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Policy Report

FY 2013 Budget Analysis: Community Health

A Review of the Governor's Budget Report – FY 2013

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Summary

The governor's budget recommendations for FY 2013 increase state General Funds to the Department of Community Health (DCH) by $216.1 million, which represents an 11.1-percent increase compared to FY 2012. This increase is misleading. The bulk of the new funding restores funding originally diverted from the DCH budget in FY 2011 and FY 2012. Excluding the restored funding, the FY 2013 budget increases by $56.4 million, which would have been only a 2.7-percent increase.

The FY 2013 budget adds only a portion of the funding needed for projected enrollment growth from FY 2012 to FY 2013. While DCH forecasted the need for $120.4 million for projected enrollment growth in FY 2013, the governor's budget provides only $26.3 million. If growth occurs as originally projected by the agency, new funding will be needed in the supplemental budget for FY 2013. In the Amended FY (AFY) 2012 budget, projected enrollment growth is funded by using unspent funding carried forward from FY 2011.[1]

In addition to growth in existing programs, the governor's proposal adds funding in both AFY 2012 and FY 2013 to the PeachCare program to implement a new option which allows children of state employees to enroll in PeachCare, and to increase provider reimbursement rates in the PeachCare program. Previously, federal law prohibited states from enrolling children of state employees in PeachCare, however, the Affordable Care Act now allows states to provide this option. Although the PeachCare program needs additional funding to accommodate the children who enroll under this option, the program generates savings in the State Health Benefit Plan (SHBP). In fact, the savings in the SHBP offset the new costs in PeachCare because federal funds pay for more than three-quarters of the costs of the PeachCare program.
The budget also restores a FY 2012 provider reimbursement rate cut and adds funds to reflect a smaller increase to Medicaid and PeachCare co-pays than was originally proposed in the FY 2012 budget.

Department of Community Health

The Department of Community Health (DCH) houses a variety of health-related programs and functions, including:

- Georgia's Medicaid and PeachCare programs that serve low-income, elderly, and/or people with disabilities.
- The State Health Benefit Plan, which covers Georgia's state employees, teachers, and other school district employees.
- The Indigent Care Trust Fund, which uses federal funds to help offset uncompensated care costs for hospitals.
- Health care facility regulation and other planning activities such as the Certificate of Need program.

The FY 2013 budget for DCH includes $2.17 billion from state General Funds and $498.4 million from other appropriated state funds (excluding intra-state governmental transfers to fund the State Health Benefit Plan). The combined state funds total is $256.8 million above FY 2012 as shown in Table 1.

The FY 2013 budget also increases state funding for DCH compared to the pre-recession budget of FY 2009. This increase stems from the passage of a temporary hospital provider fee and the increased use of Tobacco Settlement funds to fund Medicaid. Compared to FY 2009, General Funds fall by more than $100 million (nearly five percent), while the use of other appropriated fund sources increases substantially. The temporary hospital provider fee expires at the end of FY 2013 and the Medicaid program will face a funding shortfall in FY 2014 without new funding.

Table 1 Department of Community Health Fund Changes, FY 2009 - FY 2013

Fund Source	FY 2009 Original Budget	FY 2012 Original Budget	FY 2013 Governor's Budget	FY 2012-FY 2013 Change $	FY 2012-FY 2013 Change %	FY 2009-FY 2013 Change $	FY 2009-FY 2013 Change %
General Funds	$2,276,272,267	$1,952,320,827	$2,168,382,172	$216,061,345	11%	$(107,890,095)	-5%
Tobacco Settlement	$61,573,695	$102,193,257	$110,193,257	$8,000,000	8%	$48,619,562	79%
Hospital Fees	$-	$224,138,048	$235,302,027	$11,163,979	5%	$235,302,027	N/A
Nursing Home Fees	$120,805,958	$131,321,939	$152,874,380	$21,552,441	16%	$32,068,422	27%
Total State Funds	**$2,458,651,920**	**$2,409,974,071**	**$2,666,751,836**	**$256,777,765**	**11%**	**$208,099,916**	**8%**

The number of individuals served by the department has increased significantly since FY 2009, and the new funds have been used to cover the added costs of a growing state population.

The following sections examine the governor's FY 2013 budget recommendations for DCH in more detail.

Medicaid and PeachCare

The governor's budget includes $2.09 billion in state General Funds and $498.4 million in other appropriated state funds for Georgia's Medicaid and PeachCare programs totaling $2.59 billion in state appropriated funds. Medicaid and PeachCare represent 96 percent of DCH's state General Funds total in FY 2013.

Together, the Medicaid and PeachCare programs combine to serve more than 1.7 million Georgians as of September 2011 and are expected to bring in more than $5 billion in federal funds to Georgia's health-care sector in FY 2013. State funds for Medicaid and PeachCare total $251.8 million (10.8 percent) above FY 2012 and $259.7 million (11.2 percent) above FY 2009. The funding increase since FY 2009 is driven entirely by increases in funding from other state funds, as state General Funds for Medicaid and PeachCare fell $66.9 million (3.1 percent) from FY 2009. See Table 2.

Table 2 Medicaid & PeachCare Fund Changes, FY 2009 - FY 2013

Fund Source	FY 2009 Original Budget	FY 2012 Original Budget	FY 2013 Governor's Budget	FY 2012-FY 2013 Change $	FY 2012-FY 2013 Change %	FY 2009-FY 2013 Change $	FY 2009-FY 2013 Change %
General Funds	$2,154,365,795	$1,876,356,808	$2,087,447,605	$211,090,797	11%	$(66,918,190)	-3%
Tobacco Settlement	$50,973,695	$102,193,257	$110,193,257	$8,000,000	8%	$59,219,562	116%
Hospital Fees	$-	$224,138,048	$235,302,027	$11,163,979	5%	$235,302,027	N/A
Nursing Home Fees	$120,805,958	$131,321,939	$152,874,380	$21,552,441	16%	$32,068,422	27%
Total State Funds	**$2,326,145,448**	**$2,334,010,052**	**$2,585,817,269**	**$251,807,217**	**11%**	**$259,671,821**	**11%**

FY 2013 Budget Highlights

- **Restores $77.5 million originally diverted to the SHBP in FY 2012 and adds $82.2 million to the Medicaid and PeachCare programs to fund the 12th monthly capitation payment in FY 2013.** In FY 2012, $77.5 million was diverted from the Medicaid program to cover a shortfall in the State Health Benefit Plan (SHBP). In addition, the FY 2012 budget funded only 11 of the 12 monthly "capitation" payments that are made to the Care Management Organizations that serve the bulk of the Medicaid and PeachCare programs. While these funding diversions helped to balance the overall FY 2012 budget, budget writers acknowledged that the funding would need to be restored to DCH.[2]
- **Adds $26.3 million for projected enrollment and cost increases.** Although the budget adds funding for enrollment growth, the funding level falls short of the projections issued by DCH. In July 2011, DCH projected $120.4 million in new FY 2013 costs associated with enrollment and cost growth. This forecast was based on projected enrollment growth of slightly more than three percent from FY 2012 to FY 2013.[3]
- **Adds $8 million to allow eligible children of state employees to enroll in the PeachCare program (generating state savings in the State Health Benefit Plan (SHBP).** Prior to 2012, federal law prevented states from enrolling children of state employees in their Children's Health Insurance Programs (PeachCare in Georgia). The Affordable Care Act repeals this prohibition and Georgia began implementing this option in January 2012. Although the budget adds funding in the PeachCare program, allowing eligible families to enroll their children in PeachCare — instead of the SHBP — generates savings in the SHBP program.[4]
- **Adds $4.7 million to increase reimbursement rates for providers serving the PeachCare program.** Generally, Medicaid and PeachCare pay providers less than commercial health insurance or the SHBP. This rate increase is proposed so that providers do not realize reimbursement cuts when serving children who switch from SHBP coverage to PeachCare. These state funds generate $14.8 million in federal matching funds, for a total increase to PeachCare providers of $19.5 million.[5]

In addition to the items discussed above, the governor's budget includes the following funding additions and subtractions to the Medicaid and PeachCare programs:

- Adds $5.1 million to restore a provider rate cut of 0.5 percent in FY 2012.
- Adds $2 million to revise a co-payment proposal from FY 2012. Under the revised proposal, co-pays originally proposed in FY 2012 are rounded down to the nearest whole dollar, which reduces the state savings estimate. As in the original FY 2012 proposal, the new co-pays are extended to the PeachCare program for the first time. The new co-pays are expected to take effect in April 2012.
- Adds $17.4 million to account for a lower federal match rate for Medicaid and PeachCare.

- Saves $4.2 million in state General Funds as a result of department efforts to reduce utilization of inappropriate and medically unnecessary services.
- Saves $8 million in General Fund by offsetting General Funds with increased Tobacco Settlement revenue.

Amended FY 2012 Budget Highlights

Several of the changes for FY 2013 are also made for the AFY 2012 Budget. In particular, the AFY 2012 budget:

- Restores $159.7 million for the Medicaid and PeachCare;
- Restores the half-percent provider rate cut originally enacted in FY 2012;
- Funds the January 2012 implementation of the policy to allow state employees' children to participate in PeachCare and the April 2012 implementation of the modified co-pay proposal discussed above; and,
- Uses carry-forward balances from FY 2011 to fund projected Medicaid and PeachCare enrollment not originally funded in FY 2012.

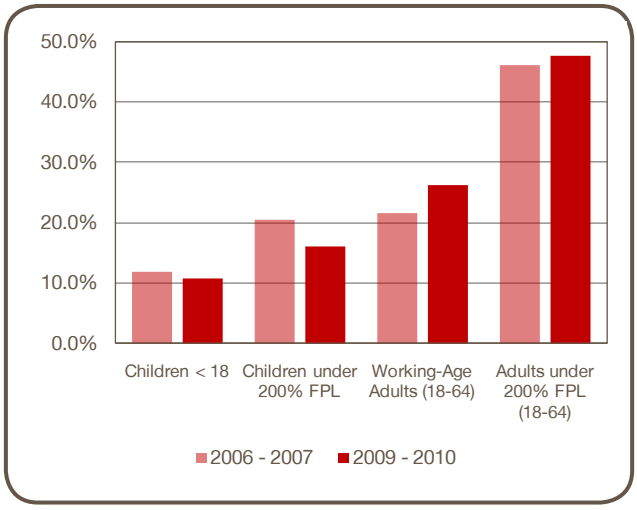
Recent Trends

Since the recession began in 2008, total enrollment in Medicaid and PeachCare has increased by more than 200,000 individuals, about 14 percent.[6] The vast majority – about three-quarters – of these newly enrolled Georgians are children, and children now make up nearly two-thirds of the total enrollment in the two programs combined. Elderly Georgians and individuals with disabilities made up approximately 18 percent of the new enrollees, while less than seven percent of the newly enrolled Georgians are non-elderly adults without a qualifying disability.

Despite the increased Medicaid enrollment, the number of Georgians who lack health coverage has increased substantially since the recession started. Employer-sponsored health coverage has declined dramatically from pre-recession levels, and many of those who lose that coverage are not eligible for Medicaid. This issue is especially prevalent for adults ages 18-64 (working-age adults) who are less likely to be eligible for public coverage (Medicaid and/or Medicare) than are children or elderly Georgians.

In the two years prior to the recession (2006-2007), approximately 65.3 percent of working-age Georgians had employer-sponsored health coverage. According to the most recent Census data (2009-2010), this rate has declined to 56.7 percent; more than 400,000 fewer working-age adults have employer-sponsored health coverage than prior to the recession. Not surprisingly, this decline has led to a sharp increase in the number of working-age Georgians without health coverage. In 2009-2010 approximately 1.6 million working-age adults lacked health insurance, a rate of 26.3 percent. These figures are up from 1.3 million (21.5 percent) in 2006-2007.[7]

Figure 1 Percent of Uninsured Georgians



While Georgia's working-age adults have seen a substantial decline in health insurance coverage rates compared to pre-recession levels, increased Medicaid enrollment among Georgia's children has mitigated the negative effect on children's health coverage.

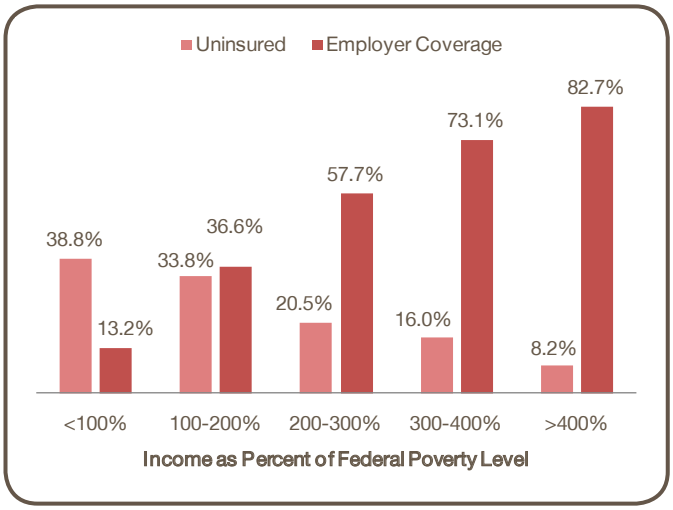
In fact, from 2006-2007 to 2009-2010, the percent of Georgia's children lacking health coverage declined modestly from 11.9 percent to 10.9 percent, as shown in Figure 1. While this modest decline means that approximately 282,000 children in Georgia still lack health coverage, the decline stands in stark contrast to the sizable jump in the uninsured rate for Georgia's working-age adults.[8]

Outlook and Policy Considerations

Georgia's Medicaid and PeachCare income eligibility thresholds are substantially less generous for Georgia's working-age adults than for children, elderly Georgians, and individuals with disabilities. As a result, working-age adults are less likely to have health coverage than either children or elderly Georgians. The lack of coverage is most acute for working-age adults with incomes below twice the poverty level (approximately $21,800 for a single adult or $37,000 for a family of three). In 2009-2010, as shown in Figure 1, 47.5 percent of Georgia's low-income working-age adult population went without health coverage. This figure is nearly triple the rate for children from low-income families (16 percent) and access to Medicaid and PeachCare is the primary reason why these children are more likely to have coverage.[9]

Access to employer sponsored coverage is heavily dependent on family income, as shown in Figure 2. Declining employer-sponsored health coverage in Georgia and throughout the nation puts substantial pressure on families losing coverage as well as on public programs such as Medicaid and PeachCare. Although growth in Georgia's Medicaid program has helped keep tens of thousands of children from falling into the ranks of the uninsured, Georgia's limited coverage of non-elderly adults means that many low-income adults without job-based health coverage remain uninsured.

Figure 2 Employer Coverage and Uninsured Rate by Income 2009-2010
(Georgians aged 0 to 64)



While Medicaid eligibility thresholds for low-income adults currently lag behind the thresholds for children in Georgia, provisions in the Affordable Care Act that take effect in 2014 will greatly increase access to health insurance for low-income adults in Georgia who currently lack coverage. The Medicaid expansion in particular will expand coverage to adults in Georgia with incomes up to 133 percent of the poverty level, and will be fully financed at the federal level for three years, and funded with 90 percent federal funds in the long term. This expansion will significantly increase access to health coverage for hundreds of thousands of Georgians who are currently without coverage.[10]

Although the federal funding will pay for 100 percent of the costs of the Medicaid expansion for the first three years, the state still needs to begin preparing for the influx of new enrollees now. To that end, the FY 2012 budget included $10 million in state bond funding, which brings in $90 million in federal matching funds, to revamp the state's outdated Medicaid eligibility system. While a new computer system is certainly necessary in the absence of the coming coverage expansion, the coming expansion makes the need for a new system more pressing.

The state should also examine ways to strengthen the Medicaid and PeachCare provider networks. Although the FY 2013 budget includes funding to increase reimbursement rates for PeachCare providers, it is equally necessary to increase funding for providers serving the Medicaid population. To the extent the Medicaid and PeachCare reimbursement rates continue to be below rates paid by private insurers, individuals getting coverage through these programs will continue to face difficulties in accessing medical care where and when they need it.

State Health Benefit Plan

The State Health Benefit Plan (SHBP) is the health insurance plan for state employees, teachers, and other "non-certified" school service personnel throughout the state. As of January 2012, the SHBP covered more than 675,000 active and retired employees and their dependents.

The SHBP does not receive direct General Funds appropriations in the DCH budget. Instead, the plan receives funding from state agencies and school districts for employer and employee contributions on behalf of participating employees. These funds are appropriated as other funds in the DCH budget, but include General Fund contributions as well as contributions from other funding sources such as federal funds, local school district funds, and worker and retiree monthly premiums.

The SHBP currently faces significant funding shortfalls in part due to the state's use of plan reserves to replace new contributions as part of efforts to close statewide budget gaps in FY 2009 and FY 2010. The following section provides a brief overview of the changes the department began implementing in January 2012.

Wellness Program

In January 2012, DCH began phasing-in a broadly-based wellness program for SHBP members. The program uses the employee premium structure to incentivize members to move into "wellness plans," and then requires members in those plans to meet or maintain certain benchmarks in future years.

Children of State Employees to Participate in PeachCare for Kids

In January 2012, DCH is taking advantage of provisions in the Affordable Care Act to allow children of state employees to participate in Georgia's PeachCare program. In total, the state projects that approximately 21,000 children will take advantage of this option, which will reduce SHBP expenditures on their behalf while increasing expenditures in the PeachCare program.

Children of state employees are not required to move to PeachCare. Families will still be required to meet the same income eligibility requirements as other Georgia families to participate in the program. Based on the 2011 eligibility guidelines, a family of three with income up to $43,500 could potentially move their children to PeachCare, while for a family of four the income limit would be approximately $52,500.

Based on DCH projections, the governor's budget estimates that the migration of some children from SHBP to the PeachCare program will save $16 million in FY 2012 and $32 million in FY 2013.[11]

Increased Employer and Employee Contributions

In January 2012, employee premiums are increasing by 11 to 17 percent, depending on whether or not employees participate in the wellness plan. DCH reports that a portion of this increase pays for provisions of the Affordable Care Act that require insurers to provide preventive services without cost sharing and that expand dependent coverage to 25-year-olds even if they are no longer in school.

DCH is also increasing employer contributions from both state agency employers as well as participating school districts. First, the governor's budget directs new funding to state agencies in both AFY 2012 and FY 2013 to increase the employer contribution to the SHBP. In addition, SHBP is increasing the per-member/per-month contribution made by school districts and proposes a "direct billing" methodology for non-state agency employers to take effect in July 2012. In total, the increased employer contributions from state agencies as well as from school districts will generate $113.4 million in new plan revenue in AFY 2012 and $224.6 million in new revenue in FY 2013.[12]

Other Benefit Cuts

DCH is implementing a variety of other benefit and cost-sharing changes for the SHBP in 2012. These changes include:

- Implementing a tobacco cessation program;
- Eliminating coverage of bariatric surgery;
- Implementing a new mail-order drug program and a new specialty drug benefit;

- Eliminating vision coverage (currently only in the HMO option);
- Increased cost-sharing for the HRA and Medicare Advantage plans;
- Reducing reimbursement rates for out-of-network providers; and,
- Adding a Tricare supplemental plan for Tricare (military health care) members.

Together, DCH forecast that these changes reduce plan expenses by $77.2 million in AFY 2012 and $119.5 million in FY 2013.[13]

Recent Trends

The SHBP currently faces a structural shortfall. There are several factors that have led to this problem. Prior to the national economic downturn, the SHBP had accumulated fairly sizable financial reserves. In recent years, however, state budgetary decisions to use plan reserves in lieu of new state contributions in order to help fill substantial gaps in the state budget have contributed to the exhaustion of these reserves. In FY 2009 and FY 2010, for example, agency contributions to the SHBP were lowered and the plan used approximately $863.5 million in prior year reserves and other one-time revenues in place of new employer contributions. By the end of FY 2011 the plan had no unencumbered reserve funding and only $50 million to pay remaining FY 2011 claims that had not yet been reported.[14]

Secondly, participating school systems pay less on behalf of their non-certificated employees than the employees consume in health care services. In fact, according to recent DCH figures, the plan faces a deficit in this portion of the plan exceeding $430 million. The employees themselves, it should be noted, pay the same monthly premiums that all other participating members pay.

At times the Georgia Department of Education (DOE) has been appropriated funding to contribute to the SHBP in part to offset the fact that school systems were charged less for their non-certificated employees. In FY 2007 and FY 2008, DOE transferred more than $520 million (in the two years combined) to SHBP for this purpose. The SHBP received less than $50 million from DOE in FY 2010 and FY 2011 combined, however, and is receiving no funding from DOE in FY 2012. In September 2011, DCH increased the monthly amount the school districts pay to the SHBP for each participating employee from $246.20 to $296.20. The per-member monthly charge will increase to $446.20 effective July 1, 2012, and DCH plans to increase the monthly rate by $150 in July of 2013 and 2014, respectively.[15]

Outlook and Policy Considerations

In recent years, the SHBP lost substantial plan reserves to broader state budgetary decisions to use plan reserves to offset agency contributions and generate statewide budgetary savings. Furthermore, reduced employer contributions, increasing retirement rates, and overall growth in health care costs have contributed to a structural deficit now facing the plan. Although plan efforts to incentivize wellness activities among enrollees is a positive step, broader changes in the financing of the plan will likely be necessary to structurally balance the plan for the long term. Ideas such as tiered employee premiums based on income, increased state contributions, and reforms to the ways in which providers are paid should all be considered.

Departmental Administration and Other Programs

The remaining budgetary programs in the DCH budget – Administration, Health Care Access, Facility Regulation, and the Indigent Care Trust Fund – make up about four percent of the General Funds in the FY 2013 budget for DCH, or approximately $80.9 million.

The FY 2013 budget increases state General Funds for these programs by nearly $5 million (6.5 percent), for a variety of initiatives and reasons. Even with this increase, however, the proposed funding level for these programs remains 38 percent (nearly $50 million) below the pre-recession FY 2009 budget.

Notable additions to these programs proposed in the FY 2013 budget include:

- $2 million in General Funds to identify inappropriate and unnecessary medical services utilization in the Medicaid program (the FY 2013 budget also assumes savings in the Medicaid program as a result of these efforts);
- $1.6 million to implement expanded diagnosis and procedure codes in conjunction with the ICD-10 (the 10th edition of the International Classification of Diseases) transition;
- $650,000 in General Funds for the Medicaid evaluation contract with Navigant Consulting;
- $600,000 to evaluate the department's outpatient reimbursement methodology; and,
- $1.2 million for increased health and retirement contributions for state employees and other statewide technical adjustments.

Reductions included in the FY 2013 budget include:

- $1 million in General Funds to reflect the elimination of one-time FY 2012 funding from the budget; and,
- $1.3 million reduction to operating and contract costs in the Administration program.

Endnotes

[1]The funds carried from FY 2011 are not true surplus or reserve funds, but rather would be needed to pay for "incurred but not reported" (called IBNR) claims from FY 2011. Due to the nature of the Medicaid program, there is often extra funding to pay IBNR claims from the prior year.
[2]Georgia's Medicaid and PeachCare program contract with Care Management Organizations (CMOs) to deliver care to most enrollees. The state pays the CMOs monthly per-member / per-month payments called capitation payments. The original FY 2012 budget would have paid CMOs in July 2012 (FY 2013) instead of in June 2012 (FY 2012). The governor's budget reflects making the payment in June 2012 and adds corresponding money in FY 2013 to fund 12 monthly capitation payments in both AFY 2012 and FY 2013.
[3]Figures are from the original DCH budget presentation to the DCH Board in August 2011. The governor's budget does not explicitly lower the growth forecast. If additional funds are needed for FY 2013 enrollment growth, they could be added as part of the supplemental budget process in FY 2013.
[4]State employees seeking to enroll their children in PeachCare must still meet all other eligibility criteria that any other Georgia families must meet to be eligible, and must pay any applicable monthly premiums like any other participating family. The current income threshold for PeachCare is 235 percent of the Federal Poverty Level, which is approximately $43,500 for a family of three. Premiums range from $10 to $75 per month, depending on family income and the number of children enrolled in the program.
[5]The proposal is not for an across the board increase for all PeachCare services. Instead, proposal would increase reimbursement paid for many of the most common primary care office visit reimbursement codes to match Medicare reimbursement rates. Instead, the proposal would increase reimbursement paid for many of the most common primary care office visit reimbursement codes to match Medicare reimbursement rates. Also, the proposal would increase some of the most common hospital services reimbursement rates by 15 percent.
[6]Enrollment data from DCH, January 2012.
[7]Data from U.S. Census table creator, compiled by GBPI January 2012.
[8]Ibid.
[9]Ibid.
[10]For more information on the 2014 Medicaid expansion and the impact on Georgia, please visit www.GBPI.org
[11]Data from DCH budget presentation to Joint Appropriations Committee, January 2012.
[12]Ibid.
[13]Ibid.
[14]DCH presentation on SHBP funding status to the DCH Board, July 2011.
[15]Data from DCH budget presentation to Joint Appropriations Committee, January 2012.

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