Health Reform in South Carolina

John Supra – August 15, 2013
Health Care Spending
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%.

Health Spending
United States, 1960 to 2020, selected years

IN BILLIONS

Notes: Health spending refers to National Health Expenditures. Projections (6) include the Impact of the Affordable Care Act.

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Dramatic Growth in Medicaid Spending

*Historical and projected Medicaid expenditures and annual growth rates, FYs 1966-2020*

- **Medicaid expenditures**
- **Annual growth**

Expenditures (in $ billions)

- Actual
- Projected

Annual growth rate (percent)

- Historical data from 1966 to 2020 shows significant growth in Medicaid expenditures, with a projected increase in future years.

Source: Centers for Medicare and Medicaid Services
Health care spending on Medicaid and Medicare now consumes **23%** of the federal budget.

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”

**Medicaid expansion is borrowed money**
Total State Spending on Medicaid Now Surpasses K-12 Education

Medicaid and K-12 spending

Note: Figures are for total state expenditures, including both general fund spending and federal funds
Source: National Association of State Budget Officers (NASBO), State Expenditure Report, 2010

Percentage of total state expenditures

2007 2008 2009 2010 2011

Medicaid
K-12
Comparison of Cumulative Member Months to Costs

Source: Milliman Spring 2013 Forecast and Department budget documents

8/13/2013
$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)
Triple Aim

• Reduce per Capita Cost of Health Care
• Improve the Health of Populations
• Improve the Patient Experience
  – Quality and Satisfaction
“To address the lackluster health outcomes and unsustainable health care expenditures of the United States, a critical first step is to focus national efforts by setting a national target for health system performance on two key measures: longevity and per capita health spending.”

– “For the Public’s Health: Investing in a Healthier Future”
  Institute of Medicine, April 2012
Health Services Are Not a “Market”
When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?

the American health care market has transformed tax-exempt ‘nonprofit’ hospitals into the towns’ most profitable businesses...

the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington

the bills they churn out dominate the nation’s economy and put demands on taxpayers to a degree unequaled anywhere else on earth
“Medical care, of course, is merely one component of our overall health.”

“As a nation, we now spend almost 18 percent of our GDP on health care.”

“…the federal government spends eight times as much on health care as it does on education, 12 times what it spends on food aid to children and families, 30 times what it spends on law enforcement… Education, public safety, environment, infrastructure—all other public priorities are slowly devoured by the health-care beast.”

“Health insurance is the primary payment mechanism not just for expenses that are unexpected and large, but for nearly all health-care expenses.”
Health Insurance

Access to *Effective* Health Services

Health & Well-Being
The Reality

Health and Well-Being

- Social Determinants
- Health Services

Important Factors Contributing to Health:
- Education
- Environment
- Individual behaviors (diet, exercise)
- Biology & genetics
- Health services
• “Many people believe that medical care and individual behaviors...are the primary reasons for the declines in health.”

• “But socioeconomic factors such as the percentage of a county’s population with a college education and the rate of children living in poverty had equally strong or stronger relationships to...mortality rates”
In 1950 US life expectancy ranked 12th at 68.9 years.

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 two decades.
Prevalence of Select Diseases* Among South Carolina Medicaid Recipients
19 Years and Older by ZCTA, FY 2011
Getis-Ord Gi* Statistic (Hot Spot Analysis)

* Select Diseases include ADHD, ALS, Alzheimer's Disease, Asthma, Autism, Breast Cancer, Cervical Cancer, COPD, CVD, Dementia, Depression, Diabetes, ESRD, HIV/AIDS, Hypertension, Multiple Sclerosis, Muscular Dystrophy, Obesity, Ovarian Cancer, Parkinson's Disease, Sickle Cell Disease, and Stroke.

Source: South Carolina Medicaid Information System, FY2011.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, September 2012.
### Percentage of Eligible Medicaid Beneficiaries Meeting Standard

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<th>FFS</th>
<th>State Avg</th>
<th>Best Plan</th>
<th>NCQA Mean</th>
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<td>Adolescent Well Care Visits</td>
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<td>Lead Screening in Children</td>
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<td>Breast Cancer Screening</td>
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<td>Diabetic Eye Exams</td>
<td>10.5</td>
<td>27.1</td>
<td>41.5</td>
<td>53.1</td>
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*Source: CY 2011 SC Medicaid HC Performance Report*
What should we do?

• Meet the commitments of our current Medicaid program in South Carolina

• Deliver the greatest health value for the investments we are making

• Drive innovation within the health care services industry
Medicaid Expansion in SC: 513,000 New Enrollees by 2015

**Without Medicaid Expansion:**
- 101,000 may drop private insurance
- 162,000 currently eligible but may enroll in 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
Even Without Medicaid Expansion, SC’s Uninsured is Reduced 71%

By 2015
Over half a million people will gain access to affordable health insurance coverage as defined under the new health care law, even without Medicaid expansion

The system will have a difficult time absorbing this growth – it may require between 250-300 full-time physician equivalents
Percentage of US Office-Based Physicians Accepting New Medicaid Patients

Source: 4/24/2013
Shifting Payor Mix Under ACA

Uninsured

Private Market

Medicaid

Medicare

What percent of cost do current and future payor types cover?

How many lives will shift?

How does utilization change by payor type?

How does ACA affect patient out of pocket?

What dynamics will change related to payment and coverage at time of service?

4/24/2013
According to South Carolina’s BEA, from 2000-2011, growth in health jobs was about twice the number of the second largest 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

After SC Medicaid rate cuts, health care jobs in SC increased several thousand from 153,400 in April 2012 to 160,600 in October 2012

Source: Board of Economic Advisors (BEA)
Health Care Business Model Must Change

Move from fee-for-service that drives market share growth and utilization to population management

Transparency in pricing and outcomes for consumers to make better decisions

Remove barriers to competition at all levels

Focus on total costs which requires clinical integration and more focus on social determinants

Consumer must share more cost – we are overinsured and too separated from the consequences of our actions
Insurance Exchanges, Medicaid and the Uninsured
Access to Federal Health Insurance Exchange using the Federally Facilitated Marketplace (FFM, was Federally Facilitated Exchange/FFE)

SC Citizens will be able to “start” with the Federal Marketplace/Exchange or with State/Medicaid – new online application

Subsidized health plans eligible based on income and FPL 100%-400%

Available through www.healthcare.gov
• SC Department of Insurance estimates rise in insurance premiums in individual and small group markets
  – Guaranteed issue (includes pre-existing conditions)
  – Qualified Health Plan (QHP) and essential benefits
  – Coverage of children through age 26
  – 80/20 rule for medical loss ratio (MLR)

• Four carriers have submitted plans to sell on the federal exchange in South Carolina
Purchasing Insurance in the Exchange

• www.healthcare.gov (800.318.2596)
• In-person Assistance in South Carolina
  – Insurance brokers and agents
  – Navigators
  – Consumer assistance counselors
• Small Business Health Options Program (SHOP)
  – Employer mandate delayed for one year (until 2015)
  – Small businesses with less than 25 employees may be eligible for small business health care tax credit
• Continue working on improving value in the health system
  – Focus on identifying and coordinating care for the uninsured
  – Set performance expectations
  – Strengthen core programs

• Manage and measure enrollment growth and shifts under ACA

• Invest in health hotspots and building capacity

• Apply for flexibility in 2017 when ACA waivers are available
• Development of Healthy Outcomes Plans to coordinate care for the uninsured
  – Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Free Clinics and Hospitals

• Greater accountability in use of Medicaid DSH

• Increased transparency in patients served, health pricing and health quality

• SCDHHS working to implement requirements of Proviso 33.34
“The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong questions.”

– Peter Drucker