

**STATUS OF HEALTH CARE  
IN SOUTH CAROLINA**

**A PRELIMINARY REPORT**

An Internal Report Prepared  
For

THE PALMETTO INSTITUTE  
BOARD OF DIRECTORS  
OCTOBER 2005

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# Introduction

Issues relating to health care have emerged at the forefront of policy discussion due, in large part, to the strain of health care costs upon state budgets, to the new Medicare prescription drug benefit plan, and to recent attempts by states to assess health care reform and curb attendant costs and the burden it places on businesses to be more competitive due to the increasing cost to employers. This paper selectively analyzes some of the more critical issues necessitating dialogue and further gathers reliable data relating to various segments of health care. It is not an attempt to capture comprehensively all health care related issues. It is an effort, however, to provide a baseline for the Palmetto Institute Board to use in deciding if further research is recommended.

The discussion is divided into six sections, beginning with an overview of health care in South Carolina. Section 1 profiles generally how South Carolina compares to the nation and select neighboring states. Section 2 presents an accounting of health care costs and spending, and Section 3 discusses the Medicaid program and its impact upon the State's budget. Section 4 addresses the uninsured population and those persons covered by differing types of health insurance programs. Finally, Sections 5 and 6 present issues that specifically affect South Carolina's minorities and children. This paper also examines briefly the cost-shifting effect to employees and to employers, who particularly continue to bear the lion's share of increasing health care costs. Wherever possible, all findings are stratified by racial/ethnic status.

## Executive Summary

South Carolina's picture of health care is a collage of both good news and bad news. A state-by-state, snapshot study ranked South Carolina 47<sup>th</sup> in quality of health, despite high spending on health care. South Carolina is a national leader in 6 of the leading 10 causes of death due to chronic diseases, such as heart disease, stroke, and diabetes. One factor contributing to such diseases is excess weight. Since 1990, South Carolina's obesity rates have doubled. In 2003, the State had the 13<sup>th</sup> worst obesity rate in the U.S., and all racial, ethnic, and gender groups are impacted. Approximately 3 out of 5 South Carolina adults (61%), and 30% of children, are considered to be overweight or obese. Overall, our State ranked 8<sup>th</sup> for age-adjusted deaths in 1999. The rate of cancer deaths has increased from nearly 190 to 206 deaths per 100,000 population. South Carolina's African-American population suffers disproportionately from chronic health conditions. Twenty-five percent of South Carolinians are smokers.

A poor health environment leads to higher spending costs. South Carolina spends approximately 11% of its general fund on health expenditures. The Medicaid program, which is administered by both the federal and state governments, continues to squeeze the State's budget. The number of Medicaid enrollees has climbed 5.8% in state fiscal year 2004, although growth in previous years averaged 11.5%.

Increased Medicaid costs have shifted higher spending burdens to private payors. Increases in employment-based health insurance costs are steadily on the rise. In 2003,

South Carolina employers paid out more in family coverage insurance premiums – more than \$6,000 – than both Georgia and North Carolina, although contributing at a smaller percentage rate (71%). Although employees have, directly and indirectly, assumed a greater burden of their relative share of increased costs, inherent limits in shifting costs to employees have stimulated employers to try and bring their own costs under control.

Despite increased spending on health care, more than 40 million Americans lack health insurance, with more than 50 million projected to be without coverage by the year 2006. Similarly, thousands of South Carolinians continue to go without health care coverage, particularly our more vulnerable segments of society. Approximately 14% of the population are currently uninsured and, interestingly, most of them come from working families. A higher uninsured population also imposes additional burdens upon private payors by spreading unreimbursed costs.

Our health picture is not entirely bleak – we have made some progress. For instance, although obesity remains a problem, particularly among children, the overall rate of obesity has decreased from 25.8% to 24.5% of the population. And, although the decline was slower than that experienced in other states, the State did see a decrease in the number of people who smoke and an increase in access to prenatal care. Moreover, in terms of workforce, South Carolina's thriving health care economy has pushed our State toward the front in terms of employment growth within the health care sector.

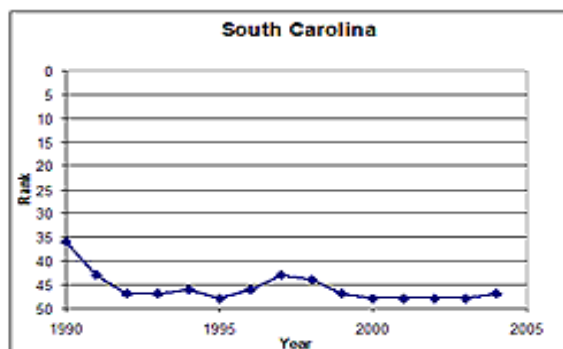
# Section 1

## How Does South Carolina Compare to Other States?

In 2004, South Carolina ranked 47<sup>th</sup> in United Health Foundation's annual rankings, a slight improvement from 48<sup>th</sup> in 2003.<sup>1</sup> **Figure 1-1** tracks South Carolina's rankings and illustrates the dip in rankings since reporting began.

**Figure 1-1**

Rankings: 1990 to 2004



Source: UHF, State Health Rankings (2004)

South Carolina ranked near the bottom in having a high prevalence in the following areas: smoking, motor vehicle deaths, infectious diseases, limited activity days per month, infant mortality rate, and premature death rate. Moreover, a leading stroke organization has reported that those living in the Southeast suffer from the highest stroke mortality rates in the nation, leading to the phrase, “Stroke Belt.”<sup>2</sup> Strikingly, South Carolina, in addition to North Carolina and Georgia, is referred to as the “stroke buckle” of the Belt because its stroke mortality rate is higher than other Belt states, and two times higher than the national rate.<sup>3</sup> Reasons proposed for the higher rate include

environmental factors and regional lifestyle differences, such as higher rates of tobacco use and preferences for salty, high-fat foods.<sup>4</sup>

The State is also among the bottom 10 states for health disparities among the races. In addition, it ranked low in combined measures of risk factors, such as personal behaviors, community environment and health policies, and outcomes, predicting the State is not likely to ameliorate its “unhealthy” environment any time soon.

Despite its poor health environment, South Carolina remains strong in the amount of money allocated to public health – 8.0% of the state health budget – ranking 12<sup>th</sup> in the nation for state budget allocations (9<sup>th</sup> place in 2003).<sup>5</sup> Moreover, the State ranked 10<sup>th</sup> in per capita public health spending (6<sup>th</sup> place the previous year), at \$88 per person (**Appendix A**).<sup>a</sup> Spending amounts range from a high of \$716 in Alaska to a mere \$7 in Georgia.

A table showing the State’s rankings in relevant risk factors and outcomes is located at **Appendix B**.

South Carolina’s thriving health care economy has pushed our State toward the front in terms of employment growth within the health care sector. Employment in health care related industries grew more than 173% between 1980 and 2000, leaving South Carolina ranked 2<sup>nd</sup> in health care employment growth.<sup>6</sup> In the 6-county Midlands area, health care services constituted the largest employment sector. In medical services and health insurance, Columbia and Florence ranked 9<sup>th</sup> and 6<sup>th</sup>, respectively, while South Carolina ranked number 7 overall among the 50 states.

Our State sits at #1 in employment growth of nursing and personal health care facilities and of “other” types of health care practitioners (excludes, *e.g.*, doctors, dentists, osteopathic physicians). South Carolina ranked #2 in employment concentration in these

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<sup>a</sup> A new measurement used by the United Health Foundation (“UHF”), per capita public health spending measures the dollars per person spent on public or population health in a state. UHF states that higher spending reflects a proactive approach in preventive and education programs, although current spending amounts may include homeland security funding, thereby creating uncertainty as to the efficacy of the spending. UHF, *State Health Rankings* (2004).

other types of health care practitioners, with Myrtle Beach ranked 9<sup>th</sup>. Other employment growth rankings for the State include #4 in the hospital sector, #3 in the medical and dental laboratories sector, and #7 in the home health care services sector. Overall, in all health care related industries, South Carolina ranked #2.

As shown below in **Table 1-1**, personal health care consumption in South Carolina is higher than in neighboring states and the nation,<sup>7</sup> due, in part, to a sizeable increase in the elderly population. See **Appendix C** for a comparison of the regions from 1980 to 2000.

**Table 1-1**

Personal Health Care Expenditures as a  
Percent of Gross State Product (2000)

<b>S.C.</b>	<b>N.C.</b>	<b>G.A.</b>	<b>U.S.</b>
<b>13.2%</b>	11.4%	10.7%	11.7%

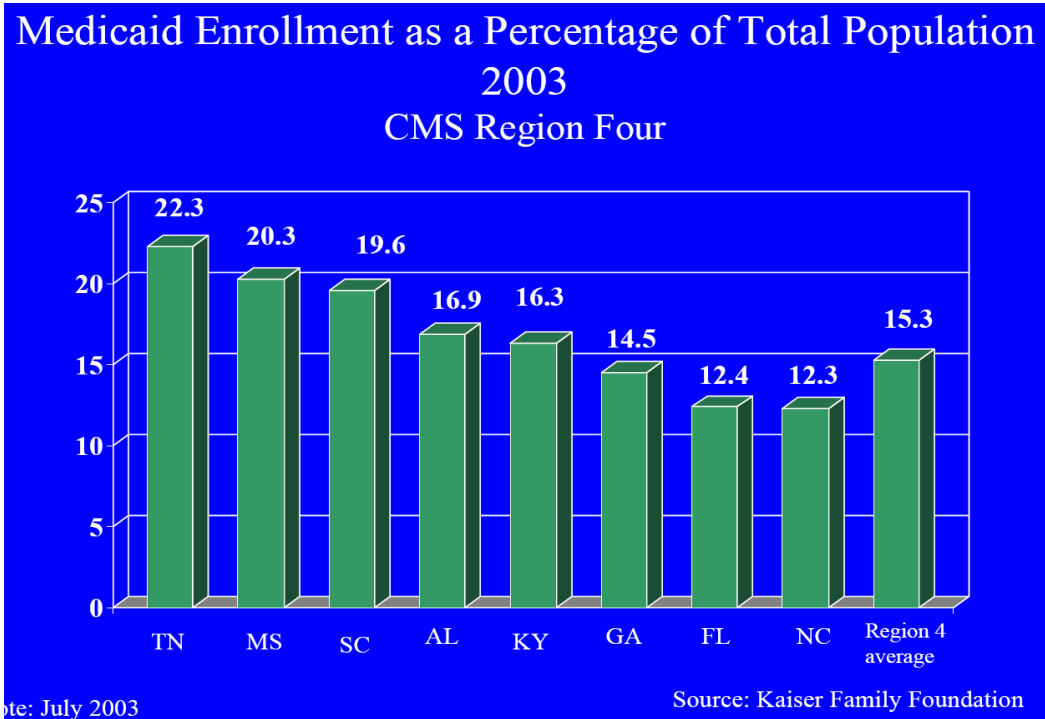
Source: CMS, Office of the Actuary, National Health Statistics Group.

In South Carolina, Medicaid spending plays a major role in health care expenditure increases and accounts for a large share of health care spending – approximately 9.1% of general fund expenditures in SFY 2003, compared to 14.7% in North Carolina, 11.0% in Georgia, and 16.% nationally.<sup>8</sup> Unlike other states, however, South Carolina has not experienced recent Medicaid shortfalls,<sup>b</sup> although Medicaid enrollment has outpaced most other Southeastern states (**Figure 1-2**).

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<sup>b</sup> A shortfall occurs, for example, when costs rise beyond projected amounts and funding must be drawn from other sources, or where providers receive underpayments (underfunding may occur where actual Medicaid allowable costs are less than actual rates paid). Underpayments can lead to distribution of higher costs for coverage, such as higher insurance premiums. During the past legislative session, some members of the South Carolina General Assembly stated that Medicaid had been “fully funded.” Twenty-two states reported Medicaid shortfalls in fiscal year 2004, with twenty-eight states experiencing such shortfalls in fiscal year 2005. NASBO, 2005 Fiscal Survey, Endnote 16, at 4.

**Figure 1-2**



## Section 2

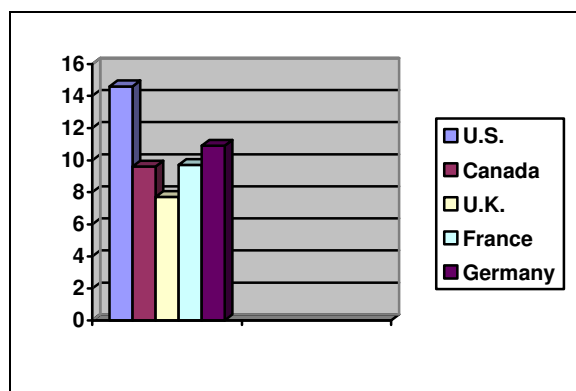
# Health Care Expenditures

### Spending on Health Care<sup>c</sup>

Since 1970, health care consumption in the U.S. has more than doubled: from 7% of Gross Domestic Product (“GDP”) to in excess of 15%.<sup>9</sup> That number is expected to reach nearly 19% by 2013 due to a projected sizeable increase in the elderly population.<sup>10</sup> Compared to other developed nations, the U.S. spends more money on health expenditures as a share of its GDP, as shown in **Figure 2-1**:<sup>11</sup>

**Figure 2-1**

National Health Expenditures as a Percentage of GDP (2002)



Source: WHO Health Report, 2005.

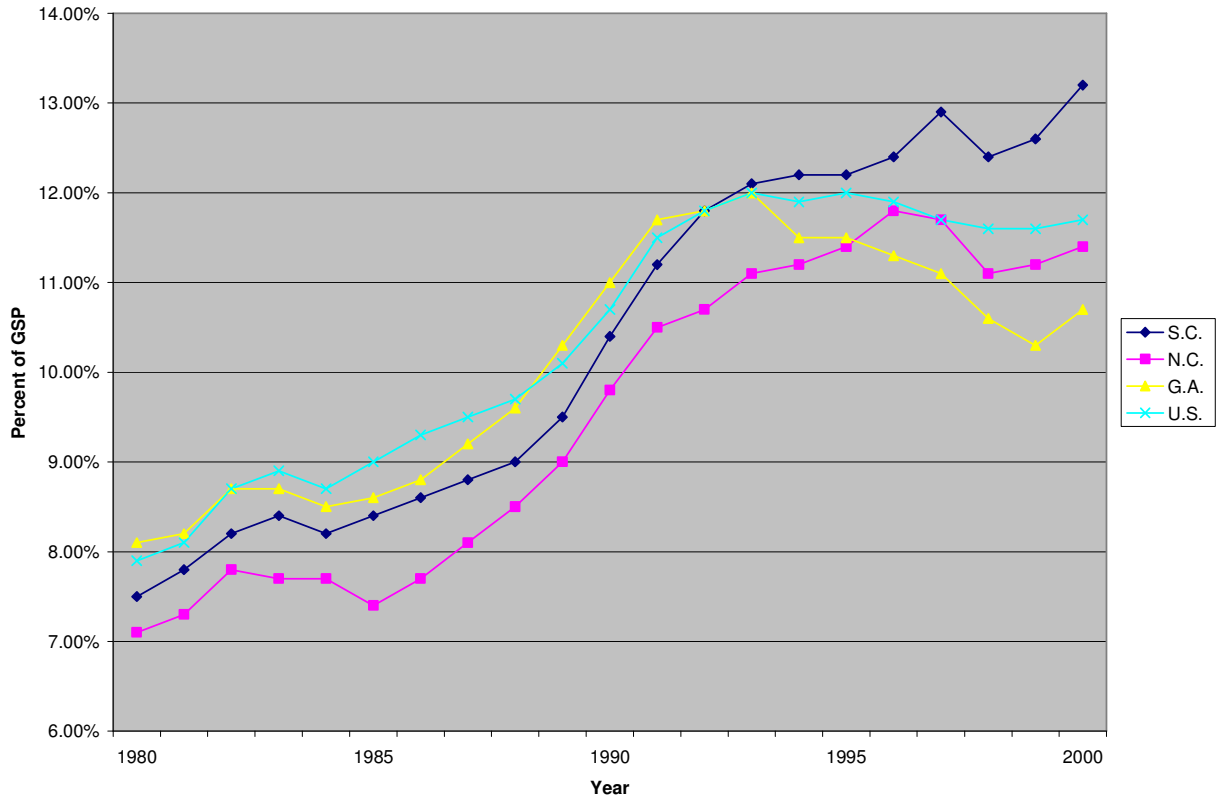
The rise in personal health expenditures as a percent of GDP implicates two premises: (1) personal health care spending is growing faster than the overall economy, and (2) medical goods and services are embracing a larger share of economic resources.<sup>12</sup>

<sup>c</sup> Expenditures related specifically to the State Medicaid program are detailed more fully in the “Medicaid” discussion in Section 3 below.

South Carolina’s total spending on health care as a share of its Gross State Product (“GSP”) continues to grow – from 7.5% in 1980 to 13.2% in 2000 – and is steadily outpacing Georgia and North Carolina (Figure 2-2; Appendix C).

**Figure 2-2**

State Personal Health Care Expenditures as a Percentage of Gross State Product (1980-2000)



Sources: CMS, Office of the Actuary, National Health Statistics Group; U.S. Bureau of Economic Analysis, 2004.

South Carolina’s personal health care expenditures in FY 2000 amounted to \$14.9 billion, compared to \$1.1 trillion nationally.<sup>13</sup> Hospital care, physician and clinical services, nursing home and home health care, and prescription drugs have consistently made up the bulk of both national and South Carolina health care expenditures.<sup>14</sup> (Table 2-1; Figure 2-3; Appendix D).<sup>15</sup> Recently, South Carolina state budget officers specifically listed

health care market forces, such as rising pharmacy costs, technology costs, and staff shortages in the medical fields, as the most significant health care issues facing the State.<sup>16</sup>

**Table 2-1**

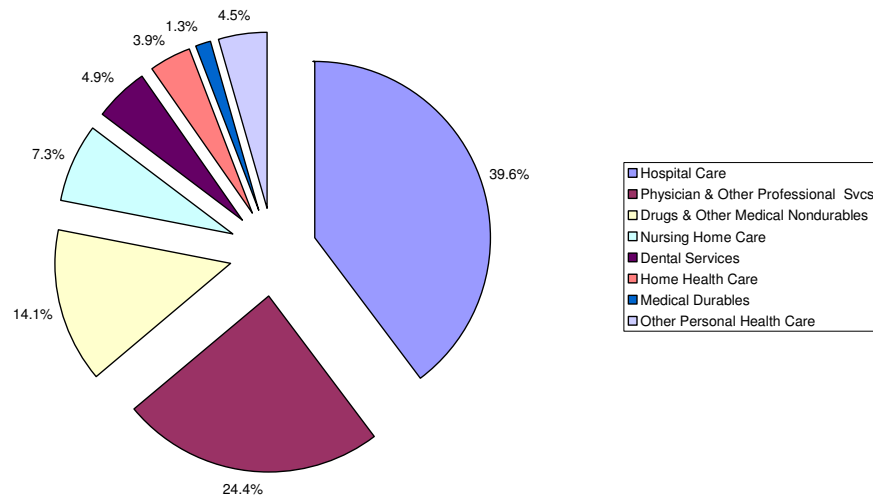
Distribution of Personal Health Care Expenditures by Service (in millions) (FY 2000) – S.C. and U.S.

	SC \$	SC %	US \$	US %
Hospital Care	5,914	39.6	413,131	36.4
Physician & Other Professional Services	3,650	24.4	328,983	29.0
Drugs & Other Medical Nondurables	2,112	14.1	151,926	13.4
Nursing Home Care	1,089	7.3	95,296	8.4
Dental Services	729	4.9	60,726	5.3
Home Health Care	580	3.9	31,616	2.8
Medical Durables	192	1.3	17,750	1.6
Other Personal Health Care	672	4.5	36,687	3.2
Total	14,937	100.0	1,136,115	100.0

Source: CMS, State Health Expenditures Accounts.

**Figure 2-3**

Distribution of Personal Health Care – S.C.



Source: CMS, State Health Expenditure Accounts.<sup>17</sup>

## Growth in Spending

Nationally, personal health care spending has grown significantly since 1960. Between 1960 and 2002, expenditures for personal health care grew from \$23.4 billion to \$1.3 trillion.<sup>18</sup> In 2002, over \$1.6 trillion was spent on health care and health-related activities. Nationwide, personal health care expenditures hovered around \$1.6 trillion in 2002, \$1.7 trillion in 2003, and are expected to reach \$2.9 trillion by 2010.<sup>19</sup> **Appendix E** depicts the growth in nominal personal health care expenditures from 1960 to 2002, along with a projected outlook.

In South Carolina, between fiscal years 1980 and 2000, personal health expenditures increased at an average annual rate of 10.3%, compared to 8.7% nationally.<sup>20</sup>

Total personal health care per capita expenditures vary substantially among the states. Expenditures are affected by factors such as population statistics, health, payment rates, and supply of services.<sup>21</sup> Per capita spending depends significantly on primary source of coverage. For example, nationally, the lowest spenders are the uninsured population, while the highest spenders are those covered under employment-based plans. As out-of-pocket expenses rise, the level of services decrease.

Prescription drug costs have been a primary driver in spending growth. South Carolinians have 13.2 prescriptions filled per capita, compared to the national average of 10.7.<sup>22</sup> In 2003, South Carolina ranked 33<sup>rd</sup> in high cost of average retail price of prescriptions filled.<sup>23</sup> The average price increased 5.7% between 2002 and 2003.<sup>24</sup>

## Who Pays for Health Care?

The nation's health insurance scheme is based predominantly upon an employer-based health system, with many Americans and South Carolinians covered through their employers, either while actively employed or through a retirement plan. Approximately

52% of South Carolinians have employment-based health insurance (**Table 2-2**). See **Appendix F** for source of payment for personal health care expenditures in the U.S.

**Table 2-2**

Population Distribution by Insurance Status – Selected Areas

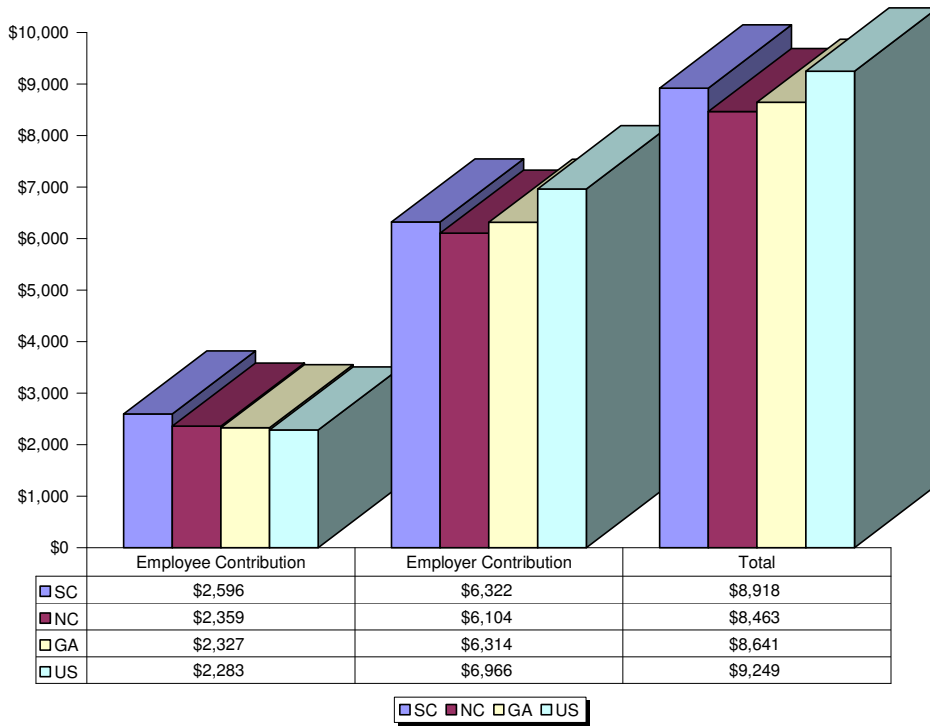
	S.C.	N.C.	G.A.	U.S.
<i>Employer</i>	<b>52%</b>	52%	59%	54%
<i>Individual</i>	<b>4%</b>	4%	4%	5%
<i>Medicaid</i>	<b>16%</b>	14%	12%	13%
<i>Medicare</i>	<b>14%</b>	13%	9%	12%
<i>Uninsured</i>	<b>13%</b>	17%	16%	16%

Source: Kaiser Foundation, State Health Facts, 2002-2003<sup>25</sup>

Costs for employer-sponsored health insurance in the U.S. since 2000 have been rising five times faster on average than workers' earnings, according to a recent survey conducted by The Kaiser Family Foundation,<sup>26</sup> leaving far less money to be spent on other items. The Kaiser study found that although contribution amounts had substantially increased in recent years, employees had contributed a smaller amount to the premiums in 2003 compared to amounts paid in 1993.<sup>27</sup> Although the overall growth rate of health insurance premiums have declined for the second straight year, premiums nevertheless increased 9.2% in 2005.<sup>28</sup>

In 2003, South Carolina workers paid on average 20% of the single coverage premium, or \$668 annually, and 29% of the family coverage premium, or \$2,596 annually (**Figure 2-4**).<sup>29</sup> Employers, on the other hand, shoulder the burden of increasing health care costs. Smaller businesses are more likely to experience premium increases of more than 15%,<sup>30</sup> and South Carolina's business community is predominantly comprised of small- and medium-sized firms. In 2003, although South Carolina employers contributed a smaller percentage to family coverage premiums than Georgia and North Carolina, it nevertheless spent more dollars – more than \$6,000.<sup>31</sup>

**Figure 2-4**  
**Average Annual Cost of**  
**Employment-Based Health Insurance (2003)**  
*Family Coverage*



Source: Kaiser, Employment-Based Health Insurance Costs (2003).

## **Section 3**

### **Medicaid**

The Medicaid program is the nation's largest public health insurance program, providing health and long-term care coverage to an estimated 52 million low-income children, elderly, disabled, and families in FY 2004, the largest group of which was children.<sup>32</sup> In comparison, Medicare served approximately 42 million individuals.

Medicaid is designed to provide medical and health-care related services for certain means-tested people, including eligible low-income, elderly, and disabled persons. Eligibility is determined by specified federal and state criteria, and the program is administered jointly by the federal and state governments. Medicaid covers a range of comprehensive services, including prescription drug benefits, nursing home care, and physician and hospital care.<sup>d</sup>

#### *Enrollment Trends*

Generally, Medicaid coverage is structured into two categories: mandatory and optional. States must cover low-income mothers and children, and pregnant women. "Low income" is defined as those persons whose income falls below the federal poverty guidelines. Those persons who receive Supplemental Security Income and those formerly eligible for Aid to Families with Dependent Children, must also be covered. States may, but are not required to, cover "optional" categories, such as certain aged, blind, or disabled adults who have incomes above the mandatory eligibility but below the

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<sup>d</sup> In 1997, Congress enacted the State Children's Health Insurance Program so as to expand coverage to children in low-income families through Medicaid, a separate children's health program, or a combination of both, and increases the federal government's contribution to the cost of covering children (*i.e.*, the federal matching rate) relative to Medicaid. South Carolina did not separate the children's health program and, therefore, is retained entirely under the Medicaid program.

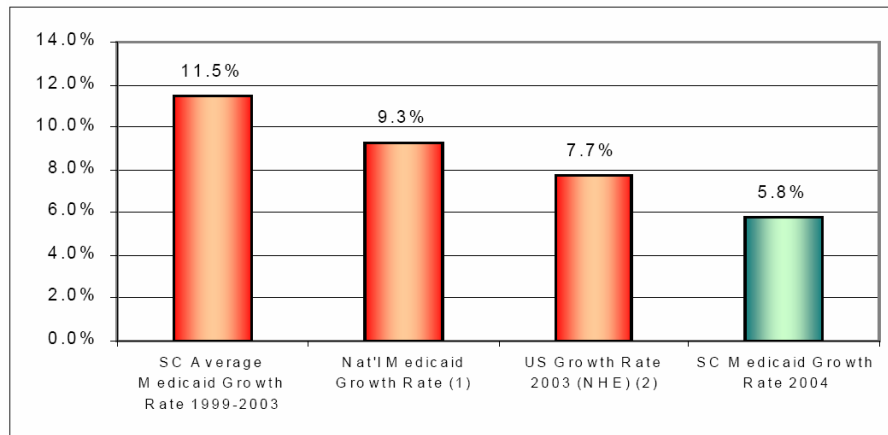
federal poverty level. In South Carolina, a family of three must make less than \$2,000 a month to qualify for Medicaid benefits (as of 2004).

Nearly 63% of Medicaid eligibles are female, while 41% are white, 49% are black, and 2.6% are Hispanic (although that figure is growing rapidly).<sup>33</sup> In FY 2004, 850,000+ South Carolinians were actually enrolled in Medicaid, representing approximately 20% of the State's total population, with more than half – around 520,000 – of them children.<sup>34</sup>

South Carolina's Medicaid program experienced a 5.8% growth in state fiscal year 2004, compared to an average of 11.5% in previous years. The national growth in 2003 was 9.3%, with total health care spending growing by 7.7% (Figure 3-1; Table 3-1).<sup>35</sup>

**Figure 3-1**

Comparison of Health Care Growth Rates



Sources: The Kaiser Family Foundation, State Fiscal Conditions and Medicaid, Release November 2003; CMS, National Healthcare Expenditure Annual Projections (does not include Disproportionate Share payments).

**Table 3-1**

## Annual Percentage Medicaid Growth Rate

	Fiscal 2004(Actual)			Fiscal 2005(Est.)			Fiscal 2006(Recommended)		
	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds
<b>S.C.</b>	9.7	11.8	9.1	32.0	3.3	6.2	6.8	4.0	5.6
<b>N.C.</b>	-9.3	27.2	11.8	17.9	6.7	10.5	12.0	12.4	12.24
<b>G.A.</b>	4.6	15.6	11.2	14.3	3.6	7.6	8.3	9.8	9.2
<b>Nat'l Avg.</b>	3.3%	12.0%	8.6%	16.8%	4.8%	8.4%	7.1%	3.7%	5.0%

Source: NASBO, 2005 Fiscal Survey.

As seen below, no additional growth is expected in fiscal 2005 or fiscal 2006.

**Table 3-2**

## Percent Change in Medicaid Enrollment

	FY 2004 Actual	FY 2005 Est.	FY 2006 Recommended	Group Contributed Most to Enrollment Change	Group Contributed Most to Medicaid Expenditures
<b>S.C.</b>	2.8	0.0	0.0	Pregnant women and Infants and Aged, Blind, Disabled	Pregnant Women and Infants and Aged, Blind, Disabled
<b>N.C.</b>	4.6	2.1	4.0	SOBRA Children and Disabled	Disabled and SOBRA Children
<b>G.A.</b>	6.0	6.0	4.0	Low income adults and children – 100% FPL and Pregnant women and children – Up to 185% FPL	Disabled adults and Children
<b>Nat'l Total</b>	4.2%	4.1%	3.8%	--	--

Source: NASBO, 2005 Fiscal Survey.

Enrollment figures, however, may fluctuate depending upon internal changes within the program. For example, South Carolina Medicaid officials reported an 8.0% decrease during FY 2004 in enrollment because of changes in eligibility processes for family and children taken in FY 2003. One such change was the elimination of “passive

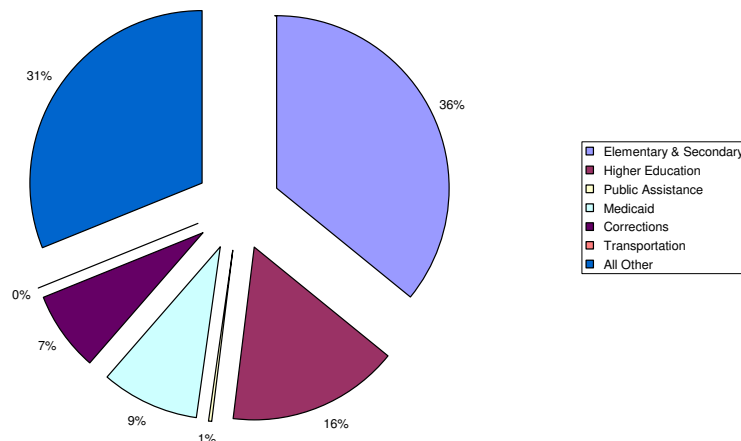
review”<sup>e</sup> of eligibility for Medicaid children, which resulted in significant decreases in the number of enrolled low-income children.

### Medicaid Spending

Escalation in the number of Medicaid enrollees has led, in part, to increased expenditures.<sup>36</sup> Total state and federal Medicaid spending in South Carolina in FY 2003 was \$3.6 billion, compared to \$266.8 billion nationally.<sup>37</sup> Between FY 2000 and FY 2003, Medicaid expenditures in South Carolina rose at an average rate of 10% per year.<sup>38</sup> During fiscal year 2001, expenditures to pay for Medicaid cost South Carolina \$562 million, representing 11% of the State’s total \$5.1 billion budget. By 2003, the cost had risen to \$824 million, 14% of the total \$5.8 billion budget (**Figure 3-2; Appendix G**).

**Figure 3-2**

Distribution of S.C. General Fund Expenditures  
(dollar amount in millions): SFY 2003



Source: NASBO, 2003 State Expenditure Report.

<sup>e</sup> “Passive review” is a process in which persons covered under Medicaid may renew their coverage without taking an affirmative step, such as a face-to-face interview, where no changes had occurred from the preceding eligibility period.

Richland County experienced the highest amounts of both provider and recipient expenditures during FY 2002-2003, while McCormack County experienced the lowest (**Appendix G**).<sup>39</sup>

Only 30% of Medicaid funds are spent on children, although they represent 55% of Medicaid recipients.<sup>40</sup> Approximately 7.5 million individuals in the U.S. are considered dually eligible under both the Medicaid and Medicare programs and, although they comprise only 14% of the Medicaid population, they account for approximately 40% of Medicaid expenditures and are the highest per capita spenders among all beneficiaries (**Table 3-3**).<sup>f</sup>

**Table 3-3**

Medicaid Expenditures for Dual Eligibles (2003) – Selected States

Expenditures (in Millions)

State	Total	Premiums & Medicare Acute*	Prescribed Drugs	Other Acute Care	Long-Term Care	Percent Expenditures on Long-term Care	Dual Eligible Spending as % of Total Medicaid	Spending per Dual Eligible
United States	\$105,405	\$16,719	\$15,172	\$4,106	\$69,392	66%	40%	\$14,114
<b>South Carolina</b>	<b>\$1,358</b>	<b>\$388</b>	<b>\$229</b>	<b>\$39</b>	<b>\$702</b>	<b>52%</b>	<b>31%</b>	<b>\$10,970</b>
Georgia	\$1,769	\$391	\$307	\$22	\$1,048	59%	31%	\$9,631
North Carolina	\$3,283	\$556	\$607	\$89	\$2,031	62%	43%	\$11,670

Source: Urban Institute estimates based on data from MSIS and Medicaid Financial Management Reports.

\* Includes Medicare premiums and acute care services that Medicare may already cover in whole or part.

Another reason for increased Medicaid costs is the gradual decline of the federal match ratio contributed (**Table 3-4**).<sup>g</sup> During a six-year study period ending FY 2000, the match ratio requirement cost South Carolina approximately \$28 million.

<sup>f</sup> Some individuals may be dual eligibles; that is, individuals who are entitled to Medicare who are also eligible for some level of Medicaid benefits. “Full” dual eligibles qualify for full Medicaid benefits, including long-term care. “Partial” dual eligibles are not eligible for full Medicaid benefits, but may receive assistance with some or all of their Medicare premiums and cost sharing.

<sup>g</sup> Taking into account that some states may not be in parity in sharing the costs of Medicaid, the federal government pays between 50-83% of Medicaid-related services, with states absorbing the remaining depending upon its Federal Medical Assistance Percentage (“FMAP”). The FMAP is the match ratio at which the federal government will reimburse a state’s own Medicaid outlays.

Subsequently, the match ratio has increased from 30.08% in FY 2000 to 30.31% in FY 2003, costing the State an additional \$8 million. The State has met the match increases through higher taxes on hospitals, increased appropriations, non-recurring revenue sources, and increased efficiency of use of the match.<sup>41</sup> Despite decline of the match, South Carolina experiences one of the highest match ratios of all 50 states, ranking 13<sup>th</sup> in the U.S. in FY 2000 (**Table 3-5**).

**Table 3-4**

South Carolina Match Ratios  
(SFY 1993-2003)

FY	Composite State Share	Composite Federal Match
1993	28.38%	71.62%
1994	28.87%	71.13%
1995	29.20%	70.80%
1996	29.25%	70.75%
1997	29.49%	70.51%
1998	29.72%	70.28%
1999	30.06%	69.94%
2000	30.08%	69.92%
2001	29.68%	70.32%
2002	30.39%	69.61%
2003	30.31%	69.69%

Source: S.C. Medicaid Study, 2003 Update, tbl. F.

Note: State Fiscal Year begins on July 1 and ends on June 30.

**Table 3-5**

Match Ratio Comparison  
S.C. vs. U.S. and Southeast  
(FFY 1993-2003)

FFY	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
<i>US</i>	61.23	61.09	60.70	60.31	59.98	60.27	60.48	60.56	60.60	60.25	60.65
<i>SE*</i>	68.20	67.94	67.51	67.25	66.81	66.50	66.52	66.54	66.74	66.33	66.89
<b>SC</b>	<b>71.28</b>	<b>71.08</b>	<b>70.71</b>	<b>70.77</b>	<b>70.43</b>	<b>70.23</b>	<b>69.85</b>	<b>69.95</b>	<b>70.44</b>	<b>69.34</b>	<b>69.81</b>
<i>GA</i>	62.08	62.47	62.23	61.90	61.52	60.84	60.47	59.88	59.67	59.00	59.60
<i>NC</i>	65.92	65.14	64.71	64.59	63.89	63.09	63.07	62.49	62.47	61.46	62.56

Source: S.C. Medicaid Study, 2003 Update, tbl. G.

\*Note: Southeastern Average; FFY runs from October 1 through September 30

Yet another reason for the rise in costs is due to increased amounts spent on particular items. In a 50-state survey administered by The Kaiser Family Foundation, South Carolina Medicaid officials listed pharmaceutical costs, physician access and hospital utilization, and eligibility issues as the most important factors contributing to Medicaid expenditure growth in 2005, and pharmaceutical costs (sales of prescription drugs increased by 10.7%, to \$179.2 billion, in 2003, compared to 14.9 in 2002), physician access and ambulatory related service increases (clinical, lab, and x-ray), and managed care rates as the contributing factors for growth in 2004.<sup>42</sup> Moreover, tobacco use cost the Medicaid program approximately \$252 million in gross Medicaid expenditures in SFY 2001, of which \$76 million was estimated to be state funds.<sup>43</sup> In addition to Governor's Sanford's waiver proposal, which is discussed below, the State has recently taken or attempted cost-containment measures in an effort to curb spending:<sup>44</sup>

- Elimination of “passive review”
- Restricted provider payments
- Pharmacy controls, such as increasing number of drugs subject to prior authorization, preferred drug list, and supplemental rebates
- Long-term care and community and home-based services programs
- New or higher co-payments for services
- Fraud and abuse initiatives, such as new or enhanced fraud and abuse detection or prevention activities, including recipient lock-in, establishment of a new Medicaid fraud unit within the state Office of Inspector General, and greater focus on third party liability recoveries
- New or expanded disease or case management programs
- Managed care expansion

### *Governor Sanford's Waiver Proposal*

Projected growth in enrollment and spending for Medicaid appears to be a significant concern in most states, including South Carolina. In June 2005, Governor Sanford submitted to Centers for Medicare and Medicaid Services, the arm of the U.S.

Department of Health and Human Services that administers the Medicaid program, a proposal seeking federal approval for 30 changes, or waivers, in the State Medicaid program.<sup>45</sup> The proposal, entitled “South Carolina Medicaid Choice,” would create health savings accounts containing a fixed amount of money, and permit enrollees to use that money to pay for part of their medical expenses. Debit cards would also be distributed, with those amounts used to pay for medical deductibles. The South Carolina Department of Health and Human Services, which administers the State program, said that the changes are necessary to contain the explosion in costs and also to improve health services for Medicaid recipients.<sup>46</sup>

The plan, which is predicted to cut medical benefits of more than 800,000 of the State’s poorest residents (most of them children), has generated substantial, controversial national attention. Two private research institutions, Center on Budget and Policy Priorities and Georgetown University’s Public Policy Institute, recently called the plan “the most radical and far-reaching waiver in the country submitted to date,” and stated that the plan would unlikely offer adequate funding to cover the disabled and those with long-term, chronic illnesses, such as cancer, diabetes, and heart disease.<sup>47</sup>

Below are highlights of the Governor’s original proposal:

- Limit Medicaid beneficiaries to a fixed amount of annual spending (currently, unlimited spending), with amount dependent upon recipient’s age, sex, and health condition (amount to be paid presently undetermined)
- Allow beneficiaries to use amount received to purchase high-deductible insurance or medical services
- Charge co-payments for drugs and treatment to all beneficiaries (currently, adults pay a co-payment but children do not). All beneficiaries would pay \$10 for all Medicaid medical services, \$100 for inpatient hospital visit, and \$25 for outpatient surgery (currently, co-payments are limited to token amounts or none at all)
- End children’s benefits at age 18 instead of 21, reducing the scope of allowable benefits and affecting 25,000 beneficiaries

- Limit the amount of federal contributions

In response to criticism, State HHS officials plan to submit a revised plan to the federal government for approval, with hope of receiving approval by the end of 2005. Among other items not yet identified, the new proposal would not eliminate medical benefits for children.

## **Section 4**

### **Health Insurance Coverage**

The most recent figures from the U.S. Census Bureau indicate that the number of Americans without health insurance rose to 43.6 million in 2002, and some groups estimate the current number to be closer to 85 million.<sup>48</sup> The National Coalition on Health Care projects that 51.2 to 53.7 million Americans will be uninsured by 2006.<sup>49</sup>

In South Carolina, approximately 14% of the population is uninsured,<sup>50</sup> although this rate ranges anywhere from 8-20% depending upon how uninsured is defined.<sup>h</sup>

#### *Who are the Uninsured in S.C.?*

The plight of the uninsured is worse for those in our more vulnerable communities: 42% of Hispanics and approximately 10% of children under the age of 18 do not have health insurance. If this trend continues, uninsured rates will only continue to grow because as of 2002, South Carolina had the fourth fastest-growing Hispanic population in the U.S. (behind Georgia, Nevada, and North Carolina), experiencing a 268% increase between 1990 and 2002.<sup>51</sup> Unlike the overall national trend, no significant differences exist as to uninsured rates between African-Americans and whites (**Table 4-1; Figure 4-1**).

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<sup>h</sup> The disparate range depends upon how restrictively, or expansively, “uninsured” is defined. For instance, if applying a more inclusive definition, nearly 20% of the population is uninsured if currently uninsured or uninsured at any time during the previous 12 months. Alternatively, a more restrictive definition would place the rate at slightly over 8% where defined as currently without coverage and not covered at any time during the previous 12 months. Although a more practical definition would be to define uninsured as only currently uninsured, resulting in an uninsured rate of approximately 12%, conclusions within this section are based upon the inclusive rate of 19.4% of population unless stated otherwise. SCDOI, Health Grant at 8.

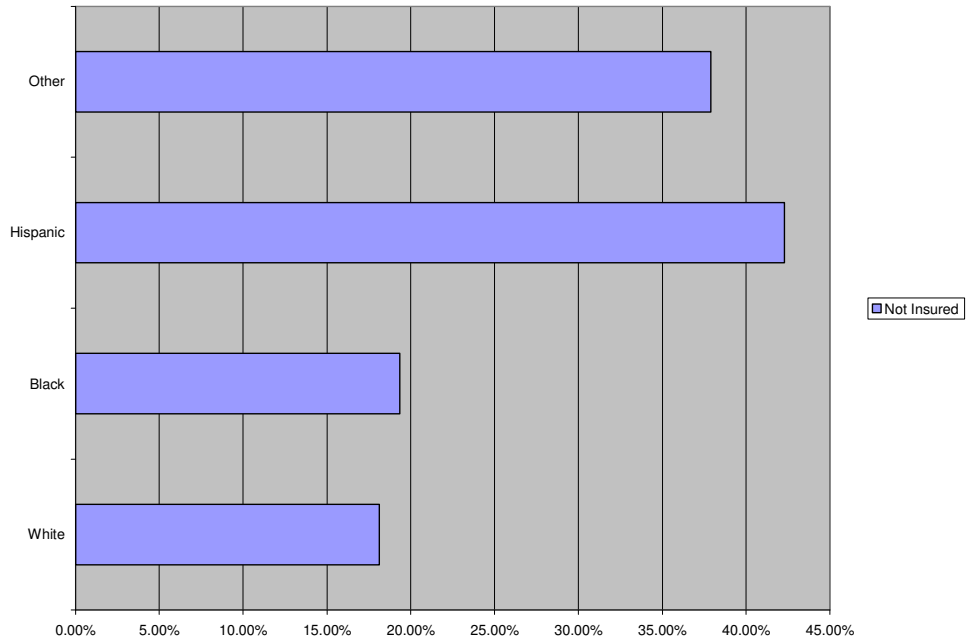
**Table 4-1**

Insured/Uninsured by Race/Ethnicity – S.C.

Race/Ethnicity	White	Black	Hispanic	Other
SC Total Population	2,714,848	1,207,512	98,575	86,250
Percentage	66.1%	29.4%	2.4%	2.1%
Insured	81.87%	80.65%	57.72%	62.1%
Not Insured	18.13%	19.35%	42.28%	37.9%

**Figure 4-1**

Uninsurance by Race/Ethnicity – S.C.



Source: SCDOI, Health Grant at 14.

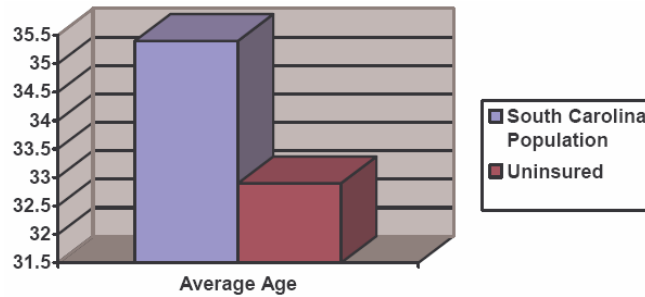
Most of the uninsured are between the ages of 18 and 65, with the average age of the uninsured at around 33 years old (**Table 4-2; Figure 4-2**). No significant differences exist between uninsured men and women, with 48.81% of men and 51.19% of women representing the uninsured.<sup>52</sup>

## South Carolina Insurance Status by Age

**Table 4-2**

Insurance Status by Age	Average Age
South Carolina Population	35.4
Uninsured	32.79

**Figure 4-2**



Source: SCDOI, Health Grant at 10.

Nearly 44% of the uninsured has a gross household income between \$20,000 and \$50,000, with nearly 22% earning more than \$50,000 annually (**Table 4-3**).

**Table 4-3**

### South Carolina Uninsurance Status by Income Level

2002 Gross Income	Percent
\$20,000 – 29,999	18.25%
\$30,000 – 39,999	16.13%
\$40,000 – 49,999	9.177%
\$20,000 – 49,999	43.55%
\$50,000 or more	21.82%

Source: SCDOI, Health Grant at 9.

## Where Do the Uninsured Live in S.C.?

The Pee Dee area comprises the bulk of the uninsured population – 21.2% (**Table 4-4**) – and the impact of a large service/retail sector is evident in Horry County experiencing the highest uninsurance rate by county, at nearly 31% (**Table 4-5**).

**Table 4-4**

### South Carolina Uninsurance Status by Region

<b>Pee Dee</b>	<b>21.2%</b>
Low Country	19.1%
Midlands	18.2%
Upstate	17.1%

Source: SCDOI, Health Grant at 15.

**Table 4-5**

### Uninsurance Rates by County

<b>COUNTY</b>	<b>REGION</b>	<b>% UNINSURED</b>
Horry	Pee Dee	30.9%
York	Upstate	24.1%
Spartanburg	Upstate	20.7%
Lexington	Midlands	19.6%
Charleston	Low Country	19%
Aiken	Midlands	17.1%
Florence	Pee Dee	16.8%
Anderson	Upstate	16.4%
Richland	Midlands	16.3%
Berkeley	Low Country	15%
Pickens	Upstate	14.5%
Greenville	Upstate	14%
Orangeburg	Midlands	13.3%

Source: SCDOI, Health Grant at 16.

## Contributors to Uninsurance Status

Availability does not seem to be a significant contributing factor to the increasing uninsured population. A national survey indicated that the primary reason Americans lack health coverage is because the cost of coverage is too expensive.<sup>53</sup>

Those people working in small firms are at the greatest risk of lacking employment-based health coverage (the Lowcountry has the highest rate) and, the smaller the firm, the less likely insurance coverage is offered (**Table 4-6; Table 4-7**), particularly in the service industry.<sup>54</sup> Larger businesses are in a better position to take advantage of the economies of scale, and approximately 70% of South Carolina businesses employ 50 people or less.<sup>55</sup> Moreover, despite legislative attempts aimed at increasing the number of working insured,<sup>i</sup> the State has lost 55 insurance carriers that write small group insurance since 1997, and only 23 small business carriers remain in the State.<sup>56</sup>

**Table 4-6**

Small Business Firms Not Offering Health Insurance by Number of Employees

Less than 10 employees	<b>58%</b>
11 – 20 employees	39%
21 – 50 employees	8%
51 – 100 employees	8%

Source: SCDOL, Health Grant at 17.

**Table 4-7**

Small Business Firms Not Offering Health Insurance by Region

<b>Low Country</b>	<b>27%</b>
Pee Dee	26%
Midlands	22%
Upstate	16%

Source: SCDOL, Health Grant at 15.

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<sup>i</sup> Actions include the Small Employer Health Insurance Availability Act in 1995, S.C. Code Ann. § 38-71-1310 *et seq.* (2002), and the Health Insurance Portability and Accountability Act in 1997, S.C. Code Ann. § 38-71-840 through 38-71-880 (2002).

Moreover, the increase in the uninsured population is due in large part to the drop in those covered by employer-based plans,<sup>57</sup> especially in the manufacturing industry and, surprisingly, in the medical and professional areas (**Table 4-8**).<sup>58</sup>

**Table 4-8**

Percent of Uninsured Working in S.C. Medical and Professional Employees by Group Size

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

Source: SCDOL, Health Grant at 17.

*Consequences of Being Uninsured or Underinsured?*

Without appropriate coverage, more people will use a hospital emergency room for routine or minor health care concerns,<sup>59</sup> thereby driving up medical costs. Economists have found that as the uninsured population rises, an increase in health care costs also occurs.<sup>60</sup> In addition, a higher uninsured population leads to increased premiums and decreased policy benefits.<sup>61</sup>

## Section 5

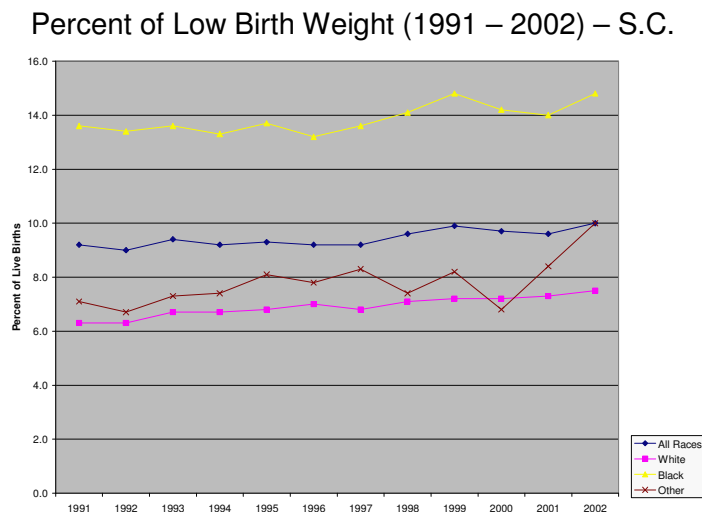
### Minority Health

Racial and ethnic health disparities continue to exist in both the U.S. and in South Carolina. South Carolina is among the bottom 10 states for health disparities among the races,<sup>62</sup> with African-Americans particularly susceptible to suffering high rates of asthma, heart disease, and HIV/AIDS.<sup>63</sup>

Although no significant differences exist in insurance coverage between South Carolina's African-Americans and whites,<sup>64</sup> uninsurance rates among Hispanics, however, hover around 42% of the State's Hispanic population.<sup>65</sup> As discussed above, the uninsured rate will likely worsen as the population increases.

A larger proportion of South Carolina's African-American infants die within the first year of birth and, further, suffer from a low birth rate, which can contribute to serious health problems (**Figure 5-1**). In South Carolina, only 63.7 percent of pregnant African-American women receive adequate prenatal care, compared to 76.9 percent of pregnant white women.<sup>66</sup>

**Figure 5-1**



Source: DHEC, Mother and Children Health Report.

# Section 6

## Children's Health

Approximately 10% of South Carolina's children under age 18 are uninsured, while approximately 26%-31% are covered under the State's Medicaid program (**Table 6-1; Figure 6-1**). Between 1997 and 2003, the percent of uninsured children has declined, while participation has increased (**Figure 6-1**).

**Table 6-1**

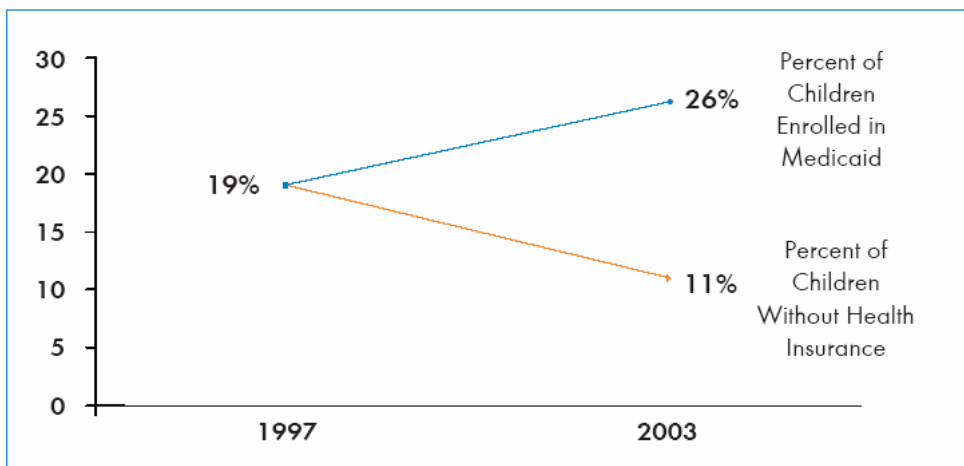
Distribution of Children 18 and Under by Insurance Status

	<b>S.C.</b>	<b>N.C.</b>	<b>G.A.</b>	<b>U.S.</b>
<i>Employer</i>	<b>55%</b>	50%	57%	57%
<i>Individual</i>	<b>4%</b>	4%	3%	4%
<i>Medicaid</i>	<b>31%</b>	32%	26%	27%
<i>Medicare</i>	<b>2%</b>	1%	0	0
<i>Uninsured</i>	<b>9%</b>	13%	13%	12%

Source: Kaiser State Health Facts, 2002-2003

**Figure 6-1**

Percent of S.C. Uninsured and Medicaid-Covered Children (1997 – 2003)

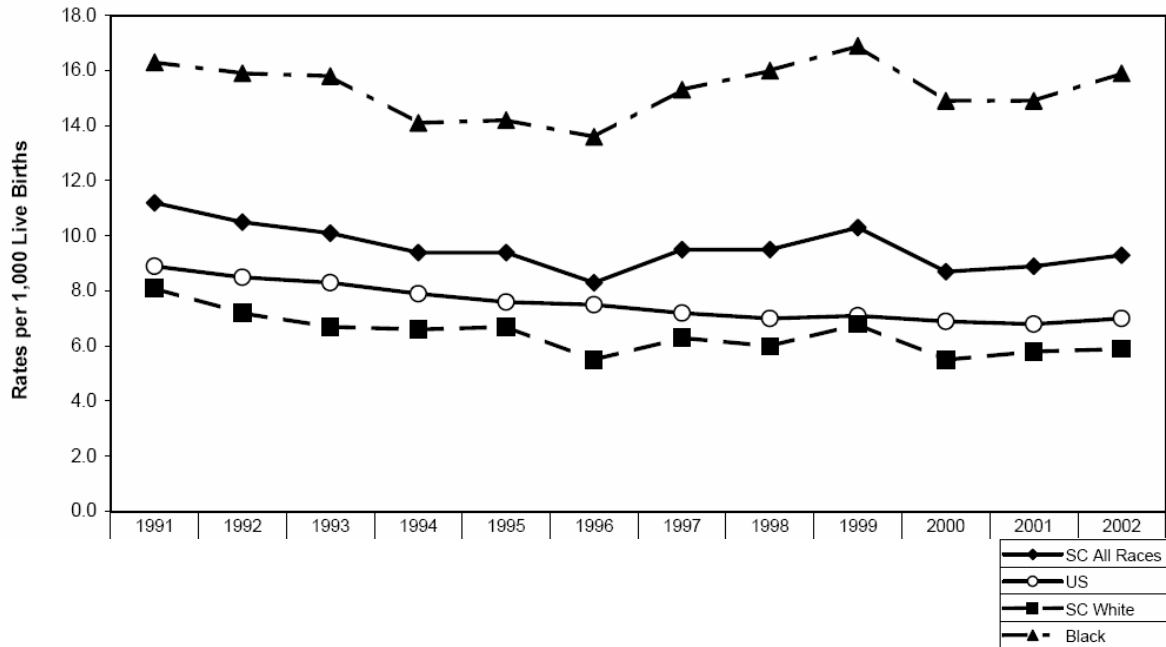


Source: CCF analysis of Census Bureau, Current Population Survey, March Supplement, 1998 and 2004, Weighted Data.

South Carolina suffers from a high prevalence of infant deaths, particularly among African-American infants during their first year (**Figure 6-2**).

**Figure 6-2**

One-Year Infant Mortality Rates (1991-2002) – S.C. and U.S.



Source: DHEC, Mother and Child Health Report.

Despite a poor showing in some areas for the State’s children, South Carolina has experienced progress:<sup>67</sup>

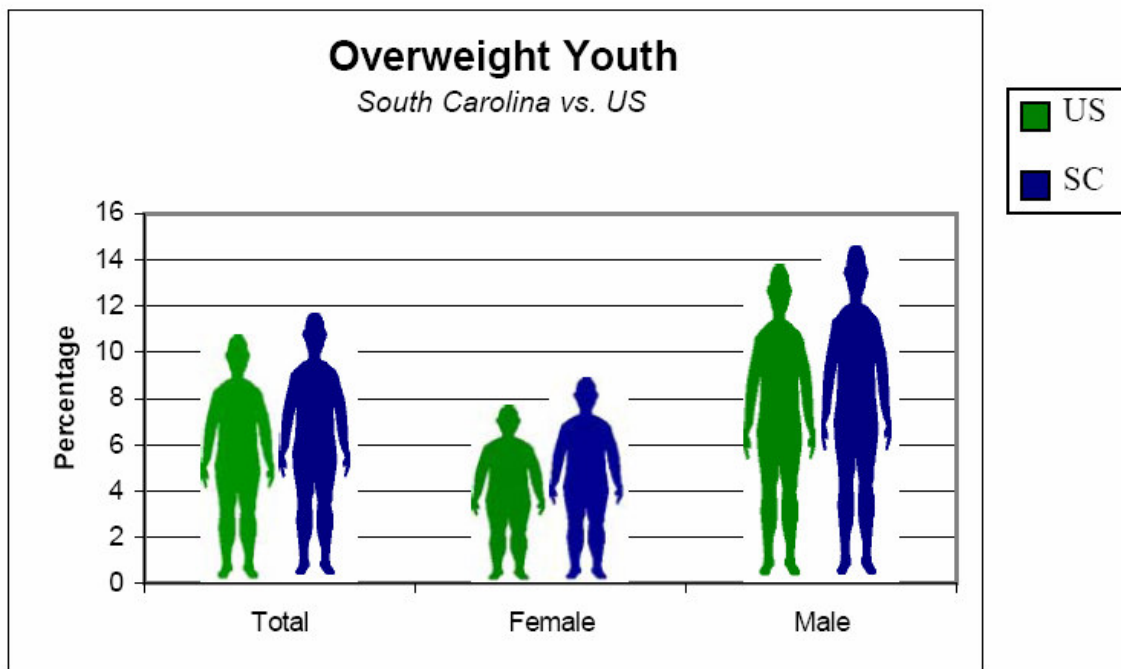
- Birth rate to mothers under age 18 declined from 7.21 per 100 live births in 1995 to 4.64 in 2002.
- Teen pregnancy rate among age 10-14 females declined from 2.02 per 1,000 in 2000 to 1.57 in 2002.
- Teen pregnancy rate among age 15-17 females declined from 43.20 per 1,000 in 2000 to 38.20 in 2002.
- Percent of mothers who received adequate prenatal care according to the Kotelchuck Index<sup>j</sup> increased from 72.46 in 2000 to 75.58 in 2002.
- Rate of live births occurring to unmarried women 18-19 years old declined from 547.8 per 1,000 in 1998 to 505.3 in 2002.

<sup>j</sup> Although it does not measure the quality of prenatal care, the Kotelchuck measure, also called the Adequacy of Prenatal Care Utilization Index, is an index of adequacy of prenatal care based upon time prenatal care began, number of prenatal visits, and gestational age of infant at birth.

- Congenital malformation rate (such as spinal bifida, heart malformation, and Down’s Syndrome) dropped from 23.84 per 1,000 live births in 1995 to 17.56 in 2002, subject to some fluctuations.

One issue of growing national and state concern is obesity. Obesity, and its health-related problems, is on the rise, and children living in South Carolina – approximately 1 in 5 – are becoming more overweight with each passing year.<sup>k</sup> In 2002, 26% of low-income children ages 2-5 were considered overweight or at risk of becoming overweight.<sup>68</sup> Approximately 15% of high-school-age African-Americans are overweight. Obesity is linked to an increase in high blood pressure, diabetes, and other chronic conditions, as well as to rising health care costs. It is estimated that obesity costs the nation approximately \$75 billion in health care costs, with \$1 billion of that occurring in South Carolina.<sup>69</sup>

**Figure 6-3**



Source: SCNRC, PALMETTO Obesity Project.

<sup>k</sup> In 2004, the South Carolina Coalition for Obesity Prevention Efforts, made up of business, community, health care institutions, schools, and other groups, was created to develop a state plan to address obesity prevention and control.

Behaviors displayed by South Carolina's children that are characteristic in contributing to overweight and obesity include, for example:

- Less than 1/5 of adolescents reported eating the recommended 5-9 servings of daily fruits and vegetables.
- By age 14, 32% of girls and 52% of boys are consuming 3 or more sugared soft drinks daily. Each 12 ounce sugared soft drink is associated with a 60% increase in risk of obesity.
- Two out of five adolescents do not meet recommended standards for physical activity – 10% higher than the national average – with approximately 47% of young African-Americans and 46% of young females failing to meet the recommended standards.
- South Carolina mothers rank 43<sup>rd</sup> in the nation in breastfeeding rates (shown to reduce risk of obesity).

## Conclusion

Health care is rapidly becoming a critical component in the cost of doing business. Therefore, it is time to explore and engage *comprehensively* our health care framework so as to further our goal of increasing the State's competitiveness and raising per capita income. Medicaid costs and an increasing uninsured population are having a tremendous effect upon the ability of the State to compete for new businesses, sustain existing companies, and provide a better quality of healthcare to all of its citizens. Sometime during the health care debate of the early 1990's, an oft-cited statistic declared that the price of every automobile produced on the lines in Detroit included \$500-\$700 in health care costs. Given that more money is spent on health care today than a decade ago, that same car now costs even more, leaving less money to spend on other items. Moreover, as public health budgets rise, less money is left over to invest in education, venture capital, or infrastructure.

Both a higher rate of insureds and low health care costs are directly, and strongly, linked to a robust and resilient competitive environment. Uninsurance and high health care costs are shouldered upon those who pay privately, leading to increased premium rates. A leading expenditure is Medicaid and, although South Carolina has not experienced a reported shortfall in funding Medicaid expenditures, an anticipated deficit may nevertheless be on the horizon given the aging of the population and possible

revenue shortcomings. Moreover, the economic effects of the new Medicare Part D prescription program (and the resulting “clawback,” or partial state reimbursement) create fiscal uncertainty and states should begin to address the idea of health care reform.

In response to increased costs, some employers have reduced benefits so as to maintain the same level of spending from the previous year. Alternatively, some employers are taking the initiative to implement cost-saving measures. For instance, Mid-Carolina Steel & Recycling Co., a South Carolina company, recently entered into an agreement with private, community-based, non-profit health centers in which the centers will provide preventative and primary care (more comprehensive services available in certain locations) to its approximately 25 employees and their families on a sliding fee scale based upon family income.

Alternative approaches allow an opportunity to offer health coverage to employees that, otherwise, may not have been economically feasible. As costs have increased, the percentage of U.S. firms offering benefits to their employees has decreased – from 69% in 2000 to 60% in 2005.

Higher costs lead to numerous negative consequences. Costs shift to employees in the form of fewer rewards, lower wages, higher out-of-pocket expenses, and reduced benefit plans. Employers experience lower profits and less available capital. Consumers pay higher product prices. Ultimately, our ability to compete suffers.

Some states, already faced with Medicaid shortfalls and a growing uninsured population, are aggressively approaching the issue of overhaul of their health care systems. For instance, New York recently implemented its “Healthy New York” program, which is designed to encourage small businesses to purchase reduced cost coverage for their employees by, among other things, allowing employers a 100% deduction of premiums paid on behalf of employees and permitting employees to pay their share with pre-tax dollars. Governors in Florida, Georgia, Massachusetts, and Vermont are considering consumer-driven Medicaid proposals such as the one submitted by Governor Sanford. Massachusetts is also working to sign up more Medicaid eligibles who remain unenrolled. In addition, it is currently devising “Commonwealth Care,” which will offer new care options for more than 200,000 uninsured, working individuals who earn over 300% of the federal poverty level but are unable to afford monthly premiums. The cost to the employee would be no more than \$200 per month. This monthly amount would actually amount to less if the provision to allow for payment with pre-tax dollars is approved. The State is also reviewing a provision that would target working poor by subsidizing the premiums on behalf of those who earn up to 200% of the poverty level.

The American Medical Association has also referred to the possibility of offering tax subsidies to employees whose employers do not offer coverage, and noted that uninsured low-income workers often contribute (through taxation) to the insurability of

others and, because of a regressive tax structure, spend more on health care for others than for their own families.

To increase Medicaid program revenue, states are looking to allocate tobacco settlement funds (see **Appendix J**), increase beneficiary payments, raise the cigarette tax, and manipulate upper provider payment limits so as to maximize the federal match.

Any successful reform will only come about through the efforts of the private sector, as evidenced by images of the *Harry and Louise* ads that defeated former President Clinton's health care plan. Failure to engage these issues may work at cross-purposes with the goal of fostering competitiveness. Denial of care to potential beneficiaries will likely increase avoidable, costly emergency room visits and lead to cost-shifting as more people become uninsured. Costs will pass to consumers and employers in the private insurance market, resulting in a more costly and less efficient market, as well as poorer health outcomes for our disadvantaged. Of course, as health conditions decrease, more care is sought, creating a circular impasse that could go on indefinitely.

**APPENDIX A**  
**Per Capita Public Health Spending (2001)**

Rank (1-50)	State	\$ per person
1	Alaska	\$716
1	Minnesota	\$187
1	Texas	\$162
4	Arizona	\$128
5	Hawaii	\$124
6	Delaware	\$118
7	New Hampshire	\$106
8	Pennsylvania	\$98
9	New York	\$92
<b>10</b>	<b>South Carolina</b>	<b>\$88</b>
10	Wisconsin	\$88
12	Illinois	\$83
13	North Dakota	\$80
14	Massachusetts	\$78
15	Missouri	\$76
16	Nebraska	\$74
16	Oklahoma	\$74
18	Rhode Island	\$72
19	Montana	\$69
20	Alabama	\$67
21	Florida	\$66
22	Maryland	\$61
23	Vermont	\$60
24	Michigan	\$59
25	Arkansas	\$57
26	Kentucky	\$44
27	West Virginia	\$43
28	Tennessee	\$40
29	South Dakota	\$39
30	Indiana	\$36
31	Maine	\$34
32	Nevada	\$34
33	Ohio	\$33
34	Mississippi	\$30
35	Kansas	\$26
36	Colorado	\$24
36	New Mexico	\$24
38	Wyoming	\$23
39	Washington	\$22
40	Louisiana	\$22
41	California	\$21
42	Virginia	\$20
43	Oregon	\$19
43	Utah	\$19
45	Connecticut	\$18
46	Iowa	\$16
47	Idaho	\$14
48	New Jersey	\$14
48	North Carolina	\$14
50	Georgia	\$7
<b>United States</b>		<b>\$59</b>

## APPENDIX B

### State Health Rankings (2004) – S.C.

Rankings			S.C. Risk Factors/Outcomes	Measurement Data		
2004	2003	1990		2004	2003	1990
41	42	8	Smoking (% of population)	25.5	26.6	27.1
41	47	43	Vehicle Deaths (per 100 million miles driven)	2.0	2.2	3.1
38	48	43	Obesity (% of population)	24.5	25.8	13.6
28	21	28	Percent with No Health Insurance	14.4	12.5	12.8
42	39	33	Infectious Diseases (cases per 100,000 population)	29.2	28.8	36.7
12	9	-	% of Health Dollars for Public Health (% of health exp.)	8.0	8.0	-
11	6	-	Per cap. Public Health Spending (\$ per person)	\$88	\$78	-
37	33	49	Adequacy of Prenatal Care (% of pregnant women)	72.3	73.2	56.7
42	44	43	Limited Activity Days (days in last 30 dys)	2.4	2.3	5.6*
36	37	47	Cardiovascular Deaths (deaths per 100,000 population)	349.5	363.5	441.4
28	25	13	Cancer Deaths (deaths per 100,000 population)	205.9	205.1	189.4
38	38	40	Total Mortality (deaths per 100,000 population)	922.0	929.9	921.0
46	45	49	Infant Mortality (deaths per 1,000 live births)	8.8	8.8	13.0
47	47	49	Premature Deaths (years lost per 100,000 population)	9,479	9,597	10,599
<b>47</b>	<b>48</b>	<b>36</b>	<b>Overall</b>	<b>-12.9</b>	<b>-15.3</b>	<b>-6.2</b>

Source: UHF, State Health Rankings (2004).

## APPENDIX C

### Personal Health Care Expenditures as a Percent of Gross State Product – Selected Areas

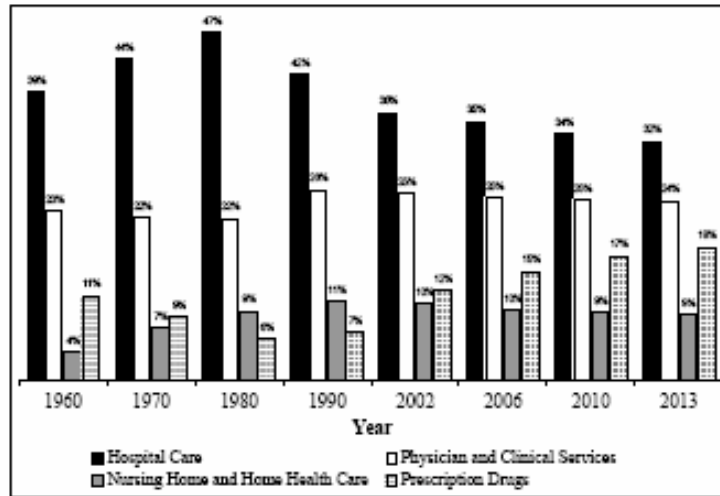
	S.C.	N.C.	G.A.	U.S.
1980	7.5%	7.1%	8.1%	7.9%
1981	7.8%	7.3%	8.2%	8.1%
1982	8.2%	7.8%	8.7%	8.7%
1983	8.4%	7.7%	8.7%	8.9%
1984	8.2%	7.7%	8.5%	8.7%
1985	8.4%	7.4%	8.6%	9.0%
1986	8.6%	7.7%	8.8%	9.3%
1987	8.8%	8.1%	9.2%	9.5%
1988	9.0%	8.5%	9.6%	9.7%
1989	9.5%	9.0%	10.3%	10.1%
1990	10.4%	9.8%	11.0%	10.7%
1991	11.2%	10.5%	11.7%	11.5%
1992	11.8%	10.7%	11.8%	11.8%
1993	12.1%	11.1%	12.0%	12.0%
1994	12.2%	11.2%	11.5%	11.9%
1995	12.2%	11.4%	11.5%	12.0%
1996	12.4%	11.8%	11.3%	11.9%
1997	12.9%	11.7%	11.1%	11.7%
1998	12.4%	11.1%	10.6%	11.6%
1999	12.6%	11.2%	10.3%	11.6%
2000	13.2%	11.4%	10.7%	11.7%

Source: CMS, Office of the Actuary, National Health Statistics Group.

Note: Gross State Product, U.S. Bureau of Economic Analysis, 2004. Gross State Product equals sum of Gross State Product in all States.

## APPENDIX D

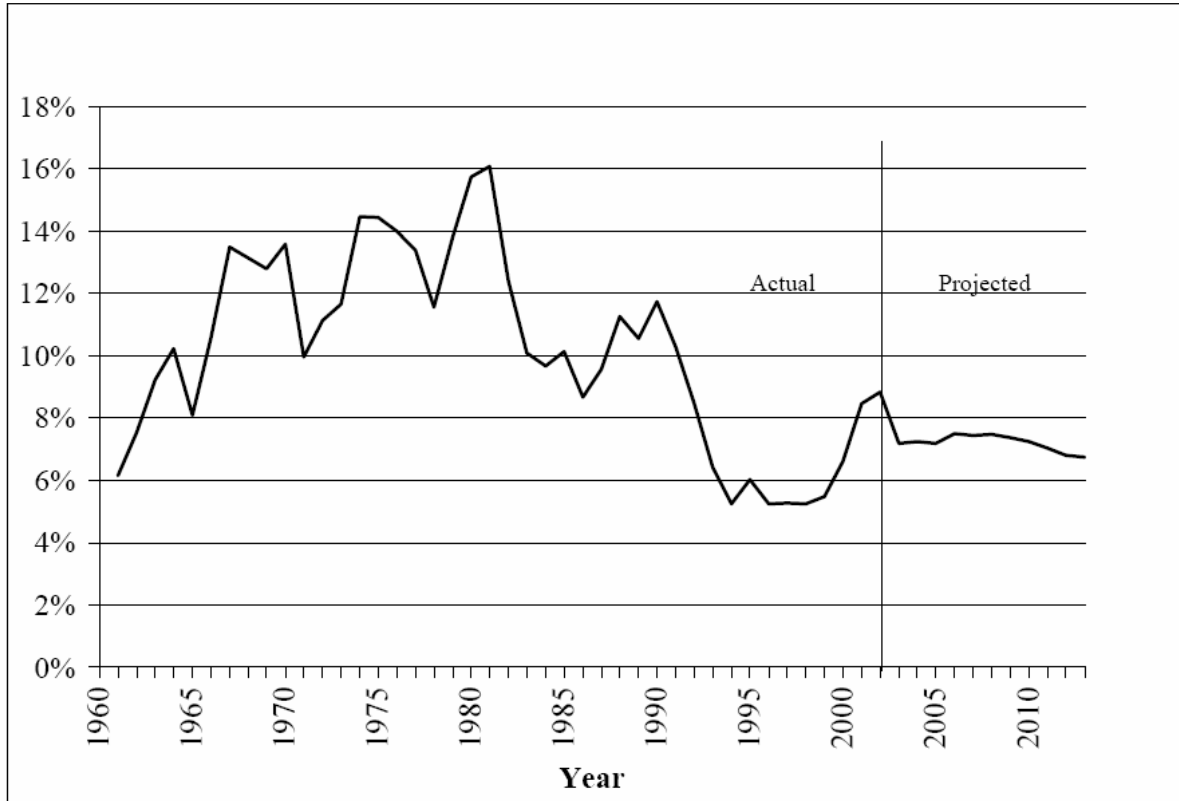
### Major Categories of Personal Health Care Spending as a Percent of Total Personal Health Expenditures – U.S.



Source: CRS, Health Care Spending.

## APPENDIX E

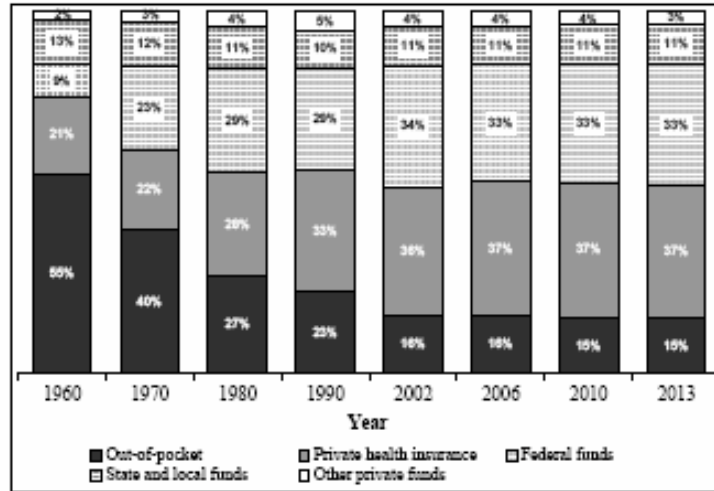
### Growth in Nominal Personal Health Care Expenditures – U.S.



Source: CRS, Health Care Spending.

## APPENDIX F

### Source of Payment for Personal Health Care as a Percent Of Total Personal Health Care Expenditures – U.S.



Source: CRS, Health Care Spending.

## APPENDIX G

### **Distribution of S.C. General Fund Expenditures (dollar amount in millions): SFY 2003**

	SC \$	SC %	US \$	US %
Elementary & Secondary	1,795	35.8	177,292	35.5
Higher Education	802	16.0	60,547	12.1
Public Assistance	27	0.5	11,067	2.2
Medicaid	455	9.1	82,322	16.5
Corrections	370	7.4	35,087	7.0
Transportation	0	0	3,009	0.6
All Other	1,560	31.1	130,103	26.1
Total	5,009	100.0	499,425	100.0

Sources: National Association of State Budget Officers, 2003 State Expenditure Report, Tables 1 (All expenditures), Table 7 (Elementary and Secondary Education), Table 12 (Higher Education), Table 18 (Public Assistance), Table 28 (Medicaid), Table 32 (Corrections), Table 38 (Transportation), Table 43 (All Other), *available at* <http://www.nasbo.org/Publications/PDFs/2003ExpendReport.pdf> ["NASBO, 2003 State Expenditure Report"]. Figures may not sum to totals due to rounding. Data represent General Fund expenditures, with fiscal year beginning on July 1 and ending on June 30.

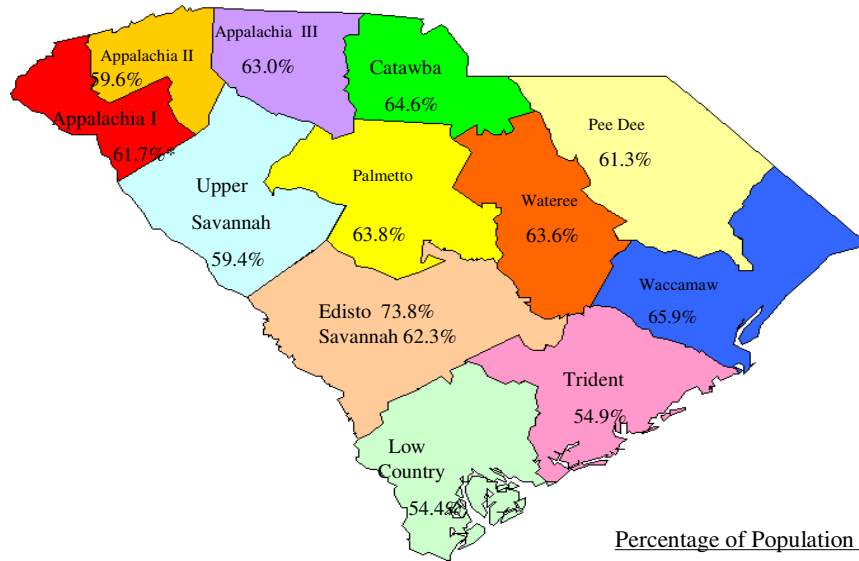
## APPENDIX H

### SFY 2002-2003 County Medicaid Expenditures<sup>70</sup>

<u>COUNTY</u>	<u>PROVIDER EXPENDITURES</u>	<u>COUNTY</u>	<u>RECIPIENT EXPENDITURES</u>
RICHLAND	713,358,107	RICHLAND	265,779,707
CHARLESTON	409,870,093	GREENVILLE	244,524,509
GREENVILLE	358,626,925	CHARLESTON	220,258,345
FLORENCE	203,309,694	SPARTANBURG	165,971,849
SPARTANBURG	186,606,868	FLORENCE	138,001,353
LEXINGTON	128,923,805	LEXINGTON	124,312,996
ANDERSON	123,374,311	HORRY	124,197,851
HORRY	115,779,103	ANDERSON	111,783,811
ORANGEBURG	87,930,216	AIKEN	104,986,488
YORK	84,340,090	YORK	95,797,545
AIKEN	81,411,803	ORANGEBURG	93,545,821
SUMTER	74,919,871	LAURENS	88,696,175
LAURENS	69,082,823	SUMTER	85,708,355
GREENWOOD	66,309,958	BERKELEY	81,804,871
DARLINGTON	62,779,850	DORCHESTER	79,176,408
DORCHESTER	51,731,784	DARLINGTON	72,650,563
BEAUFORT	51,491,310	PICKENS	59,166,298
GEORGETOWN	51,005,386	LANCASTER	51,128,925
PICKENS	46,309,352	BEAUFORT	48,699,730
LANCASTER	39,382,636	GEORGETOWN	48,472,845
MARION	36,749,238	MARION	47,334,697
BERKELEY	35,303,001	OCONEE	45,315,521
COLLETON	33,564,973	GREENWOOD	45,157,029
OCONEE	33,192,470	CHESTERFIELD	44,178,494
CLARENDON	32,840,944	WILLIAMSBURG	41,458,838
KERSHAW	28,596,692	COLLETON	41,453,525
CHEROKEE	26,460,948	CLARENDON	41,250,185
CHESTERFIELD	26,077,285	CHEROKEE	38,235,578
DILLON	21,338,881	DILLON	37,090,507
WILLIAMSBURG	21,332,667	KERSHAW	35,607,364
NEWBERRY	20,305,196	NEWBERRY	31,763,728
CHESTER	20,202,848	CHESTER	30,233,650
MARLBORO	20,126,644	MARLBORO	29,910,775
UNION	19,837,372	UNION	27,885,710
BARNWELL	19,658,608	LEE	27,631,567
BAMBERG	16,686,971	FAIRFIELD	27,403,831
FAIRFIELD	14,396,876	BARNWELL	27,253,178
HAMPTON	12,400,714	HAMPTON	19,598,271
LEE	11,031,218	BAMBERG	18,953,820
JASPER	10,125,039	ABBEVILLE	18,440,091
ALLENDALE	9,245,255	JASPER	17,048,668
ABBEVILLE	9,232,605	CALHOUN	16,306,791
SALUDA	8,261,492	EDGEFIELD	15,717,127
CALHOUN	8,162,422	SALUDA	14,745,301
EDGEFIELD	7,668,477	ALLENDALE	14,582,078
MCCORMICK	6,105,754	MCCORMICK	8,767,102
GEORGIA	46,577,539	GEORGIA	0
NORTH CAROLINA	30,995,913	NORTH CAROLINA	0
OTHER NON-SC	97,486,762	OTHER NON-SC	0
ADJUSTMENT	61,281,344	ADJUSTMENT	683,802,265
<b>ALL COUNTIES</b>	<b>3,751,790,135</b>	<b>ALL COUNTIES</b>	<b>3,751,790,135</b>

**APPENDIX I**

**Percentage of Population Overweight/Obese by Health District**



Percentage of Population Overweight/Obese

\*South Carolina (Statewide) = 61.4%

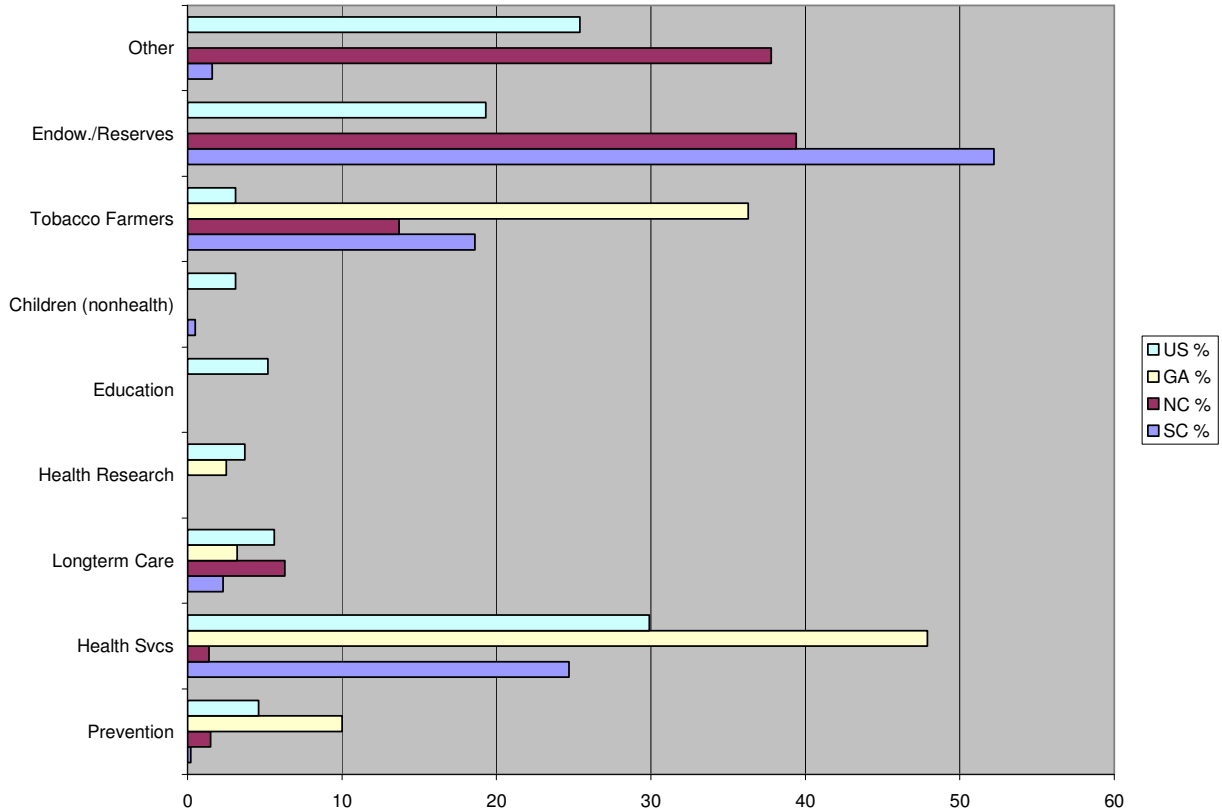
\*United States (Nationwide) = 59.2%

Source: SCNRC, PALMETTO Obesity Project.

Notes: Based on 2002 data; “obese” defined as BMI of 30 or >; “overweight” defined as BMI of 25-29.9.

## APPENDIX J

### Allocation of Tobacco Settlement Funds, Cumulative Total, SFY2000 through SFY2004



Source: Kaiser Tobacco Settlement Funds, available at <http://www.statehealthfacts.org>.

## ENDNOTES

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<sup>1</sup> UNITED HEALTH FOUNDATION, AMERICA'S HEALTH: STATE HEALTH RANKINGS (2004 EDITION), available at <http://www.unitedhealthfoundation.org> (follow "resources" hyperlink; then follow "state health rankings") (last visited Aug. 4, 2005) [hereinafter "UHF, State Health Rankings (2004)"].

<sup>2</sup> National Institute of Neurological Disorders and Stroke, available at <http://www.ninds.nih.gov/disorders/stroke>.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> UHF, State Health Rankings (2004), *supra* note 1.

<sup>6</sup> Milken Institute, America's Health Care Economy (Aug. 2003). This study examined more than 300 metropolitan areas, as well as all 50 states, to quantify the impact of the health care sector on regional, state, and U.S. economies. The researchers examined employment in 13 health care industries, including drugs, hospitals, medical supplies, health insurance, and medical research.

<sup>7</sup> Centers for Medicare and Medicaid Services ("CMS"), Office of the Actuary, National Health Statistics Group; U.S. Bureau of Economic Analysis, Gross State Product, 2004. U.S. Gross State Product equals sum of Gross State Product in all states.

<sup>8</sup> The Henry J. Kaiser Family Foundation ("Kaiser"), Distribution of State General Fund Expenditures, SFY 2003, available at <http://www.statehealthfacts.org>.

<sup>9</sup> CMS, Health Care and the U.S. Economy, available at <http://www.cms.hhs.gov/charts/healthcaresystem>.

<sup>10</sup> *Id.*

<sup>11</sup> World Health Organization, The World Health Report 2005, at 192 tbl.5, available at <http://www.who.int/shr/en> [hereinafter "WHO Health Report, 2005"]. Figures were computed by WHO to assure comparability and do not necessarily represent the official statistics reported by individual nations.

<sup>12</sup> The Library of Congress, Congressional Research Service, Health Care Spending: Past Trends and Projections (updated Apr. 8, 2004), Paulette C. Morgan, RL 31094 [hereinafter "CRS, Health Care Spending"].

<sup>13</sup> Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, State Health Expenditure Accounts 2005, available at <http://www.cms.hhs.gov/statistics/nhe/#state> [hereinafter "CMS, State Health Expenditures Accounts"]. State Health Expenditure (SHE) Accounts measure spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of provider. Costs such as insurance program administration, research, and construction expenses are not included in this total. Per capita health spending estimates cannot be directly constructed from state-of-provider spending. State-of-provider estimates reflect spending for services delivered in that state to residents and nonresidents, while the population estimates used to construct per capita estimates are based on residency.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> National Governors Association, National Association of State Budget Officers, The Fiscal Survey of States (June 2005), at 42 tbl.A-11 [hereinafter "NASBO, 2005 Fiscal Survey"].

<sup>17</sup> Note: Figures may not sum to totals due to rounding. State Health Expenditure Accounts measure spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of provider. Costs such as insurance program administration, research, and construction expenses are not included in this total.

<sup>18</sup> Centers for Disease Control, National Center for Health Statistics, Health Expenditures, available at <http://www.cdc.gov/nchs/fastats>.

<sup>19</sup> *Id.*

<sup>20</sup> CMS, State Health Expenditure Accounts, *supra* note 15.

<sup>21</sup> Centers for Disease Control, National Center for Health Statistics, Health, United States, 2004, available at <http://www.cdc.gov/nchs/hus.htm>.

<sup>22</sup> Kaiser, Health Costs and Budget, Prescription Drugs, available at <http://www.statehealthfacts.org> [hereinafter "Kaiser, Prescription Drug Costs"]. Calendar year 2003 data are based on Vector One<sup>(TM)</sup>:National by Verispan,

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L.L.C., which collects data from a panel of retail pharmacies, third party payers, and data providers. Retail pharmacies include independent pharmacies, chain pharmacies, food stores, and mass merchandisers found in 814 defined regional zones. These data describe the number of prescriptions filled by retail pharmacies only and exclude those filled by mail order.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> The chart is derived from the U.S. Census Bureau's Current Population Survey, a self-reporting instrument, and compares the insurance status of South Carolina with North Carolina and Georgia and with the nation generally. However, please note that national statistics are inconsistent at times with information maintained by the differing state agencies.

<sup>26</sup> Kaiser, Employee Health Benefits, 2004 Annual Survey, available at <http://www.kff.org/insurance> [hereinafter "Kaiser, 2004 Health Benefits Survey"].

<sup>27</sup> *Id.*

<sup>28</sup> Kaiser, Employer Health Benefits, 2005 Annual Survey, available at <http://www.kff.org/insurance> [hereinafter "Kaiser 2005 Health Benefits Survey"].

<sup>29</sup> Kaiser, Health Costs and Budgets, Employment-Based Health Premiums, available at <http://www.statehealthfacts.org> [hereinafter "Kaiser, Employment Health Premiums"].

<sup>30</sup> Kaiser, 2005 Health Benefits Survey, *supra* note 28.

<sup>31</sup> Kaiser, Employment Health Premiums, *supra* note 29.

<sup>32</sup> Centers for Medicare and Medicaid Services ("CMS"), Office of the Actuary, National Health Statistics Group, available at <http://www.cms.hhs.org>.

<sup>33</sup> South Carolina Department of Health and Human Services, South Carolina Medicaid: Annual Report for State Fiscal Year 2004 (Mar. 2005) [hereinafter "SCDHHS, 2004 Medicaid Annual Report"].

<sup>34</sup> *Id.*

<sup>35</sup> Kaiser, State Fiscal Conditions and Medicaid, Release November 2003; CMS, National Healthcare Expenditure Annual Projections (does not include Disproportionate Share payments).

<sup>36</sup> South Carolina Budget and Control Board, Office of Economic Research, The South Carolina Medicaid Study, 2003 Update at iii [hereinafter "S.C. Medicaid Study, 2003 Update"].

<sup>37</sup> Urban Institute estimates for the Kaiser Commission on Medicaid and the Uninsured, based on Form 64 from The Centers for Medicare and Medicaid Services, 2004. All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about \$275.5 billion in FY 2003.

<sup>38</sup> S.C. Medicaid Study, 2003 Update, *supra* note 36.

<sup>39</sup> MMIS Medicaid Expenditures by County Report - SFY 2003; MMIS CCA8500 Report - SFY2002 [hereinafter "MMIS County Medicaid Expenditures"].

<sup>40</sup> SCDHHS, 2004 Medicaid Annual Report, *supra* note 33, at 9.

<sup>41</sup> S.C. Medicaid Study, 2003 Update, *supra* note 36, at ii.

<sup>42</sup> See Kaiser, 2004 Health Benefits Survey, *supra* note 26; Kaiser, 2005 Health Benefits Survey, *supra* note 28.

<sup>43</sup> S.C. Medicaid Study, 2003 Update, *supra* note 36, at vii.

<sup>44</sup> Kaiser, The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005. Results from a 50-State Survey, Appendix B. Kaiser Commission on Medicaid and the Uninsured, October 2004, available at <http://www.kff.org/medicaid/7190.cfm>.

<sup>45</sup> The South Carolina Department of Health and Human Services, South Carolina Medicaid Choice: An 1115 Demonstration Waiver Proposal.

<sup>46</sup> *The State*, S.C. Proposes Major Cuts in Medicaid Benefits for Poor, Jul. 24, 2005.

<sup>47</sup> *The State*, Think Tanks Blast S.C. Medicaid Plan, Aug. 10, 2005.

<sup>48</sup> See, e.g., Families USA, Health Care: Are You Better Off Today Than You Were Four Years Ago? (Sept. 2004), No. C4-04-100, available at <http://www.familiesusa.org/site/DocServer?docID=4601>.

<sup>49</sup> National Coalition on Health Care, Facts About Health Insurance, Health Insurance Coverage, available at <http://www.nchc.org>.

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<sup>50</sup> South Carolina Department of Insurance, State Planning Grant Staff, Expanding Insurance Coverage and Stabilizing Rates within the South Carolina Small Group Market: Final Report to the Secretary, United States Department of Health and Human Services (Sept. 30, 2004) [hereinafter “SCDOI, Health Grant”]. The grant looked at South Carolina-specific data on the uninsured and was designed to identify the working uninsured and suggest policy decisions to expand coverage to individuals and small businesses. Generally, the study employed a more broad definition of “uninsured”: an individual is considered uninsured if currently uninsured or had been at any time during the previous 12 months.

<sup>51</sup> U.S. Census Bureau, Census 2000, *available at* <http://www.census.gov>.

<sup>52</sup> SCDOI, Health Grant, *supra* note 50, at 10.

<sup>53</sup> Kaiser, The Uninsured: A Primer, Key Facts about Americans without Health Insurance, 2004 (Nov. 10, 2004), *available at* <http://www.kff.org/uninsured>; *see also* SCDOI, Health Grant, *supra* note 50, at 3.

<sup>54</sup> SCDOI, Health Grant, *supra* note 50, at 3.

<sup>55</sup> *Id.* at 16.

<sup>56</sup> *Id.* at 5.

<sup>57</sup> SCDOI, Health Grant, *supra* note 50.

<sup>58</sup> *Id.* at 3.

<sup>59</sup> *Id.*

<sup>60</sup> *See, e.g.*, Michael Chernew, David Cutler, and Patricia Seliger Kennan, Rising Health Care Costs and the Decline in Insurance Coverage, *Economic Research Initiative on the Uninsured*, ERIU Working Paper No. 8 (Draft), September 2002, *available at* <http://www.umich.edu/~eriu/pdf/wp8.pdf>.

<sup>61</sup> SCDOI, Health Grant, *supra* note 50.

<sup>62</sup> UHF, State Health Rankings (2004), *supra* note 1.

<sup>63</sup> *Id.*

<sup>64</sup> SCDOI, Health Grant, *supra* note 50.

<sup>65</sup> *Id.*

<sup>66</sup> South Carolina Department of Health and Environmental Control, South Carolina Mother and Child Health Data Book (2004), *available at* <http://www.scdhec.net/co/phsis/biostatistics/> [hereinafter “DHEC, Mother and Child Health Report”].

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> South Carolina Nutritional Research Consortium, Pediatric and Adolescent Long-term Monitoring and Evaluation to Track Obesity (PALMETTO) Project, *available at* <http://www.scnrc.org/palmetto.shtml> [hereinafter SCNRC, PALMETTO Obesity Project”].

<sup>70</sup> MMIS County Medicaid Expenditures, *supra* note 39. Provider Expenditures refers to the county of the provider. Recipient Expenditures refers to the county of the recipient. Provider Expenditures include gross adjustments. Recipient Expenditures do not include adjustments or transportation.