South Carolina
PUBLIC EMPLOYEE BENEFIT AUTHORITY

PEBA

South Carolina Public Employee Benefit Authority Meeting/Educational Session Minutes (Adopted 3/20/2013)

Thursday, January 31, 2013, 9:00 A.M.

Wampee Conference Center
Assembly Hall
1274 Chicora Dr, Pinopolis SC 29469

Board Members Present:

Mr. Art Bjontegard, Chairman (in person)
Ms. Peggy Boykin (in person)
Mr. Frank Fusco (in person)
Ms. Cynthia Harley (in person)
Ms. Stacy Kubu (in person)
Sheriff Leon Lott (in person)
Mr. Steve Matthews (in person)
Mr. Joe "Rocky" Pearce (in person)
Mr. Audie Penn (in person)
Mr. John Sowards (in person)
Mr. David Tigges (in person)

Others present for all or a portion of the meeting:

David Avant, Lil Hayes, Robbie Bell, Geneva McIntosh, Stephen Van Camp, from the South Carolina Public Employee Benefit Authority (PEBA); Mike Madalena, Bill Hickman and Amy Cohen from Gabriel, Roeder, Smith & Company (GRS); Donald Tudor, Wayne Bell and Wayne Pruitt from the State Retirees Association; Matt Schafer, Brooks Goodman, Dr. Will Harms and Maria Platanis from Blue Cross Blue Shield; Robin Scott Karen Cathcart from Express Scripts; Judy Baskins from Palmetto Health; and Tony Keck from DHHS.

I. CALL TO ORDER; ADOPTION OF PROPOSED AGENDA

Chairman Bjontegard called the meeting to order at 9:00 a.m. Ms. Hayes confirmed meeting notice compliance with the Freedom of Information Act.

II. DISCUSSION OF HEALTH TRENDS by GRS

Chairman Bjontegard introduced Mike Madalena, Bill Hickman and Amy Cohen from Gabriel, Roeder, Smith & Company. A lengthy program followed with discussion on health trends, Health Plan data and policies. Mr. Hickman began by explaining the background of the State Health Plan. He described the historic increases in composite monthly premiums. He also described the history of the plan's deductibles, coinsurance percentages, coinsurance maximums, and per-occurrence deductibles. He explained the current design of the State Health Plan, commenting that it is essentially a 1990's health plan model.

Mr. Hickman went on to explain that the greatest single source of cost-sharing within health plans is provider discounts. These are the portions of fees for which providers agree to waive reimbursement. It also includes rebates from drug manufacturers for brand drug utilization. The next largest source is the Federal government—in the form of Medicare, the Retiree Drug Subsidy for

plans providing prescription coverage for Medicare-eligible members, and the Early Retirement Reinsurance Program. Mr. Hickman stated that the third largest source of healthcare funds is employer contributions. Subscriber contributions and coordination of benefits are the remaining significant sources for healthcare funds.

Mr. Hickman went on to explain that 0.8% of the total number of lives insured by the State Health Plan is responsible for 24.7% of claims paid by the plan. He listed significant sources of claims expenses. These include breast cancer, "encounter procedures," chronic renal failure, heart disease, and single live-born children. He also listed the top 10 providers to whom the plan pays claims and the top prescription drugs.

Next, Mr. Hickman explained that there are certain programs available for Medicare-eligible members. These include Medicare Advantage Plans and the Employer Group Waiver Plan (EGWP). He also listed potential programs and plan design considerations that could be included in a long-term strategic initiative to reduce costs by the Board.

Ms. Hartley commented on the success of the State Health Plan's network reimbursement model. She praised the efforts made by the Employee Insurance Program (pre-PEBA) management to reduce and keep down network reimbursements. She acknowledged that provider reimbursements make up a component she and the Healthcare Policy Committee had not considered in keeping down costs.

A discussion began between Board members and various presenters about considerations for reducing prescription drug costs. Dr. Will Harms from BlueCross BlueShield of South Carolina spoke up from the back of the room to assert that a major unnecessary cost regarding prescription drugs involves "drug-seeking" patients. These are patients who, due to likely dependence and/or addiction, attempt to obtain greater quantities of strong drugs—such as narcotics and psychotropic medications—for themselves or to sell. Because there are limits to the quantity of such drugs a physician can and will prescribe, Dr. Harms explained, patients will visit many different providers and/or facilities to obtain duplicate prescriptions.

Lunch Break

III. Educational Session and Discussion

Chairman Bjontegard introduced Matt Schafer, Brooks Goodman, Maria Platanis and Dr. Will Harms from Blue Cross Blue Shield. Their program focused on Patient-centered Medical Homes. Mr. Schafer described the changing dynamics of increased costs in healthcare. He explained that payment amounts are moving from mere quantity of services rendered to the actual quality of care given. He added that more costs are being incurred in outpatient settings whereas in previous decades hospitals were the primary venue of care. Mr. Schafer mentioned that care is being more customized to the individual patient and that record keeping is becoming less-and-less paper-driven and increasingly electronic.

Mr. Schafer then explained that new healthcare models are being developed on the basis of rewarding quality care over volume. Examples of these models include the Patient-centered Medical Homes and Accountable Care Organizations. He then introduced the Triple Aim Platform for improving health care in South Carolina. This includes increasing the experience of care, improving population health, and reducing per capita cost. The result will be a healthier population in South Carolina.

Mr. Schafer continued by explaining the Patient-centered Medical Home approach. He described the way the PCMH is designed to reduce costs, increase quality of care, and improve the relationship between healthcare providers and health plans. This method requires moving from fee-for-service to rewarding higher performance. This higher performance, he added, is based upon overall improvement in health outcomes. These include reduced hospitalization, reduced Emergency Room utilization, and an overall increase in patient satisfaction. The PCMH is a model which integrates

several components to create a complete health care model which is based upon improvement of outcomes, increased communication, and streamlining of the payment structure. This payment structure, he explained is a blend of fee-for-service, regular prospective payments, and bonuses for high-quality outcomes. He concluded by describing the implementation methods for creating the PCMH in South Carolina.

The Chairman introduced Robin Scott and Karen Cathcart from Express Scripts. Ms. Cathcart explained the various approaches currently being taken by the State Health Plan to contain prescription costs. These include regularly-revised formularies to keep up with a changing drug market, step-therapy, and volume-pricing using the mail order pharmacy. Mr. Penn asked if patients are being directed to certain pharmacies or if the payments are the same at any pharmacy. Ms. Cathcart explained that Express Scripts has a mail-order pharmacy which fills maintenance drugs on a volume-pricing basis, but that this is not exclusive. She continued by explaining that step-therapy is a system in which the plan requires certain less-costly alternative treatments be attempted or considered before the plan will authorize payment on a more expensive treatment. This usually involves a pre-authorization request to be submitted by the physician.

The Chairman introduced Ms. Judy Baskins, VP of Operations, Palmetto Health, who spoke on Clinically Integrated Physician Networks. Ms. Baskins began by explaining who Palmetto Health is and their vision. She explained that the Integrated Physician Network system includes physician practices, home health and hospice services, ambulatory and outpatient services, residency programs and education, and PACE—the Program of All-inclusive Care for the Elderly. Ms. Baskins then explained the purpose for Clinically Integrated Physician Networks. She explained that there are basically four forces which will shape health care costs in the future. These are: decelerating price growth, continuing cost pressure, shifting payer mix, and deteriorating case mix. She explained that the only two ways of stabilizing these forces are to reduce pricing or to reduce utilization. She explained that reducing prices will require a narrower network to ensure sufficient volume. Ms. Baskins added that this will also help reduce redundancy and waste, standardize processes, and establish internal protocols which would reduce harm and quality issues which can result in higher cost and more utilization. She introduced the PACE program, adding that Palmetto SeniorCare was the first PACE program in South Carolina. SeniorCare is an integrated system which provides coordinated, comprehensive care for the frail elderly. She concluded by explaining the Palmetto Health Quality Collaborative, which resulted in a 7% reduction in costs last fiscal year and is projected to result in an 11% reduction for the current fiscal year.

Chairman Bjontegard introduced Mr. Tony Keck, Director, SC Department of Health and Human Services. Mr. Keck explained the implications of South Carolina's decision to expand Medicaid. He explained that an expansion of Medicaid could result in an increase of enrollment of nearly 100%, due to eligible citizens dropping private insurance to go on Medicaid as well as overall increase in the number of eligible citizens. He explained that South Carolina's Medicaid expenditures have increased 38.21% since FY2007. He explained that enrollment growth is the major driver of increased costs to Medicaid. He reiterated the Triple Aim Platform previously discuss by Mr. Schafer. He pointed out those areas of the state where there are higher and lower concentrations of disease. The higher concentrated areas are in the Midlands/Pee Dee region, whereas the lower concentrated areas are the upstate and the low-country. Mr. Keck explained that the implementation of the Affordable Care Act will likely strain the health care system in South Carolina due to rapid growth in the number of citizens gaining access to affordable health insurance coverage. He explained that this number is projected to be 71% of the uninsured population in South Carolina—even without an expansion of Medicaid. He added that this would assist in improving health care

costs in South Carolina by increasing revenue. He concluded by echoing the need to improve outcomes, decrease utilization, and integrate care to avoid duplication and waste.

Chairman Bjontegard thanked all the presenters for the day. He then requested a motion to adjourn. Mr. Sowards moved to adjourn. Mr. Penn seconded. The Board unanimously voted to adjourn at 5:15 p. m.

South Carolina Public Employee Benefit Authority
Board of Directors Educational Sessions

Thursday, January 31, 2013

9:00 a.m. – 5:00 p.m.

Wampee Conference Center
Assembly Hall
1274 Chicora Dr, Pinopolis SC 29469

Agenda

I. Mike Madalena, Bill Hickman, Amy Cohen, Gabriel, Roeder, Smith (GRS)

- Discussion of Health Trends

II. 12 p.m.-1:00 p.m. Lunch

III. Educational Session and Discussion

- Brooks Goodman and Associates, Blue Cross Blue Shield
- Robin Scott and Associates, Express Scripts
- Judy Baskins, VP of Operations, Palmetto Health: Clinically Integrated Physician Networks
- Tony Keck, Director, SC Department of Health and Human Services

IV. Adjourn

State of South Carolina

Medical & Pharmacy Benefits Overview
PEBA Board Retreat

January 31, 2013

GRS
Gabriel Roeder Smith & Company
Consultants & Actuaries
www.gabrielroeder.com

Agenda

- Background of the State Health Plan (SHP)
  - Composite Monthly Premiums
  - History of Plan Design
    - Deductibles, Coinsurance
    - Per Occurrence Deductibles
    - Prescription Drug Copays
  - History of Premium Increases
- Who Pays the Cost of Healthcare?
- State Health Plan Model
- Programs for Medicare Primary Participants
- Long-term Strategic Initiatives
- Terminology

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BACKGROUND OF THE STATE HEALTH PLAN

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Standard Plan

Composite Monthly Premium

Year	Employer Share	Enrollee Share	Employer Contribution Percentage
2000	$216.37	$44.00	81.7%
2001	$259.65	$48.40	82.9%
2002	$284.31	$48.40	81.3%
2003	$284.31	$48.40	76.1%
2004	$284.31	$48.40	71.4%
2005	$301.65	$48.40	67.0%
2006	$316.13	$147.68	68.2%
2007	$325.93	$147.68	68.8%
2008	$357.55	$147.68	70.8%
2009	$357.55	$147.68	70.8%
2010	$357.55	$152.01	70.2%
2011	$393.62	$153.69	71.9%
2012	$413.65	$160.72	72.0%

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Standard Plan

History of Plan Design

Year	Deductible	In-Network Coinsurance	Coinsurance Maximum
2000	$200	85/15	$1,500
2001	$250	80/20	$1,500
2002	$250	80/20	$1,500
2003	$250	80/20	$1,500
2004	$350	80/20	$2,000
2005	$350	80/20	$2,000
2006	$350	80/20	$2,000
2007	$350	80/20	$2,000
2008	$350	80/20	$2,000
2009	$350	80/20	$2,000
2010	$350	80/20	$2,000
2011	$350	80/20	$2,000
2012	$350	80/20	$2,000

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Standard Plan

History of Per Occurrence Deductibles

Year	Outpatient Hospital	Emergency Room	Physician Office
2000	N/A	N/A	N/A
2001	N/A	N/A	N/A
2002	$50	$100	N/A
2003	$50	$100	N/A
2004	$75	$125	$10
2005	$75	$125	$10
2006	$75	$125	$10
2007	$75	$125	$10
2008	$75	$125	$10
2009	$75	$125	$10
2010	$75	$125	$10
2011	$75	$125	$10
2012	$75	$125	$10

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Standard Plan

History of Prescription Drug Copays

Year	Generic Copay	Brand Copay	Non-Preferred Brand Copay	Copayment Maximum
2000	$5	$20	N/A	$1,500
2001	$5	$20	N/A	$1,000
2002	$7	$22	N/A	$1,100
2003	$7	$22	N/A	$1,100
2004	$10	$25	$40	$2,500
2005	$10	$25	$40	$2,500
2006	$10	$25	$40	$2,500
2007	$10	$25	$40	$2,500
2008	$10	$25	$40	$2,500
2009	$10	$25	$40	$2,500
2010	$9	$30	$50	$2,500
2011	$9	$30	$50	$2,500
2012	$9	$30	$50	$2,500
2013	$9	$30	$50	$2,500

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Standard Plan

History of Premium Increases

Year	Employer	Enrollee	Overall
2000	10.0%	0.0%	8.0%
2001	20.0%	10.4%	18.3%
2002	9.5%	22.6%	11.7%
2003	0.0%	36.9%	6.9%
2004	0.0%	27.6%	6.6%
2005	6.1%	29.7%	13.0%
2006	4.8%	0.0%	3.2%
2007	3.1%	0.0%	2.1%
2008	9.7%	0.0%	6.7%
2009	0.0%	0.0%	0.0%
2010	0.0%	0.0%	0.0%
2011	10.3%	0.0%	7.2%
2012	4.5%	4.5%	4.5%
2013	4.6%	4.6%*	4.6%

* Pending resolution of Appellate Case No. 2012-213099 and No. 2012-212723

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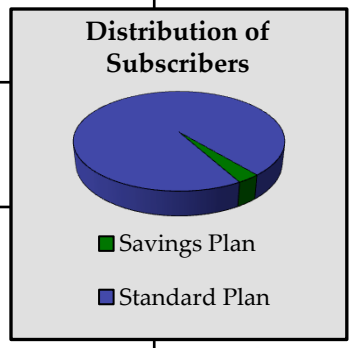
Current Plan Design

	Savings Plan		Standard Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Single Family	$3,000 $6,000		$350 $700	
Coinsurance	80%/20%	60%/40%	80%/20%	60%/40%
Coinsurance Maximum Single Family	$2,000 $4,000	$4,000 $8,000	$2,000 $4,000	$4,000 $8,000
Physician's Office Visit Per-occurrence Deductible Coinsurance Chiropractic Limit	N/A 80% $500	N/A 60% $500	$10 80% $2,000	$10 60% $2,000
Emergency Room Per-occurrence Deductible	N/A (Coinsurance applies)		$125	
Outpatient Hospital Per-occurrence Deductible	N/A (Coinsurance applies)		$75	
Prescription Drugs Retail Pharmacy Mail Order Pharmacy Maximum Copay	80% after the annual deductible is met; 100% after the coinsurance maximum is met; N/A		$9/30/50 $22/75/125 $2,500 max	
Composite PEPM[1]	$426.02		$603.75	



[1] PEPM means "per subscriber per month."

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WHO PAYS THE COST OF HEALTHCARE?

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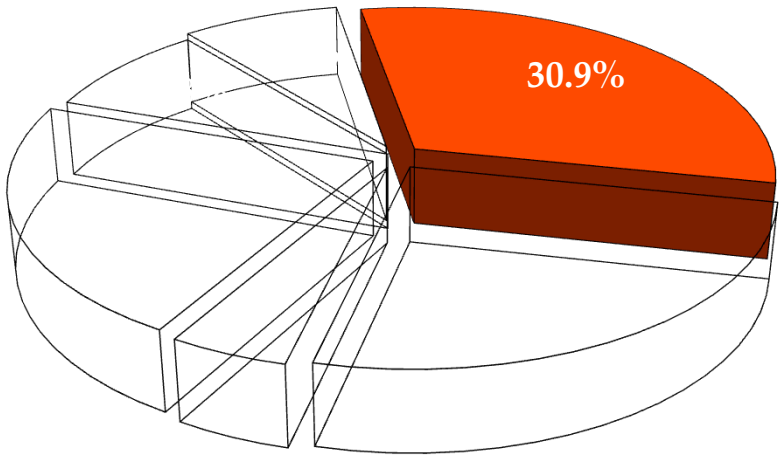
Who Pays the Cost of Healthcare?



- Provider Discounts
  - $1,388.7 million in 2011
  - Sources
    - Discounts off the submitted charges from physicians and hospitals
    - Discounts off the Average Wholesale Price (AWP) of drugs from the PBM
    - Rebates for brand drug utilization paid by Pharmaceutical Manufacturers
  - Management
    - Medical – The State currently contracts directly with providers. Unit cost reimbursements are established by the State annually for both physicians and institutional providers.
    - Pharmacy – The State contracts with a PBM selected as a result of a competitive bid process. Procurement activities are required in order to obtain the lowest prices in the current market.

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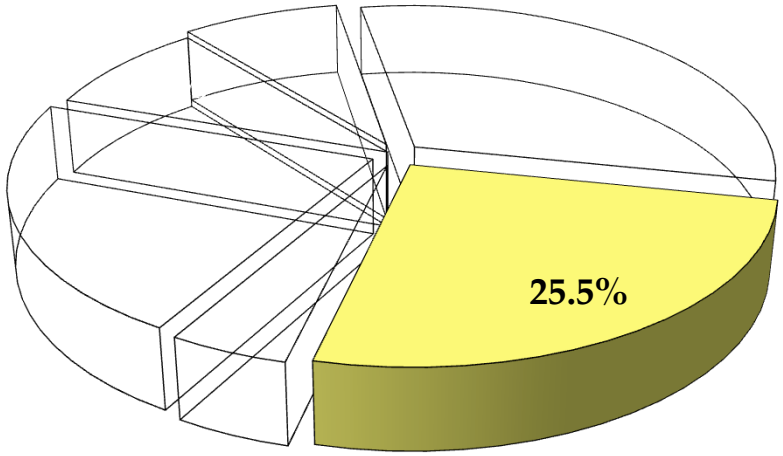
Who Pays the Cost of Healthcare?



- Federal Government
  - $1,195.8 million in 2011
  - Sources
    - Medicare is the primary payor for Medicare eligible individuals.
    - RDS provides subsidy for prescription drug costs for Medicare eligible individuals not enrolled in a Part D plan.
    - ERRP[1] provided subsidy for medical costs of pre-65 retirees and their dependents equal to 80% of costs between $15,000 and $90,000.
  - Management
    - The State routinely monitors available programs offered by the federal government.

[1] The Early Retirement Reinsurance Program (ERRP) was a temporary program under the Affordable Care Act (ACA). This program is not anticipated to be available in the future.

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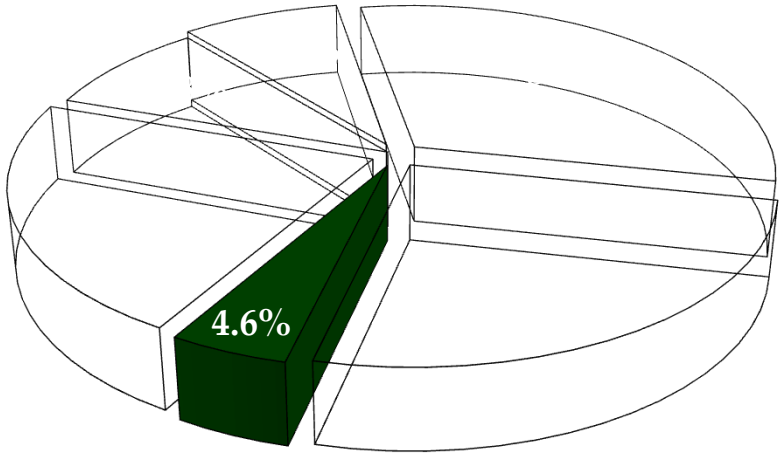
Who Pays the Cost of Healthcare?



- Coordination of Benefits
  - $214.1 million in 2011
  - Sources
    - Other employer group plans for which the subscriber or member is eligible to participate.
    - Worker's compensation benefits.
  - Management
    - The State's medical and prescription drug TPAs administer coordination of benefit provisions on the State's behalf.

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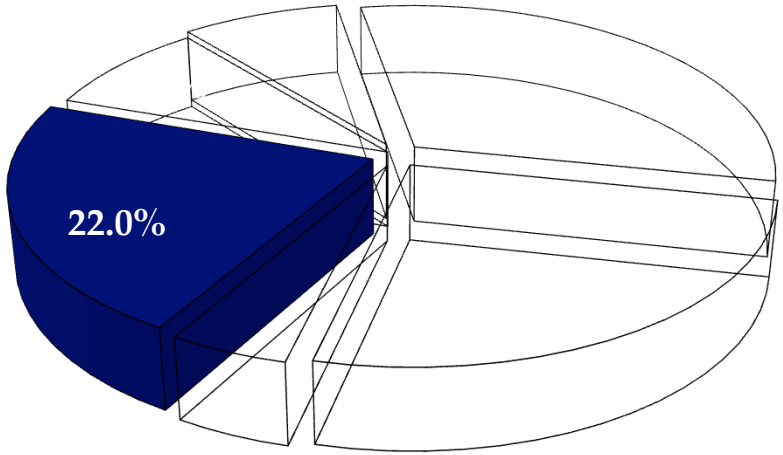
Who Pays the Cost of Healthcare?



- Employer Contributions
  - $1,030.8 million in 2011
  - Sources
    - State Agencies & Higher Education
    - Local Subdivisions (e.g. counties, municipalities, etc)
    - School Districts
    - Other entities
  - Management
    - Contributions are established annually during the budget setting process.

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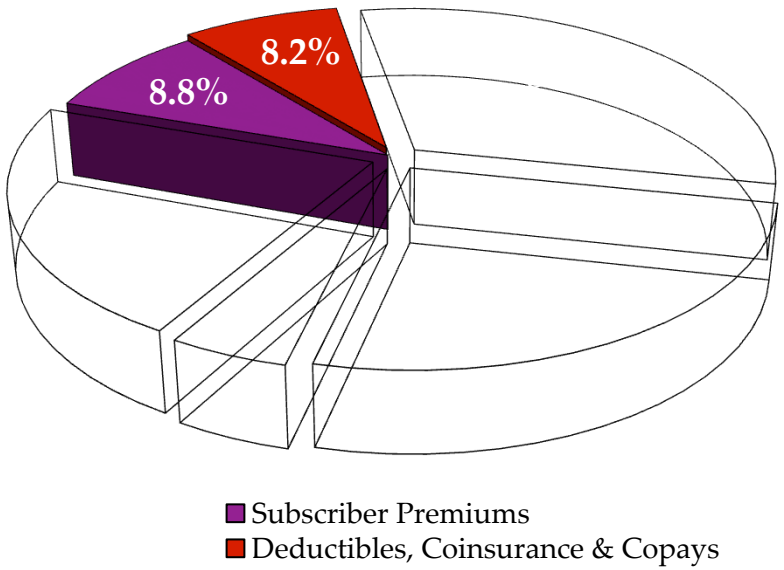
Who Pays the Cost of Healthcare?



- Subscriber Contributions
  - $798.3 million in 2011
  - Sources
    - Premiums
    - Deductibles
    - Coinsurance
    - Copayments
  - Management
    - Premiums are established annually during the budget setting process.
    - Potential plan design changes are considered annually.

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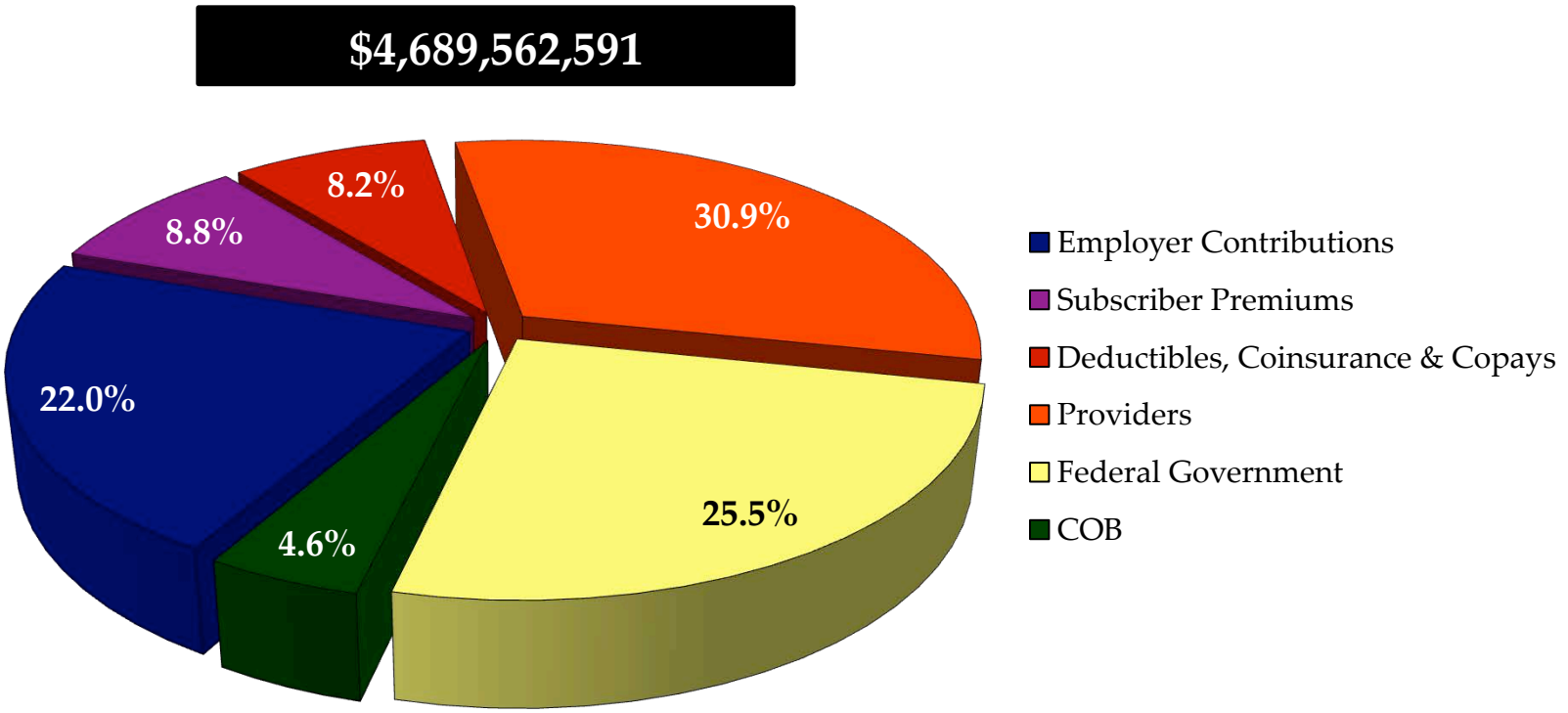
Who Pays the Cost of Healthcare?



The chart above is based on Plan Year 2011 data as of September 30, 2012.

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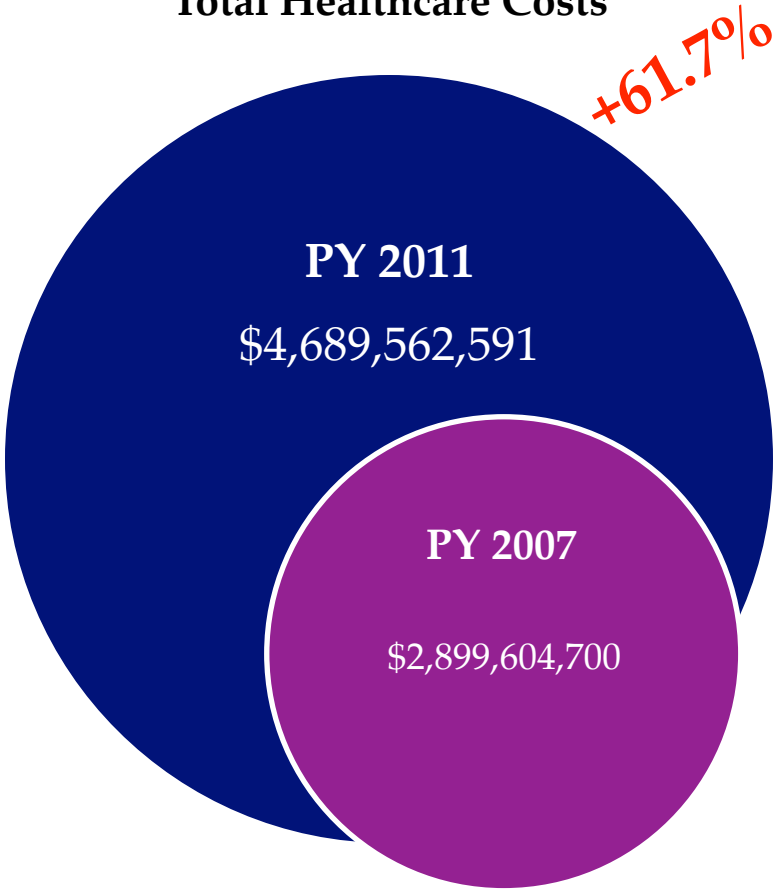
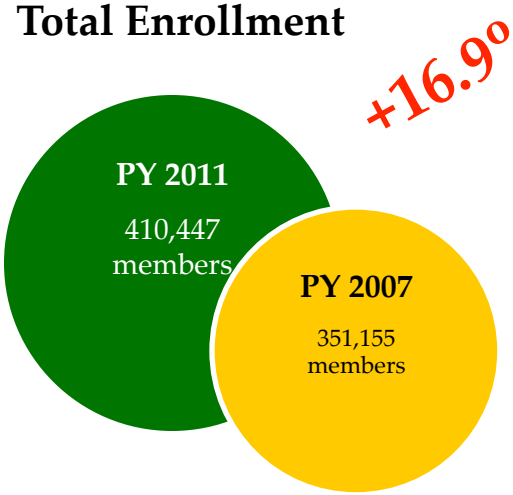
Four-Year Growth

Total Healthcare Costs



Total Enrollment



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STATE HEALTH PLAN MODEL

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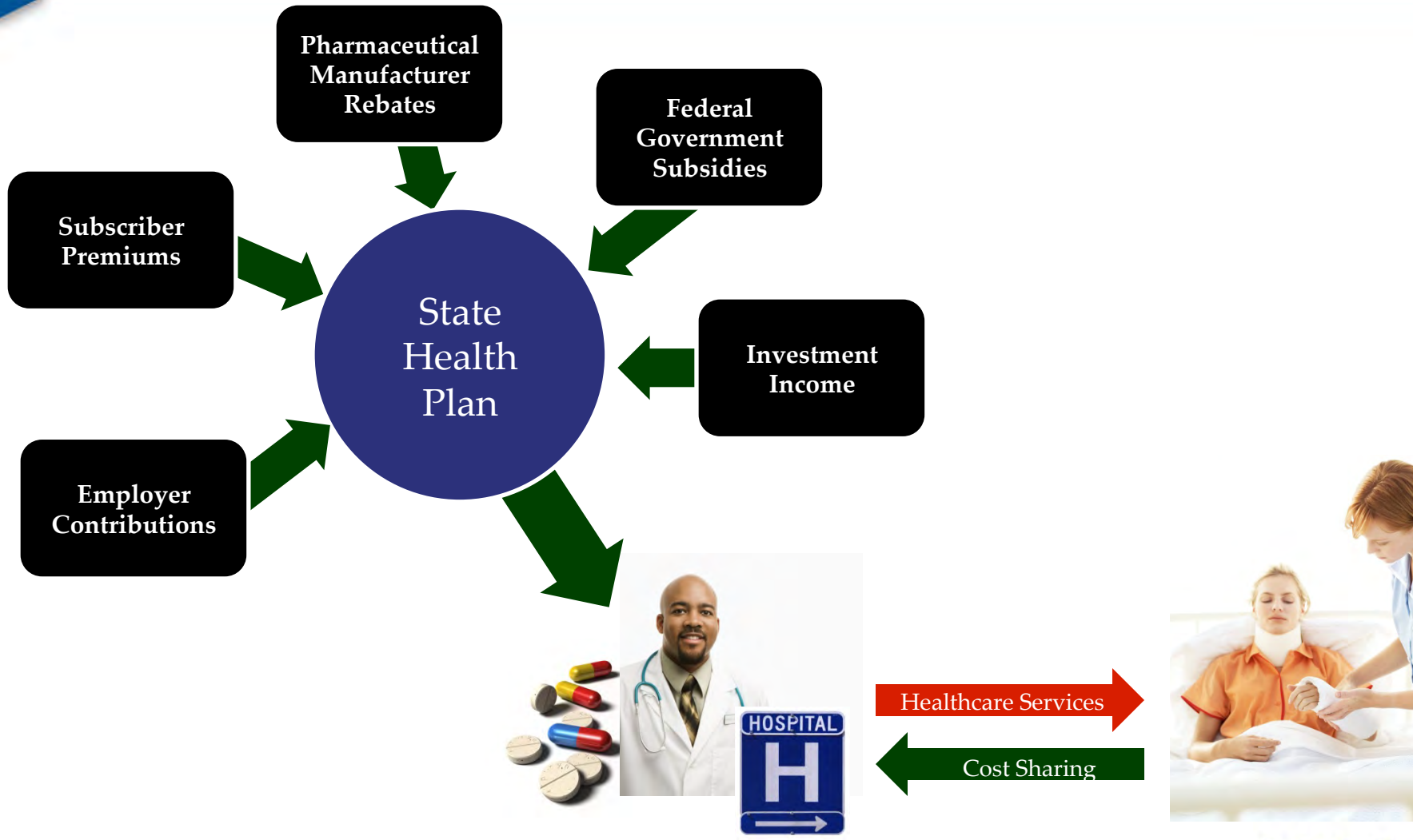
State Health Plan Model



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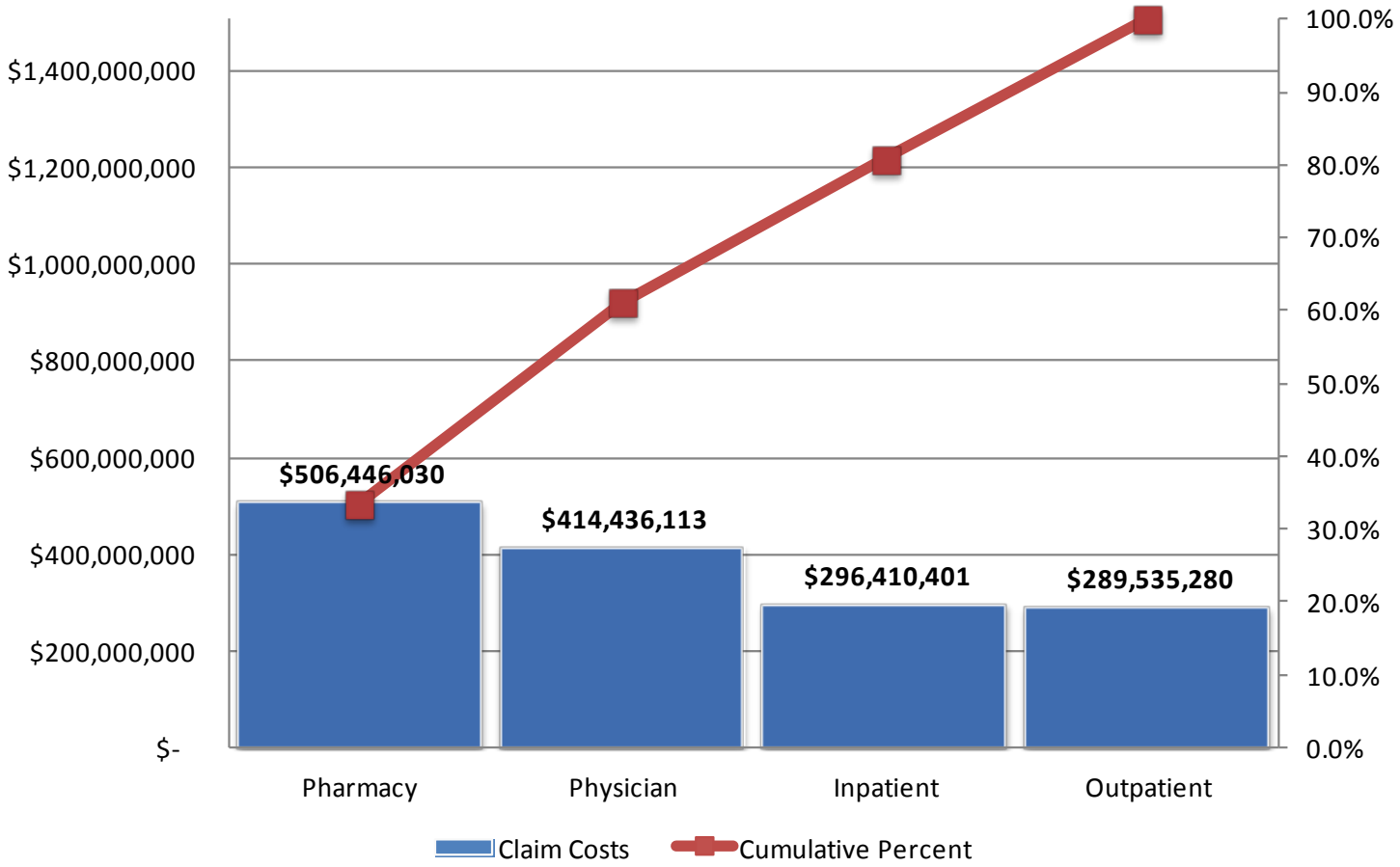
Standard Plan

2011 Incurred Claims Cost



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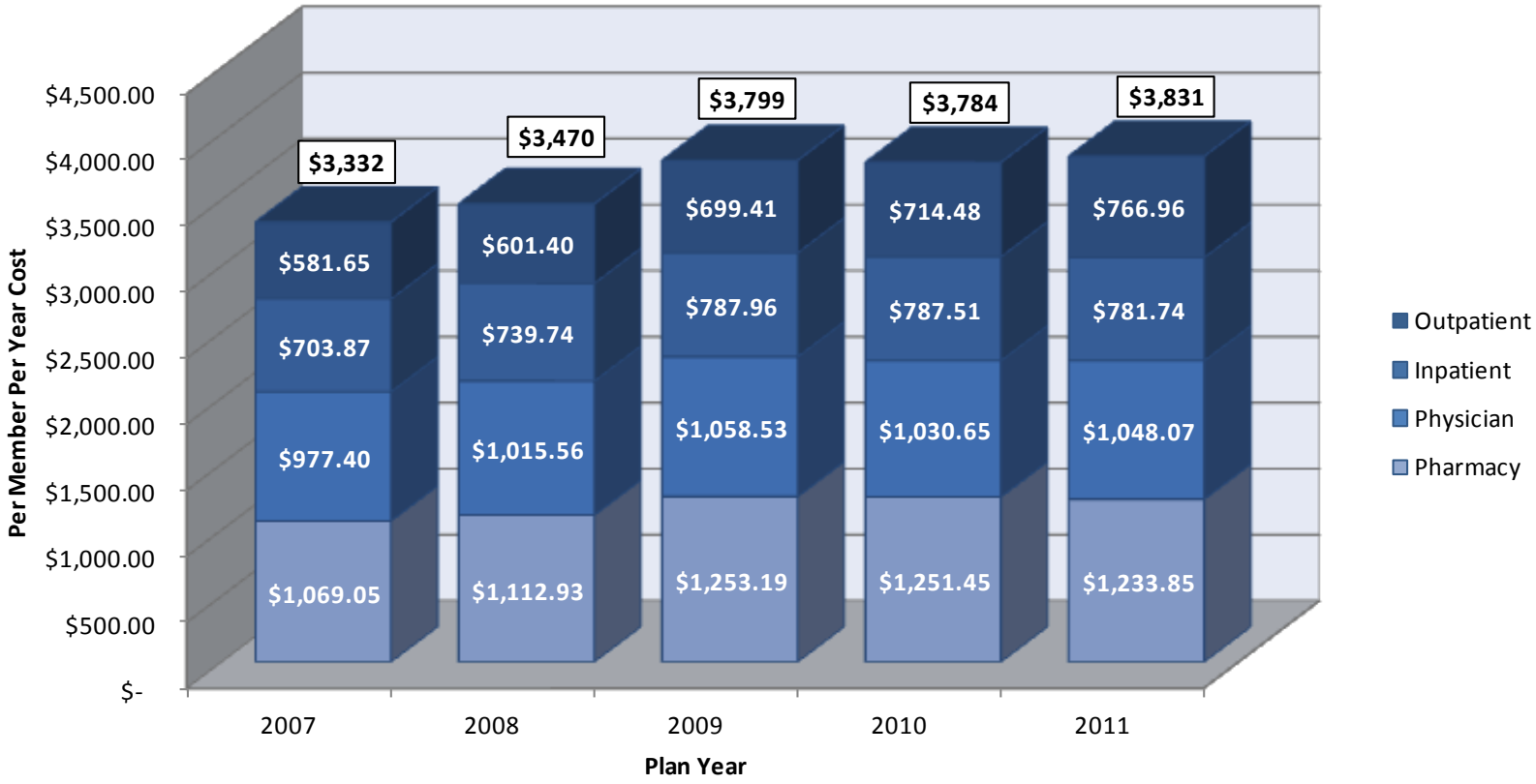
Standard Plan

Annual Distribution of Claims Cost



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2011 Claims Distribution Table

Paid Claims Range	Exposure		Claims	% of Exposure	Cumulative %	% of Claims	Cumulative % of Claims
$250,001 +	157.16	$	71,978,085	0.04%	0.04%	4.41%	4.41%
$200,001 to $250,000	81.15	$	19,402,107	0.02%	0.05%	1.19%	5.60%
$150,001 to $200,000	214.60	$	42,231,995	0.05%	0.10%	2.59%	8.19%
$100,001 to $150,000	557.39	$	75,400,819	0.13%	0.23%	4.62%	12.82%
$50,001 to $100,000	2,575.39	$	193,603,965	0.59%	0.82%	11.87%	24.69%
$45,001 to $50,000	628.17	$	33,424,751	0.14%	0.96%	2.05%	26.74%
$40,001 to $45,000	806.21	$	37,155,593	0.18%	1.15%	2.28%	29.02%
$35,001 to $40,000	1,007.51	$	41,259,397	0.23%	1.38%	2.53%	31.55%
$30,001 to $35,000	1,381.65	$	48,380,183	0.32%	1.69%	2.97%	34.51%
$25,001 to $30,000	2,170.21	$	64,082,328	0.50%	2.19%	3.93%	38.44%
$20,001 to $25,000	3,116.68	$	75,944,955	0.71%	2.90%	4.66%	43.10%
$15,001 to $20,000	5,169.33	$	98,352,790	1.18%	4.08%	6.03%	49.13%
$10,001 to $15,000	11,713.55	$	159,653,589	2.67%	6.75%	9.79%	58.92%
$9,001 to $10,000	3,918.52	$	39,918,395	0.89%	7.64%	2.45%	61.37%
$8,001 to $9,000	5,151.89	$	47,011,208	1.18%	8.82%	2.88%	64.25%
$7,001 to $8,000	7,006.82	$	55,957,575	1.60%	10.42%	3.43%	67.68%
$6,001 to $7,000	8,760.20	$	60,491,190	2.00%	12.42%	3.71%	71.39%
$5,001 to $6,000	11,081.50	$	64,737,191	2.53%	14.94%	3.97%	75.36%
$4,001 to $5,000	***14,993.54***	***$***	***71,898,281***	***3.42%***	***18.37%***	***4.41%***	***79.77%***
$3,001 to $4,000	21,657.84	$	80,985,046	4.94%	23.31%	4.97%	84.74%
$2,001 to $3,000	32,774.17	$	87,596,643	7.48%	30.79%	5.37%	90.11%
$1,001 to $2,000	56,877.61	$	92,083,611	12.98%	43.76%	5.65%	95.75%
$901 to $1,000	7,834.96	$	8,476,564	1.79%	45.55%	0.52%	96.27%
$801 to $900	8,648.94	$	8,387,148	1.97%	47.52%	0.51%	96.79%
$701 to $800	9,629.94	$	8,288,235	2.20%	49.72%	0.51%	97.30%
$601 to $700	10,827.88	$	8,073,069	2.47%	52.19%	0.50%	97.79%
$501 to $600	12,243.81	$	7,783,530	2.79%	54.99%	0.48%	98.27%
$401 to $500	14,333.67	$	7,514,270	3.27%	58.26%	0.46%	98.73%
$301 to $400	16,976.34	$	6,999,080	3.87%	62.13%	0.43%	99.16%
$201 to $300	20,858.90	$	6,165,532	4.76%	66.89%	0.38%	99.54%
$101 to $200	28,845.89	$	5,102,641	6.58%	73.47%	0.31%	99.85%
$1 to $100	45,396.88	$	2,465,850	10.36%	83.83%	0.15%	100.00%
$0.00	70,871.90	$	(698)	16.17%	100.00%	0.00%	100.00%
Total	438,270.23	$	1,630,804,919	100.0%		100.0%	

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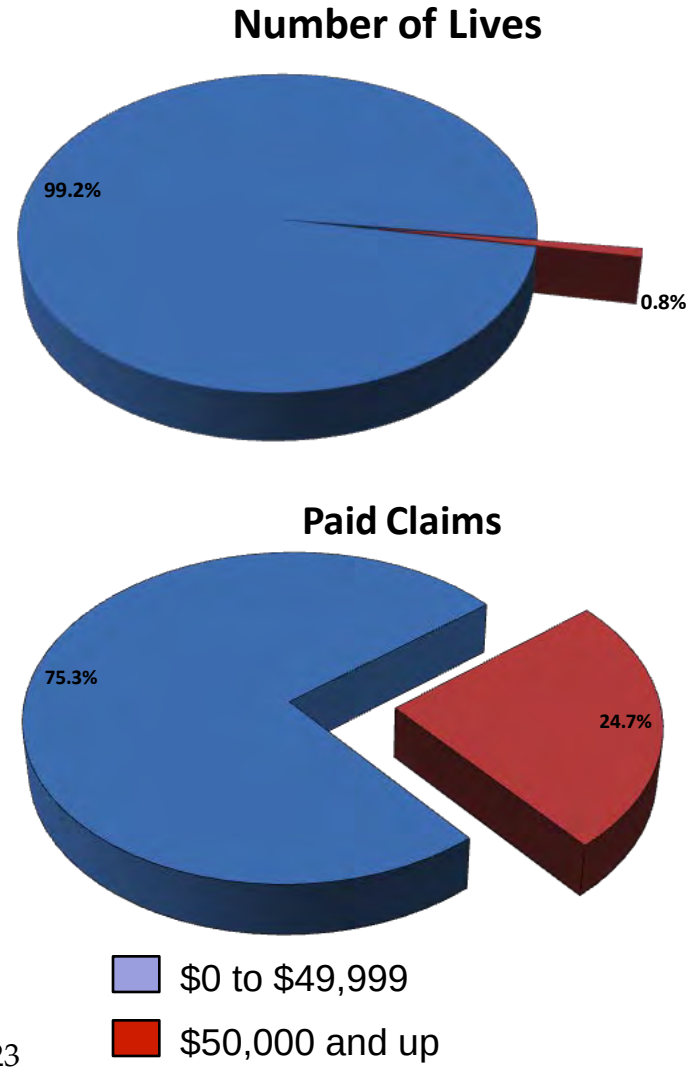
Summary of 2011 Data



Fewer than 1% of members account for approximately 25% of paid claims.

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Top 10 Diagnoses

Members with Claims > $50,000

2011					
Rank	Diagnosis	Patients	Claims Paid	% of Total Paid	Rank in Prior Year
1	Malignant Neoplasm of Female Breast	384	$ 18,534,075	5.8%	1
2	Encounter Procedure / Aftercare Not Elsewhere Classified	1,965	$ 15,869,306	5.0%	3
3	Chronic Renal Failure	383	$ 13,576,846	4.3%	2
4	Other Chronic Ischemic Heart Disease	705	$ 11,766,334	3.7%	4
5	Single Liveborn	60	$ 7,891,119	2.5%	7
6	Septicemia	207	$ 7,465,780	2.3%	13
7	Malignant Neoplasm Colon	145	$ 6,805,357	2.1%	8
8	Rehabilitation Procedure	745	$ 6,784,982	2.1%	6
9	Replace & Graft Complications	484	$ 6,749,379	2.1%	5
10	Malignant Neoplasm of Trachea / Lung	159	$ 5,907,011	1.9%	10

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Top 10 Providers

Members with Claims > $50,000

2011				
Rank	**Provider**	**Patients**	**Claims Paid**	**% of Total Paid**
1	Medical University Hospital	843	$38,350,743	12.6%
2	Palmetto Health Richland	409	$14,303,007	4.7%
3	McLeod Regional Medical Center	272	$10,496,111	3.4%
4	South Carolina Oncology	251	$ 8,975,378	2.9%
5	Spartanburg Regional	190	$ 8,025,546	2.6%
6	Greenville Hospital System	307	$ 7,958,097	2.6%
7	Roper Hospital	268	$ 6,245,739	2.0%
8	Carolinas Medical Center	163	$ 5,955,960	1.9%
9	Alere Healthcare	751	$ 5,797,437	1.9%
10	Self Regional Healthcare	134	$ 5,784,995	1.9%

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Top 10 Prescription Drugs
Members with Claims > $50,000

2011						
Rank	Drug Name	Treatment	Patients	Claims Paid	% of Total Paid	Rank in Prior Year
1	Revlimid	Multiple Myeloma	69	$4,549,786	9.7%	1
2	Gleevec	Myelogenous Leukemia (CML); Gastrointestinal Stromal Tumor (GIST)	41	$2,336,707	5.0%	2
3	Tracleer	Pulmonary Arterial Hypertension (PAH)	26	$1,716,190	3.7%	3
4	Copaxone	Multiple Sclerosis	35	$1,285,659	2.7%	18
5	Kogenate FS	Hemophilia	4	$1,065,880	2.3%	6
6	Cinryze	Allergy	3	$1,063,921	2.3%	4
7	Acthar H.P	Multiple Sclerosis, Reumatoid Arthritis	7	$ 974,049	2.1%	200
8	Xeloda	Colon Cancer	86	$ 812,797	1.7%	8
9	Humira	Rheumatoid Arthritis, Psoriasis	34	$ 778,465	1.7%	5
10	Thalomid	Multiple Myeloma	19	$ 777,052	1.7%	7

- All of the above medications are specialty drugs.
- Acthar H.P. was approved by the FDA in the 4th quarter of 2010.

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Major Diagnostic Category (MDC)

Rank*	Major Diagnostic Category	2009		2010		2011	
		Rate Per 1,000 Members	Cost Per Member	Rate Per 1,000 Members	Cost Per Member	Rate Per 1,000 Members	Cost Per Member
1	Musculoskeletal System and Connective Tissue	$ 356.73	$ 403.97	$ 362.94	$ 391.05	$ 359.51	$ 407.58
2	Circulatory System	$ 357.34	$ 274.77	$ 361.23	$ 281.64	$ 358.37	$ 271.27
3	Factors Influencing Health Status and Other Contacts With Health Services	$ 646.04	$ 240.26	$ 658.01	$ 256.06	$ 639.91	$ 266.11
4	Digestive System	$ 182.03	$ 178.91	$ 187.28	$ 180.75	$ 182.09	$ 181.03
5	Skin, Subcutanious Tissue and Breast	$ 370.96	$ 190.85	$ 375.72	$ 173.11	$ 373.11	$ 180.64
6	Kidney and Urinary Tract	$ 159.42	$ 143.09	$ 168.82	$ 144.90	$ 167.98	$ 143.61
7	Endocrine, Nutritional and Metabolic	$ 309.26	$ 97.72	$ 326.89	$ 96.74	$ 323.69	$ 102.96
8	Nervous System	$ 77.96	$ 89.98	$ 79.11	$ 93.79	$ 78.32	$ 101.21
9	Female Reproductive System	$ 121.24	$ 96.62	$ 122.95	$ 96.48	$ 117.88	$ 92.53
10	Respiratory System	$ 152.19	$ 86.00	$ 138.34	$ 81.23	$ 134.57	$ 83.16
11	Hepatobiliary System and Pancreas	$ 22.82	$ 64.60	$ 23.01	$ 67.99	$ 22.96	$ 73.70
12	Pregnancy, Childbirth, And The Puerperium	$ 15.28	$ 67.18	$ 15.78	$ 69.98	$ 15.70	$ 66.99
13	Ear, Nose, Mouth and Throat	$ 336.51	$ 67.60	$ 325.13	$ 65.45	$ 316.92	$ 66.74
14	Injuries, Poisonings, And Toxic Effect Of Drugs	$ 71.55	$ 63.83	$ 72.52	$ 63.49	$ 71.92	$ 66.50
15	Newborns And Other Neonates With Cond.	$ 19.52	$ 49.58	$ 20.58	$ 52.33	$ 17.05	$ 51.51
16	Myeloproliferative Diseases And Disorders, And Poorly Diff. Neoplasms	$ 55.11	$ 55.44	$ 61.10	$ 46.47	$ 63.47	$ 51.20
17	Blood And Blood Forming Organs And Imm. Dis.	$ 77.76	$ 41.78	$ 83.98	$ 50.49	$ 81.39	$ 45.54
18	Eye	$ 196.27	$ 43.56	$ 193.75	$ 43.96	$ 190.20	$ 44.96
19	Infectious and Parasitic (Systemic or Unspecified)	$ 105.66	$ 30.96	$ 77.00	$ 23.25	$ 90.59	$ 31.40
20	Male Reproductive System	$ 42.80	$ 28.14	$ 44.53	$ 30.75	$ 44.04	$ 30.66
21	Ungroupable - MDC 98	$ 38.58	$ 17.44	$ 41.22	$ 17.98	$ 42.77	$ 20.62
22	Mental	$ 111.34	$ 16.30	$ 117.15	$ 15.73	$ 122.22	$ 16.59
23	Burns	$ 2.00	$ 2.77	$ 2.18	$ 2.66	$ 2.13	$ 5.88
24	Alcohol/Drug Use or Alcohol/Drug Induced Organic Mental Disorders	$ 1.81	$ 0.81	$ 2.01	$ 1.07	$ 2.30	$ 1.62
25	HIV Infections	$ 1.09	$ 2.42	$ 1.15	$ 1.79	$ 1.13	$ 1.37

* Based on 2011 Cost Per Member

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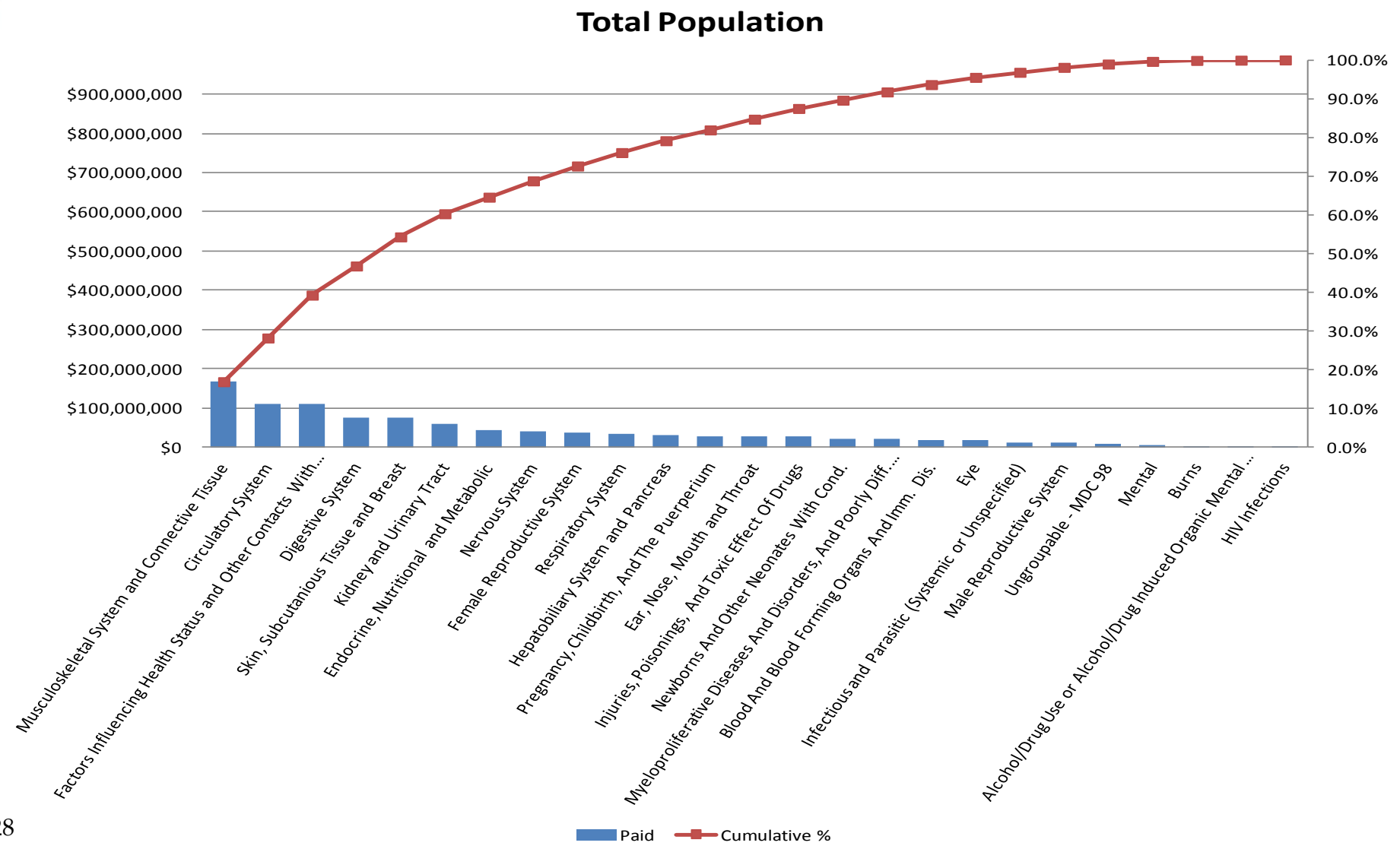
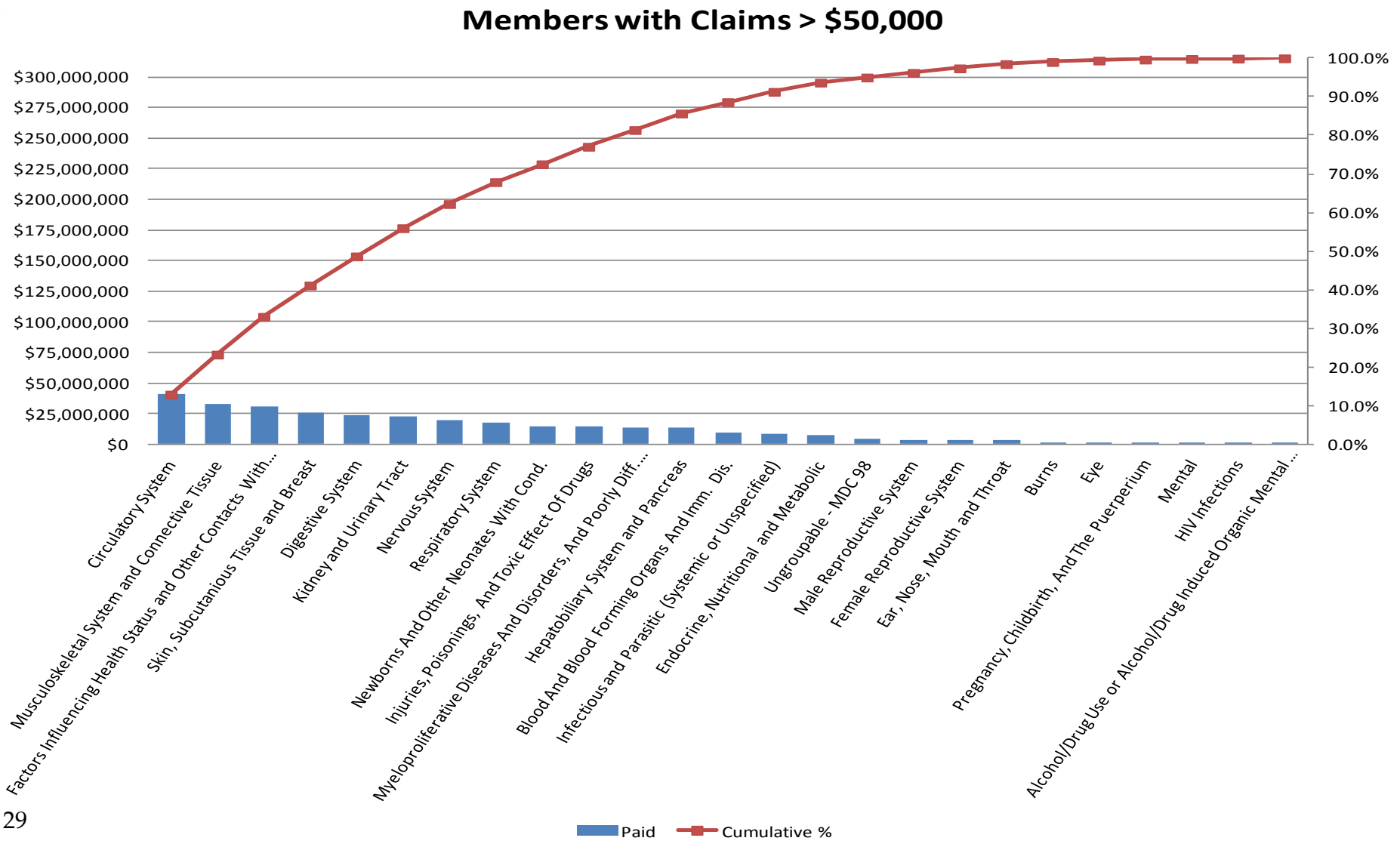
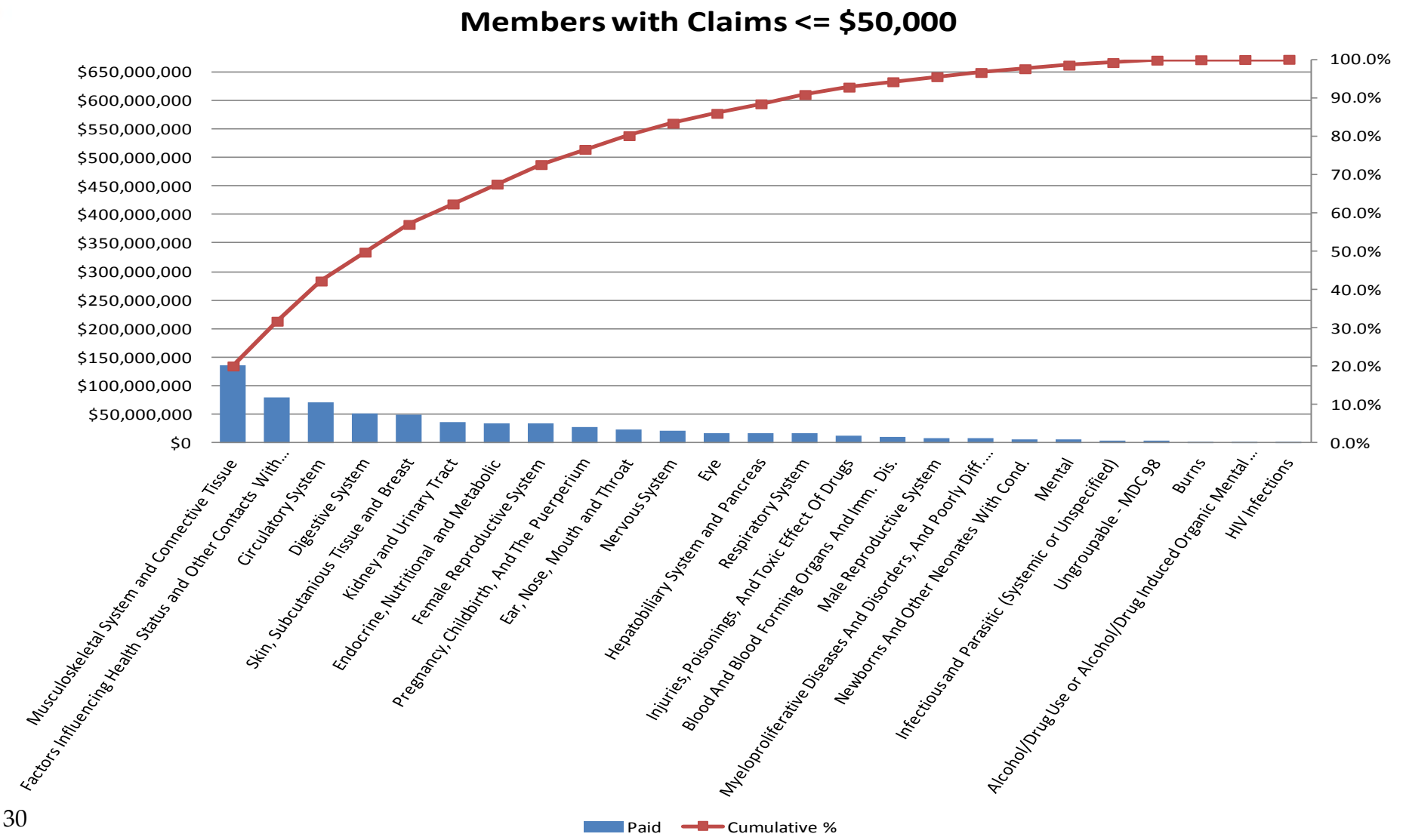
2011 Claims Analysis by MDC



2011 Claims Analysis by MDC



2011 Claims Analysis by MDC



High Cost Claimants

Year*	Number of Members in Excess of 250,000	Claims Paid	Per Member
2011	154	$ 56,763,514	$ 368,594
2012	165	$ 68,120,683	$ 412,853

* Incurred and paid during plan year

- On a per capita basis, paid claims for high cost claimants increased by 12% in calendar year 2012.
- These individuals increase in cost contributed 0.55% to overall plan trend.

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Current Per Capita Trend

Component	Medical	Pharmacy
Utilization	3.49%	4.72%
Inflation & Mix of Services	2.37%	6.91%
Leverage	1.12%	2.71%
Total Trend	**6.98%**	**14.34%**

Based on claims paid through 10/26/2012 and enrollment as of 10/1/2012.

- Utilization trend – the change in the frequency of services provided to members.
- Inflation - the change in allowed price per service for the same service.
- Mix of Services – the change in types of services being rendered.
- Leverage – the change in value (to the member) of an unchanged plan design.

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PROGRAMS FOR MEDICARE PRIMARY PARTICIPANTS

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Medicare Advantage Plan

- What is it?
  - A health plan offered by a private insurance company that has contracted with Medicare to provide Part A and Part B benefits on behalf of Medicare.
- Advantages
  - Offers a single payor system instead of the current two-payor approach
  - May include additional benefits not covered by Medicare
- Disadvantages
  - May require additional out-of-pocket costs depending on plan design
  - Mandates significant CMS communication materials
  - Requires an opt out provision

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Indirect EGWP + Wrap Plan

- What is it?
  - An Indirect EGWP with Wrap arrangement begins with a Standard Part D plan design and then combines it with a separate, second plan which "wraps" around the standard EGWP so that both plans together can provide essentially the same benefits as the original plan design.
- Advantages
  - Additional revenue streams from federal reinsurance program and Coverage Gap Discount program
  - All administration handled by the PBM
- Disadvantages
  - Potential change in formulary
  - Mandates significant CMS communication materials
  - Requires an opt out provision

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Indirect EGWP + Wrap Plan

- PEBA is preparing to issue a Request for Proposals (RFP) for Pharmacy Benefit Management services for January 1, 2014.
  - Collect both technical and financial proposals from qualified Offerors for the current prescription drug program
  - Collect both technical and financial proposals from qualified Offerors and evaluate the feasibility of implementing an Indirect EGWP + Wrap for Medicare primary participants

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LONG-TERM STRATEGIC INITIATIVES

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Long-term Strategic Initiatives

- Payment reform pilot programs
  - Accountable Care Organizations
  - Global and Case Rate reimbursement
  - Patient Centered Medical Homes
  - On-site clinics operated by the State
- Plan Design
  - Value based plan design
    - Rewarding members for efficient use of health care through incentives (e.g. plan design, cash, etc.)
  - Specialty pharmacy
    - Implement higher levels of management on high cost pharmaceuticals
- Network Structure
  - High performance networks
    - Contract only with hospitals and physicians that meet quality and cost standards

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TERMINOLOGY

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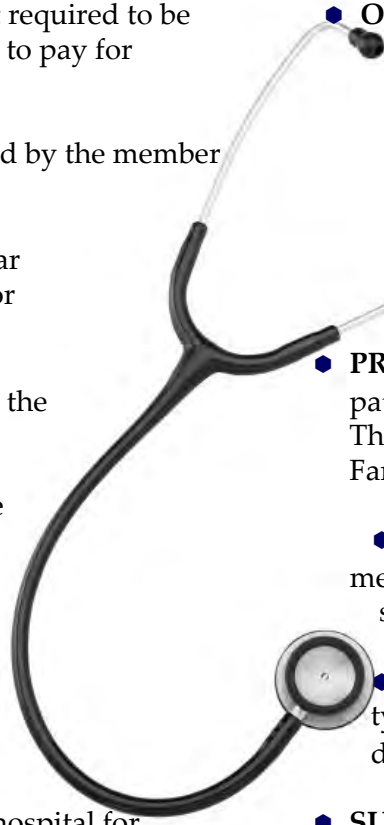
Terminology

- **ANNUAL DEDUCTIBLE** The dollar amount required to be paid by the member before health plan begins to pay for covered expenses and services.
- **COINSURANCE** The percentage of costs paid by the member for covered expenses and services.
- **COINSURANCE MAXIMUM** The total dollar amount of coinsurance paid by the member for covered expenses and services.
- **COPAYMENT** The fixed dollar costs paid by the member for covered expenses and services.
- **COVERED EXPENSE** An event or procedure that will be paid for either in full or in part by the health plan.
- **EMPLOYER CONTRIBUTION** The amount paid to the health plan by the employer(s) on a monthly basis to fund the health plan.
- **INPATIENT** A patient who is admitted to a hospital for medical treatment that requires at least one overnight stay.
- **NETWORK** A list of physicians, hospitals and other medical service providers who contract with the health plan to provide healthcare services at a discounted rate.



- **OUTPATIENT** A patient who is receiving medical treatment without being admitted to the hospital.
- **PER-OCCURRENCE DEDUCTIBLE** The dollar amount required to be paid by the member before the health plan begins to pay for covered expenses in a professional provider's office, emergency room or outpatient facility.
- **PRIMARY CARE PHYSICIAN (PCP)** A physician who is a patient's first point of contact for an undiagnosed condition. This physician is usually a Pediatrician, General Practitioner, Family Practitioner, OB/GYN, or Internist.
- **PROVIDER** A doctor, hospital or other licensed medical professional/facility that provides healthcare services.
- **SPECIALIST** A doctor who specializes in a certain type of medical care (*e.g.* cardiologist, podiatrist, eye doctor).
- **SUBSCRIBER CONTRIBUTION** The amount paid to the health plan by an employee/retiree on a monthly basis in order to be covered under the health plan.

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Terminology

- **ACCOUNTABLE CARE ORGANIZATION (ACO)** A network of doctors and hospitals that share responsibility for providing care to patients. Provider reimbursements are a function of both quality, appropriateness and efficiency of care.

- **EXCLUSIVER PROVIDER ORGANIZATION (EPO)** A managed care health plan in which all covered services are rendered by in-network providers. A PCP is not required and referrals are not needed to see other providers for covered services.

- **HEALTH MAINTENANCE ORGANIZATION (HMO)** A managed care health plan in which all covered expenses are rendered by in-network providers, except in an emergency situation. A PCP is required under an HMO plan.

- **HEALTH SAVINGS ACCOUNT (HSA)** A savings account used by individuals covered by a High Deductible Health plan to pay for current and future eligible medical expenses on a tax free basis.

- **HIGH DEDUCTIBLE HEALTH PLAN (HDHP)** A health plan with an annual deductible of at least $1,200 for individuals and $2,400 for family coverage, and annual out-of-pocket expenses do not exceed $6,050 for individuals and $12,100 for family coverage.

- **MEDICARE ADVANTAGE PLAN (MA)** A private health plan that is approved by Medicare to provide medical benefits in place of Medicare Part A and Part B to Medicare eligible individuals who are enrolled in both Medicare Part A and Part B. (Also called Part C.)

- **MEDICARE PART A** The national health plan administered by the United States government. Part A covers inpatient hospital stays for individuals age 65 and over and individuals of any age with certain disabilities.

- **MEDICARE PART B** The national health plan administered by the United States government. Part B covers physician and outpatient hospital services for individuals age 65 and over and individuals of any age with certain disabilities.

- **PATIENT CENTERED MEDICAL HOME (PCMH)** A system of comprehensive coordinated healthcare for individuals facilitated by a PCP who is responsible for leading a team of professionals in providing both preventive and chronic care management.

- **PREFERRED PROVIDER ORGANIZATION (PPO)** A managed care health plan provides both in-network and out-of-network benefits. A PCP is not required and referrals are not needed to see other providers for covered services.

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Terminology

- **POINT OF SERVICE (POS)** A managed care health plan that provides both in-network and out-of-network benefits. A PCP is required; however, the member may choose an out-of-network provider for an additional out-of-pocket cost.

- **THIRD PARTY ADMINISTRATOR (TPA)** The organization that processes claims, maintains a provider network, utilization review and/or membership functions on behalf of the health plan.

- **BRAND DRUG** A medication sold by a single pharmaceutical company under a trademark protected name.

- **EMPLOYER GROUP WAIVER PLAN (EGWP)** An employment based group plan which provides prescription drug benefits to Medicare eligible individuals. An EGWP plan replaces a Part D plan sponsored by Medicare.

- **FORMULARY** The list of brand and generic drugs covered by the prescription drug or health plan.

- **GENERIC DRUG** A medication that is comparable to a brand drug in dosage form, strength, route of administration, quality, performance characteristics and intended use but is not protected by a trademark name.

- **MEDICARE PART D** The national health plan administered by the United States government. Part D covers prescription drug benefits for individuals age 65 and over and individuals of any age with certain disabilities.

- **PHARMACY BENEFIT MANAGER (PBM)** A company that administers drug benefit programs for individuals and/or groups.

- **RETIREE DRUG SUBSIDY (RDS)** A federally sponsored program which reimburses plan sponsors for a portion of paid prescription drug expenses for Medicare eligible individuals.

- **TIER** The method by which drugs are grouped within the formulary to indicate the applicable copay (e.g. Tier 1 = generic – lowest cost alternative; Tier 2 = brand – higher cost alternative; Tier 3 = brand – highest cost alternative; etc).

- **SUBSCRIBER** The employee/retirees who are eligible to receive benefits through the health plan.

- **MEMBER** The individuals who are enrolled in the health plan (*e.g.* employees, retirees and eligible dependents).

- **DEPENDENT** A spouse or eligible child who meets the eligibility requirements set forth by the health plan.

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Because it matters how you're treated

PEBA Board Presentation

January 31, 2013

South Carolina

State Health Plan Contract Responsibilities

- State of SC/PEBA
  - Planholder and Administrator
  - Determines Plan design, maintains Plan Document
  - Determines Employer and Employee contributions
  - Conducts Procurement of Contracts
  - Monitors performance of all contracts
  - Contracts directly with providers – hospitals and physicians
  - Determines and maintains participant eligibility
  - Performs second level appeals

State Health Plan Contract Responsibilities

- Blue Cross Blue Shield of South Carolina
  - Acts as Third Party Administrator
  - Enrollment processing
  - Claims Administration
  - Medical Management
  - Network Administration and Consultation
  - Provide national network (outside of SC)
  - Legal Support (Indemnify)
  - Actuarial and benefit design consultation
  - Reporting
  - Member Engagement and Wellness

Value

Expertise

Consultation

Execution

National Benchmark Averages

	SC State	Exec, Legislative, General Gov.	All Industry Benchmark
Combined members	349,874	2,269,374	27,483,858
Combined Services			
Paid PMPM	$220.52	$278.13	$244.99
Avg. Member Cost Share	20.3%	13.1%	15.3%
Inpatient			
Paid PMPM	$68.76	$71.88	$69.00
Avg. Length of Stay	4.2	4.3	4.1
Admits/1,000	68.1	61.8	59.3
Avg. Paid/Admit	$12,114	$13,946	$13,957
Outpatient Facility			
Paid PMPM	$68.34	$92.62	$79.81
Services/1,000	8,958	14,617	10,293
Professional Services			
Paid PMPM	$72.55	$96.11	$79.19
Services/1,000	17,133	16,429	14,421
Avg. Paid/Service	$51	$70	$66
Other Services			
Paid PMPM	$10.84	$17.39	$16.96
Age Gender Factor	1.16	1.16	1.06

2010 BHI

Factors That Impact Medical Spend

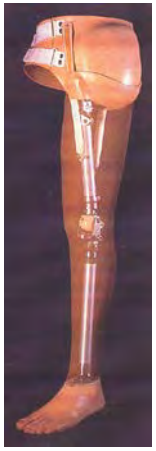
Leveraging
- When health care expenses rise, but member's copayments stay the same, the impact to overall costs is called leveraging

Burden
- Selection impacts overall costs when someone with lower than average benefit expenses leaves the group

Intensity
- The impact of replacing a product or service with a more expensive one

Utilization
- The number of health care products and services provided

Price
- The per unit amount that insurers pay out in benefits to hospitals, physicians, and other health care providers on behalf of their members



Standard Prosthetic Leg

$7,000-$10,000

C-Leg

$50,000-$60,000

How Cost Sharing Impacts Trend

	Total Cost	Member Co-pay	Benefit Costs	% Increase in Trend
Year 1 office visit	$50	$10	$40	
Year 2 with underlying 10% increase in costs				
No change in co-pay	$55	$10	$45	12.5%
10% increase in co-pay	$55	$11	$44	10%
Cost pass thru to co-pay	$55	$15	$40	0%

Cost Sharing/Trend Example

	2012	2013	% Increase
Claim	$500	$575	15%
Deductible	-$350	-$350	0
	$150	$225	
	X .8	X .8	
EIP Payment	$120	$180	50%

ER Visit Data

ER Visits	Claimants	Claimants % of Total	ER Visits
1	43,212	75.3%	43,212
2	9,140	15.9%	18,280
3	2,887	5.0%	8,661
4	1,083	1.9%	4,332
5	472	0.8%	2,360
6	242	0.4%	1,452
7	139	0.2%	973
8	66	0.1%	528
9	54	0.1%	486
Greater Than 10	120	0.2%	2,012

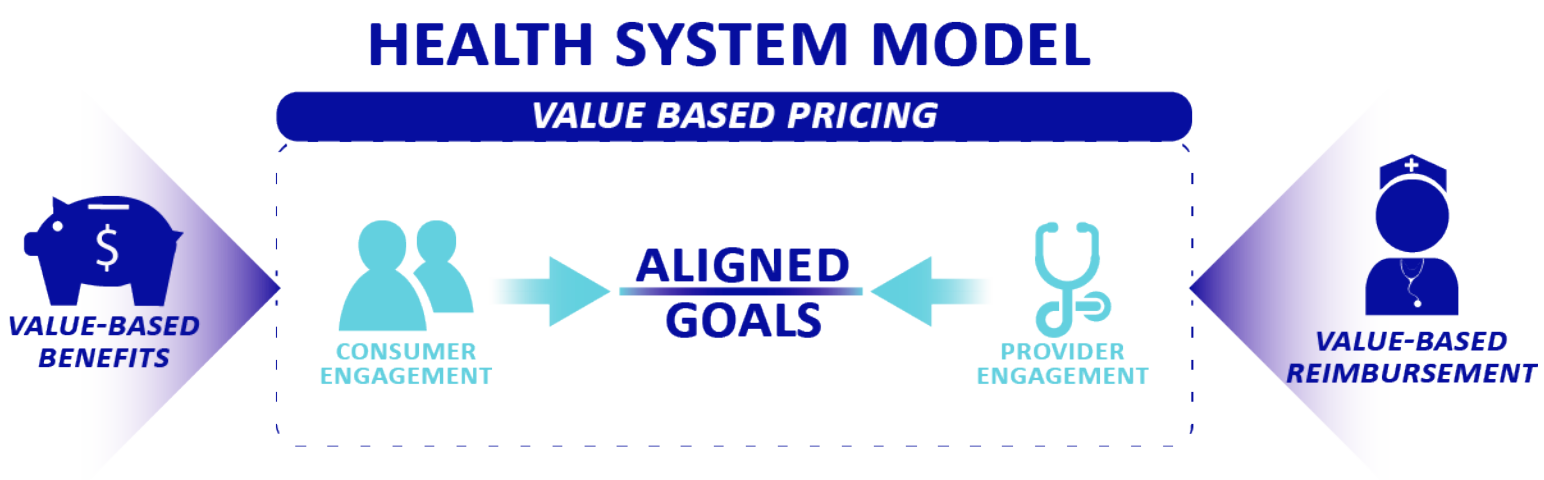
ER Visit Per 1,000

Reporting Period	Nov '11-Oct '12			Nov '10-Oct '11		
Measure Type	Company	Benchmark	% Variance	Company	Benchmark	% Variance
Allowed PMPM	$19.19	$19.19	0.0%	$21.97	$21.97	0.0%
Paid PMPM	$7.37	$7.37	0.0%	$6.42	$6.42	0.0%
Services/1000	215.8	215.8	0.0%	203.0	203.0	0.0%
Allowed/Service	$1,067	$1,067	0.0%	$1,299	$1,299	0.0%

Key Statistics by Service Category

Service Category	Reporting Period	Nov '11-Oct '12	Nov '10-Oct '11	Trend
Inpatient Facility	Allowed	$706,838,381	$836,395,841	(15.5%)
	Allowed PMPM	$154.47	$187.80	(17.7%)
	Allowed/Service	$19,401.05	$23,566.42	(17.7%)
	Services/1000	95.5	95.6	(0.1%)
	% Reduction Billed to Paid	78.20%	78.08%	0.2%
Outpatient Facility	Allowed	$723,319,455	$849,978,708	(14.9%)
	Allowed PMPM	$158.07	$190.85	(17.2%)
	Allowed/Service	$874.67	$1,167.04	(25.1%)
	Services/1000	2,168.6	1,962.4	10.5%
	% Reduction Billed to Paid	80.84%	80.54%	0.4%
Professional	Allowed	$756,555,342	$705,838,654	7.2%
	Allowed PMPM	$165.33	$158.48	4.3%
	Allowed/Service	$84.95	$85.08	(0.2%)
	Services/1000	23,353.3	22,352.1	4.5%
	% Reduction Billed to Paid	75.54%	75.25%	0.4%
Summary	Allowed	$2,186,713,177	$2,392,213,204	(8.6%)
	Allowed PMPM	$477.86	$537.12	(11.0%)
	Allowed/Service	$223.85	$264.05	(15.2%)
	Services/1000	25,617.4	24,410.1	4.9%
	% Reduction Billed to Paid	78.16%	77.87%	0.4%

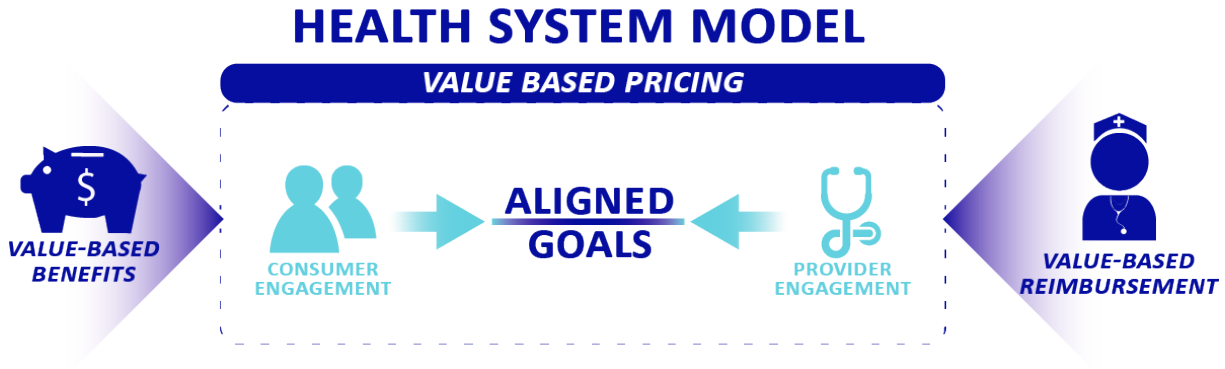
Health Insurance Cost Drivers



- Health plans contract with and reimburse providers based on the outcomes and value of care rather than on units of service or price.
- Consumers are engaged in health care decision making and use clear, meaningful information to routinely select their healthcare providers on the basis of value.
- Health benefit designs reward healthy behavior, encourage management of chronic disease while creating disincentives for noncompliance, low value services and poor lifestyle choices.
- Incentives are aligned across payers, providers and consumers. As a result value based health care delivery, evidence based decision making and healthy member behavior increases.

Used with permission Oliver Wyman Integrated Health Management Study 2010

Health Insurance Cost Drivers



Consumer Strategies

- Improve wellness and prevention
- Reduce risk factors—e.g., obesity, smoking, depression
- Improve health engagement, awareness, and decision-making
- Improve treatment compliance
- Improve chronic care management

~30% of the savings opportunity

Provider Strategies

- Reduce practice variation
- Modify the care model by health segment
- Reduce patient risk factors
- Eliminate clinical redundancies
- Manage the treatment plan
- Coordinate care for complex patients

~70% of the savings opportunity

Source: David Wennberg, M.D., MPH, 2008
Western Leadership Conference

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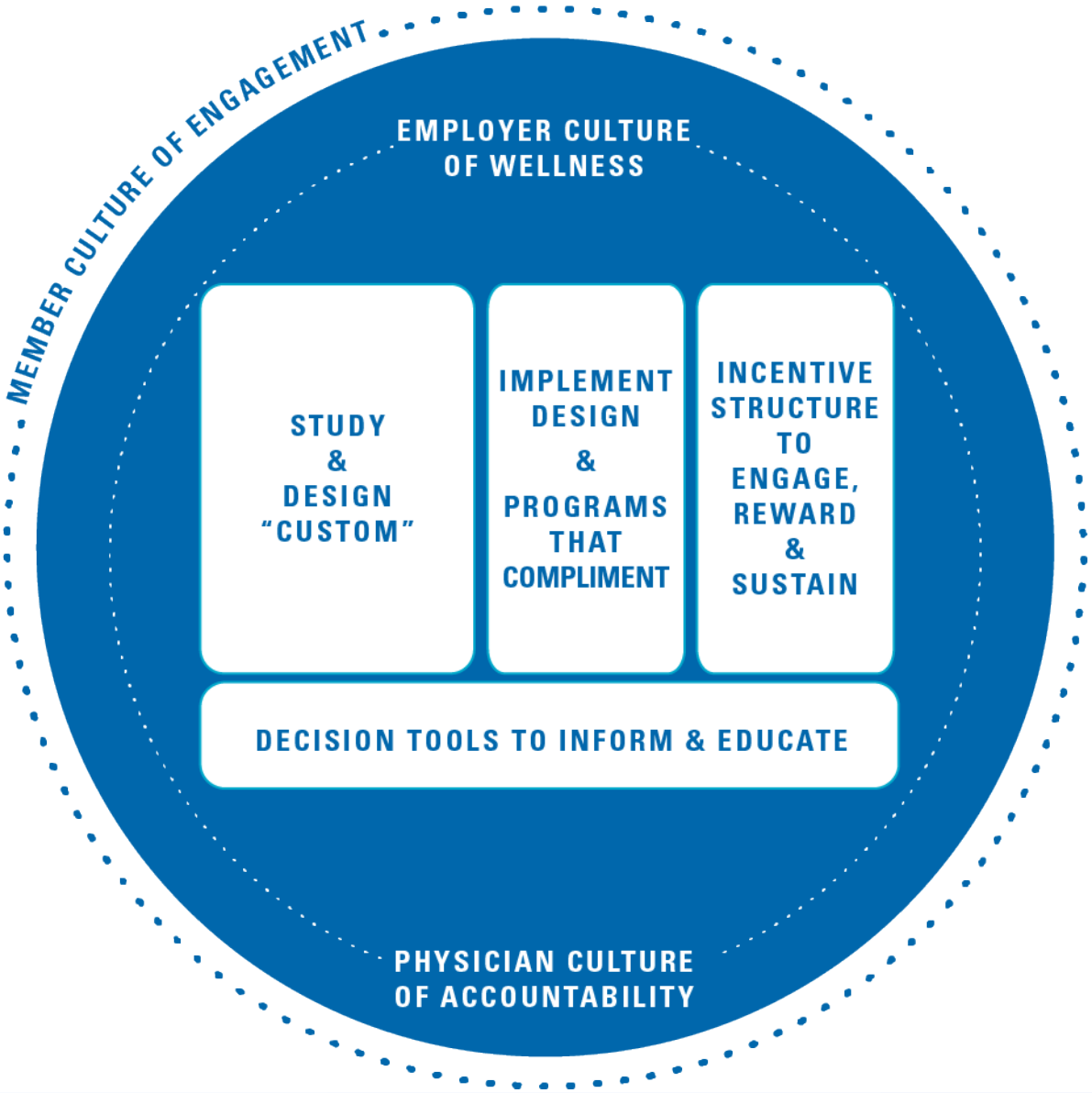
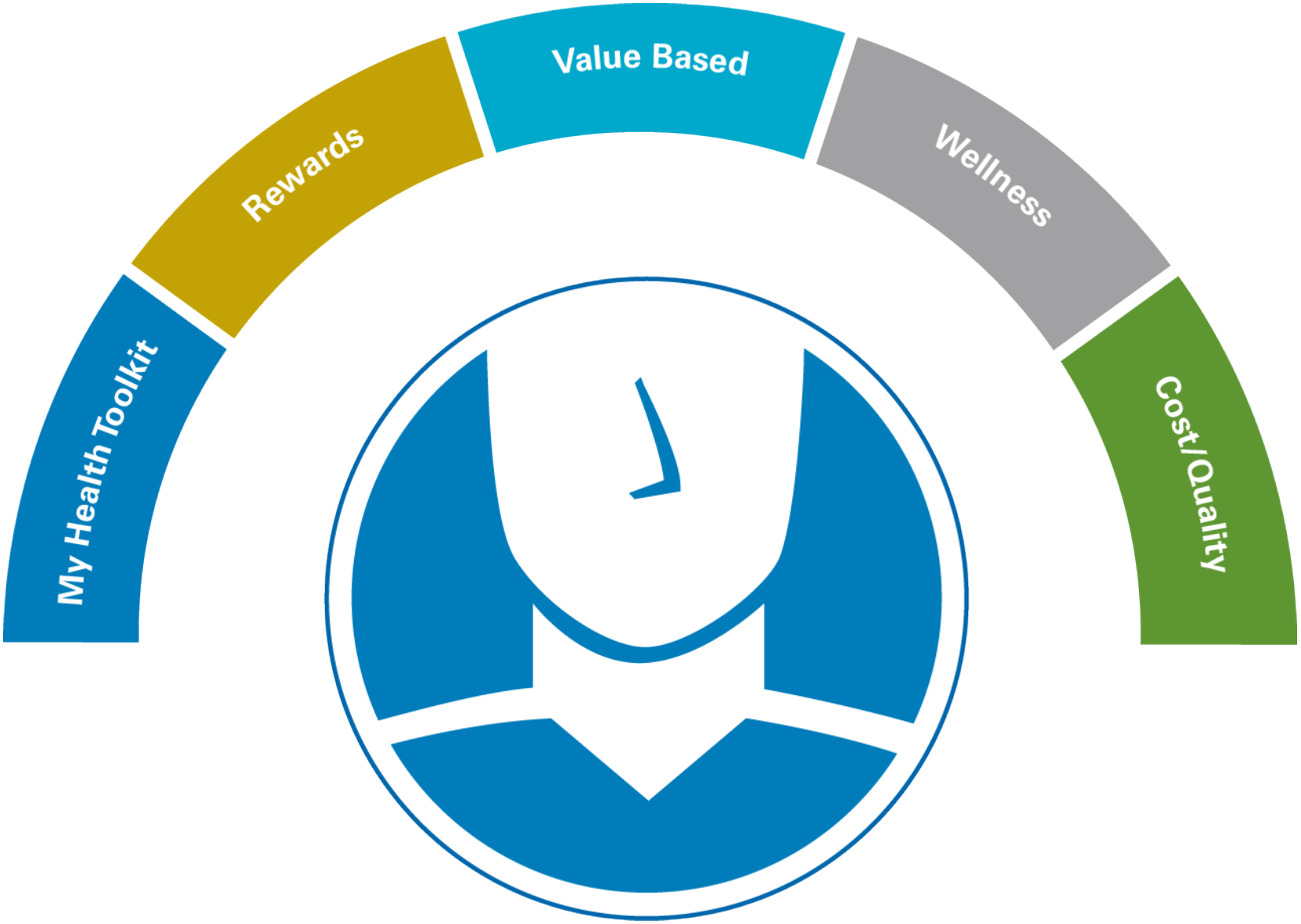
Winning Formula – All Constituencies



Components for Improved Engagement

Consumer Strategies



My Health Toolkit

Rate your Visit is accessed through the Resources Menu or the Quick Links

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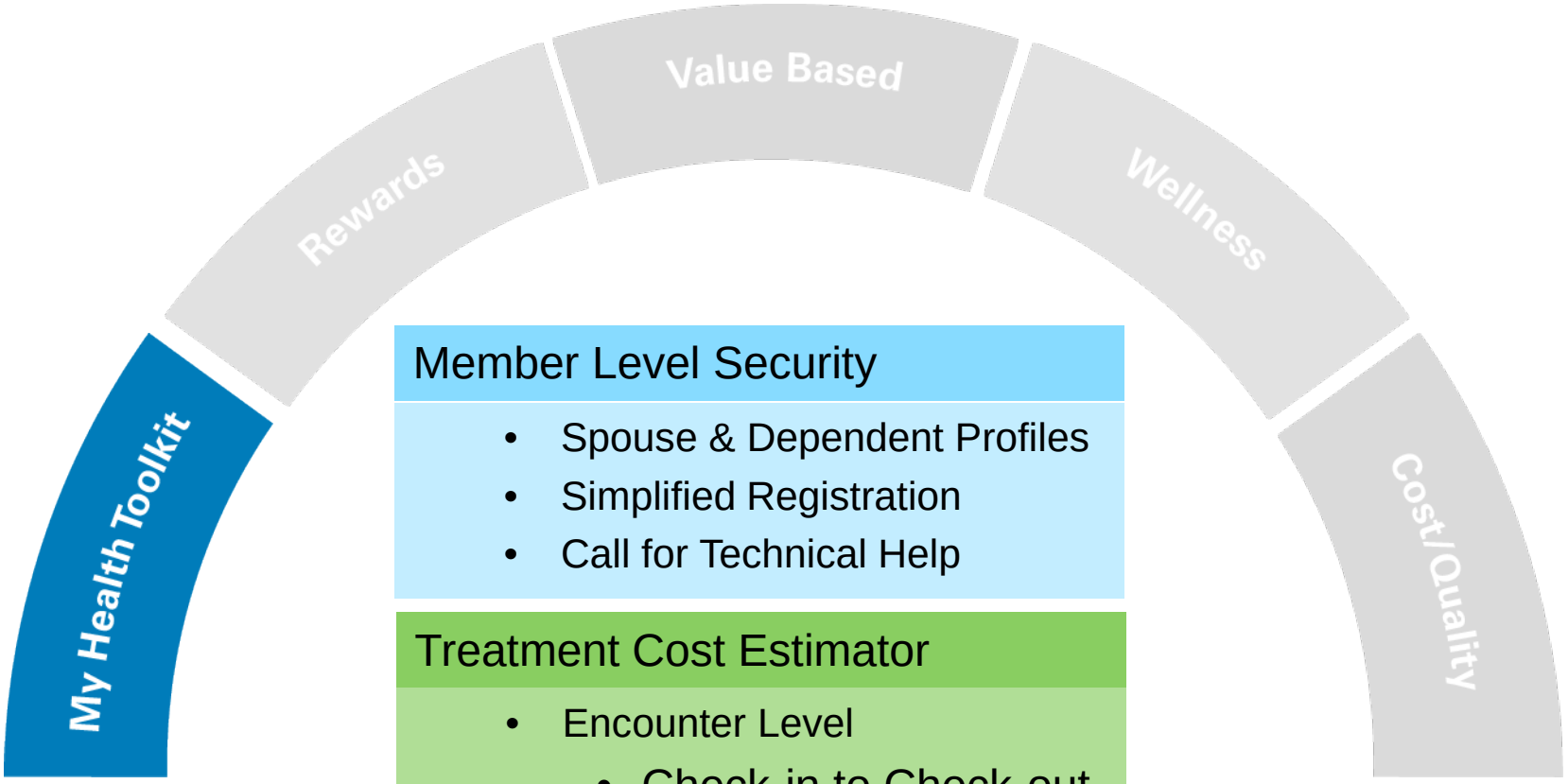
My Health Toolkit



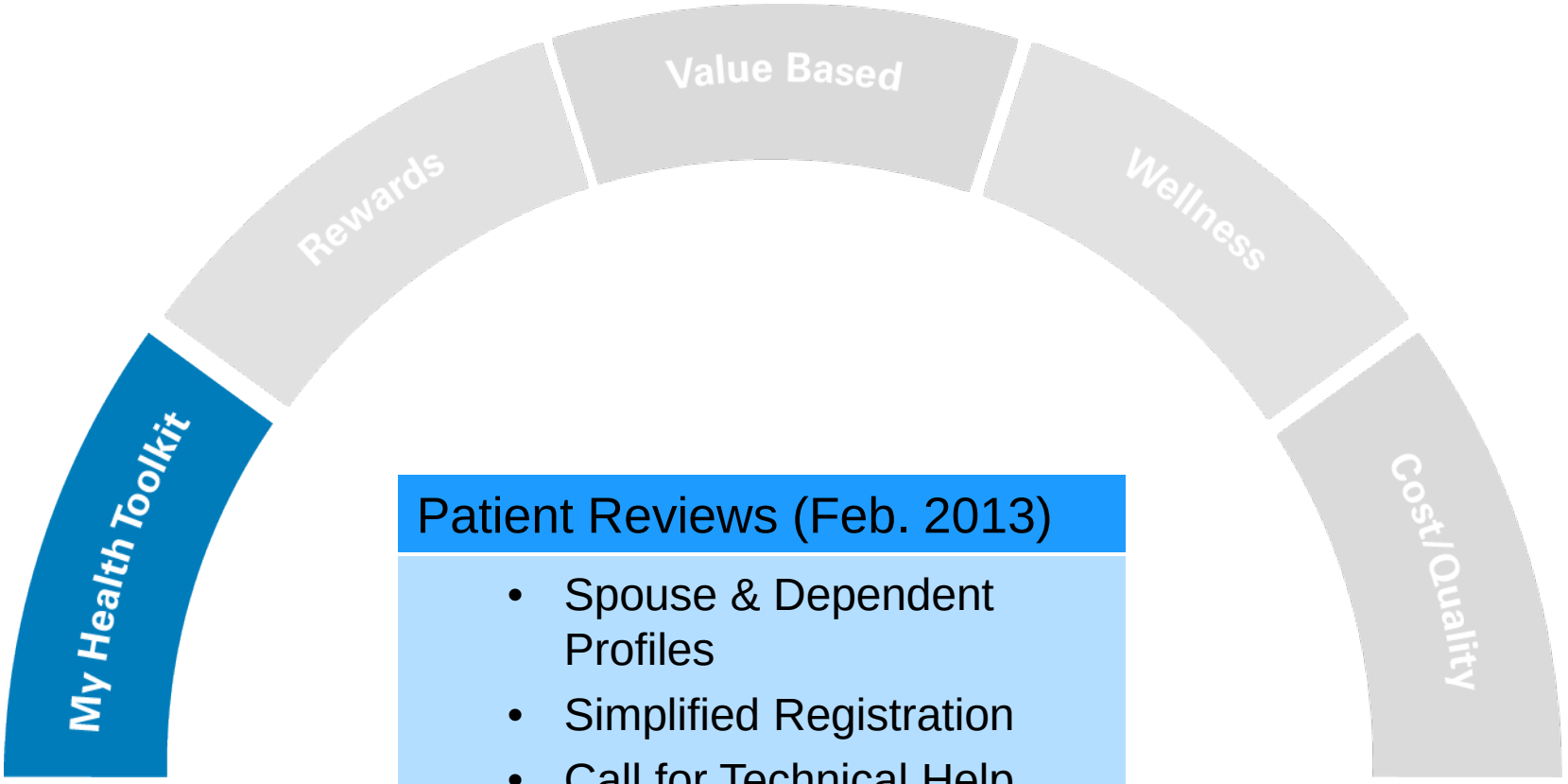
Member Level Security

- Spouse & Dependent Profiles
- Simplified Registration
- Call for Technical Help

Treatment Cost Estimator

- Encounter Level
  - Check-in to Check-out
- More Treatments
- Cost and Quality Information

My Health Toolkit



Patient Reviews (Feb. 2013)

- Spouse & Dependent Profiles
- Simplified Registration
- Call for Technical Help

Managing Trend with VBBD

Savings of High Value Services through Incentives

Optimal structure for Company 1 is a $400 incentive program for chronics, targeting 5 conditions

Condition	Total Net Savings		Net Savings (PMPM)	
	Low	High	Low	High
Condition 1	$230,594	$373,734	$1.12	$1.81
Condition 2	$205,409	$273,469	$1.00	$1.33
Condition 3	$34,373	$229,976	$0.17	$1.12
Condition 4	$51,901	$132,258	$0.25	$0.64
Condition 5	($10,129)	$25,579	($0.05)	$0.12
Total All 5 Conditions	**$512,148**	**$1,035,016**	**$2.49**	**$5.03**

Save $512,000 - $1,035,000 (1.1% - 2.1%) per year or $2.49 - $5.03 PMPM

Rewards

Monthly me
statements **ir**
and **motiv**

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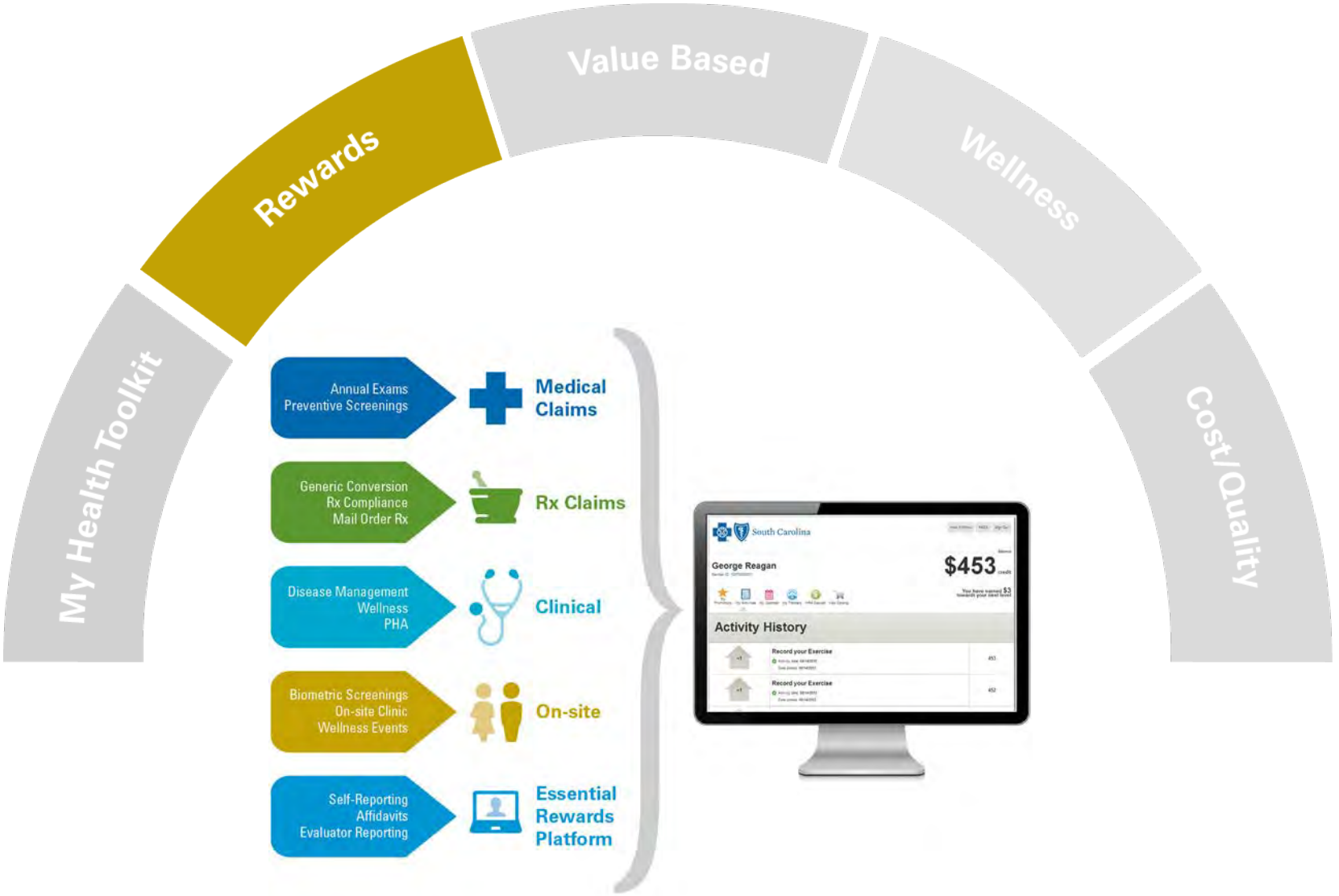
Rewards



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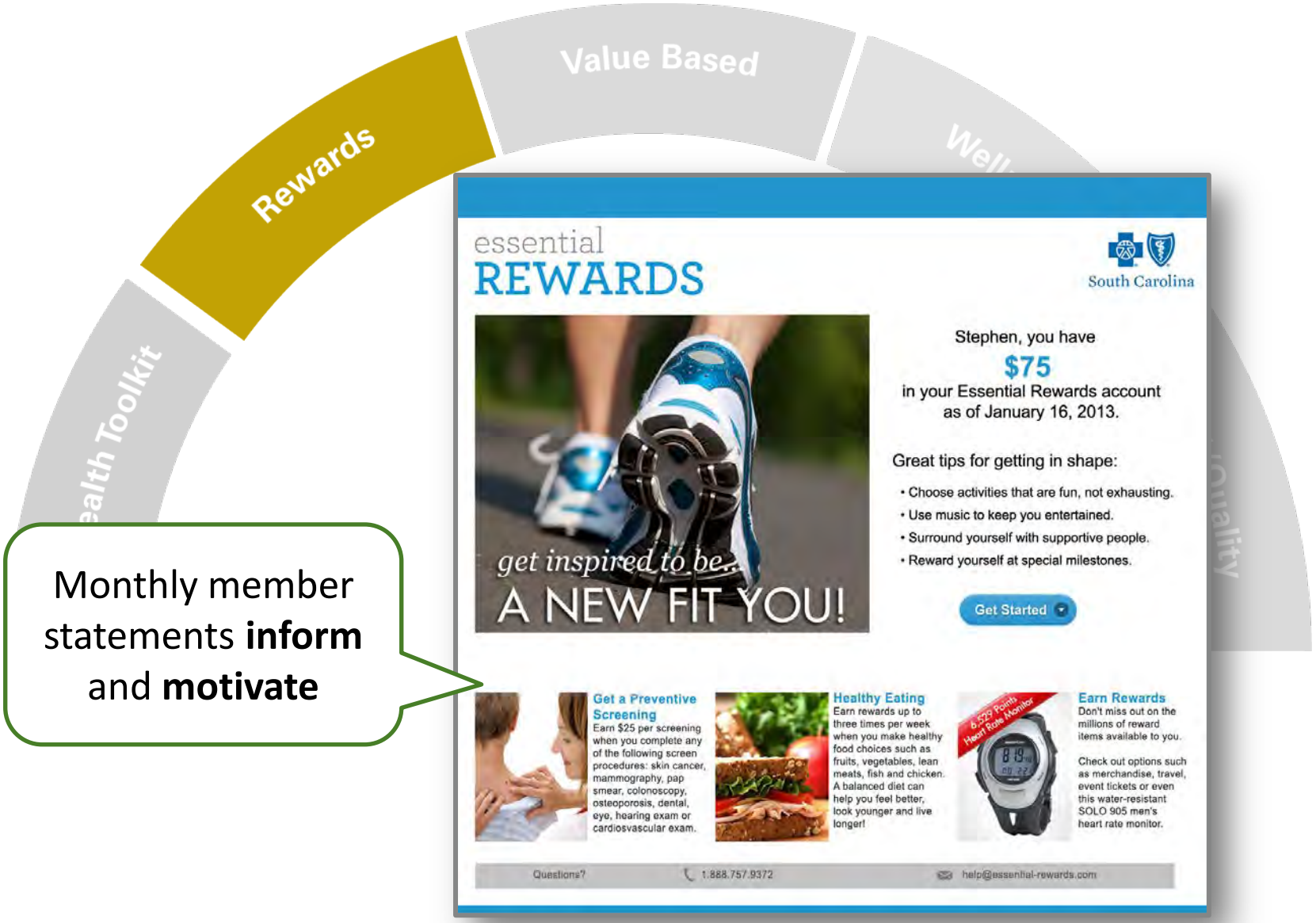
Rewards



Monthly member statements **inform** and **motivate**

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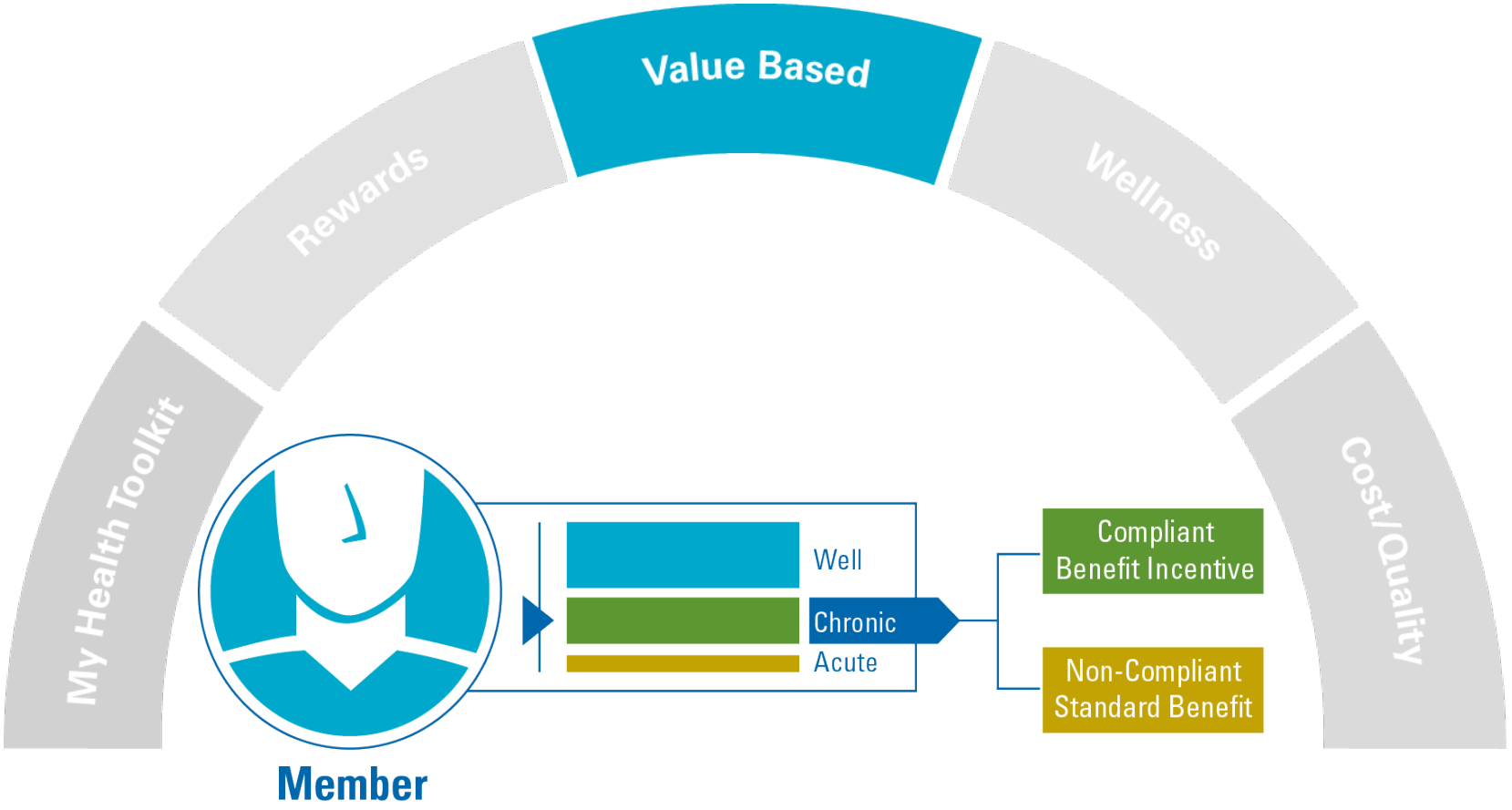
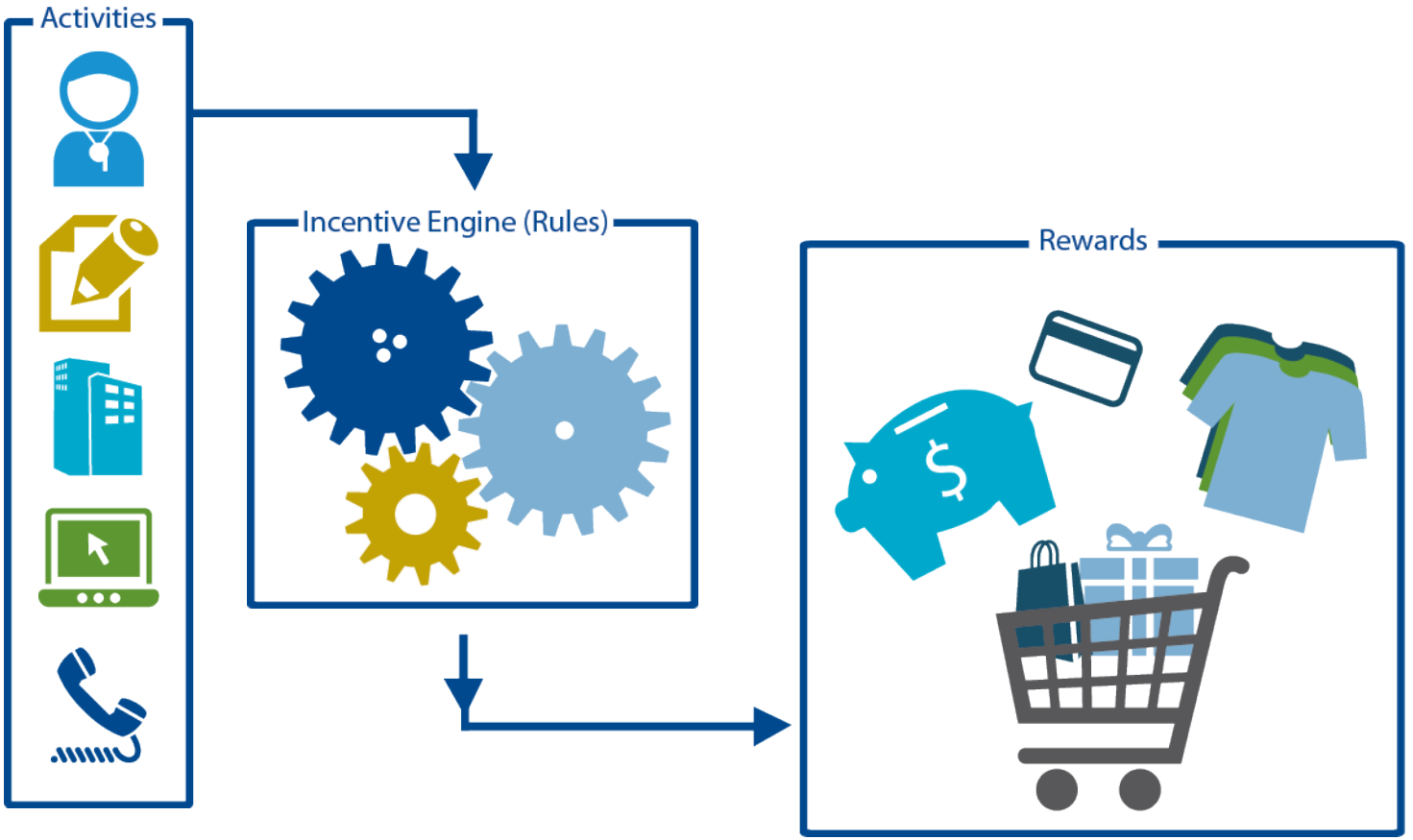
Value Based


Value Based
Rewards
Wellness
My Health Toolkit
Cost/Quality
Well
Chronic
Acute
Compliant
Benefit Incentive
Non-Compliant
Standard Benefit
Member

ESSENTIAL REWARDS



ESSENTIAL REWARDS

Preventive

- WELLNESS EXAM
  Medical
- WELLNESS EXAM
  Dental
- PREVENTIVE
  SCREENINGS
  Mam, Pap, PSA, Col
- BIOMETRIC SCREENING

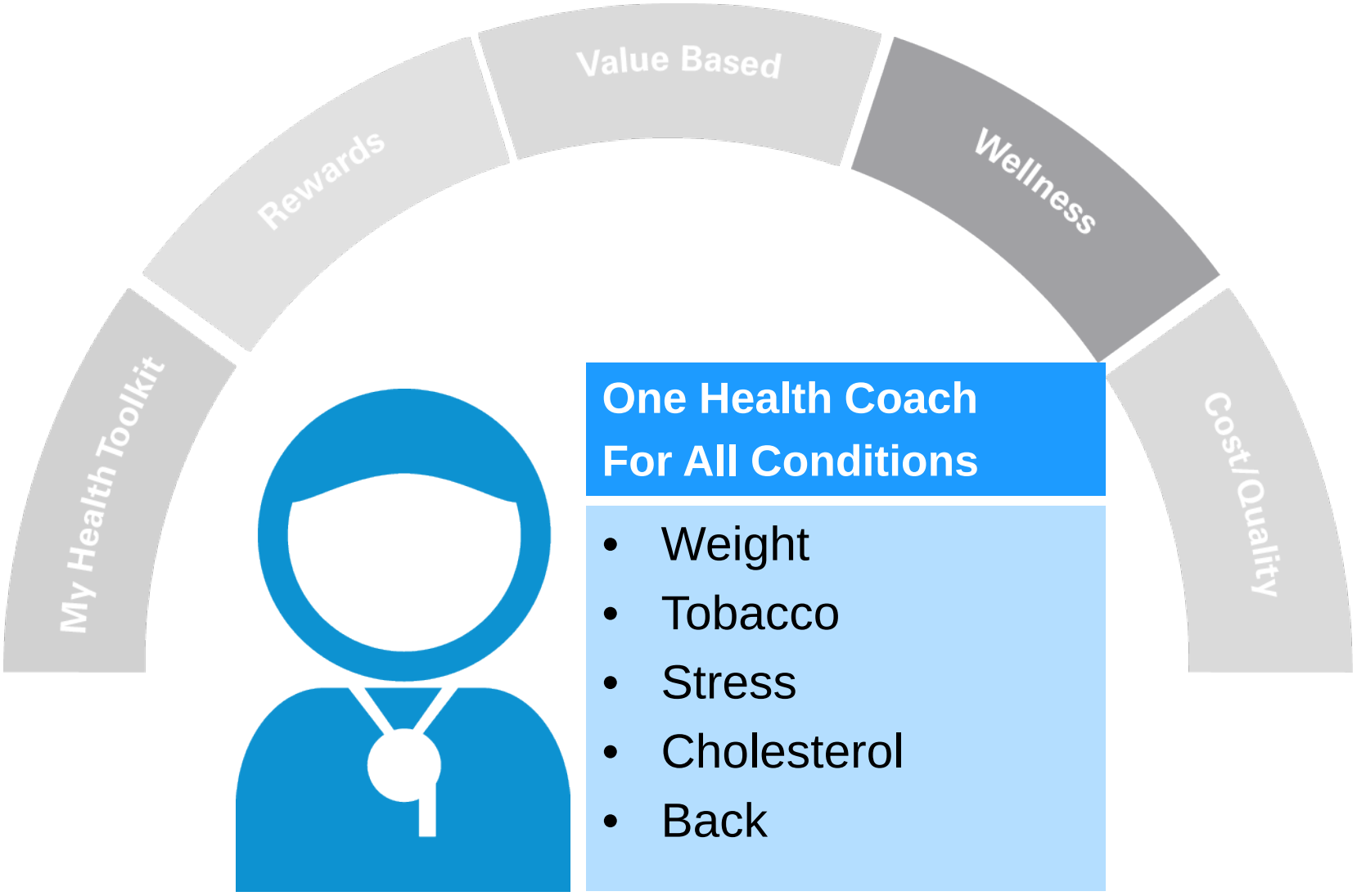
Online

- PERSONAL HEALTH
  ASSESSMENT
- ONLINE WELLNESS
  Healthy Living
  Programs, Monthly
  Seminars,
  Conversations and
  Quarterly Challenges

Coaching

- CHRONIC
  Asthma, Diabetes, CAD,
  COPD, CHF, Migraines
- WELLNESS
  Tobacco, Weight, Stress,
  Back and Cholesterol
- BEHAVIORAL
  Depression and Alcohol
  Intervention

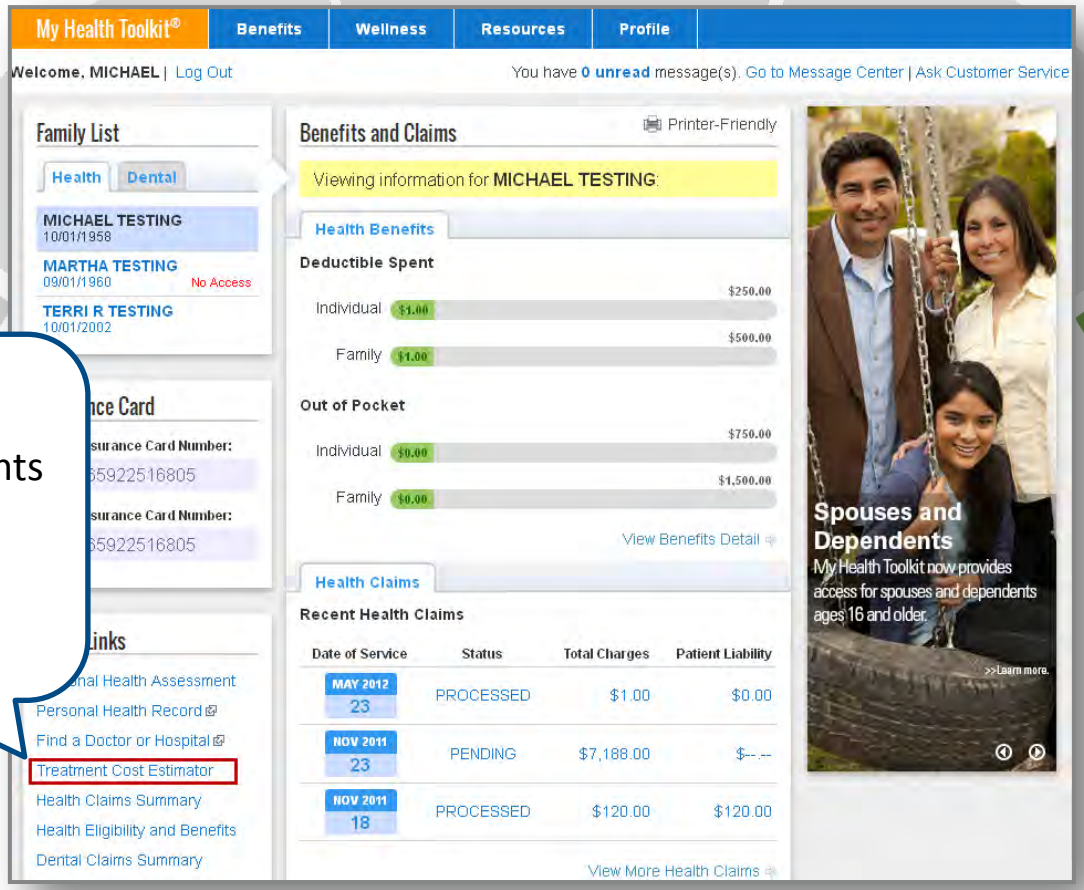
Wellness



One Health Coach For All Conditions

- Weight
- Tobacco
- Stress
- Cholesterol
- Back

Cost/Quality



Get your out-of-pocket costs for common treatments and services by browsing a list of services or search for a procedure.

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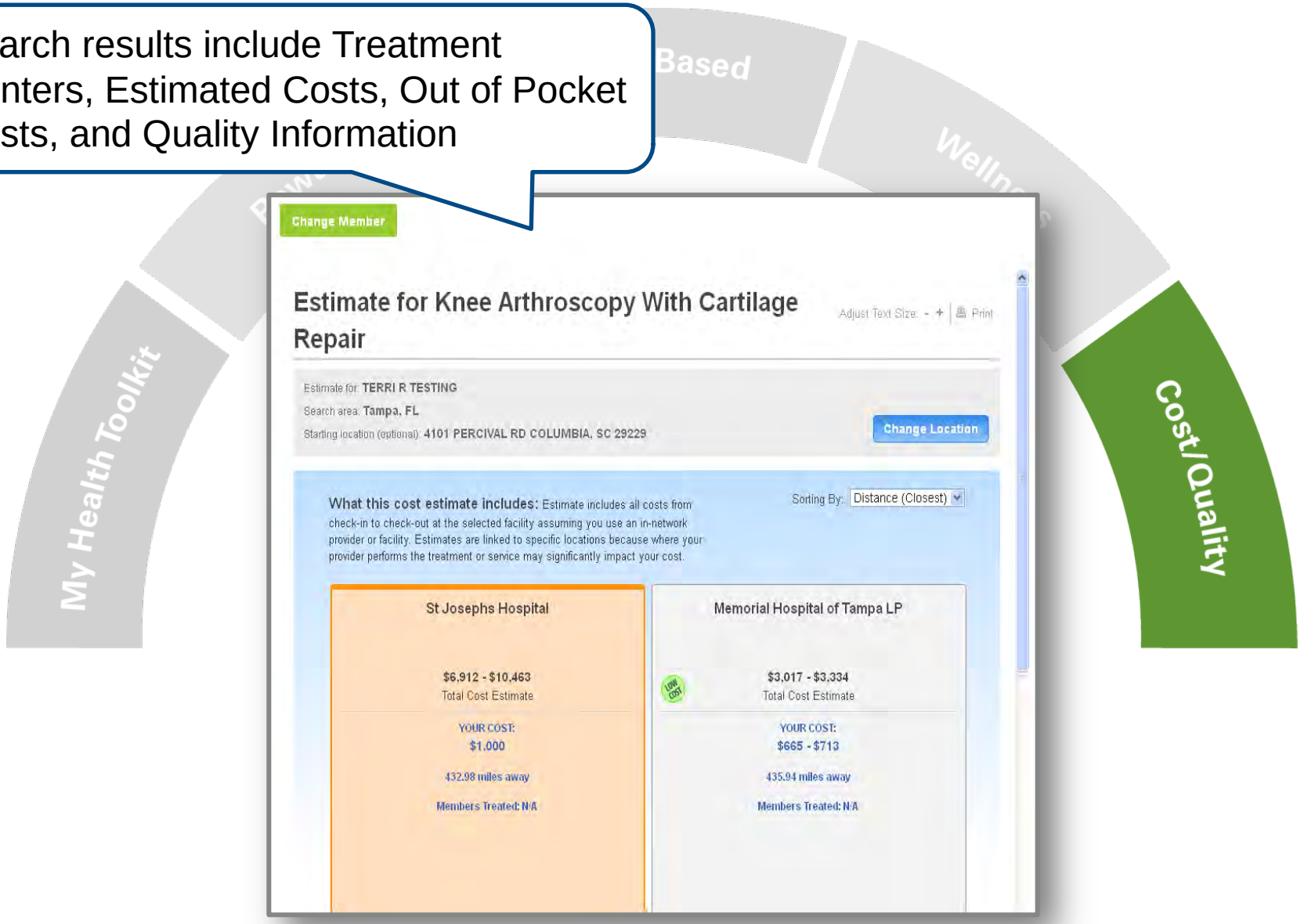
Cost/Quality

Search results include Treatment Centers, Estimated Costs, Out of Pocket Costs, and Quality Information



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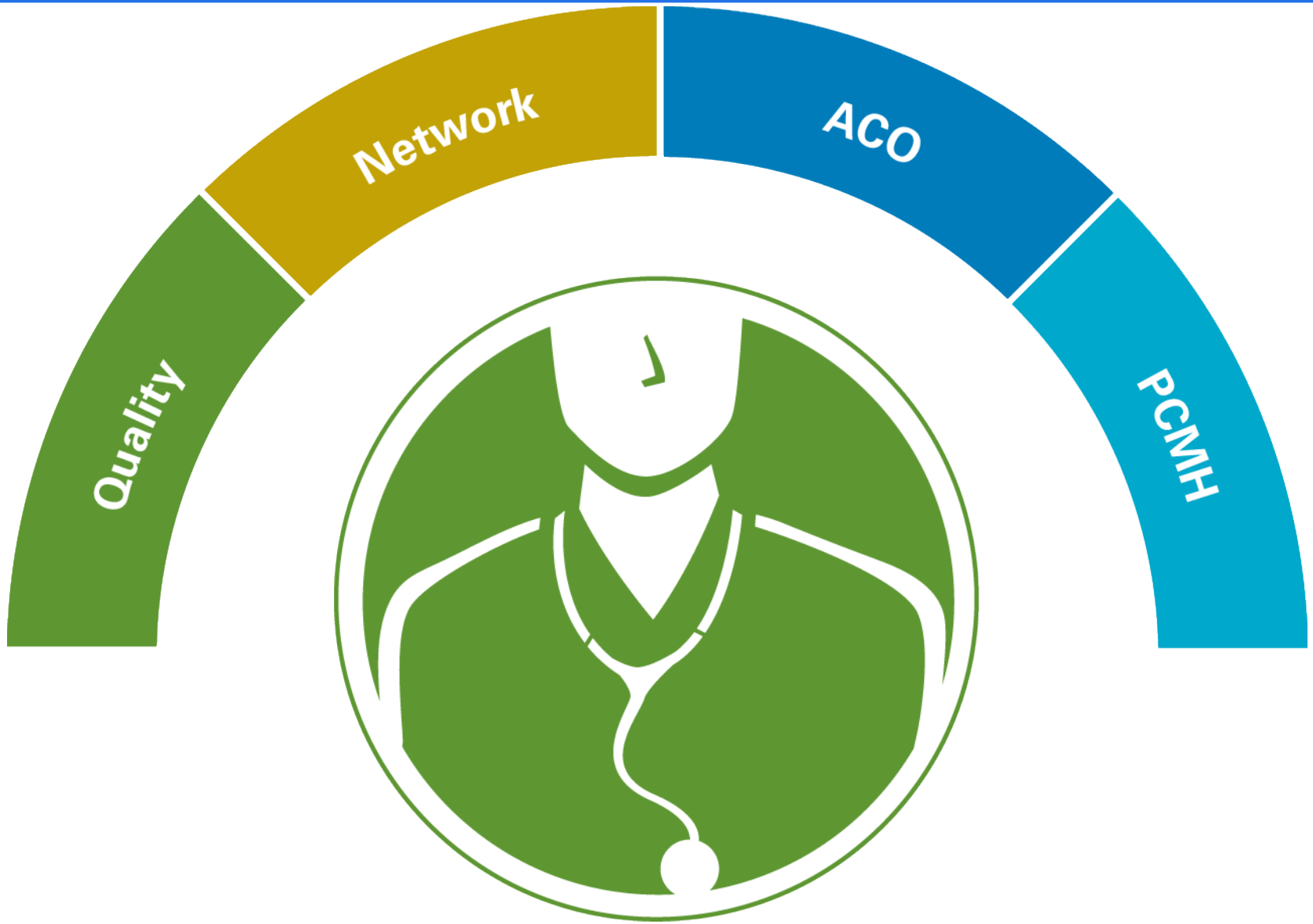
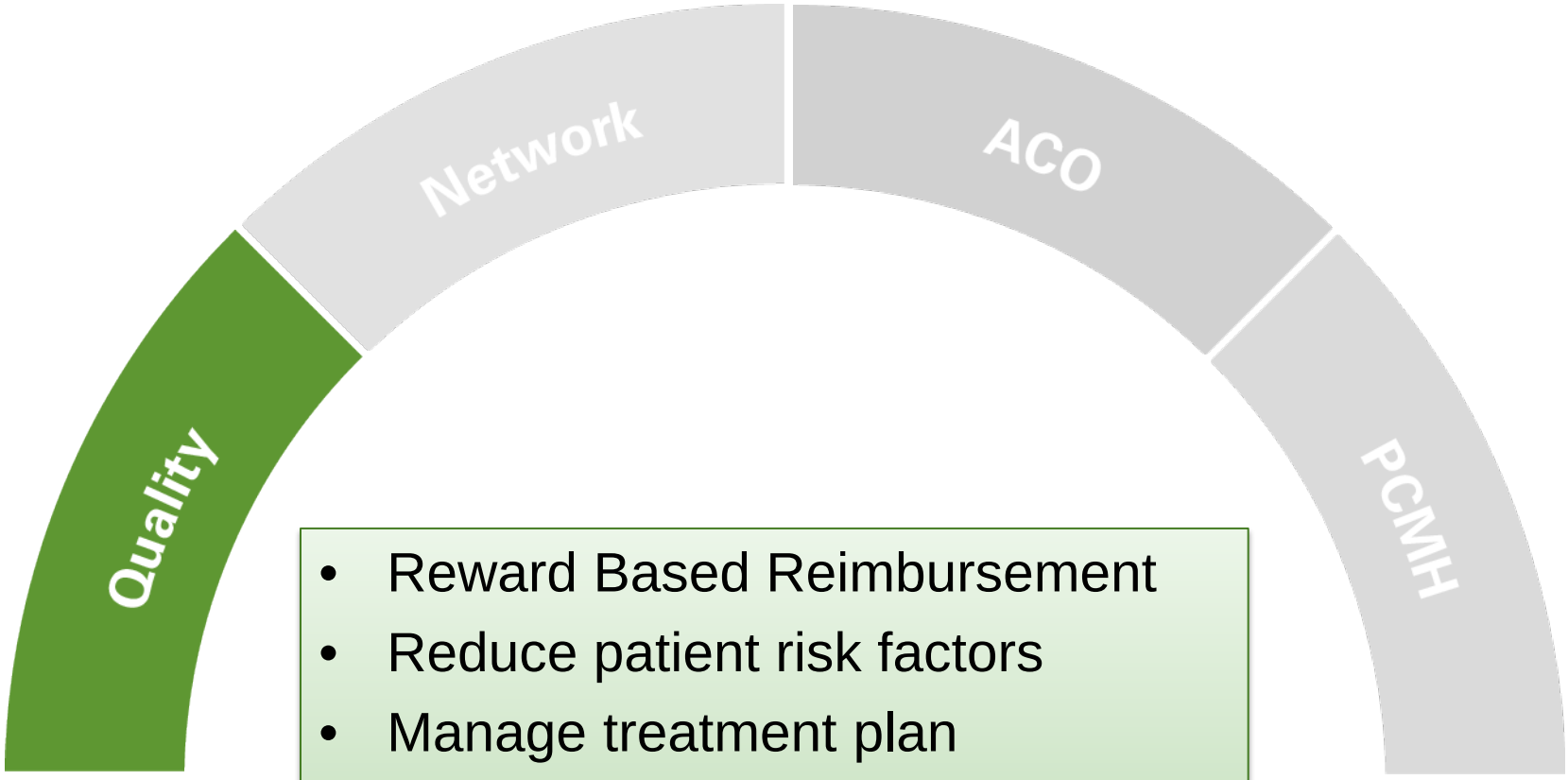
Provider Strategies

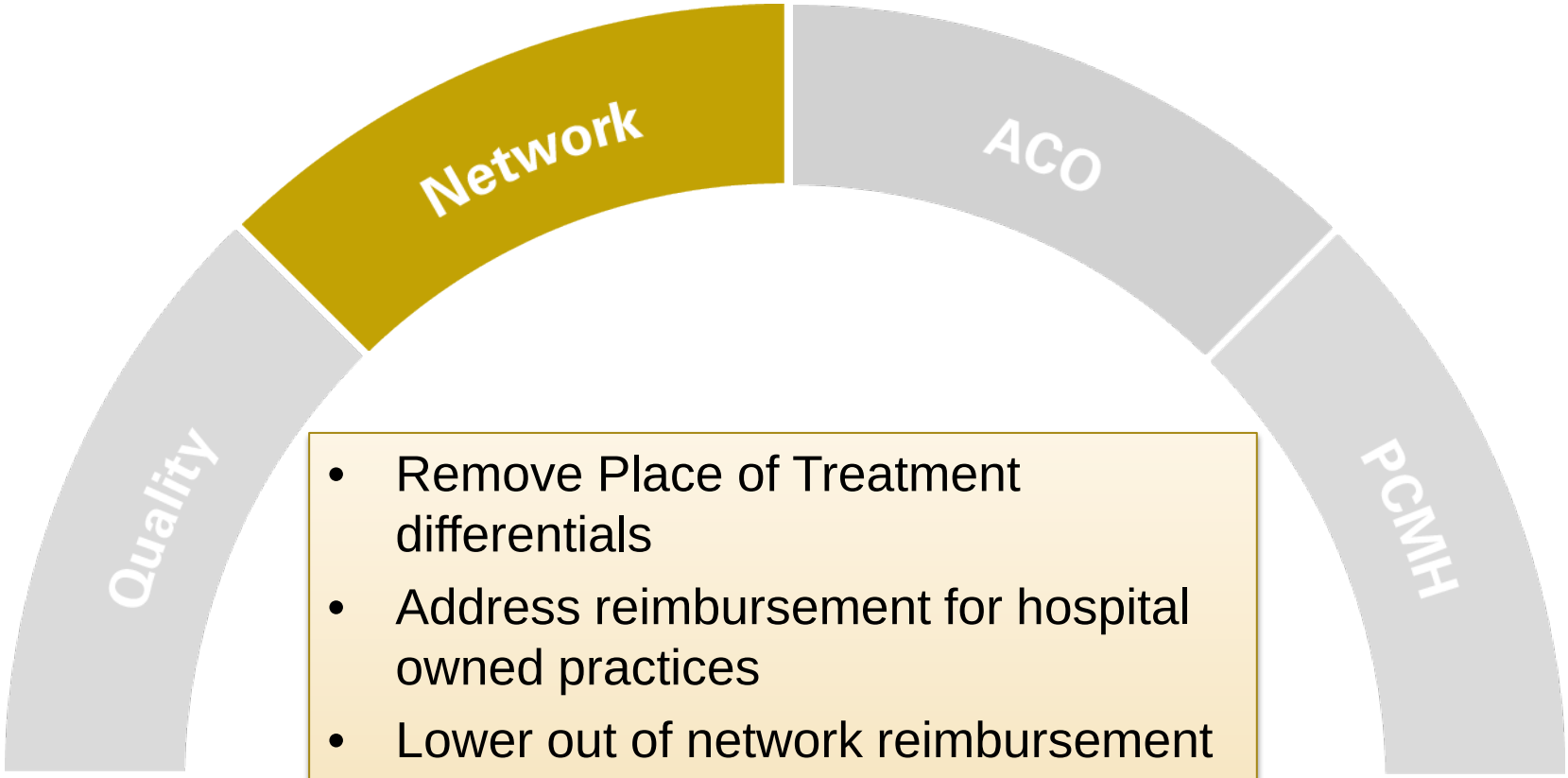


Quality



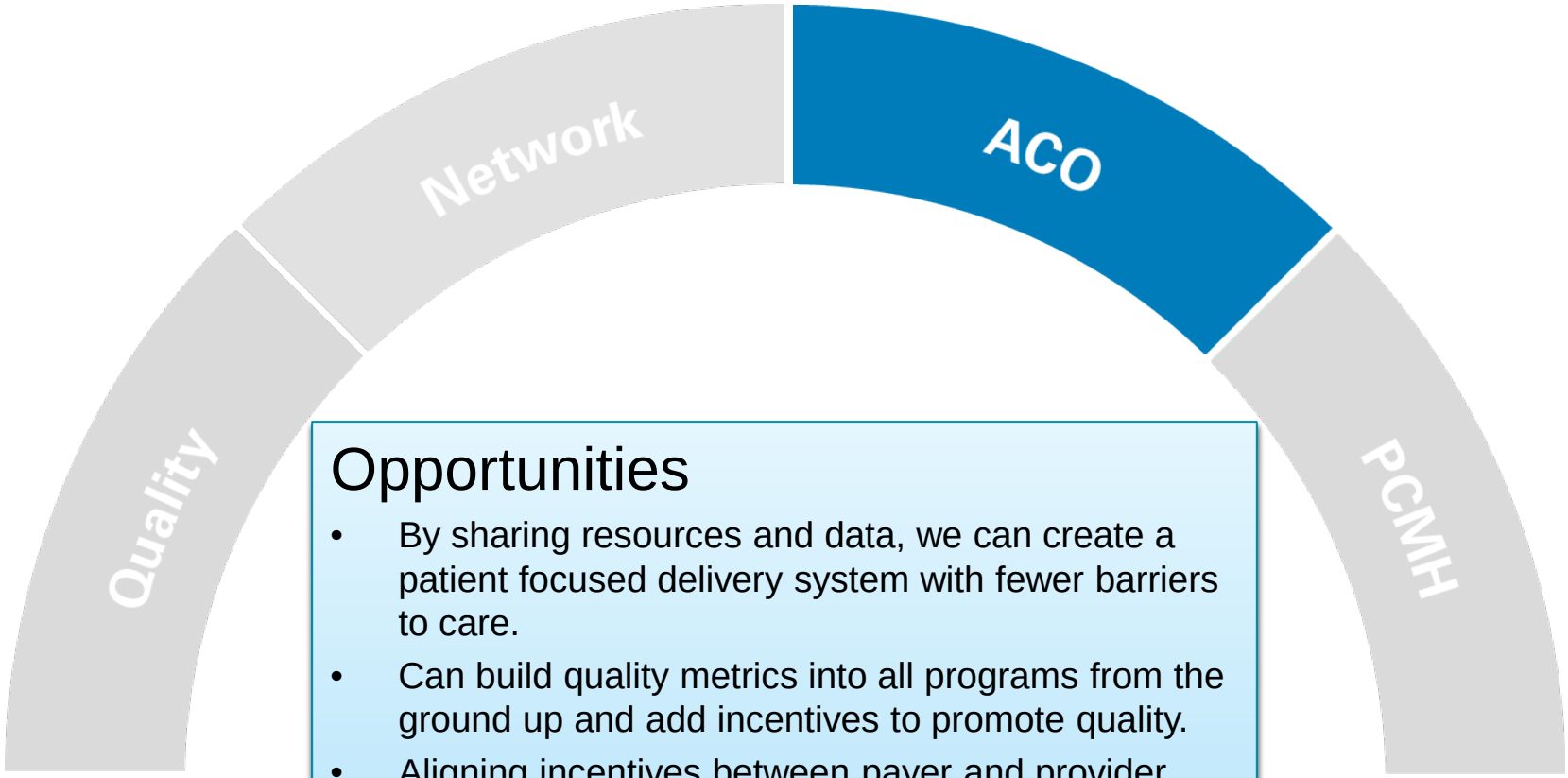
- Reward Based Reimbursement
- Reduce patient risk factors
- Manage treatment plan
- Coordinate care for complex patients

Network



- Remove Place of Treatment differentials
- Address reimbursement for hospital owned practices
- Lower out of network reimbursement
- Drive services to lower cost setting
- Establish a network for certain high cost services

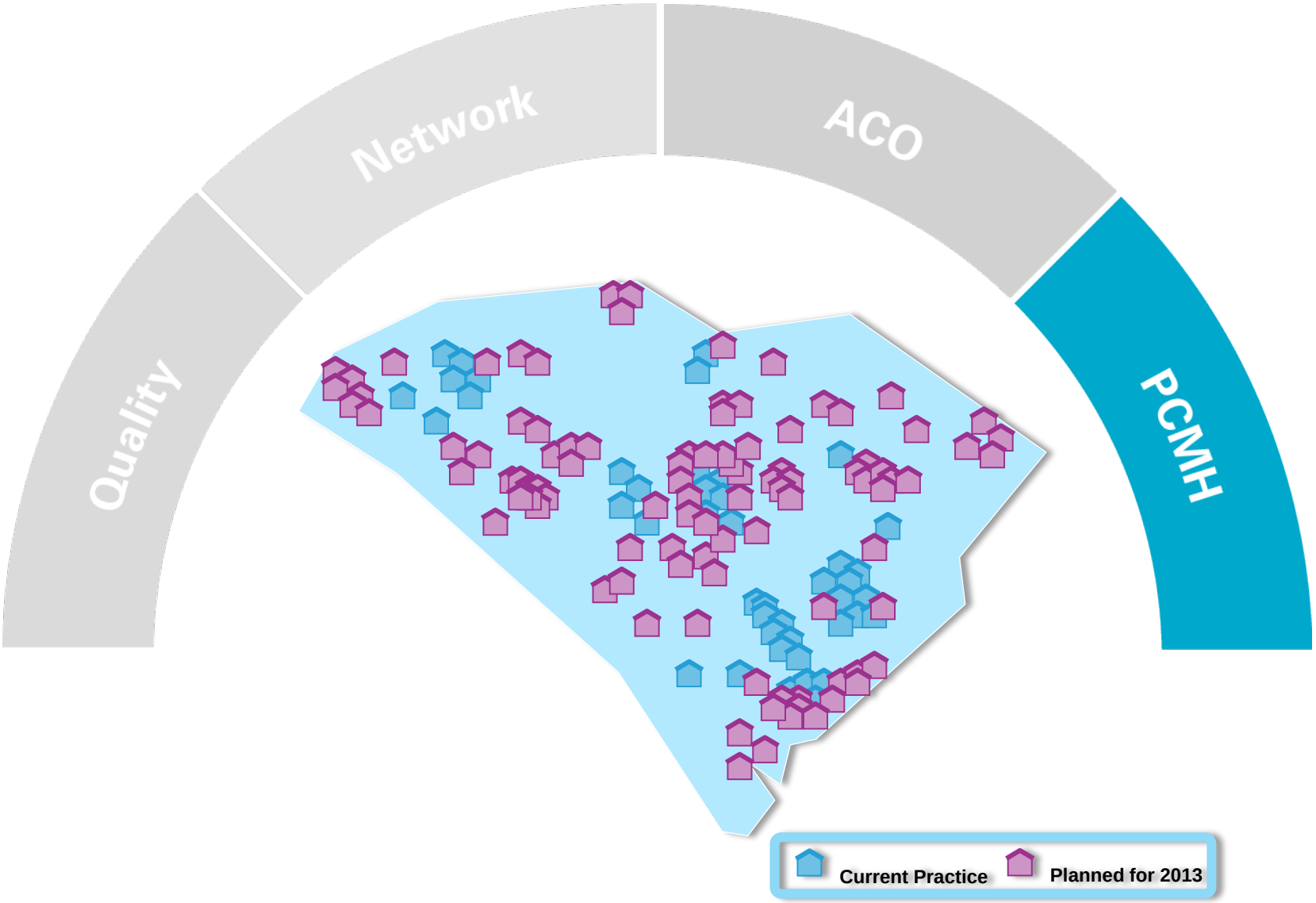
Accountable Care Organizations



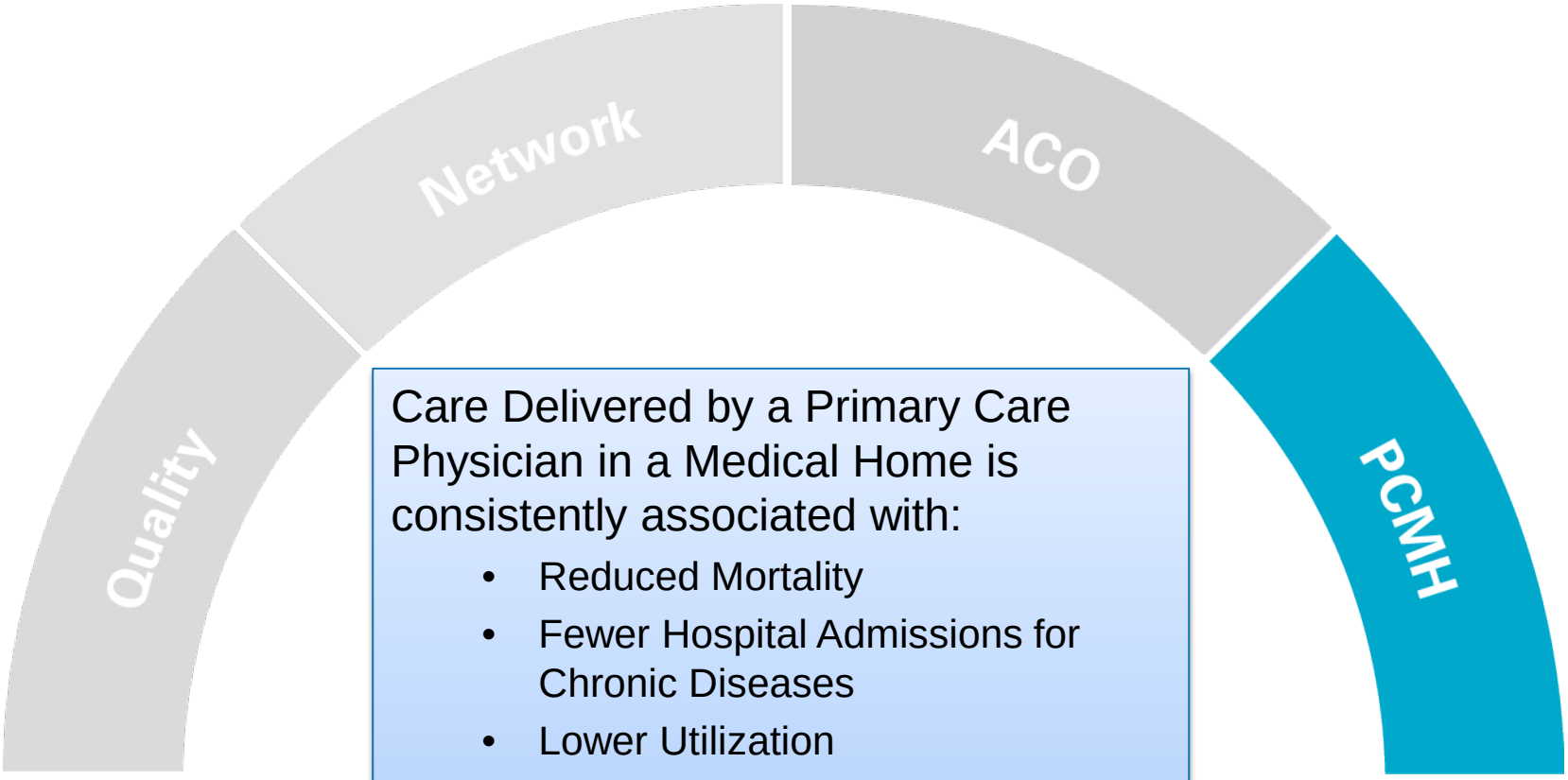
Opportunities

- By sharing resources and data, we can create a patient focused delivery system with fewer barriers to care.
- Can build quality metrics into all programs from the ground up and add incentives to promote quality.
- Aligning incentives between payer and provider, allows for shared savings from improved care.

Patient Centered Medical Home



Patient Centered Medical Home



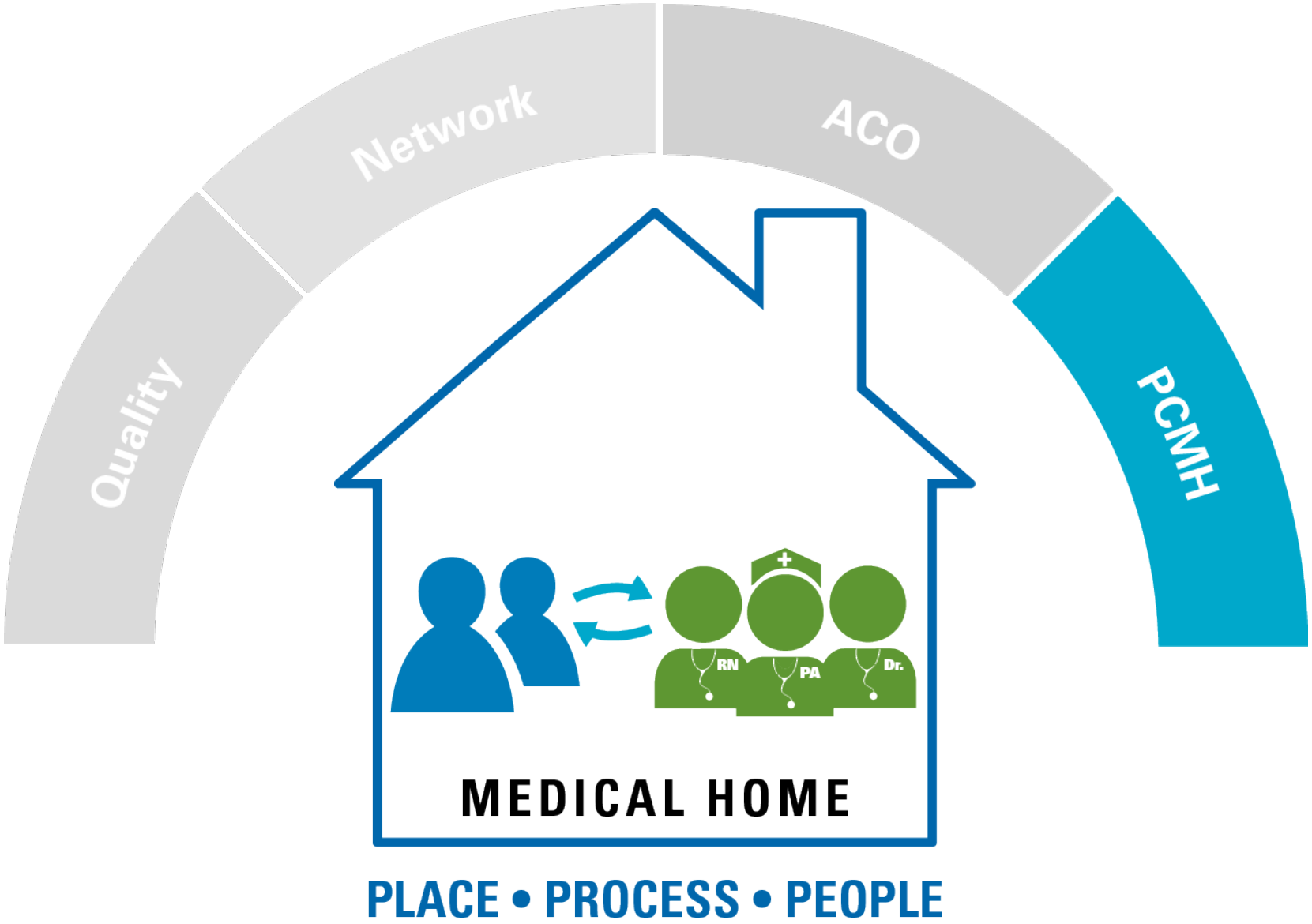
Care Delivered by a Primary Care Physician in a Medical Home is consistently associated with:

- Reduced Mortality
- Fewer Hospital Admissions for Chronic Diseases
- Lower Utilization
- Better Outcomes
- Improved Patient Compliance

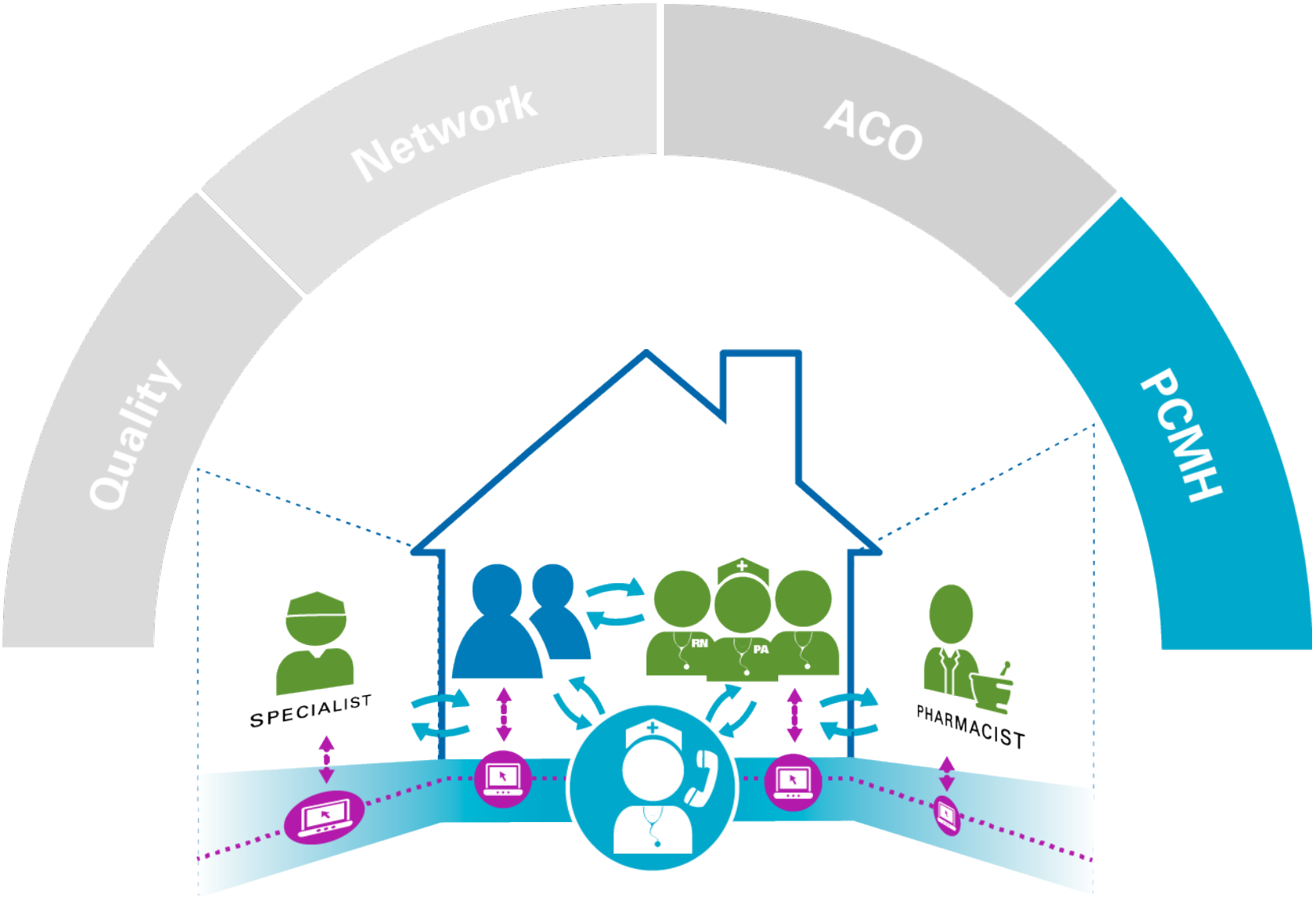
www.pcpcc.net/content/evidence

Patient Centered Medical Home

Patient Centered Medical Home



Patient Centered Medical Home



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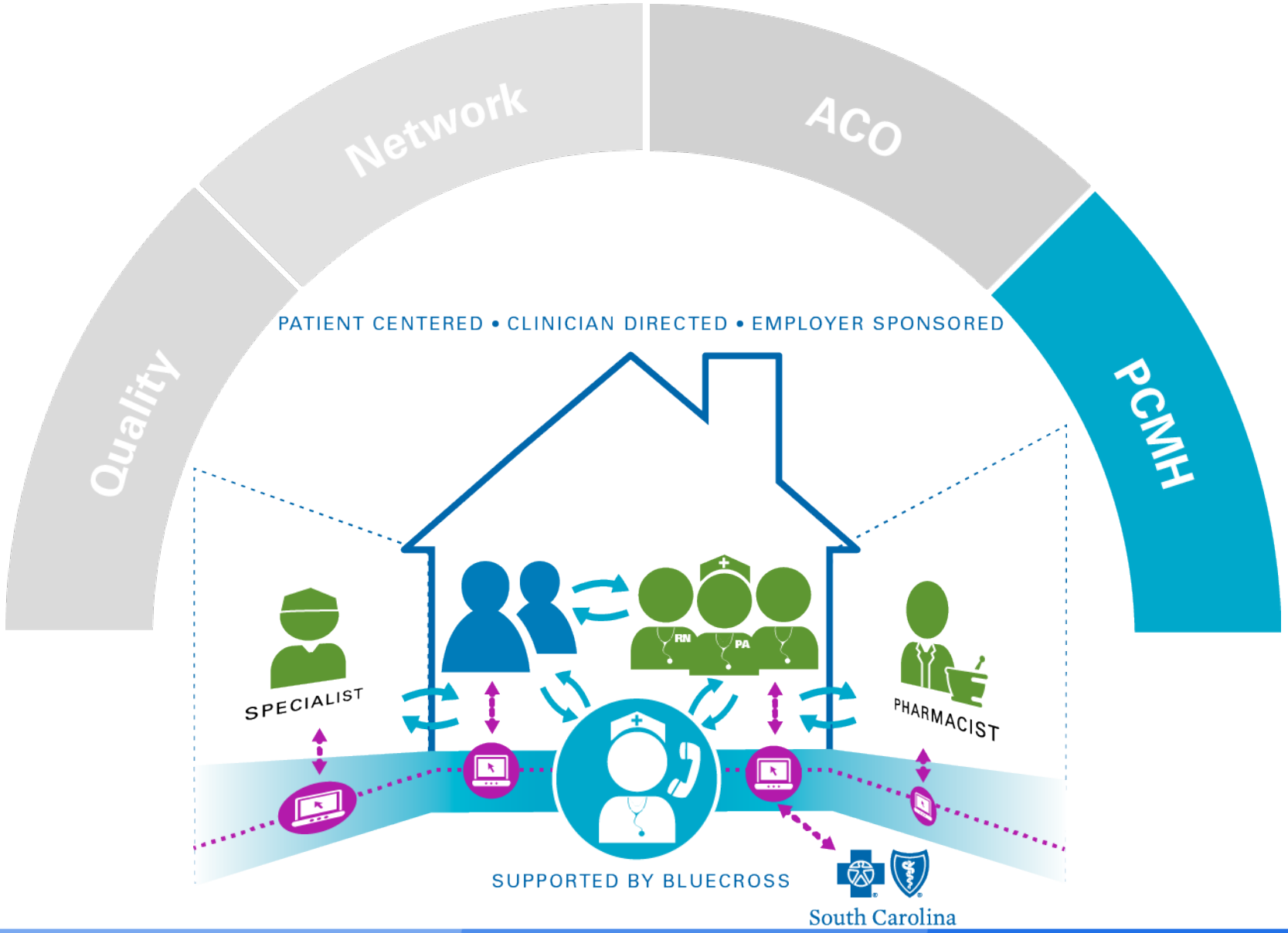
Patient Centered Medical Home



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Fundamentals of Effective Program Development

Leveraging Experience

Key Findings:

- It's all about the nurse talent
- It's not the gadgets, it's the case management
- It's the whole "medical home"
- It's the workflow
- Measure all variables / document processes
  - Data is crucial for both provider and patient
- It's keeping patients out of the hospital
- Until behavioral health needs are addressed, limited ability to help in other areas
- "Training" patients to self care

Source: Building an Effective Patient-Centered Medical Home Model, Joe Gifford, MD, Regence BCBS 2010

Because it matters how you're treated

Retiree Benefits

South Carolina

State Health Plan Retiree Benefits

- Expertise and infrastructure to design State specific plans
- Pharmacy Employer Group Waiver Program (EGWP)
- Offer an employer group plan
- Keep the administration a function of the current contract
- PEBA Should retain control over plan design
- Offer a portfolio of plan designs with a range of coverage levels and cost
- Could be self insured or fully insured

A discussion with

PEBA Board of Directors

State of South Carolina, EIP

Craig Kessler – Senior Director

Robin Scott – Senior Account Manager

Karen Cathcart – Director, Clinical Services

January 31, 2013

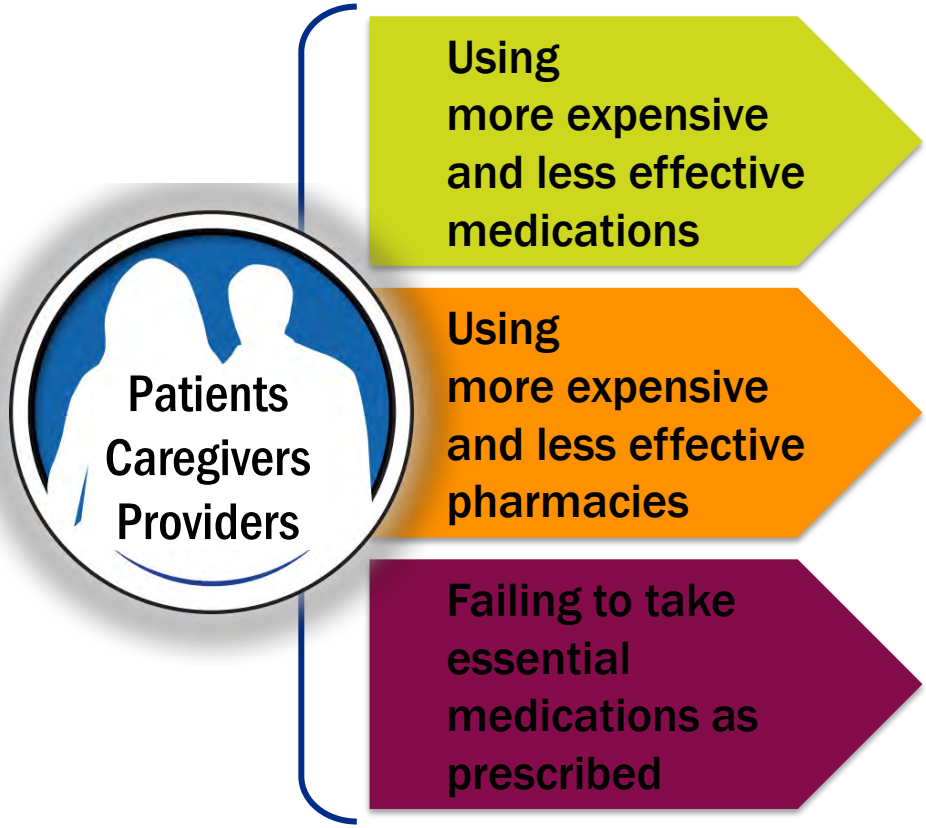
Agenda

- Express Scripts Introduction
- Plan Demographics
- Historical Plan Overview
- Plan Cost Drivers
- ESI's Role in Reducing Plan Costs
  - Better Decisions ⟶ Healthier Outcomes™

EXPRESS SCRIPTS®

Better Decisions | Healthier Outcomes™

The Problem: Bad Decisions Are Killing Us



Unhealthy Financial Outcomes

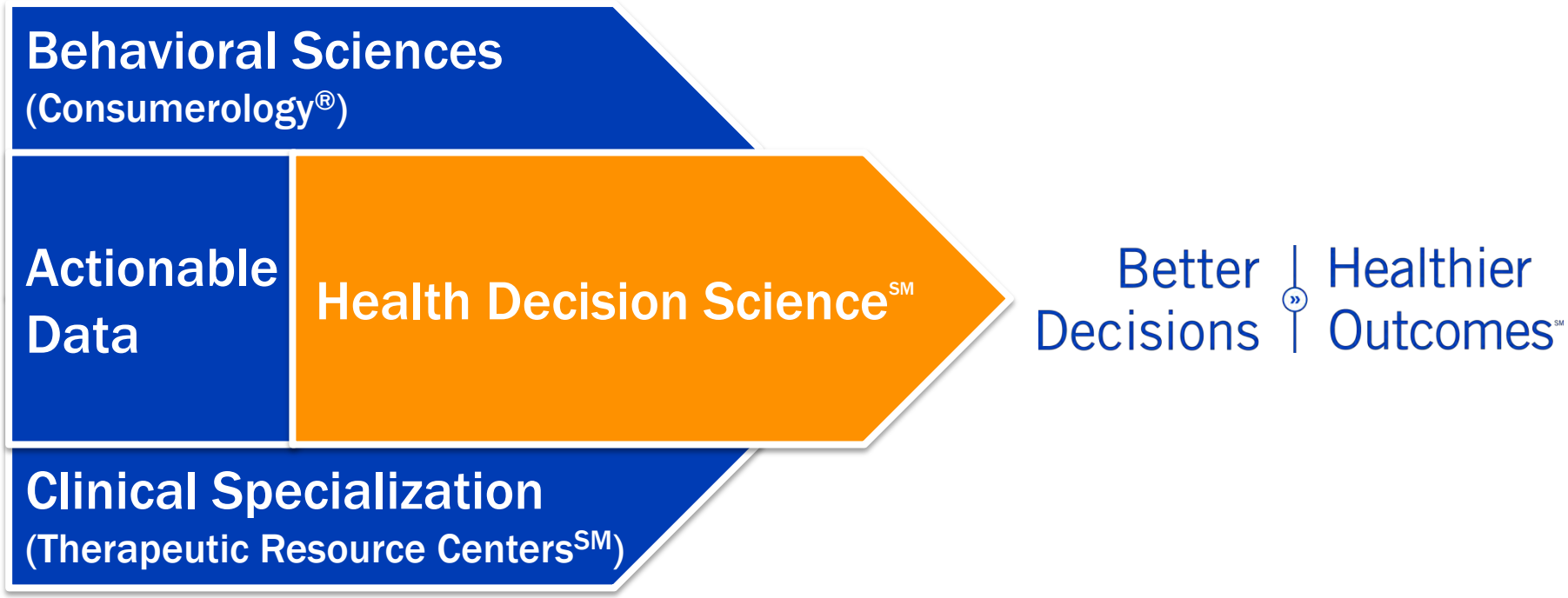
- $408 billion in annual pharmacy-related waste

Unhealthy Clinical Outcomes

- Significant gaps in care
- Prolonged illnesses
- Preventable ER visits and hospitalizations
- Avoidable harm (pain and suffering, injury, disability, death)

Waste: Any avoidable healthcare cost that provides no additional health benefit
Source: Express Scripts 2011 Drug Trend Report

Combining Three Complementary Capabilities Creates Our Unique Approach



Patient Stratification

Well

Wrinkles, Baldness, Impotence, Contraception, Vitamins

Acute

Colds & Flu, Strep Throat, Ear Infection, Headache, Sprains

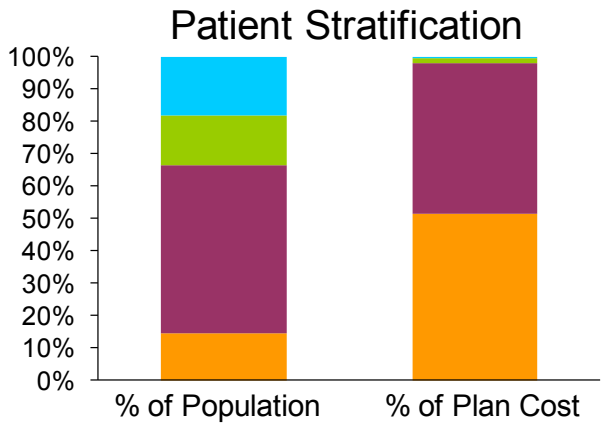
Chronic

Heart Disease, Diabetes, Arthritis, High Blood Pressure, High Cholesterol, Dementia, Back Pain

Complex

Multiple Chronic Conditions such as Heart Failure & Diabetes, Cancer, AIDS, Multiple Sclerosis, Metabolic Syndrome

- Provides specialized patient-centric care for members with chronic or complex conditions.
- **66.6%** of the population are Chronic or Complex patients and represent **98.0%** of Plan Cost in 2012.

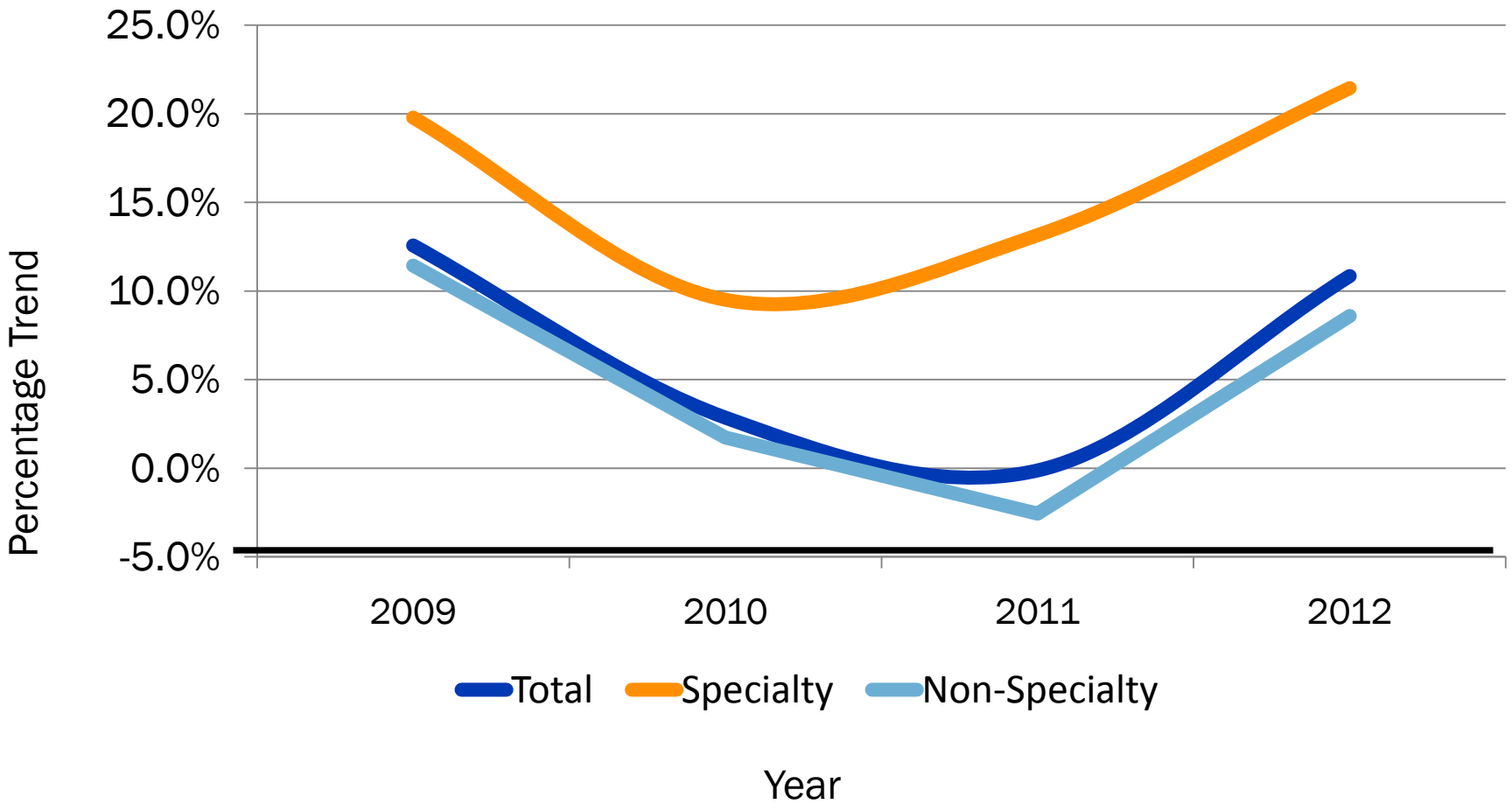


	Well	Acute	Chronic	Complex	Total
Members	74,279	62,571	213,400	59,539	409,789
Members%	18.1%	15.3%	52.1%	14.5%	100.0%
Plan Cost	$2,940,708	$8,086,682	$257,076,777	$282,349,637	$550,453,804
Plan Cost %	0.5%	1.5%	46.7%	51.3%	100.0%
Member Age (Avg.)	28.9	26.5	46.2	57.6	43.2
Chronic Disease Score (Avg.)	0	1	14	39	33
Copay	$814,841	$3,091,633	$75,673,774	$51,718,552	$131,298,800
Copay/Member	$11	$49	$355	$869	$320
Total Plan Spend/Member	$40	$129	$1,205	$4,742	$1,343
Days of Therapy/Member	19	63	656	1,712	603
GDR %	75.8%	86.0%	76.5%	74.6%	76.0%
Mail Pen %	3.9%	1.8%	8.1%	8.4%	8.1%

Historical Top Line Performance Metrics

	State of South Carolina EIP				
Key Plan Statistics	**2008**	**2009**	**2010**	**2011**	**2012**
Plan Cost	$375M	$432M	$475M	$489M	$551M
Plan Cost Per Member per Month	$88	$99	$102	$101	$112
Total Members (includes dependents)	356K	364K	389K	402K	410K
Total Member Cost Share (%)	24.9%	22.9%	22.6%	21.9%	19.2%
Total Rxs	6.6M	6.8M	7.2M	7.3M	7.6M
Rxs/Member	18.6	18.7	18.4	18.3	18.5
Plan Cost/Rx	$57	$63	$66	$67	$72
Generic Dispensing Rate (GDR)	63.4%	64.8%	69.3%	71.9%	76.0%
Mail Penetration (%)	9.8%	9.2%	8.9%	8.5%	8.1%
Total Specialty Cost (%)	13.7%	14.6%	15.5%	19.0%	20.6%

Historical Drug Trend – State of South Carolina

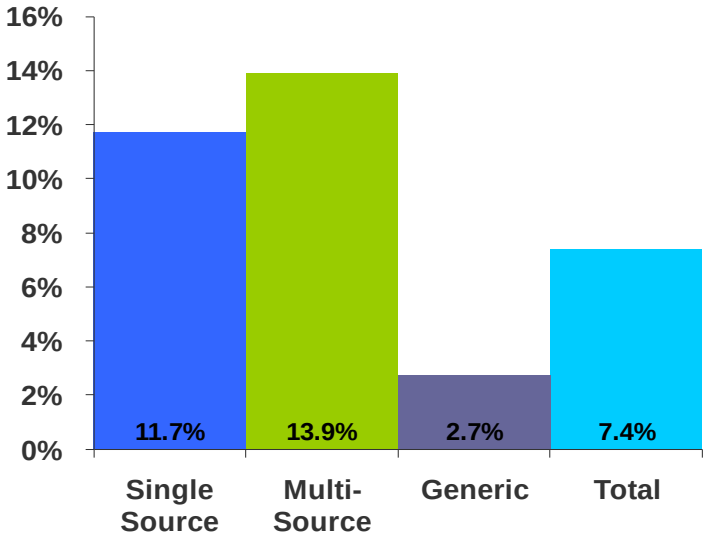


Top 3 Cost Drivers – State of South Carolina

- Inflation
  - The increase in the manufacturer's price of a drug.
- Cost Share/Channel Utilization
  - The percentage the member contributes to drug costs and where the member fills the prescription (Retail Pharmacies versus Express Scripts Home Delivery)
- Specialty Drugs
  - Drugs that are used to treat complex diseases, require specialized patient training and/or coordination of care and have a potential for significant waste due to the high cost of the drug.

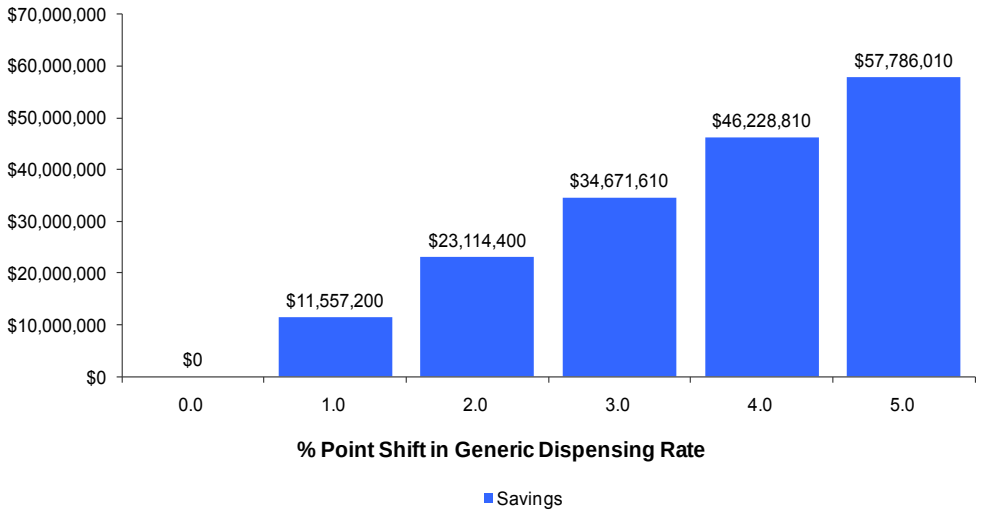
Inflation

- Inflation on Brand drugs continues to be the largest driver of the PMPM trend.
- Brand drugs experienced Inflation in the 14% - 12% range, while generics experienced 2.7%.
- Plans can reduce this impact by moving members away from high inflationary Brands to generic therapeutic alternatives.



Generic Dispensing

- Generic Dispensing Rate increases will continue to save the plan money year after year.
- Generics inflate at a much lower rate than brands.
- For every 1% increase in GDR the plan could save approximately 2.1% of total plan cost.



Clinical Programs – PST Rules Help Reduce Plan Costs and Inflation

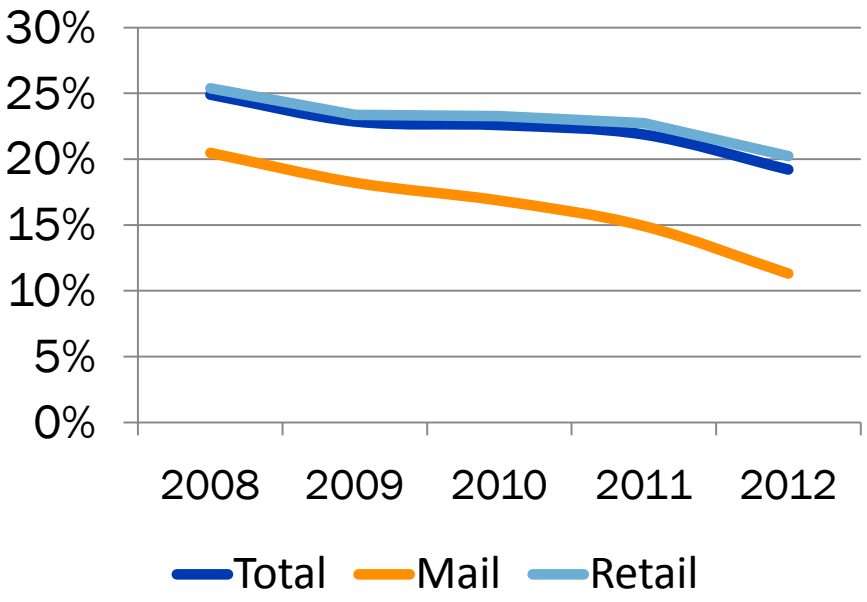
Clinical Program	*Rationale*
Preferred Step Therapy (moderate member impact) – Currently Enrolled	System generated point of sale edits that deny claims for a targeted drug if there are no claims for a preferred drug (Proton Pump Inhibitors, SSRIs, Osteoporosis, Hypnotics, Migraine Therapies, Angiotensin Receptor Blockers, and Intranasal Steroids)

PDST Rule	*State of South Carolina – Spend in each category*	*Savings (% of spend)*
Proton Pump Inhibitors	$25,894,093	7.9%
SSRI's	$5,163,502	13.9%
Osteoporosis	$6,043,298	5.2%
Hypnotics	$3,151,203	17.2%
Migraine Therapies	$3,465,531	43.7%
Angiotensin Receptor Blockers	$19,749,583	5.6%
Intranasal Steroids	$3,355,289	46.4%

Clinical Utilization Programs for traditional drugs saved the State $24M in 2012 (including the PST program discussed above).

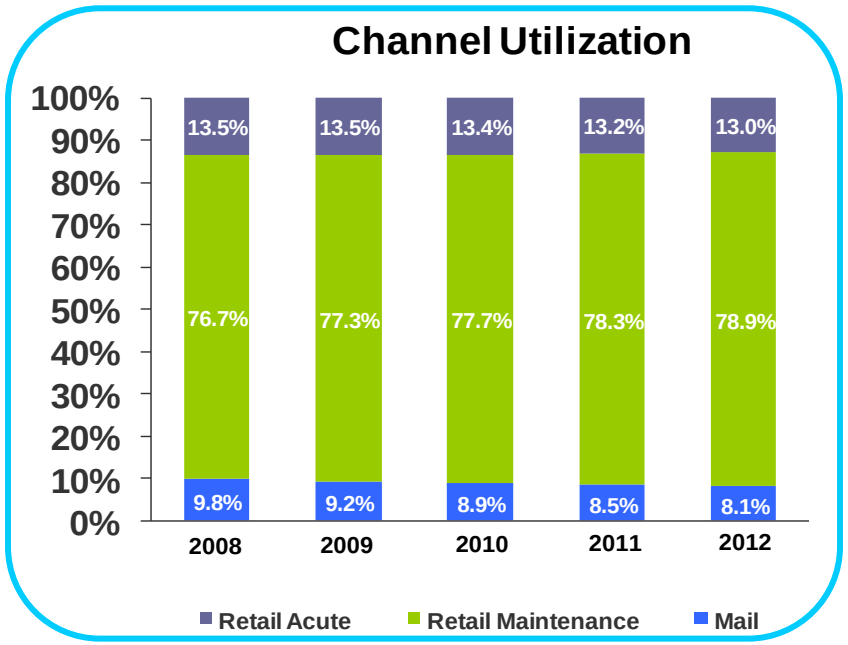
Member Cost Share

- Members chose to fill preferred medications (includes generics) 93.9% of the time in 2012, an increase of 0.9 percentage points from 2011.
- Total Member Cost Share in 2011 was 21.9%, while 2012 was 19.3%.



Channel Utilization

- As the population ages the percentage of Retail Maintenance utilization increases.
- Mail penetration has dropped each year from a high of 9.8% in 2008 to its current level of 8.1% for 2012.



Channel Management– RRA Shifts Utilization to Lower-Cost Channel

Clinical Program	*Rationale*
Retail Refill Allowance (RRA) or Incentive Mail (moderate member impact)	Use incentives and communications to encourage members to use the lower-cost mail channel for a specific group of chronic, long-term medications. RRA also helps plan sponsors to reduce their drug trend without restricting coverage.

Retail Refill Allowance (RRA) Modeling --- Mail Channel Only

% of Retail Maintenance Rx's Shifted to Mail	Plan Savings	Member Savings	% New Mail Penetration Rate
25%	$10,000,000	$2,500,000	27.7%
40%	$16,000,000	$4,000,000	39.6%
55%	$22,300,000	$5,500,000	51.4%
70%	$28,300,000	$7,100,000	63.3%

Maintenance Channel Optimization - Day Supply Limits

Days Supply Limits at Traditional Retail Pharmacies	Total Savings
Limit to 60 Days Supply	$3,200,000
Limit to 31 Days Supply	$4,100,000
* Assumes 92% of days supply will move to the retail maintenance channel and the remaining 8% will move to mail.	

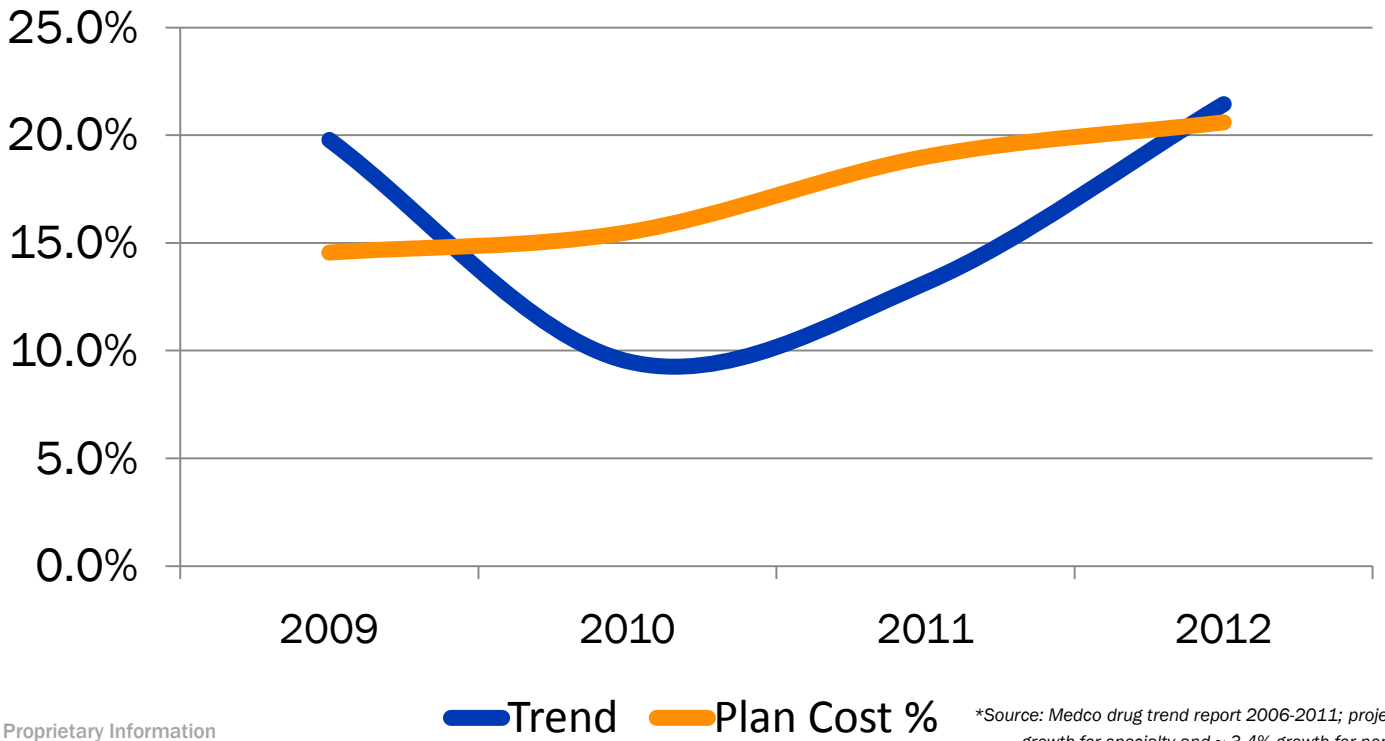
Specialty Drug Spend

Historical

- Specialty spend continues to increase in 2012, trending at 22.6%.
- Specialty Plan Cost represents 20.6% of the Total Plan Cost for 2012.

Forecasted

- Specialty drugs are projected to represent **21% of plan costs by 2013** and **40% of plan costs by 2020***



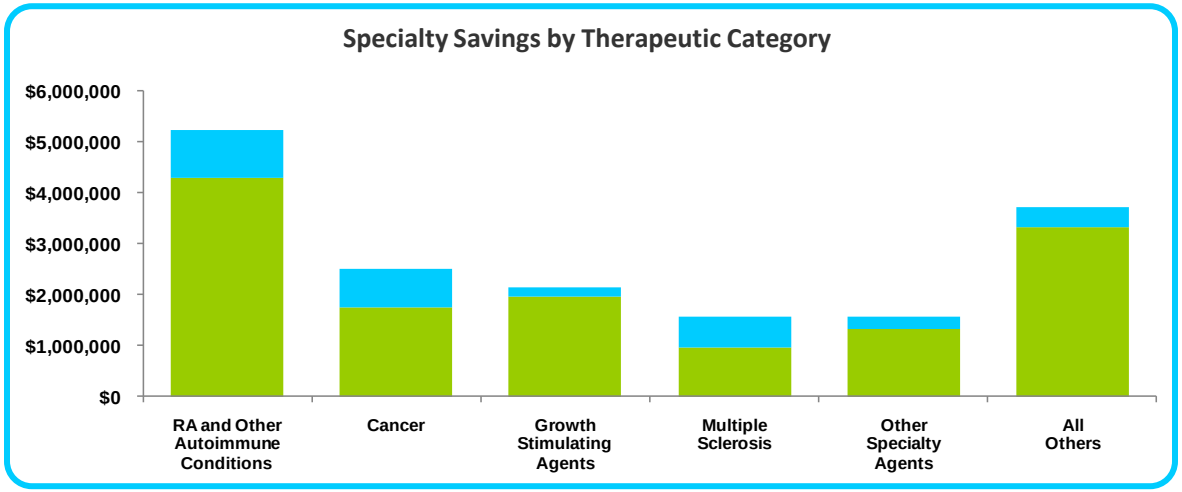
Source: Medco drug trend report 2006-2011; projection based on ≈17% growth for specialty and ≈ 3-4% growth for non-specialty drugs

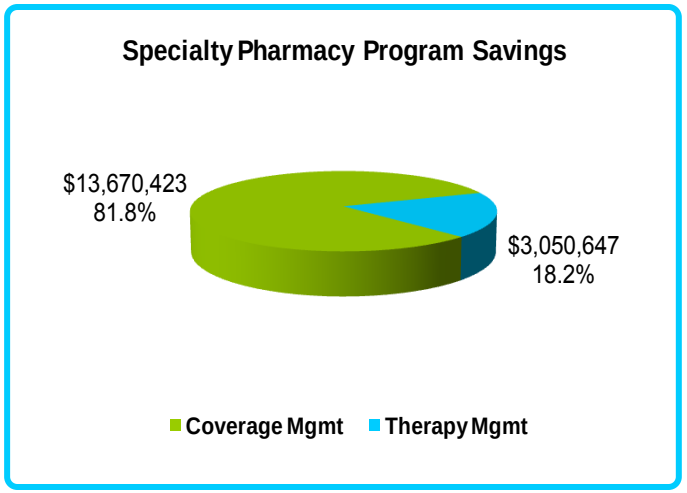
Top Specialty Savings 2012

- Specialty Plan Cost totaled $113.6M and represented 20.6% of the Total State of South Carolina Plan Cost.
- Your savings summary demonstrates the top savings driven by Therapy Management and Coverage Management by therapeutic category.
- Specialty Savings for 2012 totaled $16.7M. This increased by $7.77M from 2011 due to new clinical rules implemented by the State.

Top Savings by Therapeutic Category

Therapeutic Category	Savings	% of Total	Plan Cost	% of Total
RA and Other Autoimmune Conditions	$5,226,752	31.3%	$32,503,433	28.6%
Cancer	$2,501,828	15.0%	$22,950,434	20.2%
Growth Stimulating Agents	$2,151,424	12.9%	$2,558,632	2.3%
Multiple Sclerosis	$1,565,817	9.4%	$16,401,255	14.4%
Other Specialty Agents	$1,565,353	9.4%	$4,382,070	3.9%
All Others	$3,709,895	22.2%	$34,845,500	30.7%
Total Specialty	$16,721,069	100.0%	$113,641,323	100.0%





Managing Overall Cost and Enhancing Quality of Care

Better Clinical Care

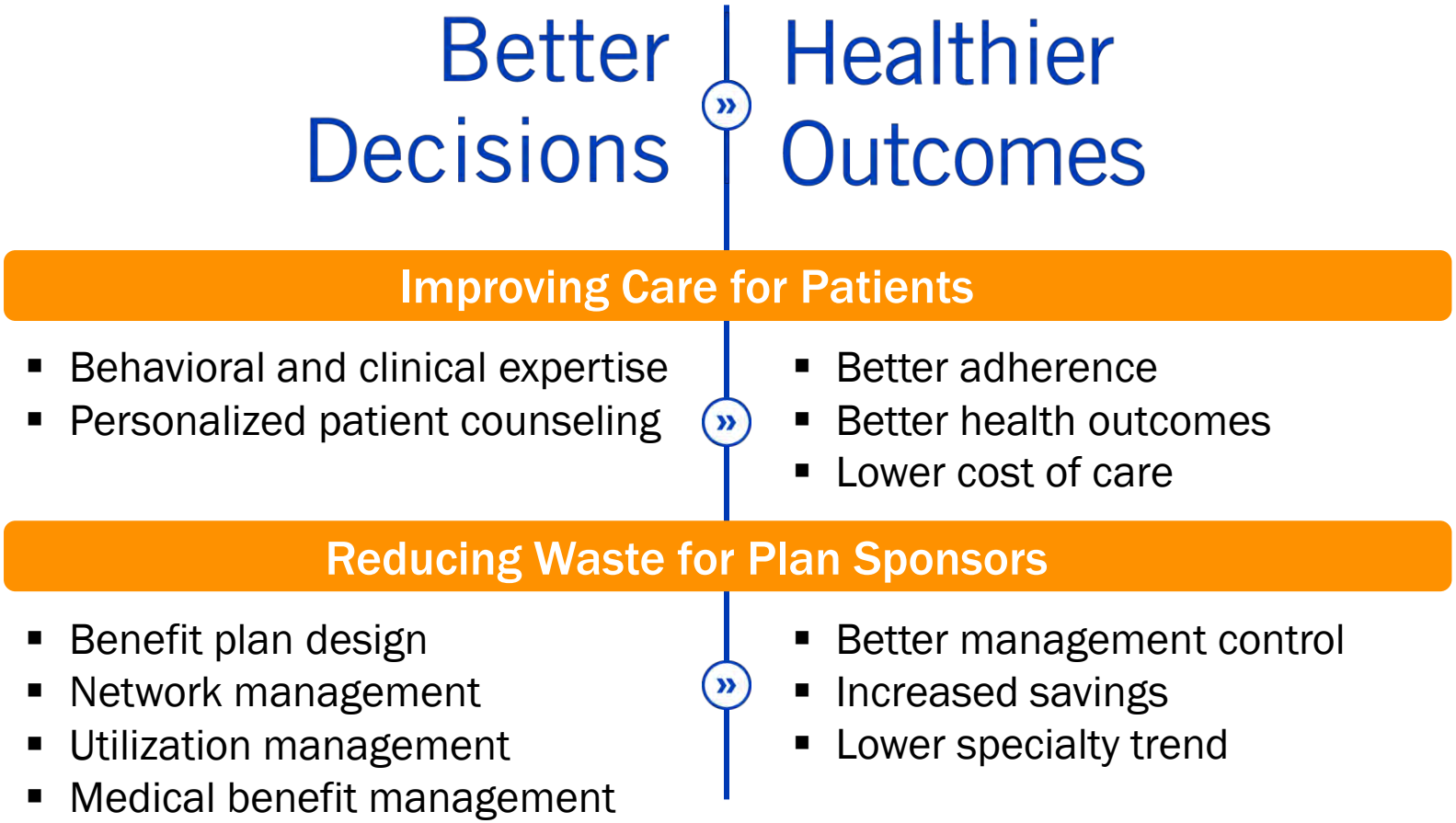
- CareLogic and TRCs
- Specialty-trained pharmacists and nurses
- Complete medication and medical profile
- Comprehensive therapy management
- Proactive outreach to 100% of patients
- Teachable moments maximized

Results in…

Better Adherence	Better Health Outcomes	Lower Costs
Pulmonary arterial hypertension (PAH) ▪ 17% higher than retail	▪ 32% fewer hospitalizations 35% fewer ER visits	▪ $13,000 less medical expense annually per patient
Rheumatoid arthritis (RA) ▪ 29% higher than retail	▪ 12% fewer hospitalizations 17% fewer ER visits	▪ 20% annual savings on medical expenses
Multiple sclerosis (MS) ▪ 32% higher than retail	▪ 39% fewer hospitalizations 39% fewer ER visits	▪ 31% annual savings on medical expenses

Express Scripts Benefit Services

Improving care and reducing waste



Thank You

Palmetto Health's Clinically Integrated Physician Network

The PHQC (Palmetto Health Quality Collaborative)

January 31, 2013

About Palmetto Health

Our 9,100 team members, 1,100 physicians and 400 volunteers are working together to transform the healthcare experience and fulfill Palmetto Health's vision:

"To be remembered by each patient as providing the care and compassion we want for our families and ourselves."

About Palmetto Health

Palmetto Health serves 70%+ of Richland County residents and 55%+ of the Richland County/Lexington County metropolitan area.

Four acute-care hospitals/1,138 licensed beds

- Palmetto Health Baptist
- Palmetto Health Children's Hospital
- Palmetto Health Heart Hospital
- Palmetto Health Richland

Integrated delivery system:

- Physician practices
- Home health and hospice
- Ambulatory and Outpatient Services
- Residency programs and education
- Program of All-inclusive Care for the Elderly (PACE)

Why do we need Clinically Integrated Physician Networks?

Four Forces Shaping Future Margins

Financial, Clinical Profiles Shifting Dramatically

Decelerating Price Growth

- Federal, state budget pressures constrain public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost shifting stretched to the limit

Continuing Cost Pressure

- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accretive

Shifting Payer Mix

- Baby Boomers entering Medicare rolls
- Coverage expansion boosting Medicaid eligibility
- Most demand growth over the next decade comes from publicly-insured patients

Deteriorating Case Mix

- Medical demand from aging population threatens to crowd out profitable procedures
- Incidence of chronic disease, multiple comorbidities rising

Source: Health Care Advisory Board interviews and analysis.

Entering the Affordability Economy

Only Two Paths to Financial Sustainability

Twin Demands from Purchasers

1 Reduce Pricing

Narrow networks

Steerage

Rate cuts

2 Lower Utilization

Cost shifting

Care management

Benefit design

Source: Health Care Advisory Board interviews and analysis.

A Clinically Integrated Network…

- Is a narrow network that theoretically will be able to reduce the cost of care overall per patient by:
  - Reducing duplication and waste;
  - Standardizing processes (which leads to lower supply cost, etc.);
  - Reducing harm and costly quality issues (which result in higher cost and more utilization); and
  - Incorporating care management.

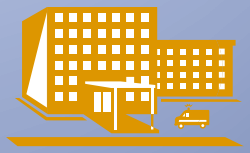
What is a Clinically Integrated Physician Organization?

- An organized group of physicians
  - who have come together for the purpose of improving quality and decreasing cost;
  - Who function in an integrated way and can reasonably expect to improve performance more than could have been accomplished without the infrastructure of the organization;
  - Who hold each other accountable to meet the standards set by the organization;
  - And who have agreed to jointly contract.

Palmetto Health Quality Collaborative

Medical Home Infrastructure

Patient Activation



SNF/Nursing Home

Home Health Care

Prevention/ Wellness

Disease Management

Primary Care Access

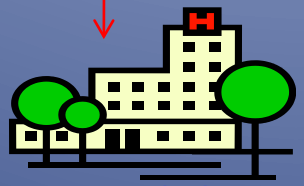
Population Health Analytics

Electronic Medical Records

Health Information Exchanges

Clinically Integrated Network

Palmetto Health



Ambulatory Care/Post Acute Care

New Co

Care Coordination

Palmetto SeniorCare -PACE

A case study of clinically integrated care over 25 years with proven success:

- Palmetto SeniorCare was the first PACE program (Program of All-Inclusive Care for the Elderly-PACE) in the state, and the only project directly structured as part of a hospital organization.
- Cares for frail elderly patients who meet the criteria for nursing home eligibility but are cared for in the community.

Palmetto SeniorCare- PACE

- Integrated system of care for the frail elderly that is community-based, coordinated, comprehensive, and capitated under Medicare and Medicaid
- Provides innovative person-centered care for older adults that allows them to stay in their homes and communities and out of nursing homes

Palmetto SeniorCare Outcomes

- 5.67 prescriptions per patient
- LOS for hospital admissions 3. days
- Hospital Days per 1000 per annum PSC-1039 Medicare Managed Care 1897
- Readmission rate within 30 days for PSC 8% for all conditions
- Average LOS in program 4.2 years compared to 2.3 for nursing home
- Payment under Medicaid is 53% of nursing home cost for care

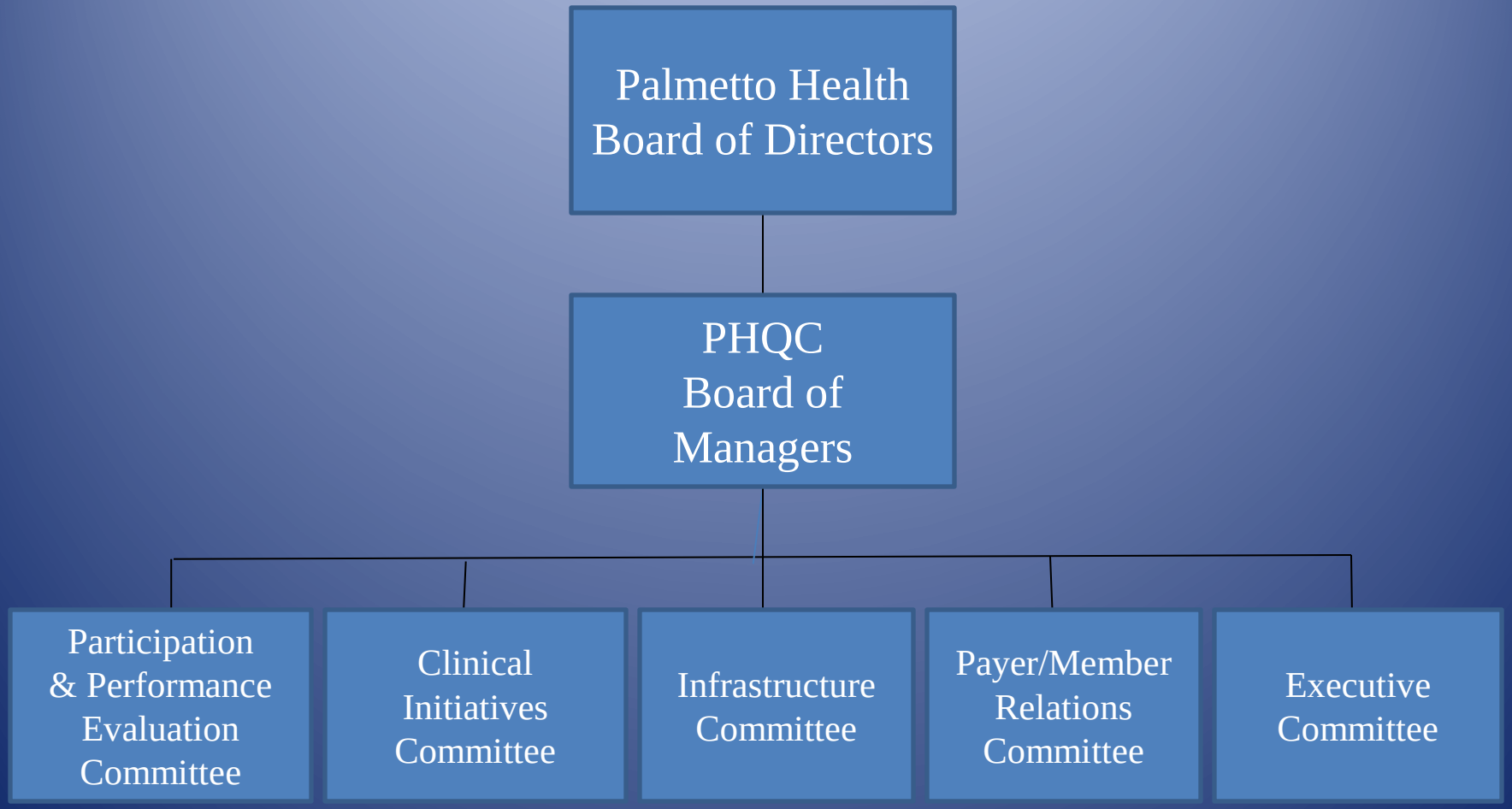
Key components of PACE

1. An established network of providers that can flexibly meet the needs of population health
2. Transitional care coordination model that bridges inpatient and outpatient care
3. Primary care that encompasses the Patient-Centered Medical Home Model
4. An interdisciplinary team to manage care across the continuum
5. Care is coordinated across the system to assure outcomes based on quality of life and effective disease management.
6. Patient and family are critical components of the care team

PHQC Organizational Structure & Governance

- PHQC is a South Carolina Limited Liability Company completely owned by Palmetto Health.
- The operations of PHQC are managed by a Board of Managers comprised of thirteen managers (10 “physician” and 3 “hospital”).
- Membership of 550+ MDs including those employed by Palmetto Health, the faculty of the USC School of Medicine, and private physicians from the community.

Organizational Structure & Governance



What are we doing?

- Each specialty has 5-10 clinical initiatives they are actively working on:
  - Specific metrics such as diabetic care PQR measures and broad initiatives such as implementation of PCMH for all primary care practices;
  - Reducing inappropriate blood transfusions or improving compliance with evidence based care sets for antibiotic use for surgical patients.
  - Broad initiatives such as implementing standard care sets for diabetic patients or patients with back pain.
- Total of 66 clinical initiatives we are tracking (generally at the physician level) on a monthly basis.

Early wins for PH and the PHQC

- Blood Management:
  - recent evidence in the literature shows our criteria for giving blood should be more stringent as often blood transfusion is actually a harm even for a patient – and blood is really expensive!
  - By instituting evidence based guidelines for transfusions, we have improved patient care and saved $568,000 last fiscal year (a reduction of 7% in PH's spend for blood products); so far this year we have maintained those savings and expect an additional savings of $315,000 in further reductions (a reduction of 11% in PH's spend for blood products).

Early wins for PH and the PHQC

- Surgical Standardization:
  - The PHQC pulled together groups of surgeons who do similar cases and reviewed the variation in the surgical supplies used and the costs used to perform the same procedures, asking surgeons to identify areas where they could standardize or move to lower cost items without jeopardizing patient safety or quality.
  - We have identified $2.8 million (a decrease of 6.5% in the PH surgical supply spend) in possible savings if all surgeons move to the standard procedure cards.

Building Blocks of an Integrated Care Network

- Ability to collect data to improve performance
- Ability to leverage physician engagement to improve quality and reduce cost
- Infrastructure in place to provide flexibility in care delivery
- Ability to develop care pathways around population health
- Funding from a payer system to deliver care

Is this the same as a Medicare ACO?

- It could be…
  - A Clinically Integrated Network is an accountable care organization that has the structure to be able to contract under the Medicare Shared Savings plan;
  - Or with other payors for specific projects or as a narrow network;
  - Or directly with insurers.

How does this fit with other initiatives?

- A clinically integrated network coupled with value based insurance design allows the alignment of patient incentives with physician incentives and organizational processes.
- A clinically integrated network integrates PCMH practices in primary care with specialists and the hospital system, focusing on improvement at transitions points in care a common care plan across settings, etc.

What's Next:

- Continued development of infrastructure and data capabilities.
- Improved sophistication in performance improvement methodologies and engagement with physicians.
- Development of population management competencies and care management infrastructure necessary to take on additional risk.
- Additional pilots: for example, shared savings for specific populations, bundled payment for specific clinical conditions.

PEBA Retreat

South Carolina Department of Health and Human Services

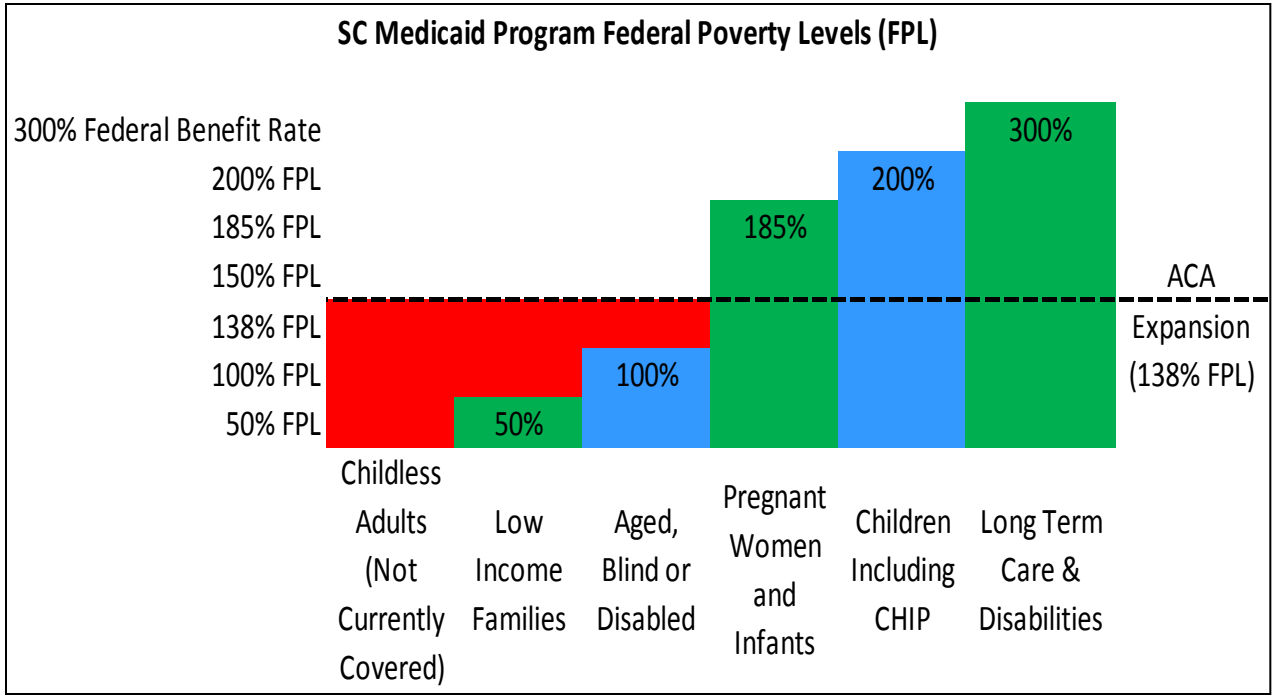
Anthony Keck
keck@scdhhs.gov

January 29, 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.

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

South Carolina Health & Human Services



Without Medicaid expansion:

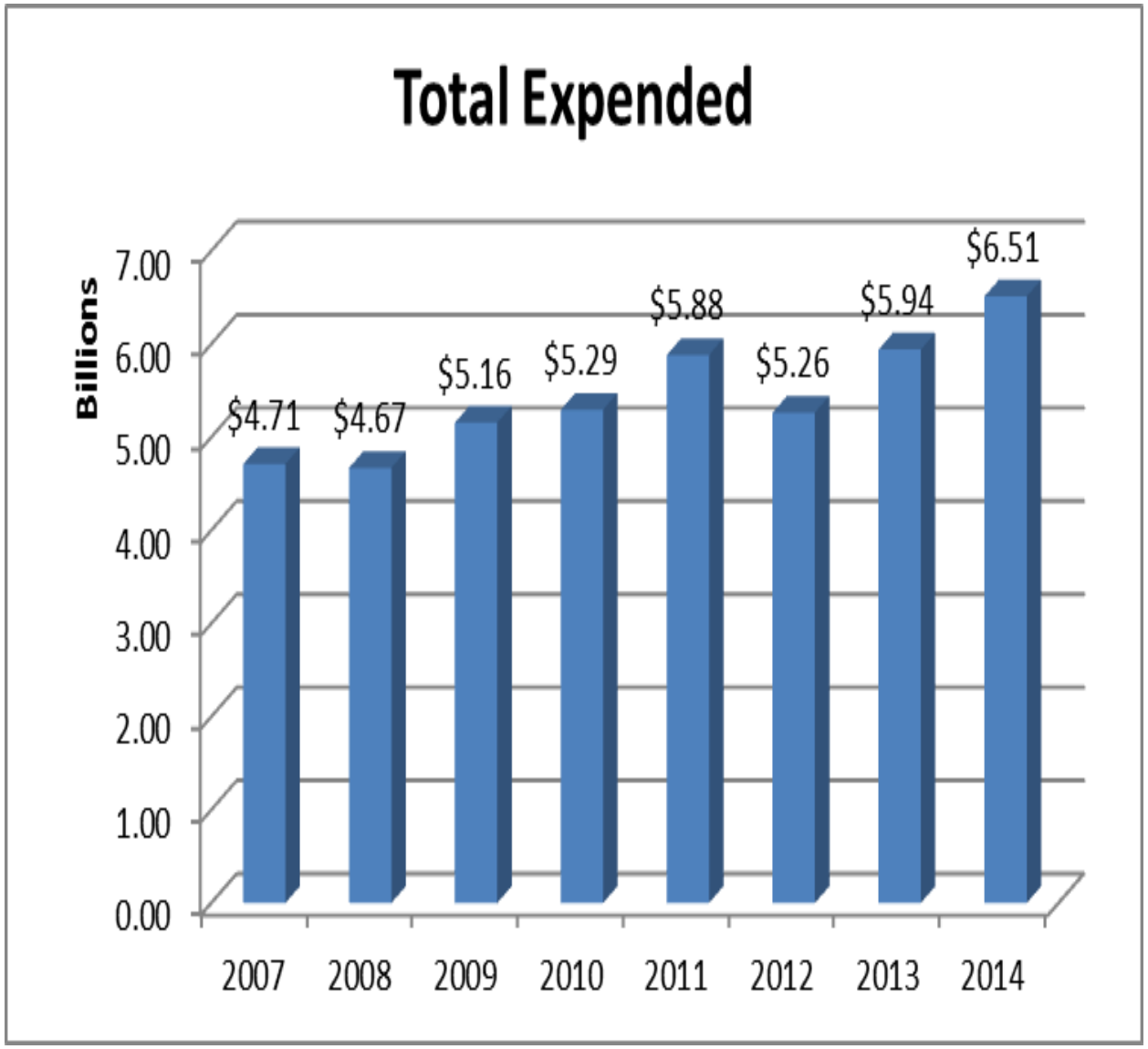
- **101,000 may drop private insurance**
- **162,000 currently eligible but unenrolled will join Medicaid (Welcome Mat effect)**

With Medicaid Expansion:

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

SC Medicaid Total Expenditures

South Carolina Health & Human Services



The Medicaid expenditures have grown 38.21% from FY2007 to FY2014.

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

Budget Driver History

South Carolina Health & Human Services

Comparison of Cumulative Member Months to Costs

Source: Milliman Spring 2012 Forecast and Department budget documents

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

Triple Aim

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

$765 billion excess cost in 2009

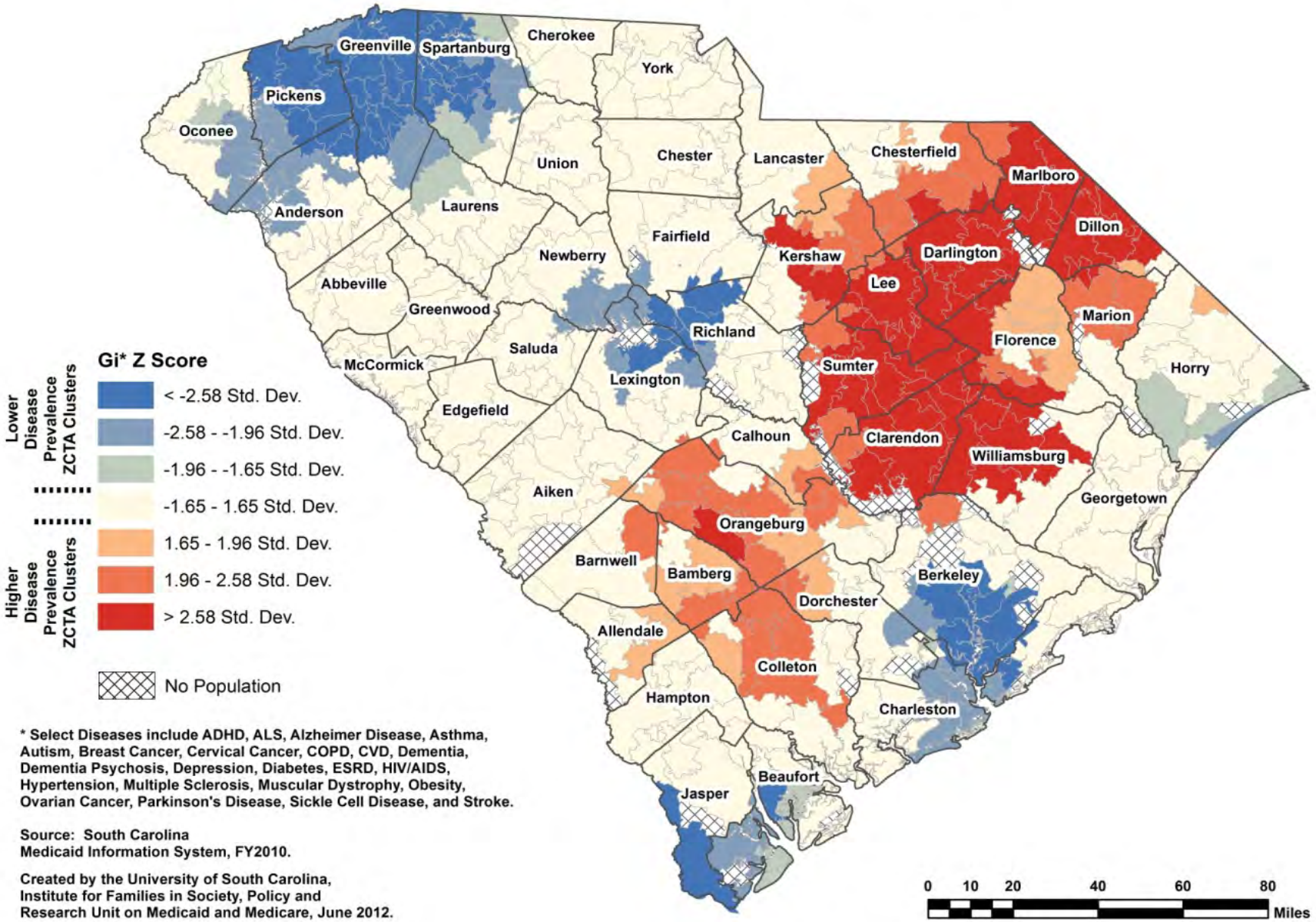
South Carolina Health & Human Services

- $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)***

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.

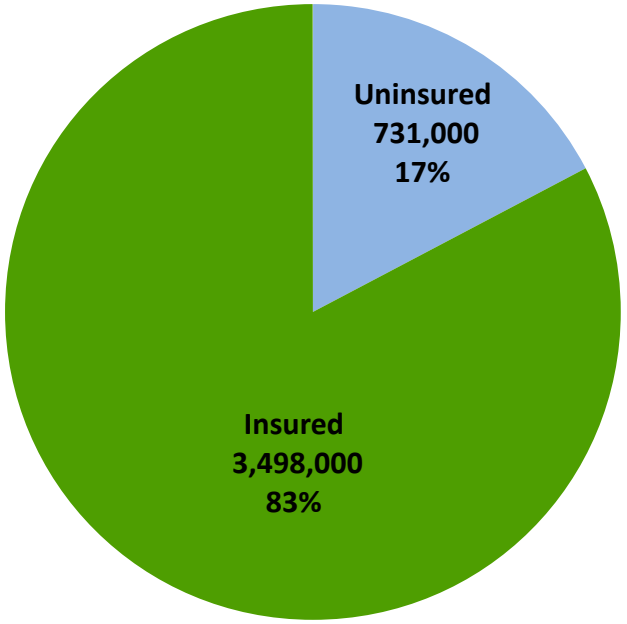
Source: South Carolina Medicaid Information System, FY2010.

Created by the University of South Carolina, Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, June 2012.

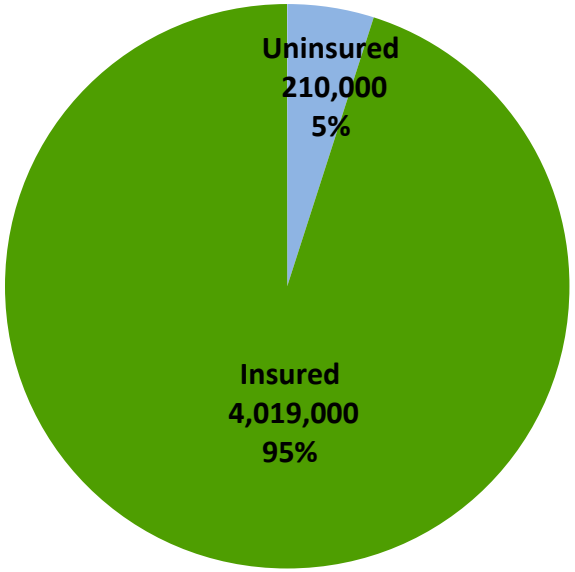
ACA impact on South Carolina access to affordable health insurance coverage

South Carolina Health & Human Services

Pre-ACA: 2013 Uninsured



Post-ACA: 2015 Without Access to affordable health insurance



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

How Will the Market Change with ACA's Optional Medicaid Expansion?

South Carolina Health & Human Services

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**

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

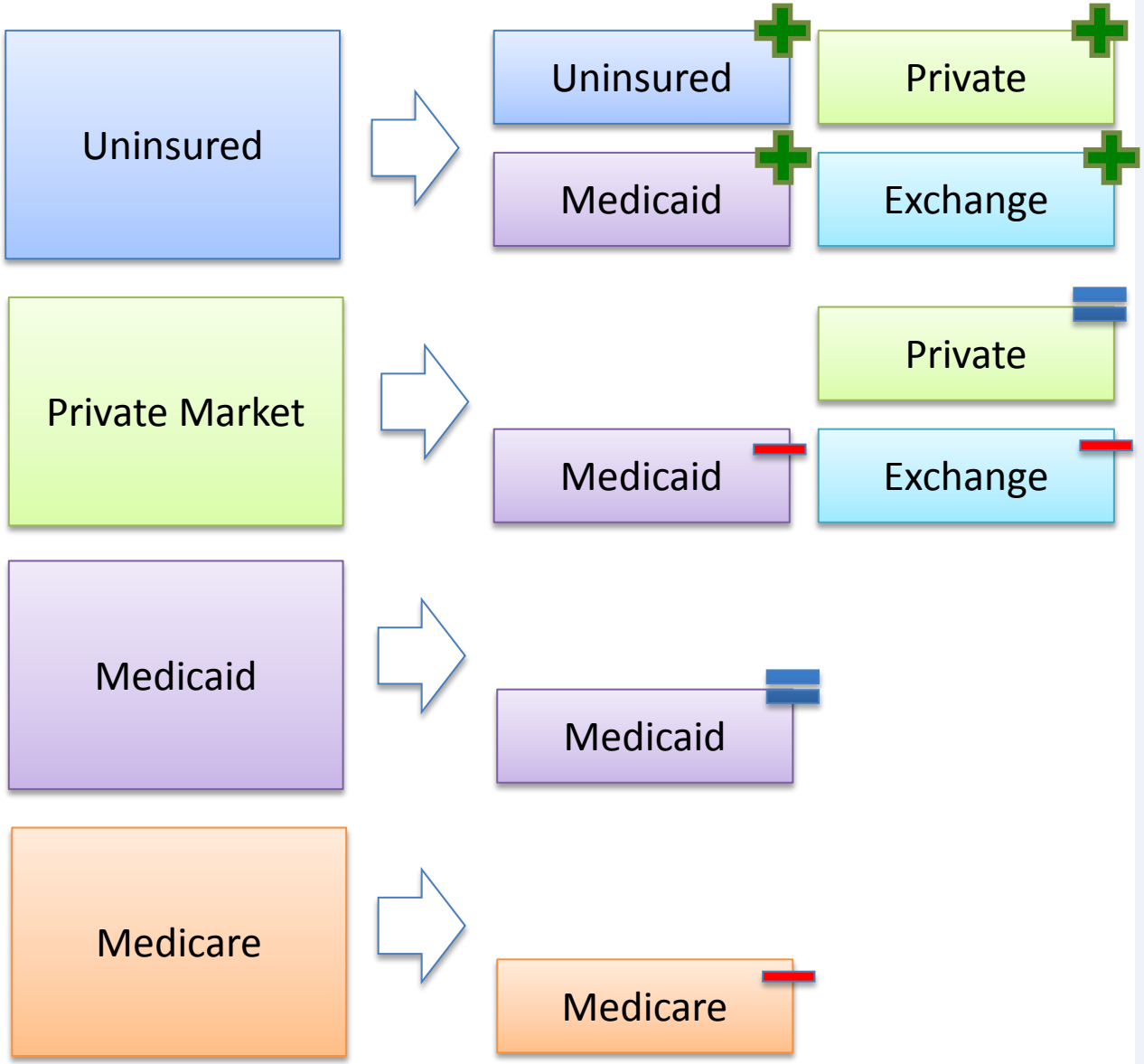
Significant growth will occur in the number of insured adults in both the Medicaid and private market

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

Shifting Hospital Payor Mix under ACA

South Carolina Health & Human Services



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

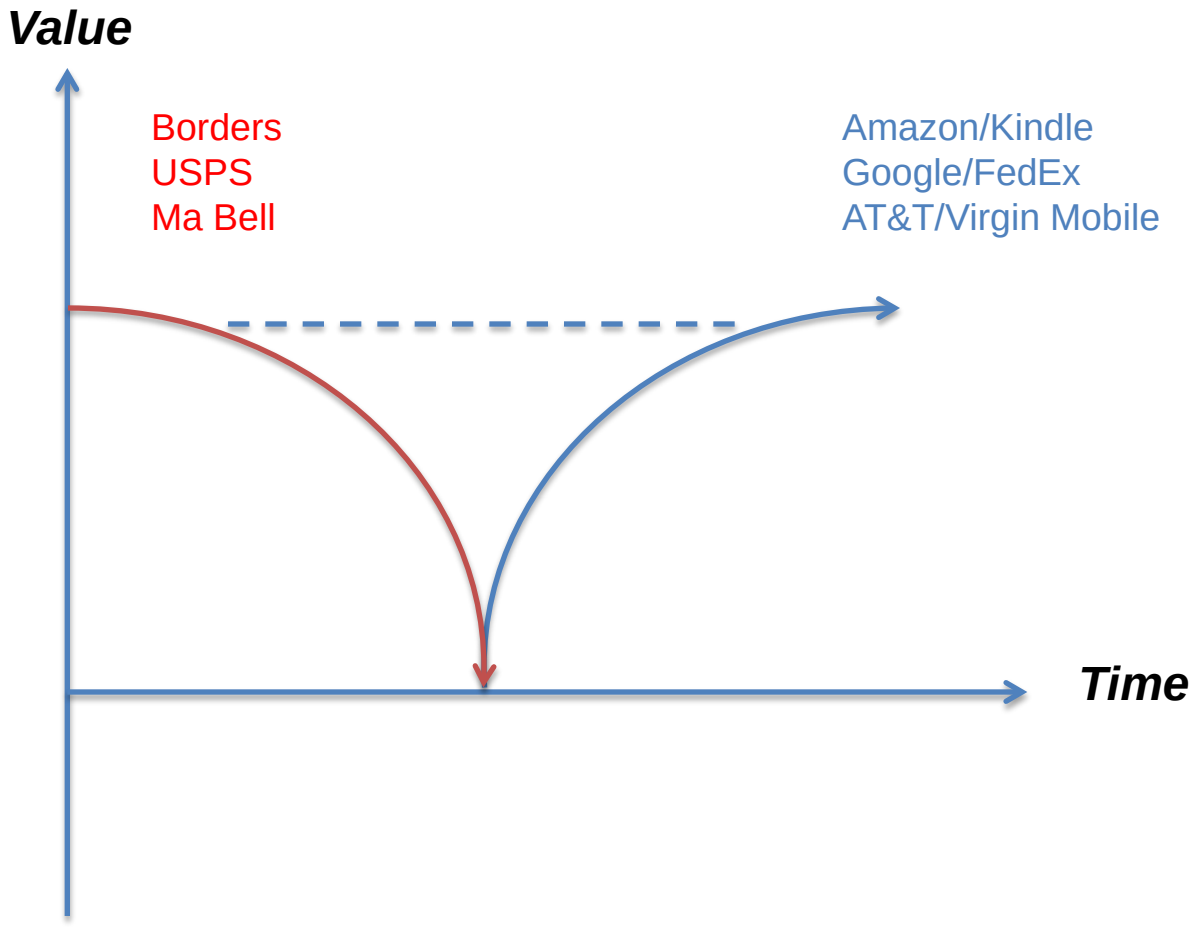
How many lives will shift?

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?

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

South Carolina Health & Human Services

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

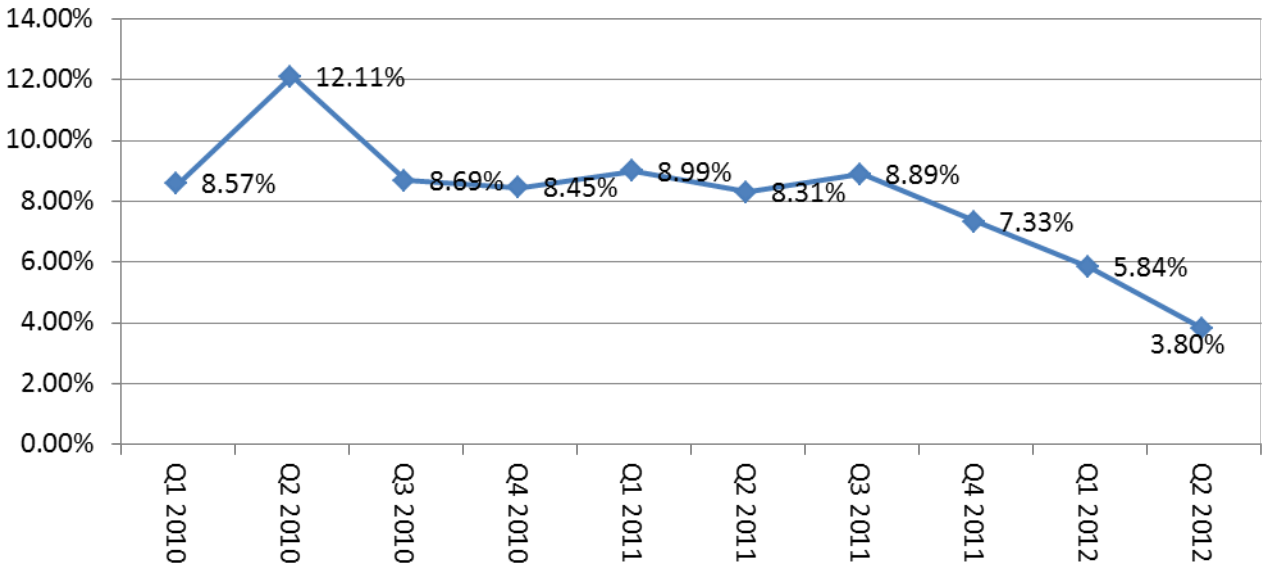
Catalyst for Payment Reform Model Contract

- *Value Oriented Payment*
  - *Pay providers according to performance*
  - *Pay to reduce unwarranted variation*
  - *Educate, measure, report and incentivize clinical guidelines*
  - *Reference and COE pricing*
  - *Rebalance primary & specialty care*
- *Transparency*
  - *Providecomparative reports on provider performance*
  - *TPA provide contract transparency*
  - *Eliminate gag and MFN clauses*
- *Third-party Data Use*
- *Consumer Tools and Incentives*
  - *Publish comparative reports on provider performance*
  - *Support selection of high value providers through info & incentives*
- *Competition*
  - *Measure and evaluate provider competition*
  - *Encourage competition through tiered and narrow networks, ACO, RPFs*
- *Evaluate Results*
  - *3-5 years plans*
  - *CPR National Scorecards*

Hotspots & Disparities: Birth Outcomes Initiative

South Carolina Health & Human Services

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

South Carolina's Path Forward

South Carolina Health & Human Services

- 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 hotpots and disparities
- Apply for flexibility in 2017 when ACA waivers are available

Projection risk is very high

A conservative budget approach is imperative

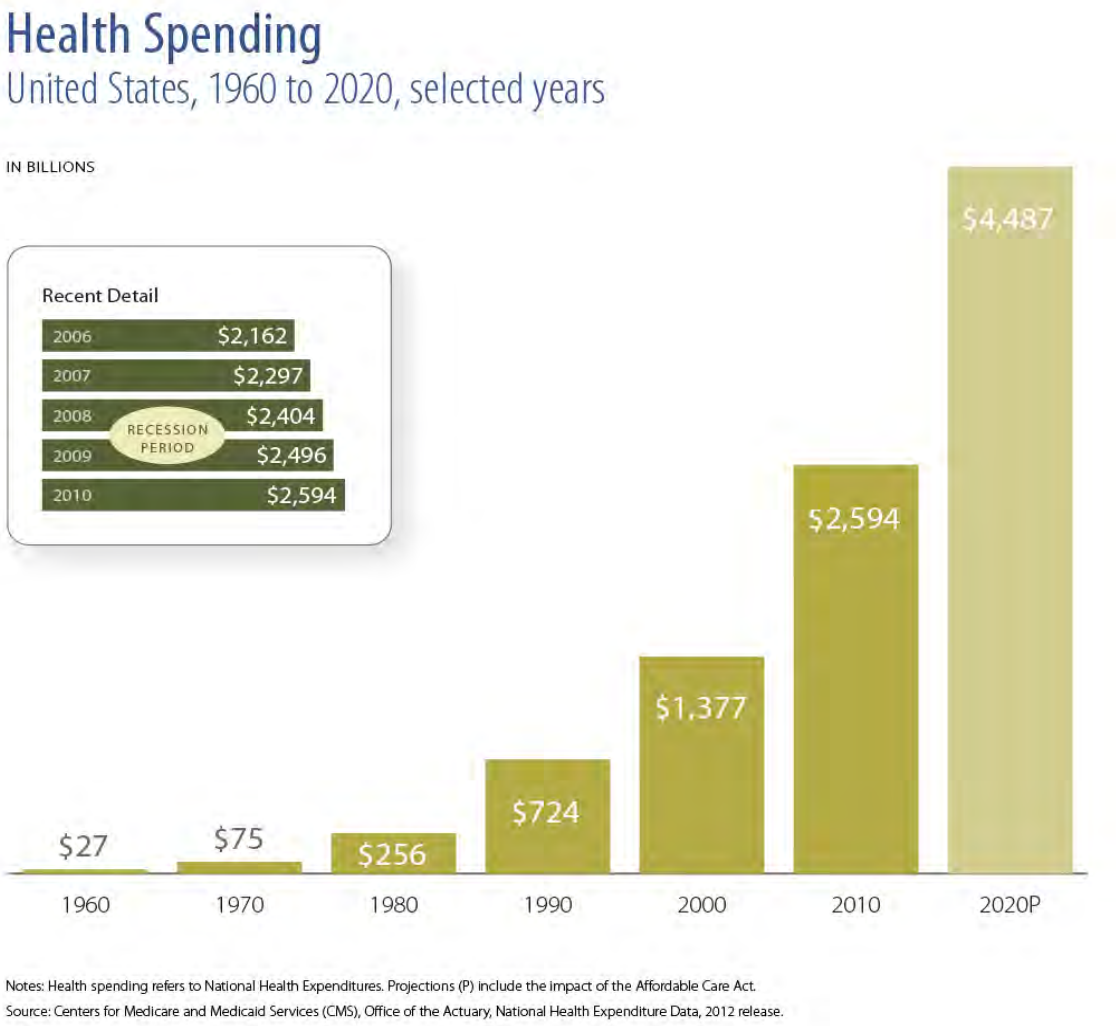
The amount of implementation risk is significant

Just expanding coverage does not ensure that meaningful connection will be made between providers and patients

Additional Slides

Constant Health Spending Growth

South Carolina Health & Human Services



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)

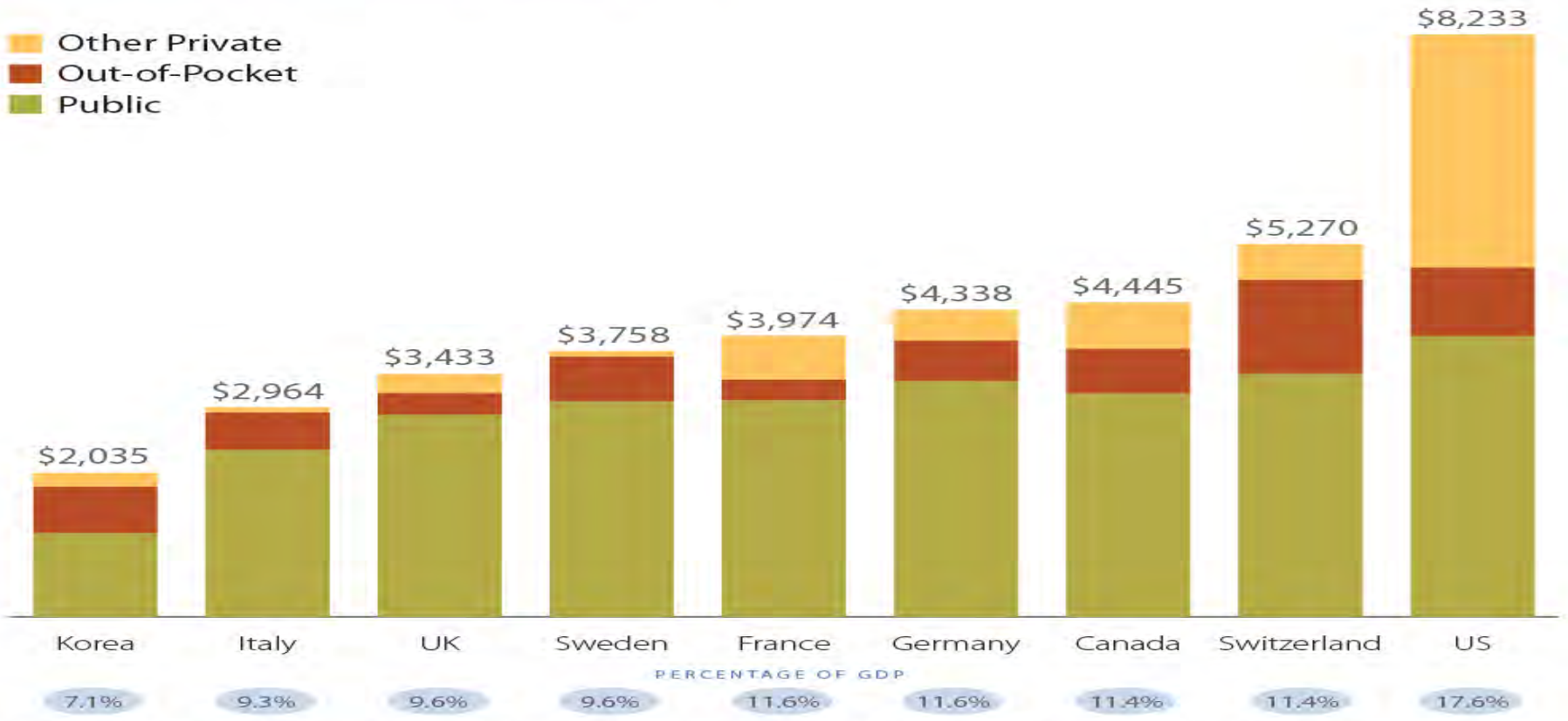
In each of those years real GDP grew (3.1%), 2.4% and 1.8%

There is enough money in the system

South Carolina Health & Human Services

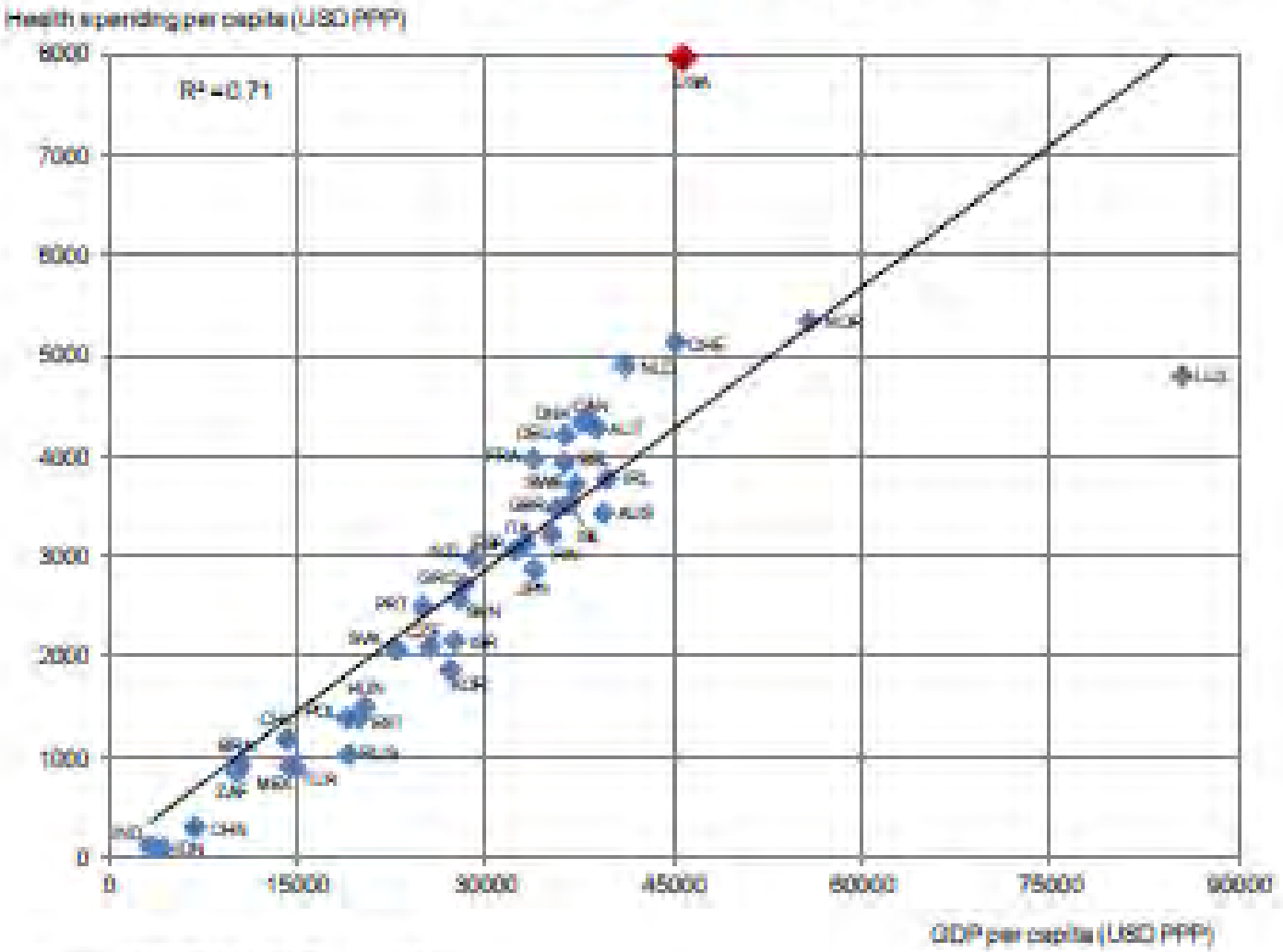
Health Spending Per Capita and as a Share of GDP

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.

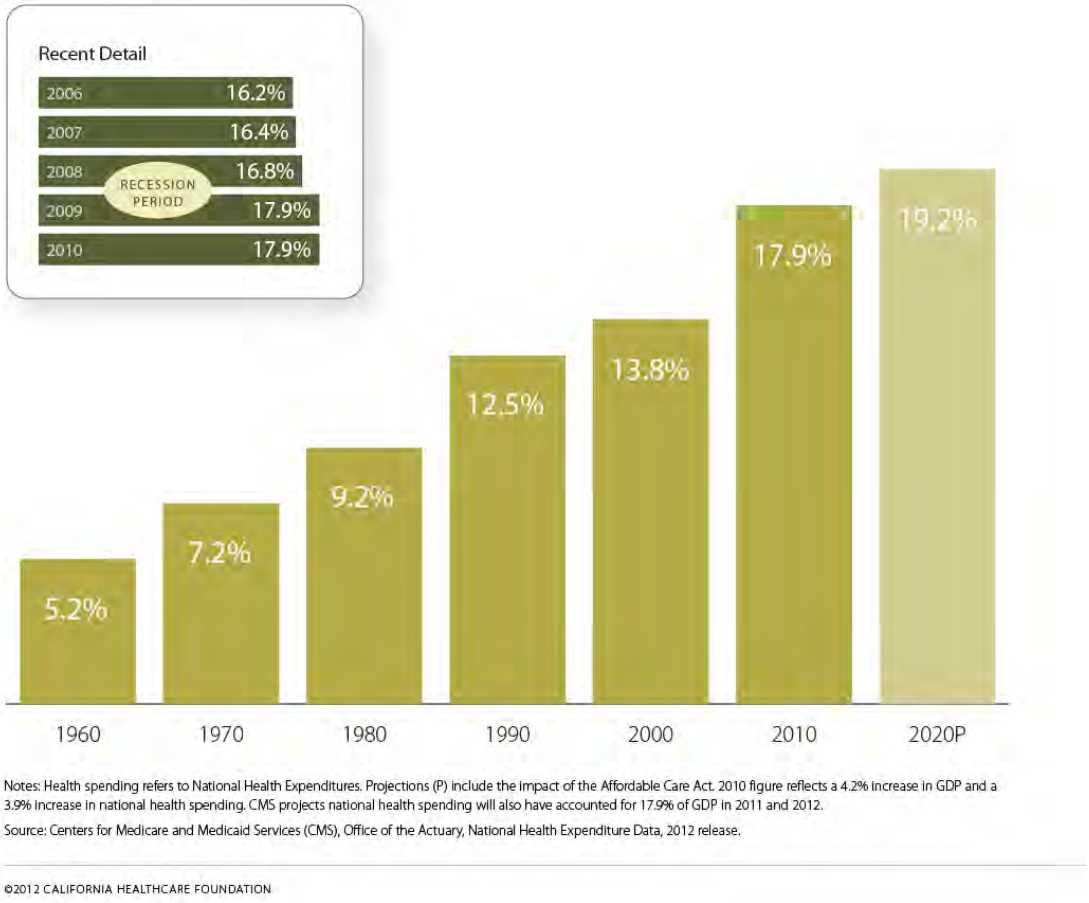
Chart 3: Total health expenditure per capita and GDP per capita, 2009 (or nearest year)



Source: OECD Health Data 2011.

US Health Spending as a Share of GDP Grows under ACA

South Carolina Health & Human Services



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.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

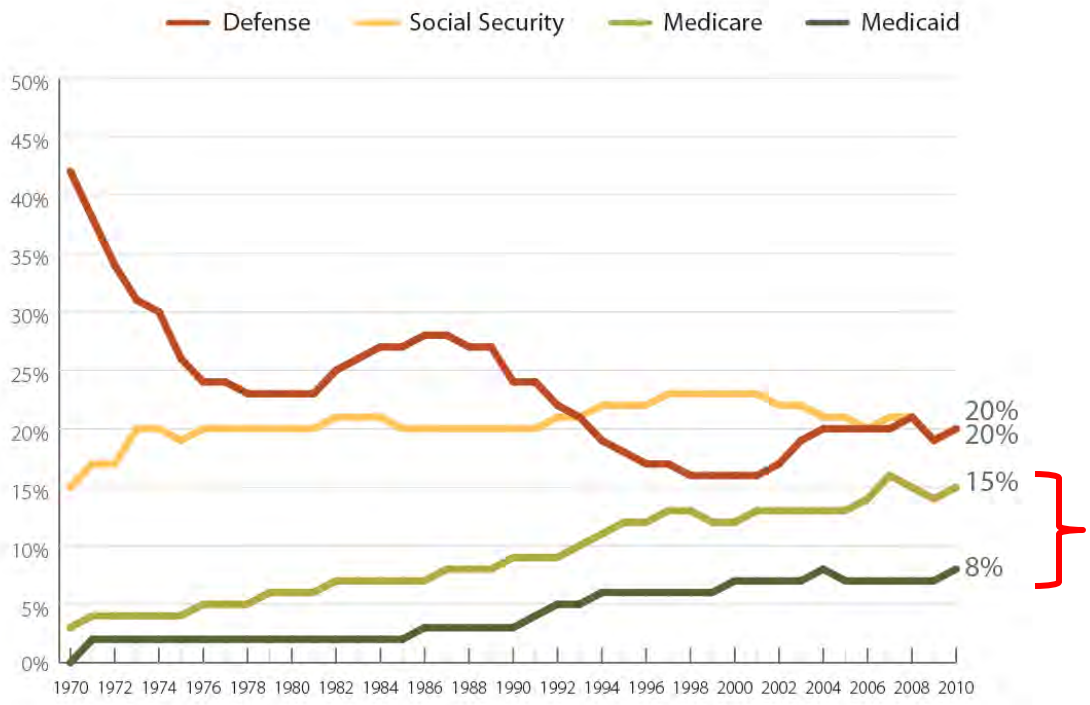
A larger portion of paychecks, payrolls and government budgets are going to health care every year

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

Major Programs as a Share of the Federal Budget

South Carolina Health & Human Services



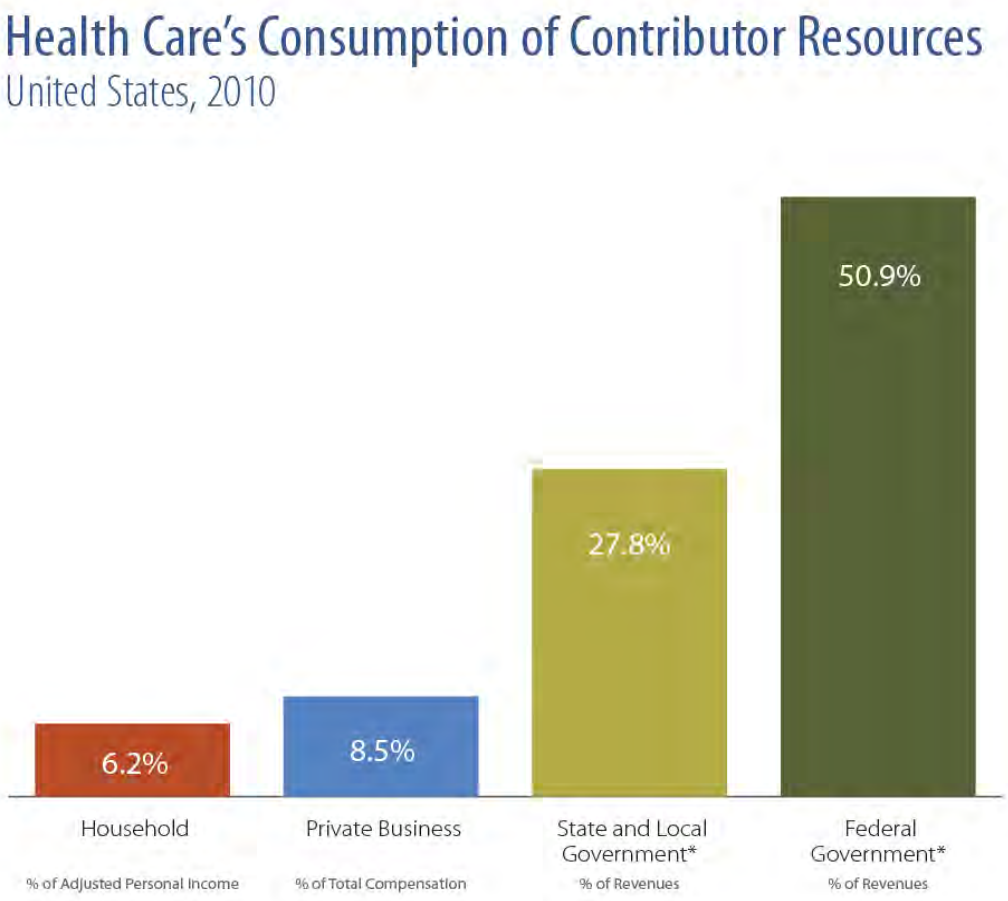
Notes: Spending shares computed as percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion of Medicaid).

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.

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

Major Programs as a Share of the Federal Revenue

South Carolina Health & Human Services



50.9% of federal revenues for Medicaid and Medicare compared to 23% of the federal budget

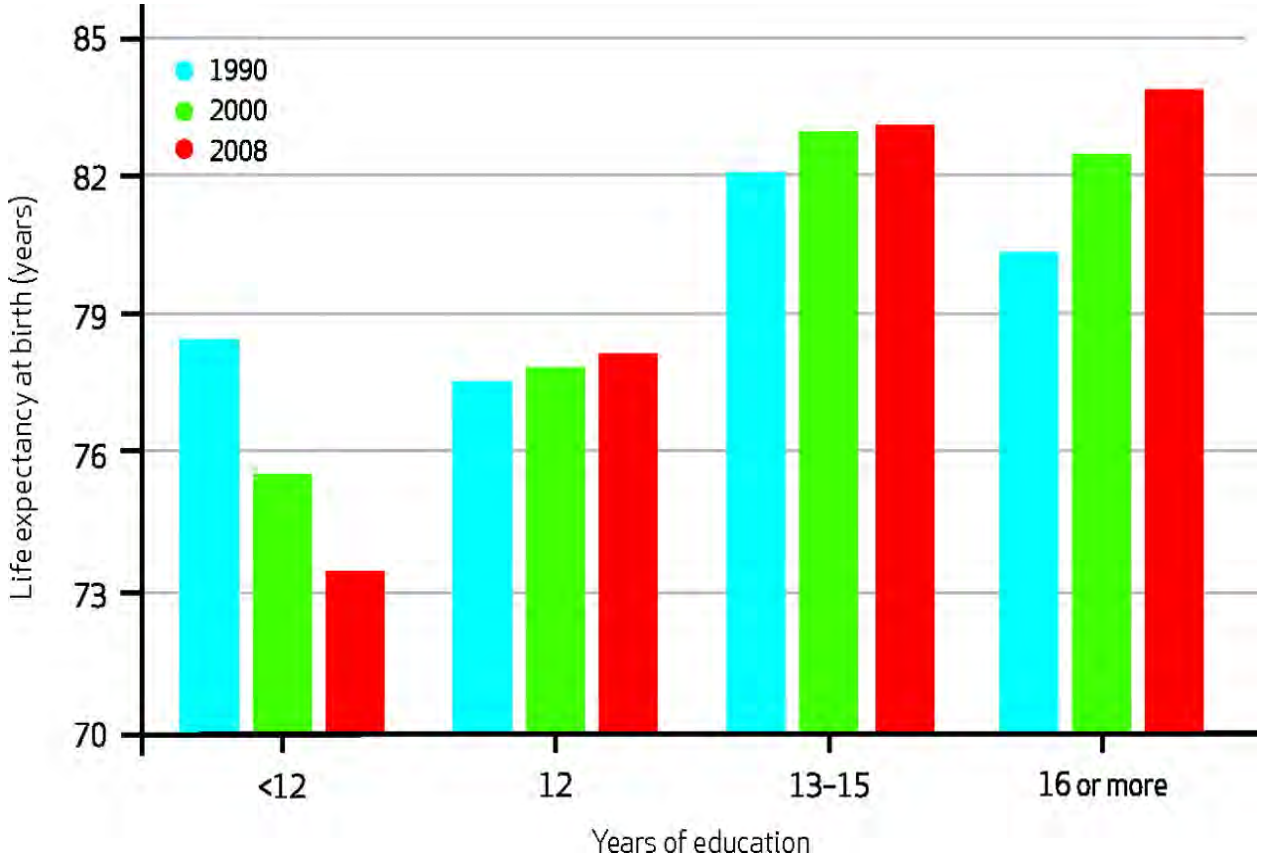
The fine print: "due to borrowing federal government revenues are less than outlays"

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

US is Falling Behind in Life Expectancy

South Carolina Health & Human Services

Life expectancy for white women by years of education



In 1950 US life expectancy ranked 12th at 68.9 years

In 2009 the US ranked 28th at 79.2 years

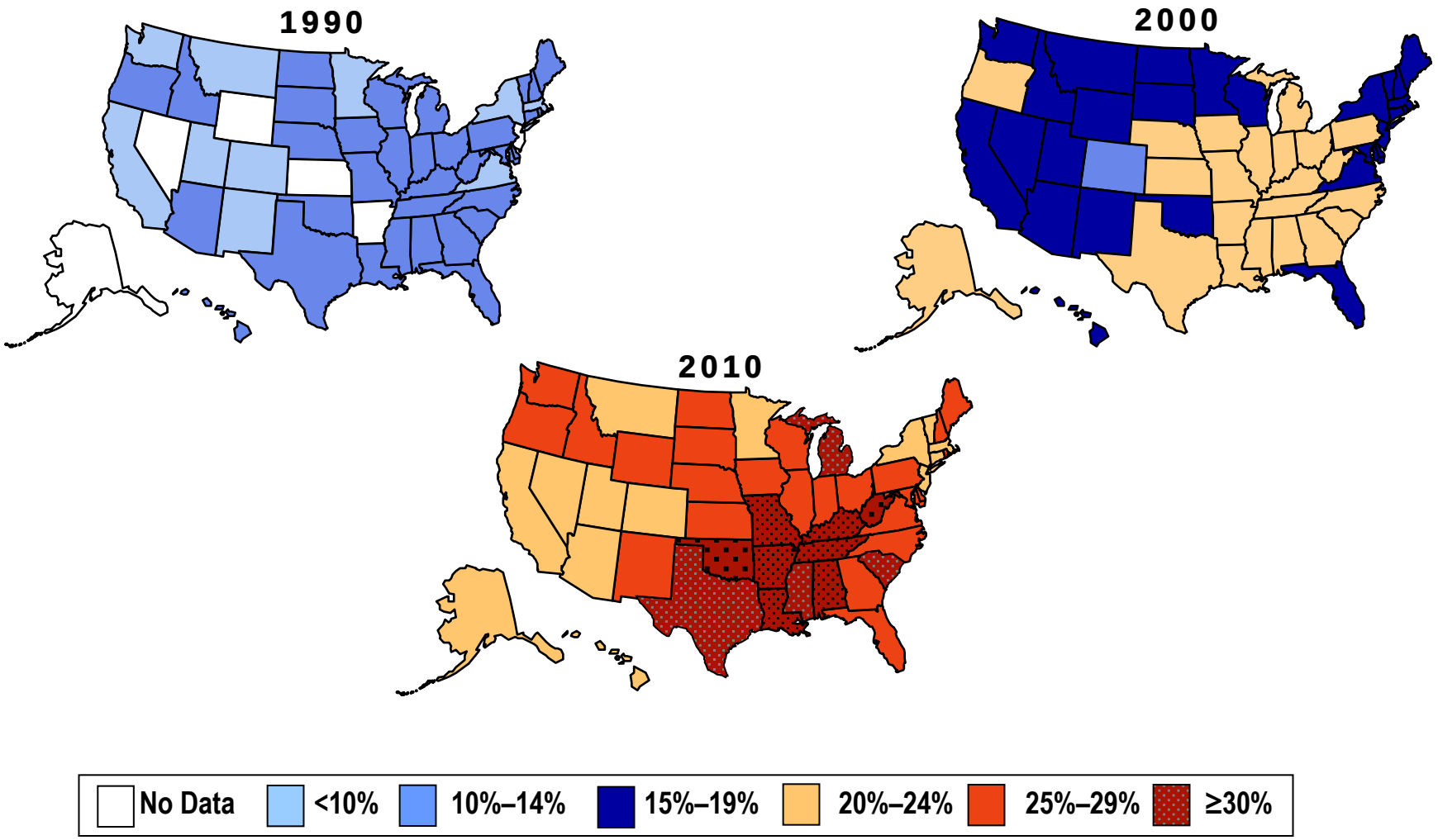
South Carolina ranked 42nd in US in 2007 at 76.6 years

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

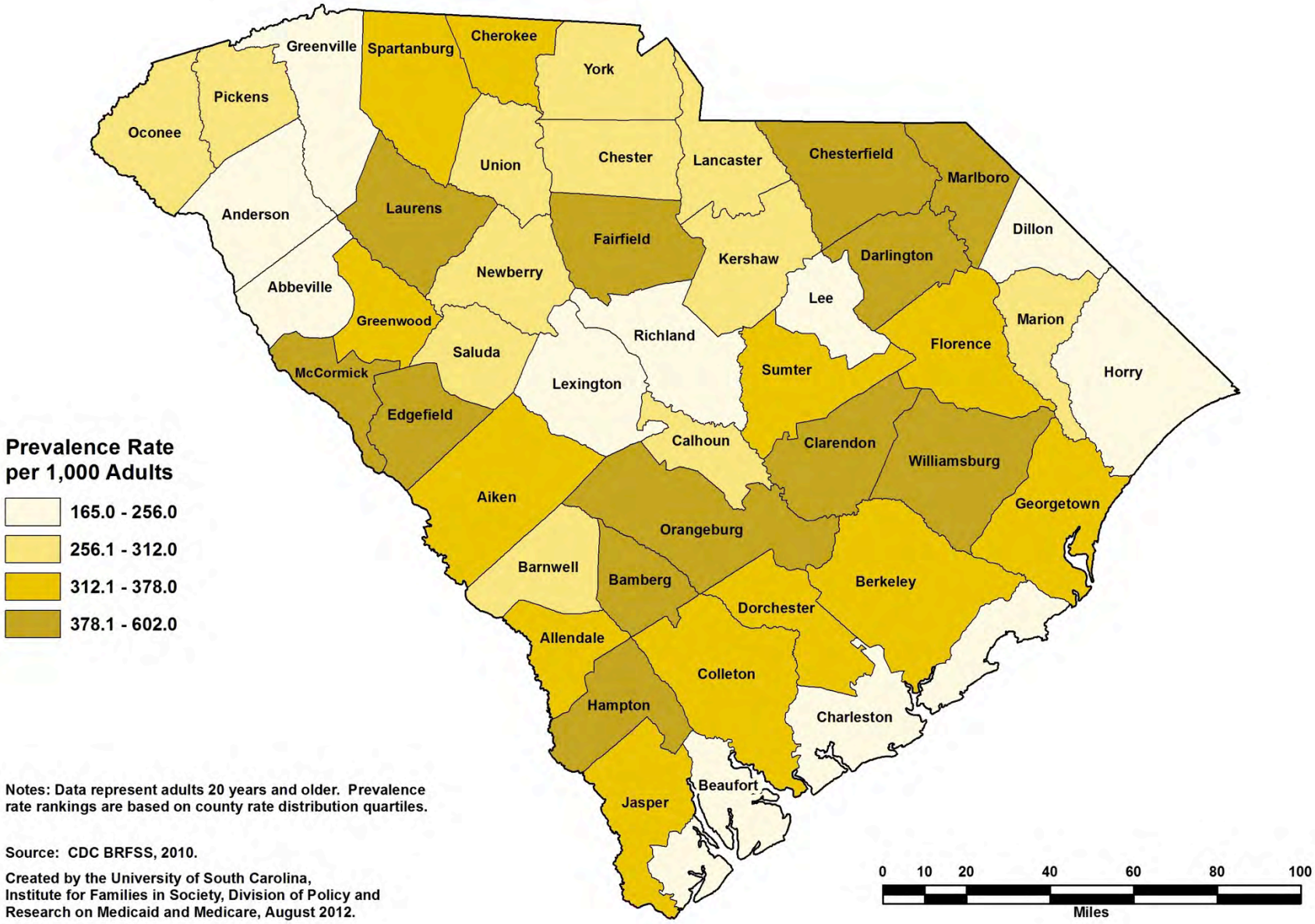
Obesity Trends* Among U.S. Adults

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



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.

ACA Overview and Impact

South Carolina
Health & Human Services

S.C. ACA Timeline

South Carolina Health & Human Services

- 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: 1.7 Million Enrollees by 2020

South Carolina Health & Human Services

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

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

South Carolina Health & Human Services

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**

Source: Milliman ACA Impact Analysis

Income profile of the uninsured in SC

South Carolina Health & Human Services

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

South Carolina's Alternative

Governor's Investment in Rural Hospitals

		Rural Area Designation				
	CAH	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

DSH payments for Uncompensated Care

South Carolina Health & Human Services

- 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

South Carolina Health & Human Services

- 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

South Carolina Health & Human Services

- 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

South Carolina Health & Human Services

- 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 "out of scope".**
- **The report did no sensitivity analysis considering it "out of scope".**
- **The report considered labor constraints in SC "out of scope".**