SOUTH CAROLINA'S HEALTH INSURANCE EXPANSION AND RATE STABILIZATION PLANNING GRANT INITIATIVE

Grant Number: 1P09OA00041

INTERIM FINAL REPORT

Funded through a HRSA Planning Grant

PRESENTED TO
THE US SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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EXECUTIVE SUMMARY

South Carolina has been successful in reducing the number of uninsured children, but other segments of our population have not fared as well. The availability and affordability of health insurance is one of the most important issues confronting South Carolina. National studies indicate that between 14% and 17% of South Carolinians are without insurance. Our preliminary data supports this conclusion. Our data results indicate that 19% of South Carolinians are currently uninsured and/or have been uninsured at some time during the previous twelve months (from the date the survey was completed). Eleven percent of the individuals surveyed stated that they were not currently insured, and 8% stated that they were not currently insured nor were they covered at any time during the last twelve months. Section One provides additional details on results from the Household Survey.

South Carolina's grant is entitled, "Expanding Health Insurance Coverage and Stabilizing Rates within the South Carolina Small Group Market." It focuses on the small group market because most businesses in South Carolina fall within that category (i.e., they employ 2-50 employees). The insurance issues confronting this segment of the market are numerous, and include the following:

- Insurance Affordability
- Increased cost sharing with decreased benefit plans
- Decreased competition within the small group insurance market
- Lack of familiarity (among small employers, employees, and agents) with:
  - Public policy options available to the working poor
  - Small group laws, and
  - Appropriate utilization of health care services and providers.

The purpose of South Carolina's grant project was to collect data that would support the state's initiatives to develop policy options designed to stabilize health insurance rates and expand access to health insurance coverage, particularly in the small group market. The Progress Report below summarizes our accomplishments to date and the activities that will be completed during the next twelve months. We are confident that we are on track with our original project plan due to the recent no-cost extension approval.

PROGRESS REPORT:

Health Insurance Policy Advisory Committee (HIPAC). HIPAC was created to bring experts and concerned parties together for the purpose of policy research and development. It consists of a cross-section of individuals who are most impacted by the plight of the uninsured. We have 15 voting members, 4 researchers, 21 regular participants, a contracted actuary, and 3 staff members from the South Carolina Department of Insurance that attend the monthly HIPAC meetings. Our goal in establishing the HIPAC was to build a team of experts, from a variety of backgrounds, to participate in creating policy options to expand health insurance coverage. In order to achieve this goal, we started the process by educating members of the HIPAC on the issues affecting and literature about the uninsured. We have provided educational programs to the HIPAC on existing issues such as, uninsurance, private insurance, and public health care programs. In

addition, we have given the HIPAC members an opportunity to discuss existing programs, to propose new programs, and to discuss new programs under development.

Our next goal for the HIPAC is to gain consensus on policy options proposed as a result of the uninsured data collected over the past nine months. We will continue to focus our meetings on education on current topics, including policy options being considered by other states, policy options under development by the HIPAC Policy Development Subcommittee and data updates. We are very excited to offer 20 HIPAC members the opportunity to attend an offsite meeting and National Health Insurance Symposium in August 2003. The Symposium is sponsored by the National Association of Insurance Commissioners (NAIC) and the South Carolina Department of Insurance. The agenda includes topics such as "Is Universal Health Care the Answer", "", "The Long Road to Universal Health Care—Where Are We?", "The Challenge of the Uninsured", "Consumer Driven Health Care—New Tools for a New Paradigm", and discussion of a number of state-based initiatives to expand health insurance coverage.

The HIPAC is represented by the following South Carolina organizations:

South Carolina Department of Insurance
The Governor's Office for the State of South Carolina
South Carolina Department of Health and Human Services
Office of Research and Statistics, Division of the Budget and Control Board
South Carolina General Assembly
South Carolina Managed Care Alliance
South Carolina Medical Association
South Carolina Hospital Association
National Federation of Independent Businesses
Small Business Chamber of Commerce
Central Carolina Community Foundation
Palmetto Richland Memorial Hospital
Clemson University
University of South Carolina
South Carolina Primary Health Care Association
Tri County Project Care
South Carolina Association of Non-Profit Organizations
South Carolina Health Alliance
South Carolina Department of Consumer Affairs

Data Collection and Analysis. The South Carolina Department of Insurance contracted with the South Carolina Office of Research and Statistics of the South Carolina Budget and Control Board, to coordinate, and conduct the data collection activities under our grant. This agency is also primarily responsible for the data analysis. Our data collection design consisted of the following:

- ? Random Digit Dial Household Survey;
- ? Employer Survey;
- ? Utilization Survey;

- ? Employee Survey[1];
- ? Focus Groups; and
- ? Key Informant Interviews.

The HIPAC designated a Data Subcommittee to monitor the data collection process and to keep the full committee informed of its progress. Our data collection is incomplete. What follows is a detailed description of the aforementioned data collection initiatives:

Key Informant Interviews

Key Informant Interviews were held with representatives from the following groups:

Large South Carolina Company, Insurance Manager and Human Resources Officer
Faith-Based organization, Administrator
Rural Health Clinic, Administrator and Director
Health System, Administrator
South Carolina Licensed Insurance Company, Administrator
State Government, Administrator
Community/Provider Coalition, Representative
Managed Care Association, Director
South Carolina Legislature, Elected Official

Surveys

The following surveys were conducted:

South Carolina Small Employer (2 – 100 employees) Survey - Mailing
South Carolina Household Survey – random digit dialing, sample size of 1,600, with supplementary sample size 400 uninsured households.
Uninsured Utilization Survey – Mailing - sample of 7,500 emergency room and inpatient patients identified as uninsured (i.e. indigent/self pay) on the UB-92 data system in 2002.

Focus Groups

The following Focus Groups were conducted:

3 Small Employer Focus Groups
3 Employee Focus Groups (including one Hispanic)
1 Agent/Broker Focus Group

Policy Option Development and Recommendations. The HIPAC designated a group of representatives from the South Carolina Department of Insurance, the South Carolina Department of Health and Human Services, the South Carolina Managed Care Alliance, the South Carolina Hospital Association, the South Carolina Medical Association, and community

[1] This survey had to be eliminated because we were unable to obtain a statistically valid sample from the data at South Carolina Employment Security Commission.

care centers. This group has been charged with developing policy options that correspond with the state-specific grant data collected, and support the grant goals of improving access and affordability to health insurance within the South Carolina small group market. The Subcommittee is recommending that a multiple policy program approach be considered. This approach includes an educational component, a subsidized small group option, and a community-based program that will assist other non-working, non-Medicaid eligible uninsured. The Subcommittee's objective over the next year is to work towards gaining consensus on coverage options and develop a long-term plan for covering the uninsured. The Subcommittee recommends that HIPAC continue on a volunteer basis to monitor, analyze and continue to look at access and affordability issues in our State.

One example of a policy option under consideration is the South Carolina Health Access Program (SCHAP). In the mid 1990's, the South Carolina Department of Health and Human Services obtained a Section 1115 Medicaid waiver that was used to design and implement this program. SCHAP provided coverage to families through small businesses in two counties. The program was successful and was only discontinued because the small groups could not find an entity to take over the administration of the program after the four-year Medicaid demonstration project ended. This program addressed access and affordability of health care coverage for the working poor in our State, a target population that this grant program has paid particular attention to, based on available national statistics.

Grant Administration. We recently received a one-year no-cost extension from HRSA. In addition, we have requested supplemental funds, which will be used to implement a statewide marketing plan. This plan will include educational television programs, public service announcements, business forums, a grant-specific Website and billboards. The key message will include updates on the grant's progress, the state-specific uninsured issues, and provide information on what individuals can do to help. A final report is due to HRSA on July 31, 2004. Effective July 1, 2003, the grant reduced the project management staff [2] to 1 project manager. This person will be work part time (30 hours per week) on the grant during its second year. Additional administrative help will be hired to assist with the marketing plan if we are approved for supplemental funding.

RECOMMENDATIONS FOR FEDERAL ACTION TO SUPPORT STATE EFFORTS:

There are several federal actions that have been recommended by the HIPAC. This list will certainly expand as we work through existing and new issues while developing our policy options over the next eleven months. Suggestions include:

- Provide more money to the State for Medicaid and Medicaid expansion programs.
- Simplify the application process for waiver funding.
- Consider increasing the federal portion of the federal/state (currently 70/30) match to incent states to address issues of the uninsured (e.g. 80/20).
- Explore different options to improve access to medical savings accounts for small and large employer groups.

[2] The project had two project managers: one charged with the responsibility of monitoring the data collection activities and the other responsible for policy development.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

South Carolina has attempted to address the needs of the uninsured small employer employees and dependents through enacting the Small Employer Health Insurance Availability Act in 1995 and later, the small employer protections under HIPAA. The provisions in these laws addressed guaranteed issue, guaranteed renewability, rate restrictions, guaranteed plan designs (basic and standard), and portability, which all impact access to healthcare. Unfortunately, none of these initiatives has addressed the issue of market stability or affordability. As a result, South Carolina has seen the following occur:

- South Carolina has experienced a significant decrease in competition in the small group market, having lost 55 small employer insurers since 1997.

- There has been an increase in state and federal mandates, which have increased both medical and administrative costs. Recent examples include external review and HIPAA privacy.

- We have seen a trend of increasing rates and decreasing benefit design which has put more of the financial burden on the employee by increasing his/her out of pocket expenses.

This grant has allowed the state to collect state-specific data on the uninsured. This data will assist South Carolina in formulating and implementing policy options for the uninsured whose need can be supported with reliable data. We have conducted a Household, Utilization and Employer Survey, 6 Focus Groups and Key Informant Interviews requesting personal information and opinions regarding the issues facing the uninsured in South Carolina. The results are preliminary. Employer Surveys continue to be mailed in and the supplemental Household Survey of uninsured households is still in progress. We anticipate that the data from the supplemental Household Survey will substantially impact the preliminary results described below.

For the purposes of the data summary, the following definitions apply:

"Inclusive" uninsured:	The individual does not have insurance now, or has not had insurance in the past 12 months
"Current" uninsured:	The individual answered "no" to all questions about insurance.
"Chronic" uninsured:	The individual does not have insurance now, and has not had insurance in the past 12 months.

1.1 **What is the overall level of uninsurance?** Identifying the uninsurance rate in South Carolina depends upon the specific measure chosen. The broadest definition, "inclusive", treats an individual as uninsured if the individual has been uninsured currently or at any time during the previous twelve months. Based on this definition 19% of the population

has been uninsured. A somewhat more restrictive definition, "current", asks individuals if they are currently insured. Using this definition 11% are currently uninsured.

The most restrictive definition, "chronic", identifies the chronically uninsured. These individuals are currently uninsured and were not covered by insurance at any time during the previous twelve months. This group constitutes 8% of the population. By contrast, national statistics indicate that between 14% and 17% of South Carolinians are uninsured.

1.2 **Characteristics of the uninsured**. These results are based on analysis of the uninsured data drawn from the Household Survey. They are preliminary due to the relatively small numbers supporting these estimates. A much more reliable set of estimates will be available once the supplemental Household Survey is completed.

Income. It is not apparent from the data how gross income influences "inclusive", "chronic" or "current" uninsured individuals. In fact, 41% of uninsured South Carolinians have a gross household income of more than $30,000. Twenty-eight percent have a gross household income of more than $40,000. Again, we are confident that the additional data we receive from the supplemental Household Survey will impact these results.

Age. The average age of the uninsured in South Carolina is between 29 and 30. National statistics indicate that the median age of South Carolinians is 35.4.

Gender. For the "chronic" uninsured, the split between males and females was about 55% male and 45% females. The gender distribution for the "current" uninsured is very similar (56% male and 44% female). However, for the "inclusive" uninsured the gender distribution shifts slightly (51% male, 49% female). It appears that the "inclusive" uninsured look most like the population distribution (50/50), and males make up a higher proportion of the chronically uninsured.

Family Composition. On average the uninsured have 3 people living on the gross household income. This is consistent with the 2000 US Census data, which indicates that the average household size is 2.53 people, and the average family size is 3.02. Of these 3 people, on average 1 is under 21 years old.

Health Status. Interestingly, 83% of uninsured South Carolinians consider themselves as at least in "good" health. Approximately 4% state that they are in "poor" health. The response to this question is based on self-perception and may not give us much insight to why these people are uninsured. These responses are ironic considering the following statistics have been reported about South Carolina:

- South Carolina ranked eighth highest for age-adjusted deaths in 1999,
- 59% of South Carolinians are obese,
- 24.9% of adult South Carolinians are smokers, and
- South Carolina has a very high incidence of diabetes, heart disease and asthma.

Employment Status. Seventeen percent of the "chronic" and "current" uninsured indicated that they are self-employed or own their own business. Fourteen percent of the "inclusive" uninsured indicated that they are self-employed or own their own business. Since the South Carolina small employer insurance laws do not impact groups of less than 2 employees, the options remaining are limited to an individual plan or possibly an association plan. If a self-employed individual has a pre-existing condition, there are no affordable options available. In the 3 different uninsured categories between 43% and 49% were employed and uninsured. These numbers clearly indicate a problem with access to affordable insurance in the small employer and self-employed markets.

Availability of Private Coverage (including offered but not accepted). Approximately 62% of the uninsured said that the main reason they did not buy insurance was because it was too expensive. No other reason came close to this response. The percentage changed very little in a separate question, which asked parents why they had not purchased insurance for themselves. The only exception was the "chronic" uninsured, where the response rate jumped to 73%.

Two main issues surfaced when asked why an individual was not included in the employer's insurance plan. For the "inclusive" and "current" uninsured, 40% stated it was because they could not afford it, and 34% said it was because they had not worked at the company long enough to qualify for insurance coverage. Of the "chronic" uninsured 46% stated that they could not afford coverage and 27% stated they had not worked at the company long enough to be eligible for coverage. These responses are not surprising because this group is probably made up of the working poor, who make little money and who frequently move from job to job.

Availability of Public Coverage: Responses to this question were infrequent (only 6 responses per uninsured category) and therefore the data is not valid. The responses to why he/she would not enroll in a SC health program included "because when you die they take everything from your children [to] pay back what they did for you", "does not want government support" and "parent is trying to enroll 20 year child" [sic].

Race/Ethnicity. According to the 2000 US Census Report, 67.2% of South Carolinians are Caucasian and 29.5% are Black/African American. According to the preliminary data, these numbers are consistent for the uninsured. "Inclusive" uninsureds were split 64% Caucasian, and 31% Black/African American. "Current" and "chronic" uninsured were split 66% Caucasian and 29% Black/African American. It is clear from this breakout that South Carolina's uninsured issues do not appear to be defined by race.

Immigration Status. Approximately 98% individuals responded that they were United States citizens. We believe that the supplemental Household Survey may impact this percentage.

Duration of Uninsurance. When asked if the individuals had any health insurance in the past 12 months, 26% responded "yes" and 57% responded "no".

1.3 **Population groupings particularly important to South Carolina in developing targeted coverage expansion options.** The population that appears to be in most need of a policy change is the working uninsured. While the working poor have obvious issues about the affordability of insurance, it is clear from the data that several middle class professions also indicate that they are uninsured due to the cost of health insurance. One particular group worthy of more attention is the employees that indicated their job descriptions were medical and/professional. This group seems like a potential advocate for making change in the current health insurance market. A preliminary breakdown of the data indicates the following about this group:

The percentage of all companies that do not offer coverage by group size:

Less than 10 employees	58%
11 – 20 employees	7%
21 – 50 employees	5%
51 – 100 employees	29%

Employees by group size:

	Professional	Medical
Less than 10 employees	47%	18%
11 – 20 employees	6%	4%
21 – 50 employees	3%	10%
51 – 100 employees	44%	68%

Negative impact of not having employer-sponsored insurance in attracting employees:

	No Impact	Impact
Medical	46%	54%
Professional	49%	51%

The percentage of medical and business professionals who indicate that "affordability" is the reason they are not insured is 48%

In summary, this is a group of individuals that believe employer sponsored insurance is important to retaining employees, and yet are of the opinion that the options available are not affordable. This is particularly true for businesses of less than 20 employees. On the other hand, retail trade (83%) and hotel, motel, restaurant or entertainment businesses (56%), had high percentage of uninsured but responded that they did not think health insurance was an issue in attracting new employees. These statistics give us an opportunity to focus on the types of businesses that most need, and want, affordable health insurance. It also may provide us with a strong advocate for change in the small group market.

1.4 **Affordable health care coverage**. The answer to what is affordable coverage depends on whom you ask. It is clearly difficult to define, and the answer varies depending on whether you ask a large employer, small employer, employee, young person, older person, low income or middle income individual. The data shows that South Carolinians

making $30,000 with professional and/or medical jobs still find health insurance unaffordable. Many people look at the cost of health insurance the same way they look at all of their monthly expenses. In other words, they prioritize what has to get paid (mortgage, food, child care) and whatever is left pays the rest of the bills. Many times health insurance is not considered a priority when food and shelter take up most of the monthly family income. The key is that not everyone can pay the same amount, which is typically how group insurance premiums are calculated.

Employee Focus Group participants suggested that they might be able to pay between $25 and $175 per month for health insurance, although some participants could not pay more than $10 per month. The response to this question during the Key Informant Interviews was that employees should pay 20% to 25% of the total premium cost as an incentive to make them more accountable for health care utilization. Agents suggested that a good rule of thumb is that employees should pay 2% to 3% of their income on health insurance, and never more than 5%. Employers thought that $1 per hour of wages, or 10% of the after tax income would be affordable for their employees. Small employers struggle to provide health insurance as part of their benefit package to maintain and attract a strong workforce, however the administrative costs of providing coverage can be burdensome. Several respondents to the Utilization Survey wrote that they had incurred huge medical bills while they were uninsured. In addition, some people experienced providers who would not continue care if outstanding bills were unpaid. Certainly, the question of affordable heath coverage takes on a different meaning for people facing issues of bad debt.

1.5 **Non-participation in public programs**. Responses to the question why have you not enrolled in public programs when eligible, during the Employee Focus Groups centered on lack of access/transportation, the cost of benefits not covered by public programs (prescription drugs) and the treatment received from physicians when they do not get paid promptly for services previously provided. Some respondents indicated that the Veteran's Administration facilities in South Carolina were in poor condition. During the meetings with Key Informants, this question elicited responses such as "there is a stigma attached to public programs", "eligible individuals do not know they are qualified for public programs", "bureaucracy and paperwork is cumbersome" and "public programs are considered sub-standard care". It is interesting to note the differences between people who are eligible for public assistance and people who think they understand how eligible participants in a public program must feel.

1.6 **Disenrollment from public programs**. It appears that most Employee Focus Group members responded that they became ineligible (change in work status, pre-existing condition) and therefore were unable to re-enroll due to a loss of eligibility. In addition, Key Informants felt that enrollees were discouraged to re-apply.

1.7 **Non-participation in employer sponsored coverage**. When eligible, most uninsured chose not to participate in their employer's insurance plan due to cost. This includes the cost to employees and their dependents, who typically are not subsidized by the employer. Others have coverage through a spouse's employer. Some employees

indicated that they did not feel a need for health insurance. The reasons given included "young and healthy", and "the government will take care of me if I get sick". The Key Informants were also asked why people did not have health insurance. Including the above responses, Key Informants stated, "employees would rather have a raise, than health care coverage", "the health coverage offered is not adequate", and "lack of education regarding high debt for unpaid health care services".

1.8 **Employer sponsored health insurance**. Key Informants interviewed felt that health insurance was necessary to help retain and recruit good employees. They also felt that many employers feel a degree of responsibility to their employees and families for providing access to health insurance. On the other hand, employers experiencing rising health insurance costs, high turnover, and low profits may be forced to make a decision not to provide health insurance.

Employees in the Focus Groups expected affordable health insurance to be available through their employer, but felt that what was provided was either too expensive and/or had inadequate benefits. Many spoke of the need for government intervention and posed suggestions such as a basic coverage plan, sliding scale premiums based on income, and small employer associations created for the purpose of purchasing insurance.

The State requires insurers to offer a "basic" and "standard" health plan to all small employers. Following the guarantee issues provisions of HIPAA, many insurers stopped marketing these plans because all plans were guarantee issue. However, these two plans are still mandated by law.

1.9 **Availability of subsidies, tax credits or other incentives**. Based on responses in the Focus Groups and with Key Informants, subsidies and tax credits are helpful, but have not been enough to incent people to make a change. Other suggestions include:

- Mandatory requirement that employer's contribute 65% towards health insurance premiums;
- Mandate to cover basic benefit plan with "reasonable" out of pocket costs;
- Develop an incentive for doctors who work with government programs and cooperative outreach programs (e.g. higher reimbursement);
- Incent insureds to manage personal utilization and healthy habits throughout the year;
- Government oversight of provider and insurance costs; and
- Determine individual premium contribution based on wages.

1.10 **Other barriers besides affordability that prevent the purchase of health insurance**. Without a doubt, most uninsured are uninsured due to the cost of health insurance premiums and associated out of pocket expenses. Other barriers suggested in Focus Groups and with Key Informants include: no coverage available for illegal immigrants, lack of transportation, part-time and seasonal employment, lay-offs, pre-existing condition exclusions, lack of education regarding appropriate use of available health care facilities and coverage options, and enrollment/re-enrollment is not an easy process.

1.11 **The uninsured and their medical needs**. When asked how the uninsured are getting their medical needs met, the Focus Group participants stated that many uninsured used the emergency room and free clinics. Others went without health care services.

1.12 **The features of an adequate, barebones benefit package**. Responses to the question of what are the features of an adequate, barebones benefit plan varied depending on the respondent. A Focus Group employee participant stated that health care should provide everything that is needed to make a person well enough to work. People suggested that a bare bones plan includes prescription drugs, wellness, emergency room and hospitalization. Others indicated that mental health care, cosmetic surgery, eye care and dental were not necessary. Lastly, some people thought that catastrophic care should be considered as a barebones plan.

1.13 **Definition of Underinsured**. "Underinsured" was defined generally as having coverage that had high out of pocket costs that the individual could not afford to pay. Others defined underinsured and uninsured as the same thing. One interesting definition was having only one family member covered under an insurance plan.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

These results are based on analysis of the uninsured drawn from the Employer Survey.

2.1 **Characteristics of firms that do not offer coverage**:

Employer size (including self-employed): Sixty-five percent of employers with 0 to 50 employees are uninsured, compared with 35% of employers with 51 – 100 employees. As previously discussed this data supports the need for affordable small group health insurance options.

Industry sector: Businesses less likely to provide group health insurance are hotel/motel/restaurant/entertaining, professional and related services and retail trade. Other than "professional", this data supports the lack of health insurance options for part time and seasonal employees. Since 27% of the respondents indicated "other" under type of business, we will pull these and try to determine if we can better categorize this group.

Employee income brackets: It appears that most uninsured South Carolinians have an average salary for full time employees between $10,000 and $50,000. Twenty-five percent stated average salaries were between $10,000 and $15,000, 21% stated average salaries were between $15,000 and $20,000, 22% stated average salaries were between $20,000 and $25,000, and 24% stated average salaries were between $25,000 and $50,000. Four percent of working South Carolinians have an average salary of less than $10,000.

Percentage of part-time: On average, 25% of the uninsured are part-time employees.

Geographic location: The employer survey did not substantially cover every county of the state and it is therefore not possible to determine any information about the uninsured by county.

Effect on ability to attract employees: Fifty-seven percent of the employers who do not offer insurance stated that it did not have an effect on employment retention and recruitment.

Employers who do offer coverage:

- Level of contribution: On average employees contribute between 0 and 50% towards their monthly premiums. Thirty percent pay nothing towards their premium, 34% pay between 1% and 25%, and 29% pay between 26% and 50%.

- Percentage of employees offered coverage who do not participate: Sixty-two percent of the time, employers indicated that <u>some</u> employees were offered coverage but did not elect to participate. Twenty-two percent of the employers stated that "none" of the eligible employees chose not to participate in group coverage when offered it by the employer.

2.2 **Influences on the employer's decision about whether or not to offer coverage/ Primary reasons employers give for electing not to provide coverage**. The number one issue for employers choosing whether or not to offer group health insurance is cost. Small employers are very sensitive to the cost of employee benefits because their profit window is much smaller than large businesses. In addition, the administrative burden of a group health insurance plan can be significant. Companies believed that there was a lack of competition in the group health insurance market, which influences the average cost of coverage. In South Carolina insurance companies do have the ability to price within a range of the index or actuarial base rate, and this can cause problems for employers with one or more high claims. Employers have been forced to offer reduced benefits to keep costs in line with previous year premiums and employee contributions. Some employers expressed a concern about offering health insurance benefits in a small company because one person/one claim has the ability to dictate the rates for the entire group.

2.3 **Employer's decisions about the health insurance offered to employees/Factors that go into their decisions regarding premium contributions, benefit package and other features of the coverage**. Employers have to keep the premiums at a level that both they and the employees can afford. Agents suggest that employees can pay no more than 5% of their income for health insurance. Another common issue is continuity of care for employees, particularly those who have chronic conditions. Although it is normal for small employers to shop for better rates/benefits each year, moving coverage to a different insurance company every year can disrupt care and end up costing employees more in out of pocket expenses. Premium costs are the number one decision maker to offering and continuing health insurance.

2.4 **Likely employer response to an economic downturn or continued increase in costs**. In order to keep insurance premiums down or at least level year after year, employers are reducing the benefits offered in the group health plan. Usually this is in the form of higher copayments and deductibles, and reducing maximum annual and lifetime limits on certain benefits. Some employers are considering moving towards consumer-driven health plans to incent employees to be responsible for personal utilization and provider choices. The outcome for low-wage employees may be a reduction in primary and wellness care, since these are examples of services that the employee would pay. Other employers are offering money to employees that would go towards the employee's cost of health insurance or health bills. Hiring part-time workers to replace full-time workers is another trend we are seeing in South Carolina. The economic downturn and the rapidly rising costs of health care continue to force employers to reconsider health insurance as an employee benefit.

2.5 **Employer and employee groups most susceptible to crowd-out.** The most vulnerable groups are small employers with 0 to 14 employees. This does not appear to be a market that most small employer insurers are interested in developing. Therefore, any programs targeted towards this group will "crowd-out" insurers, but not impact the private insurance market significantly.

2.6 **Employers who do not offer coverage to be influenced by**:

- **Expansion/development of purchasing alliances**. South Carolina insurance law allows small businesses to band together for the purpose of purchasing health insurance. However, there has been very little movement towards creating these alliances. It is believed that the main reason for the lack of interest is that there is not an entity that is willing to develop, market and manage a small business purchasing alliance. However, benefits of an alliance would be pooled claims, possible reduced premiums, and administrative costs. Some individuals suggested letting small employers buy into the state health plan.
- **Individual or employer subsidies**. Employee tax incentives are helpful, but would have to be significant to incent employees to purchase health coverage. Employer tax credits may not be useful if they have no income against which to apply the credit.
- **Additional tax incentives**. During the Focus Groups, additional suggestions were made, including a rebate incentive for low utilizers, and a tax incentive for insurance companies who assist the state in providing high quality insurance at affordable costs.

2.7 **Other alternatives available to motivate employers not providing or contributing to coverage**: Focus Group participants mentioned more federal and state involvement in developing a healthy workforce and bringing in new businesses to the state, but no specific details were provided. It was also suggested that a basic benefit plan be mandated. The state already mandates that all small group insurers provide a basic and standard benefit plan to small employers. While insurers have not heavily marketed these two particular plans, the small group market is requesting similar limited benefit plans and reduced premiums from insurers. Again, the problem is not access to health insurance, but affordability.

Participants also suggested simplifying claims payment and other administrative procedures, limit prescription drug advertising, limit profits to insurance companies, and reduced liability for medical providers.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

3.1 **Adequacy of existing insurance products for persons of different income levels or persons with pre-existing conditions**. "Adequacy" in our response to this question is defined as scope of services. While South Carolina insurance companies have a wide array of group and individual products available, at different benefit and price levels, there are no existing products that are purely based on income. In addition, products have not been developed for individuals who are in pre-existing condition waiting periods, although all insurers comply with HIPAA portability laws. For individuals who have been declined coverage by an insurer, or who have premium rates that exceed the South Carolina Health Insurance Pool (SCHIP), can apply for coverage under SCHIP. However, pre-existing condition limitations may still apply.

3.2 **The variation in benefits among non-group, small group, large group and self-insured plans**. Again, insurers offer a variety of coverage options in the individual and small group market. However, large groups (generally 100 to 1,000 employees) and self-insured groups typically have much more flexibility in plan design.

3.3 **Prevalence of self-insured firms in your State/Impact on the State's marketplace**. Approximately 60% of South Carolina employees are covered by self-insured plans, with 340,000 of these employees covered under the State Health Plan. There appears to be no impact on the marketplace in South Carolina.

3.4 **Impact of State as a purchaser of health care (e.g. Medicaid, SCHIP and State employees)?** The State Health Plan and Medicaid negotiate independently with providers and are able to set low reimbursement rates. Inevitably, there is cost shifting by the providers to insurers and self-paid patients.

3.5 **Impact of current market trends and the current regulatory environment on various models for universal coverage/Changes needed to current regulations**. Current marketplace trends include double-digit rate increase and benefit plan reduction. There is currently a moratorium on health care mandates and we have not seen any significant health insurance legislation in several years. Without having fully explored policy options in South Carolina, it would be difficult to respond to the impact of universal coverage policy options in the current market.

3.6 **Universal coverage's affect on the financial status of health plans and providers**. Possible affects of universal coverage include a decrease in cost shifting and an improvement of provider financial status due to a reduction in uncompensated care. Any other affects will not be known until our policy options are fully developed.

3.7 **How the planning process took safety net providers into account**. HIPAC is made up of various safety net providers, all of who are taking part in the development of policy options for the uninsured.

3.8 **Utilization changes due to universal coverage**. Changes could include a decrease in inappropriate use of the emergency room. Also, there may be an increase in high cost medical care, such as surgery, diagnostics and prescription drugs, since people typically put off these services when they are uninsured.

3.9 **Did you consider the experience of other States with regard to expansions of public coverage, public/private partnerships, incentives for employers to offer coverage and regulation of the marketplace?** HIPAC researched all of the other HRSA grantees to determine what policy initiatives were considered and discarded. We are particularly interested in the Arkansas minimum benefit plan, the Third Share Plans in Illinois, no mandate plans, and the SCHAP plan in South Carolina. The information available on the web is incredibly helpful in considering policy options for the State.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

We have been working through the HIPAC Policy Development Subcommittee on various policy options for small group employees who cannot afford traditional small group insurance products. The preliminary data from our surveys will be presented in our July HIPAC meeting. The August HIPAC meeting will focus on the data and its implications for the policy options we have reviewed. We will also address the need to include other policy option based on the data. Our primary goal for the meeting will be to define policy options that are in line with the data and outline our goals and objectives for the remaining eleven months of the grant program.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 **Governance structure used in the planning process/involvement of key State agencies, key constituencies (provides, employers and advocacy groups) and key State officials in the executive and legislative branches**. The South Carolina Department of Insurance ("Department") is the lead agency and has primary responsibility for managing the grant project. Over the past several years, the Department has been meeting with members of the South Carolina General Assembly, industry leaders and the medical and business communities to discuss expansion of coverage options for the uninsured and rate stabilization in the small group health insurance market.

Our partners on this project include a coalition of representatives from the medical, legislative, insurance, and business communities. Members of HIPAC include representatives from the following agencies:

Governor's Office
State General Assembly
South Carolina Office of Research and Statistics, Division of the Budget and Control Board
Clemson University and University of South Carolina
Department of Health and Human Services
Managed Care Alliance
Medical and Hospital Association
Community Health Centers
Business advocates such as NFIB and the Small Business Chamber of Commerce
Department of Consumer Affairs, and
Primary Health Care Association

State agencies with any involvement with healthcare policy and other groups that are impacted by uninsurance are invited to participate in the project. The issue of affordable health insurance is very important to members of our state government and their participation on the HIPAC is critical. We believe that our team will enable us to effectively implement the recommendations of the HIPAC.

5.2 **Methods used to obtain input from the public and key constituencies**. Seven Focus Groups have been held, 3 employee, 3 employer and one for agents/brokers. The Focus Groups have allowed us not only the opportunity to gain insight from these groups, but also to inform South Carolinians about the grant project and its objectives. In the near future, we plan to add business forums, a public forum, an interactive web site, and five half hour shows on local educational television. All of these forums provide individuals an opportunity to discuss their personal challenges and to have input into the policy development process. Finally, we have organized the HIPAC to solicit input from agencies, businesses, providers and individuals and hope to use this group to gain consensus for our proposed policy options throughout the State.

5.3 **Activities to be conducted to build awareness and support**. In addition to the activities described in 5.2, South Carolina has applied for supplemental grant funding to launch a statewide marketing blitz. If additional funding is approved, we will use it to inform and educate politicians, business leaders, agents/brokers, and associated state department heads on the plight of the uninsured in South Carolina. The forums we will use include educational television, public service announcements, an independent web site, billboards and business forums.

5.4 **Affect of planning effort on the policy environment**. At this point in our project plan, our work has not had a tremendous impact on the current policy environment. As with all states, South Carolina is struggling with budget cuts and Medicaid restructuring. These things have been part of the planning process and we are trying to develop policy options that either will not require funding or will be funded through private or federal grant funds.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 **The importance of State-specific data to the decision-making process**. Although our state-specific survey data has not been finalized, we believe that it will have more significant impact with South Carolinians, than census or other national databases. Thus far, the data supports our initial supposition that for small group, particularly with the groups with less than 10 employees, affordability of health care coverage is the number one reason why employers don't provide group health insurance and why employees don't elect to participate when offered. The preliminary data will give us the support base needed to make appropriate changes in the small group market and to impact affordability through a reduced benefit package and subsidized premium assistance.

The qualitative data was less informative, but was valuable as a tool to increase knowledge and gain support for the grant program. It also gave individuals an opportunity to brainstorm about solutions to health insurance rate stability, access and affordability.

6.2 **Most effective data collection activities relative to resources expended in conducting the work**. Using the South Carolina Office of Research and Statistics was cost effective in that this agency serves as the state repository for other statistical information. Existing information used for the purposes of the grant was available at no cost. The Employer Survey was probably the most cost-effective survey we completed because we had great response rates. However, there are some concerns about the validity of the sampling frame. The Household Survey is the centerpiece of our research and contains the most reliable information. It was also the most expensive survey instrument to administer.

6.3 **Data collection activities originally proposed or contemplated that were not conducted**. The only data collection activity that was not conducted was the employee survey. This survey was dropped after it was determined that we were not able to get a reliable data set to draw from that had all of the information we needed (employer size, employee home address, etc.). More than likely, this survey would have overlapped with the Household Survey anyway so it was not critical to our overall data objectives.

Additionally, we did not conduct as many employer and employee Focus Groups as we had originally planned due to cost. Again, this change did not impact our overall data objectives.

6.4 **Effective strategies in improving data collection**. Our approach to the survey was a great blend or quality and frugality that allowed us to collect sufficient data for specific needs within the relatively tight confines of the budget. Phone contact helped eliminate misclassified businesses from the Employment Security Commission frame, and was also useful in answering questions that allowed employers to complete the survey.

6.5 **Additional data collection activities needed**. The only additional data collection we are proposing be done through supplemental funding, is to develop a cost impact statement of

uninsurance to the health care system in South Carolina. We will complete this report if we are approved for supplemental funding.

It is our opinion that data collection should occur every 3 to 5 years to ensure that the policy options implemented are working and that the categories of uninsured have not significantly changed. We have no long-term plan to fund this follow up data collection project at this time.

6.6 **Organization or operational lessons learned during the course of the grant**. The most important recommendations we have are to start early and ask for help. We have accomplished a lot in one year, but have not come close to finishing our research and analysis. As more and more states some into the HRSA grant program, it should become easier for fellow states to ask for help from another state with similar demographics, political environment, etc. When we start to share ideas, research and methodology, it significantly cuts down on the amount time and energy spent by each individual state.

6.7 **What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?** We are unable to respond to these questions at this point in our project.

6.8 **Key recommendations to other States regarding the policy planning process**. See response in 6.6.

6.9 **Political and economic environment changes over the course of the grant**. Two changes occurred in South Carolina over the past year. One significant change is that we had a change of leadership and a Republican Governor was elected. However, Governor Sanford re-appointed Ernie Csiszar, the Director of Insurance, and thus our work and objectives have remained the same.

The other significant change during the last legislative session was the budget cuts and subsequent changes in Medicaid. At this point, we do not know how these budgetary issues will affect our future policy considerations. HIPAC will continue to take funding into consideration when working on policy recommendations.

6.10 **Change in project goals change during the grant period**. Our project goals have become more defined, but have not changed. We remain focused on finding a solution to stabilize health insurance rates and expand access in the small group insurance market.

6.11 **What will be the next steps of this effort once the grant comes to a close**? Due to HRSA approval of a no-cost extension, ending June 30, 2004, we will not respond to this question at this time.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 **What coverage expansion options selected require Federal waiver authority or other changes in Federal law SCHIP regulations, ERISA)?** We are unable to respond to these questions at this point in our project.

7.2 **What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the federal government make those changes**? We are unable to respond to these questions at this point in our project.

7.3 **What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?** State-specific data is extremely important and would probably be more credible coming out of a survey implemented by the state. Our preliminary data suggests that the national statistics about the number of uninsured in South Carolina are low.

7.4 **What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?** Household and Employer Surveys should be conducted every 3 to 5 years, in order to track our progress. If the States is responsible for this data collection, additional funding will be needed.

APPENDIX I: BASELINE INFORMATION

Population: Total population according to the 2000 U.S. Census Bureau is 4,012,012

Number and percentage of uninsured:

Answered "NO" to all questions on type of insurance coverage or was not covered by insurance at some time during the past twelve months – [All inclusive]		
NOINSUR3	**Frequency**	**Percent**
Yes	3266	81.01
No	766	18.99

Answered "NO" to all questions on type of insurance coverage – [Currently Uninsured]		
NOINSUR1	**Frequency**	**Percent**
Yes	3583	88.89
No	448	11.11

Answered "NO" to all questions on type of insurance coverage and was not covered by insurance at any time during the past twelve months – [Chronic]		
NOINSUR5	**Frequency**	**Percent**
Yes	3712	92.10
No	319	7.90

Average age of population:

Age (Don't have insurance OR none in past 12 months) – [All inclusive]	
N	767
Mean	29.89871
Median	29.00000
Std Deviation	16.95016

Age (Answered No or Don't Know to all question on type of insurance)- [Current]	
N	469
Mean	30.92481
Median	30.00000
Std Deviation	15.84731

Age (Don't have coverage AND none in past 12 months)- [Chronic]	
N	343
Mean	32.09742
Median	32.00000
Std Deviation	15.55643

Percent of population living in poverty (>100% FPL): According to the 2000 U.S. Census Bureau, 14.1 individuals and 10.7 families are living below the FPL.

Primary industries: Top ten, largest to smallest:

Manufacturing
Educational, health and social services
Retail trade
Arts, entertainment, recreation, accommodations and food services
Construction
Professional, scientific, management, administrative, and waste management services
Finance, insurance, real estate, and rental and leasing
Transportation and warehousing, and utilities
Other services (except public administration
Public administration

Number and percent of employers offering coverage:

Unknown at this time

Number and percent of self-insured firms:

60 to 70% of employees are covered under self-insured firms in South Carolina.

Payer mix (percentage estimates based on all responses to survey questions. Some individuals gave more than one response.):

Respondent's employer	28.9%
Someone else's employer	27.1%
Medicare	14.1%
Medicaid	9.3%
Bought by respondent	7.2%
TRICARE	5.3%
Bought by someone else	3.7%
CHIP	2.2%
Active military	1.1%
Railroad retirement plan	0.5%
S.C. Health Association	0.4%

Provider competition: This varies by county…the major metropolitan areas (Charleston, Greenville/Spartanburg and Columbia) have more competition between hospitals and specialists. The largest membership insurers have almost all providers in their networks.

Insurance market reforms: There is currently a no-mandate moratorium in place so all health insurance mandates must go before an appointed committee for a full review and pricing. Compared to most states, South Carolina has relatively few mandates and anti-managed care laws.

Eligibility for existing coverage programs (Medicaid/SCHIP/other): See attached report "South Carolina Medicaid Program: Major Coverage Groups (May 2003)"


Reports.htm

Use of Federal waivers:

Prescription Drug Benefit for South Carolina's Low Income Seniors
South Carolina HCBS Waiver: Aged and Disabled (0104)
South Carolina HCBS Waiver: HIV/AIDS (0186)
South Carolina HCBS Waiver: MR and related conditions (0237)
South Carolina HCBS Waiver: Physically Disabled (0284)
South Carolina HCBS Waiver: Aged and Disabled (0405)

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES:

SURVEY RESULTS

INCOME:

2002 HH Gross Income (Don't have insurance OR none in past 12 months) - [All inclusive]		
Income	**Frequency**	**Percent**
Less than 5,000	20	2.45
5,000 to 7,499	18	2.30
7,500 to 9,999	30	3.74
10,000 to 12,499	31	3.83
12,500 to 14,999	55	6.93
15,000 to 19,999	58	7.31
20,000 to 24,999	63	7.92
25,000 to 29,999	36	4.53
30,000 to 34,999	51	6.39
35,000 to 39,999	46	5.76
40,000 to 49,999	74	9.30
50,000 to 59,999	40	5.07
60,000 to 74,999	45	5.61
75,000 or more	99	12.44
Don't know	72	8.98
Refused	59	7.44

2002 HH Gross Income (Answered No or Don't Know to all question on type of insurance) – [Currently uninsured]		
Income	**Frequency**	**Percent**
Less than 5,000	16	3.28
5,000 to 7,499	8	1.64
7,500 to 9,999	23	4.65
10,000 to 12,499	22	4.56
12,500 to 14,999	32	6.63
15,000 to 19,999	40	8.24
20,000 to 24,999	30	6.17
25,000 to 29,999	25	5.13
30,000 to 34,999	37	7.50
35,000 to 39,999	25	5.23
40,000 to 49,999	46	9.50
50,000 to 59,999	28	5.76
60,000 to 74,999	18	3.67
75,000 or more	44	9.01
Don't know	54	11.11

Refused	39	7.92

2002 HH Gross Income (Don't have coverage AND none in past 12 months) – [Chronic]		
Income	**Frequency**	**Percent**
Less than 5,000	13	3.82
5,000 to 7,499	7	1.93
7,500 to 9,999	16	4.53
10,000 to 12,499	20	5.83
12,500 to 14,999	23	6.70
15,000 to 19,999	30	8.45
20,000 to 24,999	22	6.23
25,000 to 29,999	14	4.21
30,000 to 34,999	29	8.26
35,000 to 39,999	22	6.20
40,000 to 49,999	24	6.92
50,000 to 59,999	18	5.06
60,000 to 74,999	9	2.65
75,000 or more	27	7.84
Don't know	46	13.02
Refused	29	8.35

GENDER:

Gender (Don't have insurance OR none in past 12 months)- [All inclusive]		
Sex	**Frequency**	**Percent**
Male	415	51.12
Female	397	48.88

Gender (Answered No or Don't Know to all questions on type of insurance) –[Current]		
Sex	**Frequency**	**Percent**
Male	276	55.81
Female	219	44.19

Gender (Don't have coverage AND none in past 12 months)- [Chronic]		
Sex	**Frequency**	**Percent**
Male	197	55.14
Female	160	44.86

FAMILY COMPOSITION:

# Who live on Household Income (Don't have insurance OR none in past 12 months)- [All inclusive]	
N	754
Mean	3.466789
Median	3.000000
Std Deviation	2.30042

# Who live on Household Income (Answered No or Don't Know to all questions on type of insurance)- [Current]	
N	459
Mean	3.449612
Median	3.000000
Std Deviation	2.40231

# Who live on Household Income (Don't have coverage AND none in past 12 months)- [Chronic]	
N	334
Mean	3.307643
Median	3.000000
Std Deviation	2.29831

# of kids under 21 Who live on Household Income (Don't have insurance OR none in past 12 months)- [All inclusive]	
N	757
Mean	1.363939
Median	1.000000
Std Deviation	1.37314

# of kids under 21 Who live on Household Income (Answered No or Don't Know to all questions on type of insurance)- [Current]	
N	461
Mean	1.272731
Median	1.000000
Std Deviation	1.31750

# of kids under 21 Who live on Household Income (Don't have coverage AND none in past 12 months)- [Chronic]	
N	336
Mean	1.149337
Median	1.000000
Std Deviation	1.27139

HEALTH STATUS:

Health Rating (Don't have insurance OR none in past 12 months)- [All inclusive]		
HSTAT	**Frequency**	**Percent**
Excellent	291	35.81
Very good	210	25.80
Good	190	23.33
Fair	88	10.79
Poor	28	3.39
Don't know	4	0.53
Refused	3	0.36

Health Rating (Answered No or Don't Know to all questions on type of insurance)- [Current]		
HSTAT	**Frequency**	**Percent**
Excellent	154	31.22
Very good	130	26.31
Good	126	25.54
Fair	60	12.10
Poor	17	3.52
Don't know	4	0.71
Refused	3	0.59

Health Rating (Don't have coverage AND none in past 12 months)- [Chronic]		
HSTAT	**Frequency**	**Percent**
Excellent	103	28.70
Very good	93	26.13
Good	91	25.59
Fair	50	13.99
Poor	14	4.01
Don't know	4	0.98
Refused	2	0.59

EMPLOYMENT STATUS (including seasonal and part-time employment and multiple employers):

Health Rating (Don't have insurance OR none in past 12 months)- [All inclusive]		
HHEMP	**Frequency**	**Percent**
Self employed or own your business	87	13.85
Employed by someone	307	49.07
An unpaid worker for family business, farm, or home	7	1.18
Retired	24	3.82
Unemployed	151	24.16
Don't know	48	7.63
Refused	2	0.29

Health Rating (Answered No or Don't Know to all questions on type of insurance)- [Current]		
HHEMP	**Frequency**	**Percent**
Self employed or own your business	69	17.14
Employed by someone	172	42.83
An unpaid worker for family business, farm, or home	5	1.15
Retired	8	2.07
Unemployed	122	30.28
Don't know	24	6.08
Refused	2	0.46

Health Rating (Don't have coverage AND none in past 12 months)- [Chronic]		
HHEMP	**Frequency**	**Percent**
Self employed or own your business	51	17.21
Employed by someone	137	46.37
An unpaid worker for family business, farm, or home	3	0.87
Retired	6	1.92
Unemployed	80	27.04
Don't know	19	6.30
Refused	1	0.30

AVAILABILITY OF PRIVATE COVERAGE (including offered but not accepted):

Main Reason He/She Has Not Bought Health Insurance (Don't have insurance OR none in past 12 months)- [All inclusive]		
OWNCOV	**Frequency**	**Percent**
Do not need or want any health insurance	4	1.01
Rarely Sick	9	2.27
Do not know where to begin/where to go	6	1.41
Too much hassle/paperwork	2	0.60
Could not afford/too expensive	244	62.23
Expect to be covered by a health insurance policy shortly	15	3.78
Benefit package didn't meet needs	2	0.57
Not eligible for reason other than health	3	0.84
Doubt eligible/rejected because of a health condition	7	1.80
Other	56	14.37
Don't know	40	10.26
Refused	3	0.86

Main Reason He/She Has Not Bought Health Insurance (Answered No or Don't Know to all questions on type of insurance)- [Current]		
OWNCOV	**Frequency**	**Percent**
Do not need or want any health insurance	4	1.01
Rarely Sick	9	2.27
Do not know where to begin/where to go	6	1.41
Too much hassle/paperwork	2	0.60
Could not afford/too expensive	244	62.23
Expect to be covered by a health insurance policy shortly	15	3.78

Benefit package didn't meet needs	2	0.57
Not eligible for reason other than health	3	0.84
Doubt eligible/rejected because of a health condition	7	1.80
Other	56	14.37
Don't know	40	10.26
Refused	3	0.86

Main Reason He/She Has Not Bought Health Insurance (Don't have coverage AND none in past 12 months)- [Chronic]		
OWNCOV	**Frequency**	**Percent**
Do not need or want any health insurance	3	0.97
Rarely Sick	8	2.71
Do not know where to begin/where to go	4	1.51
Too much hassle/paperwork	2	0.83
Could not afford/too expensive	178	62.32
Expect to be covered by a health insurance policy shortly	6	2.13
Benefit package didn't meet needs	1	0.40
Not eligible for reason other than health	3	1.16
Doubt eligible/rejected because of a health condition	6	2.02
Other	36	12.56
Don't know	35	12.21
Refused	3	1.19

Main Reason Parents Have Not Bought He/She Insurance (Don't have insurance OR none in past 12 months)- [All inclusive]		
OWNCV2	**Frequency**	**Percent**
Do not know where to begin/where to go	3	3.64
Too much hassle/paperwork	2	2.66
Could not afford/too expensive	59	66.15
Expect they will be covered by a health insurance policy shortly	5	5.52
Benefit package didn't meet this child's needs	1	1.05
Other	6	5.94
Don't know	14	13.94
Refused	1	1.09

Main Reason Parents Have Not Bought He/She Insurance (Answered No or Don't Know to all questions on type of insurance)- [Current]		
OWNCV2	**Frequency**	**Percent**
Do not know where to begin/where to go	3	3.64
Too much hassle/paperwork	2	2.66
Could not afford/too expensive	59	66.15
Expect they will be covered by a health insurance policy shortly	5	5.52
Benefit package didn't meet this child's needs	1	1.05
Other	5	5.94
Don't know	12	13.94
Refused	1	1.09

Main Reason Parents Have Not Bought He/She Insurance (Don't have coverage AND none in past 12 months)- [Chronic]		
OWNCV2	**Frequency**	**Percent**
Do not know where to begin/where to go	1	1.40
Too much hassle/paperwork	2	4.03
Could not afford/too expensive	43	72.71
Expect they will be covered by a health insurance policy shortly	1	1.47
Benefit package didn't meet this child's needs	1	1.59
Don't know	10	17.14
Refused	1	1.65

Main Reason He/She Is Not Covered Under Parents Plan (Don't have insurance OR none in past 12 months)- [All inclusive]		
PACV5	**Frequency**	**Percent**
0	272	96.01
5	1	0.41
6	6	2.22
8	4	1.36

Main Reason He/She Is Not Covered Under Parents Plan (Answered No or Don't Know to all questions on type of insurance)-[Current]		
PACV5	**Frequency**	**Percent**
0	160	93.40
5	1	0.68
6	6	3.68
8	4	2.24

Main Reason He/She Is Not Covered Under Parents Plan (Don't have coverage AND none in past 12 months)- [Chronic]		
PACV5	**Frequency**	**Percent**
0	114	91.87
5	1	0.94
6	5	4.10
8	4	3.09

Main Reason Did Not Get Insurance Thru Family Member (Don't have insurance OR none in past 12 months)- [All inclusive]		
COV5	**Frequency**	**Percent**
Could not afford/too expensive	12	62.73
After waiting period will be covered by family member's policy	2	9.76
Doubt eligible/rejected because of health condition	1	3.69
Other	4	18.66
Don't know	1	5.16

Main Reason Did Not Get Insurance Thru Family Member (Answered No or Don't Know to all questions on type of insurance)- [Current]		
COV5	**Frequency**	**Percent**
Could not afford/too expensive	12	62.73
After waiting period will be covered by family member's policy	2	9.76
Doubt eligible/rejected because of health condition	1	3.69
Other	4	18.66
Don't know	1	5.16

Main Reason Did Not Get Insurance Thru Family Member (Don't have coverage AND none in past 12 months)- [Chronic]		
COV5	**Frequency**	**Percent**
Too much hassle/paperwork	6	59.23
Benefit package didn't meet needs	1	10.79
Doubt eligible/rejected because of a health condition	1	7.20
Other	1	12.70
Don't know	1	10.07

Why He/She Is Not Included In Employers Insurance Plan (Don't have insurance OR none in past 12 months)- [All inclusive]		
EMPCOV4	**Frequency**	**Percent**
Could not afford/too expensive	25	40.42
DO NOT work enough hours in a week	4	6.59
Have NOT worked there long enough	21	34.22
Benefit package didn't meet needs	2	3.78
9	7	12.05
12	1	1.36
Don't know	1	1.59

Why He/She Is Not Included In Employers Insurance Plan (Answered No or Don't Know to all questions on type of insurance)- [Current]		
EMPCOV4	**Frequency**	**Percent**
Could not afford/too expensive	25	40.42
DO NOT work enough hours in a week	4	6.59
Have NOT worked there long enough	21	34.22
Benefit package didn't meet needs	2	3.78
	7	12.05
	1	1.36
Don't know	1	1.59

Why He/She Is Not Included In Employers Insurance Plan (Don't have coverage AND none in past 12 months)- [Chronic]		
EMPCOV4	**Frequency**	**Percent**
Could not afford/too expensive	19	45.52
DO NOT work enough hours in a week	4	9.66
Have NOT worked there long enough	11	26.72
Benefit package didn't meet needs	1	2.84
9	5	12.93
Don't know	1	2.33

AVAILABILITY OF PUBLIC COVERAGE:

Why He/She Would Not Enroll In SC Health Program (Don't have insurance OR none in past 12 months)- [All inclusive]		
PUB4	**Frequency**	**Percent**
1	4	66.46
2	2	33.54

Why He/She Would Not Enroll In SC Health Program (Answered No or Don't Know to all questions on type of insurance)- [Current]		
PUB4	**Frequency**	**Percent**
1	4	66.46
2	2	33.54

Why He/She Would Not Enroll In SC Health Program (Don't have coverage AND none in past 12 months)- [Chronic]		
PUB4	**Frequency**	**Percent**
1	1	36.38
2	2	63.62

RACE/ETHNICITY:

Race (Don't have insurance OR none in past 12 months)- [All inclusive]		
HHRACE2A	**Frequency**	**Percent**
White	513	63.56
Black, African-American	249	30.92
Asian	4	0.50
American Indian	2	0.22
Other Pacific Islander	1	0.16
Some other race	31	3.89
Don't know	6	0.74

Race (Answered No or Don't Know to all questions on type of insurance)- [Current]		
HHRACE2A	**Frequency**	**Percent**
White	321	65.72
Black, African-American	141	28.76
Asian	3	0.57
American Indian	2	0.37
Some other race	22	4.32
Don't know	1	0.26

Race (Don't have coverage AND none in past 12 months)- [Chronic]		
HHRACE2A	**Frequency**	**Percent**
White	231	65.29
Black, African-American	101	28.52
Asian	3	0.78
American Indian	2	0.51
Some other race	16	4.54
Don't know	1	0.36

IMMIGRATION STATUS:

Citizen of USA (Don't have insurance OR none in past 12 months)- [All inclusive]		
Citizen	**Frequency**	**Percent**
Yes	799	98.37
No	7	0.89
Don't know	1	0.15
Refused	5	0.59

Citizen of USA (Answered No or Don't Know to all questions on type of insurance)- [Current]		
Citizen	**Frequency**	**Percent**
Yes	485	98.00
No	5	0.96
Don't know	1	0.24
Refused	4	0.79

Citizen of USA (Don't have coverage AND none in past 12 months)- [Chronic]		
Citizen	**Frequency**	**Percent**
Yes	348	97.47
No	5	1.33
Don't know	1	0.34
Refused	3	0.87

GEOGRAPHIC LOCATION (as defined by State—urban/suburban/rural, county-level, etc.): N/A

DURATION OF UNINSURANCE:

Had Any Health Insurance In Past 12 Months		
H15	**Frequency**	**Percent**
Yes	138	26.02
No	303	57.26
Don't know	42	8.01
Refused	46	8.71

What are the characteristics of firms that do not offer coverage, as compared to firms that do?

EMPLOYER SIZE (including self-employed):

Uninsured Size		
Size	**Weighted Frequency**	**Percent**
0-50	315	65.37
51-100	167	34.63

Insured Size		
Size	**Weighted Frequency**	**Percent**
0-50	304	15.14
51-100	1703	84.86

Size Chi-Square DF=1 Value=158.9046 Prob=.0001

INDUSTRY SECTOR:

Uninsured Business Type		
Business	**Weighted Frequency**	**Percent**
Agriculture	9	1.89
Construction	68	14.20
Hotel motel restaurant or entertainment	73	15.20
Manufacturing	34	7.14
Medical	30	6.17
Other	132	27.48
Professional and related services	79	16.54
Retail Trade	55	11.37

Insured Business Type		
Business	**Weighted Frequency**	**Percent**
Agriculture	14	0.68
Construction	240	12.00
Government	41	2.06
Hotel motel restaurant or entertainment	171	8.57
Manufacturing	359	17.96
Medical	146	7.31
Other	578	28.91
Professional and related services	187	9.36
Retail Trade	263	13.15

Business Type Chi-Square DF=8 Value=30.3335 Prob=.0002

EMPLOYEE INCOME BRACKETS:

Uninsured Average Salary of Full-time Employees		
Salary	**Weighted Frequency**	**Percent**
Less than $10000	20	4.44
$10000-$15000	116	25.31
$15001-$20000	95	20.79
$20001-$25000	100	21.76
$25001-$50000	111	24.23
$50001-$75000	11	2.47
More than $75000	5	1.00

Insured Average Salary of Full-time Employees		
Salary	**Weighted Frequency**	**Percent**
Less than $10000	2	0.12
$10000-$15000	73	3.75
$15001-$20000	238	12.18
$20001-$25000	469	24.03
$25001-$50000	1097	56.28
$50001-$75000	66	3.40
More than $75000	5	0.24

Salary Chi-Square DF=6 Value=109.2122 Prob=.0001

PERCENTAGE OF PART-TIME AND SEASONAL WORKERS:

% Uninsured Part-time Employees	
N	167
Mean	0.247752
Median	0.095238
Std Deviation	0.31113

% Insured Part-time Employees	
N	540
Mean	0.140143
Median	0.026667
Std Deviation	0.22453

GEOGRAPHIC LOCATION:

Geographic Distribution of the Employers NOT offering Insurance		
COUNTY	**Weighted Frequency**	**Percent**
Abbeville	2	0.47
Aiken	9	1.89
Allendale	5	0.95
Anderson	16	3.31
Bamburg	5	0.94
Beaufort	34	7.05
Berkeley	14	2.84
Charleston	66	13.66
Cherokee	9	1.89
Chesterfield	11	2.37
Clarendon	5	0.95
Darlington	11	2.36
Dillon	2	0.47
Dorchester	5	0.94
Florence	14	2.83
Georgetown	9	1.90
Greenville	41	8.49
Greenwood	14	2.84
Horry	39	8.02
Jasper	2	0.47
Kershaw	7	1.41
Lancaster	5	0.94
Laurens	2	0.47
Lexington	25	5.17
Marion	7	1.41
Marlboro	2	0.47
Newberry	7	1.42
Oconee	5	.94
Orangeburg	14	2.83
Pickens	14	2.83
Richland	45	9.41
Spartanburg	14	2.82
Sumter	14	2.83
Union	5	0.95
York	7	1.41

Geographic Distribution of Employers Offering Insurance		
COUNTY	**Weighted Frequency**	**Percent**
Abbeville	9	0.46
Aiken	25	1.25
Allendale	2	0.11
Anderson	64	3.19
Bamburg	14	0.69
Barnwell	5	0.23
Beaufort	98	4.90
Berkeley	34	1.71
Calhoun	4	0.23
Charleston	199	9.91
Cherokee	11	0.57
Chester	14	0.68
Chesterfield	14	0.68
Colleton	11	0.57
Darlington	14	0.68
Dillon	5	0.23
Dorchester	48	2.39
Edgefield	5	0.23
Fairfield	9	0.46
Florence	85	4.22
Georgetown	53	2.62
Greenville	244	12.17
Greenwood	32	1.59
Hampton	11	0.57
Horry	128	6.38
Jasper	7	0.34
Kershaw	27	1.37
Lancaster	7	0.34
Laurens	25	1.25
Lee	2	0.11
Lexington	117	5.81
Marion	7	0.34
Marlboro	2	0.11
Newberry	18	0.91
Oconee	11	0.57
Orangeburg	14	0.69
Pickens	46	2.28
Richland	206	10.25
Saluda	2	0.11
Spartanburg	217	10.83

Sumter	53	2.62
Union	9	0.45
Williamsburg	2	0.11
York	96	4.79

LEVEL OF CONTRIBUTION:

Approximately what percentage of the total cost of insurance does each employee contribute towards the cost of his/her coverage each month (excluding coverage for family members)?

Percent Employees Contribute		
Contribution	**Frequency**	**Percent**
0%	582	30.37
1%-25%	643	33.52
26%-50%	558	29.09
51%-99%	98	5.12
100%	36	1.90

PERCENTAGE OF EMPLOYEES OFFERED COVERAGE WHO DO NOT PARTICIPATE:

Eligible but do not participate		
Nonparticipants	**Weighted Frequency**	**Percent**
Almost All	98	5.10
Over Half	197	10.23
Some	1196	62.21
None	432	22.46

OTHER (Material not specifically requested by HRSA):

Effect on Ability to Attract Employees (for businesses that don't offer insurance)		
Negative Effect	**Weighted Frequency**	**Percent**
No	275	57.35
Yes	205	42.65

EMPLOYEE, EMPLOYER AND AGENT FOCUS GROUP REPORT

Not Available Currently - Under Quality Assurance review.

KEY INFORMANT INTERVIEWS SUMMARY

The key informant interviews were the first of a set of surveys to be conducted for the South Carolina State Planning Grant. The goal was to interview key individuals in leadership roles about their concerns regarding the increased uninsured population of South Carolina. It was very important to not just collect their concerns, but also to solicit views about possible strategy and programmatic options. In combination with the outcomes of the other surveys (the South Carolina Households Survey, the South Carolina Uninsured Survey, the South Carolina Health Insurance Survey, the Employee Health Insurance Survey, and the Employer and Employee insured and uninsured focus groups), the Health Insurance Policy Advisory Committee will formulate policies to assist in decreasing the uninsured in South Carolina.

What follows is a list of the participant descriptions of each Key Informant interviewed. Please note that more than one person in each category may have been interviewed. Next there is a summary listing of questions and answers obtained during the interview process. In several cases questions were refined based on the interviewee's experience and/or work place.

Key Informant Interviewees:

Insurance Manager for Large Corporation
Faith-Based Administrator
Human Resources Officer for a Corporation
Rural Health Clinic Administrator
Rural Health Director
Health System Administrator
Insurance Company Administrator
State Government Administrator
Community/Provider Coalition Representative
Health Coalition Administrator
Company Human Relations Director
Elected Official

Questions & Answers:

1. Based on your experiences in South Carolina, why don't people have health insurance? What factors cause them not to have health insurance?

- Affordability
- Insurance not provided by some small employers at all or is only offered to select individuals in the company.
- Illegal immigrants do not have access to public or private health care coverage. Additionally, these individuals may be reluctant to use public health care service for fear of getting reported to the INS.
- Young, healthy adults do not appreciate the value of health insurance.
- South Carolina is mostly made up of small employers, who do not always provide coverage to their employees due to high premium costs.

- Employers who do offer coverage to employees and dependents do not usually pay the dependent portion of the premium.
- Many employees, if given a choice, would rather have a raise, then be offered health insurance.
- Lay offs are affecting mid level/middle class employees, leaving them with no health insurance.
- Health plans offered do not provide adequate coverage (high out-of-pocket costs, pre-existing limitations and/or limited benefits). Also known as "underinsured".
- The uninsured may feel that the government will take care of them if they get sick.
- Health insurance is not available to part time employees.
- Individual health care coverage in unaffordable and has pre-existing condition limitations.
- Employees choose not to participate in the employer-sponsored plan.
- Health care coverage is available but not affordable.
- Cost shifting from Medicaid/Medicare to the private insurers.
- Lack of education about the value of health insurance, the potentially severe consequences of being uninsured, and the personal problems that can occur from high debt for unpaid health care services.
- Medicaid and SCHIP eligibility restrictions.
- Lack of transportation.
- Lack of convenient access to physicians, free medical care clinics and Medicaid providers.
- Lack of competition…insurance market in South Carolina is dominated by a few high profit companies.
- High cost of medications.
- High malpractice insurance costs.
- HIPAA as well as other federal and state regulations that add to the complexity of delivering and insuring health care.
- Cost trends by hospitals and other providers.
- Overuse of health care services.

2. What influenced your company's decision to offer insurance to your employees?

- Retention and recruiting good employees.
- The employer feels a degree of responsibility to the employees and their families.
- Highly qualified employees request compensation for their efforts.

3. What influenced your company's decision to not offer insurance to your employees?

- Employers cannot afford to pay premiums.
- Rates are higher for small employers because they have a smaller risk pool than large companies
- Employers might not offer health care coverage because they are indifferent to competition.

4. What are the issues/problems you have had to grapple with in order to provide insurance to your employees?

- ✍ Cost…over the past three years insurance premiums have increased by 60%. These costs are passed on to the employees in terms of higher premiums or lower benefits.
- ✍ High employee turnover.
- ✍ High cost of health care.
- ✍ Small employers cannot contribute as much to employee and dependent costs as large employers.
- ✍ Employers are faced with making a decision on what health care coverage they can afford…often only providing coverage for life-threatening incidents, versus paying the employees more in wages.
- ✍ Cost of health care coverage, cost of employee out-of-pocket expenses and the profitability of the company.

5. Could incentives such as tax breaks, subsidies, or any other incentives help employers afford health insurance?

- ✍ Tax incentives to employees would assist in affording health care coverage, as long as the tax break is not included as part of medical deductions reported to the IRS.
- ✍ None of these options would help because the employer may not meet the eligibility threshold.
- ✍ Require employers to pay 65% of the health care coverage premium would help.
- ✍ Require employers to provide coverage with reasonable out-of-pocket expenses.
- ✍ Allow tax deduction for employers providing group coverage and tax credit or deduction for employees participating in group or individual coverage.

6. Have any employees declined to participate?

- ✍ Only 2% of employees declined to participate.

7. What should employees pay for their health insurance?

- ✍ To be competitive, employees should pay 20 to 25% of the total cost of insurance premiums; this would make them more accountable for their health care utilization/costs.

8. Do current insurance regulations deter some companies from participating in your opinion?

- ✍ They will participate if there is a need to be competitive.

9. Will things change at times of economic downturn?

- ✍ At times of economic downturn, it is a buyer market in terms of selecting employees. In the short-term, economic downturn has little impact for large corporations; however, the small markets are volatile with less dynamics working for the benefits of the small employers.
- ✍ Employers will adjust their portion of the health care premiums and employees will have to make a financial determination of purchase health care coverage.

10. Drawing on your view from a rural standpoint, why don't people have health insurance?

- Individuals from rural areas generally have lower income jobs and employers are not able to offer health care coverage as a benefit.
- Health care coverage premium in rural areas is generally more expensive (less provider competition/less managed care).

11. Why do you think some people don't participate in public programs even though they are eligible?

- There is a stigma attached to participation in public programs.
- Eligible/qualified individuals do not know all of the programs available.
- Public health programs are not well marketed.
- DSS outreach programs have been eliminated due to budget problems.
- Government inefficiency in promoting market competition.
- State government has a vested interest in maintaining the status quo.
- People are not educated on the availability of public health programs and why they should enroll.
- People do not understand or appreciate the value of health care coverage.
- If health care coverage is not made readily available, people do not think about it.
- Bureaucracy and paperwork is frightening and cumbersome.
- Illegal immigrants may not want to enroll or may not know if they are eligible.
- Lack of schooling necessary to complete application.
- People do not meet the qualification criteria for federal poverty level set by Medicaid.
- It is considered sub-standard care.

12. Why do some people dis-enroll from public insurance programs?

- Enrolled individuals become ineligible.
- Enrollees are discouraged to re-apply.

13. What is your experience, from a business standpoint, with public insurance programs?

- Medicaid enrollment process has improved.
- Average reimbursement has increased for rural providers.
- Existence of federally subsidized community health centers.
- Public health programs are essential in covering health care costs for the uninsured.
- Employers pay more for private insurance to offset the cost shifting by providers.
- If public programs were reduced or eliminated, employer sponsored health care premiums would increase and some employers would no longer offer coverage to employees.
- If public programs were reduced or eliminated, providers would not be reimbursed at all for uninsured patient care.
- It would be good to develop a plan that allows small businesses to come together in a public program for a comprehensive benefit package at a reasonable cost.

14. What is your experience from a health care perspective, with public insurance programs?

- Providers feel that the public insurance programs such as Medicaid and Medicare offer an acceptable level of health coverage.
- Successful SCHIP enrollment.

15. If the state expands public insurance programs, would that affect your company?

- **Yes, the expenses associated with the uninsured cost everyone, including large employers.**
- **Healthcare costs have increase 15% over the past 5 years.**
- **The current system lacks consumer and provider accountability.**
- **Utilization must be strictly managed.**
- **The use of cost shifting should be managed.**
- **Medicaid should make use of federal funding in South Carolina.**
- **Look at emergency room usage and manage the utilization by moving eligible individuals into primacy care centers.**
- **Focus on preventative medicine**
- **Education on health care costs and utilization is needed.**
- **The Government is unwilling to fund Medicaid at a rate that is required to give quality care.**
- **Medicaid fee schedules are so poor that providers cannot pursue this as an appropriate business decision.**
- **Expand Medicaid to be on par with Medicare fee schedules and rules.**

16. In your opinion, what are the priority populations that need to be covered or looked at carefully?

- Certain ethnic groups.
- The working poor, which includes a high number of minorities.
- Working people that do not qualify for Medicaid.
- Pregnant woman.
- Children.
- Children from broker homes and single parent homes.
- Elderly.

17. Would you be interested in expansion of programs? How would this help?

- Medicaid program expansion while controlling inefficiencies.
- Pilot project to cover employees.
- Increase the amount of Medicaid funding.
- Expansion of community-based health insurance programs for small employers statewide funded partially by state money, employer and employee contributions.
- Expansion of senior pharmacy program – the Silver Card
- Expansion of Medicare and Medicaid to cover more of the pharmacy benefits.
- Program to serve the illegal immigrants via free clinics with children eligible for SCHIP.
- Expansion of existing programs with close attention to waste and misuse.
- It will take a federal initiative to tackle the lack of health insurance affordability and accessibility.

- Need to increase provider reimbursement to gain more provider participation.
- There is a fear that the low rate of reimbursement and the increase in government regulations on health care financing and delivery might affect the quality of care.
- Expand coverage to include services that promote life-style changes such as wellness, prevention, and nutrition.
- Closer matching relationship between Medicaid and Federal government.
- Keep funding of existing programs at the current level and adjust annually for inflation.
- Existing programs should not include mental health care.
- Raise SCHIP eligibility requirement to 200% of the federal poverty level.
- Many uninsured would not sign up for health care coverage because they are not willing to except the responsibility of purchasing health insurance coverage.

18. What constitutes a minimum health insurance plan?

- The minimum benefit level that is competitive enough to retain highly skilled employees.
- Preventive services, basic medical surgical coverage, prescription drugs and basic dental care, designed with financial incentives in mind to ensure the public backing of its cost-effectiveness.
- Cover basic health care needs only…no dental or eye glass coverage.
- Hospitalization, prenatal and maternal care, no waiting period with matching contributions between the employer and employee.
- Gatekeeper coverage, specialty care and hospitalization. Primary care physician focuses on improving and/or maintaining health of enrollees. Basic primary coverage, preventative care, prescription coverage and basic lab services.
- Free annual physical, eye care, minimal primary care visits and prescription drug coverage.
- Catastrophic and hospitalization coverage with affordable out-of-pocket expenses to keep patients accountable for their healthcare utilization. No limit of office visits.
- Basic primary care, specialty care, hospital services, and medications to at minimum cover the top five chronic diseases.
- Cover all medically necessary services.
- Benefits designed based on the special needs/age of the enrollees.
- Easy to use, competitive, and low cost.
- Provider discounts to self-pay patients. Self-pay individuals may not seek care if quoted "billed charges" from providers because they cannot afford it and/or the final charges are not clear.
- Cover basic and catastrophic medical services, plus optional voluntary products plus long-term disability and life insurance.

19. Would you define underinsured?

- A plan that does not attract and retain employees.
- No health care coverage.
- Health plan that does not provide adequate coverage. Problem with small employers who offer limited benefit plans instead of nothing…it is preferable to be underinsured than uninsured.
- Catastrophic care…no coverage for drugs, doctor visits, ancillary care or specialty care.
- High deductible plans with out-of-pocket expenses that are too expensive to afford.

- A family of four with only one adult insured.
- Inadequate structure of the plan and lack of provider participation.
- Barriers to access to healthcare services.
- Out-of-pocket expenses of greater than $1,000.
- People who delay services due to lack of coverage…varies according to individual's age and lifestyle.
- Medicare beneficiaries without supplemental benefits.

20. How are the uninsured people getting their health care needs met?

- A combination of free clinics and use of emergency rooms as primary care centers.
- Expansion of Medicaid programs.

21. How can we insure everyone, or at least the uninsured?

- It would be less expensive than having to pay the emergency room services for those who do not have coverage.
- Use this study to develop policy recommendations.
- It is not possible because not everyone wants health care coverage.
- Homeless and migrant workers are hard to insure.
- Too many issues to solve the uninsured problem…fighting against insurance companies.
- Require employed persons to make a minimum contribution…cheaper than paying for uninsured people to use the emergency room.
- Find ways to stabilize group rates.
- Focus on small business market.
- Expand public programs to make it affordable and promote alternate lifestyles to reduce utilization.
- Educate people about what programs are available for the uninsured and underinsured.
- Limit the benefits.
- Find ways to take advantage of federal/state matching funds.
- Eliminate government health care coverage mandates.
- Minimize laws/regulations on underwriting healthcare benefit products.
- Use managed care products.
- A sense of compassion to care for all people…need leadership to formulate and implement a plan that addresses the healthcare issues in South Carolina.
- Offer prenatal and dental care.
- Expand the Community Health Care Centers concept.
- Economic improvement of the working poor.
- Private insurance companies need to find creative ways to meet small business needs…tailor products to meet the changing insurance needs of employees.
- The Medicaid program ought to be the current program for the chronically uninsured in South Carolina; for this, qualification criteria need to be expanded for increasing eligibility and covering employed persons with no insurance.

22. Will grass roots initiatives help?

- Yes…need to inform individuals of available health care services.

23. Can you comment on the relationship of welfare reform on public health insurance coverage?

- Very Close relationship- Prior to welfare program, 30% of Medicaid eligible were on welfare, but with the welfare program, only 6% of the Medicaid recipients are on welfare; Now, the Medicaid program is becoming a public insurance program for children and uninsured families with at least 1 working adult – a quasi small employer insurance program.

24. How can we best inform people about programs that are available?

- Engage in outreach activities which had to be minimized because of bad economy; Medicaid should sent a Beneficiary Benefit Newsletter to the 800,000 Medicaid recipients about available services and preventive measures to care for their health.

25. What advice do you have for legislators for closing the health insurance gap?

- Cover health care for all individuals.
- Find out who are the uninsured and work to remedy the problem.
- Address the preexisting conditions limitations in health plans.
- Consider some tax relief.
- Enhance competition in the small group market...find out why small employer insurers are leaving the market.
- Stabilize pricing in the small group market.
- Consider a solution combining the public and private insurance markets, employers and employees…each paying one third of the costs of health care coverage.
- Take a critical look at successful programs (Horry County, Greenville, PEP, Richland Care) and see if they can be duplicated in other areas of the state.
- Use the current structures and develop supplemental programs that are not seen as welfare.
- Make the public aware of the health care programs available.
- Make use of Medicaid matching federal funds.
- Stress preventative care in health plans.
- Job opportunities are the non-visible engine to offering health care by the small employer and affording health insurance by the employee.
- Invest in public, consumer-oriented healthcare education programs.
- Fund Medicaid appropriately.
- Legislators should work with and support health care providers with businesses and agencies such as the United Way, developing innovative approaches at the state, regional and local levels to offer primary care.
- Consider expanding the number of Medicaid skilled nursing facility beds to meet the needs of the again population (same number of beds since 1984).
- Consider tort reform legislation.
- Tax incentives would probably pay for themselves by reducing dependence on public assistance or devise a program that low income or under-employed would be able to buy into. Gives them self-respect, not to be viewed as a public handout, with incentives to use it the incentives prudently. Such tax incentives may be devised by a joint legislative, Medical Society, and Hospital Association group – this would be a step above straight Medicaid funded by the government.

- ✍ Consider legislation to limit the increase in prescription drug costs through discounts. Require use of generics and/or mail order for maintenance medications. Create a prescription drug formulary.
- ✍ Increase Medicaid reimbursement for primary care services.

26. Additional Comments.

- ✍ Families applying for loans to buy homes may be turned down because of bad credit as a result of not being able to pay for unpaid medical bills.
- ✍ Companies are not able to pay for health insurance for affiliate executive directors because of the high cost of insurance.
- ✍ Find a way to include small businesses into large insurance or association pool so as to minimize the cost of health insurance.
- ✍ Cost shifting is a major issue.
- ✍ Provide primary and preventative health care coupons or vouchers for the underinsured and uninsured.
- ✍ Need to find a solution that has no negative impact on the existing healthcare system.
- ✍ Examine what is being done in other states.
- ✍ Community Health Centers serve our citizens all over the State. Yet few know they exist, what is their mission, or how to participate? Invest in awareness. These centers receive federal funds. Since they are already in place, an investment on the part of the state could have maximum effect if combined with an awareness campaign.
- ✍ Too many consolidations in the insurance market which affect health insurance rates.
- ✍ Need to recognize the issue beyond the political framework – too many people are suffering now because of the bad economy.
- ✍ Difficult to change public policy; Let the market takes its course by promoting competition.
- ✍ Individual and small group health group market is highly regulated.
- ✍ Regulations artificially add to the price of health insurance premium by dictating the coverage and price of the insurance policies.
- ✍ Better way to have equal access to health care, especially the working poor.
- ✍ Find a balanced way to insure individuals without the economic burden on the local and state governments.

ADDITIONAL RESOURCES

Websites: South Carolina Department of Insurance: www.doi.state.sc.us
Click on blue box entitled "Health Insurance Grant"

South Carolina Department of Health and Human Services: www.dhhs.state.sc.us
Report of Major Coverage Groups

Centers for Medicare and Medicaid Services: www.cms.hhs.gov
South Carolina Waiver Programs and Demonstrations

South Carolina Statistical Heath Data: http://www.ors2.state.sc.us/abstract/chapter11.html

Reports: United States Census 2000 – South Carolina

Other: State Coverage Initiatives
Academy Health
HRSA