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.
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%

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.
Dramatic Growth in Medicaid Spending

Historical and projected Medicaid expenditures and annual growth rates, FYs 1966-2020
South Carolina Medicaid expenditures have grown 38.21% from FY2007 to FY2014. This is a 4.8% annual growth.

SFY 2014 spending would be $1.2 billion (64%) higher without agency actions to control costs and improve outcomes since 2011. This would have been a 7.3% annual growth.

2007-2012 are actual expenditures, 2013 and 2014 are projected expenditures.
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 17.0% of GDP in 2011 and 2012.


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Health care spending on Medicaid and Medicare now consumes **23%** of the federal budget.
Health Care’s Consumption of Contributor Resources
United States, 2010

Major Programs as a Share of the Federal Revenue

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

*Federal revenues are receipts minus contributions for government social insurance; due to borrowing, federal government revenues are less than outlays.

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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)
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
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?
“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”
### SC Hospitals Profitability 2008-2011

<table>
<thead>
<tr>
<th>Category</th>
<th>Top (12)</th>
<th>Small Rural (19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Days</td>
<td>6,047,417</td>
<td>544,225</td>
</tr>
<tr>
<td>Profit (Loss)</td>
<td>$1,298,270,722</td>
<td>($25,605,551)</td>
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</table>
Hospitals Hiring Suggests Good Times

SC Hospital Job Postings, August 2011-February 2013
### Projected Enrollment Growth

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

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

**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

**Current Medicaid needs $2.4B more 2014-2020**

Expanding costs an additional $613M to $1.9B
ACA Supporters Mistaken Logic

Health Insurance

Health Services

Health & Well Being
Health and Well Being

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

* Select Diseases include ADHD, ALS, Alzheimer Disease, Asthma, Autism, Breast Cancer, Cervical Cancer, COPD, CVD, Dementia, Dementia Psychosis, 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, FY2010.
Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, June 2012.
Our health care system is not performing

• “We found that female mortality rates increased in 42.8% of counties...”

• “…none of the medical care factors – such as rates of primary care providers or preventable hospitalizations or percentage of uninsured – predicted changes in male [and female] mortality...”

Kindig and Cheng, Health Affairs, March 2013
### Percentage of Eligible Medicaid Beneficiaries Meeting Standard

<table>
<thead>
<tr>
<th>Measure</th>
<th>FFS</th>
<th>State Avg</th>
<th>Best Plan</th>
<th>NCQA Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Well Care Visits</td>
<td>8.1</td>
<td>24.3</td>
<td>36.0</td>
<td>48.1</td>
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<tr>
<td>Lead Screening in Children</td>
<td>40.9</td>
<td>46.2</td>
<td>55.6</td>
<td>66.2</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>28.5</td>
<td>43.3</td>
<td>53.9</td>
<td>51.3</td>
</tr>
<tr>
<td>Diabetic Eye Exams</td>
<td>10.5</td>
<td>27.1</td>
<td>41.5</td>
<td>53.1</td>
</tr>
</tbody>
</table>

* Source: CY 2011 SC Medicaid HC Performance Report
Percentage of US Office-Based Physicians Accepting New Medicaid Patients

Source: 2013/7/2013

3/7/2013
Obesity Trends* Among U.S. Adults
BRFSS, 1990, 2000, 2010

(*BMI ≥30, or about 30 lbs. overweight for 5’4” person)
“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”

Kindig and Cheng, Health Affairs, March 2013
Total State Spending on Medicaid Now Surpasses K-12 Education

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
A “robust” strategy is necessary

• “Such a strategy would include redirecting savings from reductions in health care inefficiency and increasing the health promoting impact of policies in other sectors such as housing and education”

• “Each county...needs to examine it outcomes and determinants of health to determine what cross-sectoral policies would address its own situation most effectively and quickly”

Kindig and Cheng, Health Affairs, March 2013
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
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
• Telemedicine/Monitoring

Hotspots & Disparities
• Birth Outcomes Initiative
• Express Lane Eligibility
• Foster Care Coordination
• Health Access/Right Time (HeART)

Improve value by lowering costs and improving outcomes:

Increased investment in education, infrastructure and economic growth

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

Increased coverage/treatment of vulnerable populations
A Path Forward

• Continue working on improving value in the health system
  – 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

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
Self-funded Alternatives to Obamacare

- **Hospital Accountability**
  - $50m in annual incentive payments
  - Required to participate in cost transparency program
  - Must co-manage high flyers with FQHCs
  - Claims must be submitted for uninsured
  - Access to affordable insurance status must be determined

- **Rural Hospital Stabilization**
  - 100% payment of UCC for small rural hospitals
  - All requirement above
  - Partnership incentives

- **FQHCs/RHC/Free Clinics**
  - Stabilization funding
  - Co-management of high flyers in ER

- **Capacity building and access**
  - Telemedicine investment at MUSC
  - New accountability for all GME funding
  - MUSC OB coverage in underserved areas with high infant mortality

- **Community-based services**
  - New level of care in assisted living centers with higher reimbursement
  - Higher standards of performance for all CRCF
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.

Projected Q1 FY 2013 cesarean deliveries was 2,532; actual for Q1 FY 2013 was 1,944.

Projected Q1 FY 2013 total NICU admits was 624; actual for Q1 FY 2013 was 443.

These efforts resulted in savings of $6 million for first quarter FY 2013.
Ideas for systemically reducing health care costs

• 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

• Medicaid budgeting
  – Biennial budgeting
  – Growth cap tied to economic performance

• Remove barriers to competition
  – Eliminate CON
  – Remove restrictions to scope of practice not based on evidence

• Transparency
  • Require quotes for medical procedures above a certain dollar amount

• Personal Responsibility
  – Limit state expenditures on the uninsured to individuals with demonstrated need

• Administrative waste reduction
  • Universal pharmacy prior authorization form

• Tort reform
Additional Slides
## How Will the Market Change with ACA’s Optional Medicaid Expansion?

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Market</th>
<th>2014 No Expansion</th>
<th>2014 100% FPL Expansion</th>
<th>2014 133% FPL Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>731,000</td>
<td>210,000</td>
<td>42,000</td>
<td>42,000</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1,059,000</td>
<td>1,228,000</td>
<td>1,438,000</td>
<td>1,572,000</td>
</tr>
<tr>
<td>Private Market</td>
<td>2,439,000</td>
<td>2,358,000</td>
<td>2,316,000</td>
<td>2,266,000</td>
</tr>
<tr>
<td>Exchange</td>
<td>0</td>
<td>433,000</td>
<td>433,000</td>
<td>349,000</td>
</tr>
<tr>
<td>Total</td>
<td>4,229,000</td>
<td>4,229,000</td>
<td>4,229,000</td>
<td>4,229,000</td>
</tr>
</tbody>
</table>

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

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.
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/$250k 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
“If states participate in the ACA’s full Medicaid expansion, the long-term share of federal support is projected to be 61%, with states picking up the other 39%, assuming that the federal government does not retreat from the ACA’s generous FMAP rates.”

-Charles Blahous, Mercatus Center at George Mason University, March 2013

Source: Centers for Medicare and Medicaid Services, 2011 Actuarial Report
USC performed a similar analysis in 2011. SCHA argued Medicaid cuts would cost 5,452 jobs.

After the cuts health-care jobs in South Carolina increased 7,200 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

- 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.”
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”.
According to South Carolina’s 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.

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

Source: Board of Economic Advisors (BEA)
The Health Care Jobs Fallacy: ACA Expansion as Economic Development?

Will Medicaid Expansion Create that Many Jobs?
“For the average state, failure to account for the exchange subsidies means that estimated job gains from Medicaid expansion are overstated … Failure to account for job losses associated with taxes required to cover state matching funds for the expansion means that job gains are overstated”
– Chris Conover, Forbes, February 2013

Are Health Care Jobs the Most Efficient Investment?
“Between 1990 and 2011, labor productivity in health care fell. After education, personal services and construction, health care showed the least growth over time.”
– Georgetown University, June 2012

Is ACA’s Health Care Stimulus a Viable Economic Development Strategy?
“Treating the health care system like a (wildly inefficient) jobs program conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price.”
– New England journal of Medicine, June 2012

Putting substantial more money into Medicaid will increase jobs, but at what cost?
Are these jobs the most efficient investment?
ACA’s optional Medicaid expansion would cover up to 138% FPL

<table>
<thead>
<tr>
<th>FPL</th>
<th>&lt;100% FPL</th>
<th>100% FPL to 138% FPL</th>
<th>139% FPL to 200% FPL</th>
<th>201% FPL to 399% FPL</th>
<th>&gt;400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Annual Income - Family of 4</td>
<td>&lt;$23,050</td>
<td>$23,051 to $31,809</td>
<td>$31,810 to $46,100</td>
<td>$46,101 to $69,150</td>
<td>&gt;$69,150</td>
</tr>
<tr>
<td>Uninsured</td>
<td>284,000</td>
<td>106,000</td>
<td>131,000</td>
<td>127,000</td>
<td>83,000</td>
</tr>
<tr>
<td>% of Uninsured</td>
<td>39%</td>
<td>15%</td>
<td>18%</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

* Source: 2011 American Communities Survey, projected to 2014
Prevalence of Obesity Among All South Carolina Adults by County

Prevalence Rate per 1,000 Adults
- 165.0 - 256.0
- 256.1 - 312.0
- 312.1 - 378.0
- 378.1 - 602.0

Notes: Data represent adults 20 years and older. Prevalence rate rankings are based on county rate distribution quartiles.

Source: CDC BRFSS, 2010.
Created by the University of South Carolina, Institute for Families in Society, Division of Policy and Research on Medicaid and Medicare, August 2012.
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
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 currently is our major expenditure driver

Source: Milliman Spring 2012 Forecast and Department budget documents
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

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

• Reduce the per capita cost of health care
• Improve the health of populations
• Improve the patient experience (quality and satisfaction)
US is Falling Behind in Life Expectancy

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 2 decades

Life expectancy for white women by years of education

- In 1990
- In 2000
- In 2008
### The Expansion Disconnect: Affordability and Access Issues

<table>
<thead>
<tr>
<th>State</th>
<th>Pursuing ACA Medicaid Expansion?</th>
<th>Sustaining Current Medicaid Program?</th>
<th>Physicians Currently Accepting Medicaid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Yes</td>
<td></td>
<td>57%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Yes</td>
<td></td>
<td>61%</td>
</tr>
<tr>
<td>Illinois</td>
<td>Yes</td>
<td></td>
<td>65%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Yes</td>
<td></td>
<td>40%</td>
</tr>
<tr>
<td>New York</td>
<td>Yes</td>
<td></td>
<td>62%</td>
</tr>
</tbody>
</table>
States’ Participation in Medicaid Expansion

Where the States Stand - March 1, 2013
24 Governors Support Medicaid Expansion

Note: As of 3/1/13 all policies subject to change. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.