

Health Care for the Medically Indigent of South Carolina: Final Report

Duke University

Center for Health Policy, Law and Management

December 1998

Supported by:



South Carolina Health Alliance

With Funding From:

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Hester Haverkamp Davies

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Preface

The research summarized in this report was performed as part of an update of a 1992 study. This updated study was begun in October 1997 and completed in December 1998. Two documents have been produced as part of this study; this *Final Report* and a companion summary titled *What South Carolina Policymakers Need to Know About Health Care for the Medically Indigent*.

This report provides the analytic summary of study findings, with more detailed data and an explanation of data sources and methodology included in unpublished *Appendix* tables available from the authors. As with the earlier report, we have been able to improve the quality of the estimates provided in this report by relying more extensively on South Carolina-specific data. Therefore, we believe that the results reported here are even more accurate than those in prior reports.

We have included a *County Profiles Appendix*, which provide county-level estimates of demographic, economic,

education and employment characteristics of the population, the distribution of employment by major industry and firm size, the number of uninsured by age, sources of health insurance coverage, the size of the medically indigent population, and access to physician and hospital care.

This final report has five major sections. The first is a brief introduction. The second summarizes the number and characteristics of the medically indigent, including a discussion of how South Carolina compares to other states and some projections of future trends. The third section assesses barriers to access for the medically indigent, including a review of their health status and current barriers to access. The fourth section reviews the financial burden posed by the medically indigent, including a discussion of the size of that financial burden, how it is financed in the current system and how the burden is distributed across institutions and individuals in the state. The final section summarizes alternative approaches to financing care for the medically indigent.

Summary

This report summarizes the major findings of this updated study of health care for the medically indigent of South Carolina. The medically indigent are those who cannot obtain adequate health care at an affordable cost.

For purposes of analysis, the medically indigent/"at risk" population includes all persons who either cannot pay for some or all of their health needs out of their own resources (i.e., those on Medicaid), along with those who are "at risk" of becoming medically indigent, namely those who are uninsured or underinsured.

NUMBER AND CHARACTERISTICS OF THE MEDICALLY INDIGENT

The key empirical findings related to the size of the medically indigent/"at risk" population are as follows:

- The problem is very large: South Carolina has more than 1.4 million people who are "at risk" of becoming medically indigent. The uninsured and underinsured make up nearly 40 percent of the state's population. Across counties, this medically indigent/"at risk" share ranges from less than one third to more than one half of residents.
- The problem is concentrated among those with the lowest incomes: nearly three fifths of those "at risk" have incomes below 200 percent of poverty.

On an average day, nearly 200,000 have incomes below poverty and are completely without health insurance.

- The problem is not restricted to the uninsured: nearly 60 percent of those "at risk" have no insurance, while the remainder have inadequate insurance.
- South Carolina's overall uninsured problem is similar to that of other states in the region or nation, but the problem of lack of insurance among the poor appears to be worse.
- The medically indigent are disproportionately young, female and black. A large fraction are single adults or children in one parent families. They are concentrated in the southeastern portions of the state--in counties with the highest poverty and unemployment rates.

This problem is large principally because of strict Medicaid eligibility standards and because many employers do not offer health insurance coverage to workers or their dependents.

- Medicaid covers less than half of South Carolina's poor each year, partly because of state eligibility restrictions, but also because federal eligibility rules make nearly one eighth of the poor ineligible even if they have no income.

- Many of those "at risk" have potential access to insurance coverage through an employer: five-sixths of the uninsured live in families headed by full- or part-time workers.
- Uninsured workers tend to earn low wages and are concentrated in retail industries, construction, services and manufacturing.
- Small firms (25 or fewer employees) account for more than half of the working uninsured, with nearly two fifths of such workers employed by firms that currently do not offer a health plan.
- Conversely, among uninsured workers in large firms, more than five sixths work for an employer already offering a health plan, but such workers are not eligible because they are new on the job or are part-time/seasonal workers.

The size of the medically indigent population has grown during the decade and is expected to continue growing in the decade ahead even without any changes in the state's economic climate.

- Between 1990 and 1996, the risk of being uninsured in South Carolina rose by one fifth--a higher rate of growth than in the region or nation.

Barriers to Access for the Medically Indigent

In general, this study found that the medically indigent/"at risk" are in greater need of health care than those in the general

population. But due to a variety of barriers to access--most of which are self-imposed--they receive fewer services than those with adequate insurance.

- The medically indigent "at risk" are in worse health than the general population--regardless of how health is measured.
- The uninsured are much more likely than the insured to defer needed preventive care.
- Lack of access to care also results in worse health for the medically indigent. Because uninsured patients are more likely to die compared to those with private coverage, *roughly 500 South Carolina residents die every year because they are uninsured.*
- The poor health status of the medically indigent may have adverse implications for the state's ability to compete for economic development since South Carolina ranks next to last in the region on overall health.

The study also examined barriers to access for both ambulatory and hospital care.

- Access to ambulatory care depends heavily on county of residence. The number of medically indigent/"at risk" per primary care physician ranges from 444 to more than 6,300 across counties.
- Indigent patients appear to be less likely than those with insurance to seek

hospital care outside their own county. It is unclear whether this means they have good access to care within their own counties or whether it implies they have lower access to secondary and tertiary care outside their own counties.

Financial Burden of the Medically Indigent

The study also examined the financial burden of paying for indigent care and how it is distributed across individuals and institutions in South Carolina.

- In 1996, \$2.4 billion was spent on health care for those who cannot fully afford to pay for it themselves.
- This includes more than \$965 million for Medicaid (excluding long term care), more than \$500 million for public medical programs, and roughly \$450 million for hospital free care and nearly the identical amount in free care from physicians and other providers.
- Of the \$447 million in economic losses experienced by hospitals, less than \$125 million was offset through state and county tax appropriations or other revenues. The balance was covered through revenue surpluses earned from patients paying more than their own share of expenses.
- In South Carolina, the ratio of private patient payments to the costs of their hospital care is higher than in any other state in the country.

- At the same time, the ratio of Medicaid payments to actual hospital costs for Medicaid patients is higher in South Carolina than in all but one other state. However, this payment advantage for South Carolina hospitals will soon disappear due to federal restrictions on disproportionate share payments. Once scheduled reductions in such payments have been phased in, hospital economic losses in the state will increase by more than one third even if there is no change in the number of medically indigent.
- The amount of free care given by physicians and other providers is nearly identical to the economic losses of hospitals in 1996, just as was true in 1986.

The study determined who receives the large amount of subsidized care now being provided in South Carolina.

- Nearly half of all subsidized care is provided to persons below poverty, while nearly one fifth is given to the near poor (between 100 and 200 percent of poverty). A typical poor person receives more than \$2,000 a year in subsidized health services.
- The uninsured account for less than one quarter of all subsidized care and the uninsured poor receive only one ninth of the total. This highlights the importance of addressing the problem of the underinsured, not just that of the uninsured.

- A typical uninsured poor person receives more than \$1,300 a year in subsidized care. If all of the uninsured poor obtained health insurance coverage (e.g., through employers), the potential savings to state and county government and providers would amount to \$265 million a year.

The burden of providing care for the medically indigent is very unevenly distributed.

- The federal government directly finances 42 percent of all indigent care in South Carolina, with an additional 9 percent exported to taxpayers outside of South Carolina. State government covers roughly 15 percent and private payers absorb nearly one third of the total.
- The extra amount paid by full-pay patients to cover uncompensated costs averages 37 percent of costs for such patients, but is much lower in hospitals that are large, publicly owned or are major teaching hospitals. This is because these latter facilities receive more tax appropriations; hence, the "sales tax" that is added to private full-pay patient bills is higher in non-profit facilities and for-profit hospitals than in public hospitals.
- The burden of paying for indigent care is very regressive: the share of income used to pay for indigent care is nearly four times as large for poor families compared to those with incomes over 400 percent of poverty.

Options for Financing Health Care for the Medically Indigent

It was not the purpose of the study to examine in detail options best suited to address the medically indigent problem in South Carolina. But the following broad conclusions can be drawn:

- Universal coverage cannot be achieved without making the purchase of coverage mandatory.
- South Carolina already has adopted many of the incremental insurance reforms used by states to expand coverage, including a high risk pool for the medically uninsurable, small group and individual market reforms and purchasing alliance for small businesses.
- Medicaid expansion offers the most cost-effective approach to expanded coverage since the state only has to cover 30 percent of the added cost for new Medicaid eligibles.

On balance, there is no simple or cheap solution to the problem of health care for the medically indigent, because it is much too complex. Universal coverage cannot be achieved if insurance remains voluntary unless the state is willing to provide extremely high subsidies to encourage certain groups to get coverage. Therefore, if universal coverage is the goal, a compulsory approach would be much less expensive.

The final phase of the study reviewed the various options for financing health care for the medically indigent.

- South Carolina invests a lower share of the state's personal income on state funding of Medicaid than all but two other states in the South Atlantic region. To eliminate the funding gap between South Carolina and the region, the state could afford to expand its Medicaid program by \$33 million (of which only \$10 million would come from state/local funds).
- If the state matched the regional average in terms of total state and local taxes per \$10,000 personal income, it could afford to spend an additional \$68 million on Medicaid. When matched with federal funds, this would allow an overall expansion of \$268 million.
- The current patchwork system of financing care for the medically indigent is unfair. In South Carolina, for example, hospital taxes are used to help pay for Medicaid and to cover hospital economic losses. The share of income that poor families must pay under such a hospital tax is nearly seven times as large as the share paid by families with incomes over 400 percent of poverty.
- Although it may be tempting to rely on a state lottery to finance indigent care, a lottery is nearly as unfair as a hospital tax and would result in a relative burden on poor families that is 12 times as large as that for families over 400 percent of poverty.

There is no simple, cheap or universal solution to the problem of the medically indigent. If the problem were not complex, it would have been solved long ago. Because of its size and complexity, the medically indigent problem cannot be solved either by the public sector or private sector working alone. A strategy which combines public and private sector cooperation can result in drastically reducing the size of the population "at risk." Therefore, a viable long term approach almost certainly will require a sustained partnership between the public and private sector in the years ahead.

A lot of people think this problem is so complicated that states should wait for federal action to deal with this problem. But the federal government attempted and failed to enact health care reform in 1994. It is unclear when Congress might be willing to take this up again. National health insurance has been debated for more than 75 years, so there is no reason to believe a consensus will be achieved soon. States cannot afford to sit on their hands waiting for federal action. States have served as very useful laboratories to test different approaches to this problem. South Carolina has the financial means to reduce its uninsured problem by up to 30 percent through a Medicaid expansion to cover all children. But whether the state will move in this direction depends critically on the importance attached to the medically indigent problem.

Acknowledgments

This study was co-authored by Christopher J. Conover and Hester Haverkamp Davies, but it could not have been performed without extensive cooperation and assistance from a variety of individuals. This study required extensive contacts with numerous state agencies and private organizations in South Carolina.

There is no way to list here everyone who gave their help, but special thanks are due to certain key individuals. These include Jim Head (South Carolina Health Alliance) for giving us access to 1996 AHA data on South Carolina hospitals. Barbara Longshore (Health and Human Services Finance Commission) was helpful in supplying Medicaid data as needed. James Deaton and Matt Petrofes (Department of Health and Environmental Control) were especially helpful in pulling together information on program activity and expenditures in each of DHEC's major programs. Marianne Melton of the South Carolina Department of Health and Human Services provided useful information on the state's hospital tax financing system. Mary Pease (Division of

Research and Statistics) was helpful in performing special data runs from the Division's extensive hospital database, while Pete Bailey, in the same Division, gave us access to Census data on county expenditures for health-related activities.

Thanks also are due to Peter Rankin of the Center for Health Policy, Law & Management for his excellent work in doing all programming required to obtain estimates from the Current Population Survey, AHA Survey, Consumer Expenditure Survey, 1990 Census and Area Resource Files and for preparing documentation for the Center for Health Services and Policy Research in the Institute of Public Affairs at University of South Carolina. We also appreciate excellent secretarial support from Sarah Arnemann in assisting with preparation and assembly of the finished report.

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I. Introduction

This report summarizes the findings of a major study on health care for the medically indigent of South Carolina. There were two purposes for this study: first, to determine the size and nature of the medically indigent problem in South Carolina; and second, to explore the impact and costs of a wide range of options for dealing with it.

The study was *not* intended to produce a definitive recommendation regarding how to solve this serious problem. However, it has resulted in detailed baseline estimates from which such a solution can be fashioned in the future.

The problem of the medically indigent affects everyone, since one fourth of all health costs in South Carolina are subsidized. A typical South Carolina family of four pays more than \$950 a year in higher taxes and medical prices just to pay for health care of the medically indigent.

This direct cost is enormous, but of equal concern is the possible *indirect* cost that this problem may have on South Carolina's ability to compete with other states for jobs and growth. An unhealthy work force is less productive than one that is not. And school children who are sick learn less than if they

are well. The ability of the economy to remain growing and vibrant is further crippled when large sums must be invested on health expenditures that are preventable. An example are the large sums spent on care of premature infants whose mothers failed to obtain adequate prenatal care. For all these reasons, the issue of indigent care merits serious attention by South Carolina's policymakers.

There were four major areas covered in this study: 1) the number and characteristics of the medically indigent; 2) the barriers to access that prevent the medically indigent from obtaining adequate health care; 3) the financial burden of paying for care of the medically indigent; and 4) alternative approaches to financing indigent health care.

This report contains summary data and conclusions only. Much more detailed estimates are contained in unpublished *Appendix* tables, which describes in detail all sources of data and computations used to obtain the estimates on which the conclusions of this study are based. These can be obtained directly from the authors. Included in this report is a *County Profiles Appendix* that provides county-level estimates of the size and characteristics of the medically indigent population.

