



CALIFORNIA
HOSPITAL
ASSOCIATION

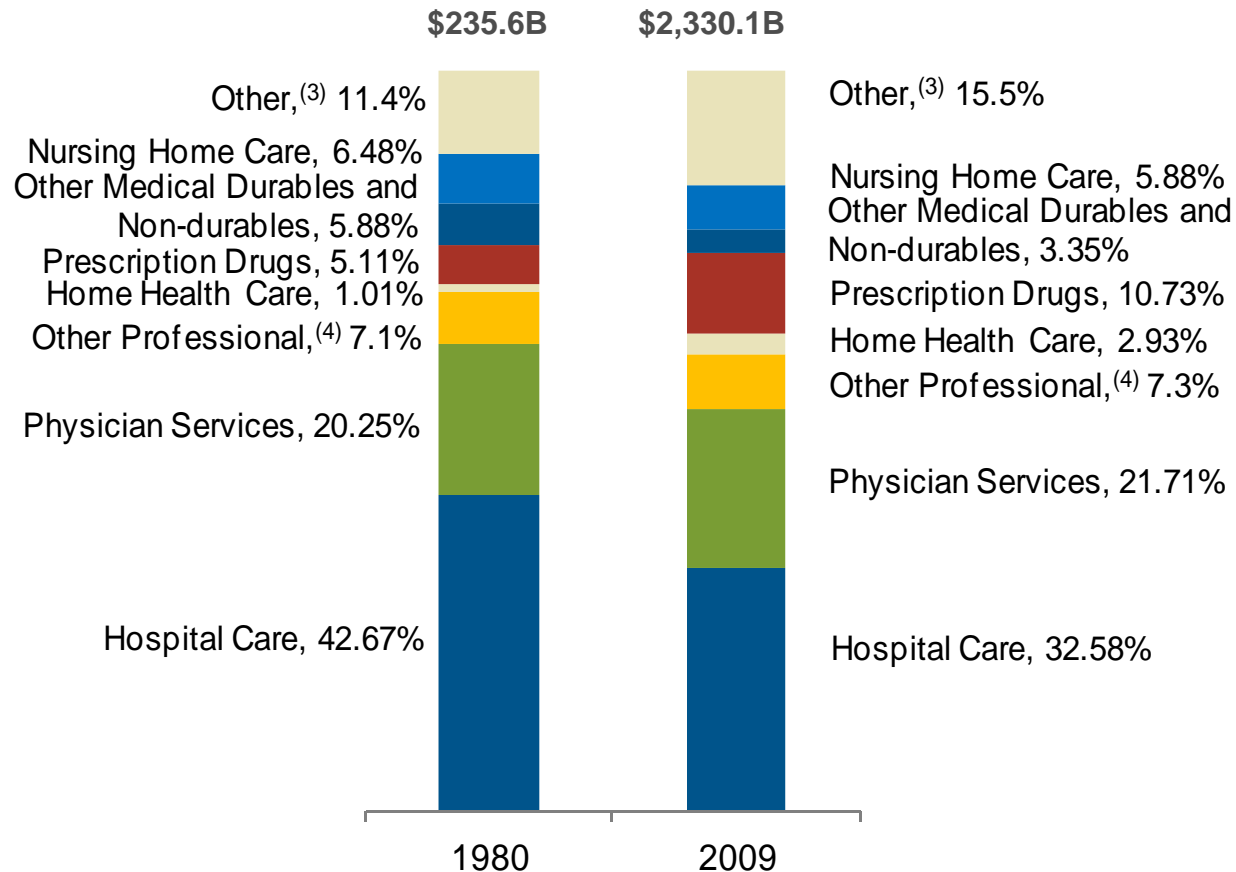
*Providing Leadership in
Health Policy and Advocacy*

California Hospitals: Innovative, Cost Efficient and Working to Implement Health Care Reform

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California Hospital Association

NATIONAL HEALTH EXPENDITURES BY CATEGORY



Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 6, 2011.

(1) Excludes medical research and medical facilities construction.

(2) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see <http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf>.

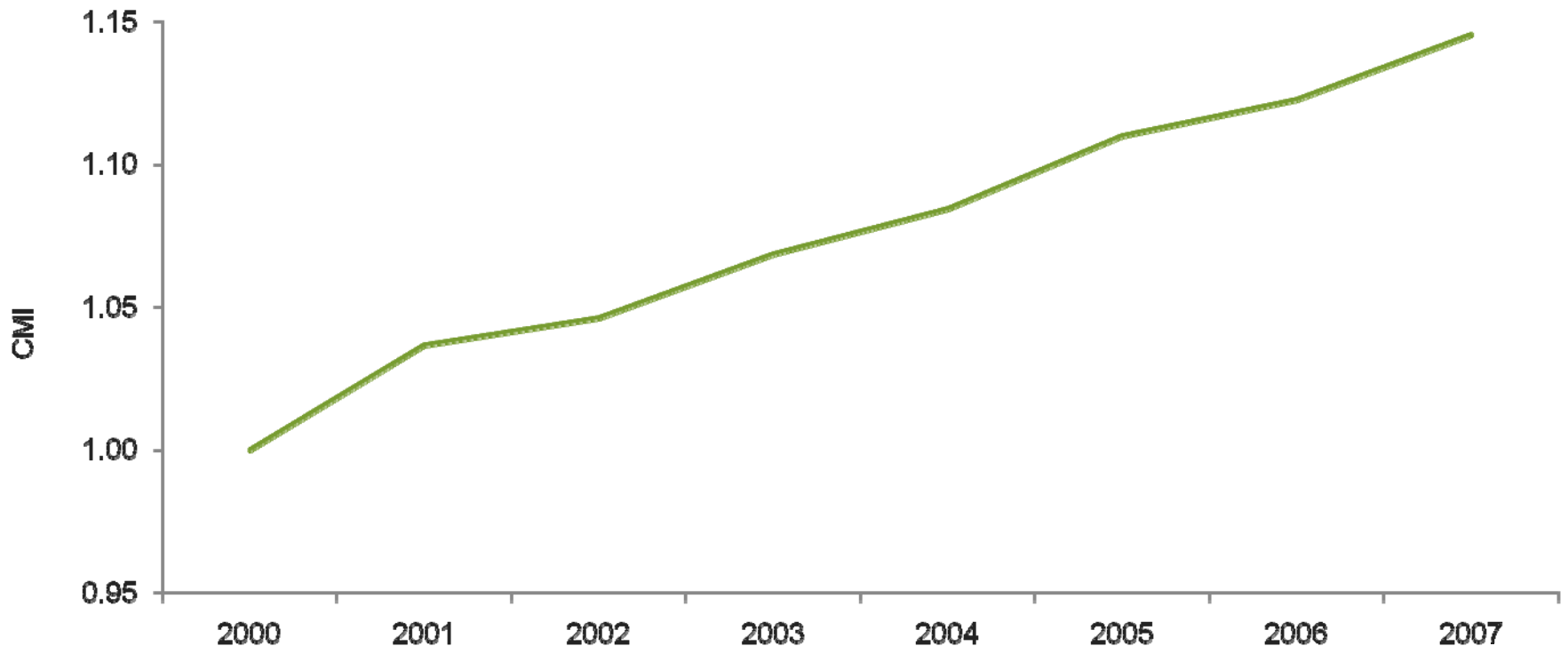
(3) "Other" includes net cost of insurance and administration, government public health activities, and other personal health care.

(4) "Other professional" includes dental and other non-physician professional services.

Source: American Hospital Association

HOSPITALS TREAT SICKER PATIENTS THAT REQUIRE SPECIALIZED CARE

Inpatient Case-mix⁽¹⁾ Index (CMI) for the Medicare Population, 2000-2007



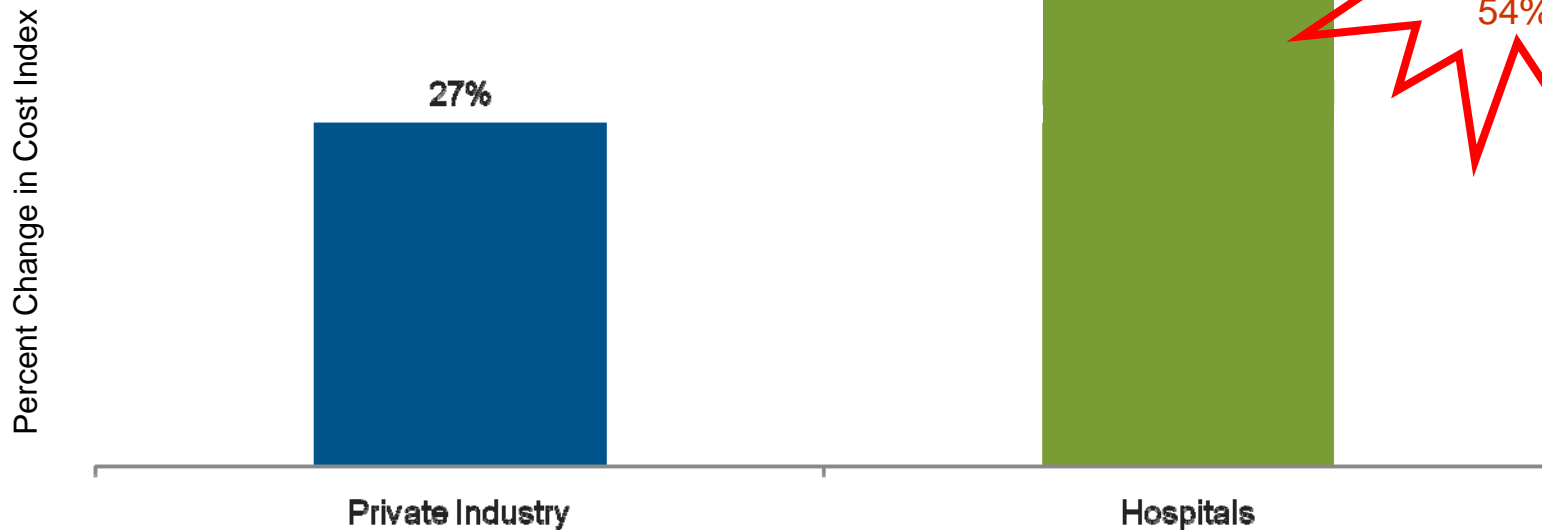
Source: Deb, P. (2010). *Trends in Case-mix in the Medicare Population*. Paper presented to the American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges.

(1) Case-mix is defined as the mix of patients across diagnosis-related groups (DRGs) in a hospital.

Source: American Hospital Association

SHORTAGES OF WORKERS DRIVE UP LABOR COSTS FOR HOSPITALS

Percent Change in Employment Cost Index,⁽¹⁾ All Private Industries and Hospitals, March 2001 to March 2010



Source: Bureau of Labor Statistics. (2010). *Employment Cost Index Historical Listing Current-dollar March 2001 – December 2010*. Access at <http://www.bls.gov/web/eci/echistrynaics.pdf>.

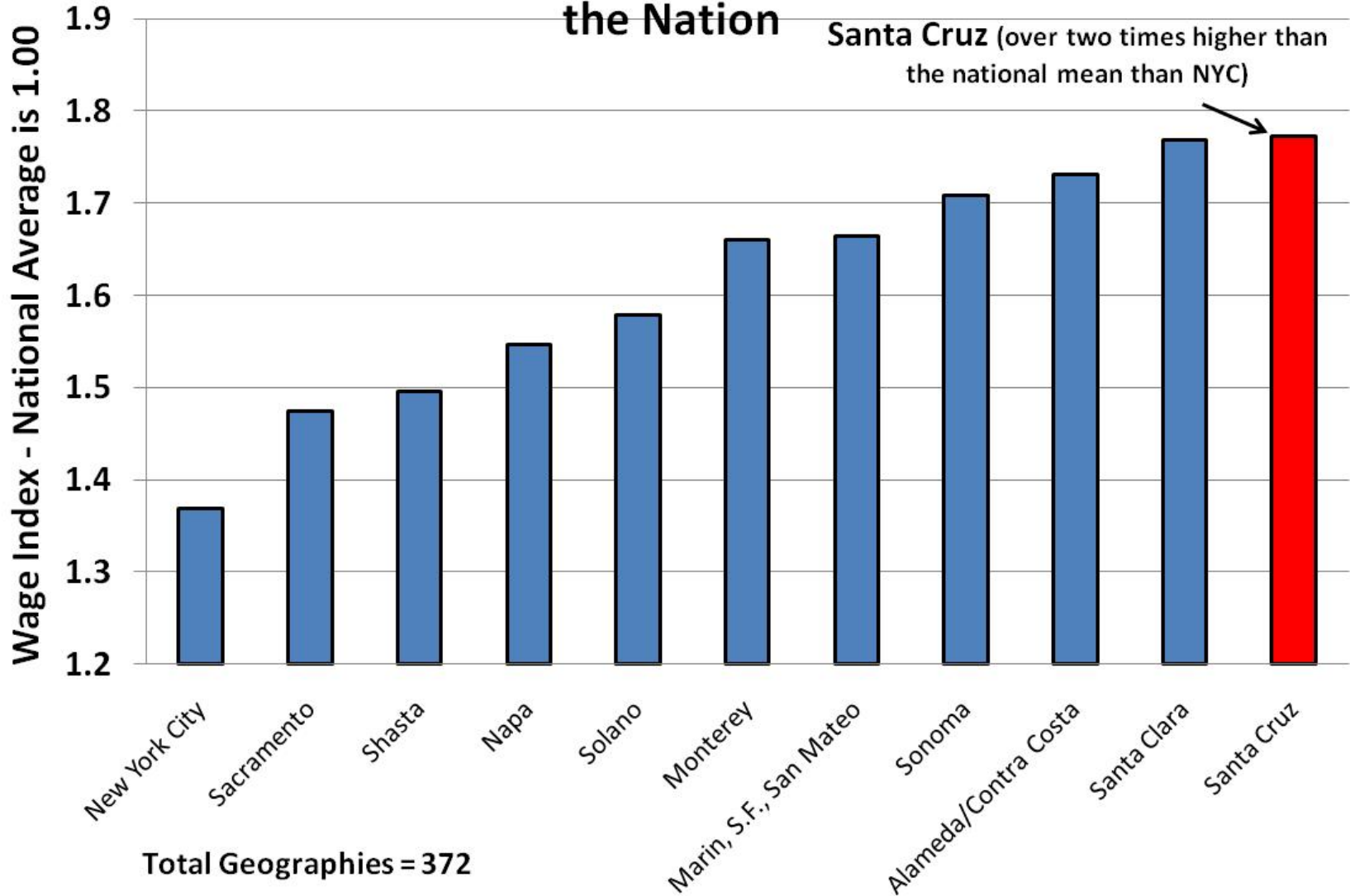
⁽¹⁾ The ECI is a measure of the change in the costs of labor.

Source: American Hospital Association

NATIONAL WAGE INDEX

2011 Medicare Hospital Wage Index - the Top 11 in the Nation

Santa Cruz (over two times higher than the national mean than NYC)



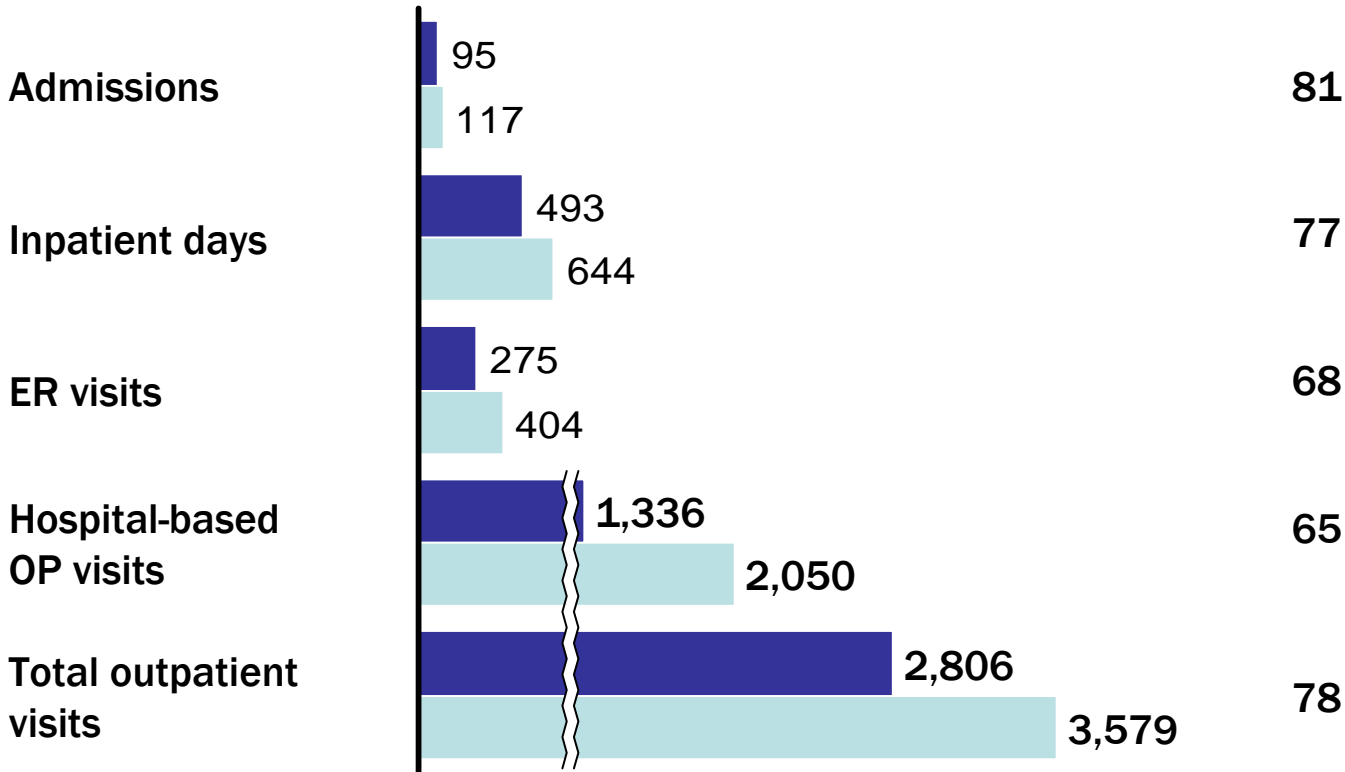
CALIFORNIA UTILIZATION RATES ARE LOW

Utilization rates in 2008¹

Number of encounters/days per 1000 population

CA utilization as percent of U.S. average

Percent

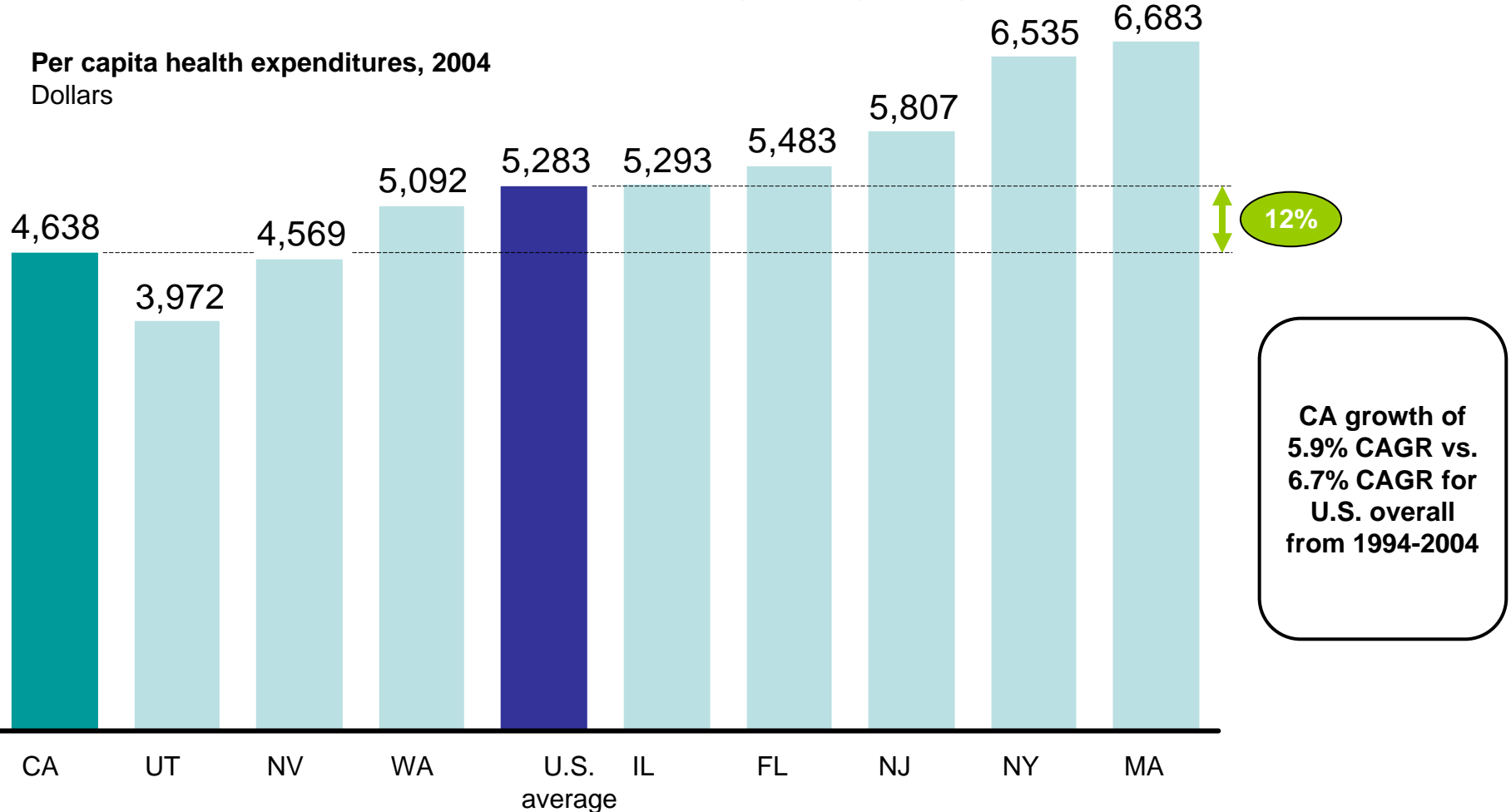


¹ Data are for total population of community hospitals (85% of all hospitals). Federal hospitals, LTC hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

SOURCE: Kaiser State Health Facts

CALIFORNIA HEALTH EXPENDITURES PER CAPITA BETTER THAN U.S. AVG

California per capita costs historically below many other states, 12% below the U.S. average, and growing at slower rate



SOURCE: National Health Expenditure Accounts

SEVERAL STRENGTHS IN CA'S HEALTH CARE SYSTEM THAT WE CAN AND SHOULD BUILD ON:

Some defining attributes

Extensive use of accountable and coordinated care structures, with shared risk among health plans and providers

>35 yrs of Knox-Keene regulation

> 10 M lives in delegated model

> ½ of residents now covered by HMOs

Innovative payment and delivery systems tailored to serve California's diverse population – **not “one size fits all”**

Employers and State institutions that have pioneered value-based purchasing and benefit designs to reward healthy behaviors

Results

Health care costs are below the national average, and growing more slowly – despite:

>Much higher cost of living and of doing business in CA

>High levels of cost-shifting inherent in the system, with Medi-Cal costs among the lowest in the nation

A major driver of our relative cost advantage is our much better ability to manage utilization, especially in the private sector

MEDICARE REALITY

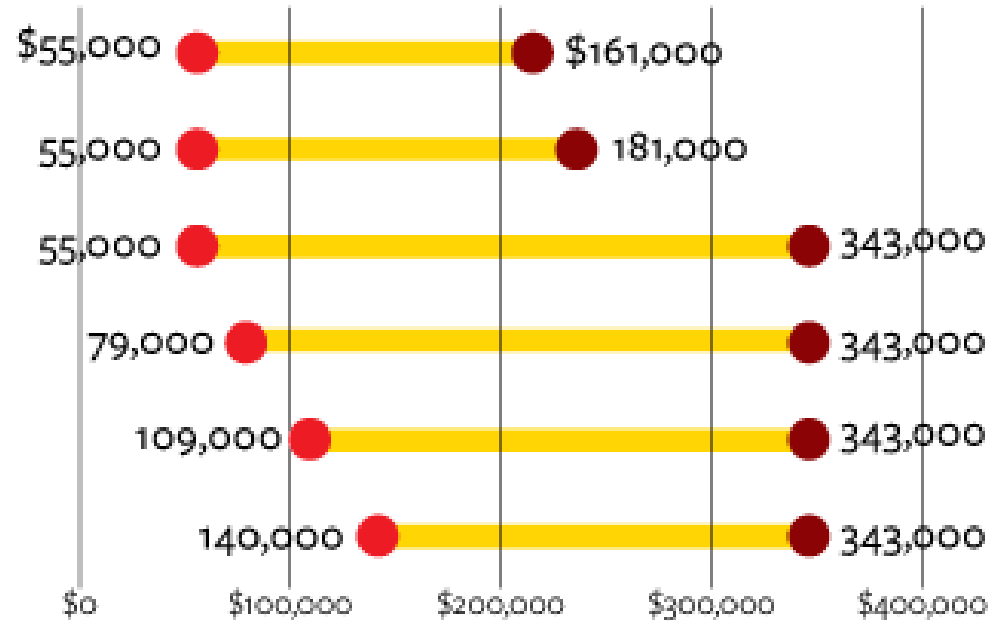
Medicare Taxes and Benefits

On average, people retiring in 2010 will receive Medicare benefits totaling far more than they paid in over their working lives.

● Average Medicare taxes paid over a lifetime

● Average Medicare benefits received over a lifetime

Single man, average wage



Single woman, average wage

One-earner couple, average wage

Two-earner couple, one average, one low

Two-earner couple, both average

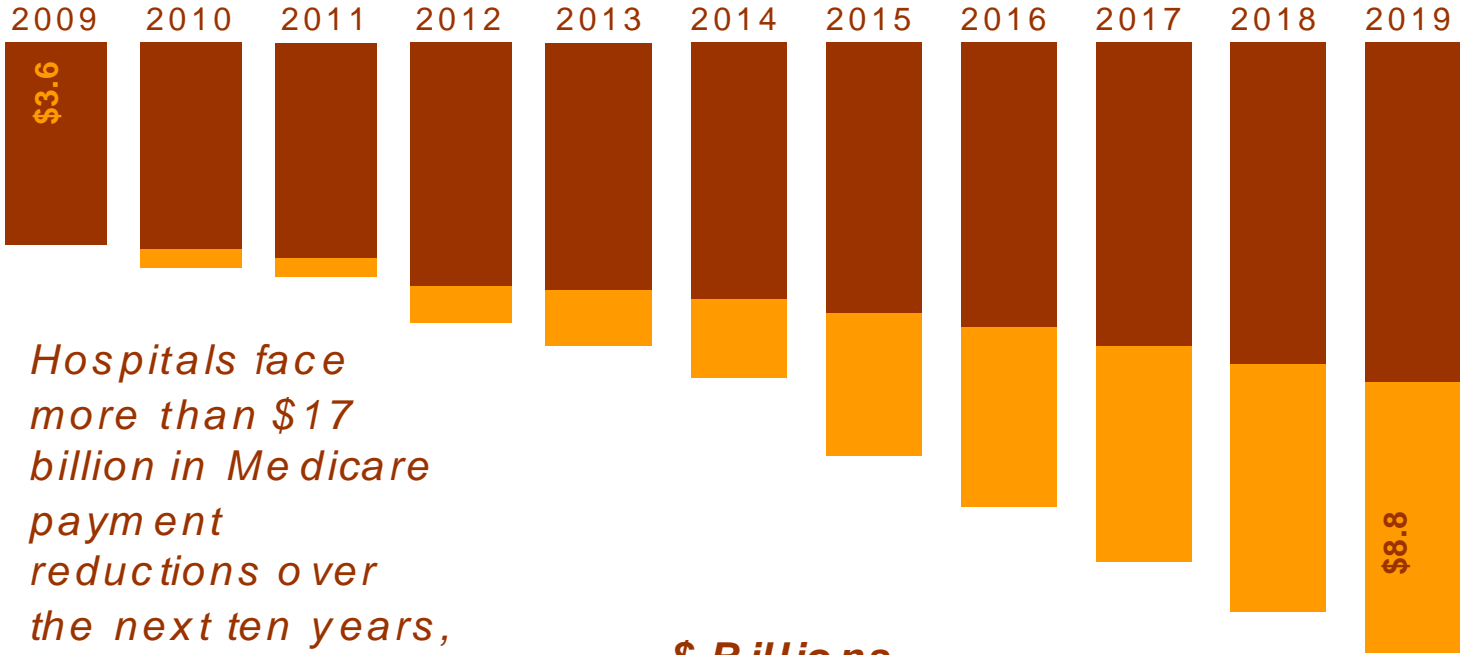
Two-earner couple, one high, one average

NOTES: Figures are for 2010 retirees. Low wage equals \$19,400 per year; average wage equals \$43,100 per year; high wage equals \$68,900 per year.

Source: Urban Institute

IMPLEMENTING REFORM WILL CREATE FINANCIAL CHALLENGES FOR HOSPITALS

Expected Medicare Shortfall Over the Next 10 Years

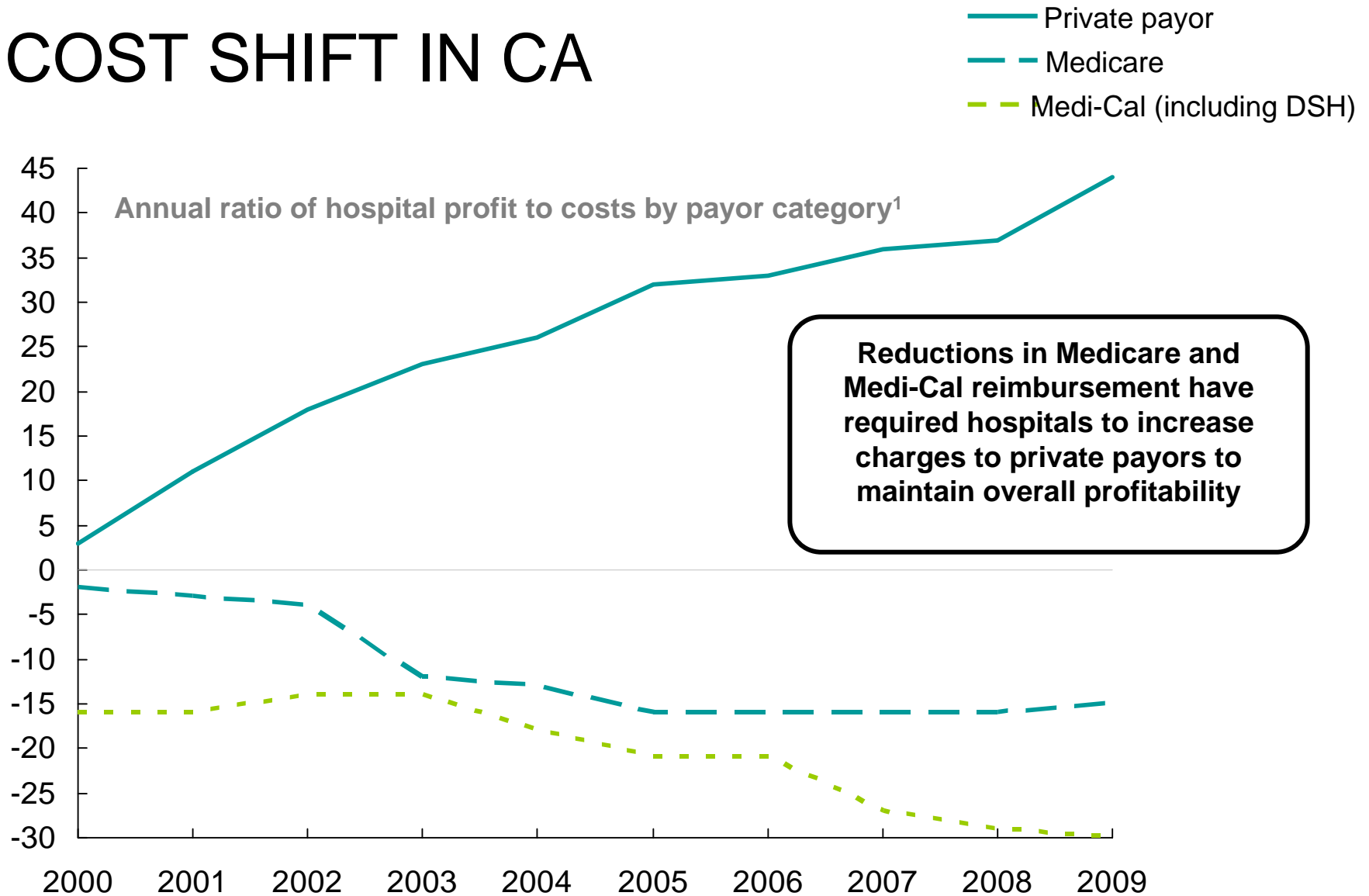


Hospitals face more than \$17 billion in Medicare payment reductions over the next ten years, creating massive financial burdens on top of historical payment shortfalls.

\$ Billions

- Hospital Medicare Losses
- Medicare Reductions PPACA

COST SHIFT IN CA



1 Profit-to-cost ratio calculated by payor category in each year using the formula: $(\text{Net Patient Revenue} - \text{Hospital Costs}) / (\text{Hospital Costs})$

SOURCE: OSHPD Quarterly Data Files, 2000-09

CALIFORNIA HEALTH BENEFIT EXCHANGE

All Representatives to the California Exchange Board
have been appointed

California Exchange Board Appointments

Susan Kennedy



Political Affiliation:

Democrat

Past Positions:

- Chief of Staff to Gov. Schwarzenegger
- Member of the California Public Utilities Commission
- Cabinet Secretary and Deputy Chief of Staff for Gov. Davis

Kimberly Belshé



Political Affiliation:

Republican

Past Positions:

- Secretary of the California HHS Agency
- Program Director for the James Irvine Foundation

Diana Dooley



Current Position:

Secretary of the CA
HHS Agency

Past Positions:

- CEO of the California Children's Hospital Association
- General Counsel and Vice President for the Children's Hospital Central California

Paul Fearer



Appointed:

March 3, 2011

Appointed by:

Assembly speaker

- Sr Exec Vice President Union Bank
- Deputy Director Human Resources at Stanford
- Chair Pacific Bus Group on Health

Dr. Robert Ross



Appointed:

June 22, 2011

Appointed by:

Senate Rules Cmte

- President California Endowment
- Board USC Center Public Policy
- LA Leadership Group

HEALTH BENEFIT EXCHANGE

Three Designs for an Exchange:

Passive/Distribution

- No control beyond ACA requirements
- “Billboard”
- No certs, QHP, minimum benefits or off-exchange rules

Manage/Coordinate

- Beyond ACA requirements but no aggressive plan negotiation
- Minimum bens and product rules
- Off-exchange rules similar to On

Active Market Mgmt

- Manages the insurance market
- Negotiates with plans strict CERT for plans
- Requirements in addition to ACA

The potential dangerous cycle that could be triggered

1 Federal and state governments further reduce Medicare and Medi-Cal reimbursement rates



Medical costs

■ Medicaid/Medicare

■ Private payors

2 Cost shifts from public to private payors, significantly increasing commercial premiums



3 High premiums cause further employer "dropping" and rise in subsidized individual coverage and uninsured, further burdening federal and state government budgets



Leads to significant risk pool deterioration in insurance market and destabilization of overall payment and delivery system

ACA implementation will pose further challenges for California

Unique challenges of ACA implementation in California

Already high levels of cost-shifting, given low Medi-Cal payment rates and high uninsured population

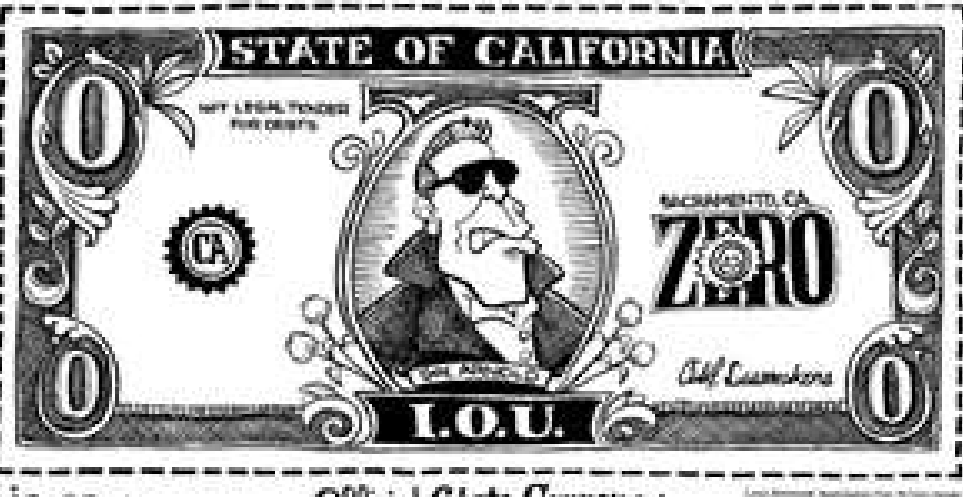
High level of Medicare Advantage penetration, where dramatic cuts will take place near-term

Insurance Exchange where many changes (rate compression, outside activity) will take effect and may cause disruption

\$17 billion in cuts to hospital Medicare FFS payments through 2019

Severe State budget crisis and high levels of unemployment continue in California

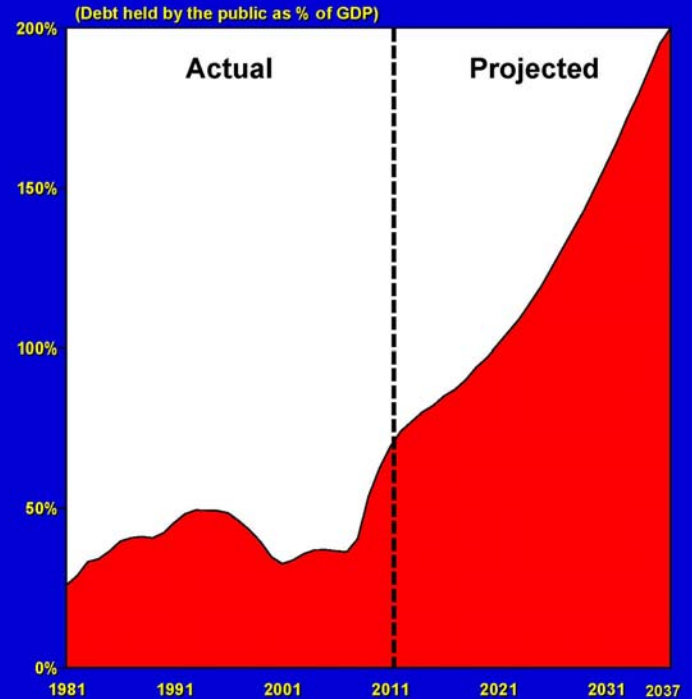
UNCERTAINTY EXISTS



Official State Currency



CBO Long-Term Debt Outlook



Source: CBO Long-Term Budget Outlook, June 2011
Note: CBO alternative fiscal scenario.