0.0	(\$26.8)	(\$43.7)		(\$61.4)
Sensitivity - Increase Physician Reimbursement to 100% Medicare	\$0.0	\$610.5	\$620.8		\$665.1
Sub-total	\$360.7	\$1,326.0	\$1,551.0		\$2,305.1
Post-ACA : Expected Program Growth	\$2,432.0	\$3,397.3	\$3,622.3		\$4,376.4

Budget Driver History



Comparison of Cumulative Member Months to Costs



Source: Milliman Fall 2012 Forecast and Department budget documents

Historical:

Cumulative member months are currently projected to grow 51.2% or 4,681,823 from FY 2009 to budgeted FY 2014

PMPM is currently projected to decline 16.9% or -\$95.54 from FY 2009 to budgeted FY 2014

FY 2014 Executive Budget:

MM is expected to increase by 13.4% or 1,631,244 from FY 2013 to FY 2014

PMPM is expected to decline by 4% or -\$19.30 from FY 2013 to FY 2014

Snapshot enrollment growth of 18.9% or 198,845 is projected from June 30, 2013 to June 30, 2014

- ACA Mandatory Enrollment growth of 169,326 or 85.1%
- Natural Enrollment Growth of 29,519 or 14.9%

Executive Budget Request is \$6.475B



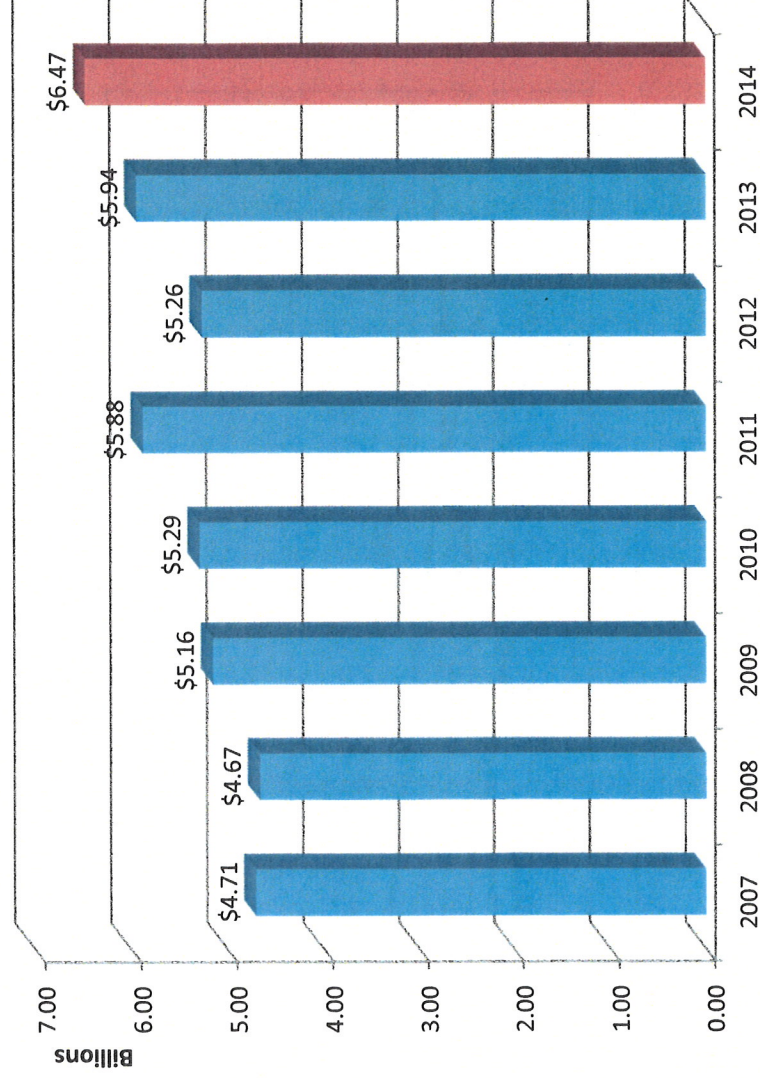
The Executive Budget request is \$6.476B which is a 8.9% or \$528,816,269 increase over FY 2013

The State Match Request is an 6.6% or \$123,144,472 increase over FY 2013

Major Changes from FY 2013 to FY 2014:

- *Natural Enrollment Growth (+)*
- *Mandatory ACA Enrollment Growth (+)*
- *Inflation (+)*
- *FMAP Changes (-)*
- *Savings and Efficiencies (-)*

Total Expended

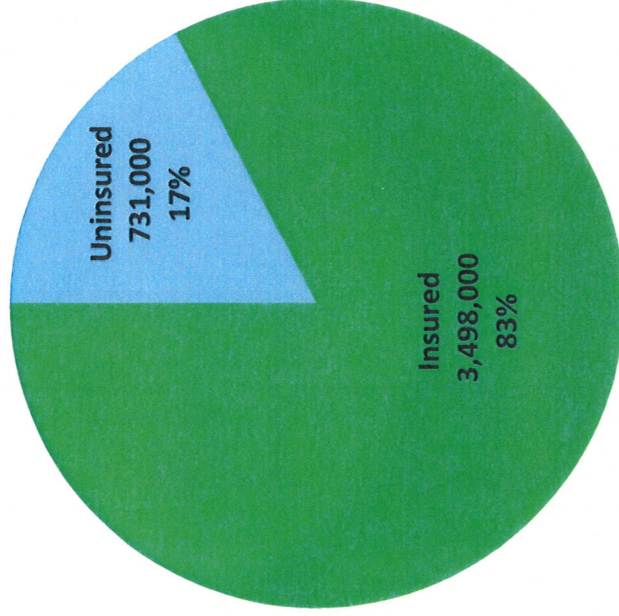


* 2007-2012 are actual expenditures, 2013 and 2014 are projected expenditures.

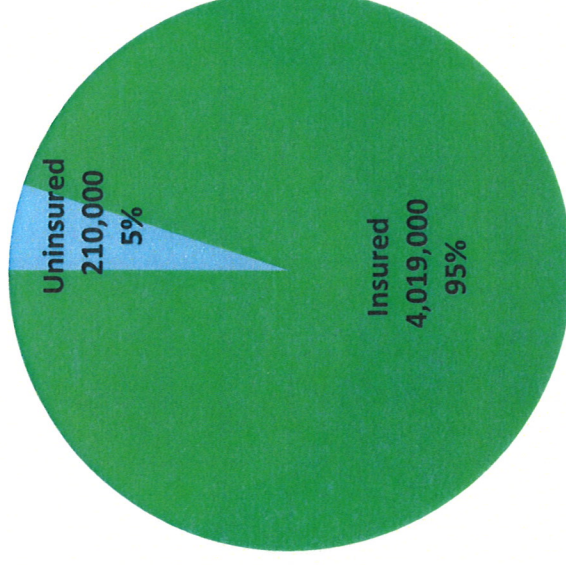
ACA impact on South Carolina access to affordable health insurance coverage



Pre-ACA: 2013 Uninsured



Post-ACA: 2015 Without Access to affordable health insurance



By 2015

Even without Medicaid expansion 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

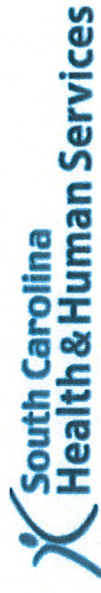
Income profile of the uninsured in SC



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

* Source: 2011 American Communities Survey, projected to 2014

How Will ACA Change the Market?



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

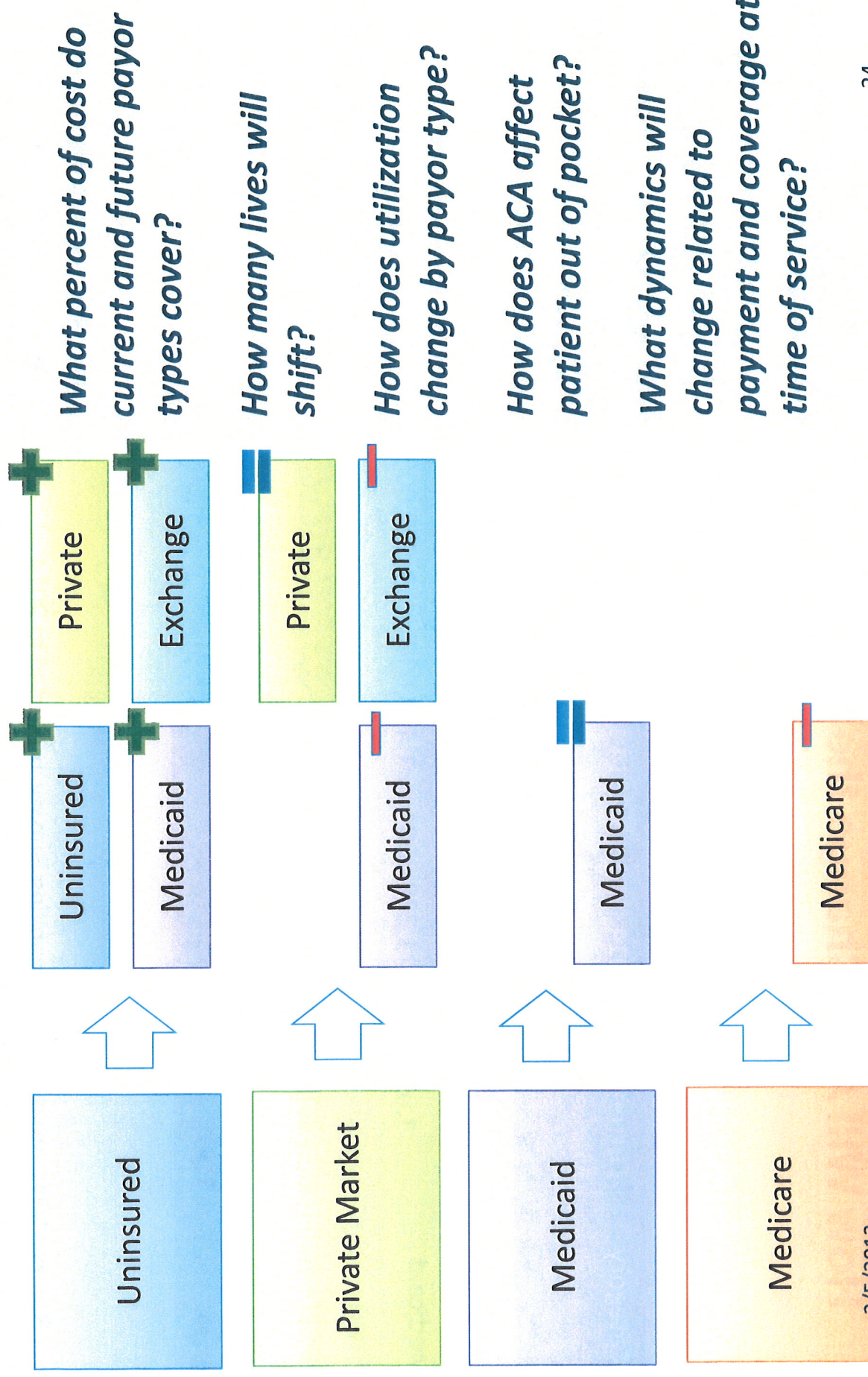
Category	Current Market	2014 No Expansion	2014 100% FPL Expansion	2014 133% FPL Expansion
Uninsured	731,000	210,000	42,000	42,000
Medicaid	1,059,000	1,228,000	1,438,000	1,572,000
Private Market	2,439,000	2,358,000	2,316,000	2,266,000
Exchange	0	433,000	433,000	349,000
Total	4,229,000	4,229,000	4,229,000	4,229,000

71 percent (521,000) of South Carolina'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

Source: 2011 American Communities Survey, projected to 2014
Medicare coverage is not affected by the ACA and is not reflected above.

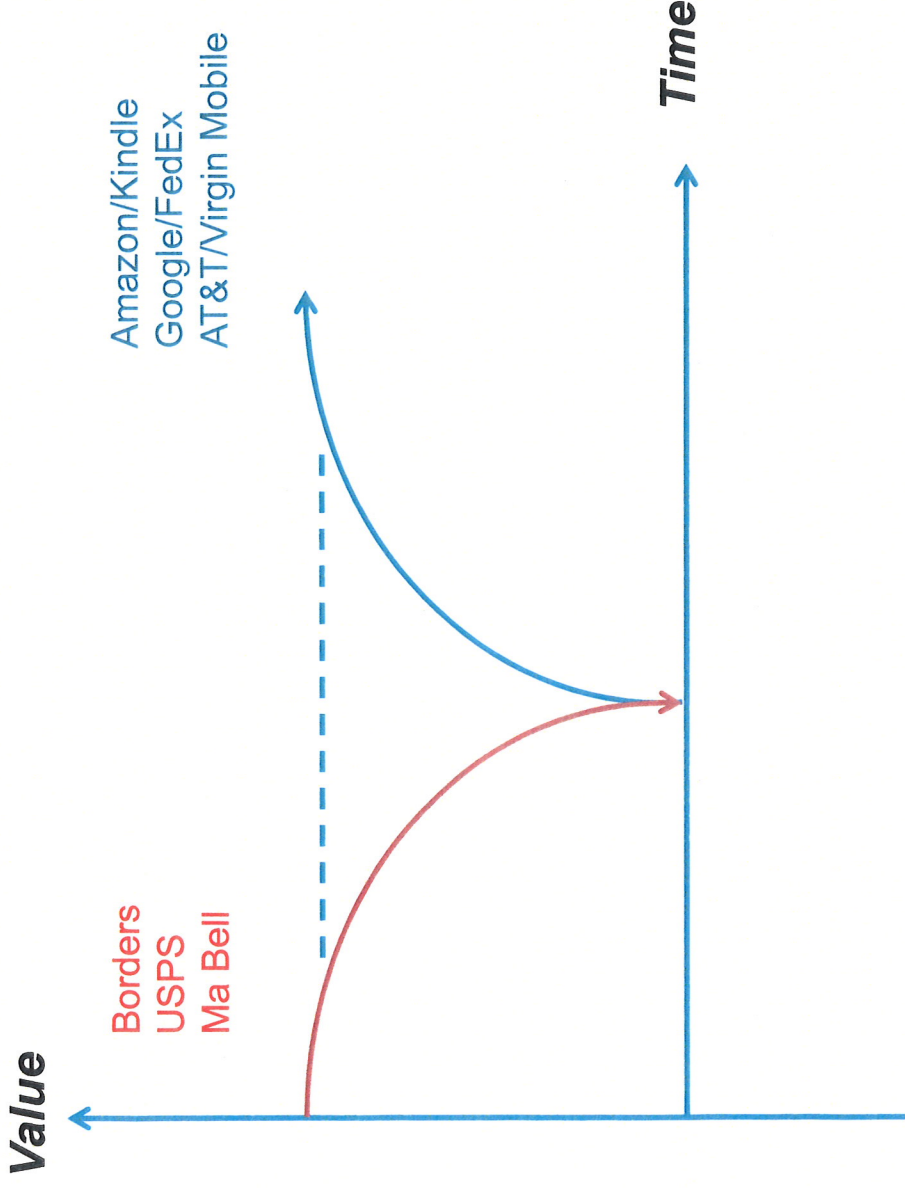
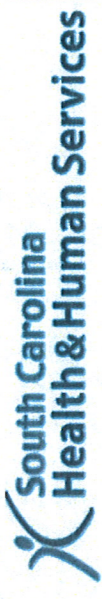
Shifting Hospital Payor Mix under ACA





South Carolina's Alternative

Health care business model must change



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?

DHHS 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

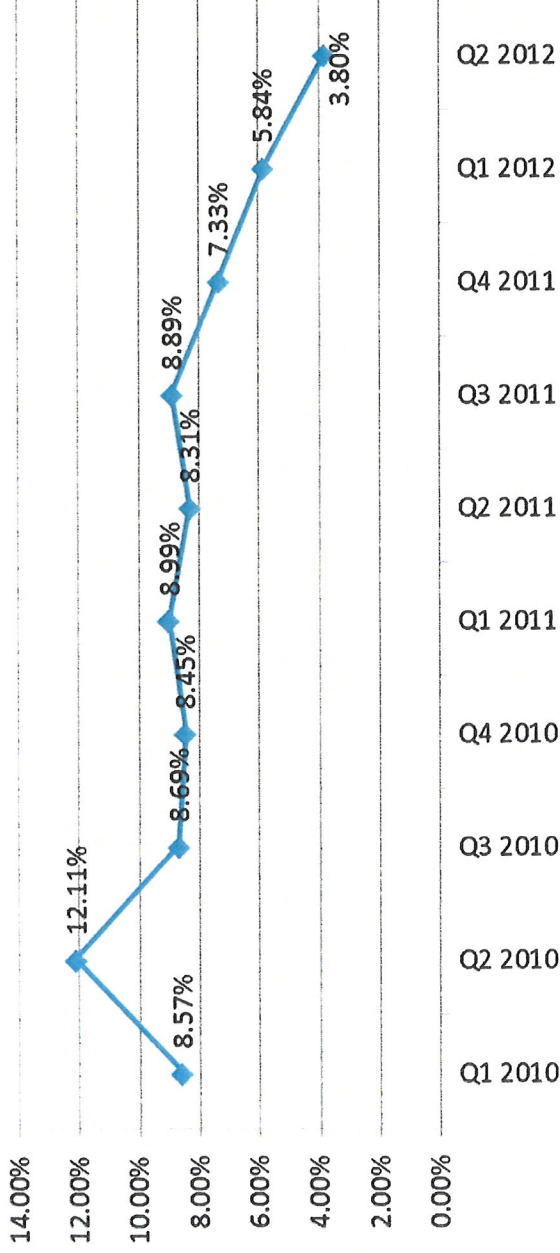
Increased coverage/treatment of vulnerable populations

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 \$6 million for first quarter FY 2013

Governor's Investment in Rural Hospitals

	CAH	Rural Area Designation				
		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



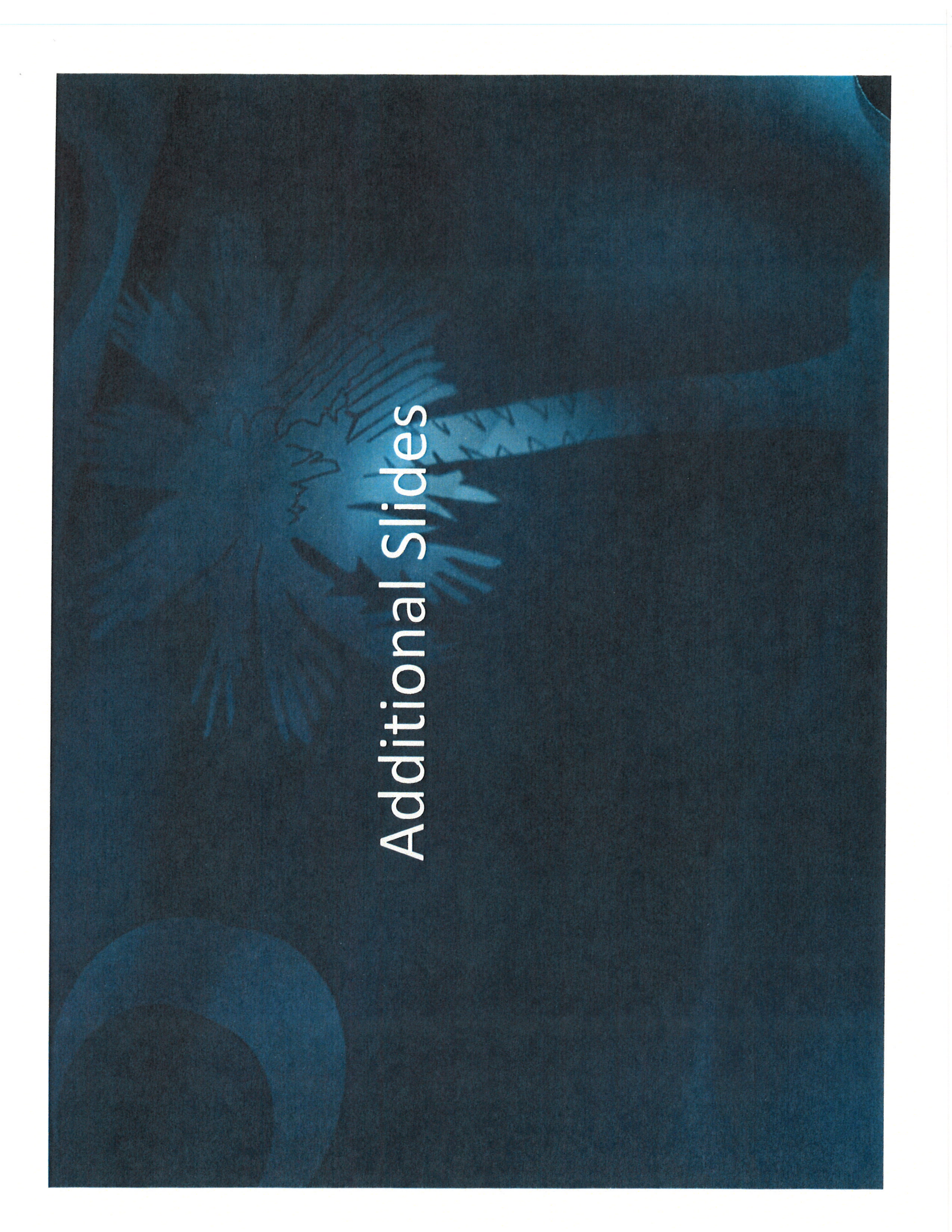
- Continue working on improving value in the health system
 - Set performance expectations
- Manage and measure enrollment growth and shifts under ACA
 - Hedge downside risk in UCC
 - Revise UCC expectations
- Invest in health hotpots and building capacity
- Apply for flexibility in 2017 when ACA waivers 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 budgeting approach is imperative



Additional Slides

DSH payments for Uncompensated Care



- DSH pays hospitals for the cost of uncompensated care (UCC). This year DHHS will pay \$461.5 million 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 payment.

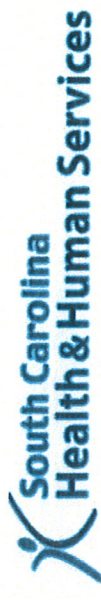
Federal reductions under ACA do not begin until 2017

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 South Carolina 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 percent 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 percent 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 South Carolina *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 5.6 million with or without *Obamacare*

SCHA Jobs Report

- Impact analysis generally ignore constraints on the labor market (such as physician and nurse shortages). Their job growth is theoretical.
- Impact analysis ignore 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 assume 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 it “out of scope”.
- The report did no sensitivity analysis considering it “out of scope”.
- The report considered labor constraints in SC “out of scope”.

