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

Source: OECD Health Data 2011.
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.


©2012 CALIFORNIA HEALTHCARE FOUNDATION
$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

*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.*
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”

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

Source: Health Affairs, August 2012
Obesity Trends* Among US Adults

BRFSS, 1990, 2000, 2010
(*BMI ≥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 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.
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.
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
# Medicaid Expansion in SC: 1.7M Enrollees by 2020

<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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expansion Population (Newly Eligible)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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>Total Expansion from ACA Participants</strong></td>
<td>513,000</td>
<td>545,000</td>
<td></td>
</tr>
</tbody>
</table>

| 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

---

**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

<table>
<thead>
<tr>
<th>Category</th>
<th>Without Expansion – Welcome Mat Effect (Best Estimate Participation)</th>
<th>With Expansion to 138% FPL (Best Estimate Participation)</th>
<th>With Expansion to 138% FPL (100% Participation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-ACA : Expected Program Growth</td>
<td>$2,071.3</td>
<td>$2,071.3</td>
<td>$2,071.3</td>
</tr>
<tr>
<td>ACA Impact to Current Program</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>
</tr>
<tr>
<td>DSH Payment Reduction</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>($189.9)</td>
</tr>
<tr>
<td>ACA Impact - Currently Eligible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible but Not Enrolled - Uninsured</td>
<td>$520.5</td>
<td>$520.5</td>
<td>$746.6</td>
</tr>
<tr>
<td>Eligible but Not Enrolled - Currently Insured</td>
<td>$476.4</td>
<td>$476.4</td>
<td>$790.3</td>
</tr>
<tr>
<td>CHIP Program – Enhanced FMAP</td>
<td>($66.3)</td>
<td>($66.3)</td>
<td>($97.9)</td>
</tr>
<tr>
<td>ACA Impact - Expansion Population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion Population - Uninsured</td>
<td>$0.0</td>
<td>$330.3</td>
<td>$407.9</td>
</tr>
<tr>
<td>Expansion Population - Currently Insured</td>
<td>$0.0</td>
<td>$120.6</td>
<td>$215.2</td>
</tr>
<tr>
<td>SSI Eligible</td>
<td>$0.0</td>
<td>$14.8</td>
<td>$14.8</td>
</tr>
<tr>
<td>Health Insurer Assessment Fee</td>
<td>$138.0</td>
<td>$149.7</td>
<td>$164.4</td>
</tr>
<tr>
<td>Physician Fee Schedule Change</td>
<td>$3.5</td>
<td>$3.5</td>
<td>$3.6</td>
</tr>
<tr>
<td>Expenditure Shift from Other State Agencies</td>
<td>$0.0</td>
<td>$3.5</td>
<td>$4.8</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>$61.1</td>
<td>$193.4</td>
<td>$285.5</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>$360.7</strong></td>
<td><strong>$973.9</strong></td>
<td><strong>$1,701.4</strong></td>
</tr>
<tr>
<td>Non-Medicaid Other State Agency Offsets</td>
<td>$0.0</td>
<td>($43.7)</td>
<td>($61.4)</td>
</tr>
<tr>
<td>Sensitivity - Increase Physician Reimbursement to 100% Medicare</td>
<td>$0.0</td>
<td>$620.8</td>
<td>$665.1</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>$360.7</strong></td>
<td><strong>$1,551.0</strong></td>
<td><strong>$2,305.1</strong></td>
</tr>
<tr>
<td>Post-ACA : Expected Program Growth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,432.0</td>
<td>$3,622.3</td>
<td>$4,376.4</td>
<td></td>
</tr>
</tbody>
</table>
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
The Medicaid expenditures have grown 38.21% from FY2007 to FY2014.

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

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

<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></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<td></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>
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.**

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

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

Source: 2011 American Communities Survey, projected to 2014
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
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?
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
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

<table>
<thead>
<tr>
<th>Rural Area Designation</th>
<th>CAH</th>
<th>Isolated</th>
<th>Small</th>
<th>Large + HPSA</th>
<th>Large W/O HPSA</th>
<th>Large - TLB of 90 Or Less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Facilities</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Total Number of Beds (HFY 2011)</td>
<td>125</td>
<td>90</td>
<td>302</td>
<td>315</td>
<td>1,835</td>
<td>229</td>
</tr>
<tr>
<td>Percent Change 2008-2011</td>
<td>-18.30%</td>
<td>-19.49%</td>
<td>-24.49%</td>
<td>-12.49%</td>
<td>-8.85%</td>
<td>-15.71%</td>
</tr>
<tr>
<td># Losing Bed Days 2008 - 2011</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>2011 Total Occupancy Rate</td>
<td>18.49%</td>
<td>48.01%</td>
<td>31.74%</td>
<td>28.46%</td>
<td>50.68%</td>
<td>37.51%</td>
</tr>
<tr>
<td>2011 Percentage of Medicaid Days</td>
<td>8.25%</td>
<td>16.47%</td>
<td>21.01%</td>
<td>20.49%</td>
<td>19.77%</td>
<td>24.52%</td>
</tr>
<tr>
<td>4 Year Cumulative Profit (Loss) $</td>
<td>($7,141,295)</td>
<td>($31,459,033)</td>
<td>$34,363,582</td>
<td>($33,767,551)</td>
<td>$381,308,641</td>
<td>$9,983,161</td>
</tr>
<tr>
<td># Operating at a Loss 2008 - 2011</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td># Operating at a Loss 2011</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
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
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/$250k 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
• 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”
End