

# **Improving the Health Care Marketplace in South Carolina**

**Strategies and Policies Recommended by the South Carolina  
Health Planning Committee**

**November 2011**

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## Executive Summary

On March 10, 2011, Governor Nikki R. Haley issued Executive Order 2011-09 establishing the South Carolina Health Planning Committee. The Committee was created to assist with the formulation of policy recommendations regarding the feasibility of establishing a health insurance exchange in South Carolina as provided under the Affordable Care Act (ACA). If the Committee recommended that the State decline to establish a state-operated exchange, it was charged with recommending alternative strategies and policies to improve the health insurance marketplace in South Carolina.

The twelve-member Committee included representatives from the South Carolina General Assembly, a consumer/non-profit organization, the business community, state agencies, the insurance industry and the medical community. It held its first meeting in April 2011 and over the past eight months received numerous briefings and presentations including from the South Carolina Institute of Medicine and Public Health, the Institute of Public Service and Policy Research, the South Carolina Department of Insurance, Mark Tompkins PhD, the South Carolina Hospital Association, the South Carolina Medical Association, the University of South Carolina, Health Sciences South Carolina, the South Carolina Office of Research & Statistics, Blue Cross and Blue Shield of South Carolina, AccessHealth South Carolina, TriCounty Project Care, UnitedHealthcare and Deloitte Consulting.

To assist with its work, the Committee established four subcommittees to review various exchange and other marketplace issues. To provide for a broad representation, not unlike the full committee, the four subcommittees were comprised of both Committee members and those representing other outside interests. The four subcommittees combined held over twenty meetings and allowed for the Committee to receive more detailed briefings on a variety of issues from the history of the health insurance markets in South Carolina to demonstrations of private insurance exchanges to issues related to medical liability insurance.

The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act were enacted by the United States Congress in March 2010 and collectively are referred to as the Affordable Care Act (ACA). It is the most comprehensive health care reform legislation since Medicare and Medicaid were passed in the mid-1960s and makes significant changes to both those programs. The ACA was intended to address the increasing number of Americans without health insurance coverage, rising health care costs and to improve the quality of medical care services. The ACA, in part, expands Medicaid to 138 percent of the federal poverty level (FPL) and expands private health insurance coverage through the establishment of health insurance marketplaces, exchanges, for individual and small employers. It provides premium subsidies for those with incomes between 138 and 400 percent of the FPL, tax credits for small employers, and certain preventive services and screenings without cost sharing for Medicare and private insurance holders. The ACA allows for the development of new health care delivery and finance models to improve quality and health outcomes and substantially impacts both the insurance and health care markets.

The ACA also provides funding opportunities for a variety of programs and initiatives. These funding opportunities range from expanding community health centers to increasing the number of primary health care providers to implementing health insurance exchanges. South Carolina sought and received a State Planning Grant to determine the feasibility of establishing a health insurance exchange. Those funds assisted the efforts of the South Carolina Health Planning Committee.

## **Research**

As part of this study, the University of South Carolina's Institute of Public Service and Policy Research (IPSPR) and the Institute of Medicine and Public Health (IOMPH) were contracted to conduct independent research on the uninsured in South Carolina. The research was conducted in three phases: a household survey, a key informant survey and the conducting of focus groups. Similar research was conducted by the IPSPR for DOI in 2003 and provided a very good base for comparison on many of the questions studied.

The household survey conducted in June and July 2011 included landline and cell phone exchanges, and collected data from 1,649 households representing 3,843 individuals. An additional sample was collected of 415 households, representing 601 individuals, with at least one person per household without health insurance. The key informant survey conducted by IPSPR surveyed individuals knowledgeable about the health insurance and health care systems. The survey was sent to individuals from different sectors including large and small businesses, health care providers, health researchers, non-profit organizations and the health insurance industry. It included questions about the ACA, benefit plans, insurance markets and products. Additionally, it collected their thoughts on the direction South Carolina should take in response to options provided under ACA. Six focus groups were conducted from July to September 2011 by the IOMPH. Participants included insurance companies, healthcare system administrators, representatives of consumer organizations and consumers. Participants were provided general information about the purpose of the research including the disclaimer that the establishment of a health insurance exchange is only one aspect of the law, and the discussion was not intended to be a debate on health care reform.

## *Findings*

The survey measured three broad definitions of insurance status: no insurance at the time of the interview, uninsured at some time during the past 12 months, and no health insurance during the past year. To estimate the total number of people in each category, percentage responses were applied to South Carolina population data. A projected 633,675, or 13.7 percent, were uninsured at the time of the interview. A projected 892,695, or 19.3 percent, were uninsured at some point in the past year and a projected 522,666, or 11.3 percent, were uninsured for the entire previous 12 months.

From 2003 to 2010 South Carolina's population grew by 478,212 (an 11.5 percent increase) from 4,147,152 to 4,625,364. In terms of total estimated population, the number of South Carolinians uninsured at the time of the interview increased from 474,380 (11.5 percent) in 2003 to 633,675 (13.7 percent) in 2011. The broadest measure of the uninsured, those without insurance at some point during the previous 12 months, increased by 11 percent- roughly the same growth as the general population- from 804,455 to 892,695. For the chronically uninsured, those without any health insurance for the entire previous 12 months, the number increased by 179,538, from 343,128 to 522,666 (8.3 to 11.3 percent). While the population grew 11.5 percent during this eight-year period, the chronically uninsured grew at a significantly higher rate.

Uninsured levels closely correlate with income. Adjusted for household size, those with incomes less than 100 percent of the FPL had the highest uninsured rate, 39.7 percent. Of those, more than 27 percent had no health insurance for the entire previous year. For those with incomes greater than 400 percent of the FPL, 6.7 percent were uninsured at one point in the previous year and 1.9 percent were chronically uninsured. Most of the uninsured were employed but cited affordability

as the reason they did not have insurance. South Carolina's median household annual income was \$41,709 in 2010.<sup>1</sup> The average annual insurance premium nationwide for individual and family coverage for employer-sponsored insurance was \$4,835 and \$13,871 respectively.<sup>2</sup>

Sources of insurance are primarily employment-based. For those insured, 62 percent had insurance either through their employer or a family member's employer. Twenty-one percent purchased insurance directly, although approximately only four percent were individual policies. Medicare covers 18.7 percent and 26.8 percent were covered through Medicaid or the Children's Health Insurance Program.

### **Recommendations**

South Carolina consistently ranks as one of the least healthy states in the nation having very high rates of cardiovascular disease, diabetes, obesity, and strokes. The poor health status of the population costs the state, the businesses in the state, and the citizens of the state not only in higher health care expenditures but also in the productivity of the workforce and in the ability of many people to maintain productive employment. As a result, any changes in the funding or provision of healthcare services should be in the context of a goal to improve the health status of South Carolinians, improve the quality and experience of healthcare services, and do this in a fiscally responsible way that will reduce the per capita cost of healthcare. While goals like these are neither easily attainable nor possible of being realized completely in a short period of time, they are essential as a benchmark for any proposed reforms. The Subcommittee recommends that the state adopt guiding health policy principles like these as a first step and an overarching framework for any reforms it undertakes.

Healthcare is a local phenomenon. There are already numerous local, collaborative initiatives underway in the state aimed at achieving some or all of the objectives described above. The state should take advantage of programs that already exist and build on them rather than starting from scratch with new initiatives.

As the Committee reviewed through its charge the various options for healthcare coverage expansion, value was recognized in each of the options toward certain target populations. However, there is not a strong ability to utilize these options in a global way to achieve our goal of improved healthcare status of all South Carolinians through the triple aim: increased access, improved quality, and lower costs. Missing from these options is the ability to engage and motivate consumers to change behavior in the utilization of healthcare services and make good healthy lifestyle choices. The state should foster grassroots community-based efforts to achieve this engagement and affect these changes.

The health issues in South Carolina are specific to the state and its communities. It is, therefore, imperative that the solution be local as well. In order for the state to fully integrate the funding and provision of health services, it is imperative that the state maintain control over all aspects of healthcare funding and provision including control over any marketplace reforms.

Per discussion and debate at the SCHPC meetings on November 10, 2011 and November 18, 2011, the Committee recommends, in part, the following:

1. The state cannot implement state-based health insurance exchanges as defined under PPACA and ill-defined and unfinished HHS regulations.

2. The state should encourage and facilitate the establishment and expansion of private exchanges designed to serve the needs of a variety of consumers.
3. The state should encourage full consumer empowerment, engagement and responsibility in health and health care decision making.
4. The state should continue to inform and engage the federal government using these state-based alternatives as the foundation for all conversations and agreements regarding health insurance reform in South Carolina.
5. Any changes in the funding or provision of healthcare services should be in the context of a goal to improve the health status of South Carolinians, improve the quality and experience of healthcare services, and do this in a fiscally responsible way that will reduce the per capita cost of healthcare.

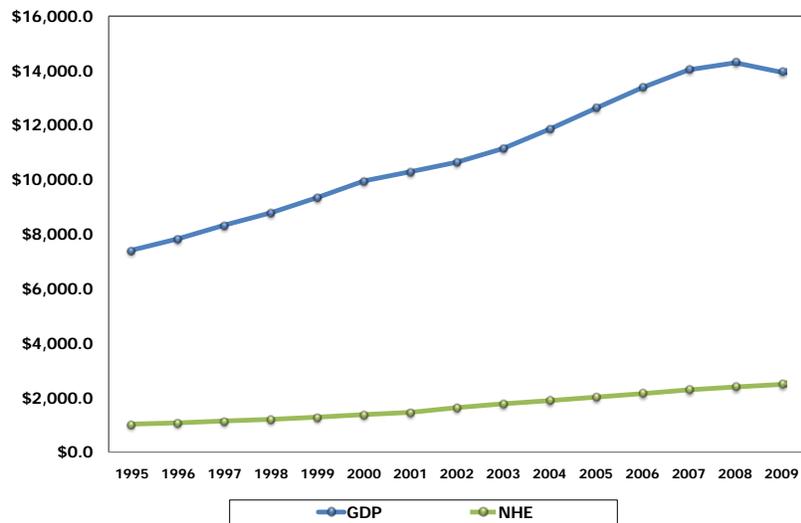
Other recommendations can be found in Chapter XI (pages 96-100).

# I. Introduction

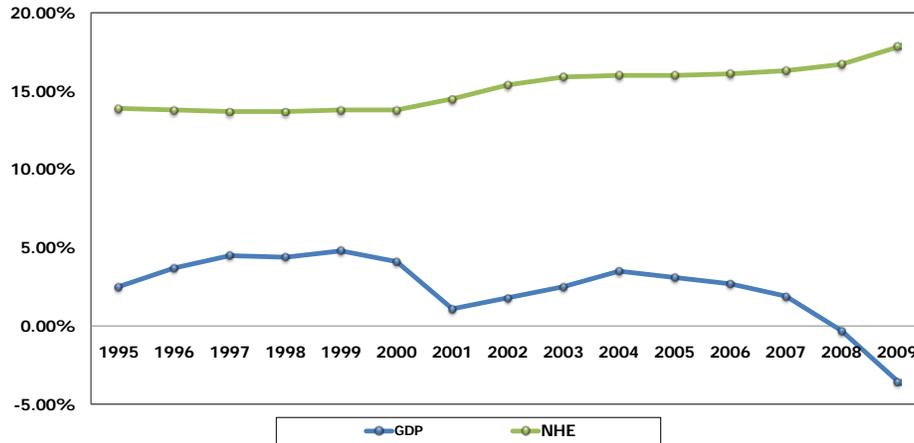
## Health Care Costs

Even with the recent recession, declines in employment and its resulting impact on health insurance coverage, total national health expenditures reached \$2.5 trillion in 2009, which is \$8,086 per capita and a 4.0 percent increase over the previous year. Health expenditures comprised 17.8 percent of the Gross Domestic Product (GDP) in 2009. Over the last 15 years, health expenditures in the United States rose 2.6 times faster than GDP. From 1995 to 2009, the GDP increased an average of 2.5 percent per year with health expenditures increasing 6.5 percent annually. Medical care prices rose an average of 3.8 percent annually during this time period, 58 percent higher than the Consumer Price Index (CPI). From 1995 to 2010, the average annual increase in the CPI and Medical Care CPI was 2.4 and 3.8 percent respectively. The increases in health expenditures reflected increases in both prices and utilization.

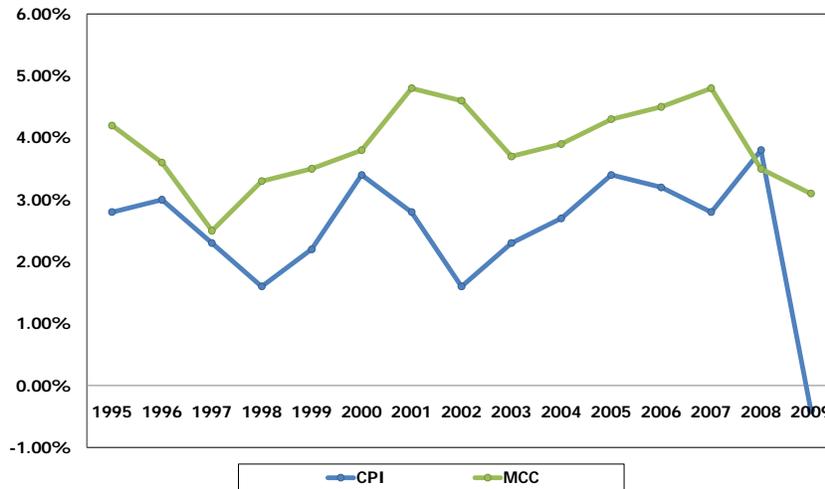
**Figure 1**  
**Gross Domestic Product (GDP) and National Health Expenditure (NHE) Costs**



**Figure 2**  
**Gross Domestic Product (GDP) and**  
**National Health Expenditure (NHE) Percent Change**



**Figure 3**  
**Consumer Price Index and Medical Care Cost**  
**Percent Change**



**The Uninsured in South Carolina**

In 2010, South Carolina’s population reached 4.6 million. Of those, four million were 64 years of age or younger, which is the non-Medicare population (since most of those 65 and older are covered by Medicare. For purposes of simplicity references to the general population will be for those 64 and younger, unless otherwise noted). From 2000 to 2011, the percentage of uninsured individuals in South Carolina increased from 13.5 to 19.3. While there were increases in the

uninsured nationwide, those increases were not as great as those experienced in South Carolina. Nationwide, the percentage of uninsured increased from 15.5 to 18.3. In those 11 years, South Carolina's uninsured population increased from two percent below the national average to 1.4 percent above.

**Figure 4**  
**South Carolina and United States Uninsured Populations**

	South Carolina	United States
<b>2010 Population</b>	4,625,364	308,745,538
<b>2010 Population &lt;65</b>	3,993,490	268,477,54
<b>2009 Uninsured</b>	763,000	49,998,000
<b>% Uninsured</b>	19.7%	18.8%
<b>2011 Uninsured</b>	907,647	
<b>% Uninsured</b>	19.3%	

**Figure 5**  
**Health Insurance Coverage Status Percentage Uninsured**  
**South Carolina and United States**  
**2000 - 2011**

	South Carolina	United States
<b>2000</b>	13.5	15.5
<b>2001</b>	13.5	15.9
<b>2002</b>	13.9	16.6
<b>2003</b>	15.7	17.0
<b>2004</b>	16.9	16.8
<b>2005</b>	19.6	17.2
<b>2006</b>	18.1	17.8
<b>2007</b>	18.8	17.1
<b>2008</b>	18.3	17.3
<b>2009</b>	19.7	18.3
<b>2011</b>	19.3	

In the last decade, the percentage of population younger than 65 years of age without insurance has increased from 13.5 to 19.3 percent in South Carolina, a 43 percent increase<sup>3</sup>.

**Impact: Higher Prices, Worse Outcomes**

Even if uninsured, virtually everyone eventually needs medical care services. For chronic diseases or high-cost cases, outcomes are worse and total costs are higher when diagnosis and treatment are delayed or altogether absent. To the extent that these costs remain uncompensated, the costs for this care are borne by the system. For everyone else, prices are higher than they otherwise would be, resulting in higher health insurance premiums.

## **Status of Health Insurance Markets**

Over the last two decades, South Carolina, like many other states, addressed issues in the individual and small group markets, through legislative attempts which were intended to increase the availability and affordability of health insurance. Most attempts around the country proved unsuccessful, primarily as a result of high health care costs leading to high, unaffordable premiums.

Competition in the health insurance marketplace can be measured in several different ways. One way the market can be measured is by calculating the percentage of the market (i.e., measured in terms of the number of people enrolled) represented by the largest insurer in the state. A second way is to consider the number of insurance carriers representing a threshold portion of the market (> five percent), quantifying the extent of choices available to consumers among plans with material enrollment. A third measure of market competition is the Herfindahl-Hirschman Index (HHI) which measures how evenly market share is spread across a large number of insurers.

The values of HHI range from zero to 10,000 with values closer to zero indicating a more competitive market and values closer to 10,000 indicating a less competitive market. This scale is further broken into three categories: an unconcentrated market is represented by a 1,000 to 1,500 value range, a moderate concentration is represented by a 1,500 to 2,500 value range and a highly concentrated market has a value above 2,500.

According to a 2009 Kaiser Family Foundation study, which is the most recent U.S. data on the coverage types to date, 17 percent were uninsured, 12 percent were covered by Medicare, 16 percent were covered by Medicaid, one percent was covered by other public coverage, 49 percent were covered by employer-sponsored coverage, and five percent were covered by individual policies.

In South Carolina, for the same period, 16 percent were uninsured, 15 percent were covered by Medicare, 13 percent were covered by Medicaid, two percent were covered by other public coverage, 50 percent were covered by employer-sponsored coverage, and four percent were covered by individual policies.

### *Individual Market*

The individual health insurance marketplace in many states is highly concentrated. Thirty states plus the District of Columbia had individual health insurance marketplaces with at least half the market dominated by a single insurance carrier in 2010. The median market share held by the largest health insurance carrier in each state was 54 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,761. It should be noted that in 45 states and the District of Columbia, the HHI exceeds 2,500. South Carolina's largest state insurer has a market share of 54 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 3,296.<sup>4</sup>

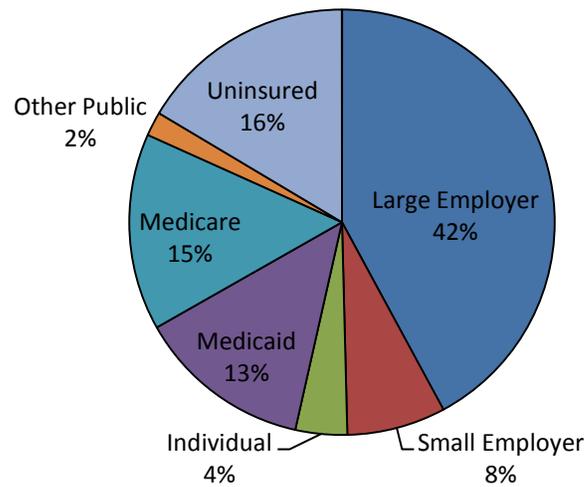
According to the Supplemental Health Exhibit<sup>5</sup> filed with the National Association of Insurance Commissioners (NAIC) in 2010, there are 64 companies with earned premiums in South Carolina for individual comprehensive health insurance. The top 10 companies account for 90 percent of all premiums earned in the state.

### *Group Markets*

The employer-sponsored percentage for South Carolina can be broken down into large and small group coverage. The 50 percent of South Carolinians covered by employer-sponsored coverage breaks down to 42 percent for large employers and eight percent for small employers. Using South

Carolina-specific data from the 2010 Medical Expenditure Panel Survey (MEPS), the breakdown between large and small employers can be derived.<sup>6</sup> MEPS provides the number of employees, the percentage of employees in companies offering health insurance, the percentage of employees eligible for health insurance, and the percentage of eligible employees who enroll in health insurance, all broken down by companies with fewer than 50 employees and those with 50 or more employees. Using this data, the 50 percent of employer-sponsored coverage reported in the Kaiser Family Foundation data can be further divided into the relative percentages for small and large groups, as shown in the following table:

**Figure 6**  
**South Carolina Health Coverage**  
**Kaiser State Health Facts('09) and MEPS('10)**



The level of competition in the small group market is generally characterized in the same way as the individual market. The median market share held by the largest health insurance carrier in each state is 51 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,595. South Carolina’s largest state insurer has a market share of 67 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 4,783.

According to the Supplemental Health Exhibit filed with the NAIC in 2010, there are 25 companies writing business in South Carolina’s small group market out of a total of 131 authorized insurers. Here, the top five companies account for 90 percent of the marketplace. This is a significant decrease from the 1990s when South Carolina had 70-80 companies competing for small group business. This decline had stabilized by 2004 when there were 23 carriers writing business in the state.

In the large group market there are 17 companies writing fully-insured health insurance products, and the top two comprise approximately 90 percent of the marketplace. However, more than 66 percent of coverage in this market is provided by self-funded plans where the employer assumes most of the risk for the product and hires an insurance carrier or a third party administrator to administer the benefits. Specific data is not available about the number of administrators in this part of the market. However, using the total population of individuals who receive coverage

through a large employer and the total amount of businesses either insured or administered by the two largest insurers/administrators in this market shows that the two largest insurers/administrators comprise approximately 49 percent of the marketplace.

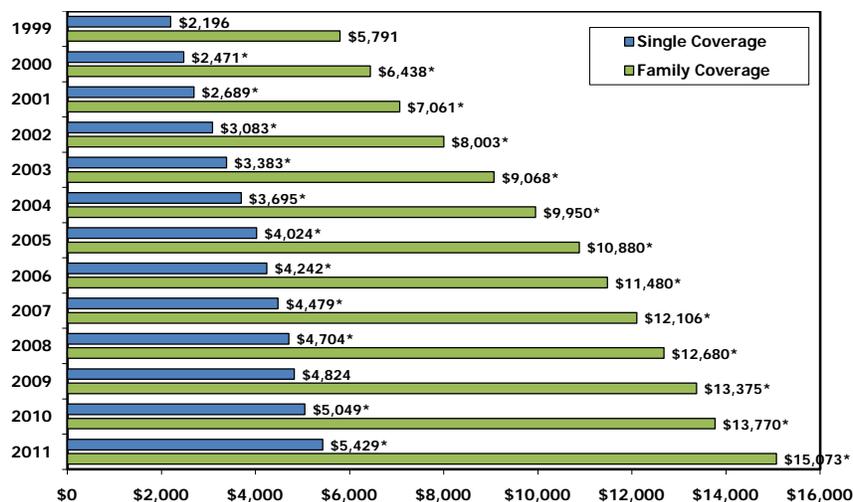
Some barriers to entry in the insurance marketplace include the inability to form provider networks and a lack of brand awareness among consumers. An insurance carrier with significant market share may face little competition and may have higher premiums and profits, but it may also be better poised to negotiate lower rates with doctors and hospitals. It is believed that plans with at least five percent of the market share potentially control sufficient market share to grow in the future.

### Cost of Insurance

According to a 2011 survey conducted by the Kaiser Family Foundation and the Health Research & Educational Trust, the national average cost for employer-sponsored health benefits in the last year increased 9.5 percent for family coverage and 7.5 percent for individual coverage (see Figure 7 below).

The national average total cost for family coverage reached \$15,073, increasing 134 percent from \$6,438, which was the average cost of family coverage in 2000. Individual coverage increased as well during this time period. From 2000 to 2011, the cost of single coverage increased 119 percent from \$2,471 to \$5,429. The 2011 survey found increases in the average annual worker premium contributions paid by covered workers for single and family coverage. In 2011, the average annual premium paid by workers was \$4,129 for family coverage and \$921 for single coverage (see Figure 8 below). From 2000 to 2011, the increases in both have been significant, increasing 155 percent for family coverage and 175 percent for single coverage<sup>7</sup>.

**Figure 7**  
Average Annual Premiums for Single and Family Coverage, 1999-2011

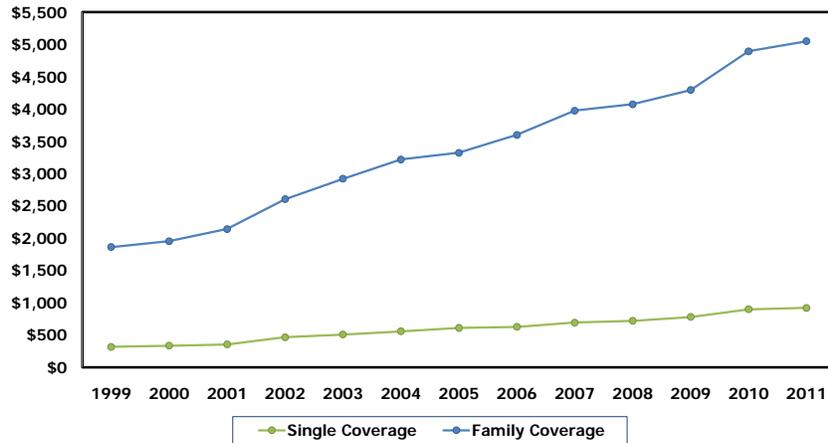


\* Estimate is statistically different from estimate for the previous year shown (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

**Figure 8**

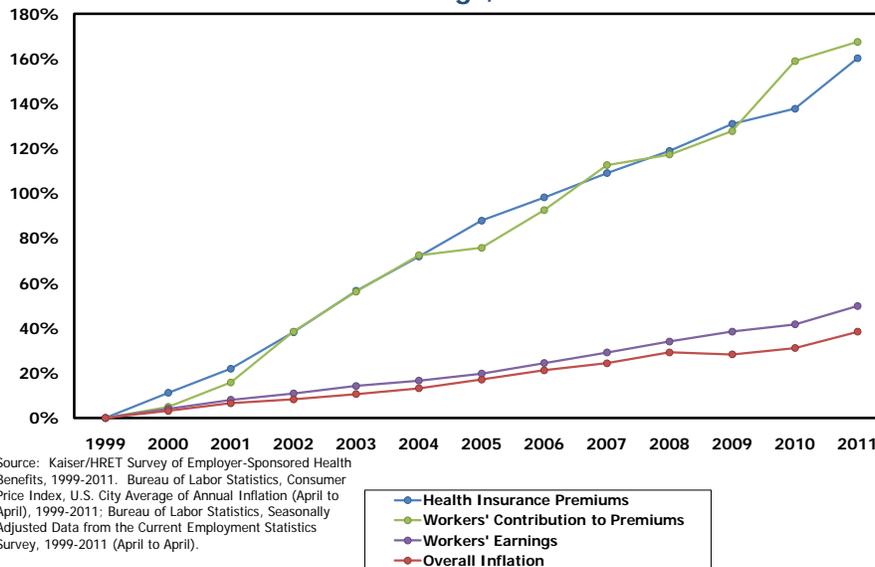
**Average Annual Worker Premium Contributions Paid by Covered Workers for Single and Family Coverage, 1999-2011**



\*Estimate is statistically different from estimate for the previous year shown (p<.05).  
 Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011.

**Figure 9**

**Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2011**

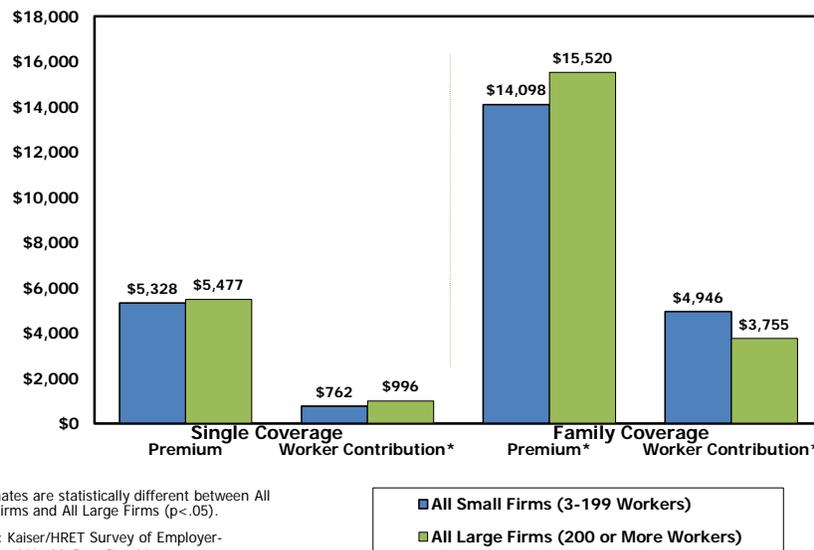


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2011 (April to April).

There have been significant increases in both health insurance premiums and workers' contributions to those premiums, representing substantial increases for employers and employees. Those rates of increases have far outpaced inflation and workers' earnings over this time period.

In 2011, the cost of health insurance coverage varied for firms when grouped by size, with small firms defined as three to 199 employees and large firms defined in this study as 200 or more employees. The cost of single coverage for large firms was 2.8 percent higher than small firms, and the cost of family coverage was 10 percent higher for large firms, both most likely reflecting more comprehensive benefits. The workers' contribution for single coverage in large firms was 30 percent higher than that in small firms. However, the same was not true for family coverage. Workers in small firms contributed substantially more for family coverage, on average \$4,946, 32 percent higher than the \$3,755 worker's contribution in large firms.<sup>8</sup>

**Figure 10**  
**Average Annual Worker Premium Contributions and Total Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2011**



**Past Studies: South Carolina’s Health Insurance Market and the Uninsured**

In 2001, the DOI completed a review of the small group health insurance market in the state, the purpose of which was to address availability and affordability of health insurance. In 2004, the DOI completed an additional study which provided more detailed information on the uninsured, and proposed state policy initiatives to reduce the number of uninsured by expanding health insurance coverage. The 2004 study, a 24-month project, found the following:

In 2003, 11.6 percent (474,380) of South Carolinians under the age of 65 were uninsured at the time of the survey. Of those, 19.4 percent (774,313) had been uninsured at some time during the previous 12 months with 8.3 percent (343,128) uninsured for the entire previous 12 months. Using the broadest measure, the percent of individuals who were uninsured at any time in the past 12 months (19.4 percent) shows that South Carolina’s uninsured population was 3.8 percent higher than the national average of 15.6 percent.

A recurring reason given for an individual’s uninsured status in 2003 was affordability, cited by 72 percent as the primary reason they were not insured. Of South Carolina’s total uninsured, 43.5 percent had a gross household income between \$20,000 and \$50,000 and 22 percent had a gross household income of more than \$50,000. The average age of those uninsured in the state was 33 years old.

Most uninsured, 60 percent (375,732), were employed. According to the 2004 report:  
 “Many South Carolinians are employed in retail and other service industries that traditionally do not offer insurance benefits. The highest percentage of uninsured South Carolinians are employed in the tourism, retail and service industry. Thirty eight percent stated they were eligible for their employers group health plan, but could not afford the employee’s portion of the premium, deductibles and co-pays. Fifteen percent of the uninsured were self-employed or owned their own business.”<sup>10</sup>

Affordability was the reason most often given by employers who did not offer coverage.

**2011 Research**

The 2004 study provides an important base from which to compare 2011 data. In May 2011, DOI contracted with the University of South Carolina’s Institute for Public Service & Policy Research and the Institute of Medicine and Public Health to conduct a household survey, key informant survey, and focus groups – similar to what had been conducted in 2003. The DOI continued by conducting demographic research and analysis of the health insurance marketplace to determine the following:

- Review and summarize existing data on the uninsured
- Determine the extent of coverage for the South Carolina Insurance Market
- Collect qualitative data from stakeholders on exchange design, operations, and options.

**Figure 11**  
**South Carolina Insurance Status 2003 and 2011**

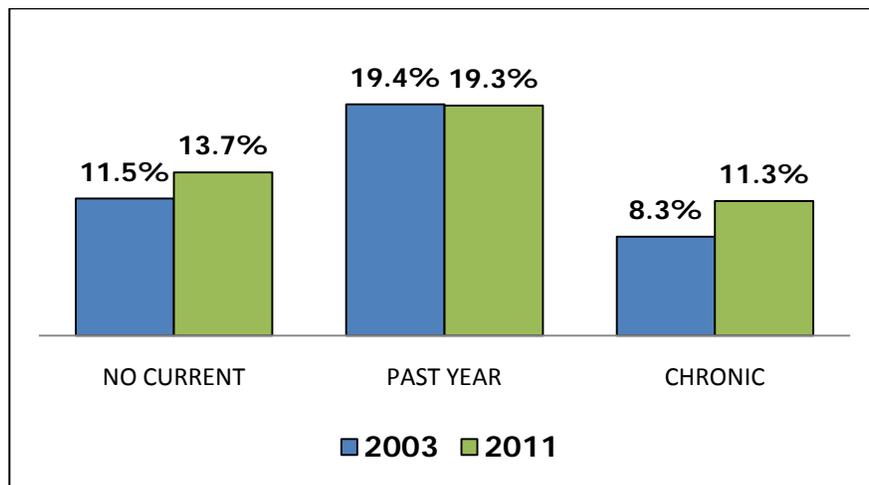
	2003	2011	Change
<b>Not Insured at time of survey</b>	476,922	633,674	156,752
<b>% of Population</b>	11.5 %	13.7%	
<b>Not Insured some time in last 12 months</b>	804,455	892,695	88,240
<b>% of Population</b>	19.4%	19.3%	
<b>No Insurance last twelve months</b>	343,128	522,666	179,538
<b>% of Population</b>	8.3%	11.3%	
<b>Population</b>	4,147,152	4,625,364	478,212

Source: 2003 & 2011 Cross-Sectional Telephone Results, Institute of Public Service and Policy Research, University of South Carolina; 2010 US Census.

As in 2003, the 2011 survey measured three broad definitions of insurance status: no health insurance at the time of the interview, uninsured at some time during the past 12 months, and no health insurance during the past year. The percentage responses were then applied to South Carolina population data to estimate the total number of people in each category. A projected 633,675, or 13.7 percent, were uninsured at the time of the interview. A projected 892,695, or 19.3 percent, were uninsured at some point the past year and a projected 522,666, or 11.3 percent, were uninsured for the entire previous 12 months.

The total South Carolina population grew by 478,212 or 11.5 percent, from 2003 to 2011. In terms of total estimated population, the number of South Carolinians uninsured at the time of the interview increased from 474,380 in 2003 to 633,675 in 2011, or 33.6 percent, which was 22.1 percent more than the population growth. The broadest measure of the uninsured, those without insurance at some point the previous 12 months, went from 804,455 to 892,695, an increase of 88,240, or 11 percent, which is consistent with total population growth. For the chronically uninsured (those without any health insurance for the entire previous year) the number increased 179,538 from 343,128 to 522,666. The increase in this category was 40.8 percent more than the growth of the total population. While the population grew 11.5 percent during this eight-year period, the uninsured grew substantially more.

**Figure 12**  
**Uninsured - 2003 and 2011**



## II. Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) were enacted by U.S. Congress in March 2010. Collectively, the two acts are referred to as the Affordable Care Act (ACA). The ACA was enacted to address the increasing number of Americans without health insurance coverage, rising health care costs, and improving the quality of medical care services<sup>11</sup>. The ACA expands Medicaid to 138 percent of the federal poverty level (FPL) and private health insurance coverage through the establishment of health insurance marketplaces for individuals and small employers. It provides premium subsidies for those with household incomes between 138 and 400 percent of the FPL, tax credits for small employers, and certain preventive services and screenings without cost-sharing for Medicaid and private insurance holders. Also, the ACA allows for the development of new health care delivery and finance models to improve quality and health outcomes, which may have significant impacts on the insurance and health care markets.

Many provisions have already taken effect and most others will take effect in 2014.

### Key Provisions That Have Taken Effect

- **Small Business Tax Credits** - Provides tax credits to businesses with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees. From 2010 to 2013, tax credits of up to 35 percent of premiums (25 percent for non-profits) will be available to firms that offer coverage. Beginning in 2014, the small business tax credits will cover 50 percent of premiums (35 percent for non-profits) for small groups that purchase coverage through a SHOP (small group) exchange.
- **Prohibits Discrimination Based on Salary** - Prohibits new insured group health plans from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees.
- **Early Retiree Reinsurance Program** - Creates a temporary reinsurance program (until exchanges are available) for employers providing health coverage to retirees over age 55 who are not eligible for Medicare. Reimburses insurers/employers for 80 percent of retiree claims between \$15,000 and \$90,000 (adjusted to \$16,000 and \$93,000 in 2011).
- **Pre-existing Condition Insurance Plan** - Creates a temporary high-risk pool to provide health coverage to individuals with pre-existing conditions who have been uninsured for at least six months. Operated by the states or the federal government, the federal government is operating this program in 23 states including South Carolina.
- **Children's Pre-existing Condition Exclusions** - Prohibits new health plans in all markets plus grandfathered group health plans from applying pre-existing condition exclusions to children with pre-existing conditions. Beginning in 2014, this prohibition applies to all persons with pre-existing conditions.
- **Extends Dependant Coverage for Young Adults up to Age 26** - Requires plans providing dependent coverage to extend coverage to adult children up to age 26.

- **Rescissions** - Coverage may be rescinded only for fraud or intentional misrepresentation.
- **Bans Lifetime Limits on Coverage** - Prohibits health insurance companies from placing lifetime caps on minimum essential benefits.
- **Bans Restrictive Annual Limits on Minimum Essential Benefits Coverage** - Restricts the use of annual limits to ensure access to needed care in all new plans and grandfathered group health plans to: \$1.25 million for plan years beginning September 23, 2011 to September 23, 2012, and \$2 million for plan years beginning September 23, 2012 to September 23, 2013. Beginning in 2014, the use of any annual limits would be prohibited for all new plans and grandfathered group health plans.
- **Minimum Medical Loss Ratios**- Requires health plans to report the premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers if the share of the premium spent on minimum essential benefits, quality improvement activities, and some fraud-prevention activities is less than 80 percent of premium, less tax, for plans in the individual and small group markets and 85 percent for plans in the large group market.
- **Review of Health Plan Premium Increases** - Creates a grant program to support states in requiring health insurance companies to submit justification for all requested premium increases. Insurance companies with excessive or unjustified premium increases will be required to disclose this information to consumers.
- **Preventive Care under New Private Plans** - Requires new private plans to cover certain preventive services without cost-sharing, including certain immunizations, preventive care for infants, children, and adolescents and additional preventive care for women.
- **Eliminates Co-payments under Medicare for Certain Preventive Care and Screenings**- Eliminates cost-sharing for certain preventive services covered under Medicare. Waives the Medicare deductible for colorectal cancer screening tests and authorizes Medicare coverage for a personalized prevention plan, including a health risk assessment.
- **Begins to close the Medicare Drug Coverage Gap** – In 2010, provided a \$250 rebate to Medicare beneficiaries who reached the Part D coverage gap, also known as the donut hole. Beginning in 2011, requires pharmaceutical manufacturers to provide a 50 percent discount on brand-name prescription filled in the Medicare Part D coverage gap and begins to phase in federal subsidies for generic prescription to completely close the coverage gap by 2020.
- **New, Independent Appeals Process** - Ensures consumers in new plans have access to effective internal and external appeals process to appeal decisions by their health insurance plan.
- **Health Insurance Consumer Information** - Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals.

- **Community Health Centers** - Increases funding for Community Health Centers to allow for the number of patients seen by the centers to nearly double over the next five years.
- **Increases the number of primary care practitioners** - Provides new investments to increase the number of primary care practitioners including doctors, nurses, nurse practitioners, and physician assistants.
- **Comparative Effectiveness Research** - Establishes the non-profit Patient-Centered Outcomes Research Institute to conduct research that compares the clinical effectiveness of medical treatments and charges new fees to employers and insurers to pay for the research.
- **National Quality Strategy** - Requires the US Department of Health and Human Services to develop and update annually a national quality improvement strategy that includes improving the delivery of health care services, patient health outcomes, and population health.

#### **Key Provisions That Take Effect In 2014**

- **Individual Requirement to Have Insurance** - Requires US citizens and legal residents to have qualifying health care coverage. Allows certain exemptions and provides for a tax penalty, phased in over three years, for those without coverage.
- **Health Insurance Exchanges** - Health insurance exchanges, scheduled to be operational by January 2014, are markets for health insurance that will allow individuals and small employers to compare and purchase health insurance coverage. Exchanges, administered by a governmental agency or non-profit organization, are intended to provide better information on cost and benefits and allow purchasers to benefit from the lower rates that have been traditionally available only to large group plans. Under the Affordable Care Act, an exchange will be established in each state; if a state chooses not to create its own exchange, the federal government will operate one in that state. The exchanges will provide tax credits for certain small employers and premium and cost-sharing subsidies to make health insurance coverage more affordable to those with incomes below 400 percent of the FPL. Health insurance exchanges were designed to provide a more competitive market by offering a choice of health plans, establishing rules for how insurance policies are offered and priced, and providing information to help consumers better understand the options available to them and the resulting costs.
- **Comprehensive Health Insurance Coverage** - All plans must include the minimum essential benefits package required of plans sold in the exchange, must comply with limitations on annual cost-sharing for plans sold in the exchange, and must conform to prescribed actuarial values.
- **Guaranteed Availability of Coverage** - Insurers must accept every employer and every individual applying for coverage. Insurers may restrict enrollment based upon open or special enrollment periods. Applies to non-grandfathered fully-insured plans.

- **Guaranteed Renewability of Coverage** - Insurers must renew coverage at the option of the plan sponsor or individual.
- **Prohibition on Excessive Waiting** - Group health plans and employers offering group health insurance may not impose waiting periods exceeding 90 days.
- **No Annual Limits on Coverage** - Prohibits annual limits on the dollar value of minimum essential benefits coverage.
- **Preexisting Condition Exclusions** - A plan may not impose preexisting condition exclusions.
- **Fair Health Insurance Premiums** - Premiums may only vary by age (3:1 maximum), tobacco use (1.5:1 maximum), geographic area, and whether coverage is for an individual or a family.
- **Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status** - A plan may not establish rules for eligibility based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
- **Non-discrimination in Health Care** - Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individual or employers based upon whether they receive subsidies.
- **Multi-State Health Plans** - The state must contract with at least two private multi-state plans (overseen by the Office of Personnel Management) and make them available for purchase through the health insurance exchange in each state. One of the two plans must be a non-profit organization.
- **Health Insurance Premium and Cost Sharing Subsidies**- Tax credits, or subsidies, will be available for those with household incomes up to 400 percent of the FPL. These subsidies will only be available to individuals purchasing health insurance through the health insurance exchange. If a silver level qualified health plan is selected, a cost sharing subsidy will also be issued.
- **Employer Requirements** - Small employers with at least 50 full-time employees will be required to offer minimum essential coverage and provide vouchers for the purchase of health insurance to those employees who qualify.

### III. Grant Application and Award

The Affordable Care Act provides a considerable number of funding opportunities for a variety of programs and initiatives. These funding opportunities range in subject matter from increasing the number of primary health care providers to implementing Health Insurance Exchanges. South Carolina sought the State Planning Grant (CFDA 93.525) to determine the feasibility of establishing a health insurance exchange in the state and proposed a four-phased approach. Subsequently, the availability of up to \$1 million was granted to the South Carolina Department of Insurance (DOI) by the U.S. Department of Health and Human Services (HHS) on September 30, 2010.

#### **Phase One**

Demographic research was conducted from May-October, 2011 under the direction of Dr. Robert Oldendick, Executive Director of the Institute for Public Service and Policy Research at the University of South Carolina. The data collection included three components: a household survey, a series of focus groups, and a key informant survey. The household survey provided an estimate of the uninsured population in South Carolina, identified the factors associated with not having insurance, and identified components important to include in a health plan offered through an exchange. The focus groups provided insight to the attitudes and concerns of small employers, medical providers, health insurance companies and consumers about health insurance exchanges. Key informant surveys obtained qualitative data from stakeholders on the design, operation and function of an exchange.

This research expanded upon data acquired through the 2004 Health Resources and Services Administration (HRSA) grant which identified detailed information on the uninsured population in the state in order to format state policy initiatives to reduce the number of uninsured citizens.<sup>12</sup>

#### **Phase Two**

In March 2010, Executive Order 2011-09<sup>13</sup> created the South Carolina Health Planning Committee (SCHPC). The SCHPC was charged with formulating policy recommendations regarding whether or not South Carolina should establish a health insurance exchange and, if so, propose a plan for its successful implementation and sustainability. The committee established four subcommittees to assist in its effort and to provide opportunities for interested parties to participate in the process.

#### **Phase Three**

Phase Three included a series of committee and subcommittee meetings to study the issues, options and opportunities related to establishing a state-based health insurance exchange. Each subcommittee prepared detailed reports on its findings.

#### **Phase Four**

The fourth phase included the generation of this Legislative Report that will be presented to the Governor. A Final Project Report on the feasibility of establishing a state-based exchange and a detailed implementation strategy, if applicable, will also be delivered to the Center for Consumer Information and Insurance Oversight (CCIIO) Grants Management office by December 31, 2011.

## IV. Executive Order Creating South Carolina Health Planning Committee

South Carolina sought the State Planning Grant (CFDA 93.525) to determine the feasibility of establishing a health insurance exchange in the state and, if deemed feasible, to recommend a plan for the successful implementation and ongoing sustainability of a state-based health insurance exchange. Subsequently, the availability of up to \$1 million was granted to the South Carolina Department of Insurance (DOI) by U.S. Department of Health and Human Services (HHS) on September 30, 2010.

The grant called for the establishment of a planning committee consisting of key stakeholders to assist with the formulation of policy recommendations and Executive Order 2011-09, issued on March 10, 2011, established the South Carolina Health Planning Committee.<sup>14</sup>

Members of the Committee were required to have substantial experience or expertise in one or more areas of health care delivery, health insurance, public health programs, or employer-sponsored health benefit programs. The Committee is comprised of twelve members appointed as follows:

1. The Project Manager of the Exchange Planning Grant, who served in an ex officio capacity as chairman of the Committee;
2. Two members appointed by the President Pro Tempore of the Senate, at least one of which must be a member of the South Carolina Senate;
3. Two members appointed by the Speaker of the House of Representatives, at least one of which must be a member of the South Carolina House of Representatives;
4. The Director of the South Carolina Department of Health and Human Services or his designee;
5. The Director of the South Carolina Department of Insurance or his designee;
6. A consumer or not-for-profit representative appointed by the Governor;
7. A small employer as defined in S.C. Code Ann. 38-71-1330(18) appointed by the Governor;
8. A health care provider appointed by the Governor;
9. A licensed insurance producer authorized with accident and health insurance authority appointed by the Governor; and,
10. A licensed health insurance issuer appointed by the Governor.

The members of the Committee are:

1. Gary Thibault, Project Manager and Chairman, Ex Officio
2. Dr. Casey Fitts, Appointed by the President Pro Tempore of the SC Senate
3. Senator Michael Rose, Appointed by the President Pro Tempore of the SC Senate
4. Representative David Mack, Appointed by the Speaker of the SC House of Representatives
5. Representative Bill Sandifer, Appointed by the Speaker of the SC House of Representatives
6. Tony Keck, Director of the South Carolina Department of Health and Human Services
7. David Black, Director of the South Carolina Department of Insurance
8. Tim Ervolina, Consumer or Not-for-Profit appointed by the Governor
9. Evelyn Perry, Small Employer appointed by the Governor
10. Dr. Mike Vasovski, Health Care Provider appointed by the Governor
11. Tammie King, Licensed Insurance Producer appointed by the Governor
12. Will Shrader, Licensed Health Insurance Issuer appointed by the Governor

The Committee was charged with:

1. Convening healthcare delivery system stakeholders and building trust and consensus among stakeholders;
2. Conducting a thorough review and analysis of current and new data on the operation of health insurance exchanges;
3. Completing an in-depth study and review of alternative approaches to establishing a health insurance exchange; and,
4. Developing and submitting a report to the Governor which sets forth the Committee's recommendation regarding whether or not the State should establish a health insurance exchange.

In the event that the Committee recommended that the state establish a state-based health insurance exchange, then the Executive Order also required it recommend a plan for the successful implementation and ongoing sustainability of an exchange and, at a minimum, provide recommendations relating to:

1. The governing structure (e.g. state agency or nonprofit entity);
2. The role(s) and function(s) of a health insurance exchange;
3. The design of qualified health plans offered in a health insurance exchange, including whether existing state mandates should be included in these plans;
4. Coordination of eligibility determination and enrollment between Medicaid and the Exchange and establishment of a policy for insureds who fluctuate between Medicaid and subsidized insurance coverage;
5. Premium allocation;
6. Process for certifying health care plans;
7. Methods for providing consumer information through internet portals;
8. Premium tax credits; and,
9. Exchange Funding and ways to hold down administrative costs.

If the Committee recommended South Carolina not establish a state-based insurance exchange, it was to recommend alternate strategies and polices to improve South Carolina's health insurance marketplace.

The Executive Order allowed for the establishment of subcommittees to include both members of the Committee as well as other experts in the related fields of healthcare and insurance to address specific issues or to assist in its work. The Committee established four subcommittees to assist in its effort and provide opportunities for interested parties to participate in the process. The four subcommittees were:

1. Competitiveness and Transparency
2. Consumer Driven Health Plans
3. Consumer Protection/Medical Liability
4. Information Technology

## V. Research

The University of South Carolina's Institute for Public Service and Policy Research and the Institute of Medicine and Public Health were contracted to assist with independent research of the uninsured in South Carolina. With assistance from the South Carolina Office of Research & Statistics, the South Carolina Budget and Control Board and the South Carolina Department of Health and Human Services, research was conducted in three phases: a household survey, a key informant survey and the conducting/holding of focus groups. These findings, along with census data and data from other studies of the uninsured, provided the information necessary and helpful for the committee's considerations.

Similar research was conducted by Institute for Public Service and Policy Research for the DOI in 2003. That study, although not identical to the current study, provides a good base for comparison on many of the questions studied. Where applicable, the 2003 study has been cited to help provide the comparison and demonstrate the changes in demographics from 2003 to 2011.

### **The South Carolina Household Survey**

Data for the household survey were collected by the University of South Carolina Institute for Public Service and Policy Research between June 1 and July 24, 2011, through a telephone sample of households in South Carolina. The sample, which included landline and cell phone exchanges, was selected using random digit dialing. The survey instrument was designed to assist in determining who are the uninsured; whether they have enrolled or plan to enroll in Medicaid or employer sponsored coverage, and if not, why. It was designed to provide information on household size, income, and insured status as well as other demographic information that would be helpful to the study of the uninsured. That information included adjustments to the income categories depending on the size of the household, providing data by specific federal poverty level (FPL) categories. This provided important information on those who might be eligible for coverage under an exchange, newly eligible for Medicaid under the Affordable Care Act (ACA), eligible for subsidies through an exchange and/or eligible for participation in a Basic Health Plan.

Appendix E, Document B: Cross-Sectional Telephone Survey Results, includes the questionnaire entitled: "South Carolina Health Care Insurance Access and Health Insurance Exchange Survey (Field Version)" which was used. Pages 29- 57 of that document provide frequency counts and the weighted percentages for each question.

Data was collected from 1,649 households representing 3,843 individuals. Data on health insurance status were collected and based on the information for all 3,843 individuals. Data for questions such as health care services were collected for one randomly selected individual within each household and the results of these questions were based on 1,649 individuals. All the data presented were weighted so that the characteristics of the individuals would match the characteristics of the South Carolina population (2010 Census) based on age, race, and sex. An additional sample of 415 households with at least one person without health insurance was also collected. The additional sample represented 601 individuals.

### **Key Informant Survey**

The key informant survey was conducted by the University of South Carolina Institute of Public Service and Policy Research with a group of individuals knowledgeable about the health care system. The survey was sent to individuals from different sectors including large and small businesses, health care providers, health researchers, non-profit organization and the health insurance industry. Questionnaires were mailed to 125 individuals with 57 completed and

returned. The intention was to seek additional qualitative data, not a representative sample, to provide an additional perspective.

The questionnaire included questions about the ACA, exchanges, benefit plans, insurance markets and products, and their thoughts on the direction South Carolina should take in response to options provided under the ACA.

Appendix E, Document D provides the questionnaire used and the number of individuals who gave each response. The answers to those questions, which required a written response, are also included.

### Focus Groups

Additional qualitative information was collected from six focus groups held throughout the state by the University of South Carolina Institute of Medicine and Public Health from July through September 2011. Participants included small business leaders, insurance agents, insurance companies, healthcare system administrators, representatives of consumer organizations, and consumers.

Six 90-minute focus groups were conducted across the state. Participants were recruited through individual contacts and referrals except for the consumer group, where a marketing firm was engaged to recruit individuals who reflected varied demographics including both insured and uninsured. Each focus group was facilitated by trained research staff using a structured discussion guide tailored to the expertise of each group. A total of 41 individuals participated and each focus group was audio-recorded, transcripts prepared and coded and common themes identified.

Participants were provided with general information about the purpose of the research as well as the format and agenda for the session and were informed that the discussion was not intended to be a debate on health care reform but a discussion on one aspect of the law, the establishment of a health insurance exchange. Information was provided, as needed, to each group regarding the basic concepts of an exchange. The convenience sample of participants across the professional groups provided a cross section of opinions and understanding in regard to the specifics of an insurance exchange.

Appendix E, Document F includes the IOMPH's report: "South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study."

**Figure 13**

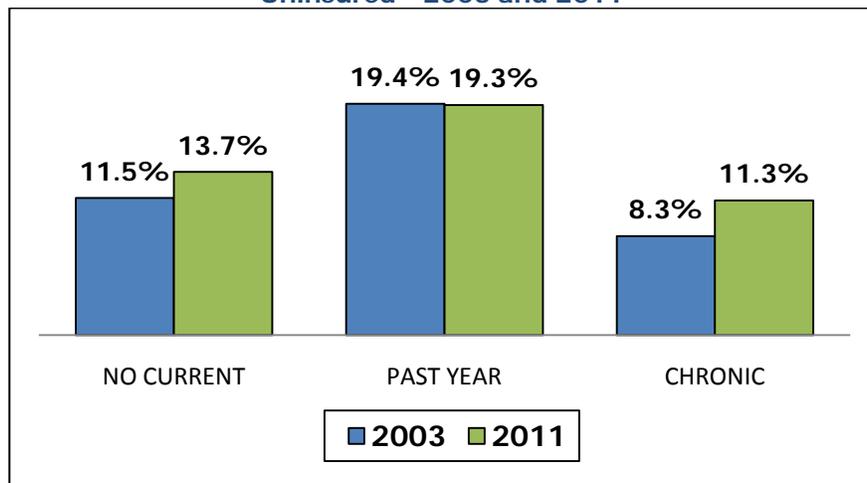
Group	# Participants	Location
Small Business Leaders (2 groups)	10	Columbia & Charleston
Insurance Agents & Carriers	8	Columbia
Healthcare System Administrators	7	Greenville
Consumer Organizations	5	Columbia
Direct Consumers	11	Greenville

### Findings-The South Carolina Household Survey

The survey measured three broad definitions of insurance status: no health insurance at the time of the interview, uninsured at some time during the past 12 months, and no health insurance during the past year. The percentage responses were then applied to South Carolina population data to estimate the total number of people in each category. A projected 633,675, or 13.7 percent, were uninsured at the time of the interview. A projected 892,695, or 19.3 percent, were uninsured at some point the past year and a projected 522,666, or 11.3 percent, were uninsured for the entire previous 12 months.

What were the differences from 2003? There was little change in the percentage of those without insurance at some point in the past year compared with 2003 (the percentage of uninsured declined slightly, from 19.4 percent to 19.3 percent). Those with no insurance at the time of the interview increased from 11.5 percent to 13.7 percent. More significantly, those with no insurance for the previous 12 months increased from 8.3 percent to 11.3 percent.

**Figure 14**  
**Uninsured - 2003 and 2011**



The total South Carolina population grew by 478,212 or 11.5 percent, from 2003 to 2011. In terms of total estimated population, the number of South Carolinians uninsured at the time of the interview increased from 476,922 in 2003 to 633,675 in 2011, or an increase more than the population growth, reflecting the rise in the percentage currently uninsured from 11.5 percent to 13.7 percent. The broadest measure of the uninsured, those without insurance at some point during the previous 12 months, went from 804,455 to 892,695, an increase of 88,240, or 11 percent, which is consistent with the growth in the total population. For the chronically uninsured, those without any health insurance for the entire previous year, the number increased by 179,538, from 343,128 to 522,666. Given the rise in the percentage of those without health insurance for a year or more from 8.3 percent to 11.3 percent, the increase in this category was much greater than the growth of the total population. While the population grew 11.5 percent during this eight year period, the uninsured grew substantially more.

**Figure 15**  
**South Carolina Insurance Status 2003 and 2011**

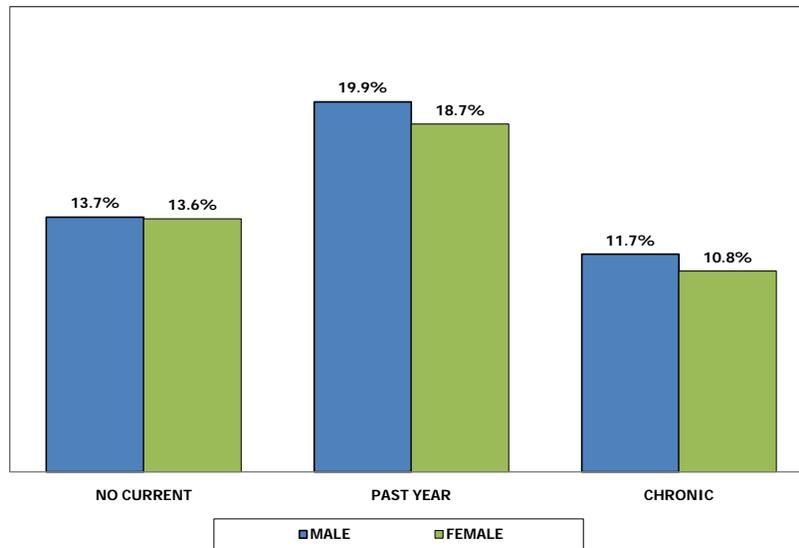
	2003	2011	Change
<b>Not Insured at time of survey</b>	476,922	633,675	156,752
%	11.5 %	13.7%	
<b>Not Insured some time in last 12 months</b>	804,455	892,695	88,240
%	19.4%	19.3%	
<b>No Insurance last twelve months</b>	343,128	522,666	179,538
%	8.3%	11.3%	
<b>Population</b>	4,147,152	4,625,364	478,212

Source: 2003 & 2011 Cross-Sectional Telephone Results, Institute of Public Service and Policy Research, University of South Carolina; 2010 US Census.

*Differences by Background Characteristics*

The data for the complete sample indicate little change in the percentage of South Carolinians who have been uninsured in the past 12 months and slight increases in the percentages who did not have health insurance at the time of the interview or who have been without health insurance for a year or more. This research also examined uninsured rates among a number of demographic subgroups and found a number of significant differences by background characteristics. For those uninsured, the differences by gender were relatively small, with females slightly less likely to be uninsured.

**Figure 16**  
**Uninsured by Gender**



Among the largest of the differences were those across age groups. The 18-29 year olds age group had the highest percentage of uninsured. Thirty-four percent of that age group had no insurance at some point this past year and 20 percent had no insurance for the entire year (This age group already is affected by the ACA provision to extend dependent coverage for adult children up to age 26 for all individual and group policies. This provision became effective with plan or policy years beginning on or after September 23, 2010). This group has also been impacted by the slowdown in the economy and the resulting increase in the unemployment rate. However, this group traditionally has the highest level of uninsured since it includes the “young invincibles” who are less

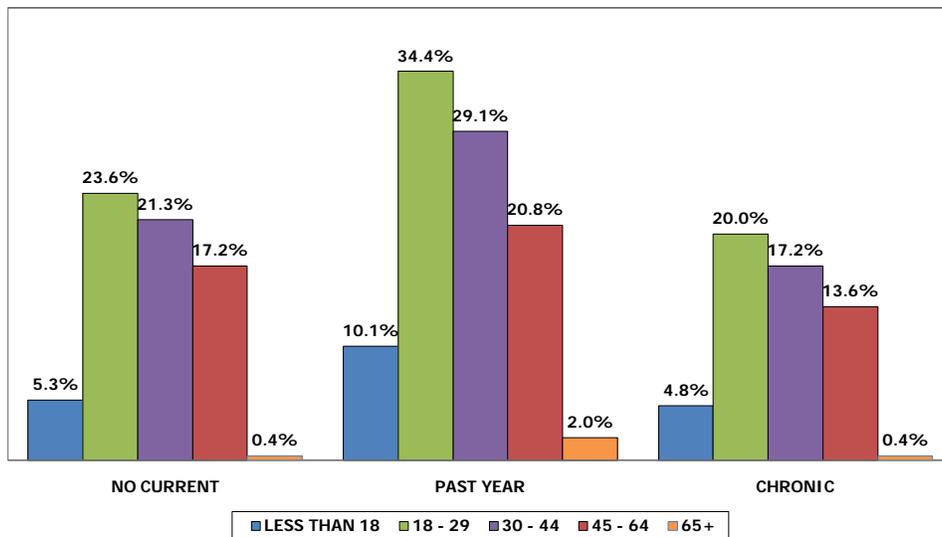
likely to understand the need to purchase health insurance and are, as a result, less likely to make that purchase.

The age groups with the lowest uninsured rates were children and the elderly. Two percent of those 65 and older, typically covered by Medicare, were uninsured at some point in the past year. Ten percent of children were uninsured at some point in the past year.

*Demographic Differences among those Ages 18 to 64*

The analysis of uninsured status among groups demonstrated that lack of health insurance is less prevalent among those under age 18 and much less for those ages 65 or older. Lack of insurance is more concentrated among those ages 18 to 64 and it is also people in this age range who are more likely candidates to consider obtaining health insurance through an exchange. As noted previously, within this 18 to 64 group there is a relationship between not having health insurance and age, with the percentage that did not have health insurance at some point in the past 12 months declining from 34.4 percent among those ages 18 to 29, to 29.1 percent for those ages 30 to 44, and 20.8 percent among those ages 45 to 64.

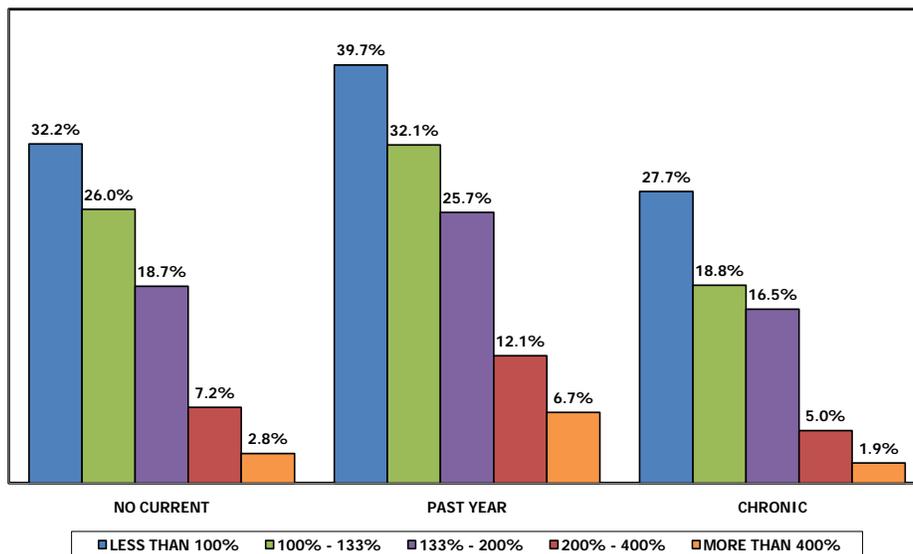
**Figure 17**  
**Uninsured by Age Group**



The impact of income on lack of insurance is even more striking within this age group than for the population overall. For those ages 18 to 64, more than 57 percent of those with incomes less than 100 percent of the federal poverty level were uninsured in the past year. This percentage declined steadily as income level increased, and was 8.6 percent among those with incomes greater than 400 percent of the federal poverty level.

Differences by income levels were also substantial and, not surprisingly, uninsured levels were highest among those with the lowest incomes. Adjusted for household size, those with incomes less than 100 percent of the FPL had the highest uninsured rate, 39.7 percent. Over 27 percent had no health insurance the entire previous year. For those with incomes more than 400 percent of the FPL, 6.7 percent were uninsured at one point in the previous year while 1.9 percent was chronically uninsured.

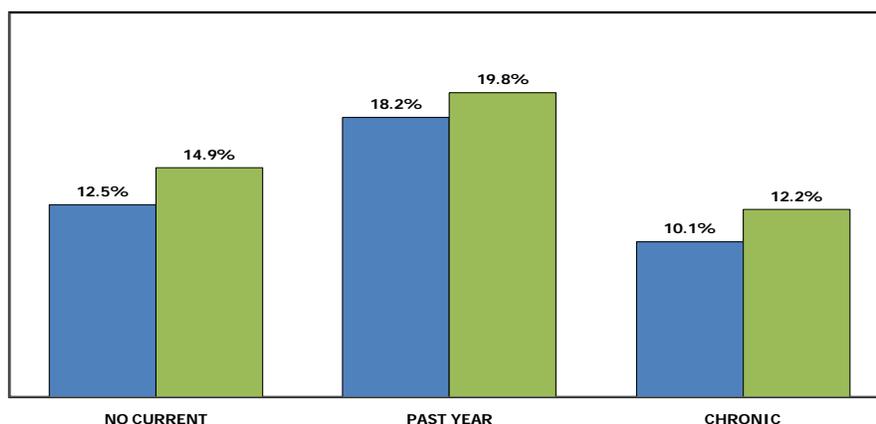
**Figure 18**  
Uninsured by Federal Poverty Level



Within this age group, differences in insurance status by education level were equally as significant. According to the survey, 54 percent of those between the ages of 18 and 64 with less than a high school education were uninsured at some point in the last 12 months. Thirty-two percent of those with a high school degree and 25 percent of those with some college were uninsured at some point in time over the past year. Fifteen percent of those with a college degree were uninsured.

There were slight differences in the uninsured rates by race but greater differences for those Hispanic versus non-Hispanic. In terms of current insurance, for example, 14.9 percent of blacks reported not having insurance, compared to 12.5 percent of whites. Blacks were also slightly more likely than whites to have been without health insurance at some point during the past year (19.8 percent to 18.2 percent) and to have lacked health insurance for more than a year (12.2 percent to 10.1 percent).

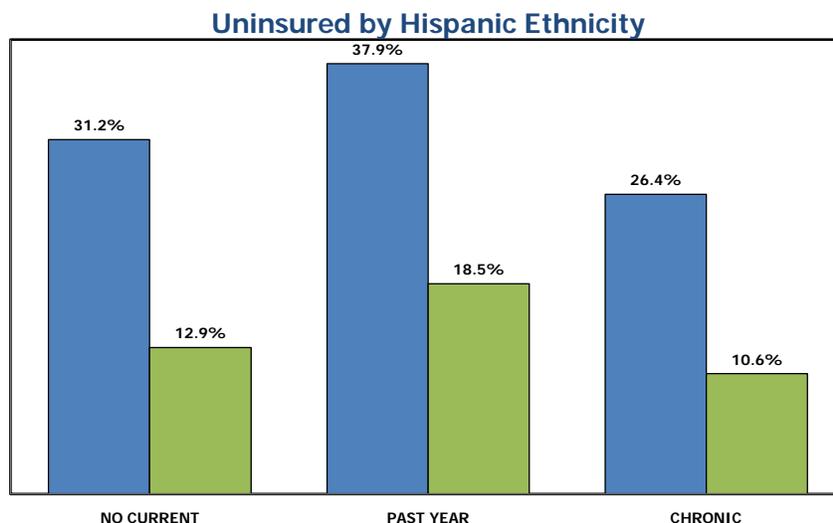
**Figure 19**  
Uninsured by Race



Differences between Hispanics and non-Hispanics were much greater. Thirty-one percent of Hispanics were uninsured at the time of the survey with 37.9 percent uninsured at some point in time this past year. For non-Hispanics, those rates were 12.9 and 18.5 percent respectively. Twenty-six percent of Hispanics were chronically uninsured, compared with 10.6 percent of non-Hispanics. Since Hispanics comprise only about five percent of the South Carolina population, the

absolute number of this group without health insurance is less than the number of non-Hispanics, but in relative terms, the problem of not having health insurance is much greater in the Hispanic than the non-Hispanic population.

**Figure 20**



### **Findings-Key Informant Survey**

Survey respondents provided various perspectives on the health insurance market as well as on the location, structure and operation of a health benefits exchange. They indicated preferences on issues that addressed adverse selection and sustainability of an exchange, as well as rating the most important objectives of an exchange. The survey also provided information on options the state should consider when structuring the individual and small group markets.

Two broad questions which respondents were asked to consider were (1) whether South Carolina should develop its own health insurance exchange or default to a federal exchange; and (2) if the State did establish an exchange, the type of business model it should adopt, either as an active purchaser, a passive clearinghouse, or some hybrid of these two approaches. Active purchasers negotiate with plans and selectively contract with insurers for exchange products, thus limiting the number of products offered. The exchange can also be a passive clearinghouse where all qualified health insurance carriers can sell their products or they can be a hybrid, with some requirements to limit the plans offered.

A clear majority of respondents felt the State should establish an exchange, with seventy percent of those responding adopting this position, 21 percent believing the state should default to the federal exchange, and nine percent undecided.

In terms of the objectives of an exchange, respondents were asked to rate a number of objectives on a scale from extremely important to not at all important. Key informants thought that the most important objectives of an exchange would be to increase competition in the insurance market, increase portability of insurance coverage, and provide cost and quality data. Other objectives, such as negotiating with health plans and helping small businesses, were rated as extremely important by smaller percentages of respondents.

**Importance of Exchange Objectives  
“Extremely Important” Response**

• Promote and increase competition	62%
• Increase portability and continuity	54%
• Provide cost and quality data	50%
• Driver of quality improvement and cost containment	44%
• Negotiator of health plans	37%
• Help small businesses	32%
• Promote consumer directed plans	31%
• Require additional quality standards	25%

One concern in establishing an exchange is that it must be self-sufficient by 2015, at which time the federal government will no longer provide funds to support the operation of a State’s exchange. Participants in the survey were asked whether or not they thought various methods should be used for funding an exchange. There was considerable variation in the percentage of these key informants who felt that various methods of financing an exchange should be used. The method that was most clearly supported was charging insurers a fee to offer plans on the exchange, which about three-fourths of the respondents thought should be used. Close to half of these respondents thought that the exchange should be supported by an increase in the current premium tax for all health plans, by charging license fees for Navigators, by an increase in the premium tax on health plans qualified to be sold through the exchange, and by charging a fee to small businesses to use the exchange. There was virtually no support for issuing bonds and borrowing money or for creating a new tax to operate the exchange.

**Methods for Financing a South Carolina  
Exchange “Should be Used”**

• Charge insurers a fee to offer plans on the Exchange	76%
• An increase in the current premium tax for all health plans	49%
• Charge license fees for Navigators	49%
• An increase in the current premium tax on health plans qualified to be sold through the Exchange	45%
• Charge a fee to small businesses to use the Exchange	45%
• Support the creation of risk pools to purchase insurance	35%
• Charge a fee to individuals to use the Exchange	29%
• Issue bonds and borrow money	6%
• Create a new tax	4%

Another concern expressed during the survey regarding the establishment of an exchange was the possibility of adverse selection.

Individuals who choose to wait until they become sick to purchase health insurance or who change benefit tiers to maximize their benefits increase the premium costs for everyone. Respondents were asked whether they would support various strategies for discouraging individuals from waiting until they became sick to purchase health insurance or for changing benefit tiers in an effort to help ensure the affordability of products sold within the exchange.

Respondents generally were supportive of various methods for limiting adverse selection, and it made little difference whether a small group market or individual market was being considered. More than 85 percent favored penalties for dropping coverage then enrolling again when ill, about two-thirds supported limited enrollment periods, and slightly more than half favored instituting a

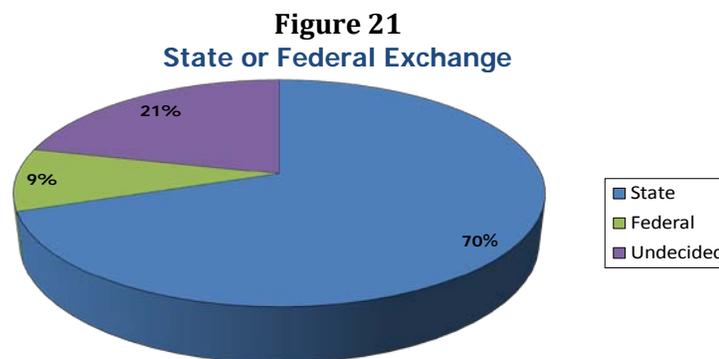
waiting period of 30 days for covered services. In terms of limiting adverse selection resulting from changes in benefit tiers, 70 percent supported individuals to move up or down only one benefit level relative to the previous year's benefit level. There was slightly less than majority support for charging a fee to move up or down a benefit level, and less than one-fourth of these key informants favored requiring individuals to lock in to an exchange benefit level for a multiple year period as a method for ensuring the affordability of products offered on the exchange.

**Methods for Discouraging Waiting Until Sick to Purchase Health Insurance “Support”**

- Institute penalties for dropping coverage and then enrolling again when ill for the small group market 87%
- Institute penalties for dropping coverage and then enrolling again when ill for the individual market 86%
- Institute limited enrollment periods for the individual market 67%
- Institute limited enrollment periods for the small group market 64%
- Institute a waiting period of 30 days for covered services for the individual market 55%
- Institute a waiting period of 30 days for covered services for the small group market 53%

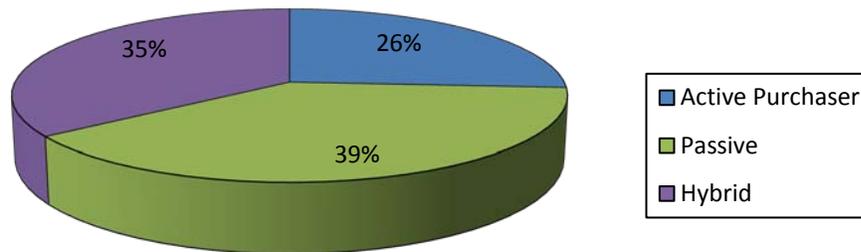
**Methods for Discouraging Changes in Benefit Tiers to Ensure Affordability “Support”**

- Allow individuals to move up or down only one benefit level relative to the previous year's benefit level 70%
- Charge a fee to move up or down a benefit level 46%
- Require individuals to lock in to an Exchange benefit level for a Multiple- year period 23%



Key informants were more divided on the question about the type of business models and what would work best for a South Carolina exchange. Thirty-nine percent favored the passive clearinghouse and 35 percent favored a hybrid approach. Twenty six percent favored the active purchaser model.

**Figure 22**  
**Exchange Business Model**



Many of the questions also provided for written responses. Those responses can be found in Appendix D.

### **Findings-Focus Groups**

Across the six groups, five themes emerged: cost escalation, openness and information, individual/personal responsibility, competition and marketplace, and fostering innovation. Among those themes were two overarching ideas: theory versus practice and the focus on broader health outcomes. The first reflected a shared vision among many participants that the theory behind an exchange -to expand health insurance coverage to the uninsured- is a laudable goal. However, the practical aspects of its operation were of concern.

#### *Cost Escalation*

Focus group participants, while believing that an exchange would increase coverage and coverage options, thought that it would do little to address the issue of health care costs, the primary driver of health insurance premiums. That concern extended to the impact of high deductible and maximum coverage health plans which are perceived as creating burdens for both consumers and healthcare systems. One healthcare system administrator remarked “Patients [with high deductible or maximum coverage policies] become, from our perspective, charity patients, and that has a tendency to cause the patient to not seek care until, lots of times, it’s pretty close to too late.”<sup>15</sup>

#### *Openness and Information*

The pricing of medical services was a concern. The differences between charges, contractual rates and prices can be confusing. A consumer representative stated the following: “To read those hospital bills and what the insurance rate was and what the adjusted rate was...it would take a genius to figure that out.”<sup>16</sup> Similarly, consumers often found insurance benefits and prices to be difficult to understand. One consumer noted: “I don’t know of a soul that I’ve talked to that understands insurance.”<sup>17</sup>

Benefits, premiums, deductibles, co-pays, and coinsurance are all terms that are difficult to understand. Charges, actual prices paid, and costs are not the same. And if you do not know those

terms and concepts, it is difficult for many consumers in this market to make purchase decisions that are in their best interest – i.e., it is difficult for market to work well when information is lacking, confusing, or both.

#### *Individual / Personal Responsibility*

Individuals across the focus groups emphasized the need to promote responsibility for healthcare choices including individual health behaviors. As the IOMPH found, the broader discussion for many was the need for guidance and education of those who require the most help with health practices.<sup>18</sup>

#### *Competition and Marketplace*

Participants in most focus groups noted a lack of competition in the insurance marketplace. Several saw some insurance carriers having greater market share than others while others mentioned the need for more quality carriers. A healthcare system administrator noted: “Competition is a concern and despite having put all the large payers essentially on par, other payers have not been able to gain market share.”<sup>19</sup> Insurance industry representatives also noted concern about the impact an insurance exchange would have on redefining the marketplace.

#### *Fostering Innovation*

Many comments centered around the opportunity that exists with any reform effort – the ability to generate new ideas and implement innovative efforts. Participants noted a number of promising practices across South Carolina and the opportunity to develop a unique, state-based solution. As one healthcare system administrator stated: “We in South Carolina probably know our people better than the feds probably know us. From the state’s perspective, I think we would be better off doing it [an exchange] ourselves.”<sup>20</sup>

There was little consensus regarding the technical aspects of establishing an exchange. However, there was general agreement that a state-run exchange would be preferable. As IOMPH noted: “Aspects of state control and tailoring to meet the unique needs of the state were seen as advantages to a state-administered exchange. Some participants did express concerns around the sustainability and cost of a state exchange, but most participants were still inclined to support a state approach despite those considerations.”<sup>21</sup>

## VI. Insurance Markets in South Carolina

### **Status of Health Insurance Markets in South Carolina**

Competition in the health insurance marketplace can be measured in several different ways. One way the market can be measured is by calculating the percentage of the market (i.e., measured in terms of the number of people enrolled) represented by the largest insurer in the state. A second way is to consider the number of insurance carriers representing a threshold portion of the market (> five percent), quantifying the extent of choice available to consumers among plans with material enrollment. A third measure of market competition is the Herfindahl-Hirschman Index (HHI) which measures how evenly market share is spread across a large number of insurers.

The values of HHI range from zero to 10,000 with values closer to zero indicating a more competitive market and values closer to 10,000 indicating a less competitive market. This scale is further broken into three categories: an unconcentrated market is represented by a 1,000 to 1,500 value range, a moderate concentration is represented by a 1,500 to 2,500 value range and a highly concentrated market has a value above 2,500.

According to the 2009 Kaiser Family Foundation, which is the most recent U.S. data on the coverage types to-date, 17 percent were uninsured, 12 percent were covered by Medicare, 16 percent were covered by Medicaid, one percent was covered by other public coverage, 49 percent were covered by employer-sponsored coverage, and five percent were covered by individual policies.

In South Carolina, for the same period, 16 percent were uninsured, 15 percent were covered by Medicare, 13 percent were covered by Medicaid, two percent were covered by other public coverage, 50 percent were covered by employer-sponsored coverage, and four percent were covered by individual policies.

#### *Individual Market*

The individual health insurance marketplace in many states is highly concentrated. Thirty states plus the District of Columbia had individual health insurance marketplaces with at least half the market dominated by a single insurance carrier in 2010. The median market share held by the largest health insurance carrier in each state was 54 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,761. It should be noted that in 45 states and the District of Columbia, the HHI exceeds 2,500. South Carolina's largest state insurer has a market share of 54 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 3,296.<sup>22</sup>

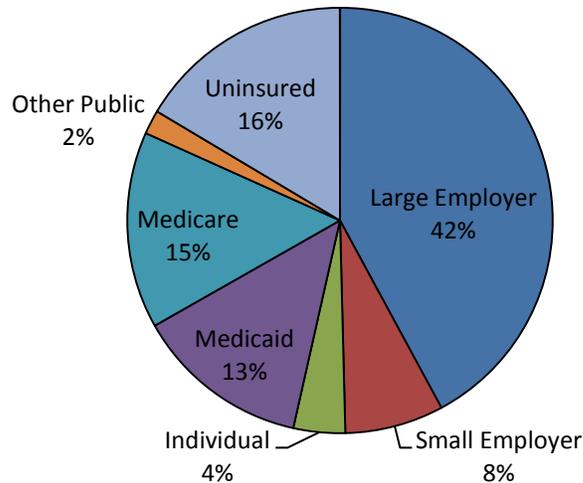
According to the Supplemental Health Exhibit filed with the NAIC in 2010, there are 64 companies with earned premiums in South Carolina for individual comprehensive health insurance. The top 10 companies account for 90 percent of all premiums earned in the state.

#### *Group Markets*

The employer-sponsored percentage for South Carolina can be broken down into large and small group coverage. The 50 percent of South Carolinians covered by employer-sponsored coverage breaks down to 42 percent for large employers and eight percent for small employers. Using data specific to South Carolina from the 2010 Medical Expenditure Panel Survey (MEPS), the breakdown between large and small employers can be derived.<sup>23</sup> MEPS provides the number of employees, the percentage of employees in companies offering health insurance, the percentage of employees eligible for health insurance, and the percentage of eligible employees who enroll in health

insurance, all broken down by companies with fewer than 50 employees and those with 50 or more employees. Using this data, the 50 percent of employer-sponsored coverage reported in the Kaiser Family Foundation data can be further divided into the relative percentages for small and large groups, as shown in the following table:

**Figure 23**  
**South Carolina Health Coverage**  
**Kaiser State Health Facts('09) and MEPS('10)**



The level of completion in the small group market is generally characterized in the same way as the individual market. The median market share held by the largest health insurance carrier in each state is 51 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,595. South Carolina’s largest state insurer has a market share of 67 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 4,783.

According to the Supplemental Health Exhibit filed with the NAIC in 2010, there are 25 companies writing business in South Carolina’s small group market out of a total of 131 authorized insurers. Here, the top five companies account for 90 percent of the marketplace. This is a significant decrease from the 1990s when South Carolina had 70-80 companies competing for small group business. By 2004, the market had stabilized with 23 carriers writing business in the state.

In the large group market there are 17 companies writing fully-insured health insurance products, and the top two comprise approximately 90 percent of the marketplace. However, more than 66 percent of coverage in this market is provided by self-funded plans where the employer assumes most of the risk for the product and hires an insurance carrier or a third party administrator to administer the benefits. Specific data is not available about the number of administrators in this part of the market. However, the total number of businesses either insured or administered by the two largest insurers/administrators in this market divided by the total population of individuals who receive coverage through a large employer determines that the two largest insurers/administrators comprise approximately 49 percent of the marketplace.

Some barriers to entry in the insurance marketplace include the inability to form provider networks and lack of brand awareness among consumers. An insurance carrier with significant market share may face little competition and may have higher premiums and profits, but it may also be better poised to negotiate lower rates with doctors and hospitals. It is believed that plans with at least five percent of the market share potentially control sufficient market share to grow in the future.

## **Recent State and Federal Strategies for Expanding Consumer Choice Inside the State**

The South Carolina Health Planning Committee received information from various experts related to potential strategies for controlling healthcare costs and their relationships with competitiveness in the marketplace.

### *State-specific Measures for Expanding Consumer Choice*

The South Carolina General Assembly enacted the small employer health group cooperative statutes<sup>25</sup> in 2008 (Act 180) to improve the ability of small employers to access affordable health insurance coverage. The basic concept of a health group cooperative is that a number of small employers, when joined together, will create a group with enough membership that they may command the same or similar coverage options that would be offered to a similarly-sized large employer. However, despite the legal ability of entities to form health group cooperatives, there seems to be a number of barriers that have limited the successful creation of cooperatives in South Carolina.

Prior to Act 180, Act 339 permitted a common group of small employers to join together for the purposes of obtaining group health, group accident, or group accident and health insurance.<sup>27</sup> The section further specified the requirements with which such a group would be required to comply. Many of these requirements are similar to those required for a health group cooperative. One noticeably different requirement is that the previous code required a group to contain at least 1,000 eligible employees, whereas Act 180 requires a small employer health group cooperative to contain at least 1,000 eligible employees *or* at least ten participating employers.

Act 180 added new provisions to and amended some of the existing statutes contained in Article 13, Chapter 71 of Title 38, known as the "Small Employer Health Insurance Availability Act," including the following:

- Provided that a health group cooperative contain at least 1,000 eligible employees *or* at least ten participating employers;
- Provided for the requirements, powers, duties, and restrictions of a health group cooperative; and,
- Required the DOI and Office of Research and Statistics to submit a report on the effectiveness of the health group cooperatives in expanding the availability of health insurance coverage for small employers by January 1, 2010. The DOI submitted the required report dated December 31, 2009.

In 1994, legislation was enacted in South Carolina which permitted a common group of small employers to join together for the purposes of obtaining group health or accident insurance.

The DOI issued Bulletin 2008-02, (*Procedures for Forming Health Group Cooperative in South Carolina*), which outlined the requirements for forming, registering and operating a group health cooperative. These provisions include the requirements that the cooperative must be registered and approved by the DOI prior to offering any insurance related services, and that any health

insurance policy offered through a cooperative must be provided by an insurer authorized by the DOI to conduct business in this state. (See Bulletin 2008-02, *Procedures for Forming Health Group Cooperatives in South Carolina*, March 14, 2008 for all provisions and requirements.) To date, one group has registered with the DOI as a health cooperative. To-date, this group has not obtained an agreement with an insurer licensed to conduct business in South Carolina. The primary reasons that small group pools have not succeeded in South Carolina or in every other state where they have been attempted are twofold: first, the premises that are used to support the establishment of pools typically are flawed and, second, the pools can become subject to anti-selection and fail.

*Federal Measures for Expanding Consumer Choice*

Section 1322 of the Affordable Care Act, titled "Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers," directs the Center for Medicare and Medicaid Services (CMS) to establish Consumer Operated and Oriented Plans (CO-OP) intended to incite member-governed, qualified, nonprofit health insurance issuers to offer CO-OP qualified health plans in the individual and small group markets (in compliance with state licensing regulations). This is intended to further competition in the health care marketplace and expand the number of health plans focused on integrated care and greater plan accountability available in each state's exchange.

CO-OPs will be directed by CMS to use any profits to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members. CO-OPs must meet all the state standards for licensure that other qualified health plans issuers must meet. To be eligible under the ACA, all of its activities must consist of the issuance of qualified health benefits plans in the state in which it operates

To assist in the formation of CO-OPs, CMS will offer two types of loans to organizations which apply to become qualified nonprofit health insurance issuers. Start up loans will provide assistance with start-up costs and have a repayment date of no later than five years after issuance. Solvency loans will provide assistance in meeting solvency requirements in the states in which the organization is licensed to issue CO-OP qualified health plans and have a repayment date of no later than fifteen years after issuance. CMS will give priority to applicants offering CO-OP qualified health plans on a statewide basis.

## VII. The Insured and Uninsured in South Carolina

South Carolina's population is 4.6 million with 4.0 million under the age of 65. Based on the research cited above, of those under age 65, 19.3 percent were uninsured at some point during the past 12 months and 13.7 percent were uninsured at the time of the interview. Also, 11.3 percent were uninsured for the entire previous 12 months (chronically uninsured). Based on these estimates, the uninsured in South Carolina are detailed as follows:

**Figure 24**

South Carolina	2003	2011
<b>Population</b>	4,147,152	4,625,364
<b>Uninsured at time of interview</b>	474,380	633,675
<b>Uninsured sometime past year</b>	804,455	892,695
<b>Uninsured for previous twelve months</b>	343,128	522,666

Based on the research, by household income, the uninsured are as follows:

**Figure 25**

South Carolina	2003	2011
<b>Less than 100 FPL</b>	34.3%	39.7%
<b>100 to 125% of FPL</b>	28.6%	32.1%
<b>126 to 200% of FPL</b>	28.1%	25.7%
<b>201 to 400% of FPL</b>	17.6%	12.1%
<b>Above 400% of FPL</b>	10.4%	6.7%

This utilizes data from both the 2003 and 2011 surveys. It is important to note that the way income was measured in the 2003 survey was not directly tied to the federal poverty level (FPL) categories for family size. For that reason, the method for measuring income was changed in the 2011 survey, creating a measure based on the number of people who live on the family's income and specific FPL categories. The way income was measured in 2003 prohibits a direct comparison between years and there are enough differences between the measures that no definitive conclusions can be reached. However, to the extent these data are comparable, the data suggest that the lack of insurance may be becoming more concentrated among those with lower household incomes. The estimates for those without insurance at any point during the past year were 19.4 percent and 19.3 percent in 2003 and 2011, respectively. However, the combined figures in the two lowest FPL categories have increased from 63 percent to 72 percent. The figures in the two highest income groups have declined from 28 percent to approximately 19 percent.

Sources of insurance are primarily employment-based, as 62.8 percent of those responding had insurance through either their employer or a family member's employer. Twenty-one percent purchased insurance directly, although approximately only four percent were for individual

policies. Medicare was stated as the insurer by 18.7 percent and 26.8 percent were insured through Medicaid or the Children’s Health Insurance Program, commonly known as CHIP. Because it is possible to have more than one source of insurance, the percentages below total more than 100 percent. For example, an individual may be covered by Medicare and purchase a supplemental policy in addition.

**Figure 26**

<b>Sources of Insurance (All Respondents)</b>	
<b>Type</b>	<b>Percent</b>
<b>Health insurance through work or union</b>	35.6
<b>Health insurance through someone else’s work or union</b>	27.2
<b>Insurance purchased directly</b>	21.5
<b>Medicare</b>	18.7
<b>Medicaid</b>	16.3
<b>Children’s Health Insurance Program (CHIP)</b>	10.5
<b>TRICARE</b>	7.2
<b>Active Military</b>	1.8
<b>Railroad Retirement Plan</b>	1.6
<b>COBRA</b>	1.2
<b>SC Health Insurance Pool or high risk pool insurance</b>	1.1
<b>Federal high risk pool</b>	.3

Figure 27 details the insurance profile for those surveyed who had insurance. Again, there can be multiple sources, or combinations, of insurance.

**Figure 27**

<b>Insurance Profile (Among respondents with health insurance)</b>	
	<b>Percent</b>
<b>Through own work or union only</b>	19.7
<b>Through someone else’s work or union</b>	19.5
<b>Medicaid only</b>	10.0
<b>Medicare only</b>	6.5
<b>Someone else’s work and purchased directly</b>	6.3
<b>Through own work and purchased directly</b>	4.5
<b>Insurance purchased directly only</b>	4.1
<b>Medicare and purchased directly</b>	3.8
<b>Medicare and Medicaid</b>	3.0
<b>TRICARE/Veteran’s Affairs only</b>	2.7
<b>Medicaid and Children’s Health Insurance Program</b>	2.4
<b>TRICARE/Veteran’s Affairs and Medicare</b>	1.8
<b>Through own work or union and Medicare</b>	1.4

<b>Through someone else's work or union and Medicare</b>	1.3
<b>Through own work and someone else's work</b>	.9
<b>Through someone else's work or union and Medicaid</b>	.7
<b>TRICARE, Veteran's Affairs and purchased directly</b>	.6
<b>Railroad retirement plus other type</b>	.4
<b>Medicaid and purchased directly</b>	.4
<b>Through own work or union and Medicaid</b>	.3
<b>COBRA only</b>	.2
<b>Railroad retirement only</b>	.2
<b>Children's Health Insurance Program only</b>	.1
<b>South Carolina Health Insurance Pool only</b>	.1
<b>Active military only</b>	.1
<b>Other combinations of two types of insurance</b>	2.3
<b>Three or more types of insurance</b>	6.5

The following table provides the sources of insurance by income level as it relates to the FPL. All figures are percentages of responses. Again, there can be multiple sources, or combinations, of insurance.

**Figure 28**

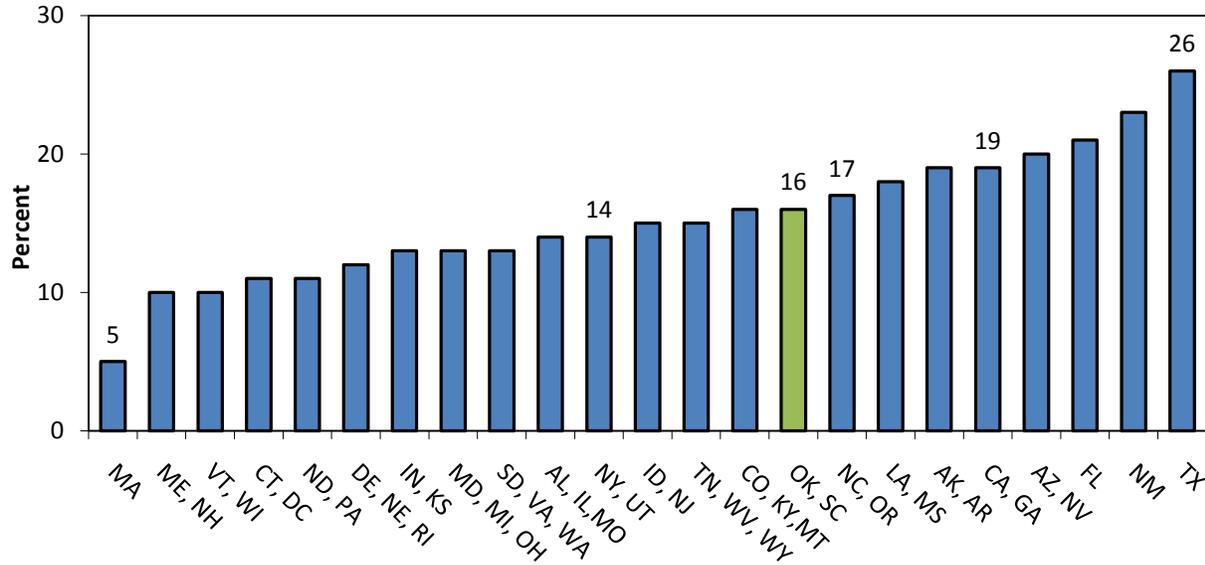
<b>Sources of Insurance By Federal Poverty Level</b>					
<b>Type</b>	<b>&lt; 100%</b>	<b>100% - 125%</b>	<b>126%- -200%</b>	<b>201% - 400%</b>	<b>More than 400%</b>
<b>Through own work or union</b>	8.3	21.2	31.5	4.16	51.4
<b>Through someone else's work or union</b>	4.8	6.8	22.8	37.5	41.8
<b>Insurance purchased directly</b>	3.0	3.5	10.0	14.7	16.7
<b>Medicare</b>	18.7	26.2	19.2	17.6	14.4
<b>Medicaid</b>	48.9	34.9	18.2	4.6	1.3
<b>Children's Health Insurance Program</b>	21.3	31.9	12.2	3.3	1.2
<b>TRICARE, Veterans Affairs</b>	4.2	2.9	5.8	11.3	6.7
<b>Active Military</b>	1.5	1.1	1.6	2.5	2.0
<b>Railroad Retirement Plan</b>	.6	2.5	.2	2.8	1.4
<b>COBRA</b>	.2	2.5	1.6	1.7	.9
<b>SC Health Insurance Pool</b>	2.7	.7	1.1	.4	1.2
<b>Federal High Risk Pool</b>	1.0	0	.4	.1	.1

Affordability was the reason most often given by those who did not have coverage (69.7 percent said that they could not afford to purchase insurance). An additional 3.3 percent stated that they were not working and could not afford insurance.

Based on 2009 data from Kaiser's State Health Facts, 16 percent of South Carolinians were uninsured while the state with the highest percentage of uninsured was Texas with approximately

one in four uninsured (26 percent). Massachusetts had the lowest number uninsured at five percent<sup>28</sup>.

**Figure 29**  
**Uninsured Rate by State**



**Figure 30**  
**2011 Federal Poverty Guidelines<sup>29</sup>**  
**(48 Contiguous States and District of Columbia)**

Federal Poverty Level							
# In Household	100%	125%	133%	150%	200%	300%	400%
1	\$10,890	\$13,613	\$14,484	\$16,335	\$21,780	\$32,670	\$43,560
2	\$14,710	\$18,388	\$19,564	\$22,065	\$29,420	\$44,130	\$58,840
3	\$18,530	\$23,163	\$24,645	\$27,795	\$37,060	\$55,590	\$74,120
4	\$22,350	\$27,938	\$29,726	\$33,525	\$44,700	\$67,050	\$89,400
5	\$26,170	\$32,713	\$34,806	\$39,255	\$52,340	\$78,510	\$104,680
6	\$29,990	\$37,488	\$39,887	\$44,985	\$59,980	\$89,970	\$119,960

## VIII. Public Programs Currently Providing Coverage

South Carolinians have access to various public insurance programs. Most seniors, low-income children, and families who meet certain eligibility requirements receive their primary source of health insurance coverage from these public programs. Medicare, Medicaid, and SCHIP are the primary public programs, while TRICARE and the Veterans Health Administration provide health benefits to many service men and women. South Carolina's indigenous populations are covered for medical care through the Indian Health Service.

### **Medicare**

Medicare is a federal social health insurance program created in 1965 which now covers 47 million elderly and disabled Americans and is one of the largest sources of health insurance in the United States. It accounted for 12 percent of total federal spending in 2010 and 23 percent of total national health spending.<sup>30</sup> The Center for Medicare and Medicaid Services (CMS), which is an operating division of the U.S. Department of Health and Human Services (HHS), administers the program. Medicare coverage is provided to most people who are age 65 or older, those who are under age 65 with certain disabilities, non-elderly people who receive Social Security Disability Insurance (after a two-year waiting period), and people of all ages with end-stage renal disease (permanent kidney failure necessitating dialysis or a kidney transplant).<sup>31</sup>

The benefits of Medicare are structured into four parts:

- Part A: Hospital Insurance
- Part B: Medical Insurance
- Part C: Medicare Advantage
- Part D: Prescription Drug Coverage

Original Medicare, or traditional Medicare, consists of Part A and Part B. Original Medicare is a fee-for-service health plan, meaning that any doctor or hospital that accepts Medicare can be chosen for care and medical services.<sup>32</sup> Drug coverage is not included in Original Medicare. If drug coverage is desired, it must be chosen from a Medicare-approved private insurance company.

Part A: Hospital Insurance covers inpatient hospital care, some skilled nursing facility care, hospice care and home health care when certain conditions are met.

In most instances, Medicare beneficiaries do not pay a premium for Part A as they or a spouse paid Medicare taxes while working. In the event the beneficiary is not eligible for a premium-free Part A, they may be able to buy it if they are age 65 or older, entitled to Part B, and meet the citizenship requirements or if they are under age 65, disabled, and their premium-free Part A ended because of a return to work.

Part B: Medical Insurance covers doctor visits, some preventive services, outpatient care, and home health care. It also helps cover some medical services not covered by Part A, like physical and occupational therapists.

Part D: Prescription Drug Coverage is an optional prescription drug benefit that may help lower prescription drug costs and is available to anyone who is eligible for Medicare. Most people pay a monthly premium for this coverage that is provided by Medicare-approved private insurance companies.<sup>33</sup>

In addition to the benefits provided by Medicare Parts A, B and D, Medicare supplemental health insurance plans (Medigap) are available to beneficiaries of Original Medicare to help cover out-of-pocket expenses, like deductibles and coinsurance costs, which Medicare does not cover.

Part C: Medicare Advantage is an alternative to Original Medicare and allows for beneficiaries to enroll in a private health plan, such as a health maintenance organization (HMO), Preferred Provider Organizations (PPOs), and Private-Fee-For-Service (PFFS) plans. The private health plans provide Medicare-covered benefits and often extra benefits, such as eye glasses or reduced cost sharing.

### **Medicaid**

Medicaid is a state-administered program that combines state and federal funding to provide care for low-income families. It is the third largest provider of health insurance in the U.S. and was originally designed to provide coverage for low income women and children. Over time, Medicaid has evolved to provide care for many groups of people with specific medical needs. Eligibility criteria and services offered vary by state.

Pregnant women can obtain insurance coverage through the SC Medicaid program Optional Coverage for Pregnant Women and Infants (OCWI). This program was established under the Omnibus Budget Reconciliation Act of 1986 to provide health insurance to low-income pregnant women and their infants less than one year of age. To qualify for OCWI, a woman must be pregnant and the pregnancy, including the expected date of delivery, must be verified. Pregnancy includes the 60-day postpartum period, which begins on the date of delivery or termination of the pregnancy. Pregnant women and infants must be SC residents, U.S. citizens, or legal immigrants and have a social security number. They must have their citizenship and identities verified and assign rights to medical support. Their countable resources must be at or below \$30,000 and their income limit must be at or below 185 percent of the Federal Poverty Level (FPL), which is \$3,446 per month for a family of four (DHHS Optional, 2011).

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA) created a coverage group known as the Breast and Cervical Cancer Program (BCCP) and was first implemented October 1, 2001. The program provides full Medicaid benefits to uninsured women who are found in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN 2/3 or atypical hyperplasia). To qualify, women must be found in need of treatment for pre-cancerous or cancerous breast and/or cervical cancer cells. The woman must not have other health insurance coverage and must not be eligible for any other SC Medicaid program. Coverage ends once treatment is completed. The family income must be at or below 200 percent of the FPL, which is currently \$2,452 per month for a family of two. There is no resource limit (DHHS Breast, 2005).

Section 9402 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) created an optional coverage group for aged, blind or disabled (ABD) individuals with family income at or below 100% of the FPL. The South Carolina Medicaid program began covering these individuals effective October 1, 1989. To qualify, the individual must be aged, blind, or disabled and SC residents, US citizens, or legal immigrants. Citizenship and identity must be verified. The individual must have a social security number; apply for and accept other benefits; assign rights to medical support; have income at or below 100 percent of the FPL, which is currently \$908 per month for an individual and \$1,226 per month for a couple; and, have countable resources at or below \$6,680 for an individual or \$10,020 for a couple (DHHS Aged, 2011).

Children and their parents or caretaker relatives who meet Family Independence (FI) financial eligibility criteria can obtain insurance coverage through SC Medicaid's Low Income Families (LIF) program. To qualify, a family must have one or more dependent child(ren) living in the home with a specified degree of relationship; must be SC residents, US citizens, or legal immigrants; and, must have social security numbers. They must have their identities and citizenship verified, apply for and accept other benefits, and assign rights to and cooperate in seeking medical support. The family must have net countable income at or below the FI standard of need, which is currently \$920 per month for a family of four. The family must have countable resources at or below \$30,000 (DHHS Low, 2011).

Children under age 19 can obtain coverage through the SC Medicaid program Partners for Healthy Children (PHC). This program was established under Title XXI of the Social Security Act for children who live in families with income at or below 200 percent of the FPL, which is currently \$3,725 per month for a family of four. These children must be SC residents, US citizens, or legal immigrants; have a social security number; and, must have their identities and citizenship verified. The family must apply for and accept other benefits, assign rights to medical support, and have resources at or below \$30,000 (DHHS Healthy, 2011).

Disabled children qualify for the SC Medicaid program under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The child must be age 18 or younger and meet the Supplemental Security Income (SSI) definition of disability. The child's income must be at or below 300 percent of the FPL, currently \$2,022 per month, and countable resources must be at or below \$2,000. The child must live at home and must meet one of the three institutional levels of care: intermediate care for the mentally retarded, nursing facility, or hospital care. The child must receive the level of care appropriate for his/her needs, but the cost of caring for the child in the home must not exceed the estimated cost of caring for the child within the proper institution of care (DHHS Disabled, 2009).

People who reside in a licensed and certified hospital or nursing home for an extended period of time qualify for long-term care through SC Medicaid's Individuals in Nursing Facilities and/or Receiving Home and Community-Based Services (HCBS) program. These individuals may also elect to receive care at home, requiring that the care is appropriate for their needs and does not cost more than the estimated cost of living in a facility. To qualify, the individual must be age 65 or older, blind, or totally and permanently disabled according to the SSI guidelines. The individual must be a resident of SC and a US citizen or a legal immigrant. Citizenship and identity must be verified. The individual must have a social security number; apply for and accept other benefits; assign rights to medical support; have income at 300 percent of the FPL (currently \$2,022) and, resources at or below \$2,000.

The Balanced Budget Act of 1997 gave optional coverage to working disabled individuals with gross income at or below 250 percent of the FPL. This allowed SC to create the Working Disabled Program (WD) effective October 1, 1998. Employed individuals under age 65 who are totally and permanently disabled under the SSI definition are eligible. The individual must be a SC resident, US citizen, or legal immigrant. A social security number and assignment of rights to medical support are required. Income eligibility is determined by two steps. First, it must be determined that the gross income, after allowable deductions, is at or below 250 percent of the FPL for family size, and second, it must be determined that the unearned income is at or below 100 percent of the FPL for an individual. The person's countable resources must be at or below \$6,680 (DHHS Individuals, 2009).

### **Children's Health Insurance Program (CHIP)**

Established in 1997 and reauthorized in 2009, the Children's Health Insurance Program (CHIP) is a state-federal partnership program that is regulated by federal guidelines. Based on state expenditures, CHIP provides capped funds on a matching basis. The state determines the design and eligibility requirements of the program, but generally CHIP provides coverage for eligible uninsured children under age 19 and pregnant women of families who do not qualify for Medicaid and fall between 150-200 percent of the FPL. South Carolina ended participation in the federal CHIP program in 2010, but continues to provide benefits for these individuals through various groups. The primary Medicaid programs for children are PHC and TEFRA .

### **Indian Health Service**

Another operating agency within HHS is the Indian Health Service (IHS) which is responsible for providing medical and public health services to its members. IHS is a federal agency that serves as the primary provider for American Indians and provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally-recognized tribes in 35 states. The Indian Health Care Improvement Act of 1976 gave IHS the ability to bill HHS and CMS for the services it provides to tribal members who also qualify for Medicaid, Medicare, CHIP, and other public programs. In addition to providing medical care and public health outreach, IHS now assists the Indian population with enrollment in available alternate resources of health care coverage. Enrollment in other public programs removes some of the financial burden from IHS. IHS and CMS meet regularly to ensure close coordination of policies, ensure increased IHS/HHS consultation, discuss innovation, implement outreach and education activities, and improve access to care for the American Indian and native populations (HHS Indian, n.d.).

### **TRICARE**

Active duty and retired service men, women, family members, and survivors of the seven uniformed services as well as members of the National Guard and Reserves and their families have access to TRICARE health benefits depending on the military status of their sponsoring member. There are many different TRICARE plans designed to meet the needs of the diverse armed services population.

#### *TRICARE Prime*

Active duty service members and activated Guard or Reserve members must enroll in TRICARE Prime. There is no enrollment fee. TRICARE Prime requires less out-of-pocket cost than other TRICARE plans, but beneficiaries must select a provider from the limited network. TRICARE Prime beneficiaries have an assigned primary care manager (PCM), either at a military treatment facility (MTF) or from the TRICARE network. The PCM refers the beneficiary to a specialist, when needed, and coordinates with a regional contractor for authorization of medical services, finding a specialist in the TRICARE network, and filing claims. There are time and distance standards of care such as appropriate wait-times for urgent, routine and specialty visits. TRICARE Prime has special programs such as enhanced vision care and preventive services with an added benefit of travel reimbursement for qualifying specialty medical services. Medical services provided by the beneficiary's PCM or a qualifying referral cost nothing for active duty service members and their families.

All other beneficiaries pay annual enrollment fees and the cost for care is based on where the care is received. Care received outside of these guidelines may require fee-for-service (TRICARE Prime, 2011).

### *TRICARE Prime Remote*

TRICARE Prime Remote (TPR) is a managed care enrollment option for active duty service personnel and their eligible family members who live and work in designated remote duty stations in the U.S. This is defined as 50 miles or an hour drive time from a military treatment facility. TPR has less out-of-pocket costs than TRICARE Standard and Extra (detailed below), but a more limited provider network. TPR beneficiaries may select a PCM from this network. In the event that a network PCM is not available, any TRICARE-authorized, non-network provider may be selected. PCMs provide the majority of medical care or may refer care to a specialist. TPR enrollment includes the same time and distance standards for care as TRICARE Prime and includes the same enhanced vision and preventive services and situational travel reimbursement. As long as care is received or referred by a PCM, there is no cost to the beneficiary, but in the event a referral is not obtained the beneficiary may be responsible for payment (TRICARE Prime Remote, 2011).

### *Tricare Standard and Extra*

Non-active duty beneficiaries in the U.S. are eligible for TRICARE Standard and Extra. This is a fee-for-service plan with automatic coverage and no need to enroll. However, current information in the Defense Enrollment Eligibility Reporting System is required. TRICARE Standard and Extra fee-for-service design allows beneficiaries to choose their provider without worrying about whether they are in or out of network. Providers must simply be TRICARE-authorized. This is also an ideal option for those who live in an area where TRICARE Prime is not available. Military treatment facilities will care for TRICARE Standard and Extra beneficiaries on a space-available basis only. No referral is required, but some services may require prior authorization. "Standard" means the beneficiary is seeing a non-network provider. "Extra" means the beneficiary is seeing a network provider. This determines how much the beneficiary will pay out-of-pocket. Using a network provider is the most cost-effective option. Costs are also affected by current military status or the beneficiary's relationship to their sponsoring family member. Once the annual deductible has been met, the beneficiary will pay only a percentage of cost (TRICARE Standard, 2011).

### *TRICARE Reserve Select*

Selected Reserve Members of the Ready Reserve and their families worldwide are eligible for TRICARE Reserve Select (TRS) requiring they are not enrolled in the Federal Employee Health Benefits (FEHB) program (as defined in [Chapter 89 of Title 5 U.S.C.](#)). TRS is a premium-based health plan that provides comprehensive health care coverage. Beneficiaries may choose a TRICARE-authorized provider, network or non-network. This determines how much the beneficiary will pay out-of-pocket. Using a network provider is the most cost-effective option. Military treatment facilities will care for TRS beneficiaries on a space-available basis only. No referral is required, but some services may require prior authorization. TRS premium rates are established each calendar year and the beneficiary is required to pay monthly premiums after enrollment (TRICARE Reserve Select, 2011).

### *TRICARE Retired Reserve*

TRICARE Retired Reserve (TRR) provides premium-based, comprehensive health care coverage to retired Reserve members, their families, and survivors worldwide and may be purchased before age 60. By law, beneficiaries must pay the full cost of coverage and will not receive a government subsidy. Beneficiaries have their choice of providers, network or non-network. Premium amounts are adjusted each calendar year to reflect changes in legislation (TRICARE Retired, 2011).

### *TRICARE for Life*

"TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries worldwide, regardless of age or place of residence, provided they

have Medicare Parts A and B (TRICARE Life, 2011).” There are no enrollment fees, but the beneficiary must be paying monthly premiums for Medicare Part B. With TFL, Medicare is the beneficiary’s primary source of coverage and TRICARE is their secondary payer. This means the beneficiary’s TRICARE benefits will cover Medicare’s coinsurance and deductible. Medicare-participating providers will be billed first and the portion that is not covered is forwarded to TFL. Because this plan relies on Medicare enrollment, it is important for beneficiaries to choose providers who are permitted to bill Medicare. This means TFL beneficiaries should not seek care from the Veteran’s Administration as they opt-out of the Medicare program (TRICARE Life, 2011).

#### *TRICARE Young Adult*

TRICARE Young Adult is available for purchase by qualified dependents and is ideal for unmarried adult children who have surpassed the age limits of regular TRICARE coverage and are approaching independence from their parents. It is a premium-based plan that provides access to comprehensive medical and pharmacy benefits. Dental coverage is excluded. Beneficiaries may choose a TRICARE-authorized provider, network or non-network. This determines how much the beneficiary will pay out-of-pocket. Using a network provider is the most cost-effective option. Military treatment facilities will care for TRS beneficiaries on a space-available basis only. No referral is required, but some services may require prior authorization (TRICARE Young, 2011).

#### *Veteran’s Health Administration*

Those who served in the armed forces and were honorably discharged or released, their spouses, and dependents may qualify for VA health care benefits. This includes Reservists and National Guard members who were called to active duty by a Federal order and completed the full period for which they were called. If the veteran enlisted after Sept. 7, 1980 or entered active duty after Oct. 16, 1981, he or she must have served 24 continuous months or the full period for which they were called. Veterans discharged for hardship or early-out for a disability incurred or aggravated in the line of duty may be exempt from these requirements. During enrollment, each veteran is assigned to a priority group. These priority groups help the VA manage demand for resources and are as follows (U.S. Veterans, 2011):

Group 1: Veterans with service-connected disabilities rated 50 percent or more and/or veterans determined by VA to be unemployable due to service-connected conditions

Group 2: Veterans with service-connected disabilities rated 30 or 40 percent

Group 3: Veterans with service-connected disabilities rated 10 and 20 percent, veterans who are former Prisoners of War or were awarded a Purple Heart medal, veterans awarded the Medal of Honor, veterans awarded special eligibility for disabilities incurred in treatment or participation in a VA Vocational Rehabilitation program, and veterans whose discharge was for a disability incurred or aggravated in the line of duty

Group 4: Veterans receiving aid and attendance or housebound benefits and/or veterans determined by VA to be catastrophically disabled

Group 5: Veterans receiving VA pension benefits or eligible for Medicaid programs, and non service-connected veterans and non-compensable, zero percent service-connected veterans whose gross annual household income and/or net worth are below the VA national income threshold and geographically-adjusted income threshold for their resident area

Group 6: Veterans of World War I; veterans seeking care solely for certain conditions associated with exposure to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; for any illness associated with participation in tests conducted by the Department of Defense (DoD) as part of Project 112/Project SHAD; veterans with zero percent service-connected disabilities who are receiving disability compensation benefits; veterans who served in the republic of Vietnam between 1962 and 1975; veterans of the Persian Gulf War that served between August 2, 1990 and November 11, 1998; and, veterans who served in a theater of combat operations after Nov. 11, 1998 as follows:

Veterans discharged from active duty on or after Jan. 28, 2003, who were enrolled as of Jan. 28, 2008 and veterans who apply for enrollment after Jan. 28, 2008, for 5 years post discharge

Veterans discharged from active duty before Jan. 28, 2003, who applied for enrollment between Jan. 28, 2008 and Jan. 27, 2011

Group 7: Veterans with gross household income below the geographically-adjusted income threshold (GMT) for their resident location and who agree to pay co-pays

Group 8: Veterans, enrolled as of January 16, 2003, with gross household income and/or net worth above the VA national income threshold and the geographically-adjusted income threshold for their resident location and who agree to pay co-pays.

Note: Due to income relaxation rules implemented on June 15, 2009, veterans with household income above the VA national threshold or the GMT income threshold for their residence location by 10 percent or less, who agree to pay co-pays, are eligible for enrollment in Priority Group 8. (U.S. Veterans, 2011).

### **South Carolina Health Insurance Pool (SCHIP)**

The South Carolina Health Insurance Pool was created by the General Assembly in 1989 to make health insurance coverage available to residents of South Carolina under 65 years of age who were either unable to obtain health insurance because of a medical condition or whose premium for health coverage exceeded 150 percent of the Pool rate. South Carolina's SCHIP benefits meet the requirements of a State Alternative Mechanism (SAM). SCHIP coverage administration is determined through a periodic competitive bidding process. There are three criteria for SCHIP eligibility: residency, medical/rate, and federally-defined or qualified Trade Adjustment Assistance-eligible individual. Rates were required to be set no higher than 200 percent of the standard risk rate. In 1997, Act No. 4 changed the requirements of the Pool to comply with HIPAA and to make other technical changes to the law. In 2002 and 2003, the Pool was further changed and was required to begin offering Medicare Supplemental coverage to persons under the age of 65 and on Medicare for reasons other than age (Acts No. 240 and 73). Rates for the supplement plans were required to be set at a level to provide fully for the expected costs of claims and expenses. To be eligible for the Pool a person must be a resident of South Carolina for no less than the last thirty days with written documentation of residency (residency must be maintained) and provide evidence of one of the following:

- A refusal by an insurer to issue comparable coverage for health reasons
- A refusal by an insurer to issue comparable coverage except with a reduction or exclusion of coverage for a preexisting health condition for a period exceeding twelve months;
- A refusal by an insurer to issue comparable coverage except at a rate exceeding 150 percent of the Pool rate;

**or**

- Be a federally defined eligible individual; or
- Be under the age of sixty-five and covered under Medicare Parts A and B for reasons other than age.

(See Section 38-74-30, South Carolina Code of Laws.)

Infants younger than 30 days old who meet the other requirements are eligible for SCHIP. If an individual is eligible for benefits through SCHIP because they are a federally-defined eligible individual or a qualified TAA-eligible (Trade Adjustment Assistance) individual, the medical/rate requirement is waived, and the residency requirement will be waived for 30 days.

As of year-end 2010, there were 2,255 individuals enrolled in the Pool. Of those individuals, 286 were enrolled in Medicare Supplement insurance with the remaining enrolled in the comprehensive major medical plans.

#### *Plan Types*

The following benefit plans are offered to those eligible for the comprehensive major medical coverage, including federally defined eligible individuals:

- 80/60 Plan – provides benefits with coinsurance levels of 80 percent for in-network services and 60 percent for out-of-network service. At the end of 2010, there were 385 individuals enrolled in this benefit plan.
- 80/80 Plan – provides benefits with coinsurance levels of 80 percent for both in-network and out-of-network services. At the end of 2010, there were 88 individuals enrolled in this plan.
- HDHP – a qualified high deductible health plan that may be used in conjunction with a health savings plan. At the end of 2010, there were 1,496 individuals enrolled.
- Medicare Supplement plans are offered in standardized Plans A and C.

#### *Calculating the Standard Pool Rate*

The standard risk rate for major medical expense coverage is determined by taking into account the individual standard rate charged by the five largest insurers offering individual coverage in the State comparable to the pool coverage. Each year premium information is collected from all health insurers operating in South Carolina and the five largest writers are determined. Rate information from these five carriers are then collected and adjusted to the level of the Pool plan benefits by an independent actuary to determine the standard risk rate.

#### *Premiums Charged in the Pool*

For the comprehensive major medical plans, rates must provide for the expected costs of claims and expenses of operation taking into account investment income and any other cost factors but may not exceed 200 percent of rates established as applicable for individual standard risks. Rates have been established as 200 percent of the standard risks each year since pool inception. There is a 25 percent extra charge for those individuals who become eligible by virtue of their premiums exceeding 150 percent of the Pool rate.

Rates established for the Medicare Supplement plans also must provide fully for the expected costs of claims and expenses of operation taking into account investment income and any other cost factor.

### *Assessments*

Assessments against member insurers are made in order to cover the losses of the Pool for all plans except the Medicare Supplement plans which must be self-sufficient. These assessments are allocated based on the amount of each insurer's health insurance premiums written in the state. The insurers are then allowed a credit against South Carolina premium taxes or income taxes up to a maximum per year of \$10 million for all companies combined.

In addition to assessments, the Pool receives yearly grant monies from the federal government which is used to reduce premiums for enrollees. In 2010 and 2011, the Pool received approximately \$1.5 million in federal grants.

Although the establishment of the high risk pool meant that virtually every South Carolinian could purchase insurance coverage either through the commercial market or through the pool, the low level of enrollment in the Pool and the continued high level of uninsured is a signal that cost is a predominant driver of individuals' decisions about whether to purchase health insurance even when the cost of the insurance is less than the cost of care without the insurance.

### **Pre-Existing Condition Insurance Plan**

Section 1101 of the Patient Protection and Affordable Care Act establishes a \$5 billion temporary high-risk pool, known as the Pre-Existing Condition Insurance Plan (PCIP), to provide health insurance coverage to individuals who cannot obtain coverage in the private insurance marketplace because of a pre-existing condition. In 2014, market forms enacted by the ACA will allow for access into the private insurance marketplace where policies are issued on a guarantee-issue basis, meaning an enrollee cannot be denied due to a pre-existing condition.

PCIP covers primary and specialty care, hospital care, and prescription drugs. All covered benefits are available on the coverage effective date, even if it is to treat a pre-existing condition as there are no waiting periods. However, applicants must have had no insurance for at least six months prior to the coverage effective date.

PCIP applicants who are approved to participate in PCIP can choose from three plan options, with different levels of premiums, calendar year deductibles, prescription deductibles and prescription co-pays. The HSA Option provides an opportunity to open a Health Savings Account, a tax-exempt account where you can deposit funds for eligible medical expenses. Each of the three PCIP plan options provides preventive care (paid at 100 percent, with no deductible) when you see an in-network doctor and the doctor indicates preventive diagnosis. Included are annual physicals, flu shots, routine mammograms, and cancer screenings. For other care, a deductible must be paid before PCIP pays for the health care and prescriptions. After the deductible is paid, the policyholder will pay 20 percent of medical costs in-network. The maximum out-of-pocket payment for covered services in a calendar year is \$5,950 in-network/\$7,000 out-of-network. There is no lifetime maximum or cap on the amount the plan pays for care. The current monthly PCIP premiums for the state are reflected below.

**Figure 31**

Standard Plan		Extended Plan		HSA Plan	
Age	Rate	Age	Rate	Age	Rate
00-18	\$139	00-18	\$187	00-18	\$144
19-34	\$208	19-34	\$280	19-34	\$216
35-44	\$250	35-44	\$336	35-44	\$259
45-54	\$319	45-54	\$429	45-54	\$331
55+	\$443	55+	\$596	55+	\$461

The U.S. Department of Health and Human Services, with the help of the U.S. Office of Personnel Management and the U.S. Department of Agriculture's National Finance Center, runs the Pre-Existing Condition Insurance Plan in 23 states, including South Carolina, and the District of Columbia. The federal government contracts with a national insurance plan to administer benefits in those states. In the other 27 states, there are state-based programs.

PCIP began taking applications for enrollment on July 1, 2010 and coverage for accepted enrollees began on August 1, 2010. The Federal government posted on October 14, 2011 that 665 South Carolinians had taken advantage of this program as of August 31, 2011.

## IX. Developments in Other States

The Affordable Care Act (ACA) of 2010 aims to expand access to health insurance coverage and to make health care more affordable. This piece of legislation has many complex provisions that are designed such that their individual efforts might concurrently increase access, decrease cost, and improve the quality of health care.

### Exchanges

A health insurance exchange is a mechanism to allow individual consumers and small employers to compare and purchase health insurance plans directly, much like travel websites Travelocity or Expedia. U.S. Department of Health and Human Services (HHS) -approved health insurance exchanges will be the only portal through which qualifying individuals may access the subsidies and cost-sharing benefits provided by the ACA for the purchase of health insurance. There are at least three types of marketplace mechanisms:

1. *State-based*: A state-based exchange must be a state agency, independent public entity, or non-profit entity. States have the option of creating separate exchanges for the individual market and the small group market, or combining the two markets into one exchange. By creating a state-based exchange, states retain the ability to certify the qualified health plans that will be offered through the exchange. State-based exchanges also offer the flexibility of allowing states to form multi-state exchanges or subsidiary exchanges. By January 1, 2013, states must be able to demonstrate to HHS that an acceptable amount of progress has been made toward establishing a state-based exchange. By January 1, 2014, the exchange must be fully or conditionally operational.
2. *Federally-facilitated*: States may choose not to establish an exchange, or state efforts toward an exchange may be deemed inadequate by HHS. In either of these scenarios the federal government will establish a federally-controlled health insurance exchange in the state.
3. *Federal-State Partnership*: On September 19, 2011, HHS released proposed regulations for this third exchange model. Five core functions of an exchange were defined: consumer assistance, plan management, eligibility, enrollment, and financial management. These core functions were divided, giving the federal government control of the enrollment, eligibility, and financial management functions. The state may control either the plan management function or the consumer assistance function, or states may choose to control both plan management and consumer assistance functions.

Each of these options necessitates a multitude of considerations. Grants designed to help states finance the various phases of planning, establishment, and implementation were made available and continue to evolve as the process progresses:

- **Exchange Planning Grant**: Intended to provide states with the necessary funds to research the options for establishing a state-based health insurance exchange. This grant was given to all states and the District of Columbia except Alaska.
- **Early Innovator Cooperative Agreements**: This funding opportunity was given to six states (Kansas, Maryland, New York, Wisconsin, Oregon, and Oklahoma) and one partnership of states (Connecticut, Massachusetts, Maine, Rhode Island, and Vermont) to investigate and create Information Technology (IT) that may be utilized by other states. To receive these

grants, the states had to demonstrate that they had made progress toward establishing a health insurance exchange and possessed the technical knowledge to create these systems.

- **Level One Establishment Grant:** State has multiple opportunities through June 2012 to apply for a Level One Grant. It provides up to two years of funding for activities which include: conducting background research, making legislative and regulatory changes, governing the exchange, establishing information technology systems, conducting financial management, performing oversight and ensuring program integrity. To receive this grant the state must demonstrate its progress toward establishing a health insurance exchange. As of November 2011, 29 states have made significant progress in creating an exchange and are receiving funding under Level One Establishment Grants. Those states include: Alabama, Arizona, California, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Mexico, New York, North Carolina, Oregon, Rhode Island, Tennessee, Vermont, Washington and West Virginia.
- **Level Two Establishment Grant:** To qualify for this grant, states must demonstrate that they have established the legal authority to create and operate an exchange.

### **Status of State-based Exchanges Across the Nation**

Two states (Massachusetts and Utah) have existing exchanges. These exchanges were established before the ACA became law and will both require further legislation to allow them to comply with the current federal regulations. Because they are ahead of other states, and because they represent two different approaches to establishing an exchange, Massachusetts and Utah have become examples that some other states are looking to for guidance. Massachusetts is a quasi-governmental active purchaser, meaning Massachusetts will selectively contract with several Qualified Health Plans (QHPs) to achieve quality and value goals. Utah is a state agency clearinghouse, meaning Utah will contract with all QHPs available to the state.

#### **At a Glance**

15 states have enacted legislation  
15 states have failed to pass legislation  
10 states have no proposed legislation  
4 states have pending legislation  
3 states have executive orders  
2 states have existing exchanges  
1 state governor announced there will be no exchange  
1 state governor vetoed legislation

The most recent comprehensive information on of each state's progress toward creating a state-based exchange was published in July 2011 and is included below as Figure 32 .

**Figure 32**  
**Status of State-Based Exchanges Across the U.S.**

State	Status of Latest State Action	Purpose of State
Alabama	Executive Order	Study feasibility of establishing an exchange
Alaska	Legislation failed	NA
Arizona	Legislation failed	NA
Arkansas	Legislation failed	NA
California	Enacted legislation	Establish an exchange
Colorado	Enacted legislation	Establish an exchange
Connecticut	Enacted legislation	Establish an exchange
Delaware	No proposed legislation	NA
District of Columbia	Pending legislation	NA
Florida	No proposed legislation	NA
Georgia	Executive Order	Study feasibility of establishing an exchange
Hawaii	Enacted legislation	Establish an exchange
Idaho	No proposed legislation	NA
Illinois	Enacted legislation	Intent to establish an exchange
Indiana	Executive Order	Intent to establish an exchange
Iowa	Legislation failed	NA
Kansas	No proposed legislation	NA
Kentucky	No proposed legislation	NA
Louisiana	Governor announced state will not have an exchange	NA
Maine	Legislation failed	NA
Maryland	Enacted legislation	Establish an exchange
Massachusetts	Existing Exchange	NA
Michigan	No proposed legislation	NA
Minnesota	Legislation failed	NA
Mississippi	Enacted legislation	Study feasibility of establishing an exchange
Missouri	Legislation failed	NA
Montana	Legislation failed	NA
Nebraska	Legislation failed	NA
Nevada	Enacted legislation	Establish an exchange
New Hampshire	Legislation failed	NA
New Jersey	Pending legislation	NA
New Mexico	Governor vetoed legislation	NA
New York	Legislation failed	NA
North Carolina	Pending legislation	NA
North Dakota	Enacted legislation	Intent to establish an exchange
Ohio	No proposed legislation	NA
Oklahoma	Legislation failed	NA
Oregon	Enacted legislation	Establish an exchange
Pennsylvania	Pending legislation	NA
Rhode Island	Legislation failed	NA
South Carolina	Legislation failed	NA
South Dakota	No proposed legislation	NA
Tennessee	No proposed legislation	NA
Texas	Legislation failed	NA
Utah	Existing Exchange	NA
Vermont	Enacted legislation	Establish an exchange
Virginia	Enacted legislation	Intent to establish an exchange
Washington	Enacted legislation	Establish an exchange
West Virginia	Enacted legislation	Establish an exchange
Wisconsin	No proposed legislation	NA
Wyoming	Enacted legislation	Study feasibility of establishing an exchange

As of July 19, 2011. Source: Kaiser Family Foundation

## X. South Carolina Health Planning Committee

The South Carolina Health Planning Committee (SCHPC) was established by Executive Order 2011-09 to assist with the formulation of policy recommendations regarding whether or not South Carolina should establish a health insurance exchange.

### **Charges & Deliverables**

- If the Committee recommends South Carolina establish a state-based insurance exchange, it must propose a plan for its successful implementation and sustainability
- If the Committee recommends South Carolina not establish a state-based insurance exchange, it must recommend alternate strategies and policies to improve South Carolina's health insurance marketplace

The SCHPC consists of representatives from the legislative, insurance, health and business communities. This team is supplemented by additional state government officials and members of the private sector with expertise in research, data collection, and issues affecting the uninsured in South Carolina. The SCHPC and these supplemental members are divided into four subcommittees:

- Competitiveness and Transparency
- Information Technology
- Consumer Driven Health Plans
- Consumer Protection-Medical Liability

Each subcommittee is charged with specific market-related issues to analyze and apply to the concept of a health insurance exchange in the state of South Carolina.

## **Competitiveness & Transparency Subcommittee**

### **South Carolina Health Planning Committee**

#### **Charges & Deliverables**

The subcommittee studied how to make health insurance and health services a better value by increasing competitiveness between health plans and between providers. This includes:

- Increasing the purchaser's ability to find health insurance plans which best meet their needs in terms of benefit design, network flexibility, risk, price and health outcomes.
- Increasing the patient's ability to choose the provider which will provide the best service and outcomes for the price which the patient is willing to pay.

#### **Deliverables**

1. Review of ability of South Carolina purchasers (employers and individuals) to find health insurance which best meet their needs in terms of benefit design, network flexibility, risk, price and health outcomes.
2. Review of patient's ability in South Carolina to choose the provider which will provide the best service and outcomes for the price which the patient is willing to pay.
3. Review of best practices of existing and proposed mechanisms for increasing purchasers and patients ability to find the best value.
4. Analysis of the federal government's health insurance exchange mandate and its cost and benefits to South Carolina.
5. Recommendations to the steering committee on potential courses of action to pursue in South Carolina to increase value for purchasers and patients.

## Competitiveness and Transparency Subcommittee Report

### **Charge**

The Competitiveness and Transparency Subcommittee was charged with examining how purchasers and patients in South Carolina and elsewhere currently find health insurance and health providers which provide the best value, examine the PPACA health insurance exchange mandate to determine its proposed role in improving value, and make recommendations to the Health Planning Committee on a recommended course of action.

### **Process**

The committee met eight times between April and November 2011. Its members were comprised of representatives from the provider community, health insurers, the general public, insurance brokers, the legislature and state agencies. Input was achieved through a variety of means: research material of interest was submitted to the sub-committee by individual members as background and the Department of Health and Human Services distributed three times a week an online “clipping service” of insurance exchange articles from other states and Washington D.C.; local and national speakers were invited to present to the sub-committee as were individual subcommittee members; members attended national conferences which discussed or were devoted to health reform and insurance exchanges including several sponsored by CMS; substantial time for broad discussions during meetings was allowed and all meetings were open and allowed time for public comment.

### **Recommendations**

The subcommittee's analysis and discussion of the research and testimony leads us to the following four recommendations for consideration by the full Health Planning Committee:

#### **Recommendation 1: The state cannot implement state-based health insurance exchanges as defined under PPACA and ill-defined and unfinished HHS regulations.**

No final rules for the operation of state-based exchange exist and HHS has failed to adequately describe how a federal exchange or hybrid exchange would operate. Committing to either course of action - a state operated exchange or federal exchange - tied into the requirements of PPACA is therefore not desirable. At the subcommittee's last count, only 16 states have enacted legislation of any sort related to PPACA and the majority of what has been implemented relates to governance – not operations or insurance regulation.

Timelines for implementation of state or federal exchanges are neither reasonable nor achievable. The federal government has already delayed policy making several months and policy making is presumably easier than actual implementation which must occur at the state and federal level and must integrate between state and federal systems. Little, if any, consideration was given at the federal level to the very practical concerns of state legislative and budgeting cycles or state procurement laws which will impact almost every aspect of exchange implementation, as well as the very real possibility of months of vendor protests related to procurement awards. In its timeline planning HHS has ignored years of nationwide experience with similar implementations of Medicaid eligibility, enrollment and information management systems which historically require years of business process redesign, procurement and implementation.

The primary function of the PPACA health insurance exchanges is to connect individuals and families with federal premium subsidies which ultimately must be reconciled on individual and joint federal tax returns. Regardless of the subcommittee member's individual opinions on the wisdom of subsidies as a means to control costs, the assignment, management and reconciliation of federal subsidies is solely a federal concern in which the state has no compelling interest.

The only organization capable of implementing the requirements of a state based exchange is the South Carolina Department of Health and Human Services, however, the department's resources and management capacity are fully committed to improving the current Medicaid program which is now serving approximately 900,000 persons monthly and preparing for a possible expansion of Medicaid required by PPACA which will bring another 500,000 to 600,000 individuals into the Medicaid Program. The Department's mission is most appropriately focused on improving the health of these individuals who are among the states most vulnerable and poor, not performing marketing, eligibility determination, enrollment and back office management for the private insurance industry.

PPACA and HHS proposed rules on navigators are poorly conceived and duplicate substantial capacity which already exists through private brokers. Assigning the role of "navigator" to a broad range of groups with little regard to licensure and liability concerns is not only naive, but potentially harmful to consumers who will now essentially be receiving tax advice from lay persons with little preparation or accountability.

Exchanges alone have not had demonstrated robust success in making health care more affordable. This is most likely due to the fact that the major underlying contributor to health insurance premiums is the cost of health services themselves - not insurance premiums and profits. And while the Institute of Medicine has identified that approximately \$190 billion of excess costs exists in the health care system due to administrative waste and duplication often the result inefficient payers practices - exchanges as operating and contemplated under PPACA do not inherently change this dynamic. In fact, according to national health expenditure data presented by the South Carolina Institute of Public Health, the net cost of insurance - which includes administrative fees to manage care, ensure quality, pay claims, as well as profit margins - only account for about 7 percent of the nation's health bill. And so while employing exchanges to increase competition among plans may reduce this net cost to some extent, they do little now (and as envisioned in PPACA) to reduce costs in the other 93 percent of our national health care expenditure.

In addition to large amounts of uncertainty created by the failure of HHS to promulgate regulations, there is considerable uncertainty as to how the Supreme Court might rule when it rules next summer on challenges to PPACA next summer. Popularity of PPACA in national tracking polls is at an all time low with over 50 percent of the population opposing the law. Given that states currently face extreme challenges to their budgets and infrastructure and under PPACA have the "escape valve" of being allowed to take control of the exchange should they determine whatever federal solution implemented is unsatisfactory, there is little apparent "first-mover" advantage to states.

**Recommendation 2: The state should encourage and facilitate the establishment and expansion of private exchanges designed to serve the needs of a variety of consumers.**

Instead of a one size fits all concept of health insurance exchanges, South Carolina can encourage currently operated private exchanges, employer groups, consumer groups and others to offer exchanges tailored to specific populations. These exchanges could operate under a variety of governance models, including that of an active purchaser - such as a group of independent employers might wish to support.

Exchanges should provide consumers with an easy to navigate set of insurance choices tailored to that individual's specific needs. They should provide accurate, up to date information on health plan and provider cost and quality.

Private exchanges that choose to do so should be allowed to process Medicaid eligibility and enrollments under contract with Medicaid.

Barriers to portability of benefits and the efficiency and adoption of defined contribution, consumer driven, high deductible and major medical plans should be removed.

The state should ensure that benefits beyond any essential benefits identified at the federal level cannot be mandated in South Carolina without the approval of the full legislature.

**Recommendation 3: The state should encourage full consumer empowerment, engagement and responsibility in health and healthcare decision making.**

The state should consider legislation from other states which requires timely, accurate and transparent reporting of health plan and provider price and quality data and removes barriers to the public disclosure of this information. It should carefully consider the additional costs of these reporting requirements on providers, health plans and purchasers to avoid unfunded mandates.

Purchasers and consumers must be able to compare both out of pocket prices and quality of services provided in order to determine which plans and providers provide the most value. Consumers should be able to receive price quotes if requested prior to receiving services. Prices paid for services on behalf of consumers by insurers should not be considered proprietary information. Data must be meaningful in order for consumers to use it to make the best purchase decisions and for providers to use it to improve care. Data must therefore be made easily understandable and usable for consumers and must be widely accepted as valid by the provider community.

An independent, multi-stakeholder body with consumer, purchaser and provider representation should be charged with implementing a provider and health plan quality and performance reporting strategy which must be publicly accessible and usable for a variety of purposes. The body should consider the standard measures of quality and performance as the basis for public reporting requirements currently adopted by national organizations such as the NCQA, CMS, and the Agency for Healthcare Research and Quality etc. An exchange infrastructure is not necessary to perform this task.

Enhanced benefits for healthy behaviors as well as penalties for unhealthy behaviors should not be restricted by law or regulation in either public or private insurance. The state should not create barriers for employers and health plans which choose to provide financial or other

incentives to employees or beneficiaries who choose high value health plans and providers based on quality and price.

A distinction should be made between the roles of insurance brokers and health care navigators. Navigators should be community based and help individuals interact with the health care system and manage their own health while brokers should retain primary responsibility for linking consumers to the highest value insurance product based on an individual's needs.

**Recommendation 4: The state should continue to inform and engage the federal government using these state-based alternatives as the foundation for all conversations and agreements regarding health insurance reform in South Carolina.**

### **Analysis**

The health insurance exchanges proposed under PPACA go well beyond the original conceptualizations of exchanges as "marketplaces" where purchasers compare insurance products in terms of benefit design, provider network, performance and price. The subcommittee devoted time to understanding various private and public exchanges currently under operation and the components of the exchanges as conceptualized in PPACA.

### ***Insurance exchange overview***

As originally envisioned by conservative groups such as the Heritage Foundation, the "purpose of a state health insurance exchange is to act as a purely administrative mechanism for implementing a defined-contribution health insurance alternative for employer-sponsored coverage." Its purpose was to create new competition for customers by insurers, provide customers with a wider range of benefit design options and decrease administrative costs in the purchase of insurance.

Exchanges may or may not go beyond simply matching customers up with plans that meet their needs at a specific price. Some facilitate enrollment in these plans. In addition, under a defined benefit model, the exchange may perform premium aggregation of one or more employer's defined contribution (and possibly the spouse's employer's), the employee's contribution and other sources of funds. Large scale adoption of defined benefit approaches combined with exchanges can also improve portability of benefits as employees change employers.

Over time, exchanges have also worked on improving the ability of customers to navigate the health insurance system. Exchange tools are becoming increasingly sophisticated in order to help consumers better understand insurance in general, and identify their specific needs and attitudes toward risk while also analyzing the financial impact of various benefit designs. In addition, some exchanges have been designed to "actively purchase" on behalf of their members by requiring plans that offer products in the exchange to meet certain minimum quality or price requirements.

While active purchasing is common among employer-based exchanges, it is controversial in government sponsored exchanges because of concerns that active purchasing may lead to setting price controls in the private market. Active purchasing is also vulnerable to adverse selection as insurers have traditionally been able to sell different plans at different prices inside and outside exchanges.

Millions of consumers currently choose and buy insurance in the individual and employer markets via privately operated health insurance exchanges operating as marketplaces. In fact, one of the nation's largest - Benefit Focus- is headquartered in South Carolina. To date, the success of

government-based exchanges has been limited. Utah's exchange has remained fairly small and insurance premiums in Massachusetts, which operates the "Massachusetts Connector", have continued to grow appreciably.

### ***PPACA insurance exchange requirements***

Health Insurance exchanges as defined under PPACA go beyond the basic marketplace model. As part of the subcommittee's work the Department of Health and Human Services asked its outside legal counsel, Covington & Burling, to define the minimum requirements required of an exchange under PPACA. These requirements are outlined in Table 1 below. A graphic display of these requirements and a potential organization are shown in Figure 1, provided to the subcommittee by Blue Cross Blue Shield of South Carolina.

Not only are exchanges as described by PPACA required to provide the basic marketplace, they are also required to certify plans as eligible to sell in the exchange, and perform enrollment, eligibility, and premium collection. In addition, they are required to actively engage in consumer assistance through a new "navigator" program and other means (such as a call center) and to actively engage in quality improvement activities and monitoring of plans.

Exchanges are left to determine if they will operate an "active purchaser" or "open market" form of exchange. PPACA also requires the controversial requirement that state-based exchanges determine eligibility for Medicaid as well as federal premium subsidies for individuals and families making between 138 percent and 400 percent of poverty. PPACA requires that states determine if they wish to run the exchange or leave this to the federal government. If states choose to operate the exchange, they may designate a state agency or a *new* not-for-profit organization to implement the requirements outlined in Figure 1. State based exchanges were initially required to be certified as ready for operation in January of 2013; however, this deadline seems to have been pushed back by CMS. If a state is deemed not ready or not capable, or if a state chooses not pursue an exchange, the federal government will establish one. Based on additional guidance, states appear to have the option, after the establishment of a federal exchange, to apply to convert to a state-based exchange, should they determine it is in the state's best interest following a one year notice period.

To date, no final regulations governing the operation of state-based or federal exchanges have been issued although a proposed rule on the establishment of exchanges and qualified health plans and a second proposed rule on risk adjustment, reinsurance and risk corridors have been issued. The comment period on these proposed rules was extended by 30 days to October 31, 2011. No proposed rule on essential benefits has been issued although a special panel of the Institute of Medicine has recently submitted required guidance to CMS on drafting this rule.

### ***Flexibility under state-based insurance exchanges***

The sub-committee is clear that the question states now face is not whether an exchange will operate in each state – notwithstanding legal or legislative challenges, under PPACA a federally operated or state operated exchange will be operational by 2014. The question at hand is should a state choose to implement and operate its own exchange or leave this to the federal government.

One argument is that regardless of the purported "flexibility" that the federal government will grant state exchanges – this flexibility is limited and can be rescinded. The other argument is that a state operated exchange provides meaningful flexibility that states should retain by choosing to operate a state exchange.

With this in mind, an important question for consideration of the committee was how much flexibility operating a state run exchange as required by PPACA would provide a state versus a federally operated exchange. Because no final rules exist to evaluate, and because proposed rules leave considerable questions unanswered (and even pose questions directly), the South Carolina Department of Health and Human Services requested that Covington and Burling analyze this question to the best of its ability.

According to Covington & Burling's analysis "because the federal requirements are quite extensive and prescriptive, the flexibility accorded to State Health Insurance Exchanges, while still important, is fairly constrained." In addition to the ability to decide whether to add any additional requirements to the federal minimum {Table 1}, a State has the flexibility to do the following:

Determine how an Exchange will be structured and governed (i.e., within a state agency, as an independent state agency, or as a non-profit). ACA § 1311(d)(1). If the Exchange is governed by a Board, however, the proposed federal rules have requirements regarding conflicts of interest, qualifications of Board members, and Board composition. Proposed 45 C.F.R. §155.110(c).

Decide how it will select the plans to be offered through the Exchange -- i.e., whether it will be an active purchaser that selects plans for inclusion on the Exchange, or whether it will be an open marketplace for all plans that meet the requirements for a qualified health plan. ACA §1311.

**Table 1. Minimum Requirements of a State Exchange**

**Certify that health plans are “qualified” to participate on Exchange, by evaluating for compliance with federal and state standards on the following (proposed 45 C.F.R. § 155.1000):**

scope of benefits and benefit structure, including cost sharing (proposed 45 C.F.R. §156.200)  
rating variations (proposed 45 C.F.R. §156.255)  
risk adjustment (proposed 45 C.F.R. §155.105)  
provider network (proposed 45 C.F.R. §156.230)  
health care quality (proposed 45 C.F.R. §155.105)  
“transparency” in plan documents and notices (proposed 45 C.F.R. §156.220)  
segregation of federal funds for plans that cover abortion services (proposed 45 C.F.R. §156.280)  
licensing (proposed 45 C.F.R. §156.200)

**Consumer Assistance**

maintain a web site that standardizes comparative information on each available health plan (including price, benefits, quality ratings, enrollee satisfaction, etc.) (proposed 45 C.F.R. §155.205)  
operate a toll-free call center (proposed 45 C.F.R. §155.205)  
establish and make available a “calculator” to facilitate comparison of available plans (proposed 45 C.F.R. §155.205)  
provide general consumer assistance functions (proposed 45 C.F.R. §155.205)  
conduct outreach and education activities (proposed 45 C.F.R. §155.205)  
contract with “Navigators” who will conduct outreach and facilitate enrollment (proposed 45 C.F.R. §155.210)

**Eligibility**

collect applications from individuals, both on-line and on paper (proposed 45 C.F.R. Subpart E)  
collect applications from employers and employees (for SHOP), on-line and on paper (proposed 45 C.F.R. §155.710)  
determine who is eligible for federal premium tax credits, cost-sharing reductions, Medicaid, and CHIP (proposed 45 C.F.R. §§155.310, 155.345), including requirement to verify information provided through trusted data sources (proposed 45 C.F.R. §§155.315, 155.320)  
determine eligibility of employers and qualifying employees for SHOP (proposed 45 C.F.R. §155.710)  
apply special eligibility standards to Indians (45 C.F.R. §155.350)  
establish an appeals process for eligibility determinations (proposed 45 C.F.R. §155.355)  
issue certificates for individuals who are exempt from the individual mandate (45 C.F.R. §155.200)

**Enrollment**

conduct annual open enrollment and provide for special enrollment periods (proposed 45 C.F.R. §§155.410, 155.420)  
conduct “rolling” enrollment for employers/employees using the SHOP (proposed §155.725)  
notify individuals and employers regarding time period for re-enrollment (proposed 45 C.F.R. §§155.410, 155.725)  
enroll individuals who are eligible for coverage in the plan they select, and communicate with the health plans, HHS, and Treasury regarding enrollment (proposed 45 C.F.R. §155.400)  
enroll individuals eligible for Medicaid (through electronic transmission of information), and refer individuals who may be eligible under specific Medicaid categories to Medicaid for further evaluation (proposed §155.345)  
monitor and submit reports regarding termination of coverage (proposed 45 C.F.R. §155.430)

**Billing and handling of premium payments**

for the SHOP, provide an employer with “aggregate billing” and accept payments for distribution to health plans (proposed 45 C.F.R. §155.240)  
coordinate with the U.S. Department of Treasury regarding payment of an individual’s advance premium tax credit to his or her health plan (proposed 45 C.F.R. §§155.105, 155.340)  
facilitate through electronic means the collection and payment of premiums (proposed 45 C.F.R. §155.240)

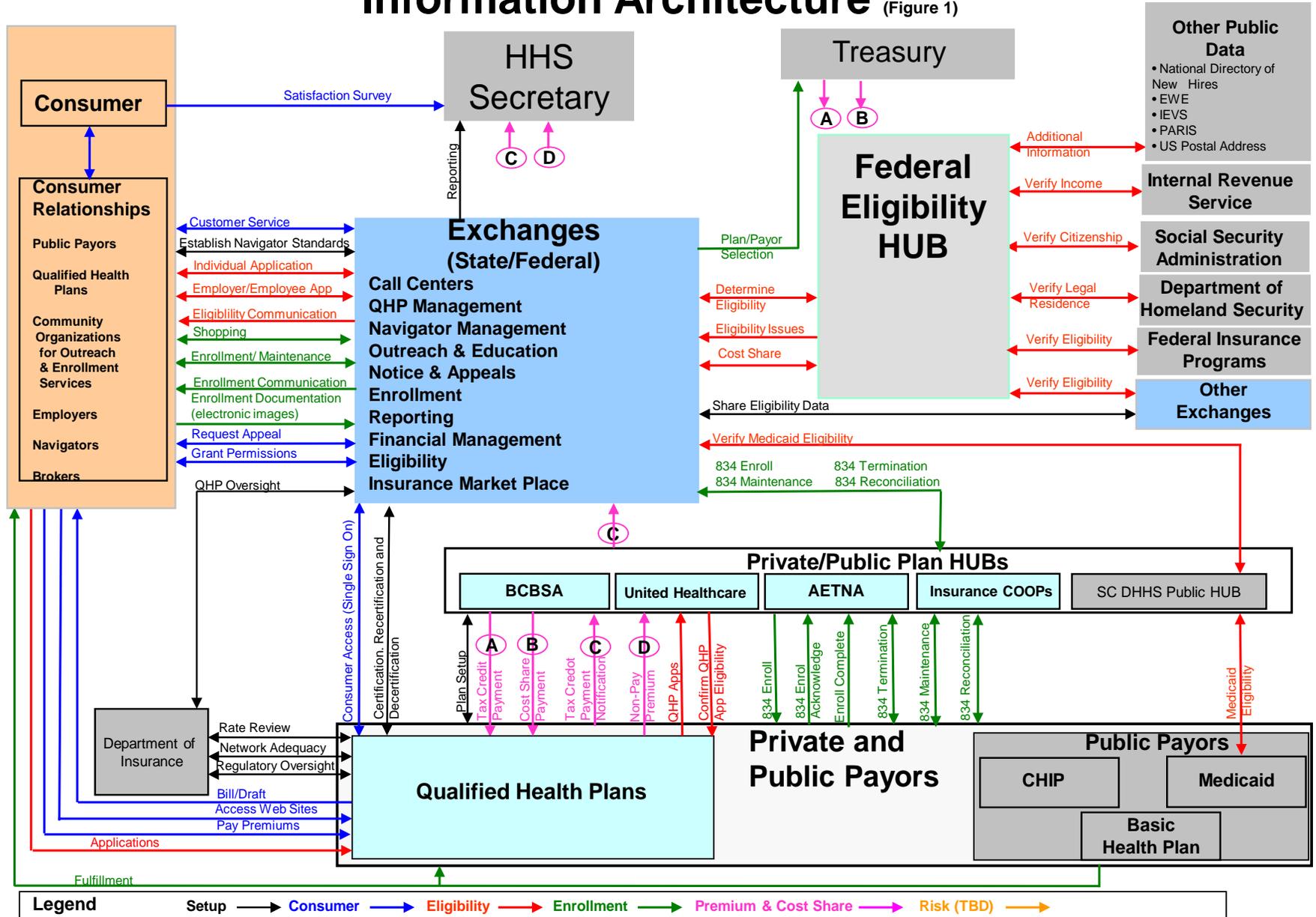
**Quality activities**

conduct enrollee satisfaction surveys (proposed 45 C.F.R. §155.200)  
conduct assessment and ratings of health care quality and outcomes (proposed 45 C.F.R. §155.200)  
monitor information disclosures (proposed 45 C.F.R. §155.200)  
report data (proposed 45 C.F.R. §155.200)  
regularly consult with stakeholders (proposed 45 C.F.R. §155.130)

**Oversight and financial integrity**

keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report on same to the federal government (proposed 45 C.F.R. §155.200)  
Collect user fees or impose statewide assessments, or otherwise implement and supervise a means of being “self-sustaining” beginning in 2015 (proposed 45 C.F.R. §155.160)

# Information Architecture (Figure 1)



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Determine whether to require qualified health plans to provide benefits in addition to the “essential health benefits.” ACA § 1311(d)(3).

Form a regional Exchange with other States or set up different Exchanges in different parts of the State. ACA §1311(f).

Operate a unified Exchange for individuals and small businesses or two separate Exchanges. Decide whether to merge the risk pools for rating the individual and small group markets. ACA §1312(c).

Decide whether to allow agents and brokers to assist individuals and employers enroll in plans through the Exchange. ACA §1312(e).

Until 2016, decide whether small employers should be defined as those employing 50 or fewer employees. In 2016, small employers are defined as those employing 100 or fewer employees. ACA §§ 1312(f)(2)(A); 1304(b)(2)-(3). Beginning in 2017, a State has flexibility as to whether to allow large employers to purchase through the Exchange.

Establish how an Exchange will be financed, through user fees or otherwise. ACA §1311(d)(5)(A).

Decide whether to offer administrative services to qualified employers in addition to aggregate premium billing and whether to allow qualified employers to have more choices regarding the qualified health plans available to their employees. ACA requires exchanges to allow qualified employers to offer their employees all qualified health plans available at a specified level. ACA §1312(a)(2); Proposed 45 C.F.R. §705(b)(2)."

Covington & Burling goes on to say:

"In sum, the principle flexibility accorded to State Exchanges is not *what* they will be doing, but *how* they will be doing it. Moreover, some of these decisions (i.e., whether or not to merge risk pools) can be made by the State as a matter of state insurance market regulation, without setting up an Exchange. Finally, to the extent that the statute and proposed rules give States certain flexibility over the Exchange, it is not clear the extent to which the decisions made by the State will be subject to federal oversight and/or negotiation. The proposed rules envision that a State will have to file an “Exchange State Plan” (similar to a Medicaid State plan) in which it sets forth how its Exchange will operate. The Plan must be federally approved in order for the Exchange to be certified. HHS has not released the components that must be included in a plan, and there is no experience that would enable a State to predict the extent to which some of its decision will be subject to federal review."

Recently, CMS proposed that they were willing to be flexible in how the state and federal government shared responsibility (“partnership”) for implementing PPACA insurance exchanges. While no rules are drafted for this partnership, under this hybrid model as explained by HHS, states could assume plan management functions such as plan selection, collection and analysis of plan rate and benefit package information, and monitoring and oversight. States could also choose to take on certain consumer assistance functions while HHS would be responsible for call center operations and website management. Since its initial unveiling in early September, little additional information has been produced about this model.

### ***Availability of pricing and quality data***

The subcommittee observes that data on price and quality is critical to lowering the cost of health care. However, until individual patients and providers have more responsibility for the financial consequences of their choices, price and quality data would continue to primarily be used by agents of consumers such as employers and health plans to manage value. Out of pocket payments as a percent of total payments for health care services are near historical lows, and despite repeated calls for payment reform, most providers are still largely paid through some variation of the fee for service system which encourages volume delivery over value delivery.

Nonetheless, as an increasing number of employers shift toward defined contribution and high deductible plans, consumers will be asked to spend more first dollar money out of pocket and will increasingly be concerned with both prices for services, utilization of services and outcomes received.

Data on health plan and provider quality does exist, but it often goes unused because it is not easily accessible at the right time and when it is, the interpretation by the average laypersons is often difficult. Still, simple rating systems used by NCQA for health plans, Healthgrades for individual physicians, compare.gov for Medicare hospitals and nursing homes are available and provide insight to the industrious consumer. Additionally, certain certification systems - such as that for Patient Centered Medical Homes - provide insight into basic quality practices.

Data on price is much more elusive. The full Health Planning Committee heard testimony from the South Carolina Hospital Association on the lack of veracity in typical hospital charge masters which often do not reflect the average price paid much less a consistent relationship to actual costs. Physicians and other medical professionals more often are able to provide prices if asked, but these are often highly dependent on the utilization and third party pricing associated with diagnostic laboratory and imaging as well as the utilization of any particular treatments which may involve medical products or pharmaceuticals.

Ultimately, it is lack of pressure and incentive to more accurately define cost and specify price that leads to poor price transparency in health care that lags far behind other industries. Until consumers and providers have more accountability for expenditures, there will not be much movement on this front. New care models such as CVS Minute Clinics are working to break this trend by clearly posting set prices for services.

## **Consumer Driven Health Plans Subcommittee**

### **South Carolina Health Planning Committee**

#### **Charges & Deliverables**

The Consumer Driven Health Plans subcommittee reviewed approaches leading to better pricing and more appropriate utilization of health care services and their effect on the health insurance market. The subcommittee reviewed past efforts to foster the health insurance market for small groups and individual policies and the outcomes of those programs.

#### **Deliverables**

1. Review health savings accounts and high deductible policies and their effect on health care costs.
2. Review the history of high risk pools and their effectiveness, both in terms of benefits provided and costs.
3. Review the history of small business cooperatives and their effectiveness.
4. Review how creating changes in how we consume health care effects costs.

## Consumer Driven Health Plans Subcommittee Report

The Consumer Driven Health Plans Subcommittee's charge was to review approaches which lead to better pricing and more appropriate utilization of health care services and its effect on the health insurance market. In addition, it was to review past efforts to foster the health insurance market for small groups and individual policies and the outcomes of those programs. The Subcommittee's deliverables were as follows:

1. Review health savings accounts and high deductible policies and their effect on health care costs
2. Review the history of high risk pools and their effectiveness, both in terms of benefits provided and costs
3. Review the history of small business cooperatives and their effectiveness
4. Review how creating changes in how we utilize health care effects costs

The Subcommittee met with two large insurance carriers who provide coverage in the individual and small group markets in South Carolina. The Department of Insurance (DOI) also made two presentations, one on the history of the insurance market in South Carolina, and the second on the South Carolina high risk pool and the development of a health insurance cooperative in the state.

Ms. Vicki Whichard, Director of Strategic Business Development, Blue Cross Blue Shield of South Carolina, reviewed the products and trends in individual and small group markets in the state. Ms. Whichard reviewed traditional plan designs and consumer directed health plans. Consumer directed health plan objectives are designed to shift decision making responsibility to the individual and the provider rather than the employer and insurer. Higher deductibles result in lower premium costs and more coverage options for individuals.

## Benefit Design Evolution

Consumer-Directed Health Plans							
Traditional Plan Designs			Account-Based Health Plans			Incentive Based Plans	
Managed Indemnity	PPO	HMO	Flexible Spending Accounts	Health Savings Accounts	Health Reimbursement Accounts	Health Incentive Account	Value Based Incentive Design

Increasing Level of Consumer Engagement, Accountability & Responsibility

Traditional plan designs, account-based health plans, and incentive based plans comprise three different approaches to health plan design. More accountability and responsibility is placed on the consumer as one moves from traditional to account and incentive based plans.

### Traditional Health Plans

- Managed Indemnity- Products with no associated network of providers and limited utilization control mechanisms
- Preferred Provider Organization (PPO) - Network-based products where the benefit is greater if the individual uses providers in the contracted network and the benefit is reduced, but not eliminated, if an individual uses providers outside of the network. Moderate levels of utilization controls are usually used and disease and case management tools are available.
- Health Maintenance Organization (HMO) - Benefits are only available within the network of providers, coverage must be coordinated through a gatekeeper physician and moderate to strict utilization controls are used together with case and disease- management tools. More recently, HMOs have introduced open access and point of service plans that resemble PPOs.

### Account-Based Health Plans

- Flexible Spending Accounts (FSA) – Accounts that can be established through an employer for employees to defer limited amounts of money on a pre-tax basis to cover qualified out-of-pocket health expenditures (as defined by the Federal Government). Funds used for qualified health expenses are not taxable to the individual. Any funds not used by the end of the calendar year are forfeited. The employer is responsible for enforcing the requirement that funds are only available for qualified expenses.
- Health Savings Accounts (HSA) – Tax-deferred savings accounts that can only be set up in conjunction with qualified high deductible plans, as defined by the Federal Government. HSAs can be used with either a qualified individual or group high deductible plan. For an

employer-sponsored plan, both the individual and the employer are allowed to make deposits in the account within allowed limits. All funds deposited into the account are the property of the employee. In an individual plan, only the individual can make deposits. Funds used for qualified health expenses are not taxable to the individual. Funds not used within a year can be carried over to subsequent years with no tax liability for the individual. The individual account owner is responsible for enforcing the requirement that the funds must only be used for qualified health expenses.

- Health Reimbursement Accounts (HRA) – a demand account established by an employer and enabled by the Federal Government that the employer controls in conjunction with a high deductible health plan. The employer sets the rules for what expenses are qualified for reimbursement, how much is available for reimbursement and whether unused amounts are carried over into subsequent years and to what extent. The HRA belongs to the employer and cannot be taken with the employee upon termination of employment unless the employer allows it under the plan definition. The HRAs are normally not funded but provide payment when an eligible expense is presented for reimbursement. Payments from the HRA are not taxable income to the employee.

### **Incentive-Based Health Plans**

- Health Incentive Account – An account established by an employer where an employee can earn funding or credits for accomplishing health-related activities defined by the employer. The accounts and the rules are set to encourage healthy behavior and for making progress toward health goals. Use of the funds is set by the employer and could range from paying part of the out of pocket medical expenses of the employee to waiving the fees for certain health-related activities.
- Value-Based Benefit Designs – Benefit designs that provide motivation for individuals with certain chronic conditions to get best-practice treatment by enriching the benefits for those conditions if the individual meets the defined criteria. As an example, a diabetic could receive a benefit that pays for 100 percent of their insulin and supplies if they follow the prescribed treatment protocols for diabetes.

According to Blue Cross Blue Shield of South Carolina, approximately 11 percent of the population currently has consumer directed health plans.

The Subcommittee also held a joint meeting with the Consumer Protection – Medical Liability Subcommittee to hear a presentation on the Individual and Small Group Markets by Dan Gallagher, President, UnitedHealthcare Community Plan and Martha Brown and Craig Hankins of UnitedHealthcare. They provided a demonstration of their Care Cost Estimator, a web portal that would be ready to go live in 2012. The website, aimed at enhancing their customers' health, provided information on: wellness benefits, premium designation programs, treatment cost estimators, and expense trackers and was designed to help consumers save money by providing specific quality and cost information.

The importance of this information was highlighted by the wide variations in cost between providers and facilities. UnitedHealthcare also spoke to the importance of collecting outcomes data noting that the market was moving more in that direction.

## **South Carolina's Insurance Market**

Mr. Andrew Dvorine, ASA, MAAA, Associate Actuary with the South Carolina Department of Insurance, presented on the History of South Carolina's Health Insurance Market, High Risk Pools and Cooperatives. Noting that the majority of states enacted small group reform to improve the availability of health insurance coverage in the 1990's, Mr. Dvorine reviewed legislative developments in South Carolina's recent history.

In 1991, Act No. 131 required rating bands for small employers (employers with 25 or fewer employees) and placed additional restrictions on renewal coverage and pre-existing condition exclusions. In 1994 the Small Employer Health Insurance Availability Act, Act No. 339, defined small employers as having two to 50 employees, established the small employer insurer reinsurance program, and provided that the actuarial-based rate for a plan could only be adjusted to reflect the case characteristics of family composition and class of business, eliminating rate bands. The guarantee issue of two new plans – the basic plan and the standard plan - was also required of all insurers in the market.

In 1997, Act No. 70 was passed, also known as the Small Employer Availability Act. This legislation took South Carolina insurance market back to the days of the early 1990's by providing for rating bands. Rates could be adjusted for age, gender, geographic area, industry, family composition, and group size. Within certain limitations, rates could be adjusted based on health status. Additional reforms were passed in 1997 which enacted provisions of the Health Insurance Portability and Accountability Act, commonly known as HIPAA. Guaranteed issue was now required of all plans, not just the basic and standard plans. Additional restrictions were placed on preexisting conditions limitations and all products were required to be guaranteed renewable.

Throughout the early 1990s in South Carolina and nationwide, there was a decline in the number of carriers in the individual and small group markets. And while the market stabilized in the early 2000's, it is a difficult market, by its nature, to be profitable particularly for new entrants. Compounding the problem has been increasing health care costs putting upward pressures on premiums in a market that battles affordability.

## **South Carolina's High Risk Pool**

The South Carolina Health Insurance Pool was created by the General Assembly in 1989 to make health insurance coverage available to residents of South Carolina who were either unable to obtain health insurance because of a medical condition or whose premium for health coverage exceeded 150 percent of the Pool rate. Rates were required to be set no higher than 200 percent of the standard risk rate. In 1997, Act No. 4 changed the requirements of the Pool to comply with HIPAA and to make other technical changes to the law. In 2002 and 2003, the Pool was further changed and was required to begin offering Medicare Supplemental coverage to persons under the age of 65 and on Medicare for reasons other than age (Acts No. 240 and 73). Rates for the supplement plans were required to be set at a level to provide fully for the expected costs of claims and expenses. To be eligible for the Pool a person must be a resident of South Carolina for no less than the last thirty days and provide evidence of one of the following:

- A refusal by an insurer to issue comparable coverage for health reasons
- A refusal by an insurer to issue comparable coverage except with a reduction or exclusion of coverage for a preexisting health condition for a period exceeding twelve months;

- A refusal by an insurer to issue comparable coverage except at a rate exceeding 150 percent of the Pool rate;
- **or,**
- Be a federally defined eligible individual; or
- Be under the age of sixty-five and covered under Medicare Parts A and B for reasons other than age.

(See Section 38-74-30, South Carolina Code of Laws.)

As of year-end 2010, there were 2,255 individuals enrolled in the Pool. Of those individuals, 286 were enrolled in Medicare Supplement insurance with the remaining enrolled in the comprehensive major medical plans.

### *Plan Types*

The following benefit plans are offered to those eligible for the comprehensive major medical coverage, including federally-defined eligible individuals:

- 80/60 Plan – Provides benefits with coinsurance levels of 80 percent for in-network services and 60 percent for out-of-network service. At the end of 2010, there were 385 individuals enrolled in this benefit plan.
- 80/80 Plan – Provides benefits with coinsurance levels of 80 percent for both in-network and out-of-network services. At the end of 2010, there were 88 individuals enrolled in this plan.
- High-Deductible Health Plan – May be used in conjunction with a health savings plan. At the end of 2010, there were 1,496 individuals enrolled.
- Medicare Supplement plans are offered in standardized Plans A and C.

### *Calculating the Standard Pool Rate*

The standard risk rate for major medical expense coverage is determined by taking into account the individual standard rate charged by the five largest insurers offering individual coverage in the State compared to the Pool coverage. Each year, premium information is collected from all health insurers operating in South Carolina and the five largest writers are determined. Rate information from these five carriers is then collected and adjusted to the level of the Pool plan benefits to determine the standard risk rate.

### *Premiums Charged in the Pool*

For the comprehensive major medical plans, rates must provide for the expected costs of claims and expenses of operation taking into account investment income and any other cost factors but may not exceed 200 percent of rates established as applicable for individual standard risks. Rates have been established at 200 percent of the standard risks each year since pool inception. There is a 25 percent extra charge for those individuals who become eligible by virtue of their premiums exceeding 150 percent of the Pool rate.

Rates established for the Medicare Supplement plans also must provide for the expected costs of claims and expenses of operation taking into account investment income and any other cost factor.

## *Assessments*

Assessments against member insurers are made in order to cover the losses of the Pool for all plans except the Medicare Supplement plans which must be self-sufficient. These assessments are allocated based on the amount of each insurer's health insurance premiums written in the state. The insurers are then allowed a credit against South Carolina premium taxes or income taxes up to a maximum per year of \$10 million for all companies combined.

In addition to assessments, the Pool receives yearly grant monies from the federal government which is used to reduce premiums for enrollees. In 2010 and 2011, the Pool received approximately \$1.5 million in federal grants.

Although the establishment of the high risk Pool meant that virtually every South Carolinian could purchase insurance coverage either through the commercial market or through the Pool, the low level of enrollment and the continued high level of uninsured is a signal that cost is a predominant driver of individual's decisions about whether to purchase health insurance even when the cost of the insurance is less than the cost of care without insurance.

### **Small Business Cooperatives**

The basic concept of a health cooperative is that a number of small employers, when joined together, will create a large enough group to purchase similar coverage, both in terms of options and costs, which would be offered to a similarly-sized large employer. In 1994, legislation was enacted in South Carolina which permitted a common group of small employers to join together for the purposes of obtaining group health or accident insurance. It required the group contain 1,000 eligible employees. In 2008, the South Carolina General Assembly enacted Act No. 180 which provided for the formation of small employer health group cooperatives in an effort to provide an additional means to obtaining affordable health insurance coverage. The 2008 Act added new provisions including that group cooperatives contain at least 1,000 eligible employers *or* at least ten participating employers.

The DOI issued Bulletin 2008-02, Procedures for Forming Health Group Cooperative in South Carolina, which outlined the requirements for forming, registering and operating a group health cooperative. Among these provisions are the requirements that the cooperative must be registered and approved by the DOI prior to offering any insurance related services, and that any health insurance policy offered through a cooperative must be provided by an insurer authorized by the DOI to conduct business in this state. (See Bulletin 2008-02, *Procedures for Forming Health Group Cooperatives in South Carolina*, March 14, 2008, for all provisions and requirements.) To date, one group has registered with the DOI as a health cooperative. However, this group was not able to obtain an agreement with an insurer licensed to conduct business in South Carolina. The primary reasons that small group pools have not succeeded in South Carolina or in every other state where they have been attempted is two-fold. First, the premises that are used to support the establishment of pools typically are flawed and, second, the pools always become subject to anti-selection and fail.

### **Consumer Operated and Oriented Plans (CO-OP)**

To further foster competition in the health care marketplace, the Affordable Care Act (ACA) provides for the creation of at least one non-profit, member-operated CO-OP in each state. To be eligible under the ACA, all of its activities must consist of the issuance of qualified health benefits plans in the state in which it operates. It must be member-run, operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of

health care delivered. Applications for the establishment of CO-OPs were due in mid-October 2011 with the US Department of Health and Human Services to announce in early 2012 which grants were successful.

### **Recommendations of the Subcommittee**

South Carolina consistently ranks as one of the least healthy states in the nation having very high rates of cardiovascular disease, diabetes, obesity, and strokes. The poor health status of the population costs the state, the businesses in the state, and the citizens of the state not only in higher health care expenditures but also in the productivity of the workforce and in the ability of many people to maintain productive employment. As a result, any changes in the funding or provision of healthcare services should be in the context of a goal to improve the health status of South Carolinians, improve the quality and experience of healthcare services, and do this in a fiscally responsible way that will reduce the per capita cost of healthcare. While goals like these are neither easily attainable nor possible of being realized completely in a short period of time, they are essential as a benchmark for any proposed reforms. The Subcommittee recommends that the state adopt guiding health policy principles like these as a first step and an overarching framework for any reforms it undertakes.

Healthcare is a local phenomenon. There are already numerous local, collaborative initiatives underway in the state aimed at achieving some or all of the objectives described above. The state should take advantage of programs that already exist and build on them rather than starting from scratch with new initiatives.

As the Subcommittee reviewed through its charge the various options for healthcare coverage expansion, value was recognized in each of the options toward certain target populations. However, there is not a strong ability to utilize these options in a global way to achieve our goal of improved healthcare status of all South Carolinians through the triple aim: increased access, improved quality, and lower costs. Missing from these options is the ability to engage and motivate consumers to change behavior in the utilization of healthcare services and make good healthy lifestyle choices. Fostering grassroots community-based efforts are needed to achieve this engagement and affect these changes.

To that end it is recommended that South Carolina foster local community programs already in existence throughout the state by establishing a Basic Health Plan Option through Community Health Programs. A pilot program authorized through the State Legislature already exists in TriCounty Project Care that is a non-insurance pilot program under State Medicaid that collects pre-payments from those under 200 percent of the Federal Poverty Level not eligible for Medicaid. It is also recommended that permanent legislation be passed to authorize these programs across the state to collect pre-payments and be eligible for the federal subsidies under the ACA available for a state's Basic Health Plan.

The health issues in South Carolina are specific to the state and its communities. It is, therefore, imperative that the solution be local as well. In order for the state to fully integrate the funding and provision of health services, it is imperative that the state maintain control over all aspects of healthcare funding and provision including control over any marketplace reforms such as exchanges. Allowing the federal government to independently direct and run the health insurance marketplace would tremendously burden the state's ability to coordinate all aspects of the funding and provision of healthcare for its citizens. The state should establish goals for marketplace reforms that are consistent with the following concepts:

### **Develop fair and efficient markets**

- Establish a level playing field for all health plans (large/small, new/established, commercial, Medicaid, local/national, for-profit/not-for-profit, provider owned or not)
- Establish non-politicized governance
- No duplication of existing state regulatory functions such as rate review
- Leverage national standards where appropriate to prevent unnecessary state-level variation

### **Promote competition, choice and innovation**

- Adopt objective standards to become a qualified health plan
- Encourage choice and innovation in product offerings on the exchange

### **Get as many people coverage while preventing adverse selection**

- Structure open enrollment periods to encourage people to purchase and maintain coverage
- Encourage enrollment through effective marketing and a simple shopping and purchasing experience

The state cannot hope to achieve these goals without maintaining control over the functions of the health insurance marketplace in South Carolina. It is recommended that the state move forward with a plan to retain control over any exchanges established in South Carolina. The Subcommittee understands that there are logistical and cost issues that stand as barriers to this goal; however, it is believed that an approach that retains control by the state but utilizes administrative resources that either already exist or which will be developed by others should be pursued so that the implementation remains as cost effective as is possible.

### **High Deductible Policies / Health Savings Accounts**

Although health savings accounts and high deductible policies have had some impact on a portion of the health care market, they have little, if any, effect on total health care costs. While they may increase sensitivity to price, though not always in a positive manner, they do not provide a comprehensive approach to the entire market. They have their place, but are of limited effect. The Subcommittee was in agreement that nothing further could be expected in terms of improving health or reducing costs.

### **High Risk Pools**

High risk pools have played a role in South Carolina's insurance markets by providing coverage to those who have not been able to secure coverage through the regular commercial market. In most cases, that is a result of their health status. However, policies issued by high risk pools are seen as cost prohibitive - premiums are too high for most to afford. In 2010 the Pre-existing Conditions Insurance Pool was established as part of the ACA. Premiums in this plan are supposed to be equal to standard risk premiums. However, an individual must be uninsured for six months before they qualify for coverage. As of July 31, 2011, there were 567 South Carolinians enrolled in this new program. The low enrollment in both the South Carolina Health Insurance Pool and the Pre-existing Condition Insurance Pool is an indication of the difficulty in achieving significant new enrollment of at-risk citizens even when coverage eligibility is guaranteed.

## **Consumer Protection / Medical Liability Subcommittee**

### **South Carolina Health Planning Committee**

#### **Charges & Deliverables**

The Consumer Protection/Medical Liability subcommittee studied market innovations to improve quality and value (improving medical quality will reduce poor outcomes thereby reducing costs and liability). The subcommittee reviewed what, if any, legal reforms would improve quality relative to cost. It will review market information in terms of size, concentration and policy costs.

#### **Deliverables**

1. Review market information for individual, small group and large group policies.
2. Review market concentration, including number of carriers, market share and market structure.
3. Review what providers and consumers can do to improve quality and control costs.

## Consumer Protection/Medical Liability Subcommittee Report

### **Background**

The Consumer Protection/Medical Liability subcommittee (CPML) was established to explore market innovation options which could lead to improved quality and value in the state's healthcare system by reducing poor outcomes and implementing appropriate legal reforms.

Several national and local professionals specializing in medical malpractice, tort reform law and peer review; actuarial analyses of the individual, small group and large group health insurance markets; health care reform and health insurance exchanges; health insurance cooperatives; and, other disciplines pertinent to the charges presented before the CPML subcommittee. The opportunity to hear from these individuals with such specialized knowledge and experience proved beneficial as the members of the subcommittee debated and discussed the recent trends as well as where there may be opportunity for improvement.

Mr. Weldon Johnson, senior partner of Barnes, Alford, Stork & Johnson, presented to the subcommittee on Tuesday, July 12, 2011. Mr. Johnson's practice includes medical malpractice defense and surety law. He also represents a wide variety of hospitals across South Carolina and the University of South Carolina School of Medicine. His presentation focused on "The State of Medical Liability in South Carolina." He addressed the different types of hospital organizational structures, the Tort Claims Act, charitable immunity, and the history of medical liability in the state.<sup>34</sup> Peer review was also discussed in depth. Peer review is a mechanism of evaluation by qualified medical professionals to maintain standards, improve performance and provide credibility for evaluating the appropriateness of medical measurement for medical quality.

Dan Gallagher, President of United Healthcare Community Plan, along with Ms. Martha Browne, Director at United HealthCare, and Mr. Craig Hankins, who serves as a consumerism lead and works in product development and innovation at UnitedHealthcare, presented on Thursday, September 8, 2011. UnitedHealthcare is an operating division of UnitedHealth Group, the largest single-health carrier in the United States. UnitedHealthcare's nationwide network includes 659,912 physicians and health care professionals, 80,000 dentists, and 5,158 hospitals. Their presentation focused on the individual and small group insurance markets.

On Monday, September 12, 2011, Wade F. Horn, PhD; Director Brian Keane, Principal; Bharat Chaturvedi, Senior Manager; and, Michelle Raleigh, Senior Manager, all of Deloitte Consulting, presented to the full SC Health Planning Committee and members of the four subcommittees. Deloitte is the largest health care consulting practice based on revenue, number of clients, and services provided. Its roster of health plan clients' combined membership equals two-thirds of all U.S. commercial health insurance enrollees. It currently maintains 14 Medicaid eligibility systems and 20 self-service systems across the United States.

The Deloitte presentation focused on three possible models for exchanges, illustrating the process and how they will integrate with other programs in the state. The presenters encouraged members of the committees to provide thoughtful consideration of the state's capacity when debating exchange options.

Mr. Andrew M. Dvorine, ASA, MAAA, an Associate Actuary with the South Carolina Department of Insurance, presented to the subcommittee on Thursday, October 6, 2011. Mr. Dvorine's presentation focused on the history of the health insurance markets in South Carolina. He reviewed the uninsured population in South Carolina and the development of the insurance markets since the

early 1990s. He also reviewed the current large employer, small group, and individual health insurance marketplaces. He concluded his presentation with data on the competitiveness of the marketplace.

The last meeting of the Consumer Protection and Medical Liability Subcommittee was held on Wednesday, October 12, 2011.

Mr. Weldon Johnson, who previously appeared before the subcommittee on July 12, 2011, introduced Mr. Charles L. Henshaw, Jr. of Furr and Henshaw to the subcommittee. Mr. Henshaw is a medical malpractice plaintiff attorney. Surgical errors, failures to diagnose and properly treat patients, and prescription and medication errors are among some of his areas of practice. He published "Torts, Annual Survey of South Carolina Law," 32 South Carolina Law Review 205, 1980 and contributed to South Carolina Damages, 2004.<sup>35</sup> He also has been actively involved in drafting health care legislation.

Mr. Henshaw gave a history of professional liability coverage which was designed to protect doctors and also provide adequate compensation to patients in the event of adverse medical care. He also discussed the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association (JUA) and the South Carolina Patients' Compensation Fund (PCF) and their role in the medical malpractice marketplace.

The JUA was created for the purpose of providing professional liability insurance and risk management services to eligible healthcare providers in our state.<sup>36</sup>

The PCF was created for the purpose of paying that portion of a medical malpractice or general liability claim, settlement, or judgment which is in excess of \$200,000 for each incident or in excess of \$600,000 in the aggregate year for one year.<sup>37</sup>

Mr. Andrew M. Dvorine, ASA, MAAA, an Associate Actuary with the South Carolina Department of Insurance (DOI), appeared before the subcommittee again. Mr. Dvorine explained the eligibility criteria for the South Carolina High Risk Pool (SCHIP) and outlined the three plans available and the number of enrollees as of 2010. He gave an explanation to the subcommittee on the methods used in calculating the standard pool rate, premiums charged in the pool and assessments against member insurers. This presentation focused on the state-run high risk pool created by the SC Code of Laws. This should not be confused with the Preexisting Condition Insurance Plan (PCIP) made available by the federal government that makes health insurance available to people who have had a problem getting insurance due to a pre-existing condition.

Mr. Dvorine also addressed health insurance cooperatives (co-ops) as allowed under state law. Co-ops join together small employers to create a group with enough membership that they may obtain the same or similar coverage options that would be offered to a similarly-sized large employer. Ms. Pam Sawicki of the South Carolina Business Coalition on Health (SCBC) and Mr. Darrell Douglas of HealthCare 21 Solutions were the final presenters of the October 12, 2011 meeting.

Ms. Sawicki gave history on the SCBC and its development as a tool to improve health and healthcare while reducing cost through multi-stakeholder involvement. The SCBC helps small businesses with limited resources and self-insured employers design benefits to decrease the risk among their employees.

Ms. Sawicki then informed the Subcommittee of the SCBC's intentions to establish a health insurance cooperative as allowable under the Affordable Care Act, defined as a private-nonprofit health insurer owned and operated by the users. She introduced Mr. Darrell Douglas of HealthCare 21 Solutions which is located in Knoxville, Tennessee. HealthCare 21 Solutions is a consulting firm that provides tools that enable clients to better understand and manage health care costs through data integration and analysis, risk identification, effective health risk coaching tools and a management mentoring program. Mr. Douglas and the HealthCare 21 Solutions team are working with the SCBC team on developing this Consumer-Operated and Oriented Plan (CO-OP).

### **Recommendations of the Subcommittee**

The subcommittee recommends that the full committee give consideration to the following items related to consumer protection:

1. More effective encouragement, by the state, of ways to promote the growth of Accountable Care Organizations as a means of controlling costs and encouraging the consistent delivery of quality healthcare services.
2. More effective recruitment, by the state, of additional health carriers to the market following a consideration of whether any changes should be made to the state's existing statutes related to small-employer health group cooperatives.
3. More effective recruitment, by the state, of additional health carriers to the market following a consideration of whether additional demographic analysis of the individual and small-group market, by region or by wage level, could yield an opportunity for additional health insurance product offerings tailored to the specific needs of consumers with modest incomes.

The subcommittee recommends that the full committee give consideration to the following items related to reducing medical cost:

1. A request for legislative review of the possibility for clarification of when peer review information should be protected from use as discoverable information in malpractice cases without causing undue hardship to a plaintiff's case. In malpractice litigation, plaintiffs often seek to discover a hospital's efforts to determine the root causes of an injury or incident. Currently there is limited protection for the processes that call for "full candor" and thus tend to inhibit frank discussion.
2. A request for legislative review of the possibility of limiting the liability of charitable and for-profit hospitals for the actions of independent contractors who are not employees of a hospital.
3. A request for legislative review of the possibility of defining with "checklists" decisions and actions by health care providers that would constitute "safe harbors" for which health care providers could not be sued.
4. A request for legislative review of the possibility of encouraging or mandating that hospitals and health care providers use professionally-created "checklists" of best practices for surgery and other health procedures, to reduce errors and improve quality of outcomes.
5. A request for legislative review of the possibility of mandating that consumers of health care be provided, at the request of the consumer, written cost estimates by health care providers before health care services are provided.
6. A request for legislative review of the possibility of allowing by law the existence and operation of community health plans not considered as providing insurance or an unauthorized insurer {see FY 2011-12 proviso 21.40 (DHHS: Community Health Plans)}, whereby participants in the plan can pay in advance for health services as provided by contract.

7. A request for legislative review of the possibility of allowing non-physician health care providers to perform more health care services under the supervision of a physician, thereby increasing and improving access to health care by consumers.
8. A request for legislative review of the possibility of the state contracting with a competent private company to perform audits to detect, prevent and stop fraud and waste regarding the provision of Medicaid services in South Carolina.
9. A request for executive and legislative review of how to reduce paperwork, minimize requirements, increase efficiency, increase patient choices and eliminate unnecessary bureaucracy regarding the provision of health insurance and of health services, and the implementation of all ideas that safely increase efficiency and quality of outcomes.

### **Status of Health Insurance Markets in South Carolina**

Competition in the health insurance marketplace can be measured in several different ways. One way the market can be measured is by calculating the percentage of the market (i.e., measured in terms of the number of people enrolled) represented by the largest insurer in the state. A second way is to consider the number of insurance carriers representing a threshold portion of the market (> five percent), quantifying the extent of choice available to consumers among plans with material enrollment. A third and very common measure of market competition is the Herfindahl-Hirschman Index (HHI) which measures how evenly market share is spread across a large number of insurers. The values of HHI range from zero to 10,000 with values closer to zero indicating a more competitive market and values closer to 10,000 indicating a less competitive market. This scale is further broken into three categories: an unconcentrated market is represented by a 1,000 to 1,500 value range, a moderate concentration is represented by a 1,500 to 2,500 value range and a highly concentrated market has a value above 2,500.

#### *Individual Market*

The individual health insurance marketplace in many states is highly concentrated. Thirty states plus the District of Columbia had individual health insurance marketplaces with at least half the market dominated by a single insurance carrier in 2010. The median market share held by the largest health insurance carrier in each state was 54 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,761. It should be noted that in 45 states and the District of Columbia, the HHI exceeds 2,500. South Carolina's largest state insurer has a market share of 54 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 3,296.<sup>38</sup>

According to the Supplemental Health Exhibit filed with the NAIC in 2010, there are 64 companies with earned premiums in South Carolina for individual comprehensive health insurance. The top 10 companies account for 90 percent of all premium earned in the state.

#### *Group Markets*

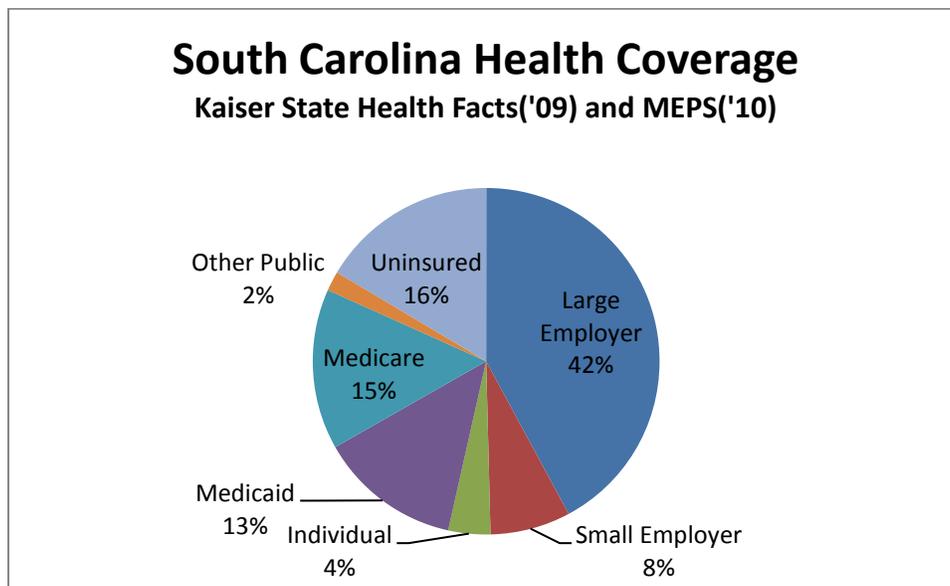
The level of completion in the small group market is generally characterized in the same way as the individual market. The median market share held by the largest health insurance carrier in each state was 51 percent. Nationally, the median number of insurers with more than five percent of the market share is four insurers, and the median HHI is 3,595. South Carolina's largest state insurer has a market share of 67 percent. The state has three insurers with greater than five percent of the market share, and the HHI is 4,783.

According to the Supplemental Health Exhibit filed with the NAIC in 2010, there are 25 companies writing business in South Carolina's small group market out of a total of 131 authorized insurers. Here, the top five companies account for 90 percent of the marketplace. This is a significant

decrease from the 1990s when South Carolina had 70-80 companies competing for small group business. This decline had stabilized by 2004 when there were 23 carriers writing business in the state.

According to the 2009 Kaiser Family Foundation, which is the most recent data on the coverage types to-date, 17 percent were uninsured, 12 percent were covered by Medicare, 16 percent were covered by Medicaid, one percent was covered by other public coverage, 49 percent were covered by employer-sponsored coverage, and five percent were covered by individual policies. In South Carolina, for the same period, 16 percent were uninsured, 15 percent were covered by Medicare, 13 percent were covered by Medicaid, two percent were covered by other public coverage, 50 percent were covered by employer-sponsored coverage, and four percent were covered by individual policies.

The employer-sponsored percentage for South Carolina can be broken down into large and small group coverage. The 50 percent of South Carolinians covered by employer-sponsored coverage breaks down to 42 percent for large employers and eight percent for small employers. Using South Carolina-specific data from the 2010 Medical Expenditure Panel Survey (MEPS), the breakdown between large and small employers can be derived.<sup>39</sup> MEPS provides the number of employees, the percentage of employees in companies offering health insurance, the percentage of employees eligible for health insurance, and the percentage of eligible employees who enroll in health insurance, all broken down by companies with fewer than 50 employees and those with 50 or more employees. Using this data, the 50 percent of employer-sponsored coverage reported in the Kaiser Family Foundation data can be further divided into the relative percentages for small and large groups, as shown in the following table:



In the large group market there are 17 companies writing fully-insured health insurance products, and the top two comprise approximately 90 percent of the marketplace. However, more than 66 percent of coverage in this market is provided by self-funded plans where the employer assumes most of the risk for the product and hires an insurance carrier or a third party administrator to administer the benefits. Specific data is not available about the number of administrators in this part of the market. However, using the total population of individuals who receive coverage through a large employer and the total amount of businesses either insured or administered by the

two largest insurers/administrators in this market shows that the two largest insurers/administrators comprise approximately 49 percent of the marketplace.

Some barriers to entry in the insurance marketplace include the inability to form provider networks and lack of brand awareness among consumers. An insurance carrier with significant market share may face little competition and may have higher premiums and profits, but it may also be better poised to negotiate lower rates with doctors and hospitals. It is believed that plans with at least five percent of the market share potentially control sufficient market share to grow in the future.

To better understand the options in South Carolina's marketplace, the subcommittee studied historical trends in market information including in individual, large and small-group policies as well as concentration, size, and costs.

During the 1990s, the majority of states enacted small group reforms designed to improve the availability of health insurance coverage. These reforms included rating restrictions, limitations on pre-existing condition exclusions, guaranteed issue requirements, guaranteed renewal, and portability of coverage.

In June of 1991, the Governor of South Carolina signed into law Act No. 131 which required rate bands for small employers, defined as a group of 25 or less, and placed additional restrictions on renewal coverage and pre-existing condition exclusions.

Act 131 did not address all of the issues in the small group market. In 1994, with concerns about access to health insurance coverage, No. 339, also called Small Employer Health Insurance Availability Act, was passed. This law defined small employers as having from two to 50 employees.

It also established the small employer insurer reinsurance program. Rate bands were eliminated and instead created a new requirement that the actuarial based rate for a plan could only be adjusted to reflect the case characteristics of family composition and class of business. Guarantee issue of two plans, called the basic plan and standard plan, was also required of all insurers.

In 1997, Act No. 70, also known as the Small Employer Availability Act, was passed. Much like the early 1990's, rating bands were again allowed; case characteristics for rating purposes were expanded to include age, gender, geographic area, industry, family composition, and group size; and, within certain limitations, health status was allowed.

Also in 1997, Act No. 5 was passed which enacted provisions of the Health Insurance Portability and Accountability Act (HIPAA). Guarantee issue was now required of all plans instead of just the basic and standard plan. There were additional restrictions on preexisting conditions limitations and guaranteed renewability of coverage provisions as well as numerous prescribed practices for insurers.

### **State and Federal Strategies for Expanding Consumer Choice Inside the State**

The CPML subcommittee received information from various experts related to potential strategies for controlling healthcare costs and their relationships with competitiveness in the marketplace.

#### *State-specific Measures for Expanding Consumer Choice*

The South Carolina General Assembly enacted the small employer health group cooperative statutes<sup>40</sup> in 2008 (hereafter referred to as Act 180) to improve the ability of small employers to

access affordable health insurance coverage. The basic concept of a health group cooperative is that a number of small employers, when joined together, will create a group with enough membership that they may command the same or similar coverage options that would be offered to a similarly-sized large employer. However, despite the legal ability of entities to form health group cooperatives, there seem to be a number of barriers that have limited the successful creation of cooperatives in South Carolina.

Prior to Act 180, South Carolina Code<sup>41</sup> (Act 339) permitted a common group of small employers to join together for the purposes of obtaining group health, group accident, or group accident and health insurance. The section further specified the requirements with which such a group would be required to comply. Many of these requirements are similar to those required for a health group cooperative. One noticeably different requirement is that the previous code required a group to contain at least 1,000 eligible employees, whereas Act 180 requires a small employer health group cooperative to contain at least 1,000 eligible employees *or* at least ten participating employers.

Act 180 added new provisions to and amended some of the existing statutes contained in Article 13, Chapter 71 of Title 38, known as the “Small Employer Health Insurance Availability Act,” including the following:

- Provided that a health group cooperative contain at least 1,000 eligible employees *or* at least ten participating employers,
- Provided for the requirements, powers, duties, and restrictions of a health group cooperative; and,
- Required the DOI and Office of Research and Statistics to submit a report on the effectiveness of the health group cooperatives in expanding the availability of health insurance coverage for small employers by January 1, 2010. The DOI submitted the required report dated December 31, 2009.

#### *Federal Measures for Expanding Consumer Choice*

Section 1322 of the Affordable Care Act, titled “Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers,” directs the Center for Medicare and Medicaid Services (CMS) to establish a CO-OP program intended to incite member-governed, qualified, nonprofit health insurance issuers to offer CO-OP qualified health plans in the individual and small group markets (in compliance with state licensing regulations). This is intended to expand the number of health plans focused on integrated care and greater plan accountability available in each state’s exchange.

CO-OPs will be directed by CMS to use any profits to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members. CO-OPs must meet all the state standards for licensure that other qualified health plans issuers must meet. To assist in the formation of CO-OPs, CMS will offer two types of loans to organizations which apply to become qualified nonprofit health insurance issuers. Start up loans will provide assistance with start-up costs and have a repayment date of no later than five years after issuance. Solvency loans will provide assistance in meeting solvency requirements in the states in which the organization is licensed to issue CO-OP qualified health plans and have a repayment date of no later than fifteen years after issuance. CMS will give priority to applicants offering CO-OP qualified health plans on a statewide basis.

#### **The State of Medical and Hospital Liability in South Carolina**

As noted in the original directive for the charges and deliverables for the subcommittee, improving medical quality will reduce poor outcomes, thereby reducing costs and liability. The subcommittee

was to review what, if any, legal reforms would improve quality relative to cost as well as what providers can do to improve quality and control costs.

### *Medical Liability Overview*

As an overview, suits against governmental hospitals and their employees were forbidden under a doctrine known as 'sovereign immunity.' Our Supreme Court abolished sovereign immunity and the legislature responded by passing the South Carolina Tort Claims Act. As amended, it allows suits against governmental hospitals, prohibits suits against individual governmental employees, caps the amount of damages that a person can recover, and prohibits the recovery of punitive damages. Similarly, charitable hospitals were immune from liability under the charitable immunity doctrine.

Our Supreme Court abolished this doctrine and the legislative response was the Uniform Solicitation of Charities Act, which limited the amount of damages that could be recovered against the institution. In an effort to allow equal treatment for governmental and charitable hospitals, the Uniform Act was amended to adopt the limits of liability set forth in the Tort Claims Act. However, suits against individual charitable employees or physicians employed by the facilities can be named if it is alleged that they were grossly negligent. Gross negligence is not defined by the statute.

For-profit hospitals were afforded no statutory protection and faced unlimited liability until 2005 when the legislature passed three Acts as part of Tort Reform legislation. This legislation created non-economic damage caps. The constitutional validity of the non-economic damage caps has not been ruled on by the Supreme Court.

In the 1970s, the availability of professional liability insurance for physicians reached a potential crisis resulting in the legislatively created South Carolina Medical Malpractice Joint Underwriting Association. This association provided insurance to physicians when there was none reasonably available in the marketplace. Since that time, malpractice premiums and malpractice litigation rose, resulting in significantly increased premium costs.

The South Carolina statute of limitations has been shortened from six years to three and carriers are now allowed to write claims-made coverage. In the last several years, coverage has become more readily available and liability premium costs seem to have leveled off in the last three or four years. Alternative Dispute Resolution has been mandated by the South Carolina Supreme Court. The Tort Reform legislation passed in 2005 now requires that a plaintiff produce an affidavit from a qualified physician setting forth at least one departure from standard of care as a prerequisite for being able to file litigation. The same legislation also requires that litigants undergo the Notice of Intent process prior to being allowed to file a lawsuit. This process requires mediation among the parties.

The complexities associated with litigation against healthcare providers in navigating the South Carolina Tort Claims Act, the Uniform Solicitation of Charitable Funds Act, the South Carolina Contribution among Tortfeasors Act, the 2005 amendments to Tort Reform, joint and several liability, and the South Carolina Fairness in Civil Justice Act of 2011 cannot be overstated.

Once an action is filed, the parties engage in significant discovery designed to determine the facts and circumstances surrounding the incident giving rise to the particular claim. Part of the discovery process often includes an effort by the plaintiff to obtain hospital-related investigations such as a root cause analysis or even the reporting requirements of an incident or Sentinel event. The existing statute that protects the hospital peer review process was enacted long before many of the federally-mandated actions were required.

The South Carolina Supreme Court expanded the potential liability of hospitals in a ruling that allows injured parties to seek to hold the facility responsible for what individual physicians such as emergency room physicians, radiologists, neonatologists, anesthesiologists, and other similar practitioners do or omit to do that causes alleged injury to the patient. Each of these physicians must carry professional liability insurance in order to be credentialed to work in a hospital. The end result is that instead of simply suing the individual physician alleged to be responsible for the injury, hospitals are now being added as additional defendants under the ruling that it owes a non-delegable duty to a patient to provide competent medical care.

Punitive damages are prohibited in actions against governmental hospitals, but are often claimed in actions against physicians and other hospitals. There has been an ongoing battle, both legislatively and judicially, to limit or prohibit the recovery of punitive damages. For instance, the protection afforded under the statute for charitable hospitals limits its exposure, but allows an action against employees who are alleged to be grossly negligent. However, South Carolina courts have given a broad definition to gross negligence. In the 2005 legislation, a plaintiff can avoid the non-economic damage caps altogether by alleging and proving that the defendants were grossly negligent. At the same time, governmental hospitals and their employees, including physicians, are immune from punitive damages and have a reasonable cap on actual damages not to exceed \$1,200,000. In a recent Supreme Court decision, the plaintiff sought to expand the cap by proving multiple occurrences leading to a single injury and arguing that each occurrence entitled the plaintiff to a separate cap.

The 2005 legislation also sought to address joint and several liability doctrine. As originally developed, any defendant found liable could be called upon by the plaintiff to pay 100 percent of the damages. This was legislatively revised to eliminate this type of liability to one found more than 50 percent negligent. In other words, one less than 50 percent negligent would only be held responsible for that percentage of liability found by the jury rather than the entire verdict. Again, this disappears if that defendant is found to be grossly negligent.

There are some recommendations that will have an impact on the cost of hospital and medical care. A strong peer review statute will allow and enable hospitals to follow the mandates of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) regarding Sentinel event reporting and investigations. At the present time, JCAHO recognizes that South Carolina is one of four states with the weakest peer review statute in the nation.

When an incident occurs in a hospital that results in injury to a patient, it increases the cost of further care and medical liability litigation. As part of hospital and medical care, incidents and errors need to be investigated to see if there is a way to prevent future events of a similar nature. In general terms, when an incident occurs in a hospital, an incident/occurrence report is prepared by the staff that finds its way to the quality improvement staff for investigation and inquiry into the hospital or medical process that led to the injury. The purpose of peer review is set forth in a South Carolina Supreme Court opinion as follows:

The overriding public policy of the confidentiality statute is to encourage healthcare professionals to monitor the competency and professional conduct of their peers to safeguard and improve the quality of patient care...The underlying purpose behind the confidentiality statute is not to facilitate the prosecution of civil actions, but to promote complete candor and open discussion among participants in the peer review process...The policy of encouraging full candor in peer review proceedings is advanced only if all documents considered by the

committee...during the peer review or credentialing process are protected. Committee members and those providing information to the committee must be able to operate without fear of reprisal...We find that the public interest in candid professional peer review proceedings should prevail over the litigant's need for information from the most convenient source (emphasis added).

Another area of potential cost reduction is in the area of reduced hospital liability insurance costs due to duplication of coverage since the South Carolina Supreme Court has held that hospitals may also be held liable for the acts of private physicians who practice within the hospital (e.g., emergency physicians and radiologists), even though the physicians are required to maintain their own professional liability insurance coverage in order to obtain hospital privileges. Governmental hospitals are not subject to this exposure and expense, as the South Carolina Tort Claims Act limits liability to that of its employees.

A simple remedy to reduce hospital liability premiums for duplicate exposure on behalf of charitable and for-profit hospitals would be a statute providing the same protection afforded to governmental hospitals and thereby limit hospital liability to acts and omissions of employees only.

Another possibility would be to revisit the 2005 Tort Reform legislation which imposed limits or caps on the amount of non-economic damages that can be recovered by one claiming to have been injured by the act or omission of a healthcare provider. The intent was to limit recovery to \$350,000 per defendant to a maximum of three defendants or \$1,050,000. However, the definition of "claimant" was defined to include anyone suffering "personal injury." The interpretation of this term has been expanded to allow multiples of the three caps. Additionally, the caps are eliminated if one is found to have been "grossly negligent," a term not defined by the statutes.<sup>42</sup>

## **Information Technology Subcommittee**

### **South Carolina Health Planning Committee**

#### **Charges & Deliverables**

The Information Technology subcommittee explored and reported on the various technical options available to South Carolina for developing and/or connecting to a health insurance marketplace. The subcommittee reviewed insurance marketplace solutions currently in operation, evaluate the technical approach, and understand the costs and business models associated with each approach and/or technology.

#### **Deliverables**

1. Criteria for evaluating insurance marketplace technologies for South Carolina.
2. Review of existing health insurance marketplace technologies.
3. Review of costs and/or business model associated with each approach.
4. Review of options and technical ability to integrate South Carolina Medicaid eligibility with each approach.
5. Review of technical readiness of existing South Carolina insurance providers to participate in a health insurance marketplace.
6. Evaluation of successful technical approaches and identification of the key criteria for success.

# Information Technology Subcommittee Report

## **Executive Summary**

The Information Technology Subcommittee explored a variety of technologies, approaches to technology implementation and related operational needs that could be used in determining how South Carolina may best address health insurance exchanges.

Whether the State attempts to run a state-based insurance exchange, defers to the federal exchange or finds an alternative approach that meets its unique needs, a strong information technology (IT) system is critical for success. Regardless of one's preference to a particular model or approach for supporting health insurance exchanges, the IT Subcommittee recognizes that the development of a dynamic modern IT system – one that is responsive to current policies while also flexible and capable of incorporating future policy directions is a fundamental shift in how we approach systems within the State.

Additionally, the Subcommittee feels that it is important to note that technology alone is not enough or even the goal itself. Rather, technology is only capable of tools that are able to support the critical and more important goal of improving the health outcomes of South Carolinians. To that end, South Carolina must consider how its existing healthcare and health-related capabilities integrate with any new technology developed or implemented in support of insurance exchanges. In addition, the Subcommittee both recognized and discussed the reality that technology alone will not take care of all our citizens' needs. The State's plan must include comprehensive consumer assistance to help those who are not able to access or understand the technology on their own. The IT Subcommittee believes that technology investments should facilitate existing and new partnerships among existing private, non-profit, and public entities in ways that will provide citizens support in their health care options and decision-making.

If the Health Planning Committee makes its recommendation solely between a state-run exchange and a federal exchange, given the information available at this time, the IT Subcommittee believes that the technical challenges and risks associated with attempting to develop a state-run exchange exceed the potential technical issues associated with relying completely on a federal exchange. The Subcommittee believes that the State should focus on the systems and programs that it already has expertise in operating and leverage existing private, non-profit, and public technologies given the short time frames and uncertainty in federal rule-making. Additionally, the Subcommittee feels that the State should push the responsibilities and complexities of new programs such as the premium tax credits and tax subsidies onto the federal government while working to manage the insurance marketplace and Medicaid programs in ways that meet the State's unique needs.

As a result of its efforts, the Subcommittee also feels that the State should continue an on-going discussion for the purposes of open discussion, dialogue and debate regarding the coordination of technology systems and operations in support of health planning and outcomes.

## **Introduction**

The South Carolina Health Planning Committee's Information Technology Subcommittee ("IT Subcommittee" or "Subcommittee") explored the current state of information technology systems and capabilities related to health care eligibility, enrollment and insurance exchange systems. The Committee examined existing and emerging systems within the state's public programs and the private sector to understand, document and ultimately recommend approaches that would best align with the goals and needs of the State of South Carolina ("the State"). The Subcommittee determined that meeting the needs of existing health benefit programs coupled with the needs of Medicaid expansion and new health insurance tax subsidies and credits available through the Patient Protection and Affordable Care Act (PPACA or ACA) along with focusing on ways to provide greater consumer information and transparency into the process of purchasing health insurance demands a comprehensive technological plan.

Whether the State attempts to run a state-based insurance exchange, defers to the federal exchange or finds an alternative approach that meets its needs, a strong information technology (IT) system is critical for its success. Regardless of one's preference to a particular model or approach for supporting health insurance exchanges, the IT Subcommittee recognizes that the development of a dynamic modern IT system – one that is responsive to current policies while also flexible and capable of incorporating future policy directions is a fundamental shift in how we approach systems within the State.

The IT Subcommittee recognized that whether the exchange was operated on a state level, federal level or by an alternative model, the focus must be on the citizen and the solution must work to minimize the challenges, confusion and complexity of applying for and maintaining health coverage and benefits. The IT Subcommittee believes that one of the key roles the IT systems should play is to assist South Carolina citizens in determining which program(s) they may be eligible for and then connect or route them appropriately. Furthermore, the Subcommittee believes that the IT systems must expand the information available to healthcare consumers in ways that focus on greater understanding of prices or costs, health outcomes and quality measures.

The Subcommittee recognizes that technology is one key component to assist the State's citizens in selecting the appropriate coverage. To that end, South Carolina must consider how its existing healthcare and health-related capabilities integrate with any new technology developed or implemented in support of insurance exchanges. In addition, the Subcommittee both recognized and discussed the reality that technology alone will not take care of all our citizens' needs. The State's plan must include comprehensive consumer assistance to help those who are not able to access or understand the technology on their own. The IT Subcommittee discussed ways in which the IT systems can and should facilitate existing and new partnerships among existing private, non-profit and public entities that can and will provide citizens support in their health care decision-making.

To develop this report and respond to its charge, the IT Subcommittee reviewed and discussed the implications of relevant sections of the ACA, explored existing private health insurance exchange technologies, explored existing public technologies, evaluated a variety of approaches the State could consider, and remained abreast of changes in the landscape throughout its deliberations. After analyzing current private and public capabilities, along with the potential impacts of the ACA, the Subcommittee believes that the information technology solution to support the needs of any model must leverage those systems and operations that already exist in the State, utilize the technologies already developed by the private sector and push back on the Federal government the

complexities of the ACA that are difficult to implement given the short time periods and incomplete guidance.

Throughout its work, the IT Subcommittee focused on the development of an integrated technology plan that is focused on the needs of South Carolinians and provides the groundwork for systematically improving health in the most cost effective way.

### **Considerations & Perspectives**

The IT Subcommittee believes that in determining the best approach for the State of South Carolina it is important to remember that the technology alone is only a means to the end and in this case the end is improving the health and well-being of South Carolinians. With that in mind, the Subcommittee recognized and deeply explored the potential for technology to be a driver of change and improvement in health and health-related outcomes for the State. However, to realize this vision, the Subcommittee believes that decisions for how best to implement technology systems that provide South Carolinians improved access to information (particularly pricing and quality) regarding their health insurance and health care choices must:

- Be consumer-centric;
- Integrate with other means of access to information such as in-person and call center support;
- Support existing providers of health insurance, health care services, and health care information;
- Enable community partners and licensed agents to be leveraged as a source of assistance.

Additionally, the Subcommittee recognized that it is in the State's long-term interest to develop a vision for how a health-related "ecosystem" can form across the State that is facilitated by technology. In order to realize such a vision, the Subcommittee believes that the following should be components in the planning:

- Focus on what is best for South Carolina's long-term needs;
- Develop a longer-term vision focused on health outcomes;
- Build upon and leverage what is already working in the State;
- Utilize existing technology/solutions when and where possible because custom development is both time and cost prohibitive.

As a result of its meaningful discussion, shared discovery and problem solving, the IT Subcommittee recommends that an on-going dialogue continue among stakeholders that brings together interested parties, in a manner similar to the Subcommittee, to continue the discussion, planning and shared implementation of the technology required for a health-related ecosystem that meets the needs of South Carolina.

### **Approach**

The Subcommittee approached the task of evaluating the information technology implications of health insurance exchanges through a three-fold approach. The Subcommittee first reviewed the sections of the ACA related to the information technology systems envisioned to support the implementation of the law. Second, the Subcommittee explored existing private and public systems/technologies currently in place or available for providing application, eligibility, enrollment and maintenance for healthcare and health insurance programs. And third, the Subcommittee evaluated a broad set of options that South Carolina could take in considering various approaches for implementation of health insurance exchanges in the State.

In order to understand the potential impacts of various options, the Subcommittee explored a number of potential scenarios that ranged from making no changes to the existing systems for the

application of health insurance programs to a complete implementation of a state-run exchange as described by the ACA and related Federal guidance. The Subcommittee then evaluated each of the approaches based on their potential outcomes and benefits for the State, the required technology (existing or new), their relative costs and potential issues, their relative risks including complexity and time to implement, as well as any other related items to each approach.

The Subcommittee also discussed key components to information technology systems and plans that are important as any organization considers information technology. The Subcommittee reviewed modern information technology concepts including:

- Enterprise architecture and ability to design a system comprised of integrated independent systems;
- Use of commercial-off-the-shelf (COTS) solutions and the trade-offs related to configuration over custom development;
- Service and component-based solutions (web-services);
- Incremental, iterative and agile technology development and implementation.

Throughout the Subcommittee's exploration of the various approaches, a number of key points continued to surface that the Subcommittee believes are salient in any decision regarding the implementation of information technology related to health insurance and health benefit programs for the citizens of South Carolina. The Subcommittee's points can be summarized as the following:

- Keep the needs of the consumer at the forefront of system planning;
- Remain focused on health outcomes and systems that support improving health;
- Consider not only the initial application process, but also the systems to support ongoing operations and support of consumers;
- Leverage existing systems and operations including existing public and private solutions to address the needs;
- Build on the State's existing strengths;
- Recognize the short timelines associated with the initial requirements and plan accordingly;
- Develop an approach that can be implemented in an incremental and iterative manner.

The Subcommittee then deliberated on the research and discussion it had in order to build a set of technical and operational recommendations for the Health Planning Committee to consider when making its recommendations to the Governor regarding the decision to implement a state-run exchange or to utilize the federal exchange.

### **Technical and Operational Recommendations**

After carefully reviewing the information presented to the Subcommittee and reflecting upon its discussions and deliberations, the IT Subcommittee recommends the following to the Health Planning Committee for its consideration in determining its recommendations to the Governor.

The IT Subcommittee believes that the State must pursue a South Carolina focused approach. The approach should enable South Carolina to build upon its existing strengths by knowing what is good for the State, its workforce and insurance industry while relying upon the federal exchange to handle those functions that are new and unique to the ACA. The Subcommittee feels that this approach would reasonably balance the State's health-driven goals with the technical and operational risks associated with developing a state-run exchange or relying completely on a federal exchange.

If the Health Planning Committee makes its recommendation solely between a state-run exchange and a federal exchange, given the information available at this time, the IT Subcommittee believes

that the technical challenges and risks associated with attempting to develop a state-run exchange exceed the potential technical issues associated with relying completely on a federal exchange.

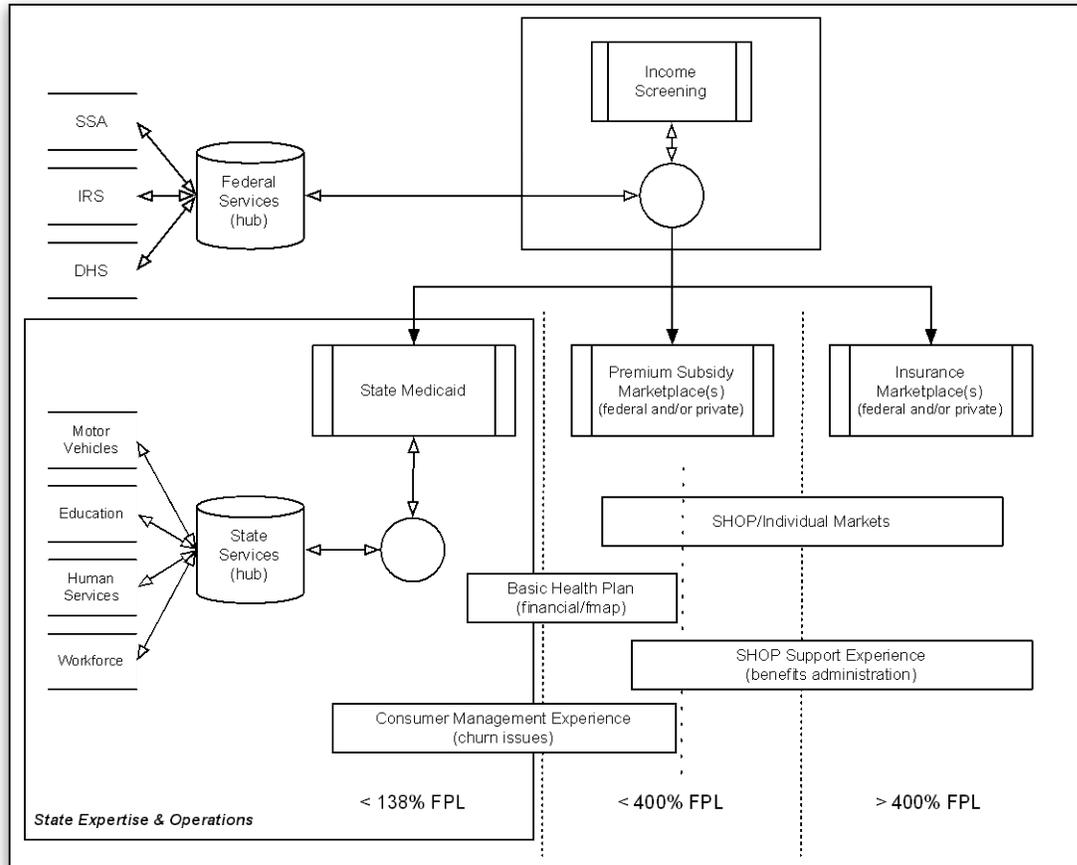
In coming to these recommendations, the IT Subcommittee explored a variety of potential models and believes that both technically and operationally a model whereby the State leverages and builds upon its existing assets and pushes the handling of the new requirements of insurance exchanges related to the ACA to the federal exchange provides a reasonable balance between benefit and risk.

By exploring a variety of potential technology approaches that would have a positive impact for South Carolina and the needs of insurance exchanges, the IT Subcommittee found that an important consideration was the type of health care benefits for which a citizen might be eligible. To that end the Subcommittee considered the following primary groups:

- Existing Medicaid recipients and those that would be eligible for Medicaid through the Medicaid expansion under the ACA;
- Citizens that would be eligible for tax subsidies and/or tax credits under the ACA;
- Citizens and small businesses that currently make up the individual and small business market, particularly those whose income exceeds 400 percent of FPL.

The Subcommittee believes that the State's existing efforts to improve eligibility and enrollment for the Medicaid program will address the needs of Medicaid recipients. Furthermore, the commercial insurance market, along with licensed agents who currently serve individuals and small groups, have developed solutions that are able to meet the needs of individual citizens and small businesses, particularly with regard to those potential consumers whose income exceeds 400 percent FPL – noting that the Subcommittee feels that additional requirements for increased information about cost, quality and outcomes can and should be provided to these consumers. That left the Subcommittee to determine the best ways to approach the group that would be eligible for tax subsidies and/or tax credits. This is an area where the State currently has limited to no experience and the rules for handling these subsidies are still under development.

The Subcommittee considered alternative approaches that would keep a consumer-centric easy-to-access entry point while leveraging the existing expertise of the Medicaid organization and commercial insurers in a way that meets South Carolina's needs. To that end, the IT Subcommittee developed a working model that creates a low risk income screening process – the unified consumer-centric entry point which then could pass consumers to the most appropriate system. This model is shown in Figure 1 below where the highlighted areas show those areas in which the State already has expertise. Specifically in operating existing programs as well as providing an initial income screening, in order to develop a consumer and citizen-centric approach to both health insurance and broader health quality and transparency information and access.



*Figure 1: Components of a Health Marketplace Organized by Type of Medical Assistance or Insurance*

The Subcommittee also considered the concept of the Federal Services Hub contemplated by the ACA as a single point of data exchange with federal resources. The Subcommittee also considered the potential benefits of creating a similar South Carolina State Services Hub that consolidates data across various state agencies. Likewise, the Subcommittee discussed the role that Medicaid and the existing South Carolina Health Information Exchange (SCHIE) could play in supporting this technology ecosystem. Figure 2 below shows state-specific systems including a possible State Services Hub that would be of benefit to many programs across the state. Additionally, the Subcommittee discussed the challenges of maintaining identity information for its citizens who receive services through these public assistance programs.

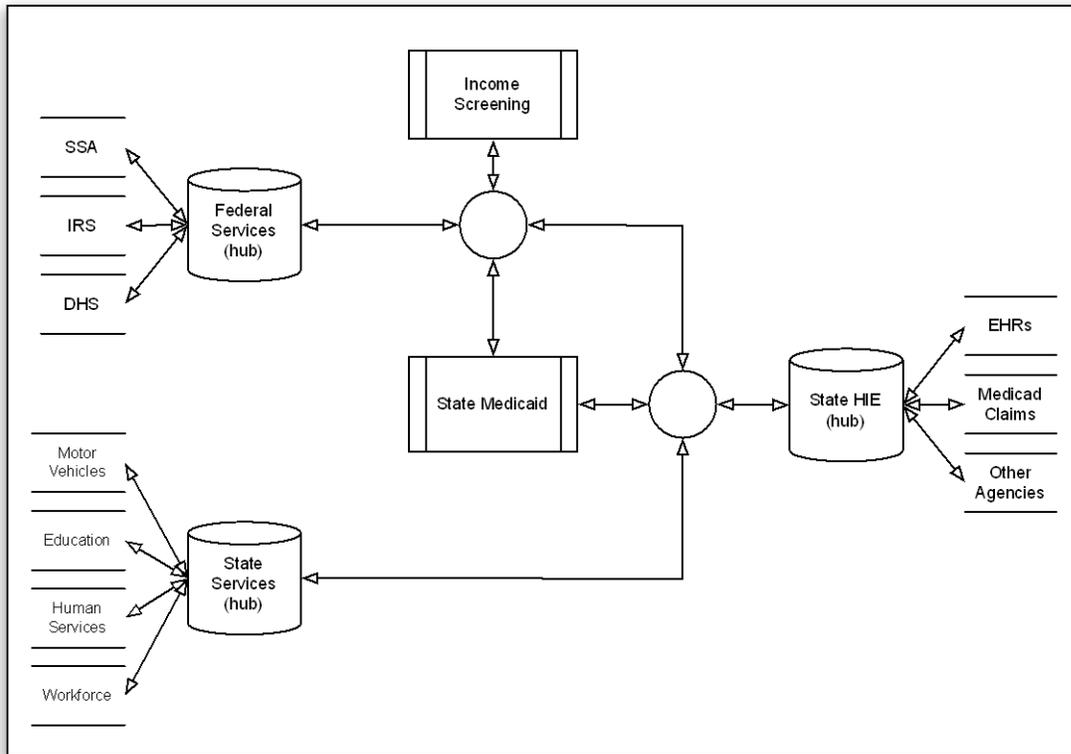


Figure 2: State Systems in Support of a Health Marketplace

### Summary

As discussed through this report to the South Carolina Health Planning Committee, it is important to keep the end goals of this effort at the forefront of any recommendation or decision related to information technology for health information exchanges. Namely, both information technology and health information exchanges are means to a broader end. Technology alone will not cure the State or nation of its health care woes, nor will insurance exchanges. The State must work to focus on better health and health outcomes and in each decision that is made the potential impact of the long-term goals must be weighed against the potential cost, risks and project realism.

### Additional Information

During its deliberations, the IT Subcommittee discussed a number of other systems that already exist within the State or that the Subcommittee believes are an important part of the State's future health information technology infrastructure. As such, the Subcommittee wanted to include brief summaries of those systems and/or concepts.

### South Carolina Health Information Exchange (SCHIE)

Health information exchanges (HIE) are designed to make information from all care providers available at any location where a patient seeks care. These exchanges are an important lever in efforts to improve individual and population health while simultaneously reducing the cost of health care. They ensure the timeliness and completeness of information needed by clinicians and patients, help avoid unnecessary duplication of services, and reduce the administrative overhead of the health system as a whole. South Carolina has the advantage of mature HIE initiatives developed over a ten-year period in both public and private sectors, which are being leveraged to enable statewide health information exchange. Serving in a lead role within the State's HIT landscape, the South Carolina Department of Health and Human Services (SCDHHS) assures that its large Medicaid

presence is closely aligned with the State HIE plan. The South Carolina Health Information Exchange (SCHIEEx) has been selected as the lead for the state HIE infrastructure, while also coordinating with several other functional HIEs in the state.

In 1992, South Carolina established a state data warehouse in the State Budget and Control Board's Office of Research and Statistics (ORS) repository. A legislative proviso requires that all state agencies submit data to the warehouse for use in program evaluation and outcomes analysis. Each agency maintains control over its own data. In 1996, state law mandated the submission of all inpatient, emergency department and outpatient claims meeting certain criteria to ORS with patient and provider identifiers. In 2006, these data assets were leveraged to build the SCHIEEx core technology platform. Pilot programs that were focused on improving patient care provided the necessary governance to implement the technology and fostered incremental expansion through 2009.

Acting on the principle of using State HIE funding to build on existing assets and provide gap-filling services, the state has leveraged the existing statewide master patient index (MPI) and Record Locator Service (RLS) to support robust health information exchange. The exchange went "live" for use by providers on January 1, 2011. SCHIEEx also enables point-to-point secure messaging by any HIPAA compliant entity, including for clinical summaries: "It is South Carolina's express intent to expose the SCHIEEx MPI, managing over 4.3 million consumers, to HIPAA compliant organizations statewide to make it a broad resources that supports directed exchange." The state also plans to leverage its MPI and claims information to implement an innovative use of Nationwide Health Information Network (NwHIN) Direct standards to send a directed message to primary care providers after an ED visit or hospital discharge.

The network design is a federated "network of networks" model coordinated through a record locator service/master patient index (RLS/MPI) currently populated with claims-based health data on more than 4.3 million citizens, nearly the entire population of the state. SCHIEEx is scaled for statewide use and supports new and existing connections for all providers and state agencies through its network-of-networks model. Under an agreement with the Office of the National Coordinator for Health IT (ONC), SCHIEEx makes its patient index available to any HIPAA compliant organization for robust health information exchange and point-to-point secure messaging. The statewide health information exchange strategy will allow every provider and HIPAA-compliant entity in the state to meet all exchange requirements for Meaningful Use in 2011 and beyond.

### ***Electronic Health Records (EHR) & Quality Data***

In order to promote and accelerate a robust health IT infrastructure, the Centers for Medicare & Medicaid Services (CMS) established the Electronic Health Records Incentive program (EHR, see also [www.healthit.gov](http://www.healthit.gov)). The Medicare and Medicaid EHR Incentive programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Additionally, the program provides funding to states to assist eligible professionals and hospitals with EHR implementation as well as to administer the program. The EHR Incentive program and associated support was established with funding from the American Recovery and Reinvestment Act (ARRA).

In South Carolina, the Department of Health and Human Services (SCDHHS) administers the EHR Incentive program in partnership with a number of other state agencies, provider associations, and stakeholders. Additionally, South Carolina's Center for Information Technology Implementation Assistance (CITIA, see also [www.citiasc.org](http://www.citiasc.org)) is the State's regional extension center for health

information technology (HIT). CITIA offers South Carolina's health care providers (particularly primary care and rural providers) a wide range of valuable consulting services, from assessing needs and selecting a vendor to managing system implementation and implementing workflow changes that improve clinical performance and efficiency. CITIA offers direct assistance on how to:

- Implement an electronic health record (EHR) system;
- Integrate the EHR system into the patient care process;
- Position yourself to receive Medicare and/or Medicaid incentive payments.

To help ensure interoperability with health information exchanges, the EHR Incentive programs require the use of certified EHR technology. Certified EHR technology assures that an EHR system or module offers the necessary technological capability, functionality, and security to assist providers in meeting the meaningful use criteria. Certification also helps providers and patients be confident that the health IT products and systems they use are secure, can maintain data confidentially and can work with other systems to share information.

Through the use of appropriate EHR technology, providers are able to begin sharing meaningful data in order to improve patient care. In South Carolina, fifteen primary care pediatric practices across the state have joined a program to improve patient care through the use of clinical quality measures and health information technology. The Quality through Technology and Innovation in Pediatrics (QTIP) program was established through a federal grant awarded by CMS as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

The QTIP project has four key goals:

- Quality – Demonstrate that newly-developed quality indicators can be successfully utilized in pediatric practices;
- Technology – Share key clinical data through a statewide electronic quality improvement network;
- Innovation – Develop a physician-led peer-to-peer quality improvement network;
- Pediatrics – Expand the use of pediatric medical homes to address mental health challenges of children in our state.

The QTIP program provides incentives to participating practices including an annual stipend for each year of participation, support to achieve National Committee for Quality Assurance (NCQA) certification, and assistance with implementation and use of EHR technology in order to connect to the statewide health information exchange and quality improvement network.

### ***Social Media's Role in Improving Health***

During its discussion, the Subcommittee explored ways in which modern technologies such as social media might be beneficial to the long-term goals of improved health in South Carolina. Health improvement research has historically shown that interventions and programs that are grounded in local communities have a stronger potential for meaningful impacts. The Subcommittee discussed ways in which the technology needed to support health insurance exchanges may be leveraged to engage the State's citizens through the use of emerging social media technology and tools to educate and incentivize healthy living at a local level.

### ***Human Connections***

Although the Subcommittee was focused on the information technology aspects of a health insurance exchange, the Subcommittee discussed the importance of human connections throughout the process, especially in assisting those most in need. It is important for the State to recognize and prepare for the significant customer service demands that broader access to health insurance will

create. Technology systems can and will assist in providing consumer outreach, however at the end of the day, human interactions and connections will be required.

The Subcommittee wants to emphasize the need for planning related to the operational aspects of the program, as well as recognizes the importance of partners in the process. Meeting the goal of improved health in South Carolina will require “a village” that includes private industry partners (particularly those in the health insurance industry including insurers and agents), small business owners, community groups (particularly non-profits), and public/state departments that must work together to ensure the right citizen gets the right information and support where and when they need it. Additionally, the technology components must provide the right tools and access for the appropriate group(s) to assist and support the State’s citizens.

## XI. Recommendations

The following recommendations were adopted by the Committee at its November 18, 2011 meeting.

1. The state cannot implement state-based health insurance exchanges as defined under PPACA and ill-defined and unfinished HHS regulations.
  - No final rules for the operation of state-based exchange exist and HHS has failed to adequately describe how a federal exchange or hybrid exchange would operate. Committing to either course of action - a state operated exchange or federal exchange - tied into the requirements of PPACA is therefore not desirable. At last count, only 15 states have enacted legislation of any sort related to PPACA and the majority of what has been implemented relates to governance – not operations or insurance regulation.
  - Timelines for implementation of state or federal exchanges are neither reasonable nor achievable. The federal government has already delayed policy making several months and policy making is presumably easier than actual implementation which must occur at the state and federal level and must integrate between state and federal systems. Little, if any, consideration was given at the federal level to the very practical concerns of state legislative and budgeting cycles or state procurement laws which will impact almost every aspect of exchange implementation, as well as the very real possibility of months of vendor protests related to procurement awards. In its timeline planning HHS has ignored years of nationwide experience with similar implementations of Medicaid eligibility, enrollment and information management systems which historically require years of business process redesign, procurement and implementation.
  - The primary function of the PPACA health insurance exchanges is to connect individuals and families with federal premium subsidies which ultimately must be reconciled on individual and joint federal tax returns. Regardless of individual opinions on the wisdom of subsidies as a means to control costs, the assignment, management and reconciliation of federal subsidies is solely a federal concern in which the state has no compelling interest.
  - The only organization capable of implementing the requirements of a state based exchange is the South Carolina Department of Health and Human Services. However, the department's resources and management capacity are fully committed to improving the current Medicaid program which is now serving approximately 900,000 persons monthly and preparing for a possible expansion of Medicaid required by PPACA which will bring another 500,000 to 600,000 individuals into the Medicaid Program. The Department's mission is most appropriately focused on improving the health of these individuals who are among the states most vulnerable and poor, not performing marketing, eligibility determination, enrollment and back office management for the private insurance industry.
  - PPACA and HHS proposed rules on navigators are poorly conceived and duplicate substantial capacity which already exists through private brokers. Assigning the role of "navigator" to a broad range of groups with little regard to licensure and liability concerns is not only naive, but potentially harmful to consumers who would essentially be receiving tax advice from lay persons with little preparation or accountability.

- Exchanges alone have not had demonstrated robust success in making health care more affordable. This is most likely due to the fact that the major underlying contributor to health insurance premiums is the cost of health services themselves - not insurance premiums and profits. And while the Institute of Medicine has identified that approximately \$190 billion of excess costs exist in the health care system due to administrative waste and duplication, often the result inefficient payers practices, exchanges as operating and contemplated under PPACA do not inherently change this dynamic. In fact, according to national health expenditure data presented by the South Carolina Institute of Public Health, the net cost of insurance - which includes administrative fees to manage care, ensure quality, pay claims, as well as profit margins - only account for about 7 percent of the nation's health bill. And so while employing exchanges to increase competition among plans may reduce this net cost to some extent, they do little now (and as envisioned in PPACA) to reduce costs in the other 93 percent of our national health care expenditure.
  - In addition to large amounts of uncertainty created by the failure of HHS to promulgate regulations, there is considerable uncertainty as to how the Supreme Court might rule next summer should it choose to hear challenges to PPACA as well as what changes national elections might bring. Popularity of PPACA in national tracking polls is at an all time low with over 50 percent of the population opposing the law. Given that states currently face extreme challenges to their budgets and infrastructure and under PPACA have the “escape valve” of being allowed to take control of the exchange should they determine whatever federal solution implemented is unsatisfactory, there is little apparent "first-mover" advantage to states.
2. The state should encourage and facilitate the establishment and expansion of private exchanges designed to serve the needs of a variety of consumers.
    - Instead of a one size fits all concept of health insurance exchanges, South Carolina should encourage currently operated private exchanges, employer groups, consumer groups and others to offer exchanges tailored to specific populations. These exchanges could operate under a variety of governance models, including that of an active purchaser - such as a group of independent employers might wish to support.
    - Exchanges should provide consumers with an easy to navigate set of insurance choices tailored to that individual's specific needs. They should provide accurate, up to date information on health plan and provider cost and quality.
    - Private exchanges that choose to do so should be allowed to process Medicaid eligibility and enrollments under contract with Medicaid.
    - Barriers to portability of benefits and the efficiency and adoption of defined contribution, consumer driven, high deductible and major medical plans should be removed.
    - The state should ensure that benefits beyond any essential benefits identified at the federal level cannot be mandated in South Carolina without the approval of the full legislature.
  3. The state should encourage full consumer empowerment, engagement and responsibility in health and health care decision making.

- The state should consider legislation from other states which requires timely, accurate and transparent reporting of health plan and provider price and quality data and removes barriers to the public disclosure of this information. It should carefully consider the additional costs of these reporting requirements on providers, health plans and purchasers to avoid unfunded mandates.
  - Purchasers and consumers must be able to compare both out of pocket prices and quality of services provided in order to determine which plans and providers provide the most value. Consumers should be able to receive price quotes if requested prior to receiving services. Prices paid for services on behalf of consumers by insurers should not be considered proprietary information. Data must be meaningful in order for consumers to use it to make the best purchase decisions and for providers to use it to improve care. Data must therefore be made easily understandable and usable for consumers and must be widely accepted as valid by the provider community.
  - An independent, multi-stakeholder body with consumer, purchaser and provider representation should be charged with implementing a provider and health plan quality and performance reporting strategy which must be publicly accessible and usable for a variety of purposes. The body should consider the standard measures of quality and performance as the basis for public reporting requirements currently adopted by national organizations such as the NCQA, CMS, and the Agency for Healthcare Research and Quality. An exchange infrastructure is not necessary to perform this task.
  - Enhanced benefits for healthy behaviors as well as penalties for unhealthy behaviors should not be restricted by law or regulation in either public or private insurance. The state should not create barriers for employers and health plans which choose to provide financial or other incentives to employees or beneficiaries who choose high value health plans and providers based on quality and price.
  - A distinction should be made between the roles of insurance brokers and health care navigators. Navigators should be community based and help individuals interact with the health care system and manage their own health while brokers should retain primary responsibility for linking consumers to the highest value insurance product based on an individual's needs.
  - The Committee recognizes the roles health insurance brokers and agents have played in the health care system. The complexity of both insurance and health care is well known, and the difficulty for consumers is well documented, as evidenced by the focus groups held by our researchers. As a result, the Committee would expect that the roles of brokers and agents will continue, and appropriate compensation will need to be determined. Whatever systems are adopted, the roles of brokers, agents and navigators will need to be clearly defined and proper oversight, including licensing issues, will need to be considered.
4. The state should continue to inform and engage the federal government using these state-based alternatives as the foundation for all conversations and agreements regarding health insurance reform in South Carolina.
  5. Any changes in the funding or provision of healthcare services should be in the context of a goal to improve the health status of South Carolinians, improve the quality and experience of healthcare services, and do this in a fiscally responsible way that will reduce the per capita cost of healthcare.

6. The Committee recommends that the state adopt guiding health policy principles like these as a first step and an overarching framework for any reforms it undertakes.
7. The health issues in South Carolina are specific to the state and its communities. It is, therefore, imperative that the solution be local as well. In order for the state to fully integrate the funding and provision of health services, it is imperative that the state maintain control over all aspects of healthcare funding and provision including control over any marketplace reforms such as exchanges.
8. The state should foster local community programs already in existence throughout South Carolina. A pilot program authorized through the State Legislature already exists in TriCounty Project Care that is a non-insurance pilot program under State Medicaid that collects pre-payments from those under 200 percent of the Federal Poverty Level not eligible for Medicaid. It is also recommended that permanent legislation be passed to authorize these programs across the state to collect pre-payments and be eligible for the federal subsidies under the ACA.
9. The state should establish goals for marketplace reforms that are consistent with the following concepts:
  - a. Develop fair and efficient markets.
    - i. Establish a level playing field for all health plans large and small, new and established, commercial, Medicaid, local and national, for-profit and not-for-profit, provider owned or not.
    - ii. Establish non-politicized governance.
    - iii. Do not duplicate existing state regulatory functions such as rate review.
    - iv. Leverage national standards where appropriate to prevent unnecessary state-level variation.
  - b. Promote competition, choice and innovation.
    - i. Adopt objective standards to become a qualified health plan.
    - ii. Encourage choice and innovation in product offerings on the exchange.
  - c. Get as many people coverage while preventing adverse selection.
    - i. Structure open enrollment periods to encourage people to purchase and maintain coverage.
    - ii. Encourage enrollment through effective marketing and a simple shopping and purchasing experience.
10. The state cannot hope to achieve these goals without maintaining control over the functions of the health insurance marketplace in South Carolina. It is recommended that the state move forward with a plan to retain control over any marketplace reforms in South Carolina.
11. Provide more effective encouragement, by the state, to promote Accountable Care Organizations and other means of controlling costs and encouraging the consistent delivery of quality health care services.
12. Provide more effective recruitment of additional health carriers to the market following a consideration of whether any changes should be made to the states existing statues related to small-employer health group cooperatives.

13. Provide a more effective recruitment of additional health carriers to the market following a consideration of whether additional demographic analysis of the individual and small-group markets, by region or by wage level, could yield an opportunity for additional health insurance product offerings tailored to the specific needs of consumers with modest incomes.
14. A request for legislative review of the possibility for clarification of when peer review information should be protected from use as discoverable information in malpractice cases without causing undue hardship to a plaintiff's case.
15. A request for legislative review of the possibility of limiting the liability of charitable and for-profit hospitals for the actions of independent contractors who are not employees of a hospital.
16. A request for legislative review of the possibility of defining with "checklists" decisions and actions by health care providers that would constitute "safe harbors" for which health care providers could not be sued.
17. A request for legislative review of the possibility of encouraging or mandating that hospitals and health care providers use professionally-created "checklists" of best practices for surgery and other health procedures, to reduce errors and improved quality of outcomes.
18. A request for legislative review of the possibility of mandating that consumers of health care be provided, at the request of the consumer, written cost estimates by health care providers before health care services are provided.
19. A request for legislative review of the possibility of allowing by law the existence and operation of community health plans not considered as providing insurance or as an unauthorized insurer (see FY 2011-12 Proviso 21.20, DHHS: Community Health Plans), whereby participants in the plan can pay in advance for health services as provided by contract.
20. A request for legislative review of the possibility of allowing non-physician health care providers to perform more health care services under the supervision of a physician, thereby increasing and improving access to health care by consumers.
21. A request for legislative review of the possibility of the state contracting with a competent private company to perform audits to detect, prevent and stop fraud and waste regarding the provision of Medicaid services in South Carolina.
22. A request for executive and legislative review of how to reduce paperwork, minimize requirements, increase efficiency, increase patient choices and eliminate unnecessary bureaucracy regarding the provision of health insurance and of health services, and the implementation of all ideas that safely increase efficiency and quality of outcomes.

## Addendum

The following recommendations/suggestions were not fully researched or discussed by the South Carolina Health Planning Committee and therefore were not approved. However, there were committee members who recognized merit in the ideas and desired further investigation on the topics. Each recommendation/suggestion is listed with the name(s) of the Committee member who requested they be included in this Addendum.

1. Request legislative review of the possibility of South Carolina joining into a Congressional-approved interstate compact with other states that would enable South Carolina, rather than the federal government, to control health care regulation and expenditures in South Carolina. (Timothy Ervolina, Dr. Casey Fitts, Tony Keck, Tammie King, Evelyn Perry, Rep. Bill Sandifer, Sen. Michael Rose, Will Shrader, Dr. Michael Vasovski)
2. Request legislative review of the possibility of South Carolinians purchasing health insurance across state lines, provided adequate consumer protections are provided. (Timothy Ervolina, Tony Keck, Evelyn Perry, Sen. Michael Rose, Dr. Michael Vasovski)
3. Request legislative review of the possibility of South Carolinians contracting directly and individually with health care providers for health services for themselves without those contracts being considered insurance, provided adequate consumer protections are provided. (Timothy Ervolina, Dr. Casey Fitts, Tony Keck, Evelyn Perry, Sen. Michael Rose, Dr. Michael Vasovski)
4. Request legislative review of the possibility of South Carolina employers contracting directly with health care providers for health services for their employees without those contracts being considered insurance, provided adequate consumer protections are provided. (Timothy Ervolina, Dr. Casey Fitts, Tony Keck, Evelyn Perry, Sen. Michael Rose, Dr. Michael Vasovski)

# Appendix A

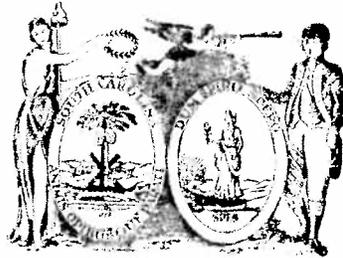
1. Executive Order

State of South Carolina  
Executive Department

FILED

MAR 10 2011

Mark H. Herring  
SECRETARY OF STATE



Office of the Governor

EXECUTIVE ORDER NO.

2011-09

**WHEREAS**, the Patient Protection and Affordable Care Act was enacted by the Congress of the United States and signed into law by the President of the United States on March 23, 2010 and the Health Care and Education Reconciliation Act (hereinafter collectively referred to as the "Affordable Care Act") was enacted by the Congress of the United States and signed into law by the President of the United States on March 30, 2010 to address some of the issues associated with the affordability and availability of health insurance; and

**WHEREAS**, the Affordable Care Act requires the establishment of health insurance exchanges by 2014; and

**WHEREAS**, Section 1311 of the Affordable Care Act provides grant assistance to the States for the planning and establishment of American Health Benefit Exchanges and requires the Secretary of the United States Department of Health and Human Services to make initial awards not later than one year after enactment; and

**WHEREAS**, the Secretary announced the first round of grants to states, known as Exchange Planning Grants, on July 29, 2010; and

**WHEREAS**, the South Carolina Department of Insurance, having been designated as the lead agency for the Exchange Planning Grant, applied for and received a grant on September 30, 2010 in the amount of \$1 million to determine whether the establishment of a health insurance exchange would be feasible for the State of South Carolina; and

**WHEREAS**, the Department of Insurance grant calls for the establishment of the South Carolina Health Exchange Planning Committee, a planning committee made up of key stakeholders to assist with the formulation of policy recommendations regarding whether it is feasible for South Carolina to establish a health insurance exchange and, if so, propose a plan for the successful implementation and ongoing sustainability of a state-based health insurance exchange; and

**WHEREAS**, the purpose of this Executive Order is to establish the aforementioned planning committee and set forth the general guidelines for its operation.

**NOW, THEREFORE**, pursuant to the authority vested in me by the Constitution and Statutes of the State of South Carolina, I hereby establish the South Carolina Health Exchange Planning Committee (Committee) for which the composition, duties and responsibilities are set forth below. The Committee shall be an advisory group whose mission is to assist with research as determined necessary by the Director of Insurance and to provide recommendations on the health insurance exchange planning process as described in the Exchange Planning Grant application.

A. The Committee shall:

1. Convene healthcare delivery systems stakeholders and build trust and consensus among stakeholders;
2. Conduct a thorough review and analysis of current and new data on the operation of health insurance exchanges;
3. Complete an in-depth study and review of alternative approaches to establishing a health insurance exchange; and
4. Develop and submit a report to the Governor by October 28, 2011 which sets forth the Committee's recommendation regarding whether or not the State should establish a health insurance exchange. This report must also propose a plan of action based upon the aforementioned recommendation as follows:

- a. Should the Committee recommend the establishment of a state-based health insurance exchange, the Committee must recommend a plan for the successful implementation and ongoing sustainability of a state-based health insurance exchange and, at a minimum, provide recommendations relating to:

- i. The governing structure (e.g., state agency or nonprofit entity);
- ii. The role(s) and function(s) of a health insurance exchange;
- iii. The design of qualified health plans offered in a health insurance exchange, including whether existing state mandates should be included in these plans;
- iv. Coordination of eligibility determination and enrollment between Medicaid and the Exchange and establishment of a policy for insureds who fluctuate between Medicaid and subsidized insurance coverage;
- v. Premium allocation;
- vi. Process for certifying health care plans;
- vii. Method for providing consumer information through internet portals;
- viii. Premium tax credits; and
- ix. Exchange funding and ways to hold down administrative costs.

- b. Should the Committee recommend the State decline to establish a state-based health insurance exchange, the Committee must recommend alternate strategies and policies to improve the health insurance marketplace in South Carolina.

- B. The Committee shall be comprised of twelve members appointed as follows:
1. The Project Manager of the Exchange Planning Grant, who shall serve in an *ex officio* capacity as chairman of the Committee;
  2. Two members appointed by the President *Pro Tempore* of the Senate, at least one of which must be a member of the South Carolina Senate;
  3. Two members appointed by the Speaker of the House of Representatives, at least one of which must be a member of the South Carolina House of Representatives;
  4. The Director of the South Carolina Department of Health and Human Services or his designee;
  5. The Director of the South Carolina Department of Insurance or his designee;
  6. A consumer or not-for-profit representative appointed by the Governor;
  7. A small employer as defined in S.C. Code Ann. 38-71-1330(18) appointed by the Governor;
  8. A health care provider appointed by the Governor;
  9. A licensed insurance producer authorized with accident and health insurance authority appointed by the Governor; and
  10. A licensed health insurance issuer appointed by the Governor.
- C. Members of the Committee must have substantial experience or expertise in one or more areas of health care delivery, health insurance, public health programs, or employer-sponsored health benefit programs. Members of the Committee shall serve without compensation, and are ineligible for the usual mileage, subsistence, and per diem allowed by law for members of state boards, committees, and commissions.
- D. The members of the Committee must meet as soon as practicable after appointment but no later than April 15, 2011. The Directors of the South Carolina Department of Health and Human Services and the South Carolina Department of Insurance shall determine the date, time, and place for the initial organizational meeting and give notice of such to all Committee members. Thereafter, the Committee shall meet regularly and as necessary to fulfill the duties required by this Order at the call of the chairman or by a majority of the members. The Committee's meetings shall comply with the requirements of the South Carolina Freedom of Information Act.
- E. The Committee may establish task forces from within its membership or outside its membership as needed to address specific issues or to assist in its work. These groups may include representatives of nongovernmental entities including, without limitation, doctors, nurses, economists, actuaries, health care professionals, patient advocates, public health advocates, consumer advocates, representatives from health plans and insurers, and businesses.
- F. The Department of Insurance shall provide the Committee with the necessary staff support and resources.

Nothing in this Executive Order shall be construed to impair or otherwise affect the authority granted by law or gubernatorial directive over the functions of the South Carolina Department of Insurance. This Executive Order is not intended to and does not create any right or benefit, substantive or procedural, enforceable at law or in equity against the State of South Carolina, its departments, agencies, entities, officers, employees or agents or any other person.

This Order is effective immediately.



GIVEN UNDER MY HAND AND THE  
GREAT SEAL OF THE STATE OF SOUTH  
CAROLINA, THIS 10<sup>th</sup> DAY OF MARCH  
2011.

  
\_\_\_\_\_  
NIKKI R. HALEY  
Governor

ATTEST:

  
\_\_\_\_\_  
MARK HAMMOND  
Secretary of State

## Appendix B

1. State Planning and Establishment Grant Application
2. State Planning and Establishment Grant Award Letter



## South Carolina Department of Insurance

MARK SANFORD  
Governor

SCOTT H. RICHARDSON  
Director of Insurance

August 31, 2010

The Office of Consumer Information and Insurance Oversight  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear OCIO Staff:

It is my pleasure to submit South Carolina's grant application for the first cycle of the Exchange Planning and Establishment Grants provided under the Affordable Care Act (ACA).

The South Carolina Department of Insurance (Department) is the designated entity responsible for ensuring the successful completion of the first cycle of the grant. The Department has existing authority to oversee and coordinate the proposed activities.

The Department intends to use the grant funds to do 1) Background Research, Data Collection and Analysis; 2) Exchange Formation and Governance; 3) Exchange Implementation Strategy, and 4) Policy Recommendations.

Andy Dvorine will serve as the Department Principal Investigator for the project. Andy's contact information is shown below:

Andy Dvorine, ASA, MAAA  
Associate Actuary  
South Carolina Department of Insurance  
145 King Street, Suite 228  
Charleston, SC 29401  
Phone: 843-577-3417  
Fax: 843-722-6105  
E-mail: [advorine@doi.sc.gov](mailto:advorine@doi.sc.gov)

I look forward to our continued partnership in implementing the important reforms to our health care system provided under the Affordable Care Act.

Sincerely,

A handwritten signature in blue ink that reads "Scott H. Richardson".

Scott H. Richardson, CPCU  
Director

<b>Opportunity Title:</b>	State Planning and Establishment Grants for the Affordability
<b>Offering Agency:</b>	Ofc of Consumer Information & Insurance Oversight
<b>CFDA Number:</b>	93.525
<b>CFDA Description:</b>	State Planning and Establishment Grants for the Affordability
<b>Opportunity Number:</b>	IE-HBE-10-001
<b>Competition ID:</b>	IE-HBE-10-001-011777
<b>Opportunity Open Date:</b>	07/29/2010
<b>Opportunity Close Date:</b>	09/01/2010
<b>Agency Contact:</b>	Donna Laverdiere Office of Consumer Information and Insurance Oversight Department of Health and Human Services (301) 492-4145 Donna.Laverdiere@hhs.gov

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

\* **Application Filing Name:**

### Mandatory Documents

Move Form to Complete

Move Form to Delete

### Mandatory Documents for Submission

Application for Federal Assistance (SF-424)  
Other Attachments Form  
Project Abstract Summary  
Project/Performance Site Location(s)  
Project Narrative Attachment Form  
Budget Narrative Attachment Form  
Budget Information for Non-Construction Program

### Optional Documents

Move Form to Submission List

Move Form to Delete

### Optional Documents for Submission

## Instructions

- 1** Enter a name for the application in the Application Filing Name field.
  - This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
  - You can save your application at any time by clicking the "Save" button at the top of your screen.
  - The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.
  
- 2** Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.
  - It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.
  - The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".
  - To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.
  - All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.
  
- 3** Click the "Save & Submit" button to submit your application to Grants.gov.
  - Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
  - Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
  - The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
  - You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

**Application for Federal Assistance SF-424**

* 1. Type of Submission: <input type="checkbox"/> Preapplication <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed/Corrected Application	* 2. Type of Application: <input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	* If Revision, select appropriate letter(s): <input type="text"/> * Other (Specify): <input type="text"/>
--	--	--

* 3. Date Received: <input type="text" value="08/31/2010"/>	4. Applicant Identifier: <input type="text"/>
--	--

5a. Federal Entity Identifier: <input type="text" value="57-62805003"/>	5b. Federal Award Identifier: <input type="text"/>
--	---

**State Use Only:**

6. Date Received by State: <input type="text"/>	7. State Application Identifier: <input type="text"/>
---	---

**8. APPLICANT INFORMATION:**

\* a. Legal Name:

* b. Employer/Taxpayer Identification Number (EIN/TIN): <input type="text" value="57-600286"/>	* c. Organizational DUNS: <input type="text" value="9628050030000"/>
---	---

**d. Address:**

* Street1:	<input type="text" value="1201 Main Street, Suite 1000"/>
Street2:	<input type="text"/>
* City:	<input type="text" value="Columbia"/>
County/Parish:	<input type="text"/>
* State:	<input type="text" value="SC: South Carolina"/>
Province:	<input type="text"/>
* Country:	<input type="text" value="USA: UNITED STATES"/>
* Zip / Postal Code:	<input type="text" value="29201-3291"/>

**e. Organizational Unit:**

Department Name: <input type="text" value="SC Department of Insurance"/>	Division Name: <input type="text" value="Legal Services"/>
---	---

**f. Name and contact information of person to be contacted on matters involving this application:**

Prefix: <input type="text" value="Ms."/>	* First Name: <input type="text" value="Cathy"/>
Middle Name: <input type="text"/>	
* Last Name: <input type="text" value="Cauthen"/>	
Suffix: <input type="text"/>	

Title:

Organizational Affiliation:

* Telephone Number: <input type="text" value="803-737-6805"/>	Fax Number: <input type="text" value="803-737-6159"/>
---	---

\* Email:

**Application for Federal Assistance SF-424**

**\* 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

\* Other (specify):

**\* 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

**11. Catalog of Federal Domestic Assistance Number:**

93.525

CFDA Title:

State Planning and Establishment Grants for the Affordable Care Act (ACA)-s Exchanges

**\* 12. Funding Opportunity Number:**

IE-HBE-10-001

\* Title:

State Planning and Establishment Grants for the Affordable Care Act?s Exchanges

**13. Competition Identification Number:**

IE-HBE-10-001-011777

Title:

**14. Areas Affected by Project (Cities, Counties, States, etc.):**

Add Attachment

Delete Attachment

View Attachment

**\* 15. Descriptive Title of Applicant's Project:**

SC Exchange Planning and Establishment Grant

Attach supporting documents as specified in agency instructions.

Add Attachments

Delete Attachments

View Attachments

**Application for Federal Assistance SF-424**

**16. Congressional Districts Of:**

\* a. Applicant

b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

**17. Proposed Project:**

\* a. Start Date:

\* b. End Date:

**18. Estimated Funding (\$):**

* a. Federal	<input type="text" value="1,000,000.00"/>
* b. Applicant	<input type="text" value="0.00"/>
* c. State	<input type="text" value="0.00"/>
* d. Local	<input type="text" value="0.00"/>
* e. Other	<input type="text" value="0.00"/>
* f. Program Income	<input type="text" value="0.00"/>
* g. TOTAL	<input type="text" value="1,000,000.00"/>

**\* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

a. This application was made available to the State under the Executive Order 12372 Process for review on

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372.

**\* 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

Yes  No

If "Yes", provide explanation and attach

**21. \*By signing this application, I certify (1) to the statements contained in the list of certifications\*\* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances\*\* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

\*\* I AGREE

\*\* The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

**Authorized Representative:**

Prefix:  \* First Name:

Middle Name:

\* Last Name:

Suffix:

\* Title:

\* Telephone Number:  Fax Number:

\* Email:

\* Signature of Authorized Representative:

\* Date Signed:

## Other Attachment File(s)

---

\* **Mandatory Other Attachment Filename:**

[Add Mandatory Other Attachment](#)

[Delete Mandatory Other Attachment](#)

[View Mandatory Other Attachment](#)

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To add more "Other Attachment" attachments, please use the attachment buttons below.

[Add Optional Other Attachment](#)

[Delete Optional Other Attachment](#)

[View Optional Other Attachment](#)

## Project Abstract Summary

**Program Announcement (CFDA)**

93.525

**\* Program Announcement (Funding Opportunity Number)**

IE-HBE-10-001

**\* Closing Date**

09/01/2010

**\* Applicant Name**

South Carolina Department of Insurance

**\* Length of Proposed Project**

12

**Application Control No.**

**Federal Share Requested (for each year)**

**\* Federal Share 1st Year**

\$ 1,000,000

**\* Federal Share 2nd Year**

\$ 0

**\* Federal Share 3rd Year**

\$ 0

**\* Federal Share 4th Year**

\$ 0

**\* Federal Share 5th Year**

\$ 0

**Non-Federal Share Requested (for each year)**

**\* Non-Federal Share 1st Year**

\$ 0

**\* Non-Federal Share 2nd Year**

\$ 0

**\* Non-Federal Share 3rd Year**

\$ 0

**\* Non-Federal Share 4th Year**

\$ 0

**\* Non-Federal Share 5th Year**

\$ 0

**\* Project Title**

SC Exchange Planning and Establishment Grant

## Project Abstract Summary

### \* Project Summary

South Carolina is seeking \$1,000,000 to determine the feasibility of establishing a health insurance exchange or exchanges (Exchange) in this state in accordance with the provisions of the Affordable Care Act (ACA). This project will be accomplished in the phases more particularly described below.

#### Phase I: Background Research, Data Collection and Analysis

During this phase, we will conduct demographic research and analyze the health insurance market to better understand the needs of the state. Research will determine 1) the number of uninsured in the State, including, but not limited to, those potentially eligible for the Exchange and those eligible for Medicaid or their employer's coverage and currently not enrolled; 2) an estimate of those who will be newly eligible for Medicaid or the Exchange, including an estimate of those who may be eligible for subsidies through the Exchange; and 3) an assessment of the insured population and the source, cost and nature of their coverage. This research will consider existing data and build upon previous studies. Additionally, we will obtain qualitative data from key stakeholders on the design, operation and function of the Exchange. This information will be used to develop financial models to estimate the cost of establishing and operating an Exchange and to evaluate various policy and Exchange design issues.

#### Phase II: Exchange Formation and Governance

A South Carolina Health Exchange Planning Committee (SCHEPC) will be formed to assist with certain grant activities. SCHEPC shall consist of the project team, key stakeholders and state officials as set forth in the project narrative. The research results and other information will be used to determine whether it is advisable and feasible for South Carolina to operate the Exchange, and if so, what the Exchange should look like and how it should function. The SCHEPC through its consultants, working groups and task forces will assess a variety of issues including: 1) whether to operate a multi-state or regional Exchanges; 2) the appropriate governance structure for the Exchange; 3) proper integration with existing state and federal programs, including the integration of HIE Exchange standards for program interoperability; 4) the extent of business operations, including an evaluation of options for state flexibility; 5) needed resources and capabilities, including staffing and information technology requirements; 6) appropriate auditing and accounting standards, including mechanisms to ensure transparency and proper internal controls and reporting standards; and 7) the most appropriate funding mechanism.

#### Phase III: Exchange Implementation Strategy

The SCHEPC will provide a detailed report on the issues that may impact the successful implementation of an Exchange. Assuming it is advisable and feasible for South Carolina to operate an Exchange, a timeline and detailed implementation plan and budget for Exchange development will be produced. In addition, the scope and detail of any required conforming or enabling legislation and any necessary policies and procedures for the Exchange will be identified.

#### Phase IV: Policy Recommendations

The information derived from all phases of this grant will be used to generate a final report to be presented to the Governor, South Carolina General Assembly and Secretary of the U.S. Department of Health and Human Services with policy recommendations on the feasibility of establishing an Exchange in this state and a detailed implementation and funding strategy, if applicable.

### \* Estimated number of people to be served as a result of the award of this grant.

700000

### Project/Performance Site Location(s)

**Project/Performance Site Primary Location**

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

\* Street1:

Street2:

\* City:  County:

\* State:

Province:

\* Country:

\* ZIP / Postal Code:  \* Project/ Performance Site Congressional District:

**Project/Performance Site Location 1**

I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

\* Street1:

Street2:

\* City:  County:

\* State:

Province:

\* Country:

\* ZIP / Postal Code:  \* Project/ Performance Site Congressional District:

**Additional Location(s)**

## Project Narrative File(s)

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\* **Mandatory Project Narrative File Filename:**

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To add more Project Narrative File attachments, please use the attachment buttons below.

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## Budget Narrative File(s)

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\* **Mandatory Budget Narrative Filename:**

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To add more Budget Narrative attachments, please use the attachment buttons below.

**BUDGET INFORMATION - Non-Construction Programs**

**SECTION A - BUDGET SUMMARY**

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Research and Analysis	93.525	\$	\$	\$ 610,000.00	\$	\$ 610,000.00
2. Staff	93.525			255,000.00		255,000.00
3. Equipment and Office Space	93.525			135,000.00		135,000.00
4.						
5. Totals		\$	\$	1,000,000.00	\$	1,000,000.00

**SECTION B - BUDGET CATEGORIES**

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) Research and Analysis	(2) Staff	(3) Equipment and Office Space	(4)	
a. Personnel	\$	142,000.00	\$	\$	142,000.00
b. Fringe Benefits		48,000.00			48,000.00
c. Travel		15,000.00			15,000.00
d. Equipment			20,000.00		20,000.00
e. Supplies			10,000.00		10,000.00
f. Contractual	610,000.00				610,000.00
g. Construction					
h. Other			105,000.00		105,000.00
i. Total Direct Charges (sum of 6a-6h)	610,000.00	205,000.00	135,000.00	\$	950,000.00
j. Indirect Charges		50,000.00		\$	50,000.00
k. TOTALS (sum of 6i and 6j)	\$ 610,000.00	\$ 255,000.00	\$ 135,000.00	\$	1,000,000.00
7. Program Income	\$		\$	\$	

**Authorized for Local Reproduction**

**SECTION C - NON-FEDERAL RESOURCES**

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Staff	\$	\$	\$	\$
9. Equipment and Office Space				
10.				
11.				
12. TOTAL (sum of lines 8-11)	\$	\$	\$	\$

**SECTION D - FORECASTED CASH NEEDS**

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	\$ 1,000,000.00	\$ 350,250.00	\$ 289,250.00	\$ 208,250.00	\$ 152,250.00
14. Non-Federal	\$				
15. TOTAL (sum of lines 13 and 14)	\$ 1,000,000.00	\$ 350,250.00	\$ 289,250.00	\$ 208,250.00	\$ 152,250.00

**SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT**

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Staff	\$	\$	\$	\$
17. Equipment and Office Space				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	\$	\$	\$	\$

**SECTION F - OTHER BUDGET INFORMATION**

21. Direct Charges:		22. Indirect Charges:	
23. Remarks:			

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**NOTE:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

<p>* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL</p> <p>Cathy Cauthen</p>	<p>* TITLE</p> <p>Director</p>
<p>* APPLICANT ORGANIZATION</p> <p>South Carolina Department of Insurance</p>	<p>* DATE SUBMITTED</p> <p>08/31/2010</p>

# DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB  
0348-0046

<b>1. * Type of Federal Action:</b> <input type="checkbox"/> a. contract <input checked="" type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. * Status of Federal Action:</b> <input type="checkbox"/> a. bid/offer/application <input checked="" type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. * Report Type:</b> <input checked="" type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change
--	--	--

**4. Name and Address of Reporting Entity:**  
 Prime     SubAwardee

\* Name: South Carolina Department of Insurance

\* Street 1: 1201 Main Street, Suite 1000    \* Street 2: \_\_\_\_\_

\* City: Columbia    \* State: SC: South Carolina    \* Zip: 29201

Congressional District, if known: SC-002

**5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:**

<b>6. * Federal Department/Agency:</b> US Depart of Health and Human Services	<b>7. * Federal Program Name/Description:</b> State Planning and Establishment Grants for the Affordable Care Act (ACA)-s Exchanges CFDA Number, if applicable: 93.525
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<b>8. Federal Action Number, if known:</b> _____	<b>9. Award Amount, if known:</b> \$ _____
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**10. a. Name and Address of Lobbying Registrant:**

Prefix \_\_\_\_\_ \* First Name N/A Middle Name \_\_\_\_\_

\* Last Name N/A Suffix \_\_\_\_\_

\* Street 1 \_\_\_\_\_ \* Street 2 \_\_\_\_\_

\* City \_\_\_\_\_ \* State \_\_\_\_\_ \* Zip \_\_\_\_\_

**b. Individual Performing Services** (including address if different from No. 10a)

Prefix \_\_\_\_\_ \* First Name N/A Middle Name \_\_\_\_\_

\* Last Name N/A Suffix \_\_\_\_\_

\* Street 1 \_\_\_\_\_ \* Street 2 \_\_\_\_\_

\* City \_\_\_\_\_ \* State \_\_\_\_\_ \* Zip \_\_\_\_\_

**11.** Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

\* Signature: Cathy Cauthen

\* Name: Prefix \_\_\_\_\_ \* First Name Scott Middle Name \_\_\_\_\_  
\* Last Name Richardson Suffix \_\_\_\_\_

Title: Director Telephone No.: 803-737-6805 Date: 08/31/2010

## **PROJECT NARRATIVE**

### **A. Project Overview**

The South Carolina Department of Insurance (DOI) submits this application for planning grant funds to determine the feasibility of establishing a health insurance exchange or exchanges (Exchange) in this state in accordance with the requirements of the Affordable Care Act (ACA). In collaboration with its partners and key stakeholders, DOI will conduct research and collect the data necessary to make informed decisions on the feasibility of South Carolina operating an Exchange and, if so, what it should look like and how it should function. This project will be conducted under the supervision of a Principal Investigator and a Project Manager with the assistance of an inter-agency project team and the South Carolina Health Exchange Planning Committee (SCHEPC). The project will be conducted in the following phases: 1) Background Research, Data Collection and Analysis; 2) Exchange Formation and Governance; 3) Exchange Implementation Strategy, and 4) Policy Recommendations. What follows is a summary of each of the grant phases.

#### **Phase I: Background Research, Data Collection and Analysis**

We will engage in demographic research and analysis of the health insurance marketplace to better understand the needs of the state and to determine:

- the number of uninsured in the state, including those who may be eligible for coverage under the Exchange; those currently eligible for Medicaid or Partners for Healthy Children (S-CHIP) but not enrolled; and those employees eligible for their employer's health plan, but not enrolled;
- the types and costs of insurance products available in the South Carolina health insurance market including: a) plan designs offered by insurers and the premium levels for these plans; b) the size of each market segment (individual, small group, large group and grandfathered); and c) the potential enrollment in the Exchange for the individual and small group markets, including those who may be eligible for subsidies through the Exchange and/ or eligible for a basic plan;<sup>1</sup>
- estimates of those who will be newly eligible for Medicaid and S-CHIP as a result of the ACA;
- the cost to the State of including state mandates in coverage offered through the Exchange;

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<sup>1</sup> Some of this information will be available via the data call that will be conducted as a part of the *South Carolina Rate Review Process and IT Infrastructure Enhancement Grant*.

- economic and actuarial models necessary to project trends such as the a) number of newly insured, and b) the impact of rating restrictions and other market reforms that become effective in 2014 on premium levels and any potential cost/savings to the state budget;
- economic and actuarial modeling of various policy issues including but not limited to a) developing a Basic Health Plan, b) merging of the non-group and small group markets, c) changing Medical Loss Ratio (MLR) requirements in the non-group/small group markets per the ACA, and d) expanding the definition of the small group market; and
- a financial model for the Exchange including break-even analysis, level of administrative surcharge, cash-flow modeling, etc.

With our partners and other stakeholders, we plan to engage in the following activities:

**a. Review and Summarize Existing Data on the Uninsured**

The Project Manager, with the assistance of the members of the Project Team, will thoroughly examine and summarize the existing data on the current status of the uninsured in South Carolina. These data will include demographic information regarding socioeconomic and characteristics of the uninsured and other persons eligible for coverage through the Exchange.

The project will have access to the data products and services of the Office of Research and Statistics (ORS) that maintains an extensive array of health, demographic and social services data. The databases are maintained in a warehouse-like structure that enables the tracking of patients/clients over time and across the various types of care and services.

Some of these databases contain information about the use of health delivery programs and services by clients of state health and human services agencies and enables the analysis of the use of services and crossover by clients among agencies. Geographic markers are added to these data to be used with ORS's Geographic Information System (GIS). The GIS allows mapping that can vary in level of detail from a specific address through all Census geography levels to zip codes to counties and to user defined areas within the state. Multiple overlays of data allow the visual presentation of complex social and health problems in an easy to understand format for policy makers. ORS is also the official repository for all U.S. Census data for the State of South Carolina.

Using these databases, the project will have access to data which tracks the utilization of healthcare services by the uninsured over time, identify pockets of uninsured using the GIS system, identify the trends in utilization of services by survey respondents, and correlate the uninsured with the type of industries located in specific county areas. It will allow the Project Team to cross-match data collected through the survey instruments to the current databases to determine whether the uninsured status is cyclical (i.e., persons are rotating on and off public health assistance programs).

**b. Determine the Extent of the South Carolina Health Insurance Market**

DOI will review existing sources of data and conduct data calls as necessary to determine the extent of coverage in the South Carolina health insurance market. This analysis will include a review of plan designs offered by insurers and the premium levels for these plans; the size of each market segment (individual, small group, and large group and grandfathered) and the potential enrollment in the Exchange for the individual and small group markets, including an estimate of those who may qualify for premium tax credits and reduced cost sharing for coverage through the Exchange.

**c. Collect Qualitative Data from Stakeholders on Exchange Design, Operation and Options**

In addition, consultant(s) will be hired to develop and implement a thorough interview tool and focus group mechanism.

**1) Key Informant Interviews**

Interviews will be conducted with small employers, members of the provider community and the insurance industry. Through the questionnaire, all key informants will be asked to review: 1) information on the ACA and health insurance Exchanges; 2) their organization's participation in the health insurance industry; 3) describe their decision process regarding options for employee benefits; and 4) identify key issues contributing to current participation levels in private or public health insurance programs. They will be asked about their knowledge of the provisions of the ACA and whether they will use and make information about health insurance Exchanges available to their employees. Key informants will be asked about their views on the operation of an Exchange (i.e., whether the Exchange should be operated at the state or federal level; benefit design requirements; and insurer participation rules, etc.).

**2) Focus Groups**

DOI will contract with a consultant to conduct and summarize the results of focus group interviews for the following demographic.

*Small Employer Focus Groups.* Working with our small business community, employers will be recruited for participation in employer focus groups. Focus groups will be stratified based on employer size and on whether they offer health insurance coverage or not. Information on the operation of health insurance Exchanges will be shared with the group. Information about employer participation will also be elicited. Small employers will be asked to identify their concerns related to offering health insurance, the cost of coverage, and potential proposals to: 1) establish a health insurance Exchange; 2) establish an individual responsibility to obtain health insurance requirement; and/or 3) require employers to offer Section 125 plans.

*Insurance Industry/Provider Focus Groups.* Separate focus groups will be held with insurance producers and insurers transacting health insurance business in this state and healthcare providers. Information will be shared with the groups about health insurance Exchanges. Each group will be asked to identify their concerns related to the operation of an Exchange. They will be asked to share their thoughts on the advantages and disadvantages of operating an Exchange at the state or federal level. Additionally, they will be asked whether South Carolina should a) establish multiple Exchanges within the state (i.e., one for non-group (individual) and another for small group or develop regional Exchanges) or b) participate in a multi-state Exchange.

*Consumer Focus Groups.* Focus groups will be conducted with individuals and families. Selection criteria for household and individual interviews will be based upon family income, presence of children in the household, participation in public or private health insurance, employment, geographic location, race and age. Statewide representation will be sought for the location of focus groups based upon county-specific profiles. Release rights from the individuals will be obtained prior to the sessions.

All interviews will be recorded in the same manner. Releases will be obtained from the individuals prior to the beginning of the interviews. All data will be transcribed, entered and coded to prepare for qualitative data analysis. Analyses of the results from the employer focus groups will generate an understanding of their knowledge of the ACA and support for health insurance Exchanges.

**d. Estimate the Persons Who May Be Eligible for Coverage Under the Exchange. Newly Eligible for Medicaid Under the ACA, Eligible for Subsidies Through the Exchange and/ or Eligible for a Basic Plan**

With the assistance of ORS and the South Carolina Department of Health and Human Services (DHHS), we will determine the specific primary data needs for this project within the first 45 days after the grant award. ORS will coordinate data collection and analysis. We envision utilizing the following data collection methodologies:

*The South Carolina Household Survey.* A household survey will be used to collect and analyze primary data on South Carolina households. This is the best method of collecting primary data on the uninsured. It is a telephone survey that assists in determining the estimation of health insurance coverage at the state level. The sample will be selected by random-digit dialing (RDD), with cell phone exchanges (i.e., numbers) included in the sampling frame. This instrument will be used to help us determine who the uninsured are; whether they have enrolled or plan to enroll in Medicaid or employer-sponsored coverage and, if they have not, why. The household survey will also solicit demographic information to help assess those who may be eligible for coverage under the Exchange, newly eligible for Medicaid under the ACA, eligible for subsidies through the Exchange and/or eligible for a basic plan. It will be administered by the University of South Carolina (USC) which has expertise with this type of quantitative research.

**e. Model and Analyze the Various Exchange Options**

Prior research conducted by the state revealed that changes in premium costs impact employers' offering of health insurance coverage, employee take-up (when offered), individual purchase of health insurance and enrollment in public programs. The assumptions that underlie the estimates for each reform should be applied together to produce the estimates for the combined reforms. The state will contract with a health insurance policy expert (health insurance actuary, health policy research group or health economist) for modeling and analysis of the options related to the scope and operation of a health insurance Exchange and their interaction with other potential policy changes. The impact of the following policy options must be considered:

- Guaranteed issue and community rating, including removal of health status as a rating and/ or underwriting factor in the small group and individual insurance markets;
- Imposing an individual responsibility to obtain health insurance coverage;
- Merging the small and individual health insurance markets into one large Exchange;

- Requiring certain employers to offer a Section 125 plan to enable pre-tax payment of health insurance premiums; and
- The expected cost of the essential benefits package and required levels of coverage, together with an estimate of the cost of any expected state mandated benefits in excess of the required coverage or any desired basic program for low income individuals.

This information will be used to develop models and make recommendations as to the cost of coverage and the costs to the state (including revenue losses and direct costs related to changes in public insurance enrollment).

## **Phase II: Exchange Formation and Governance**

For this project, DOI will form a coalition of representatives from the legislative, insurance, health and business communities. Some of these individuals will serve on SCHEPC and provide input into the Exchange's governance and administration, program design, implementation and evaluation of operations. State government officials and members of the private sector who have expertise in research, data collection and issues affecting the uninsured in South Carolina will supplement this team. Concomitantly, expert consultants will be secured to assist with the review of legal, economic and actuarial issues related to the establishment of an Exchange. DOI will partner with the following state agencies on this project: (1) the South Carolina Department of Health and Human Services (DHHS); (2) the Division of Research and Statistics of the South Carolina Budget and Control Board (ORS); and (3) the University of South Carolina (USC). These partners form the inter-agency project team (Project Team).

Stakeholders will be engaged in this process. They will be asked via focus groups, key informant interviews and at conferences to provide input on policy formulation and Exchange design. Stakeholders will be invited to participate in a series of meetings on the establishment of the Exchange. These meetings will educate stakeholders and consumers and gather information on the operational issues associated with operating a health insurance Exchange. Additionally, stakeholders will be invited to serve on task forces and working groups throughout the project. These task forces and working groups will report their recommendations and receive their direction and guidance from the South Carolina Health Exchange Planning Committee (SCHEPC). SCHEPC will be a multidisciplinary committee of stakeholders from the public and private sector that may also serve as an interim governance committee. It will be chaired by the Project Manager and will work collectively with all stakeholders to examine the issues associated with the establishment and the successful implementation of a health insurance Exchange.

SCHEPC will be charged with 1) conducting a thorough review and analysis of current and new data on the operation of health insurance Exchanges; 2) completing an in-depth study and review of alternate approaches to establishing a health insurance Exchange; and 3) the development of a report prioritizing the steps required for the successful implementation of an Exchange, detailing the advantages and disadvantages of establishing a state, multi-state, regional or federal Exchange. SCHEPC will provide recommendations on the program's initiatives to the Principal Investigator, who along with the Project Team will be responsible for preparing a report for the Governor of the State of South Carolina, South Carolina General Assembly and Secretary of the U.S. Department of Health and Human Services.

SCHEPC, through its various working groups and committees, will assist with the assessment of the following:

**a. Program Integration**

SCHEPC will identify existing state and federal programs and make recommendations as to how the services provided by these programs can be leveraged. SCHEPC will specifically review available public programs such as Medicaid, S-CHIP and the South Carolina Health Insurance Pool (SCHIP). DHHS will provide its expertise on the issues associated with integrating Medicaid and Exchange coverage and eligibility requirements. DHHS will provide its expertise and assist with the development and design of policies and communication strategies for reaching and engaging its diverse stakeholders. SCHEPC will also engage the members of the Board of Directors of SCHIP as to how best to transition participants into the Exchange and whether and how to use this state mechanism for future risk adjustment purposes. Finally, SCHEPC will identify and review other non-profit programs to determine whether the Exchange could leverage the services provided through a cooperative agreement (e.g., education, outreach, prevention screenings, etc.).

**b. Resources and Capabilities**

SCHEPC will assess current and future staffing levels and technology needs. This assessment will include an evaluation of skills and tasks required of staff personnel such as project management, communication and outreach, developing Requests for Proposals (RFPs), managing consultants, research and analysis, and facilitating inter-agency workgroups. SCHEPC will identify whether the skills needed to operate the Exchange exist in other state agencies. They will also review possible sources of funding as well as develop a workforce plan and staffing strategy.

**c. Exchange Governance**

SCHEPC will make recommendations as to the appropriate governance structure for any South Carolina Exchange established. SCHEPC shall review Exchanges being considered by various states and those currently in operation in Massachusetts and Utah as to the appropriate governance structure for the Exchange. Based upon its review of these mechanisms and the data on the uninsured in South Carolina and those newly eligible for Medicaid, SCHEPC, through its various committees, task forces and working groups, will make recommendations to the Project Manager on the following issues: 1) which mechanism would be most feasible for the State of South Carolina based upon the number of eligible individuals and the state health insurance market; 2) whether the Exchange should be a publicly sponsored (i.e., part of an existing state agency), a separate quasi-governmental entity, or a separate fully private non-profit entity; 3) whether there should be one comprehensive Exchange that handles both individual and group coverage or two separate Exchanges, one for individual health insurance coverage (e.g., American Health Benefit Exchange and another for group health insurance products for small employers (e.g., Small Business Health Options Exchange); 4) how the mechanism(s) should be governed (e.g., by a Board of Directors of a quasi-public or nonprofit entity or management of a state agency), who the members should be, conflict of interest rules and how the members to the governing authority should be selected; and 5) how the mechanism shall operate (i.e., the number of insurers allowed to offer plans, eligibility requirements for consumers, licensing requirements (if any), benefit options and design, and other consumer protections, etc.).

Should South Carolina decide to implement a state-based Exchange, it is envisioned that the Exchange will be physically located in Columbia, South Carolina, and will be managed by an Executive Director who shall report to a governing authority set forth in enabling legislation to implement the Exchange.

**d. Finance**

SCHEPC will identify necessary systems to ensure the proper handling and safeguarding of cash collections, reconciliation of premium tax credits and cost sharing subsidies, selection of an accounting system to include a general ledger, payroll, accounts payable and accounts receivable functions, and a financial management and reporting tool. SCHEPC will also make recommendations with respect to external audit/ accounting support to determine the proper accounting treatment of various Exchange transactions, appropriate internal controls and the development of financial statement reporting for disclosure to the public, including the reporting of accurate and timely financial and operational

metrics. Finally, SCHEPC will assess technical requirements such as the appropriate accounting system, servers, warehousing of data and data security as well as the hiring of specialized accounting and finance personnel.

**e. Technical Infrastructure**

The technology platform for the Exchange will be a web-based application. The state will require technical guidance to assess the infrastructure requirements necessary for a successful insurance Exchange, including guidance as to the feasibility of either building or purchasing all or portions of the web-based Exchange. In addition, the state will have to assess how the Exchange will connect to the national enrollment hub currently under construction. Further, South Carolina must determine how to integrate the state Medicaid program with the Exchange and enrollment hub. The state will need the expertise of technical consultants familiar with the ACA and its requirements for a seamless eligibility process and effective Exchange operation as well as the technological possibilities and barriers involved in achieving both. Funding will be needed to ensure the state adheres to the legal and technical specifications as it seeks future grants and begins to procure or build required systems. DHHS, in collaboration with the technology subgroup to SCHEPC, will determine the appropriate process to retain these services for the state.

Section 1561 of the PPACA indicates that within 180 days of enactment the Secretary is required to develop interoperable and secure standards and protocols that facilitate the enrollment of individuals into federal and state health and human services programs. Grants will be available to entities, including states to develop new and adapt existing technology systems to implement health information technology (HIT) enrollment standards and protocols. The enrollment HIT systems adopted using these grants will be available to other qualified state political subdivisions at no additional cost. It is anticipated that the Exchange will be able to leverage this technology.

Additionally, SCHEPC will inventory the capabilities of functioning call centers, state Medicaid eligibility and enrollment systems, websites, nonprofits and other existing state infrastructures that can be leveraged by the Exchange. This can be a cost-effective approach to determining the additional technological needs of the Exchange. A gap analysis identifying current capabilities compared to the functional requirements of an Exchange will help determine future resources and financial needs.

**f. Business Operations**

SCHEPC will establish goals for the operation of the Exchange in accordance with the guidance provided by the Project Manager and the Project Team. They will review the required Exchange functions and options for state

flexibility and make recommendations with respect to the business operations of the Exchange so that the required functions can be performed and the established goals achieved. The proposed Exchange may be required to:

- Provide education, outreach, and technical assistance for individuals and employers related to health insurance options and the advantages of paying for health insurance through a Section 125 plan;
- Provide education, outreach and technical assistance for employers establishing Section 125 plans;
- Develop state-of-the-art tools for helping consumers navigate the market, such as tools that compare health insurance options based on factors that the consumer chooses (e.g., premium, deductible, cost sharing, provider network or covered benefits);
- Provide online, telephone, written and in-person assistance to consumers and employers purchasing health insurance through the Exchange(e.g., call center);
- Provide information and enrollment assistance to people who may be eligible for coverage via the Exchange or Medicaid; and
- Act as a payment aggregator for funds withheld from employee paychecks and transmit payments to health plans.

#### **1) Eligibility Criteria**

Within the guidelines set forth in the ACA, states have the ability to establish the eligibility criteria for their insurance Exchange program. Currently, the term “small employer” is defined under the federal law as having fewer than 100 employees. States are able to define small employer as having fewer than 50 employees until 2016.

SCHEPC shall be responsible for reviewing the advisability of maintaining the 1-50 definition of small employer until 2016 and making a recommendation as to how to transition from that definition to the new definition in 2016. Additionally, SCHEPC would consider whether to impose additional eligibility criteria for individuals, such as providing a social security number, unless they are illegal or non-qualifying aliens who are seeking insurance for children who are United States citizens and who have social security numbers. The eligibility criteria for the Exchange must be integrated with the eligibility criteria for Medicaid or S-CHIP programs. The income-related eligibility criteria must be linked to the federal poverty guidelines which are adjusted annually. Individuals with incomes between 133%

and 400% of the federal poverty level may also be eligible for subsidies or reductions in premium through the Exchange. SCHEPC group will also develop eligibility criteria for health insurance subsidies, if any.

SCHEPC will also develop eligibility criteria for small employers. It shall determine what responsibilities the small employer maintains control of, such as criteria for employee eligibility, enrollment, participation and the amount the employer will contribute toward the premiums. SCHEPC shall establish the criteria to enable employees to use pre-tax dollars to purchase plans available through the Exchange. It will also be responsible for outlining the application and enrollment requirements for employers and individuals, including a provision for open enrollment each year and provisions for enrollment after a life status change, such as marriage, divorce, death of a family member, or birth of a child.

Moreover, SCHEPC will be responsible for defining participation rules for employers and insurers and establishing criteria to prevent insurers from dumping risks into the Exchange. It will also define the information requirements for insurer participation to ensure plan and Exchange transparency.

### **2) Benefit Plan Design**

The Exchange must facilitate comparison shopping for consumers. This begins with displaying and providing comparisons of benefit options, coverage levels, provider networks and costs. The SCHEPC will be responsible for making recommendations for the benefit design for the Exchange. Its recommendations will consider the definition of essential benefit package in conjunction with other benefit design parameters set forth in the ACA. It will also define a consumer outreach program to educate consumers on the benefit packages available through the Exchange. The SCHEPC will also consider the impact of benefit design on the costs to the system and the needs of the community and market. To the extent permitted, benefits should be tailored to incorporate evidence-based and consumer incentives to be reflected in the pricing.

### **3) Premium Subsidies**

The ACA provides that premium subsidies could be offered through the Exchange. The Exchange would administer the determination of eligibility for premium subsidies, collect subsidy payments from the state and remit payments to health plans. Depending on the effective date of the subsidy availability, this function could be phased in over time.

### **4) Plan Bidding and Qualifications**

The SCHEPC through the work of its various subcommittees and expert consultants will determine the participation rules for insurers. Specifically, it will make recommendations to the Project Manager on the level of insurer participation and needed qualifications to promote healthy competition within the South Carolina health insurance market. It will consider whether all insurers should be allowed to participate or whether participation should be limited to those that meet certain predetermined criteria via a bidding process.

#### **5) Rate Justifications**

DOI will ensure that issuers are including the appropriate information with rate requests once the Secretary of Health and Human Services has determined the minimum requirements for products offered through the Exchange. DOI will exercise its regulatory authority to ensure that the rates charged for products offered outside the Exchange are comparable to those offered for Exchange products.

#### **g. Funding**

The funding required to establish a health insurance Exchange could be significant. The expense will vary depending upon the functions assigned to the Exchange. Many of the functions of this Exchange are prescribed by the ACA and many will be determined based upon SCHEPC's recommendations for what the Exchange should look like and how it should function. The ACA requires that any Exchange created be self-sustaining by January 1, 2015. As a part of the strategic and operational planning process, a sustainable business model for the Exchange must be developed. Federal implementation grants appear to be the most plausible source of startup funding. The services of a health economist or other expert consultant will be secured to help develop a financial model for the Exchange including a break-even analysis. Additionally, the financial model will also analyze potential funding sources and develop a plan for financial sustainability. This model will also address whether state funding will be needed for start up costs.

Additionally, the following must be considered 1) enforcement costs; 2) service quality; 3) cost of insurance mandates; 4) subsidy requirements; 5) Medicaid and SCHIP eligibility determinations; 6) grant programs for consumer education and assistance (i.e., the Navigator Program); 7) plan qualification; 8) quality rating systems; 9) the administration of premium credits and cost sharing assistance; and 10) the plans for risk adjustments. It is envisioned that the Exchange shall be sustained by user fees and assessments. SCHEPC will establish financial policies, implement procedures to monitor spending and provide appropriate financial controls.

### **Phase III: Exchange Implementation Strategy**

SCHEPC will provide a detailed report on all issues they determine may impact the successful implementation and maintenance of an Exchange in this state. In addition, the scope and detail of any required conforming or enabling legislation and any necessary policies and procedures for the Exchange will be identified. A summary of the regulatory and legal policy issues that must be addressed by SCHEPC follows.

Any Exchange created in South Carolina would be subject to the regulatory jurisdiction of the DOI and the SCDHHS. The DOI and SCDHHS will work cooperatively to ensure the Exchange and its participants are operating in accordance with state and federal law. The DOI and members of the SCHEPC will work collaboratively to determine applicable participation rules for South Carolina insurers and employers. Additionally, SCHEPC, working in conjunction with DOI and other partners, will develop legislative recommendations aimed at making the rules applicable to policies sold outside of the Exchange comparable to the rules governing policies sold in the Exchange to prevent or lessen adverse selection. It will be recommended that participants who violate those regulations would be subject to the imposition of administrative penalties. Additionally, standards will be developed to determine whether employers or insurers are taking actions to negatively affect the risk pool.

SCHEPC will develop the initial policies and procedures for the Exchange including the establishment and implementation of privacy and security policies, planning for the operation of the Exchange, marketing, and establishing agreements and contracts for participation in and financing the Exchange, drafting certification and decertification procedures, and developing and/or implementing risk adjustment processes/mechanisms, etc. All policies and procedures will be subject to the review and approval of DOI as a part of the plan of operation of the Exchange.

One of the principal tasks of SCHEPC will be to evaluate applicable South Carolina law regarding privacy and security and to provide advice on future legislation to enable flexible but robust information management policy. An analysis of the various state and federal laws and regulations will be conducted to determine the best approach to establishing a viable Exchange while also protecting the privacy rights of consumers accessing the Exchange.

This subcommittee will also be charged with identifying and harmonizing the federal and state legal policy requirements for operation of an Exchange. Policies and contracts must be tailored to provide for implementation of technical services deemed necessary by the governing board and evaluated on an annual basis (e.g., Notices of Privacy

Practices and model consent and authorization forms). Enforcement mechanisms must be built into the policy framework to ensure compliance and accountability among participants in the Exchange.

A number of agreements will have to be developed to successfully implement the Exchange (e.g., model data sharing agreements, business associate agreements and other legal documents). During the planning of the Exchange, it will be necessary to consider the inter-relationships that will exist among public and private stakeholders. For example, different models may be developed for public-to-private data sharing and public-to-public data sharing. Other issues that must be considered include the interoperability with other states as well as the National Health Information Network and other mechanisms. It is anticipated that the governance committee will contract with healthcare, legal and regulatory experts to accomplish the ultimate development of the necessary agreements should South Carolina decide to establish an Exchange.

#### **Phase IV: Policy Recommendations**

The information derived from all phases of the grant will be used to generate a final report and policy recommendations on the feasibility of establishing an insurance Exchange in South Carolina. A detailed implementation strategy and funding plan, if applicable, will be developed and presented to the Governor, South Carolina General Assembly and Secretary of the U.S. Department of Health and Human Services for their consideration. The report will set forth the issues associated with the various Exchange options (governance, administration and benefit design), the advantages and disadvantages of each for South Carolina as well as the cost of each option.

#### **B. Project Staffing**

*The South Carolina Department of Insurance (DOI).* DOI is responsible for the regulation of the business of insurance within the state of South Carolina. DOI has been designated by Governor Mark Sanford to be the lead agency for this grant. As such, DOI will be primarily responsible for project design and management, establishing the responsibilities of its partners, obtaining external consultants to lend their expertise to the project, securing contracts and ensuring delivery of the required services, establishing the timeline/management responsibilities for the SCHEPC and generating the reports to the Secretary, the Governor and members of the General Assembly.

***Principal Investigator.*** DOI will assign a member of its existing staff to serve as the Principal Investigator for this project. The Principal Investigator shall be responsible for the overall management and policy formulation for the project. The Principal Investigator shall supervise the activities of the Project Manager and other members of the Project Team. The duties of the Principal Investigator are more particularly described the attached position description.

***The Project Manager.*** The DOI will secure via the applicable procurement or employment process an expert versed in managing health policy research projects to serve as Project Manager. The Project Manager shall be responsible for managing the day-to-day activities of the grant. Subject to the review and approval of the Principal Investigator, the Project Manager shall be responsible for development of a project management plan. The plan will describe how and when the activities for the grant will be conducted and provide timelines for completion of key grant activities. The Project Manager shall oversee the organization of the project and the planning activities and shall responsible for keeping the Principal Investigator informed. Project management will also be accomplished through regular Project Team meetings, through monitoring the accomplishment of established tasks within stated timeframes, and meetings with SCHEPC and its working groups and task forces. The Project Manager shall coordinate all grant activities for DOI and be responsible for grant reporting. This individual will also be responsible for ensuring that all entities meet the project-related terms of their contracts. See the attached position description.

***Project Coordinator/ Research Assistant.*** DOI will also hire a Project Coordinator to assist with research and to handle the day-to-day administration of the grant. This position will also handle financial reporting and accounting for funds associated with this grant. See the attached position description.

In addition to these individuals, it is envisioned that the Department will contract with experts/consultants in the following areas: research, data collection and analysis; actuarial science; econometric and institutional modeling; health law policy, etc.

## BUDGET NARRATIVE

Upon receipt of grant award, DOI will implement the following project activities as outlined below:

- **Indirect Costs.** Five percent of the total grant award or fifty thousand dollars (\$50,000.00) will be attributed to indirect costs associated with the project.
- **Project Management (Personnel).**
  - ***The Principal Investigator.*** The DOI will assign a principal investigator to oversee this grant project.
  - ***The Project Manager.*** DOI will enter into a contractual agreement with a consultant or temporary employee to serve as Project Manager. To comply with both federal and state procurement regulations, a Request for Proposal for Services may be issued, if applicable. The Project Manager will be responsible for the project management as well as the overall coordination of activities for this project. It is anticipated that this position will spend approximately 40 hours per week for the 12-month period of this project. One hundred thirty thousand dollars (\$130,000.00) has been budgeted for this position. This amount includes a salary of one hundred thousand dollars (\$100,000.00), plus fringe benefits. This position may also be hired as a temporary grant employee, if feasible. If a temporary employee is hired, this will be the equivalent of a State of South Carolina FTE, Band 9..
  - ***Project Coordinator /Research Assistant.*** A Project Coordinator will be hired for the duration of the project for 37.5 hours per week. This position will be the equivalent of a State of South Carolina FTE, Band 6. The budget provides sixty thousand dollars (\$60,000.00) for this position, including the cost of fringe benefits. This position will also track expenditures related to the grant and file any required reports.
- **Office Space and Equipment.** The budget allows forty thousand dollars (\$40,000.00) for DOI to prepare office space and to purchase equipment to house the grant personnel for the duration of the project.
- **Postage and Supplies.** Five thousand dollars (\$5,000.00) has been included in the budget for postage, printing, office supplies, and telephone usage for program operation.

- **Contractual Services.**

- **Actuarial Services.** Although actuaries are exempt from the South Carolina Procurement Code, DOI will solicit via Requests for Services Proposal the services of a certified actuary or actuarial firm to develop an actuarial model that can be used to: 1) project trends, such as the number of newly insured; 2) determine the impact of rating restrictions and other market reforms effective 2014 on premium levels; 3) evaluate the merging of individual and small group markets; 4) forecast the impacts of changing medical loss ratio requirements in the individual and small group markets; and 5) model marketplace changes resulting from expanding the definition of small group market. The budget proposal estimates seventy-five thousand dollars (\$75,000.00) for these services.
- **Health Economist.** DOI will contract for the services of a health economist to use econometric simulations to model the design options available for the Exchange and the impact on the South Carolina health insurance market including the development of a financial model that provides for the sustainability of the Exchange. The budget estimates \$50,000 for these services
- **Data Collection Activities.** DOI will contract with divisions of the University of South Carolina to conduct research and collect data on the pool that may be eligible for coverage under a health insurance Exchange. The data collection activities envisioned include a household survey, focus groups and key informant interviews. The amount budgeted for these services is two hundred thousand dollars (\$200,000.00 - \$155,000.00 for the household survey and \$45,000.00 for the focus groups and key informant interviews) and includes funding to facilitate participation of individuals who have a disability or long-term illness and their families in focus groups.
- **Data Cleaning and Analysis Services.** DOI proposes to contract with the Office of Research and Statistics to coordinate the data collection and analysis services. A detailed description of the scope of their work is included as Exhibit \_\_\_\_\_. DOI has budgeted sixty thousand dollars (\$60,000.00) for these services.
- **IT Infrastructure.** DOI will solicit via the South Carolina procurement process proposals for the services of an IT consultant that will develop the IT infrastructure and plan necessary to implement an Exchange. The amount budgeted is one hundred thousand dollars (\$100,000.00). DOI envisions

engaging for three (3) months the full-time services of an IT manager (\$125 per hour), IT analyst (\$75 per hour) and IT architect (\$100 per hour) to use the research data obtained to develop the plan and costs for the IT infrastructure.

- **Legal Services.** DOI will associate counsel to help provide legal services to the project. The legal services include, but are not limited to, drafting or reviewing the following: enabling legislation; operations manuals; claims manuals; plan of operation; business associate agreements, participating agreements; consent forms and releases; applications for coverage; reinsurance arrangements; privacy notices and acknowledgement forms; etc. The budget includes seventy-five thousand dollars (\$75,000.00) for these services.
- **Space Rentals.** DOI will need to rent space for focus groups, key informant interviews, meetings, printing and interviewee incentives, etc. The budget includes seventy-five thousand dollars (\$75,000.00) for these services.
- **Medicaid Research.** A contractual agreement will be made between the South Carolina Department of Health and Human Services for data collection review, analysis, and policy development. It is anticipated that these services will cost fifty thousand dollars (\$50,000.00).
- **Meeting Expenses.** As proposed in the project description, a planning committee will be established at the onset of the project. It is anticipated that the costs associated with the establishment of the planning committee to include meeting expenses (one meeting every other month for the project period, to include an orientation retreat and per diem) will be ten thousand dollars (\$10,000.00). This includes funding to facilitate participation of individuals who have a disability or long-term illness and their families in meetings.
- **Travel Expenses.** The budget includes travel expenses for the scheduled NAIC meetings and funds for travel to and from the Focus Group locations within South Carolina. Fifteen thousand dollars (\$15,000.00) has been included in the budget for travel and per diem expenses for members of the project staff for the 12-month grant period.
- **Printing/Publication.** Following the data collection and analysis phases of this project, the South Carolina Department of Insurance, as Lead Agency, will publish the final report on the findings. Five thousand dollars (\$5,000.00) has been budgeted for the publication and statewide dissemination of this report.



Scott Richardson  
South Carolina Department of Insurance  
1201 Main Street Ste 1000  
Columbia, SC 29201-3291

Dear Mr. Richardson:

On behalf of the Office of Health Insurance Exchanges in the Office of Consumer Information and Insurance Oversight (OCIIO), I am pleased to inform you that we will fund your project in the amount of \$1000000 under Funding Opportunity Announcement CFDA 93.525, entitled State Planning and Establishment Grants for the Affordable Care Act's Exchanges.

Health Insurance Exchanges will empower the American people to truly compare the health benefits they purchase for the first time. The Exchanges will allow individuals and small businesses access to bargaining power comparable to that of established larger groups. Health Insurance Exchanges help level the playing field by putting greater control and greater choice in the hands of consumers.

These grants are designed to help states determine whether they should establish an Exchange, and if so, assist them in beginning to conduct the critical planning activities for Exchange development. The Affordable Care Act put states on the front lines of changing the health insurance marketplace to benefit consumers. These grants will give South Carolina the necessary resources to determine how the Health Insurance Exchange can best serve consumers. HHS will help facilitate the sharing of information among states as the grants are utilized to ensure the most efficient use of federal dollars.

Your Notice of Grant Award will be mailed to you soon. Pursuant to the HHS Grants Policy Statement, terms and conditions are associated with the receipt of this grant and will be included with the Notice of Grant Award.

We at OCIIO thank you for your commitment and look forward to continued collaboration with South Carolina to ensure the Exchange in your state fulfills the principals of affordability, quality, transparency and access that are embodied in the Affordable Care Act.

Sincerely,

A handwritten signature in black ink, appearing to read "Jay Angoff", is written over a printed name and title.

Jay Angoff  
Director

## Appendix C

### South Carolina Health Planning Committee

- a. Members
- b. Meeting Agendas and Minutes/Summaries
  - i. April 14, 2011
  - ii. June 30, 2011
  - iii. July 21, 2011
  - iv. August 17, 2011
  - v. September 12, 2011
  - vi. October 10, 2011
  - vii. October 17, 2011
  - viii. November 1, 2011
  - ix. November 10, 2011
  - x. November 18, 2011
- c. Presentations and Handouts

## South Carolina Health Planning Committee: Members

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South Carolina Health Planning Committee  
Agendas and Minutes



# South Carolina Department of Insurance

Capitol Center  
1201 Main Street, Suite 1000  
Columbia, South Carolina 29201

**NIKKI R. HALEY**  
Governor

**DAVID BLACK**  
Director of Insurance

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## AGENDA South Carolina Health Planning Committee April 14, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
Gary R. Thibault, Chairman
- II. Consideration of Agenda**
- III. Introduction**  
Tony Keck, Director, Department of Health & Human Services  
David Black, Director, Department of Insurance
- IV. Overview of the Issues**  
Input from Committee Members
- V. Project Management Overview**  
Andrew M. Dvorine, ASA, MAAA  
Associate Actuary, South Carolina Department of Insurance
- VI. Understanding the Market**  
Robert Oldendick, Ph.D., Executive Director  
Institute of Public Service and Policy Research  
University of South Carolina
- VII. Establishment of Task Forces**
  1. Competitiveness & Transparency
  2. Consumer Driven Health Plans
  3. Consumer Protection / Medical Liability
  4. IT
- VIII. Other Business**
- IX. Adjourn**

Minutes  
South Carolina Health Planning Committee  
April 14, 2011 Meeting

The April 14, 2011 meeting of the South Carolina Health Planning Committee was called to order at 2:05 pm by Gary Thibault, Chairman. Also present were David Black, Tony Keck, Evelyn Perry, Tammie King, Michael Vasovski, DO, Casey Fitts, MD and Representative David J. Mack, III. Department of Insurance staff present were Andrew Dvorine, Cathy Cauthen and Kendall Buchanan. Guests present included Dr. Robert Oldendick. The meeting agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Thibault welcomed the members and guests and after introductions, discussed the organizational nature of the Committee's first meeting. Mr. Thibault thanked everyone for attending, noting the importance of the Committee's charge and the importance of getting the process started.

Dr. Fitts moved to approve the Agenda as presented. The motion was seconded by Mr. Black and unanimously approved.

Mr. Thibault briefly reviewed the background materials provided in each members packet: *Summary of the New Health Reform Law*, The Henry J. Kaiser Family Foundation; *Initial Guidance to States on Exchanges*, Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services; *Patient Protection and Affordable Care Act, Section-by-Section Analysis*, National Association of Insurance Commissioners & The Center for Insurance Policy & Research; *Glossary of Health Insurance Terms*, National Association of Insurance Commissioners & The Center for Insurance Policy & Research; *Consumer Letters/Emails Requesting Assistance*, South Carolina Department of Insurance; *Implementation Timeline*, The Henry J. Kaiser Family Foundation; *Frequently Asked Questions*, National Association of Insurance Commissioners; *How People Get Health Coverage and The Requirement to Buy Coverage* by The Henry J. Kaiser Family Foundation.

Mr. Thibault introduced Mr. David Black, Director, South Carolina Department of Insurance and Mr. Tony Keck, Director, South Carolina Department of Health & Human Services. Director Black welcomed everyone, expressing his appreciation for their willingness to devote their time and efforts to address what are very important issues to our State. Director Keck also expressed his appreciation to the committee members for their service and discussed the importance for the Committee to ask the right questions and have a broad discussion and review of alternatives to improve the health care and insurance markets in South Carolina.

Mr. Andrew Dvorine, Associate Actuary for the Department of Insurance and Project Director for the Department's exchange planning grant, reviewed the purpose of the exchange planning grant and the progress made to date. He reviewed the timeframe involved, the hiring of Mr. Thibault to serve as the Program Manager, the demographic study which was the first step of the process, and the reporting of the Committee's findings to the US Department of Health & Human Services.

Mr. Thibault introduced Dr. Robert Oldendick, Executive Director, Institute of Public Service and Policy Research, University of South Carolina. Mr. Thibault noted that Department of Insurance had contracted with the University of South Carolina to conduct the demographic research mentioned by Mr. Dvorine. Dr. Oldendick reviewed the research design and explained that data collection would include three components: a household survey, focus groups, and a key informant survey. He reviewed the household survey design and its purpose: to provide an estimate of the uninsured population in South Carolina; to identify the factors associated with not having insurance, and to identify the factors that would be important in a health plan that would be offered through an exchange.

Dr. Oldendick added that the focus groups would determine the attitudes and concerns of small employers, medical providers, health insurance companies and consumers about health insurance and health insurance exchanges. Similarly, a survey of key informants would be undertaken to determine their views.

The Committee discussed the research, the questions used in the household survey, the inclusion of cell phones in the survey, the difficulty of reaching immigrants in the state and the probability of being selected. It was agreed that the draft of the household survey questionnaire would be sent to members of the Committee. Dr. Fitts discussed the importance of health care information, the difference of health versus health insurance and the need to solve the right problems. Mr. Black suggested, and it was agreed, that a copy of the 2004 Department of Insurance's study on the uninsured be sent to members of the Committee.

Mr. Thibault reviewed the authority of the South Carolina Health Planning Committee under Executive Order 2011-09 to establish task forces/subcommittees within its membership or outside its membership to address specific issues and to assist in the Committee's work. The Committee discussed creating four task forces: Competitiveness & Transparency, Consumer Driven Health Plans, Consumer Protection – Medical Liability and Information Technology. Director Keck reviewed the proposed Competitiveness & Transparency Task Force, the importance of the research and the need to review all options open to the state. Director Black reviewed the proposed Consumer Protection – Medical Liability Task Force and Mr. Thibault reviewed the Consumer Driven Health Plans and Information Technology Task Forces. After further discussion, Dr. Fitts moved that the Committee establish the four task forces discussed, to include in their membership both members of the Committee and outside individuals as well, and authorized the Chairman to appoint the members. Dr. Vasovski seconded the motion and the motion was unanimously approved.

Mr. Thibault stated that the Committee could make changes to this task force/subcommittee structure as needed. He asked that those interested in serving on a subcommittee to let him know as soon as possible.

There being no other business the meeting was adjourned at 3:00 pm.



# South Carolina Department of Insurance

Capitol Center  
1201 Main Street, Suite 1000  
Columbia, South Carolina 29201

**NIKKI R. HALEY**  
Governor

**DAVID BLACK**  
Director of Insurance

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## AGENDA

### South Carolina Health Planning Committee June 30, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
10:30 am

- I. Call to Order & Welcome**  
Gary R. Thibault, Chairman
- II. Consideration of June 30, 2011 Agenda and April 14, 2011 Meeting Minutes**
- III. Background Briefing-Panel Discussion**  
Joseph L. Pearson, MS, DrPH  
Director, South Carolina Public Health Institute  
Moderator
- IV. Research Update**  
Robert Oldendick, Ph.D., Executive Director  
Institute of Public Service and Policy Research  
University of South Carolina
- V. Subcommittee Charges & Deliverables**
- VI. Timeframe for Subcommittee Recommendations & Committee Report**
- VII. Other Business**
- VIII. Adjourn**

Minutes  
South Carolina Health Planning Committee  
June 30, 2011

The June 30, 2011 meeting of the South Carolina Health Planning Committee was called to order at 10:30 am by Gary Thibault, Chairman. Committee members present were David Black, Tony Keck, Evelyn Perry, Tammie King, Michael Vasovski, DO, Casey Fitts, MD, Representative David Mack, Representative Bill Sandifer, William Shrader, Senator Michael Rose, and Timothy Ervolina. Department of Insurance staff present were Andrew Dvorine, Cathy Cauthen, Kendall Buchanan, Ella Dickerson, Ann Roberson, Rachel Harper and Jim Byrd. Guests present included Dr. Lee Pearson, Dr. Mary Tyrell, Cynthia Williams, Barney Osborne, Howard Einstein, and Dr. Robert Oldendick. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Thibault welcomed the members and guests and introduced two members appointed since the Committee's first meeting: Senator Michael Rose from Summerville and Tim Ervolina, President of the United Way Association of South Carolina. Mr. Thibault also introduced two members who were not able to attend the first meeting, Representative Bill Sandifer, Chairman House Labor, Commerce and Industry Committee and Will Shrader, Senior Vice President for Blue Cross and Blue Shield of South Carolina.

Representative Sandifer moved to approve the Agenda as presented. The motion was seconded by Mr. Ervolina and unanimously approved. Mr. Keck moved that the minutes be approved as presented. The motion was seconded by Representative Mack and approved. Senator Rose noted that he did not vote on the motion to approve the minutes since he was not present at the April 14th meeting because he had not yet been appointed to the Committee.

Mr. Thibault announced the establishment of the South Carolina Health Planning Committee website [www.healthplanning.sc.gov](http://www.healthplanning.sc.gov). In addition to providing general information and background materials, all Committee documents would be available on the site.

Mr. Thibault introduced Dr. Lee Pearson, Executive Director of the South Carolina Public Health Institute. Dr. Pearson introduced Dr. Mary Tyrell, Health Care Informaticist, Mr. Barney Osborne, Vice President of Finance and Reimbursement, South Carolina Hospital Association, Ms. Cynthia Williams, Program Manager, Health Sciences South Carolina, and Mr. Howard Einstein, Principal, Rosenfeld Einstein. Dr. Pearson started by presenting "Health Planning for SC: Context and Considerations." He reviewed the picture of health for the US and South Carolina, determinants of health, the return on our investment, marketplace considerations, coverage considerations and the focus of the Committee. Dr. Tyrell reviewed what the population of South Carolina looks like, what happens on an average day in health care in South

Carolina, and the trends that will change the future of health care in our state. Ms. Williams discussed Health Care Transformation: Research and Equity, Mr. Osborne reviewed health insurance coverage in United States and Mr. Einstein discussed changes from an insurance brokers perspective and the results of his firms bi-annual benefits survey. There was lengthy discussion on all topics presented including price and quality issues. Mr. Shrader requested, and the panelists agreed to provide, data for the percent of charge of Medicare and Medicaid for South Carolina hospitals. Dr. Vasovski asked that it be separated by for profit and non-profit hospitals.

The Committee discussed the take-ways from the Public Health Institute's presentation. Director Keck discussed the importance of the topic of health and noted that health care is not synonymous with health. He also stated that one of the goals of the Committee is to engage competition in the marketplace. Dr. Fitts added that South Carolina has an opportunity to be a leader in healthcare reform and stressed the importance of the task at hand not only for the Committee, but also for South Carolina lawmakers. Senator Rose agreed and responded that there are clearly identified problems and the Committee needs to find the central element of the problem in order to begin finding the solution. Representative Mack reminded the group of the importance of the need for health care and coverage, and whatever system chosen would be secondary to that. Representative Sandifer raised the issues of mandates and finances. He reminded the group of the timeframe involved and the government's responsibility to the people. Ms. Perry acknowledged that the Committee is facing a daunting responsibility and expressed her feeling that all industries can come together and make a positive solution. Dr. Vasovski stated that the Committee should explore competition theories in order to design a market that increased competition in a way that reduces prices. Mr. Shrader mentioned that among the key issues involved in improving the health care of South Carolina are patient compliance and the current fee-for-service system. Ms. King noted the importance of keeping the consumer in mind and finding a solution that is not only possible, but also feasible. Director Black thanked all the speakers for excellent presentations and the Committee members for a very engaging discussion and their commitment to working on these issues.

Mr. Thibault reaffirmed that the Committee is facing a daunting task, that how these issues are resolved will have a very significant health impact on our state and a financial and economic one as well. He emphasized the need for good information and analysis. He referred to the 2004 study on the uninsured in South Carolina and the research currently being conducted under the health planning grant. Mr. Thibault then introduced Dr. Bob Oldendick to provide an update on the research. Dr. Oldendick gave a status update of the key informant and household surveys, as well as the progress of the focus groups.

There being no other business the meeting adjourned at 2:00 pm.



# South Carolina Department of Insurance

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Director of Insurance

## AGENDA

### South Carolina Health Planning Committee

July 21, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
9:30 am

- I. Call to Order & Welcome**  
Gary R. Thibault, Chairman
- II. Consideration of July 21, 2011 Agenda and  
June 30, 2011 Meeting Minutes**
- III. Health Care and the Affordable Care Act – An Overview**  
Mark Tompkins, PhD  
University of South Carolina
- IV. Health Marketplace Technologies**  
John Supra, CIO  
South Carolina Department of Health & Human Services
- V. Subcommittee Reports**  
Competitiveness & Transparency  
Consumer Driven Health Plans  
Consumer Protection / Medical Liability  
Information Technology
- VI. Other Business**
- VII. Adjourn**

Minutes  
South Carolina Health Planning Committee  
July 21, 2011

The July 21, 2011 meeting of the South Carolina Health Planning Committee was called to order at 9:30 am by Gary Thibault, Chairman. Committee members present were David Black, Tammie King, Casey Fitts, MD, William Shrader, Senator Michael Rose and Timothy Ervolina. Attending for Representatives Bill Sandifer and David Mack was Andy Fiffick. Attending for Toney Keck was John Supra. Joining by conference call were Evelyn Perry, and DOI staff Andy Dvorine. Department of Insurance staff present were Cathy Cauthen, Ella Dickerson, Ann Roberson, Rachel Harper and Jim Byrd. Guests present included Dr. Mark Tompkins. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Thibault welcomed the members and guests. Tammie King moved that the Agenda be approved. The motion was seconded by Will Shrader and unanimously approved. Senator Rose moved that the minutes of the June 30, 2011 Committee Meeting be approved as presented. The motion was seconded by Dr. Casey Fitts and unanimously approved.

Mr. Thibault reviewed the Agenda and the articles and materials provided to the Committee.

Mr. Thibault introduced Dr. Mark Tompkins with the Department of Political Science, University of South Carolina. Dr. Tompkins presented "Health Care and the Affordable Care Act – An Overview". Dr. Tompkins reviewed the history of health reform in the United States, the health care market and access, cost and effectiveness of medical care in the country. Dr. Tompkins also reviewed the number of uninsured from 1987 to 2009 and the economics of health and medical care. He provided details of the Affordable Care Act and provisions effective by year from 2010 to 2014. He reviewed the provisions for health insurance exchanges and the eight main challenges in establishing exchanges.

The Committee discussed various aspects of the presentation, including the effects of cost on competition. Mr. Shrader noted that while the state of New York has the highest competition, it also has the highest cost. Senator Rose raised the question of buying insurance from states that are not licensed in SC. Mr. Shrader briefly reviewed state licensing requirements.

Mr. John Supra, CIO for the South Carolina Department of Health & Human Services, and Chair of the Information Technology Subcommittee, spoke on Health Marketplace Technologies and I.T. challenges that come with creating an exchange. He stated that South Carolina wants solutions that not just handle insurance, but also influence better choices.

The next item on the agenda was subcommittee reports. Subcommittee chairmen gave a brief overview of the topics discussed in their subcommittee meetings and plans for future meetings. Director Black reported for Consumer Protection / Medical Liability and, Mr. Supra reported for Information Technology. Mr. Thibault reported for Competitiveness & Transparency and for Consumer Drive Health Plans.

Senator Rose inquired as to the option of not creating exchange. He pointed out that several states have dropped out of the grant process. He added that there is significant risk associated with creating an exchange and raised the question of whether it is really prudent to be a pioneer on this front. Dr. Fitts responded by stating that if we wait, we may lose a tremendous opportunity for South Carolina to move forward adding that the federal government will be flexible with timelines. Senator Rose stated it would be beneficial to hold public hearings in various communities in the state to receive public comment. Mr. Thibault reviewed the plans to hold hearings, tentatively scheduled for mid-September.

The Committee discussed the issue of forming an exchange with another state or other states. Director Black mentioned that there had been no discussions at recent meetings of the National Association of Insurance Commissioners of a multi-state exchange.

Senator Rose reviewed the presentations he heard at the National Conference of Insurance Legislators.

The being no further business the meeting was adjourned.



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## AGENDA

South Carolina Health Planning Committee

September 12, 2011

South Carolina State Museum  
Columbia, South Carolina  
1:00 pm

- I. Call to Order & Welcome**  
Gary R. Thibault, Chairman
  
- II. Consideration of September 12, 2011 Agenda**
  
- III. Health Insurance Markets – An Overview**  
**Deloitte Consulting LLP**  
  
Wade F. Horn, PhD, Director  
  
Brian Keane, Principal  
  
Bharat Chaturvedi, Senior Manager  
  
Michelle Raleigh, Senior Manager
  
- IV. Other Business**
  
- V. Adjourn**

Minutes  
South Carolina Health Planning Committee  
September 12, 2011

The September 12, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Committee members present were Will Shrader, Tammie King, Senator Michael Rose, Director David Black, Director Tony Keck, Casey Fitts, MD, and Tim Ervolina. Committee members Evelyn Perry and Michael Vasovski, MD, joined by conference call. Department of Insurance staff present were Andy Dvorine, Cathy Cauthen, Kim Cox, and Ella Dickerson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Thibault welcomed the members and guests and reviewed the proposed agenda. Mr. Ervolina moved to approve the agenda. The motion was seconded by Mr. Shrader and unanimously approved.

Mr. Thibault introduced the following members of Deloitte Consulting: Wade F. Horn, PhD, Director, Brian Keane, Principal, Bharat Chaturvedi, Senior Manager, and Michelle Raleigh, Senior Manager. They presented a brief overview of Deloitte Consulting, their backgrounds and their work on health care reform and health insurance exchanges.

They reviewed the Affordable Care Act and the implementation timeline for the establishment of insurance benefit exchanges. Noting that existing state program structure will probably need to change, they added that the various disruptions occurring simultaneously in the health care system, including budgetary challenges, will make the changes even more difficult. Examining the exchange business and technical design, they stated that most planning is centered around technology, but the actual place to start is improving the health status of the underlying population. This will guide the overarching goals of the exchange. They suggested letting IT take incremental steps to get there once you know where you are starting and where you are heading.

When discussing the exchange design, they noted that the law is specific in some areas but also leaves states with flexibility in other areas. They expanded on the flexibility the Affordable Care Act afforded to states and the risk associated with each. Director Keck commented that many times the risk is not in the wrong solution, it's asking the wrong question. It is critical to perform a broader assessment including the state's health status and how to improve it. The representative from Deloitte agreed and stated that a clear vision should come first,

then develop a strategy, then build the business solution. He noted the importance of establishing a vision such as increased health care affordability, improved population health, or to achieve universal healthcare coverage.

To create a functional exchange, Deloitte emphasized using existing capabilities rather than reinventing the wheel. Stakeholders include individuals, small employers, employees, brokers, navigators, community partners, health plans, Medicaid, state DOI, other state and federal government agencies and health care providers. Channels of accessing the exchange include online, mail, fax, office, and phone. The exchange exists between them, all which include primary processes and functionality, underlying technology, and business functions. The business functions also define the mood of the exchange: is it public service or is it simply insurance? What is their experience going to be? Some options for exchanges include: information aggregator, retail-oriented, guided exchange, or market curator. It is important to guide people to the choices that are relevant for their income level.

On the subject of subsidies they said that other states are considering using vouchers that may be presented to private issuers who then use them through the exchange, however the federal government may not accept this method. It also may be difficult due to the fact that the voucher will need to be certified eligible through the exchange.

The topic of thin versus robust exchange included a ranking of 1-4 from thinnest to most robust. Ms. Williams commented that strategy and vision come in play here where the first option suggests there isn't a strong vision, and the fourth option suggests that there is a clear and ambitious vision. Mr. Shrader added that just because you vision is a 1 or a 2 doesn't mean the vision is not robust, it would depend on the market in the state. The Deloitte group agreed that the options of 1-4 are not qualitative.

The group presented three possible models for exchanges illustrating the process and how they will integrate with other programs in the state. They then demonstrated purchasing on the exchange without a tax credit, with a tax credit, applying for Medicaid, an employer registering their employees, an employee purchasing their insurance and highlighted choice-points on all of the demonstrations. They pointed out that most people buy health insurance based on cost as well as the availability of their physician, and that factors into the design decisions. The design must consider also confirmation of identity. This means that exchanges face the challenge of drawing from different databases, which increases the likelihood of getting conflicting information.

Deloitte posed the question of what we are interested in as a state and listed some trends of other states. They noted that our current insurance market in terms of competitiveness is similar to many other states. Director Keck asked what the common thread is in states as far as their funding level goes on the Level 1 Establishment Grants. The Deloitte group answered that they had not yet identified one. Senator Rose asked if there is enough certainty about the rules and regulations for a state to develop this business model. How much should we go forward versus hold back? Is it better to be a leader or to hold back and let other states move forward and then reap the benefits of their experience? The Deloitte group stated that the positive side of going forward is that you get to help define what the regulations are going to be. The federal government is looking to states to help them figure out the answers. That was the idea of the innovator grants. The negative is that they may not agree with the state's direction after you have already spent a lot of time and money moving forward. But you may also go part of the way and decide not to finish.

Senator Rose asked if we have failing programs in this state, is it a good idea to try and establish an exchange? The Deloitte group answered that it is important to be honest with yourself about your capacity, but you may also start down the road and change your mind. It's not necessarily a bad decision to not establish one, but not necessarily the right decision either. While the timeline for grant applications has been extended, the money starts not to work as well for you because if you start in 2014 rather than 2013 and you do not develop your systems to the extent you could have otherwise. Mr. Supra stated that regardless of where the exchange goes, we are moving forward on improving our eligibility system and our HIT.

Mr. Shrader asked if it would be more limiting on flexibility to allow the federal government to control the exchange. They responded that the feds want this to work. They aren't going to give away the store to make it work, but they aren't intentionally making it hard. Deloitte answered that they believe the federal government will make it as flexible as possible, there is no incentive to make it difficult when 50% of states will establish an exchange.

Mr. Thibault thanked Mr. Horn, Mr. Keane, Mr. Chaturvedi and Ms. Raleigh for their presentation. There being no other business, Mr. Shrader made the motion to adjourn. The motion was seconded and approved.



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## AGENDA

### South Carolina Health Planning Committee

October 10, 2011

LCI Committee Room  
4<sup>th</sup> Floor, Blatt Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
Gary R. Thibault, Chairman
- II. Consideration of Agenda**
- III. Consideration of September 12, 2011 and August 17, 2011 Meeting Minutes**
- IV. Review of Research Results**  
Robert Oldendick, PhD, Executive Director  
Institute of Public Service & Policy Research  
University of South Carolina  
  
Lee Pearson, MS, DrPh  
Director of Operations  
South Carolina Institute of Medicine & Public Health
- V. Public Comment**
- VI. Other Business**
- VII. Adjourn**

Minutes  
South Carolina Health Planning Committee  
October 10, 2011

The October 10, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Committee members present were Director David Black, Representative Bill Sandifer, Representative David Mack, Tammie King, Timothy Ervolina, Will Shrader, Senator Michael Rose, Evelyn Perry and Director Tony Keck. Department of Insurance staff present were Kim Cox, Cathy Cauthen and Ella Dickerson. John Supra, South Carolina Department of Health and Human Services, was also present. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Thibaut welcomed the members and guests and reviewed the agenda. Representative Sandifer moved the agenda be adopted. The motion was seconded by Representative Mack and approved. Mr. Thibault asked the members to review the minutes from the September 12 and August 17, 2011 meetings. Mr. Thibault asked if there were any changes. Director Black moved that the September 12, 2011 minutes be approved. The motion was seconded by Mr. Ervolina and approved. Mr. Ervolina made the motion to approve the August 17, 2011 minutes. The motion was seconded by Mr. Shrader and approved.

Mr. Thibault introduced Mr. Kester Freeman, Executive Director of the South Carolina Institute of Medicine and Public Health. Mr. Freeman gave a brief overview of the Institute and its new board of directors. Mr. Freeman discussed the purpose of the Institute - to conduct health policy research and emphasized that it did not take political positions on the issues. Mr. Thibault thanked Mr. Freeman for his remarks and the Institute's work.

Mr. Thibault introduced Dr. Robert Oldendick, Executive Director of the Institute of Public Service and Policy Research at the University of South Carolina. Dr. Oldendick lead the study for the Department of Insurance and the Department of Health & Human Services on the uninsured in South Carolina.

Dr. Oldendick described the three components of the study: the survey of the general public, the holding of focus groups and a key informant survey. He discussed the components and the findings that were significant. Dr. Oldendick presented demographic information on the uninsured in South Carolina including by age, poverty level, race, ethnicity, gender, region, urban/rural, education level and employment status.

Dr. Lee Pearson, Director of Operations at the South Carolina Institute of Medicine and Public Health, presented the results of the focus groups. Six focus groups were held across the state. Participants were asked questions that were contextual and some that were more specific. The themes were cost escalation, openness and information, individual/personal responsibility, competition and marketplace, fostering innovation, and technical and logistical issues. The overarching ideas were theory versus practice and health

SCHPC Minutes  
October 10, 2011

outcomes. Dr. Pearson reminded the committee that the timing of these focus groups occurred during the national debate over the debt ceiling. So the realities of the country's ability to afford subsidies and state governments being able to sustain an exchange were influenced by this accordingly.

The Focus Groups also allowed stakeholders knowledgeable in the health care industry to express their opinions on where improvement efforts should be focused. They were also asked about health insurance exchanges. The need to allow more competition in the health insurance market was identified as a concern and a sense of a uniquely South Carolina solution was a desire, and it was decided that innovation cannot be achieved without trying a new approach. While seventy percent of the participants felt that a state-based exchange would be preferable, sustainability was a concern. They were divided on the business model but the majority of participants did not want an active purchaser. They also expressed some difficulty in answering questions about a health insurance exchange when they did not know what one would look like. In summary the groups felt the need to take a broader view with a wider array of factors other than simply health insurance coverage.

Dr. Oldendick concluded with a presentation on results of the key informant survey.

Mr. Thibault thanked Dr. Oldendick and asked for questions. Representative Sandifer asked if the survey asked about legal status. Dr. Oldendick answered that they were not asked that question. Representative Sandifer noted that a high percentage of people in 18 to 64 uninsured age range did not use the computer. The question was asked how we get the information to them in a manner that they can digest it. Dr. Oldendick answered that the results show the tremendous amount of work that needs to be done to get the information to those who need it. Ms. Perry wanted to know if any questions were asked to find out literacy levels of people polled, they may not be able to read and therefore written information won't work. Dr. Oldendick said they did not ask literacy level, they just asked about education level attained.

Director Keck asked about the differing opinions in the role of competition in the exchange between the key informant survey versus the focus groups. Dr. Pearson answered that role of competition was varied among the participants in the focus groups and their opinion on where competition needed to be increased differed according to what their professional role was in the system. Dr. Oldendick said that the Key Informants saw competition as a main function of the exchange. Director Keck asked about the debt ceiling factor and how could the participants' amount of knowledge of the ACA and rules be measured, noting that 67% preferred the BHP option even though it is the least defined. Dr. Pearson agreed and stated that the amount of familiarity did vary, but this was expected. An overview of the ACA and exchanges was given to try and level the playing field.

Senator Rose asked what was the level of understanding of participants about state versus federal exchanges? When people said they preferred a state-run exchange, what did they think they were voting on? Dr. Oldendick answered that the responses were more of a

reflection of the desire to have control at the state level and not just taking what is given by the federal government. Dr. Pearson stated that in the Focus Groups participants did express that it was like trying to describe the ocean if you haven't seen it, but that there was a feeling of forfeiture in opting for the federal exchange.

Senator Rose asked if the ACA requires the subsidies to be offered to undocumented residents. Director Keck answered that undocumented residents are not allowed to purchase through the exchange or receive a subsidy.

There being no further questions, Mr. Thibault moved on to the public comment period. Lynn Bailey, Lynn Bailey Associates, noted that the presentation provided percentages, not absolute numbers; questioned whether there were problems with the sample since four hundred additional uninsured families were added; and questioned income information provided regarding federal poverty and family size.

Dr. Ira Williams, and left group with a cautionary tale that the efforts to reverse the trend of needless hospital deaths are headed in the wrong direction. He expressed the urgency of addressing the dysfunction of our healthcare system.

Mr. Thibault stated that the original research design included the additional 400 uninsured households, that it was not something added, that there were absolute numbers in the research and the survey did address federal poverty level categories by household size. Today's presentations and report would be available on the Committee's website: [www.healthplanning.sc.gov](http://www.healthplanning.sc.gov).

Mr. Thibault shared a letter with the committee that was submitted by Susan Leigh Bennett, who was not able to attend today's meeting. Ms. Bennett had asked that her letter, addressing the lack of Medicare supplemental insurance for those disabled, be presented to the Committee.

Senator Rose asked how the exchange would decipher who is undocumented? Director Keck answered that we verify citizenship already, you have to document that you are a legal citizen. Mr. Supra added that a federal hub will ask about IRS and homeland security will ask about citizenship.

Mr. Thibault reviewed the schedule of meetings. Representative Sandifer moved to adjourn. The motion was seconded and approved.



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## AGENDA

### South Carolina Health Planning Committee

October 17, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
Gary Thibault, Chairman
- II. Adoption of Agenda**
- III. Consideration of October 10, 2011 Meeting Minutes**
- IV. Subcommittee Status Reports**
  1. Competitiveness & Transparency  
Tony Keck, Chairman
  2. Consumer Driven Health Plans  
Michael Vasovski, MD, Chairman
  3. Consumer Protection / Medical Liability  
David Black, Chairman
  4. Information Technology  
John Supra, Chairman
- V. Discussion of Approach to Development of Committee Report**
- VI. Initial Consideration of Recommendations**
- VII. Other Business**
- VIII. Adjourn**

**Minutes**  
**South Carolina Health Planning Committee**  
**October 17, 2011**

The October 17, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Committee members present were Director David Black, Director Tony Keck, Will Shrader, Tammie King, Dr. Casey Fitts, Representative David Mack, Representative Bill Sandifer and Tim Ervolina. Department of Insurance staff present were Kim Cox, Andy Dvorine, Rachel Harper, Helen Ann Thrower and Ella Dickerson.

Mr. Thibault welcomed everyone to the meeting and reviewed the proposed agenda. Noting that a quorum was not present, the Committee proceeded to receive as information subcommittee reports.

Director Keck reviewed the Competitiveness and Transparency Subcommittee's progress in examining mechanisms that are in place to help individuals purchase health insurance. The subcommittee had seen presentations related to the insurance industry and brokers to get a broad overview of existing capabilities. Director Keck stated that even though there are a number of proposed rules for health insurance exchanges, the federal government has not provided the clarity necessary for states to make these big decisions. He added that they have tried to recognize that the charge is not to decide whether the state has an exchange or not, because the law says it will. The question is whether it will be operated by the state or federal government. The subcommittee is starting to come to a consensus that there is probably not an entity in the state that can take on the full responsibility of a health insurance exchange, that it may fall on the Medicaid program. This has required the group to do a risk assessment to determine the risks of state versus federal exchange. Some are operational, some are political, and there are many unknowns that add to the uncertainty regarding the benefits and costs. The majority of the subcommittee seems to recognize that the state wants to chose what will give it the most control, but it is not clear that answer is the state exchange as it is defined by the federal government. The subcommittee is drafting a report that begins with the belief that we have opportunities to make positive changes in health care cost, quality of care and insurance products that will bring some efficiency into the market. Under the law, the state exchange does not seem to be in the best interest of South Carolina. However, it is in the best interest of the state to create a marketplace where consumers can access information about insurance costs and quality of services. The group aims to lay out a strategy that describes what is valuable about a traditional healthcare marketplace or exchange without connecting ourselves to the more burdensome parts of the federal law.

Mr. Thibault stated that a quorum was now present and brought the consideration of the agenda and minutes before the Committee. Dr. Fitts made the motion to approve the agenda. The motion was seconded by Mr. Shrader and unanimously approved. Mr. Ervolina made the motion to approve the minutes of the October 10, 2011 meeting. The motion was seconded by Mr. Shrader and unanimously approved.

Mr. Shrader responded that Director Keck gave a good summary of the subcommittee's work, and added that there has been a lot of conversation about the context in which these things are done and the importance of doing things that promote the health of the citizens of this state. Director Keck agreed and stated that he will present a first draft of the report to the subcommittee in about a week.

Dr. Fitts stated that it seems the partnership that is being defined would be that South Carolina runs the exchange and the federal government runs the subsidy. Director Keck added that the big question is whether or not the federal government would accept that, noting that it is important to design it in a way that prevents the federal government from assuming control. It will hinge on a solid argument about South Carolina's market and the good ideas forming within the state to improve it without buying into the more problematic parts of the ACA. Sources are saying the federal government will be less likely to oppose if a credible plan is presented. It is as much about operations as it is about political negotiation to achieve our goals for South Carolina.

On behalf of Dr. Vasovski Mr. Thibault presented a brief update on the activities of the Consumer Driven Health Plans Subcommittee. He stated that they have heard presentations on the products and trends of the individual and small group markets as well as the history of South Carolina's health insurance market, including high risk pools and coops. The next meeting of the subcommittee is scheduled for October 26<sup>th</sup> and they will be submitting their report shortly thereafter.

Director Black presented an update on the progress of the Consumer Protection-Medical Liability Subcommittee stating that the group has tracked the development of tort reform and peer review and other important changes that have occurred over the years and discussed where there may be further opportunity for improvement. He added that actuaries have pulled numbers to give us the size of small group and large group markets and what has influenced them. The group has studied and discussed high-risk pools and the history of the state's insurance market. They have analyzed the possibility of cooperatives and the legal reforms needed to create that opportunity, specifically a new group that plans to utilize grants available to establish a cooperative. The subcommittee members have been asked to submit individual comments from which Director Black will compile the draft subcommittee report.

Mr. Supra presented a summary of the work of the Information Technology Subcommittee. He stated that the group looked at the state and federal components necessary to operate an exchange and the actions required to develop those components. They analyzed what needed to be done to make the

federal option work. Technology is not the end result but rather a means to get things done. The subcommittee discussed how these systems would allow South Carolina to move forward with the idea of improving health. They identified the tools necessary to support the entire system. He added that the IT subcommittee has done a great job of pulling together these components and has come to a consensus of putting the needs of the people of South Carolina first. He added that the complexity of the law made establishing a state exchange a greater risk. A federal exchange has complexity in both the known and unknowns. Within Medicaid, we know how to do eligibility and enrollment and can contemplate an expansion. But the idea of subsidies is new. When we looked at the total IT system we see that establishing a total state exchange is difficult, a federal exchange allows the federal government to take on the capabilities that states do not have. We are able to do what is best for South Carolina while protecting the market from federal take over. Mr. Supra reported that the subcommittee was in the process of drafting its report.

The subcommittee chairmen reported the dates their subcommittee reports would be completed. Director Keck stated his subcommittee was targeting two weeks and Mr. Supra thought his report could be finished in that timeframe as well. Director Black stated that his subcommittee will be finishing a little earlier than two weeks but that it would be close. Mr. Thibaut reported that the Consumer Driven Health Plans Subcommittee will meet on October 26<sup>th</sup> with their report drafted the following week. Mr. Thibault reported that Senator Rose has suggested asking for a sixty day extension to the due date for the full committee's report. Director Keck reported that the Governor's Office wanted the Committee to put together a cohesive report that achieves what we want to communicate. There is recognition that if we need a couple more weeks that will be acceptable. He noted that the Committee would need to send a formal request to the Governor based on what we have discussed. Director Black discussed the possibility of dividing the report into two reports.

Representative Mack moved to request an additional month to complete the Committee's report. The motion was seconded and unanimously approved.

Director Keck moved to adjourn. Director Black seconded the motion which was approved.



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## AGENDA

### South Carolina Health Planning Committee

November 1, 2011

LCI Committee Room  
4<sup>th</sup> Floor, Blatt Building  
Columbia, South Carolina  
1:00 pm

- I. Call to Order & Welcome**  
Gary Thibault, Chairman
- II. Adoption of Agenda**
- III. Consideration of October 17, 2011 Meeting Minutes**
- IV. Review of Research Results**  
Robert Oldendick, PhD, Executive Director  
Institute of Public Services & Policy Research  
University of South Carolina
- V. Subcommittee Reports**
  1. Competitiveness & Transparency  
Tony Keck, Chairman
  2. Consumer Driven Health Plans  
Michael Vasovski, MD, Chairman
  3. Consumer Protection / Medical Liability  
David Black, Chairman
  4. Information Technology  
John Supra, Chairman
- VI. Other Business**
- VII. Adjourn**

Minutes  
South Carolina Health Planning Committee  
November 1, 2011

The November 1, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Members present were Director David Black, Will Shrader, Tammie King, Dr. Casey Fitts and Tim Ervolina. Andy Fiffick attended on behalf of Representative Bill Sandifer. Department of Insurance staff present were Andrew Dvorine, Kim Cox, Rachel Harper, Helen Ann Thrower and Ella Dickerson.

Mr. Thibault welcomed members and guests to the meeting and reviewed the proposed agenda. Mr. Thibault noted that a quorum was not present and the agenda and minutes would be considered if a quorum was later determined.

Mr. Thibault introduced Dr. Robert Oldendick, Executive Director, Institute of Public Services & Policy Research, University of South Carolina. Dr. Oldendick provided additional information on the results of the household survey. Dr. Oldendick, working with the Health & Demographics Section, Office of Research & Statistics, provided population estimates of the uninsured in South Carolina. That data was provided for those uninsured at any point during the past twelve months, for those uninsured at the time of the interview, and for those who when uninsured for the entire past year. Data was present by age, race, sex, federal poverty level, ethnicity and region. Information on sources of information was also presented.

With Representative Mack joining the meeting, a quorum was determined to be present. Mr. Shrader moved that the Agenda be approved as presented. The motion was seconded and unanimously approved. Mr. Ervolina moved that the October 17, 2011 Meeting Minutes be approved. The motion was seconded and unanimously approved.

The Committee discussed the data presented. Mr. Ervolina asked if the findings were unique to South Carolina. Dr. Oldendick responded that the research results for South Carolina were very similar to the data he had reviewed from other states. The Committee discussed the number of people in the survey that had purchased supplemental insurance plans and the type of information available from the research. Dr. Fitts requested additional information on the uninsured by federal poverty level and Director Black asked Dr. Oldendick for a comparison with the 2004 data to show how the data has change. Dr. Oldendick stated that he would go back to the data and pull that information.

The Committee then heard status reports from each subcommittee. Mr. Shrader and Dr. Fitts, on behalf of Director Keck, provided an update on the progress of the Competitiveness and Transparency Subcommittee. Mr. Shrader stated that the subcommittee was making good progress, has been very active throughout the evaluation

South Carolina Health Planning Committee  
November 1, 2011 Minutes

process, and should have their report finished soon. Dr. Fitts added that he was encouraged by the supportive attitudes of the Competitiveness and Transparency Subcommittee members.

Mr. Thibault reviewed on behalf of Dr. Vasovski the status of the Consumer Driven Health Plans Subcommittee report, stating that the group has advocated improving the quality of health care in a way that decreases health spending. Dr. Fitts added that the subcommittee felt to affect social change, a grass roots approach must be used. Mr. Shrader added that the subcommittee understands the need to focus on South Carolina and any reform should be focused on the health of the individual citizens and decisions that would be best for the state. Mr. Thibault added that the subcommittee's report would be completed within the next week.

Director Black presented an update on the Consumer Protection - Medical Liability Subcommittee, reviewing the development of their report and noting that they should be able to share it with the full committee in the next few days.

Mr. Ervolina briefly reviewed on behalf of John Supra the Information Technology Subcommittee Report which was included in the Committee's packet. He noted that the basis of the report was the idea that information technology was not the solution, but is part of a solution and the goal was to improve health status. If the technology does not help achieve that goal, then the technology should not be implemented. The group also felt that the federal government should do what they know, and the state should do what the state knows.

Mr. Shrader reminded the group of the importance of being cognizant that the proposed regulations have received unfavorable responses, and CMS was open to the idea of making changes that allowed for different options with more flexibility on the operation of an exchange. Mr. Thibault added that the comment period ended October 31, 2011 and agreed with Mr. Shrader that CMS seems flexible. He referred the members to two documents in their packet which reviewed the functions of an exchange and proposed hybrid model that CMS was proposing.

Director Black raised the issue of navigators. Mr. Ervolina stated that there is a real need for people that are certified and it seems to be dawning on people that it is not the same navigator definition that is used in social services. He added that navigators need to be very specialized and standards would be needed. Ms. King reviewed a position paper from the South Carolina Association of Health Underwriters and added said that the role of navigator really needs to be well defined. The navigator should get people to the next place they need to be in the purchasing process, and that place may be where they buy from licensed agents. Representative Mack noted that it is important for people to understand the process and what choices are available, adding that consumers need to be able to make quality decisions. The groundwork may be costly, but in the long run it may save money.

South Carolina Health Planning Committee  
November 1, 2011 Minutes

Director Black asked the members for what they expect to be the toughest issue. Mr. Shrader thought wordsmithing would be the toughest challenge, noting that it seems conceptually people are in the same place. Mr. Ervolina agreed adding that he came into the process with the question of state or federal and has realized that the answer is not either/or, its both/and. Ms. King agreed and Representative Mack stated that he is not committed to a federal or state exchange, rather the option that will result in the best service. Dr. Fitts feels the toughest part will be coming to a position where we put into the report something that is actionable. He added that the group has only been able to go so far constrained, in part, by the time limitations. The committee needs to make a recommendation for next steps and how the committee will go forward. Representative Mack added that next year there are 170 members of the General Assembly up for re-election, and the Committee will need to consider that as well.

Mr. Thibault briefly reviewed the agenda for the next Committee meeting and asked if there was any other information needed before they started to consider recommendations. No additional information was requested.

There being no further business, Dr. Fitts moved to adjourn. The motion was seconded and approved.



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## AGENDA

### South Carolina Health Planning Committee November 10, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
1:00 pm

- I. Call to Order & Welcome**  
Gary Thibault, Chairman
- II. Adoption of Agenda**
- III. Consideration of November 1, 2011 Meeting Minutes**
- IV. UnitedHealthcare**  
Paul E. Stordahl, FSA, MAAA  
Vice President
- V. Subcommittee Reports & Recommendations**
  1. Competitiveness & Transparency  
Tony Keck, Chairman
  2. Consumer Driven Health Plans  
Michael Vasovski, DO, Chairman
  3. Consumer Protection / Medical Liability  
David Black, Chairman
  4. Information Technology  
John Supra, Chairman
- VI. Consideration of Committee Recommendations & Report**
- VII. Other Business**
- VIII. Adjourn**

Minutes  
South Carolina Health Planning Committee  
November 10, 2011

The November 10, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Members present were Director David Black, Will Shrader, Evelyn Perry, Tammie King, Dr. Michael Vasovski, Senator Michael Rose, Representative David Mack, Dr. Casey Fitts, and Tim Ervolina. Director Tony Keck joined by conference call. Representative Joan Brady attended on behalf of Representative Bill Sandifer. Department of Insurance staff present were Kim Cox, Rachel Harper, Helen Ann Thrower and Ella Dickerson.

Mr. Thibault welcomed members and guests to the meeting and reviewed the proposed agenda. Mr. Shrader moved to approve the November 10, 2011 agenda as presented. The motion was seconded by Mr. Ervolina and approved.

Mr. Thibault asked the members to review the minutes from the November 1, 2011 meeting. Mr. Thibault asked if there were any changes. Representative Mack moved that the November 1, 2011 minutes be approved. The motion was seconded by Director Black and approved.

Mr. Thibault introduced Paul Stordahl, Vice President, UnitedHealthcare. Mr. Stordahl presented the views, thoughts, and advice to the states from UnitedHealthcare on health insurance exchange development as well as UnitedHealthcare's thoughts and theories on the basic health plan option as defined by the ACA. He emphasized the importance of reaching the maximum number of consumers to keep prices down and reduce the number of uninsured in the state while minimizing disruption in the small business market. Mr. Stordahl estimated that two-thirds of the uninsured will be eligible under the expansion of Medicaid and that 20 to 25 percent of the uninsured will be buying in the exchange. It is also important to remember that 50% of the US population falls below 400% of FPL.

Senator Rose commented that the primary goal should be to increase the accessibility of health care; he reminded the group that health insurance isn't the only way to do that. He asked if it would be possible to let employers contract with providers directly in a way that is not considered insurance. Mr. Stordahl clarified that he equates accessibility with having insurance because reality is that if a person doesn't have insurance they will not be seen by a health care provider. The question of whether health care providers can directly contract with employers will be determined by whether they are legally allowed to take on that much risk without a certain level of financial reserves.

Mr. Ervolina added that the goal of the ACA is not to get more customers for insurance companies it's about making people healthier. He asked about guarantee

issue and open enrollment periods. Mr. Stordahl answered that open enrollment periods are important because it prevents people from buying insurance the moment they need it rather than before they need it, that it helps prevent adverse selection.

Dr. Vasovski asked Mr. Stordahl for specifics about the federal and hybrid exchanges. Mr. Stordahl responded that it appears the federal exchange will be an active purchaser model, however, final regulations have not been published. He added that it is anticipated that the hybrid model will be administratively complex.

Ms. Perry asked how the disruption in small businesses be minimized when the disruption seems to be that the fines are less than the premiums. Mr. Stordahl answered that one thing to worry about is whether small businesses will stop coverage when they feel like the employee has no other option. The flexibility given to the states includes the ability to define the small group by 50 or by 100 for the first two years. Those who are under 50 full time employees do not have a mandate. Some employers may even feel that they are doing their employee a disservice to continue coverage because the subsidy provides better insurance than what the employer can offer.

Because of time and other meeting obligations, the Committee proceeded to Subcommittee Reports. Director Keck provided an update on the Competitiveness and Transparency Subcommittee. Director Keck stated that he had put together a draft report and the Subcommittee will meet to discuss the draft next week. He stated he would have a final Subcommittee Report to present to the Committee shortly thereafter.

Mr. Thibault asked Mr. Stordahl to continue with the question and answer session. Dr. Fitts asked if the Basic Health Plan. Mr. Stordahl reviewed the Basic Health Plan and added that those who are deemed eligible for the BHP will not have the option of being on the exchange.

Mr. Thibault asked how are the states are approaching funding the exchanges. Mr. Stordahl discussed the options being considered including advertising on the exchange. UHC would encourage broad assessment from those who benefit from the exchange because all who participate should share the cost equally.

Mr. Stordahl added another way to minimize the risk of employers dropping health insurance coverage is to keep the individual and small group markets separate because the individual market is going to be more expensive than the small group.

Mr. Thibault thanked Mr. Stordahl for his presentation.

The next item on the agenda was consideration of Subcommittee Reports. The Committee discussed the process for their consideration and there was general consensus that the Committee would hear and accept the Committee reports with recommendations to be considered at their next meeting. Mr. Thibault reviewed the Consumer Driven Health Plans Report. Dr. Vasovski moved that the report be accepted. The motion was seconded by Representative Mack and unanimously approved.

Director Black reviewed the Consumer Protection-Medical Liability Subcommittee Report. Mr. Ervolina moved that the report be accepted. The motion was seconded by Dr. Fitts and unanimously approved.

Mr. Supra presented the Information Technology Subcommittee Report. Director Black asked if Mr. Supra had heard anything about cost from other states. Mr. Supra answered that the subcommittee discussed the size and scope of the early innovators and they were from \$25-40 million on initial implementation that grouped eligibility with the exchange, but it is important to split those out by program. Dr. Vasovski made the motion to accept the subcommittee's report. The motion was seconded by Mr. Shrader and unanimously approved.

Mr. Thibault reminded the group that discussion of the individual recommendations will be held the next week when the committee has received all of the reports.

Mr. Thibault noted the additional information from Dr. Oldendick that was in their packet.

Dr. Fitts stated that the group seems to have come to good consensus and that it is important to include the need for further discussion as a recommendation. Senator Rose agreed with the need for further discussion and asked the chairman what the process will be if a consensus is not reached. Mr. Ervolina expressed his feeling that the committee may need to have a minority report.

Mr. Thibault asked if there was any further business to come before the Committee. With no further business, Dr. Vasovski made the motion to adjourn. Mr. Ervolina seconded the motion which was approved.



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## AGENDA

### South Carolina Health Planning Committee

November 18, 2011

LCI Committee Room  
4<sup>th</sup> Floor, Blatt Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
Gary Thibault, Chairman
- II. Adoption of Agenda**
- III. Consideration of November 10, 2011 Meeting Minutes**
- IV. Consideration of Committee Recommendations & Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
South Carolina Health Planning Committee  
November 18, 2011

The November 18, 2011 meeting of the South Carolina Health Planning Committee was called to order by Gary Thibault, Chairman. Members present were Director David Black, Will Shrader, Evelyn Perry, Tammie King, Senator Michael Rose, Representative David Mack, Dr. Casey Fitts, Director Tony Keck and Tim Ervolina. Department of Insurance staff present were Kim Cox, Helen Ann Thrower and Ella Dickerson. Andy Dvorine joined by conference call.

Mr. Thibault welcomed the Committee members and guests and reviewed the agenda and the progress the Committee has made. Dr. Fitts moved to adopt the agenda. The motion was seconded by Director Keck and unanimously approved.

Director Black moved approval of the minutes of the November 10, 2011 meeting. The motion was seconded by Mr. Shrader and unanimously approved.

Mr. Thibault directed the attention of the members to the draft copy of the Committee Report and opened the discussion with summaries of the subcommittee reports from the subcommittee chairmen.

Director Keck presented the Competitiveness and Transparency Subcommittee report and addressed each recommendation. The Committee discussed the report. Senator Rose moved to adopt the Competitiveness and Transparency report's four recommendations verbatim. This motion was seconded Mr. Ervolina and unanimously approved.

In the absence of Dr. Michael Vasovski, Mr. Thibault presented the Consumer Driven Health Plans Subcommittee (CDHP) report and addressed each recommendation. The Committee discussed the report, noting that a selection of the CDHP subcommittee report should be included in the executive summary of the full committee report. Director Black moved the adoption of recommendations 1,2,4,5 and 6 found on pages 8 and 9 of the CDHP report. Mr. Shrader seconded the motion which was unanimously approved.

Dr. Fitts moved to adopt CDHP recommendation 3, page 9, striking the language "Basic Health Plan Option" and "Basic Health Plan" from the recommendation. The motion was seconded by Ms. Perry and unanimously approved.

Representative Mack joined the meeting.

Director Black presented the Consumer Protection-Medical Liability Subcommittee report and addressed each recommendation. Senator Rose moved that the CPML Subcommittee's recommendations 1 – 3 concerning consumer protection, page 5, be approved. The motion was seconded by Director Keck and unanimously approved. Senator Rose moved the adoption of Subcommittee recommendations 1 – 9, regarding medical costs, reflecting the Committee's desire for review by the legislature, be approved. Director Black seconded the motion. The motion was unanimously approved.

In the absence of John Supra, Director Keck presented the Information Technology Subcommittee report and addressed each recommendation. He stated that the intent of document was to be advisory to the Committee.

The Committee proceeded to discuss additional recommendations from members of the Committee.

Senator Rose proposed that the Committee recommend that the legislature consider the possibility of modifying or abolishing the Certificate of Need Program. After discussion, no motion was made.

Senator Rose proposed that the Committee recommend that the legislature consider allowing individuals and employers to contract directly with health care providers for medical services, and that it not be considered insurance. After discussion, no motion was made.

Senator Rose proposed that the Committee recommend that the legislature consider the possibility of South Carolina joining into a Congressional-approved interstate compact with other states that would enable South Carolina, rather than the federal government, to control health care regulation and expenditures in South Carolina.

Senator Rose made the motion that Committee members read his November 18 email concerning interstate compacts, ask any questions that they may have, and express whether they would like it to be a part of the Committee report. Ms. Perry seconded the motion. The Committee discussed the motion.

Director Keck moved the following amendment to the motion: that the Committee report include an addendum which would allow members to join in Senator Rose's specific recommendations that were not discussed in subcommittee. Ms. King seconded the motion. The Committee discussed the motion. It was clarified that if a majority voted to include this recommendation in the report then it will become part of the list of recommendations in the report. If a majority did not support it, then this recommendation would be included in the addendum - recognizing that the Committee did not have a full discussion. The motion, as amended, was approved. The main motion was unanimously approved.

Senator Rose proposed that doctors who serve Medicaid patients be allowed tax credits. After a discussion, no motion was made.

Senator Rose moved for inclusion in the addendum that the Legislature review the possibility of allowing South Carolinians to purchase health insurance across state lines.

Mr. Ervolina moved that the motion be amended to include language “along with adequate consumer protections that would need to apply.” Senator Rose seconded the motion. After discussion, the amendment failed by a vote of 4 to 5. In favor were Mr. Ervolina, Senator Rose, Ms. Perry and Dr. Fitts. Opposed were Ms. King, Mr. Shrader, Director Keck, Director Black, and Mr. Thibault. The main motion failed by a vote of 3 to 7. In favor were Senator Rose, Ms. Perry and Dr. Fitts. Opposed were Ms. King, Mr. Shrader, Director Keck, Director Black, Representative Mack, Mr. Ervolina and Mr. Thibault.

Ms. King discussed the section of the report regarding licensed agents and brokers. Ms. King moved that additional language be added distinguishing the roles between navigators and agents and allowing for flexibility on compensation. The motion was seconded by Director Keck. After a discussion the motion was unanimously approved.

Mr. Thibault asked if any member had any further recommendations for consideration by the Committee. There being none, Mr. Thibault outlined the timeframe for developing the final report. The second draft of the report, incorporating today’s recommendations, would be sent to the Committee on Tuesday, November 22. Comments would be due on Monday, November 28<sup>th</sup> at 10 am. The final draft would be completed by November 29<sup>th</sup> and the report delivered to the Governor on Wednesday, November 30<sup>th</sup>.

Mr. Thibault thanked the members for their service. Directors Keck and Black thanked Mr. Thibault for leading the Committee to complete its task.

There being no further business, the meeting adjourned.

## South Carolina Health Planning Committee: Presentations and Handouts

Presentations received and handouts distributed during meetings may be accessed on the South Carolina Health Planning website, [www.HealthPlanning.SC.gov](http://www.HealthPlanning.SC.gov). Links to each are provided below.

April 14, 2011

1. Glossary of Health Insurance Terms
2. Summary of New Health Reform Law
3. Final 2004 HRSDA Planning Grant Report: Expanding Insurance Coverage and Stabilizing
4. Requirement to Buy Cover Under the Affordable Care Act Beginning in 2014
5. How People Get Health Coverage Under the Affordable Care Act Beginning in 2014
6. Consumers' Personal Experiences
7. Initial Guidance to States on Exchanges

June 30, 2011

1. Health Planning for SC: Context and Considerations
2. SC Health Care
3. Health Insurance, Costs and Hospitals
4. Health Care Transformation: Research and Equity

July 21, 2011

1. Health and Medical Care  
A Long Journey...
2. Health Marketplace Technologies

August 17, 2011

1. The Faces of Health Care Reform
2. Health Marketplace Technologies
3. SC's Health Care Research Advantage
4. Together We Are Better
5. Achieving Value through Collaboration
6. Establishing Health Insurance Exchanges: An Update on State Efforts

7. Statement of Principles for the Development of an Exchange in South Carolina
8. Follow-Up to Data Requests from the South Carolina Health Planning Committee

September 12, 2011

1. Overview of ACA Capabilities and POV

October 10, 2011

1. SC Perspectives on a Health Insurance Exchange: A Focus Group Research Study
2. Health Insurance in South Carolina

October 17, 2011

None

November 1, 2011

1. Deloitte. The Fiscal Impact to States of the ACA: Comprehensive Analysis
2. Exchanges: A Proposed New Federal-State Partnership
3. CMS: Affordable Insurance Exchanges
4. SCAHU Comments on Exchanges
5. Appendix A: Cross-Sectional Telephone Survey Results
6. The Uninsured in South Carolina
7. Uninsured in South Carolina at Any Point During the Past Twelve Months
8. Information Technology Subcommittee Report

November 10, 2011

1. UnitedHealthcare: Thoughts on The Basic Health Option
2. UnitedHealthcare: Thoughts on Health Benefit Exchange Development
3. Data Research Follow-up Information
4. Report Table of Contents
5. Consumer Driven Health Plans Subcommittee Report
6. Consumer Protection/Medical Liability Subcommittee Report
7. Information Technology Report

November 18, 2011

1. Competitiveness and Transparency Report

## Appendix D

### South Carolina Health Planning Committee: Subcommittees

1. Competitiveness and Transparency
  - a. Membership
  - b. Meeting Agendas and Minutes/Summaries
    - i. July 11, 2011
    - ii. August 11, 2011
    - iii. August 18, 2011
    - iv. August 23, 2011
    - v. September 1, 2011
    - vi. October 6, 2011
    - vii. October 11, 2011
    - viii. November 15, 2011
  - c. Presentations and Handouts
  
2. Consumer Driven Health Plans
  - a. Membership
  - b. Meeting Agendas and Minutes/Summaries
    - i. July 12, 2011
    - ii. September 8, 2011
    - iii. October 12, 2011
    - iv. October 26, 2011
  - c. Presentations and Handouts
  
3. Consumer Protection and Medical Liability
  - a. Membership
  - b. Meeting Agendas and Minutes/Summaries
    - i. July 12, 2011
    - ii. September 8, 2011
    - iii. October 6, 2011
    - iv. October 12, 2011
  - c. Presentations and Handouts
  
4. Information Technology
  - a. Membership
  - b. Meeting Agendas and Minutes/Summaries
    - i. July 12, 2011
    - ii. July 26, 2011
    - iii. August 23, 2011
    - iv. September 28, 2011
    - v. October 25, 2011
  - c. Presentations and Handouts

## **Competitiveness & Transparency Subcommittee**

### **South Carolina Health Planning Committee**

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**Competitiveness & Transparency Subcommittee**  
South Carolina Health Planning Committee  
Agendas and Minutes



# South Carolina Department of Insurance

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## Agenda

South Carolina Health Planning Committee  
Competitiveness & Transparency Subcommittee

July 11, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
3:30 pm

### **I. Introduction**

Tony Keck, Chairman

### **II. Review of Charge**

### **III. Questions We Need to Answer**

### **IV. Timeline**

### **V. Brainstorm Speakers and Other Resources**

## **Competitiveness and Transparency Questions to Answer**

1. Review of ability of South Carolina purchasers (employers and individuals) to find health insurance which best meet their needs in terms of benefit design, network flexibility, risk, price and health outcomes.
  - What information does an individual or employer need to know in order to make an informed decision about which insurance product is best for them? (Keck)
  - According to available research and experience, what role does improving the information and choices available when purchasing insurance play in terms of lowering premiums or improving outcomes? (Keck)
  - When an individual or an employer in South Carolina determines that they want to buy health insurance, where do they most often go to find out how and what plans are available to them? What criteria do they use to make decisions? (Keck)
  - How comprehensive are these sources in terms of competing insurance products, available information and assistance provided to make good decisions? (Keck)
  - Are there any legal, regulatory or business practice barriers that hinder the ability of individuals and employers to make the best choices? (Keck)
  
2. Review of patient's ability in South Carolina to choose the provider which will provide the best service and outcomes for the price which the patient is willing to pay.
  - What information does a patient need to know in order to make an informed decision about which doctor, hospital or other health care provider will best serve their needs? (Keck)
  - According to available research and experience, what role does improving the information available to patients play in terms of lowering the cost of health care and improving outcomes? (Keck)
  - When a patient in South Carolina is choosing a physician, hospital or other provider, where do they most often turn to in order to make a good decision? What criteria do they use to make decisions? (Keck)
  - How comprehensive, accurate, timely and understandable are these sources of quality, outcomes and price? (Keck)
  - Are there any legal, regulatory or business practice barriers that hinder the ability of patients to find and use this information when making a choice of provider? (Keck)
  
3. Review of best practice existing and proposed mechanisms for increasing purchasers and patients ability to find the best value.
  - What states have implemented solutions to accomplish the above in the public and private sector and what do these solutions look like? (Keck)
  - What laws or regulations were implemented to enable these solutions? (Keck)
  - What evidence exists for their effectiveness and what design criteria are associated with success or failure? (Keck)

4. Analysis of the federal government's health insurance exchange mandate and its cost and benefits to South Carolina.
  - What are the components of the health insurance exchange mandate within the Affordable Care act and what are the regulations which will govern the exchange (Keck)
  - What are the history and experience with successful and unsuccessful exchange? (Keck)
  - Have any states entered, or are any states considering entering, into a multi state health care exchange? If yes, which states, at what stages are they and what do these models look like? (Sen. Rose)
  - I am reading about probably hundreds of decisions our committee and subcommittees will have to make about a SC health care exchange. Is someone going to suggest the models we should follow and answers to the questions, or do we committee members need to come up with proposals ourselves? (Sen. Rose)
  - What would be required of the state to pursue a state operated exchange and what would be the benefits over a federal operated exchange? (Keck)
  - What is the feasibility of South Carolina adopting/buying the IT system/software that other states already have developed, instead of SC having to develop an IT system "from scratch". (Sen Rose)
  
5. Recommendations to the steering on potential courses of action to pursue in South Carolina in increase value for purchasers and patients.

Minutes  
Competitiveness and Transparency Subcommittee  
July 11, 2011

The July 11, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Senator Michael Rose, Representative David Mack, Pam Sawicki, Carson Meehan, Kevin Barron, and Dianne Belsom. Subcommittee members Representative Bill Sandifer, Lathram Woodard, and Gregory Tarasidis, MD, were not present. Andy Fiffick attended on behalf of Representative Sandifer and Scott Hulstrand attended on behalf of Dr. Tarasidis. Department of Insurance staff present were Gary Thibault, Ella Dickerson, and Rachel Harper. Joining by conference call were Subcommittee member Casey Fitts, MD, and DOI staff member Andy Dvorine. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Senator Rose moved that the July 11, 2011 Agenda be adopted as presented. The motion was seconded by Rep. Mack and unanimously approved. Director Keck welcomed the members to the first meeting of the Competitiveness and Transparency Subcommittee and after introductions; Director Keck reviewed the charge and deliverables for the Subcommittee.

Senator Rose asked the question of whether the committee intends to bring more insurance plans into the state and referred to a bill regarding cross border purchase of insurance. Director Keck responded that the question of bringing plans into the state may be better answered by one of the other subcommittees and requested that DOI staff ensure that questions deemed appropriate for other subcommittees are addressed.

Director Keck stated that the committee must look at how an exchange will provide benefits and what the cost will be to the state. He reminded the group that the goal is to determine what is feasible. He referred to the newly proposed regulations that were issued earlier that morning and stated that the charge and deliverables must be flexible to adjust to the changing regulations.

Director Keck then referred to the third item on the agenda, the list of questions for the subcommittee to answer. Dr. Fitts voiced the importance of keeping the administrative cost as low as possible in order to prevent funds being spent on admin that could be used for health care. Dr. Fitts expressed the concern of motivating consumers to use the exchange correctly, and also manage their health care correctly and efficiently with the best outcomes. Director Keck suggested that this issue may be a good one for another committee. This was noted by the DOI staff.

Mr. Shrader offered background on how the market works.

Senator Rose brought up the issue of transparency and dissemination of information and packaging of information.

Representative Mack stressed the importance of making the language basic so it can reach more people and thereby be more efficient.

The group agreed and the question was raised of how we are going to make terms like network adequacy, out of network cost, understandable to all. Also mentioned was the issue of patients churning from one type of insurance to the next and how to ensure that healthcare providers know who to send claims to at the time of service.

Director Keck raised another issue that he felt should be addressed by another committee, the issue of integrating our health insurance marketplace with the federal subsidy. This was noted by DOI staff.

Mr. Shrader addressed risk corridors and the idea that risk adjustment must have a zero impact on the marketplace. He stated that while this subcommittee did not need to make any decisions regarding these issues, it is important to be aware.

Senator Rose asked about standardization of plans, to which Mr. Shrader explained the benefit levels provided in the Affordable Care Act.

The topic of state versus federal exchange was brought up. Mr. Shrader stated that if the exchange is turned over to the federal government, the state will lose flexibility. He stressed that the exchange will be funded by SC citizens and needs to be beneficial and cost less.

Senator Rose stated that we can learn from other states that are ahead of SC in the establishment process, and Mr. Shrader mentioned the early innovator states.

Diane Belsom raised the question of what would happen if we did not want to implement an exchange, Mr. Shrader answered that there could be tremendous consequences for individuals and for insurance companies that have to comply with other regulations in the ACA.

Representative Mack again reminded the group to not lose focus on the people of the state.

Director Keck closed the meeting by giving next steps which involved finalizing the list of questions, meeting dates, documents that will help, and speakers that may be beneficial.



# South Carolina Department of Insurance

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## AGENDA

### Competitiveness & Transparency Subcommittee

August 11, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
8:30 am

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Consideration of August 11, 2011 Agenda and  
July 11, 2011 Meeting Minutes**
- III. “Flex Points” for States in Health Insurance Exchanges**  
Will Shrader
- IV. Role of Insurance Brokers in the Individual and Small Group Market**  
Tammie King
- V. MMIS National Conference Update**  
John Supra
- VI. Future Meeting Attendees**  
Tony Keck
- VII. Public Comment & Questions**
- VIII. Adjourn**

## **No Wrong Door**

To Support “No Wrong Door”, seamless access to the exchange services is made available to any authorized entity that might connect a consumer to services they need no matter where they go for help

## **State Exchange Web Portal**

The state exchange web portal is the landing pad or web desk top for anyone who interfaces with the state exchange. That could be the Consumer or their helper or state exchange staff performing their operational tasks supporting the exchange.

Consumer Facing Functions:

- Registration
- Application Entry
- Eligibility or Enrollment Status
- Qualified Health Plan Shopping and Plan Comparisons
- Appeals

State Exchange Operational Functions (tools help Exchange employees do their job)

- Call Center tools
- QHP Management tools
- Navigator Management tools
- Federal Eligibility Determination tools
- State Program Eligibility Determinations
- Access to QHP products and information
- Access to Consumer Information

## **Federal Eligibility Hub**

The Federal Government is building an Eligibility Hub for all federal eligibility interfaces. States will not have to create interfaces to the many government entities that provide information to determine eligibility.

## **Public and Private Payor Hubs**

The payor hubs help the state by distributing the HIPAA compliant EDI transactions to the appropriate payors. For instance a BlueCross Association Hub would direct transactions in SC to the Blue Cross family of products which would include distribution to their multiple subsidiaries. A Public Payor Hub would direct transactions in SC to the various participating MCO Payors.

Minutes  
Competitiveness and Transparency Subcommittee  
August 11, 2011

The August 11, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Representative David Mack, Representative Bill Sandifer, Carson Meehan, Kevin Barron, and Lathram Woodard. Subcommittee members Senator Michael Rose and Diane Belsom were not present. Department of Insurance staff present were Gary Thibault, Director David Black, Rachel Harper, Jim Byrd and Ella Dickerson. Joining by conference call were Subcommittee members Casey Fitts, MD, Pam Sawicki, Gregory Tarasidis, MD, and DOI staff member Andy Dvorine. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Keck welcomed the members to the second meeting of the Competitiveness and Transparency Subcommittee and then reviewed the proposed agenda. Representative Sandifer made the motion to approve the agenda. The motion was seconded by Mr. Meehan and unanimously approved. Mr. Meehan moved approval of the July 11, 2011 Meeting Minutes. The motion was seconded by Mr. Shrader and unanimously approved.

Tammie King presented first on the Role of Insurance Brokers in the Individual and Small Group Market. She addressed the existing regulation of agents and brokers, and gave an overview of the provisions in the NAIC Producer Licensing Model Act. She expanded on the characteristics that drive the individual and small group markets and the specific needs that brokers fill for consumers.

Representative Sandifer asked what entity is responsible for the training of agents and do they have legal responsibilities to the quality of their work. Ms. King and Mr. Meehan spoke about the NAHU and their code of ethics. Representative Sandifer asked whether the NAHU code of ethics has any impact of law and how can it be made certain that consumers understand the terms and language in the policies they purchase. Mrs. King answered that the wording in documents are directed to the audience they are meant to serve. She added that NAHU aims to get all agents to use the same processes for conformity. Mr. Hulstrand asked whether NAHU expects the exchange to improve the complexity of the current market.

Director Keck raised the issue of navigators and how the new laws will affect the commission model. Mr. Meehan answered that navigators will not be able to collect a commission. Mr. Shrader expanded on the subject stating that the exchange will pay the navigator; the insurance companies will not be allowed to pay commissions to the navigator. The question becomes, what is the difference between agent, broker, and navigator. Ms. King offered to email the group a presentation on the difference between the three roles.

Representative Mack brought up the issue of physicians and patients having difficulty getting necessary care approved by customer service representatives of insurance companies that may not be knowledgeable. Ms. King answered that insurance companies have licensed physicians and nurses who determine the plan of care for various diagnoses. Mr. Meehan added that there are checks and a balance in place to ensure the insurance company is not denying necessary care. He reminded the group that people want insurance and they want it cheap, in order to keep cost down insurance companies have to ensure that low cost options have been considered before approving the high cost options. Director Keck added that with the right incentives patients and physicians will make the best decisions and rules and regulations should be designed to facilitate this.

Mr. Fiffick asked how a complaint driven system can be fair to the consumers who do not understand the policy language enough to know the level of service and care they are entitled to from their insurance company, and therefore don't know when they should be making formal complaints. Ms. King emphasized that the role of the navigator should be to advise consumers on issues such as these and stressed the importance of having a navigator certification program to ensure the quality of this advice.

John Supra presented a summary of the issues addressed at the MMIS National Conference. He discussed state Medicaid programs and their fear that they will be held ultimately responsible for the success of the exchanges for which they have limited control. The federal government is addressing this concern by proposing to partner with the states on the eligibility components. Most state eligibility systems have become obsolete and are using federal grant funds as an opportunity to improve their technology while remaining compliant with ACA Grant requirements simultaneously. The goal is to set up new IT systems that will drive health outcomes in the future. The way to minimize the risk of investing in new technology is to set it up in a way that is incremental, intermittent, and agile; making the system gradual, with the ability to improve with time and the ability to respond to problems. The challenge is conforming to timelines.

Anne Castro presented on Flexpoints for States in Health Insurance Exchanges. She discussed the State Exchange Model and addressed key areas of options and opportunity for states, adding that a marketplace that operates in this way has a high value for South Carolina regardless of the subsidies. She stated that it is believed that the federally imposed timelines will be flexible. It will be difficult for the federal exchange to meet the deadlines and therefore they will be lenient with the states' progress. Director Keck reminded the group that not knowing what the rules and regulations for state exchanges will ultimately be is a risk in establishing a state health exchange. He stated that it cannot be assumed that the federal government will be flexible. Mr. Keck also questioned why the state should assume the responsibility of marketing, enrollment, account management and billing for privately insured under a federally mandated subsidy program when the agency has as its primary focus purchasing the most

health for the least amount of money for over one million disabled and poor citizens.

Director Keck reviewed speakers for the upcoming Competitiveness and Transparency Subcommittee meetings. Among those listed were Benefitfocus, NCQA, and AHA. He asked the group to please email him with any other suggestions on presentations.

Director Keck asked if there were any comments or questions from the public. Being none, the meeting was adjourned.



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## AGENDA

### Competitiveness & Transparency Subcommittee

August 18, 2011

Room 415, Edgar Brown Building  
Columbia, South Carolina  
10.00 am

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Consideration of August 18, 2011 Agenda and August 11, 2011 Meeting Minutes**
- III. Building An Integrated State Health Benefit Exchange**  
John Emge, Government Programs Manager  
Benefitfocus
- IV. Report on Legislative Conferences**  
Senator Michael Rose
- V. Public Comments & Questions**
- VI. Other Business**
- VII. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
August 18, 2011

The August 18, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Senator Michael Rose, Representative Bill Sandifer, Gregory Tarasidis MD, Carson Meehan, Kevin Barron, and Lathram Woodard. Subcommittee member Diane Belsom and DOI staff member Andy Dvorine joined by conference call. Subcommittee members Casey Fitts MD, Representative David Mack and Pam Sawicki were absent. Department of Insurance staff present were Gary Thibault and Ella Dickerson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Keck welcomed the members to the third meeting of the Competitiveness and Transparency Subcommittee and then reviewed the proposed agenda. Representative Sandifer made the motion to approve the agenda. The motion was seconded by Mr. Shrader and unanimously approved. The Subcommittee then considered the August 11, 2011 minutes. Director Keck requested the following change to the last paragraph of page two: "Mr. Keck also questioned why the state should assume the responsibility of marketing, enrollment, account management and billing for privately insurers under a federally mandated subsidy program when the agency has as its primary focus purchasing the most health for the least amount of money for over one million disabled and poor citizens." Representative Sandifer moved that the minutes be approved with Director Keck's change. Mr. Shrader seconded the motion and the minutes were unanimously approved. Senator Rose requested that the minutes be distributed one day in advance of the meetings.

Director Keck introduced the speakers, John Emge and John Wilson of BenefitFocus. They provided a brief background of their company's resume including their work creating IT solutions for state health insurance exchanges. They stressed that the four key factors for a successful exchange: outreach, enrollment, integration and experience. They expanded on each of these factors and how they are addressed by their design. The software capabilities that are required by CMS were discussed and the idea of software as a service. They provided suggestions for shopping for a software vendor and defining the scope of involvement of that vendor.

The floor was opened to questions and Senator Rose asked how BenefitFocus handles emergencies or loss of service. Mr. Emge answered that BenfitFocus has a disaster recovery plan for the backup of the data that meets requirements set by law. Senator Rose asked whether the customer is in control of the data or is the data the property of BenefitFocus. Mr. Emge answered that the data belongs to the customer and that the source code and system will remain accessible. Senator Rose

## Competitiveness & Transparency

### Minutes

August 18, 2011

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asked if a state may contract with BenefitFocus to create the entire exchange. Mr. Emge answered that BenefitFocus can provide all of the web based solutions but cannot create or oversee the financial management of premiums, risk adjustment, etc.

Director Keck stated that in the state versus federal exchange debate, the federal government is offering to act as a contractor for these services. Mr. Emge responded that the federal government may have limited components to choose from and may make one standard solutions. No one knows yet.

Representative Sandifer stated that he believes it is important for many carriers to be included in the exchange. He asked Mr. Emge if all carriers would have the technical capabilities to work within the BenefitFocus system. Mr. Emge stated that BenefitFocus has the ability to work with all carriers.

Mr. Shrader asked about disclosures regarding rates. Mr. Emge answered that every page of the website has disclosures at the bottom.

Ms. King asked about verification of employee/employer relationship. Emge and Wilson described the process involved in this verification.

Mr. Wilson raised the issue of usability and the BenefitFocus approach of "one thought per screen." He stated that the system must be designed in a way that the customer does not feel the need to contact the call center because the call center is an expensive part of the operation. The customer should not need to call the call center, or return to the paper application method.

Director Keck asked whether the subsidy calculations will be real-time. Mr. Emge answered that while the team is very focused on the user experience, for an expedited process he is not sure how real-time will work. Mr. Shrader answered that it was his understanding that there will be certain identifying questions that will allow an estimate of the subsidy amount but for the actual amount to be determined it may take up to 90 days. The customer may be allowed to enroll until the end of the verification process. Director Keck asked if the subsidy information would be linked to tax returns in some way. Mr. Shrader answered that there will be questions regarding subsidy amount received on tax returns, and that employers will receive tax benefits for purchasing through SHOP.

Mr. Emge and Mr. Wilson listed other companies that are exploring the 90/10 market of health insurance exchanges. Mr. Meehan stated that with so many companies available to contract, there will be options in the event that a company is not meeting our needs.

The group was reminded by Mr. Thibault and Director Keck that, under ACA, the exchange must be a government agency, non-profit or quasi-governmental entity.

Senator Rose raised the issue of variables that will affect the establishment of exchanges such as elections, court cases and spending cuts. He suggested doing less for less risk. He stated that at

## Competitiveness & Transparency

### Minutes

August 18, 2011

Page 3 of 3

conferences he has attended on the subject, the consensus is to do little or nothing due to risk and variables. Whatever decision is made, he stressed the importance of getting the information to the lawmakers before voting time. Representative Sandifer responded that in his conversations, the majority of states are taking the minimal approach that will still avoid fines or federal take-over. He agreed with Senator Rose that the idea must be packaged appropriately in order to gain support. He reminded the group that he and Representative Mack serve on the committee that will be making this decision and that it will be given fair hearings and people will be asked to testify before the committee.

Director Keck reminded the group of the presentation submitted by Ms. King, Agents, Brokers and Navigators: Issues to Consider When Creating A State-Based Health Insurance Exchange. This presentation will be discussed in the next meeting.

Representative Sandifer made the motion to adjourn. The motion was seconded by Ms. King and approved.



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## **AGENDA**

Competitiveness & Transparency Subcommittee

August 23, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
3:00 pm

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Consideration of August 23, 2011 Agenda and August 18, 2011 Meeting Minutes**
- III. Continuation of Discussion Integrated Health Benefit Exchanges**
- IV. Other Business**
- V. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
August 23, 2011

The August 23, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Senator Michael Rose, Representative David Mack, Casey Fitts MD, Carson Meehan, and Diane Belsom. Andy Fiffick and Wyman Bowers attended for Representative Bill Sandifer and Gregory Tarasidis MD respectively. Subcommittee members were unable to join by conference call due to EMD and hurricane planning. Subcommittee members Lathram Woodard, Kevin Barron, and Pam Sawicki were absent. Department of Insurance staff present were Gary Thibault and Ella Dickerson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Keck welcomed the members to the fourth meeting of the Competitiveness and Transparency Subcommittee and then reviewed the proposed agenda. Mr. Shrader made the motion to approve the agenda. The motion was seconded by Ms. King and Ms. Belsom and was unanimously approved.

Director Keck requested that subcommittee members review the minutes that were presented. Dr. Fitts motioned to approve the minutes; the motion was seconded by Ms. King and unanimously approved.

The next item on the agenda was a continuation of the discussions from past meetings. Ms. Belsom mentioned the BenefitFocus meeting and asked how they are funded. Director Keck answered that they are funded by different entities such as insurance companies or governments. Ms. Belsom asked if tax payer money would be used if we contracted with BenefitFocus. Director Keck described the operations of an exchange as existing in buckets, one on the front end, one for processing subsidies, one for back office operations, and one for managing new regulations. Reflecting on the presentation made by BCBS's Anne Castro, Director Keck stated that he felt it was laid out very well. He addressed the concept of "least amount" and stated that it is the moving target of the design process.

Senator Rose addressed the group by saying that a state can create an exchange without approval or create one and have it rejected. He asked if it caused more harm or more good to establish an exchange because of the risks associated with it. Senator Rose stated that he wants to examine other ways of funding public insurance such as a process similar to retainers for lawyers, but designed for physicians and hospitals.

Dr. Fitts reminded the group that we need to reform how we utilize healthcare and that this is an excellent time to accomplish it. He stated that we need to be fiscally responsible and that once the risk has been evaluated get South Carolina's people covered so they may afford healthcare. Director Keck answered that he felt the ability to affect affordability through insurance and exchange is not

realistic. We want insurance to be transparent through competition but this is only a small portion of the healthcare dollar. The healthcare delivery system needs to be more affordable. He stated that we shouldn't give people subsidies to purchase products that are overpriced; rather we should devise a solution to improve the delivery system.

The topic of non-profit entities was brought up and Director Keck asked if SC has any existing non-profits that could achieve an ACA compliant exchange. Mr. Shrader clarified that in the law it states the non-profit must be newly created.

Senator Rose stated that there may never be a better opportunity to achieve an improved and more efficient healthcare delivery system for SC. If we do not act we may forever lose this opportunity. Directed to Representative Mack, he stated that he is having a difficult time packaging the idea politically. If it is polarizing we won't get anything accomplished. If we mobilize people we will make more impact. Mr. Shrader made the point that if we don't succeed, the federal government will take over the insurance market of the state. Ms. Belsom stated that the federal government will not likely have enough funds to accomplish taking over the insurance market for the many states that may refuse to create exchanges. Mr. Shrader replied that the federal government can get the funds they need. Senator Rose stated the more the private sector can do with minimal federal involvement, the more success South Carolina will have with an exchange.

Representative Mack stated that the country is currently divided on this issue and whether there is a mandate or not we need to do what is best for the people. Local, state, and federal governments need to be more efficient. Smaller government doesn't make sense because we are a big country. The US needs to find balance. Senator Rose asked whether our state may require, as a condition of establishing a state exchange, that the private sector have one as well. Director Keck clarified that the question meant an exchange that is not necessarily compliant with the ACA but rather is designed the way we want it to be for South Carolina. Senator Rose confirmed the question and added that the designed exchange could possibly be adapted to the federal plan if need be, but rather than start the planning process with the federal guidelines in mind, start the planning process with the needs of South Carolinians in mind. Director Keck further clarified that the proposition was to create a marketplace based exchange with which Medicaid would integrate.

Mr. Shrader stated that the ACA is the law and insurance companies are going to have to comply with it or face fines. He agrees that we should do the bare minimum and sell it as progress.

Mr. Shrader raised the issue of opting out of the Medicaid program entirely and the effects of that decision on other states. Director Keck asked if there will be dual track regulations. Mr. Shrader answered yes. Director Keck asked what would be the regulations and what would be the difference. Mr. Shrader answered that flexibility would be the biggest difference. If the federal government establishes an exchange they will not likely consider the state's regulations, they will make their own. Director Keck requested to see a list of options side-by-side in order for the group to weigh the options;

he also asked if the federal government establishes the exchange for the state will there be a local governing board. Mr. Shrader answered that he is under the impression that the local governing board will not exist under a federal exchange.

Mr. Shrader reminded the group that even if the federal government establishes the exchange for the state, there will still be cost to the state in the form of systems integration. Director Keck agreed and stated that Medicaid will have to prepare for any changes that occur. Our IT group is currently preparing for these changes.

Director Keck addressed Ms. King and stated that he is concerned about the 6,000 insurance brokers and their employees whose entire industry is being turned upside down. Ms. King replied that in the regulations it is stated that they can only be paid by grants, not by insurance companies, and added that a large part of their customer base will be taken away. Brokers have a lot of responsibility and have to be regulated because of HIPAA. Mr. Shrader concurred that there have been concerns raised about protection of data.

Ms. Belsom informed the group that she contacted the SC Policy Council and they told her that whether the state or the federal government runs the exchange the end result will be the same. Mr. Shrader answered that the end result will not be the same because of the restriction of flexibility. Mr. Meehan agreed with Mr. Shrader and brought forth the issue of the federal government controlling the market outside of the exchange as a result of controlling the market inside of the exchange. Mr. Shrader agreed and said that the law states that it must be one pool and the benefits and rating requirements must be the same on and off the exchange. So in effect the rulers of the exchange govern the insurance market of the state.

Director Keck noted that the issue of a health insurance exchange is both a business and a community issue. Dr. Fitts addressed the group with his feeling that the federal government wants the states to be incubators of innovation. They want us to make an effort and make a good decision and it will be approved with leniency. If the federal government designs an exchange for South Carolina, their plan may not be what is best for us. Our best effort will not be turned down by the federal government, but we may have to make adjustments.

Director Keck asked if there were any comments from the observers of the meeting. There were none. Dr. Fitts made the motion to adjourn. The motion was seconded by Ms. King and approved.



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## Agenda

South Carolina Health Planning Committee  
Competitiveness & Transparency Subcommittee

September 1, 2011

Room 415, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Introduction**  
Tony Keck, Chairman
  
- II. Consideration of September 1, 2011 Agenda and August 23, 2011 Meeting Minutes**
  
- III. Covington and Burling Analysis of the Exchange Portion of the Affordable Care Act**
  
- IV. Other Business**
  
- V. Public Comment and Questions**
  
- VI. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
September 1, 2011

The September 1, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Casey Fitts, MD, Senator Michael Rose, Gregory Tarasidis, MD, Carson Meehan, and Dianne Belsom. Subcommittee members Kevin Barron, Lathram Woodard, Pam Sawicki and DOI staff member Andy Dvorine joined by conference call. Department of Insurance staff present were Gary Thibault, Director David Black and Ella Dickerson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Keck welcomed the members and reviewed the proposed agenda. Dr. Fitts made the motion to approve the agenda. The motion was seconded by Mr. Meehan and unanimously approved. Mr. Meehan made the motion to approve the minutes from the August 23, 2011 meeting. The motion was seconded by Ms. King and unanimously approved.

Director Keck introduced Caroline Brown, an attorney with Covington and Burling of Washington, D.C. Ms. Brown has represented the South Carolina Department of Health and Human Services on a number of Medicaid issues and has twenty years experience in Medicaid. She began by stating that the ACA gives states three options: meet the regulations, exceed the regulations, or allow the federal government to run the exchange. In the proposed form, the rules are extensive. The state may add to the federal regulations but cannot fall short of the federal regulations.

The flexibility lays in how it is governed. She illustrated examples such as merging the individual and small group markets, whether to permit brokers to enroll consumers, how to select plans once they meet the minimum requirements, and how to define small employer. The list of flexpoints is small and most states are struggling with the task of the exchange running seamlessly with other systems when there is a sharp division line between those who are eligible for the subsidies and those who are eligible for Medicaid. There will most likely be considerable churning, mostly among those with incomes between 100 and 200 percent of the federal poverty level.

Ms. Brown stated that an exchange must work closely with the Department of Insurance because the rules of the exchange will determine the market outside of the exchange as well. It is important to work together to avoid adverse selection and conflicting regulations. This leads to the bigger question, state or federal.

Dr. Tarasidis asked Director Keck to clarify his quote in a recent State Newspaper article. Director Keck responded that the Governor is not going to ask for additional money from the federal government to implement a health insurance exchange. If there is value to an exchange and the system

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September 1, 2011  
Minutes

is designed around the private sector, private entities should be willing to fund it. It has been the consensus so far that we will take a minimal approach which should not require the amount of money that is being awarded to states in these grants. Rather than chase the dollars, we want to achieve our state health objectives. Dr. Tarasidis asked if the state is still pursuing a state exchange using this minimal approach. Director Keck responded that a minimal approach will be taken but whether it needs to be attached to federal law has not been agreed upon. From there, the federal government will have to make decisions.

Senator Rose asked which is more risky, state or federal. Ms. Brown answered they both have risk because we don't know how an exchange is going to look. Senator Rose asked whether it made more sense for the state to wait since the federal government can take it over anyway. Ms. Brown answered that the initial years are when states really need a seat at the table. Director Keck asked Ms. Brown if she felt that the federal government is equally as dependent on the states to implement the federal exchange locally and therefore will include states in the process. Ms. Brown stated she could not predict the level of dependency. With state involvement, there are opportunities for better coordination.

Ms. King raised the issue of compensation for brokers. Ms. Brown stated that agents and brokers can be navigators but cannot be paid by insurance companies. The default position is that they cannot enroll consumers; however the state still has flexibility. One flexpoint is whether the navigators have to be licensed or contracted. The federally operated exchange will contract with brokers. Under a state operated exchange, the state could elect to allow brokers to be paid, for example, in the small group market.

Senator Rose asked if Ms. Brown could predict whether the individual mandate will be deemed unconstitutional. She answered that she could not predict that. If it were deemed unconstitutional, and the rest of the Affordable Care Act goes forward, it may not be wise from an economic or financial sense, but the rest of the ACA, which is very comprehensive, will go forward. She added the climate in Washington is not conducive to technical corrections. Senator Rose asked if the states should wait for the ruling to happen before going forward in order to show a united stance against the individual mandate. Ms. Brown answered that she does think that would impact the Supreme Courts consideration.

Dr. Fitts raised the issue of the Basic Health Plan option for the state of SC. Ms. Brown stated that the rules for the Basic Health Plan rule have not been established but it is an option for states to cover the people that fall in-between. However, it is not funded like Medicaid - rather it is funded through the exchange. The Basic Health Plan captures the population that is expected to churn. States are interested in it, on the condition that it can be targeted in certain ways to better manage and simplify churning. States may find that it will be easier to get health insurance plans to participate in the exchange if 200% FPL and below are not included. The amount the states get from the Basic Health Plan

is based on commercial rates, but they'll be providing Medicaid type services, so they may be able to run the plan with only the money given to the state. She added states could be paid more generously under the Basic Health Plan. Other states are looking at this as an effective option to address enrollment issues.

Ms. King asked if there are any regulations on the exchange regarding access to providers. Ms. Brown answered that there are not regulations that are specifically applied to physicians, but there are regulations that require the health plans offered to have an adequate provider network, which is left to the state to define. Director Keck added that the current state mechanism is quality tests, but the federal government is becoming more prescriptive on that process. He asks if this flexpoint is really flexible or is it simply the guise of flexibility. Ms. Brown answered that she believes this flexpoint is truly flexible.

Dr. Tarasidis asked Ms. Brown how much a minimalist exchange will cost. She answered that the enrollment changes are handled through Medicaid, and then the accounting issue is assigned the expense in state dollars. Software cost, management cost, people cost. The system is supposed to simplify the enrollment process making the determination of eligibility easier. Most of the cost is in the system. The dollar amounts of the grants that are being awarded to states, when compared to the systems they are implementing, are appropriate.

Dr. Fitts stated that he believes the federal government is not going to have time to implement exchanges in many states. Ms. Brown state that the federal exchange will be generic and could be implemented in many states.

Ms. Brown added that the federal government allows states to seek a waiver, create a new idea in lieu of an exchange in 2017 and there has been legislation trying to move the date to 2014. Mr. Meehan informed the group that Vermont has opted to have a state funded health plan rather than an exchange that is designed to work like a single payer system. There is a question of whether they will receive a waiver from the federal government. He asked how likely it is that there will be tougher restrictions on what can be sold. Mr. Shrader answered that the pooled market means rating will be performed as an entity and rates inside and outside the exchange, so prices will be the same. There will not really be an off-the-exchange market, the two will just blend with what plans can be offered, how to count employees, network adequacy, operating details of plans. Premiums for the on and off-the-exchange market will go up because of guarantee issue, rate tier reductions, and underwriting of the individual market. Mr. Thibault asked what the rate increases would have been over the next few years. Mr. Shrader answered that rates are determined by the cost of care and added that without the individual mandate we will not have a functioning insurance market. There will be immediate conflict between state and federal law until 2016 when we have to transition to 100 employee definition of small employer.

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Director Black asked what are the top ambiguities. Ms. Brown answered eligibility for premium subsidies - where Medicaid has historically been calculated monthly, the federal subsidy is yearly. There is also the questions of how to deal with families that apply for premium subsidies when individual family members will be covered under different programs. On the employer side, there are questions of when and how the penalty will be applied for not offering coverage. There will be issues involving coordination and communication between employers and the exchange. The tax issue with the premium subsidy is very complicated. It is only available to individuals and involves the IRS and anticipated income then becomes kind of a tax return issued from year to year. Someone will have to explain it to all taxpayers.

Director Keck closed the conversation with the question of how much establishing an exchange is going to cost and where in the system is that cost already. Are we just moving cost or are we still leaving the cost out there, or are we actually adding to the cost? He then asked for questions or comments from the audience. There being none he motioned to adjourn.



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## AGENDA

### Competitiveness & Transparency Subcommittee

October 6, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
3:00 pm

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Consideration of October 6, 2011 Agenda and  
September 1, 2011 Meeting Minutes**
- III. Recap of Regional Meetings and National Conference**  
Tony Keck  
John Supra  
Gary Thibault
- IV. Consideration of Process and Initial Discussion of Subcommittee  
Recommendations**
- V. Public Comment & Questions**
- VI. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
October 6, 2011

The October 6, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Tony Keck, Chairman. Subcommittee members present were Will Shrader, Tammie King, Senator Michael Rose, Carson Meehan and Representative David Mack. Gregory Tarasidis, MD, joined the meeting via conference call and Andy Fiffick attended on behalf of Representative Bill Sandifer. Department of Insurance staff present were Gary Thibault, Director David Black, Kim Cox and Ella Dickerson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Keck welcomed the members and reviewed the proposed agenda. Mr. Shrader made the motion to approve the agenda. The motion was seconded by Senator Rose and unanimously approved.

Director Keck introduced John Supra who presented a recap of regional meetings and a national conference on the topic of health insurance exchanges. Mr. Supra informed the group of three exchange documents that are currently up for public comment and stated that the federal government is seeking input. He added that the original question of state versus federal has now become state, federal or hybrid. He outlined the meetings he attended and stated that the division of duties between the federal government and states is by function rather than constituencies served. Most states are responding that there is limited flexibility and that they don't need help with the core functions but rather they need help with the parts of the ACA that are unknown to the states. Mr. Shrader asked if it seemed the federal officials were open to alternatives. Mr. Supra stated that they seemed open to listening to other options. The Subcommittee discussed minimal approaches that assist the market to function better and promote better health.

Director Keck reminded the group that the Executive Order calls for the SCHPC report to be submitted by October 28, 2011 and the need to get an answer to the federal government in a timely manner. He added that there may be value in expanding on the work to include more detail such as exact implementation methods for alternative plans of action. Mr. Shrader added that it is very important for states to let the federal government know their position and, in South Carolina's case, present them with alternatives that would work for us. This method will have the best odds of getting a rational alternative that is federally approved. Mr. Supra agreed and stated that we do not know what a federal exchange looks like. Our goal is to find out what is best for SC and build on our state exchange our own way that improves both the market and health in our state. Director Keck reiterated the point of South Carolina maximizing the likelihood of doing what we want without the federal government imposing what they want on us? In doing what we want we are making progress, but we have to have a strategy that keeps the federal government from imposing a solution because we will lose that battle.

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Representative Mack reminded the group that without many initiatives that came from the federal level, like the Civil Rights Legislation, he would not be a member of the Legislature and would not be allowed to participate in the current meeting. He stress that the topic needs to be examined more closely to see what is best for the people of South Carolina. There are a lot of parts of the Affordable Care Act that are good, but there has to be a balance and the bottom line is what is best for South Carolina.

Mr. Meehan stated that it is unclear what we expect the exchange to do. It will not reduce the cost of insurance, it will not change delivery, it will not increase competition, and it will not affect the off-exchange market. All it will do is add another spreadsheet for people to access and we already have this capability. Mr. Shrader stated that it comes down to control. Even though it will not affect the off-exchange market directly, it will affect it indirectly. There is less risk to say to the federal government no we are not going to do what you want, but here is what we are going to do. It lets them know that we are taking action to solve the problem in our state, just not in the way they have prescribed.

Director Keck asked Mr. Thibault to explain to the group the process by which the larger committee will be coming to its decision. Mr. Thibault reviewed the remaining schedule, noting that the research conducted by USC will be presented at the Full Committee's meeting Monday, October 10 and that the Committee would address the remaining schedule at that meeting. In order to have a full report completed by the end of October subcommittee reports would be needed soon. It will be a tough task to meet the deadline. Director Keck concurred and added that most of the information from the various presentations just came out within the past three months. The Subcommittee discussed the process for developing its report and recommendations. Senator Rose added that the tight timeframe makes him concerned that we will leave good ideas out like Dr. Fitts' Tri-County Project. There is so much report worthy material but the deadline is a problem.

Director Black stated that the Department of Insurance is aiming to meet the deadline; it's fair to assume that we will have good material to turn in by the deadline, but will have further information to submit in November.

Director Keck asked for public comment, there being none Representative Mack moved to adjourn. The motion was seconded by Mr. Meehan and approved.



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## AGENDA

### Competitiveness & Transparency Subcommittee

October 11, 2011

Capitol Center  
1201 Main Street  
Suite 1280  
Columbia, South Carolina  
3:00 pm

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Adoption of October 11, 2011 Agenda**
- III. Consideration of September 1 and October 6, 2011 Minutes**
- IV. Improving Quality in Health Care**  
Sarah Thomas, Vice President  
Public Policy & Communication  
National Committee for Quality Assurance
- V. Ehealth**  
Sam Gibbs, President  
Government Services
- VI. Consideration of Subcommittee Recommendations**
- VII. Public Comment & Questions**
- VIII. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
October 11, 2011

The October 11, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Director Tony Keck, Chairman. Subcommittee members present were Teresa Arnold, Kevin Barron, Representative David Mack, Pam Sawicki and Will Shrader. Dianne Belsom and Dr. Casey Fitts joined by conference call, Andy Fiffick attended on behalf of Representative Bill Sandifer and Scott Hulstrand attended on behalf of Dr. Gregory Tarasidis. Department of Insurance staff present were Gary Thibault, Kim Cox, Director David Black, and Ella Dickerson.

Director Keck welcomed the members and guests and reviewed the agenda. Representative Mack moved that the agenda be approved. The motion was seconded by Ms. Belsom and unanimously approved. Mr. Shrader made the motion to approve the minutes of the September 1 and October 6 meetings. The motion was seconded by Representative Mack and approved.

Director Keck thanked AARP for the conference room and introduced Sarah Thomas, Vice President, Public Policy and Communication, National Committee for Quality Assurance. Ms. Thomas thanked the group for the opportunity to speak on "Getting Better Value for the Healthcare Dollar" and provided a brief history of the NCQA. She stated that accreditation can be seen as a way to codify the average, but NCQA sees it as a way to push people to best practices, noting that if all plans were performing as well as the best plans there would be billions of dollars in hospital care saved. NCQA focuses on private insurance and physician accreditation, but the development of ACO's is pulling them into the hospital industry as well.

Ms. Thomas discussed patient centered medical homes, PCMH, an initiative to address shortages in primary care by helping them manage their patients with chronic conditions through tools that will save them time, allowing for more time to work one-on-one with patients while achieving savings in health care spending.

Exchanges are opportunities to drive a value agenda. If you want only 5 or even 100 plans in your exchange you can still push patients toward low cost and high quality. If you don't point people in the right direction they will make a choice based on something and they deserve information on quality and price. Ms. Thomas reviewed "Choice Architecture," organizing options in a way that influences choice such as putting worst plans last, and how behavioral economics comes into play.

On the subject of navigators and brokers, Director Keck asked if NCQA has done anything about what type of training and knowledge base brokers need to have to help

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people move through the system. Ms. Thomas answered that advocates have been very interested in using people in churches or hairdressers, but NCQA is not sure that is good enough, there is a certain level of knowledge required to be a broker. Director Keck agreed stating that the skill set is wide from brokers to churches. With insurance being something that is complicated including tax credits and premiums, this is something that brokers are better trained to do.

Ms. Thomas concluded stating BCBS in Massachusetts has been giving providers data on what happens to their patients after they are referred out to hospitals or specialists. The data is showing that when physicians see poor outcomes, they will begin referring their patients to facilities that offer better quality of care. She noted that health plans have more incentive to improve the system this way.

Dr. Fitts commented that overall what we want to do is push toward uniformity and quality care, but there are concerns that when you push everyone to be taken care of by the top 10% of providers then we still have a shortage. He added that we need to elevate the bottom 10% and then pull them up later. Ms. Thomas stated that you don't want the poor performers to give up, but you do want them to try, so there are some current initiatives for payment for improvement.

Director Keck introduced Sam Gibbs, President of Government Services, Ehealth. Mr. Gibbs began with background information on Ehealth, that they have been running a type of health insurance exchange for several decades and noted the importance to build a set of technologies that the average person can use. Ehealth conducts focus groups about some of the features to get user feedback and take the approach to focus on the consumer. Ehealth has online insurance agents and you can also speak with one on the telephone. The navigators used are with third party affiliates and experience has shown that it is not as important for them to understand the financials and what the plans are about, but really the importance of having health insurance. They are not going to be good at helping people choose plans but can advocate to the importance of having insurance in general.

Director Keck asked Mr. Gibbs what he thought about the states taking money to build an exchange. Mr. Gibbs discussed the challenges in building an exchange, noting that it is much more than having a website, that it is very difficult to do. Director Keck asked if he believes the states are using the technology that is already built or are they using the money for something else. Mr. Gibbs answered that some want to build from scratch, but Ehealth is a licensing company and most states are taking that option. There are many functions that already exist today, but the subsidy piece is not yet developed. Assuming the law stays in place by 2014, the states have less and less time, so technology companies are trying to get a head start. Ehealth generated different ways to

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solve the problem of narrowing down the choices. The default is by price; the number two consideration is which doctors are in the network. Physician finders sound simple, but the health plans have the doctors listed differently, so even the seemingly simple task of creating a physician finder is very complicated. The third factor is what is everyone else doing and that is where quality scoring comes in. EHealth samples data from the millions of people that have bought over time.

Most of the states are similar to South Carolina and are not sure what the best path is for their state. They see that money is available and are using it to build a minimal exchange designed to meet their goals for their state. That way, even if the exchange idea goes away, at least a marketplace that achieves the goals for your state has been established. Director Keck asked if this process is going to bring so much value that people and employers should be willing to pay for it. If enough employers and individuals were willing to pay for it would there be private entities that would be willing to invest in going after that business. Ehealth designed healthcare.gov and notes that the federal government is nervous that states will not establish exchanges and feels there will be flexibility on what will be approved.

Director Keck asked Mr. Gibbes if he feels the timelines are realistic. Mr. Gibbes answered that in general, the approach is on the right track. However there will be a challenge with IRS type information. The timeframe is a little tough but is doable.

Director Keck referred to the subcommittee's last meeting where the process for developing the subcommittee report was discussed. It was the general consensus that Director Keck would draft the subcommittee report and send it to the members, providing time for review and comment. At that point the subcommittee will meet and discuss the final draft.

Director Keck asked if there were any comments from the public. There being no comments and no further business, the motion was made, seconded and approved to adjourn.



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## AGENDA

### Competitiveness & Transparency Subcommittee

November 15, 2011

Room 252  
Edgar Brown Building  
Columbia, South Carolina  
1:00 pm

- I. Call to Order & Welcome**  
Tony Keck, Chairman
- II. Adoption of Agenda**
- III. Consideration of October 11, 2011 Minutes**
- IV. Consideration of Subcommittee Recommendations & Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
Competitiveness and Transparency Subcommittee  
November 15, 2011

The November 15, 2011 meeting of the Competitiveness and Transparency Subcommittee was called to order by Director Tony Keck, Chairman. Subcommittee members present were Tammie King, Dianne Belsom, Will Shrader and Senator Michael Rose. Dr. Casey Fitts, Pam Sawicki, Kevin Barron, and Dr. Tarasidis joined by conference call. Andy Fiffick attended on behalf of Representative Bill Sandifer, Steve Colquitt attended on behalf of Carson Meehan, and Scott Hultstrand attended to behalf of Dr. Gregory Tarasidis. Department of Insurance staff present were Gary Thibault, Kim Cox, Director David Black, Helen Ann Thrower, and Ella Dickerson.

Director Keck welcomed the members and guests and reviewed the agenda. Ms. King moved that the agenda be approved. The motion was seconded by Mr. Shrader and unanimously approved. Ms. Belsom made the motion to approve the minutes of the October 11, 2011 meeting. The motion was seconded by Mr. Shrader and approved.

Director Keck reviewed the Subcommittee's draft report. He addressed comments that were emailed to him and adjustments that were made to the draft of the report accordingly. Mr. Hultstrand, on behalf of Dr. Tarasidis and the South Carolina Medical Association, presented a list of revised recommendations. He explained the recommendations, the focus on quality measures, ensuring they are accurate both from the perspective of the patient as well as the physician. SCMA asks that the group make the recommendation that any additional burdens not be unfunded and that methods of determining quality be statistically valid with proven accuracy by the state.

Dr. Tarasidis added that the physician community wants to ensure that quality data is accurate, and reviewed their position. The Subcommittee discussed NCQA and other quality information. Mr. Shrader added that it is difficult, from a physician perspective, given because with a small provider the data is going to be too small to be statistically significant.

Mr. Shrader stated that he agreed with the majority of the draft report, that it was a good report. He added that the only difference in opinion was where it discussed the uncertainty of the flexibility of a state-run exchange. He noted that there is complete certainty that if the federal government runs the exchange, there will be no flexibility for the state. To address that, he recommended including language that state maintain control over form and functions, using federal infrastructure where appropriate. He stated that was important for the state to retain as much control as possible, rather than take an all or nothing approach. Director Keck agreed stating that he sees it as the diplomatic approach.

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Director Keck clarified that the group is still encouraging private exchanges, but recommending that the state continue to engage with the federal government. Mr. Shrader agreed adding that the purpose is to offer an alternative, which is one of the charges of the full committee, so the group is accomplishing that goal. In the end, the federal government may say no, but as long as they are willing to continue to remain engaged then we know that they are being flexible. It was the consensus of the Subcommittee to pursue our own recommendations while continuing to engage with the federal government, prepare for what was best for South Carolina and minimize the risk of federal take-over.

The Subcommittee discussed the roles of navigators, brokers and agents.

Director Keck stated he would make the changes discussed, email it to the subcommittee members to review and vote on and once approved send it to the full committee.

Director Keck opened the floor for public comment. Lynn Bailey commented about the health insurance market, consumer input into this process, and the role of the Department of Insurance. Teresa Arnold, AARP, discussed the problems encountered when purchasing supplemental insurance for Medicare, and Medicare Part D. Peter Billings discussed the problems with such cases and the response of the Department of Insurance and the insurance industry. Director Keck and Mr. Thibault discussed the process the South Carolina Health Planning Committee had followed.

Senator Rose made the motion to adjourn. The motion was seconded by Ms. Belsom and approved.

## **Competitiveness & Transparency Subcommittee**

### **South Carolina Health Planning Committee**

Presentations received and handouts distributed during subcommittees may be accessed on the South Carolina Health Planning website. Links to each are provided below.

July 11, 2011

1. [KFF: What Are Health Insurance Exchanges?](#)
2. [Covington PPACA Memo #12: State Health Insurance Exchanges](#)
3. [Covington PPACA Memo #69: The Role of Navigators in the Exchange](#)
4. [Building a National Insurance Exchange: Lessons from California](#)
5. [NAMD: Analysis of Medicaid related provisions in the proposed Exchange regulation](#)
6. [Health Care Cost Comparison Tools: A Market Under Construction](#)
7. [AARP Cronin Report: State Health Insurance Exchange Websites](#)
8. [Early Consumer Testing of New Health Insurance Disclosure Forms](#)
9. [State Insurance Exchange Model Description](#)
10. [Questions to Answer](#)
11. [PPACA Proposed Rule: Establishment of Exchanges and Qualified Health Plans](#)
12. [PPACA Proposed Rule: Standards Related to Resinsurance, Risk Corridors and Risk Adjustment](#)

August 11, 2011

1. [Role of Brokers in the Small Group and Individual Insurance Markets](#)
2. [KFF: What Are Health Insurance Exchanges?](#)
3. [Covington PPACA Memo #12: State Health Insurance Exchanges](#)
4. [Covington PPACA Memo #69: The Role of Navigators in the Exchange](#)
5. [Building a National Insurance Exchange: Lessons from California](#)
6. [NAMD: Analysis of Medicaid related provisions in the proposed Exchange regulation](#)

7. Health Care Cost Comparison Tools: A Market Under Construction
8. AARP Cronin Report: State Health Insurance Exchange Websites
9. Early Consumer Testing of New Health Insurance Disclosure Forms
10. State Insurance Exchange Model Description

August 18, 2011

1. Agents, Brokers and Navigators: Issues to Consider When Creating A State-Based Health Insurance Exchange

August 23, 2011

None

September 1, 2011

1. Exchanges: SC Action Required to Preserve Flexibility and Regulation Authority

October 6, 2011

1. Exchanges: A Proposed New Federal-State Partnership

October 11, 2011

1. Getting Better Value for the Health Care Dollar
2. Health Insurance Exchanges

November 15, 2011

None

## **Consumer Driven Health Plans Subcommittee**

### **South Carolina Health Planning Committee**

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**Consumer Driven Health Plans Subcommittee**  
South Carolina Health Planning Committee  
Agendas and Minutes



# South Carolina Department of Insurance

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## AGENDA

Consumer Driven Health Plans Subcommittee  
South Carolina Health Planning Committee  
July 18, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
1:30 pm

- I. Call to Order & Welcome**  
Dr. Mike Vasovski, Chairman
- II. Review of Subcommittee Charge & Deliverables**
- III. Products and Trends**  
Vicki Whichard  
Director, Strategic Business Development  
Blue Cross Blue Shield of South Carolina
- IV. Timeline**
- V. Other Business**
- VI. Adjourn**

## Minutes

### Consumer Driven Health Plans Subcommittee

July 18, 2011

The July 18, 2011 meeting of the Consumer Driven Health Plans Subcommittee was called to order by Dr. Mike Vasovski, Chairman. Committee members present were Mr. Gary Thibault, Mr. Will Shrader, Senator Michael Rose, Ms. Evelyn Perry, Dr. Casey Fitts and Mr. Mark Riley. Department of Insurance staff present were Ella Dickerson and Rachel Harper. Joining by conference call were subcommittee members Ms. Teresa Arnold, Mr. Howard Einstein, Mr. Daniel Gallagher and Mr. Stephen Poole. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Dr. Vasovski welcomed subcommittee members and guests and reviewed the Subcommittee's charge and deliverables. "The Subcommittee will review approaches which lead to better pricing and more appropriate utilization of health care services and its effect on the health insurance market. The Subcommittee will review past efforts to foster the health insurance market for small groups and individual policies and the outcomes of those programs."

#### Deliverables

1. Review health savings accounts and high deductible policies and their effect on health care costs.
2. Review the history of high risk pools and their effectiveness, both in terms of benefits and provided costs.
3. Review the history of small business cooperatives and their effectiveness.
4. Review how creating changes in how we consume health care effects costs.

The next item on the agenda was a presentation on Products and Trends by Vicki Whichard, Director, Strategic Business Development, Blue Cross and Blue Shield of South Carolina. Ms. Whichard reviewed traditional plan designs and consumer directed health plans. She reviewed the objectives of consumer driven health plans, medical flexible spending accounts, qualified high deductible health plans, health savings accounts and health reimbursement accounts. Ms. Whichard also reviewed health incentive accounts, value based incentive design and trends in consumer directed health plans.

The Subcommittee discussed various aspects of the presentation. Senator Rose asked how everyone will understand this information, given that it is complicated with many choices. Mr. Riley answered that there will be minimum standards with what can be offered and this will decrease the number of choices. Mr. Shrader addressed the issue of what drives people in their choice of insurance. He noted that the driver is cost and that the plans outlined by the ACA are richer than many plans offered today and will be more expensive which may deter people from purchasing insurance through the exchange.

Dr. Vasovski stated that in a large portion of bankruptcies, health care debt is a factor; even the wealthy cannot afford catastrophic injury. He asked whether lifetime maximums are still in effect. Mr. Shrader answered that lifetime maximums are no longer permitted and annual limits will not be allowed beginning January 2014.

The Subcommittee discussed the cost of health plans. Dr. Vasovski asked what the basic plans offered in the Exchange will cost the average family of four. Evelyn Perry answered giving examples of employee backgrounds and their experience covering them through her business' small group insurance plan. Dr. Vasovski gave some examples of patients' experiences with insurance coverage. Mr. Einstein gave some averages and stated he would forward the information to the group via email.

Mr. Shrader raised the option of Value Based Benefit Design that allows patients to be rewarded for making healthy choices and reforming the way providers are paid so it is based on outcomes. Dr. Fitts referred to a five year Diabetes Management study that made patients' outcomes better but was not continued because of inadequate reimbursement. Mr. Riley concurred that patient compliance is difficult to manage and that a patient's level of health education and understanding is a key factor. He stated that incentives that are currently offered are not attracting enough people.

Dr. Vasovski stated that if incentives for healthy choices wouldn't work then perhaps consequences for unhealthy choices were a good option. He raised the issue of consequences for smoking. Mr. Shrader stated that some health conditions aren't clearly caused by poor choices, some may be caused by either poor choices or genetics, like obesity or high cholesterol.

Mr. Shrader stated that the large public health issues are not going to be solved through a benefit plan. Ms. Perry concurred stating that she felt that the uninsured in the state will not be paying their own insurance premiums, so why would they react to an incentive in premium costs, and the individual covered under small group plans will only see diluted price incentives. Dr. Fitts raised the point that people's inherent health choices are going to be a slow generational change and incentives will only make a small difference in a large social issue. He stated that he felt the subcommittee should be focusing on how to get the uninsured into the health care system so that are not a pure loss.

Dr. Vasovski asked if there were any questions from the public audience. A member of the audience brought forth subject of research on how to change community behavior. Another audience member stated that he felt the vast majority have a complaint about not being able to make consumer driven decisions without support services. He stated that he felt that to have get better decisions from consumers, consumer were going to require really good support services to aid them in the decision making process. Dr. Vasovski concurred stating that it should be easier to figure out how much medical services cost. Mrs. Perry asked if there was a resource for to calculate the cost of health care services. Mr. Shrader answered that Blue Cross and Blue Shield of South Carolina's system will take your exact benefits and calculate what it will cost to have certain procedures performed in hospitals, but that they do not have physician charge information yet. Ms. Perry replied that most people expect insurance to take care of it all. Mr. Shrader agreed and stated that the idea of Consumer Driven Health Plans is to get people to consider the payments that are being made on their behalf.

Senator Rose suggested incentivizing people to use health providers that offer the lowest charge. Mr. Shrader replied that the measure would have to include quality, not just cost and the information would have to become available. Mr. Gallagher stated via conference call that the concept has been in use for decades where the patient pays higher or lower co-pay amounts depending on where they choose to receive services but there has to be competition to drive it. Mr. Shrader mentioned that there would have to be contractual obligations but that it was possible.

Dr. Vasovski asked if anyone could give an overview of the concept of cooperatives. Mr. Riley responded that employers are required to sign a five year agreement without knowing what the rates will be in five years and at this time the risk is so high that cooperatives cannot get rated.

Ms. Arnold commented via conference call that she would go over a report on consumer access at the next meeting.

Senator Rose raised the issue of states returning grant money and asked the group what they think the state will do. In meetings he has attended it sounded like a good option because the federal government is controlling it by mandating it and have the option of taking it over anyway. He reminded the group of the importance of identifying a clear cost benefit in the plan for a state exchange. He asked to see a list of the bare minimum requirements.

Dr. Fitts reminded the group that the committee's charge is to determine whether or not the state should have a state run exchange and that should be the discussion. Mr. Thibault agreed and reviewed the Governor's order for the group.

There being no further business the meeting adjourned.



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## AGENDA

Joint Meeting  
Consumer Protection / Medical Liability Subcommittee  
Consumer Driven Health Plans Subcommittee  
September 8, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
David Black, Chairman  
Consumer Protection / Medical Liability Subcommittee  
  
Dr. Michael Vasovski, Chairman  
Consumer Driven health Plans Subcommittee
- II. Individual and Small Group Insurance Markets**  
Dan Gallagher, President  
United Healthcare Community Plan  
  
Jeffery Maddox, Vice President  
United Healthcare
- III. Other Business**
- IV. Adjourn**

**Minutes**  
**Joint Meeting**  
**Consumer Driven Health Plans and Consumer Protection Medical Liability Subcommittees**  
**September 8, 2011**

The September 8, 2011 joint meeting of the Consumer Driven Health Plans and Consumer Protection Medical Liability Subcommittees was called to order by Director David Black, Chairman, and Gary Thibault. Subcommittee members present were Will Shrader, Evelyn Perry, Senator Michael Rose, Dr. Casey Fitts, Teresa Arnold, Mark Riley, Stephen Poole, Cynthia Williams, Dan Gallagher, and Weldon Johnson. Department of Insurance staff present were Ella Dickerson and Andy Dvorine joining by conference call. Also in attendance was Martha Browne, United Health Care, and joining by conference call were subcommittee member Dr. Gregory Young and United Healthcare presenter Craig Hankins. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Black welcomed the members of both subcommittees and reviewed the agenda. Mr. Riley moved that the agenda be adopted. The motion was seconded by Ms. Williams and approved. Director Black asked the members of both subcommittees to review the minutes from their respective meetings on July 12 and July 18, 2011. Director Black asked if there were any changes. Mr. Riley moved that the minutes from July 18, 2011 Consumer Driven Health Plans Subcommittee Meeting be approved as submitted. The motion was seconded by Mr. Shrader and approved. Mr. Shrader moved that minutes of the July 12, 2011 meeting of the Consumer Protection Medical Liability Committee be approved. The motion was seconded by Senator Rose and approved.

Director Black introduced the presenter, Dan Gallagher, subcommittee member and president of United Healthcare Community Plan. Mr. Gallagher, Ms. Browne and Mr. Hankins presented on Individual and Small Group Insurance Markets. They distributed two documents: "Thoughts on Health Benefit Exchange Development" and "Thoughts on Basic the Health Plan Option." The group stressed the importance of getting a holistic view of the health care of its members. In order to achieve this we must identify complex health care decisions that members have to make (which includes decisions involving complexity in cost), and pair members with providers of good quality and efficiency rating.

The floor was opened for questions. Ms. Perry asked what party makes the final decision. Ms. Browne answered that the member will has the final decision making power. The idea is to use positive and practical innovation to improve health care of the members, but not to dictate their health care choices. Consumer driven health plans help change consumer behavior, they address the paradox of consumer behavior versus consumer intentions and the nuances of consumer decision making behavior when faced with complicated health issues. Consumer driven health plans aim to create a balance of awareness, motivation, and knowledge to elicit more optimal consumer decision making.

Mr. Thibault asked if the numbers reflect that people choosing the consumer driven health plans were healthier at the time of enrollment? Mr. Hankins stated that it was possible but there was some research had indicated no differences in health status at the outset.

Comparing and contrasting the health savings account behavior of high income versus low income, United Healthcare found that many low income people do contribute to their health savings account despite their financial challenges which include meeting deductibles. The goal is to engage consumers to better health with activation messaging, wellness benefits, premium designation programs, treatment cost estimators, and a Quicken expense tracker. Ms. Williams asked if the language used to guide members through this process was understandable to all consumers and were there other language options. Ms. Browne answered yes, the vocabulary and sentence structure is on a sixth to eighth grade level and the programs offer several language choices.

Senator Rose stated that he was impressed by this technology and wondered why and how we would be able to improve upon it. Why are we discussing all of these issues again when the technology already exists for us to utilize?

United Healthcare's Craig Hankins demonstrated United Healthcare's Care Cost Estimator for the group. It is designed to help consumers save money when procedures have a large variation in cost depending on provider and facility. Ms. Perry asked if there will be data on the outcomes. Senator Rose asked to what extent is the consumer allowed to choose poor quality due to the lack of ability to afford high quality. Is there a level of quality demanded by United Healthcare? Mr. Hankins answered that high quality and high cost do not always coincide, and that there will be quality standards.

Ms. Williams asked if there will be tools available to guide people to financial assistance when they cannot afford the care they have been prescribed. This would keep patients in a prevention mode rather than a reaction mode. Mr. Hankins answered that he does envision that application being developed as the system evolves.

The floor was opened for discussion and it was stated that the group needs to hear from the business community. Mr. Riley answered that he and his colleagues work with employers everyday on what they need to do for 2014. They are being advised and know they need to prepare but are frustrated by the fact that there is no answer yet. What we are currently creating is not a new insurance; it's a portal for accessing the information to make it transparent and competitive.

Ms. Perry commented that she feels that the people of South Carolina have unique needs; the exchange needs to be designed for SC by SC rather than accepting a cookie-cutter model designed by the federal government. Mr. Shrader agreed and stated that the big decision to be made is state or federal exchange. Ms. Williams asked the chairmen if the committee is still exploring the option of a state exchange. Director Black answered that this time the state will not be seeking additional funding

from the federal government but the state is still exploring the options of a state or federal exchange utilizing state resources only.

Senator Rose requested the information of the risks involved with the state and federal exchange option. Mr. Shrader referred him to the matrix from the meeting of the Competitiveness and Transparency Subcommittee.

Ms. Williams responded to a question posed at the last meeting about online quality resources. She provided the members with the following websites: [www.healthgrades.com](http://www.healthgrades.com), [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov), and [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov).

Director Black asked if there were any further comments or questions. There being none, he asked Mr. Thibault for a progress update. Mr. Thibault informed the group on upcoming meetings of the South Carolina Health Planning Committee and its subcommittees. Director Black thanked United Health Care for their presentation noting that it was very helpful to both subcommittees.

There being no further business the meeting adjourned.



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## AGENDA

Consumer Driven Health Plans Subcommittee  
South Carolina Health Planning Committee  
October 12, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
Dr. Michael Vasovski, Chairman
- II. Consideration of October 12, 2011 Agenda and September 8, 2011 Meeting Minutes**
- III. History of South Carolina's Health Insurance Market, High Risk Pools and Coops**  
Andrew Dvorine, ASA, MAAA  
Associate Actuary, South Carolina Department of Insurance
- IV. Consideration of Subcommittee Recommendations / Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
Consumer Driven Health Plans Subcommittee  
October 12, 2011

The October 12, 2011 meeting of the Consumer Driven Health Plans Subcommittee was called to order by Dr. Mike Vasovski, Chairman. Committee members present were Mr. Gary Thibault, Senator Michael Rose, Dr. Casey Fitts and Mr. Mark Riley. Department of Insurance staff present were Andrew Dvorine and Casey Brunson. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Dr. Vasovski welcomed subcommittee members and guests. A quorum was not present. The Subcommittee proceeded with the presentation of Mr. Andrew Dvorine, Associate Actuary of the South Carolina Department of Insurance, on the History of South Carolina's Health Insurance Market, High Risk Pools and Coops.

Mr. Dvorine reviewed the large group, small group and individual markets in South Carolina and the United States. He reviewed the source of health insurance coverage and the number of insurers providing coverage in each of the market segments. Mr. Dvorine also reviewed data from the National Association of Insurance Commissioners on market share, by premium, of the insurers licensed to conduct business in the state and reviewed the number of health insurers in five other southeastern states.

Mr. Dvorine continued his presentation with a history of high risk pools in the state, including legislative history, plan types and eligibility. He discussed how rates were calculated and the provisions for assessments. Mr. Dvorine also reviewed the history of coops in the state focusing on Act 339 in 1994 and Act 180 in 2008. He reviewed the Department of Insurance requirements for coops and informed the subcommittee that to date, only one group has registered with the Department as a health cooperative and that group had not obtained an agreement with an insurer to conduct business in the accident and health insurance market in South Carolina. The Subcommittee discussed the coop provisions in the Affordable Care Act and the differences between a state and federal cooperative.

The Subcommittee set the afternoon of October 26<sup>th</sup> as the date for their next meeting. Members would be asked to be prepared to discuss the Subcommittee's recommendations and report. Senator Rose suggested that the group request the deadline for the South Carolina Health Planning Committee's report be extended sixty days, or at least 30 days, to give it more time to consider and discuss the considerable amount of information and research before it. He also suggest that the Committee's charge be broaden to "strategies and policies to improve the health insurance marketplace", and that the tenure of the Committee be extended. Senator Rose added that the federal and state environments regarding health reform in general and health insurance exchanges in particular are fluid, dynamic and changing. The Committee has received and considered a large amount of information regarding those subjects, and needs additional information available only in the future in order for it to make informed recommendations. Extending the tenure of the Committee would enable

Consumer Driven Health Plans

October 12, 2011 Minutes

Page Two

it to monitor, consider, evaluate and make recommendations regarding new information about health delivery and reform as it becomes available. It would be a loss to South Carolina for the knowledge and insights already acquired by the Committee not to be used in the future as South Carolina makes ongoing decisions regarding health care. Since a quorum was not present, a vote was not taken. It was the consensus of the group that these suggestions be shared with the SCHPC, which Mr. Thibault agreed to do.

There being no further business the meeting adjourned.



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## AGENDA

Consumer Driven Health Plans Subcommittee  
South Carolina Health Planning Committee  
October 26, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
Dr. Mike Vasovski, Chairman
- II. Adoption of Agenda**
- III. Consideration of October 12, 2011 Minutes**
- IV. Consideration of Subcommittee Recommendations and Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
Consumer Driven Health Plans Subcommittee  
October 26, 2011

The October 26, 2011 meeting of the Consumer Driven Health Plans Subcommittee was called to order by Gary Thibault. Subcommittee members present were Teresa Arnold, Mark Riley, Dan Gallagher, Will Shrader, Evelyn Perry, Representative David Mack and Dr. Casey Fitts. Department of Insurance staff present were Kim Cox, Helen Ann Thrower and Ella Dickerson.

Mr. Thibault welcomed the members and guests and reviewed the agenda. Dr. Fitts moved the approval of the agenda. The motion was seconded by Representative Mack and approved.

Mr. Thibault asked the members for any comments or changes to the October 12, 2011 minutes. Mr. Shrader moved the approval of the October 12, 2011 minutes. The motion was seconded by Dr. Fitts and approved.

The Subcommittee reviewed recommendations for the subcommittee report submitted by three members, Mr. Gallaher, Mr. Riley and Mr. Poole. Mr. Gallagher reviewed his letter to the subcommittee. Mr. Riley presented his thoughts on high-risk pools and small business cooperatives. He added that South Carolina needs to create a state-run exchange in order to achieve the goals for South Carolina. Mr. Thibault reviewed Mr. Poole's comments.

Mr. Shrader suggested that the subcommittee combine what has been offered into a subcommittee report and added that Mr. Gallagher's message is a good one. He felt that the first point that should be made in the report is that the goal is to improve the health of the people of South Carolina by driving toward the goal of greater access to care. The next point that should be made in the report is an analysis of short-term objectives that need to be accomplished in order to reach that goal. The third item in the report should be a response to the specific charges and the deliverables of the subcommittee. It is important to note that delivery and payment improvements can be a part of the solution but not the whole solution. The subcommittee discussed Mr. Shrader's recommendations.

The subcommittee reviewed the goals of the Triple Aim: to improve access, improve quality, and reduce cost with the overall vision to improve the health status of South Carolinians. The subcommittee discussed the importance for the state to have control over the exchange rather than the federal government.

The subcommittee discussed the process for drafting its recommendations. The consensus was to recommend the establishment a state-operated exchange and not default to a federally operated exchange. Mr. Gallagher added the importance of keeping it simple and short. Mr. Shrader agreed and added that the state may not

Consumer Driven Health Plans  
Meeting Minutes  
October 26, 2011

have to do every function of the exchange; it should utilize operations that exist, but maintain control.

Mr. Thibault stated that he would draft the subcommittee report according to their discussion and send a draft to each member. The subcommittee report, once approved by the subcommittee members, would be sent to the full committee.

The being no further business, the motion was made to adjourn. The motion was seconded and approved.

## **Consumer Driven Health Plans Subcommittee**

### **South Carolina Health Planning Committee**

Presentations received and handouts distributed during subcommittees may be accessed on the South Carolina Health Planning website. Links to each are provided below.

July 12, 2011

1. [AARP State Health Insurance Exchange Websites Quality and Performance Report](#)

September 8, 2011

1. [UnitedHealthcare: Thoughts on Health Benefit Exchange Development](#)
2. [UnitedHealthcare: Thoughts on The Basic Health Plan Option](#)

October 12, 2011

1. [History of SC's Health Insurance Market](#)
2. [Bulletin 2008-02](#)
3. [SC Health Insurance Pool Documents](#)

October 26, 2011

None

## **Consumer Protection - Medical Liability Subcommittee**

### **South Carolina Health Planning Committee**

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**Consumer Protection - Medical Liability Subcommittee**  
South Carolina Health Planning Committee  
Agendas and Minutes



# South Carolina Department of Insurance

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## AGENDA

Consumer Protection / Medical Liability Subcommittee  
South Carolina Health Planning Committee  
July 12, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
9:30 am

- I. Call to Order & Welcome**  
David Black, Chairman
- II. Review of Subcommittee Charge & Deliverables**
- III. The State of Medical and Hospital Liability In South Carolina**  
Weldon Johnson  
Barnes Alford Stork & Johnson
- IV. Other Business**
- V. Adjourn**

**Minutes**  
**Consumer Protection Medical Liability Subcommittee**  
**July 12, 2011**

The July 12, 2011 meeting of the Consumer Protection Medical Liability Subcommittee was called to order by Director David Black, Chairman. Committee members present were Will Shrader, Senator Michael Rose, Cynthia Williams, Ed Byrd, Weldon Johnson, Gregory Young, and Teresa Arnold. Department of Insurance staff present were Gary Thibault, Ella Dickerson, and Rachel Harper. Joining by conference call were subcommittee members Casey Fitts, MD, Dan Bouknight, MD, and DOI staff member Andy Dvorine. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Black welcomed the members and reviewed the charges and deliverables for the subcommittee. He asked if there any questions regarding the charges and deliverables. With no questions raised, Director Black introduced Weldon Johnson, Subcommittee member and partner in the firm of Barnes, Alford, Stork & Johnson. Mr. Johnson addressed the Subcommittee on "The State of Medical and Liability in South Carolina." He addressed the different types of hospital organizational structure, the Tort Claims Act, charitable immunity, and the history of medical liability in the state.

The floor was opened for questions. Senator Rose asked why hospitals can't have one insurance plan that covers all physicians? Why do physicians have to get their own policies? Mr. Johnson asked the group whether they believed that insurers would be willing to write these policies?

Mrs. Arnold asked for data regarding how many cases were won by plaintiffs and what were the awards in the most recent data. She also brought up the topic of checklists as best practice to avoid mistakes on the front end. Mr. Johnson answered, that while he didn't have the exact number of adverse verdicts and the amounts awarded, those verdicts were increasing.

The group then discussed peer review and their need to be able to investigate why mistakes happen, however the peer review process has turned into a road map for malpractice suits.

Ms. Williams raised the question of whether there is a hospital quality database that is accessible to the public, to make the public aware of the number of incidents that have occurred in that facility.

Dr. Bouknight stressed that peer review process must be maintained for the hospital system to work. Mr. Johnson agreed and addressed the importance of strengthening the peer review process for the state.

Mr. Shrader reminded the group that a 5% reduction in malpractice is actually a very big percentage. He reiterated the importance of introducing measures that eliminate problems on the front

end because if you eliminate the problem, you also eliminate the cost incurred by that problem. He stated that transparency should be considered with providers regarding quality and adverse events. Liability should be tied to best practices.

Dr. Fitts stated that there use to be significant increases in malpractice insurance premiums, but the cap enforced by legislation worked and now there is more competition in the market and fewer increases. He mentioned that SC is currently working with checklists and other procedures to decrease errors. Another issue he raised was the duplication of services that results from the lack of transparency in the patient's medical history (chart).

Mr. Shrader informed the group that BCBS created a Medical Home Network for diabetic patients at a Charleston clinic that worked very well. The number of ER visits for these patients declined, and physicians saw an increase in profits due to earning incentives for better outcomes.

Dr. Fitts expressed his fear that the medical home model paying for outcomes will cause the sickest patients to not be seen in order to achieve better outcomes.

Senator Rose revisited the issue of checklists and stated that he thought it should be expanded upon by the group beyond just surgical use, that it should be all encompassing.

Ms. Arnold brought up the topic of advanced directives and that the ability of physicians to honor advance directive without the threat of lawsuit would greatly decrease the high medical expenditures due to end of life care.

Mr. Byrd addressed a few of the challenges of transparency, efforts to inform consumer of the importance of compliance and good health practices, how to get patients involved in their own care, and how to educate the user on how to access and understand the transparent information.

Mr. Johnson reminded the group that peer review is directly tied to quality improvement. Director Black reaffirmed that a checklist should be used to improve quality and Dr. Young stated that he would be interested to see the checklists for specific disease best practices along with other care.

Dr. Fitts suggested that the liability awards be standardized for each procedure raising the question of whether a leg is worth the same for everyone. Mr. Johnson added that it is not that simple, and unfortunately there are occurrences when evidence based medicine does not apply. There are some things that can be standardized, which is a great way to reduce cost, but requires initial investment in technology. He used the example of SC's new stroke center. Dr. Fitts agreed stating that sometimes patients' situations don't fit into the checklist format.

There being no further business the meeting adjourned.



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## AGENDA

Joint Meeting  
Consumer Protection / Medical Liability Subcommittee  
Consumer Driven Health Plans Subcommittee  
September 8, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
David Black, Chairman  
Consumer Protection / Medical Liability Subcommittee  
  
Dr. Michael Vasovski, Chairman  
Consumer Driven health Plans Subcommittee
- II. Individual and Small Group Insurance Markets**  
Dan Gallagher, President  
United Healthcare Community Plan  
  
Jeffery Maddox, Vice President  
United Healthcare
- III. Other Business**
- IV. Adjourn**

**Minutes**  
**Joint Meeting**  
**Consumer Driven Health Plans and Consumer Protection Medical Liability Subcommittees**  
**September 8, 2011**

The September 8, 2011 joint meeting of the Consumer Driven Health Plans and Consumer Protection Medical Liability Subcommittees was called to order by Director David Black, Chairman, and Gary Thibault. Subcommittee members present were Will Shrader, Evelyn Perry, Senator Michael Rose, Dr. Casey Fitts, Teresa Arnold, Mark Riley, Stephen Poole, Cynthia Williams, Dan Gallagher, and Weldon Johnson. Department of Insurance staff present were Ella Dickerson and Andy Dvorine joining by conference call. Also in attendance was Martha Browne, United Health Care, and joining by conference call were subcommittee member Dr. Gregory Young and United Healthcare presenter Craig Hankins. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Director Black welcomed the members of both subcommittees and reviewed the agenda. Mr. Riley moved that the agenda be adopted. The motion was seconded by Ms. Williams and approved. Director Black asked the members of both subcommittees to review the minutes from their respective meetings on July 12 and July 18, 2011. Director Black asked if there were any changes. Mr. Riley moved that the minutes from July 18, 2011 Consumer Driven Health Plans Subcommittee Meeting be approved as submitted. The motion was seconded by Mr. Shrader and approved. Mr. Shrader moved that minutes of the July 12, 2011 meeting of the Consumer Protection Medical Liability Committee be approved. The motion was seconded by Senator Rose and approved.

Director Black introduced the presenter, Dan Gallagher, subcommittee member and president of United Healthcare Community Plan. Mr. Gallagher, Ms. Browne and Mr. Hankins presented on Individual and Small Group Insurance Markets. They distributed two documents: "Thoughts on Health Benefit Exchange Development" and "Thoughts on Basic the Health Plan Option." The group stressed the importance of getting a holistic view of the health care of its members. In order to achieve this we must identify complex health care decisions that members have to make (which includes decisions involving complexity in cost), and pair members with providers of good quality and efficiency rating.

The floor was opened for questions. Ms. Perry asked what party makes the final decision. Ms. Browne answered that the member will has the final decision making power. The idea is to use positive and practical innovation to improve health care of the members, but not to dictate their health care choices. Consumer driven health plans help change consumer behavior, they address the paradox of consumer behavior versus consumer intentions and the nuances of consumer decision making behavior when faced with complicated health issues. Consumer driven health plans aim to create a balance of awareness, motivation, and knowledge to elicit more optimal consumer decision making.

Mr. Thibault asked if the numbers reflect that people choosing the consumer driven health plans were healthier at the time of enrollment? Mr. Hankins stated that it was possible but there was some research had indicated no differences in health status at the outset.

Comparing and contrasting the health savings account behavior of high income versus low income, United Healthcare found that many low income people do contribute to their health savings account despite their financial challenges which include meeting deductibles. The goal is to engage consumers to better health with activation messaging, wellness benefits, premium designation programs, treatment cost estimators, and a Quicken expense tracker. Ms. Williams asked if the language used to guide members through this process was understandable to all consumers and were there other language options. Ms. Browne answered yes, the vocabulary and sentence structure is on a sixth to eighth grade level and the programs offer several language choices.

Senator Rose stated that he was impressed by this technology and wondered why and how we would be able to improve upon it. Why are we discussing all of these issues again when the technology already exists for us to utilize?

United Healthcare's Craig Hankins demonstrated United Healthcare's Care Cost Estimator for the group. It is designed to help consumers save money when procedures have a large variation in cost depending on provider and facility. Ms. Perry asked if there will be data on the outcomes. Senator Rose asked to what extent is the consumer allowed to choose poor quality due to the lack of ability to afford high quality. Is there a level of quality demanded by United Healthcare? Mr. Hankins answered that high quality and high cost do not always coincide, and that there will be quality standards.

Ms. Williams asked if there will be tools available to guide people to financial assistance when they cannot afford the care they have been prescribed. This would keep patients in a prevention mode rather than a reaction mode. Mr. Hankins answered that he does envision that application being developed as the system evolves.

The floor was opened for discussion and it was stated that the group needs to hear from the business community. Mr. Riley answered that he and his colleagues work with employers everyday on what they need to do for 2014. They are being advised and know they need to prepare but are frustrated by the fact that there is no answer yet. What we are currently creating is not a new insurance; it's a portal for accessing the information to make it transparent and competitive.

Ms. Perry commented that she feels that the people of South Carolina have unique needs; the exchange needs to be designed for SC by SC rather than accepting a cookie-cutter model designed by the federal government. Mr. Shrader agreed and stated that the big decision to be made is state or federal exchange. Ms. Williams asked the chairmen if the committee is still exploring the option of a state exchange. Director Black answered that this time the state will not be seeking additional funding

from the federal government but the state is still exploring the options of a state or federal exchange utilizing state resources only.

Senator Rose requested the information of the risks involved with the state and federal exchange option. Mr. Shrader referred him to the matrix from the meeting of the Competitiveness and Transparency Subcommittee.

Ms. Williams responded to a question posed at the last meeting about online quality resources. She provided the members with the following websites: [www.healthgrades.com](http://www.healthgrades.com), [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov), and [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov).

Director Black asked if there were any further comments or questions. There being none, he asked Mr. Thibault for a progress update. Mr. Thibault informed the group on upcoming meetings of the South Carolina Health Planning Committee and its subcommittees. Director Black thanked United Health Care for their presentation noting that it was very helpful to both subcommittees.

There being no further business the meeting adjourned.



# South Carolina Department of Insurance

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## AGENDA

Consumer Protection / Medical Liability Subcommittee  
South Carolina Health Planning Committee  
October 6, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
11:00 am

- I. Call to Order & Welcome**  
David Black, Chairman
- II. Consideration of October 6, 2011 Agenda and  
September 8, 2011 Meeting Minutes**
- III. History of the Health Insurance Markets in South Carolina**  
Andrew M. Dvorine, ASA, MAAA  
Associate Actuary, South Carolina Department of Insurance
- IV. Other Business**
- V. Adjourn**

Minutes  
Consumer Protection /Medical Liability Subcommittee  
October 6, 2011

The October 6, 2011 meeting of the Consumer Protection-Medical Liability Subcommittee was called to order by Director David Black, Chairman. Subcommittee members present were Will Shrader, Senator Michael Rose, and Cynthia Williams. Subcommittee member Gregory Young, DPM, joined by conference call. Department of Insurance staff present were Gary Thibault, Andrew Dvorine, Kim Cox, Cathy Cauthen and Ella Dickerson.

Director Black noted that a quorum was not present so the September 8, 2011 minutes would be considered later if a committee member joined the meeting and a quorum was present. Otherwise, today's presentation would be received as information and the September 8 minutes would be considered at the next meeting of the Subcommittee.

Director Black introduced Andrew Dvorine, Actuary with the South Carolina Department of Insurance. Mr. Dvorine presented on the history of health insurance markets in South Carolina. He reviewed the uninsured population in South Carolina and the development of the insurance markets since the early 1990s. He reviewed the current large employer market and the small group marketplace. Mr. Dvorine included discussion of small group reforms designed to improve the availability of health insurance coverage, including rating restrictions, limitations on pre-existing condition exclusions, guaranteed issue requirements, guaranteed renewal and portability of coverage.

Mr. Dvorine reviewed several pieces of state legislation enacted including Act 131 in 1991, Act 339 in 1994 and Act 5 in 1997. He reviewed their effect on the marketplace.

Mr. Dvorine continued with a review of the individual health insurance market and concluded with general comments on the competitiveness of the marketplace. He included a list of all the insurance companies, by category – individual, small group and large group - writing health insurance in the state. For the small group, there were twenty-five companies writing with the top five comprising ninety percent of the market. In the 1990s, there were seventy to eighty companies competing for the small group business. In the large group market, there are seventeen companies, and the top two comprised ninety percent of the marketplace. Mr. Dvorine noted that the large group market was a very sophisticated market.

In comparison to other states, Mr. Dvorine reviewed South Carolina's market compared to other states: Alabama, Florida, Georgia, North Carolina, South Carolina and Tennessee. To Mr. Dvorine, the market makeup did not look appreciably different among the states. While each state had its own flavor, the marketplace for health insurance in nearby states was very similar.

Mr. Shrader added that the data on the large group market did not include those companies which were self-insured, which was a very large number.

Ms. Williams asked if there has been concern or action to look at monopolies or antitrust within the state because this doesn't look like a competitive market. Director Black asked Dr. Young if the Milliman Study of Ohio addressed that issue, that Ohio and South Carolina have a similar number of companies with approximately the same market share. Dr. Young said he had read the Milliman Report, that across the country there is an average of 5 companies in each state covering the majority of insured lives. Mr. Shrader commented that South Carolina is not unusual among the states, they have the same level of competitiveness. Ms. Williams concurred and concluded that the exchange must allow an active market. Mr. Shrader agreed and added that the exchange should in fact encourage an active market. Ms. Williams stated that the quality of plans would need to be considered.

Director Black stated that South Carolina is always looking for carriers to enter the market. Whether they find the market in SC to be favorable may be influenced by other factors. He noted that it is a challenge to bring companies to a market that can be unattractive in some areas and attractive in others. More companies equal more competition and more competition is always good, but whether the market can support more companies is the question.

Senator Rose asked if insurance plans have to apply to the Department of Insurance to raise the price of their product. Mr. Shrader answered yes and that rates in the small group market are determined by recent legislation.

Senator Rose asked why hospitals might charge an uninsured person more than a person with insurance. Mr. Shrader added that he was under the impression this had been corrected at hospitals. Senator Rose felt that this was still an issue and stated that we have an imbalance that needs to be remedied.

Ms. Williams stated that she felt the Subcommittee has spent a lot of time on the provider side and she would like to direct some time to the patient side. She distributed a list of questions that address the definition of protecting the consumer within the exchange environment. Senator Rose commented that that this list is a good starting point and what our committee should do is suggest that these items be considered but we don't need to get into the specifics of exactly how it will be done.

Director Black reminded the group that Weldon Johnson will be presenting at the next subcommittee meeting and requested topics for his presentation. Senator Rose suggested checklists and their role in medical liability.

There being no other business the meeting was adjourned.



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## AGENDA

Consumer Driven Health Plans Subcommittee  
South Carolina Health Planning Committee  
October 26, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
Dr. Mike Vasovski, Chairman
- II. Adoption of Agenda**
- III. Consideration of October 12, 2011 Minutes**
- IV. Consideration of Subcommittee Recommendations and Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
Consumer Driven Health Plans Subcommittee  
October 26, 2011

The October 26, 2011 meeting of the Consumer Driven Health Plans Subcommittee was called to order by Gary Thibault. Subcommittee members present were Teresa Arnold, Mark Riley, Dan Gallagher, Will Shrader, Evelyn Perry, Representative David Mack and Dr. Casey Fitts. Department of Insurance staff present were Kim Cox, Helen Ann Thrower and Ella Dickerson.

Mr. Thibault welcomed the members and guests and reviewed the agenda. Dr. Fitts moved the approval of the agenda. The motion was seconded by Representative Mack and approved.

Mr. Thibault asked the members for any comments or changes to the October 12, 2011 minutes. Mr. Shrader moved the approval of the October 12, 2011 minutes. The motion was seconded by Dr. Fitts and approved.

The Subcommittee reviewed recommendations for the subcommittee report submitted by three members, Mr. Gallaher, Mr. Riley and Mr. Poole. Mr. Gallagher reviewed his letter to the subcommittee. Mr. Riley presented his thoughts on high-risk pools and small business cooperatives. He added that South Carolina needs to create a state-run exchange in order to achieve the goals for South Carolina. Mr. Thibault reviewed Mr. Poole's comments.

Mr. Shrader suggested that the subcommittee combine what has been offered into a subcommittee report and added that Mr. Gallagher's message is a good one. He felt that the first point that should be made in the report is that the goal is to improve the health of the people of South Carolina by driving toward the goal of greater access to care. The next point that should be made in the report is an analysis of short-term objectives that need to be accomplished in order to reach that goal. The third item in the report should be a response to the specific charges and the deliverables of the subcommittee. It is important to note that delivery and payment improvements can be a part of the solution but not the whole solution. The subcommittee discussed Mr. Shrader's recommendations.

The subcommittee reviewed the goals of the Triple Aim: to improve access, improve quality, and reduce cost with the overall vision to improve the health status of South Carolinians. The subcommittee discussed the importance for the state to have control over the exchange rather than the federal government.

The subcommittee discussed the process for drafting its recommendations. The consensus was to recommend the establishment a state-operated exchange and not default to a federally operated exchange. Mr. Gallagher added the importance of keeping it simple and short. Mr. Shrader agreed and added that the state may not

Consumer Driven Health Plans  
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October 26, 2011

have to do every function of the exchange; it should utilize operations that exist, but maintain control.

Mr. Thibault stated that he would draft the subcommittee report according to their discussion and send a draft to each member. The subcommittee report, once approved by the subcommittee members, would be sent to the full committee.

The being no further business, the motion was made to adjourn. The motion was seconded and approved.

## **Consumer Protection - Medical Liability Subcommittee**

### **South Carolina Health Planning Committee**

Presentations received and handouts distributed during subcommittees may be accessed on the South Carolina Health Planning website. Links to each are provided below.

July 12, 2011

1. [SC Fairness in Civil Justice Act of 2011](#)
2. [SC Fairness in Civil Justice Act of 2011 Overview](#)
3. [SC Code of Laws Section 40-71-10](#)
4. [SC Code of Laws Section 40-71-20](#)
5. [SC Code of Laws Section 70-71-30](#)

September 8, 2011

1. [UnitedHealthcare: Thoughts on Health Benefit Exchange Development](#)
2. [UnitedHealthcare: Thoughts on The Basic Health Plan Option](#)

October 6, 2011

1. [SC Health Insurance Cooperatives](#)
2. [The Consumer-Operated and Oriented Plan \(CO-OP\) Initiative: Introducing Health Insurance Competition in SC](#)
3. [Bulletin 2008-02](#)
4. [HealthReform GPS: Consumer Operated and Oriented Plan \(CO-OP\) Program](#)
5. [SC Health Insurance Pool Documents](#)

October 12, 2011

1. [History of SC's Health Insurance Market](#)
2. [Bulletin 2008-02](#)
3. [SC Health Insurance Pool Documents](#)

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**Information Technology Subcommittee**  
South Carolina Health Planning Committee  
Agendas and Minutes



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## AGENDA

### Information Technology Subcommittee South Carolina Health Planning Committee July 12, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
2:00 am

- I. Call to Order & Welcome**  
John Supra, Chairman
- II. Review of Subcommittee Charge**
- III. Overview of Technology Requirements & Insurance Marketplaces**  
John Supra
- IV. Discussion on IT Strategies and Approach**
- V. Approach to Subcommittee Deliverable(s)**
- VI. Other Business**
- VII. Adjourn**

Minutes  
Information Technology Subcommittee  
July 12, 2011

The July 12, 2011 meeting of the Information Technology Subcommittee was called to order by John Supra, Chairman. Committee members present were Will Shrader, Tammie King, Senator Michael Rose, Anne Castro, Teresa Arnold, David Patterson, Tom Taylor, Sue Berkowitz and Tim Ervolina with Frank Clarke joining the meeting via conference call. Department of Insurance staff present were Gary Thibault, Ella Dickerson and Rachel Harper. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Supra welcomed the members and reviewed the charges and deliverables for the subcommittee. Mr. Supra asked the members for any comments or questions regarding the subcommittee's charges and deliverables. He then reviewed the Governor's executive order.

Mr. Supra presented an overview of the technology landscape. The main factors addressed were the citizen experience, technology goals and guidance, insurance marketplaces, Medicaid flexibility, ecosystem-interactions and interfaces, and challenges and choices regarding the establishment of a sustainable health insurance online marketplace.

Ms. Arnold informed the group of AARP's Donut Hole Calculator but also addressed the results of an AARP survey that found that 40-50% of Americans age 50 or older have never used the internet. Mr. Supra agreed and stressed the importance of integrating the online tool with navigators that will provide a one-on-one experience. Ms. King noted that the underprivileged do not have computers, but everyone has a cell phone and suggested that cell phone applications be explored.

Mr. Supra agreed and reminded the group that regardless of the method of access, navigators will play an important role because the user will still need a certain degree of instruction and some populations may require more help than others. Ms. King expressed her opinion that navigators must be licensed in order to give accurate guidance to individuals choosing health insurance plans. She suggested having an Exchange Certification process.

Ms. Castro mentioned the importance of the exchange acting as the entry way to all systems, the "no wrong door" approach. Ms. Berkowitz followed Mrs. Castro's comment by suggesting that the navigators should include people who are knowledgeable or licensed in all social services such as SNAP. Mr. Ervolina stressed the importance of integrating these systems in a way that does not duplicate efforts and thus utilizes funds in the most efficient way.

Mr. Supra noted the importance of real-time results in creating an efficient system and continued with a review of Service Oriented Architecture, stating that by using SOA, each system can access other systems and are business rules driven. These systems are scalable and

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July 12, 2011

have the ability to be evolved as technology evolves which will prevent them from becoming obsolete. Ms. Castro asked the question of what legislation needs to happen in order to achieve what the group is exploring. She reminded the group that legislation can “squeeze” what IT can accomplish. Senator Rose reminded the group that the timeline is going to be tight in the legislature and that committee reports must be concise. He stated that technology is going to be the hardest part to break through the legislature due to previous failed IT programs.

Ms. Berkowitz commented that the state may be able to borrow from existing technology being utilized in other states. Senator Rose stated that any borrowed technology would still have to be adjusted to South Carolina’s peculiarities and that will take time.

Mr. Supra addressed the topic of time by emphasizing the importance of evolving the system in a series of phases and referred to existing software companies that have already built exchanges for other states. He stated that the technology being developed by the innovator states is a changing landscape.

Mr. Supra stated that consumers have different needs that require various social services, but if they all enter through the same door and exit through the same door, the system can split into all necessary paths in the middle.

Senator Rose asked if exchanges have been in existence to sell health insurance prior to the ACA. Ms. Castro answered that yes, exchanges have been in existence. Federal subsidies are the only new component, the exchanges are the envisioned way for each state to distribute the subsidies.

Senator Rose informed the group of a report issued by The Heritage Foundation in the late 1990’s and suggested that it would be beneficial to associate the concept of an exchange with The Heritage Foundation in order to win favor in the legislature. He emphasized the need for the verbiage on the exchange website to be understandable by the masses.

Ms. Berkowitz reemphasized the need for an effective consumer assistance program. Mr. Supra expanded on the Senator’s comment that consumers may receive “points” for doing things that encourage healthy living thereby reducing the consumer’s overall health care cost. Ms. Castro expanded further with an example of an incentive for patients that attend their regularly scheduled doctor’s appointments.

Mr. Supra agreed with the importance of studying the problem of the cost of care, but reminded the group that federal money has not been extremely helpful on this front. He stated that incremental change is important for sustainability and that now is the opportunity to move from or improve upon the current system. While the state lawmakers are wary of IT changes and the cost and risk of overhaul, incremental replacement is a way to mitigate the risk of wasting money on obsolete technology.

Mr. Ervolina brought forth the topic of cloud based technology. Mr. Supra stated that Benefitfocus is cloud based. Mrs. Castro added that cloud based technology is a piece of an

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July 12, 2011

overall approach. Mr. Supra stated that the Medicaid eligibility program does not have a good cloud base right now and the group needs to keep in mind the adjustment of code for new rules and the fees associated with this task. Discussed were verification with homeland security and the IRS and the being in real-time according to the regulations of the ACA.

Mr. Supra reminded the group that there are no right or wrong answers, only best answers for our state. He emphasized that the main issues are health planning goals, what components matter the most, understanding the users and their needs. He suggested that part of the process may be changing policies in order to get what we want.

Senator Rose asked how the committee is going to present an IT strategy to the legislature given the problems the state has had in the past. Mr. Supra stated that all strategies have risk and it is important that the risks are clear, measurable, and manageable. IT strategies need to be able to be broken down to weigh successes against failures. He reiterated the importance of setting small attainable goals that allow the system to be scalable, a phased approach.

Ms. Arnold asked for estimates of how much the changes will cost. Mr. Supra stated that Innovator states required \$30-40 million, but reminded the group that these states are models and the partners they chose and other choices they made for their states determined the amount of money they spent. Ms. Berkowitz suggested that to get the legislature to support the exchange the committee should include the cost saving that could be realized in health services, and a more streamlined approach.

Senator Rose asked if it would be better to let the federal government spend their money rather than spend the state's money. Mr. Supra answered that we still have to solve the problem of what to do with the subsidies. The answer is that we can do what we are required to do and do it very well. If we drive toward the intent and spirit of the federal government's guidelines, we will get flexibility in return. If we do nothing, the biggest penalty may be within the Medicaid match.

Mr. Supra began the discussion of next steps for the group. Ms. Arnold suggested the topic of state versus federal exchange. Ms. Berkowitz expressed her opinion that consumers who may benefit will be lost with two separate exchanges. Senator Rose suggested the topic of how to justify the expense of technology while the state is in a deficit, when the federal government is going to establish the exchange regardless. Ms. Castro responded that the expense may turn out to be cost neutral. Mrs. Arnold suggested that for the next meeting Mr. Supra have different approaches identified, and their measurement criteria for the group to evaluate. Senator Rose agreed and added that there should be a cost benefit analysis.

There being no further business, the meeting adjourned.



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## AGENDA

### Information Technology Subcommittee South Carolina Health Planning Committee July 26, 2011

Room 415, Edgar Brown Building  
Columbia, South Carolina  
2:00 pm

- I. Call to Order & Welcome**  
John Supra, Chairman
- II. Consideration of July 26, 2011 Agenda and July 12, 2011 Minutes**
- III. Update from July 21, 2011 Health Planning Committee Meeting**
- IV. Discussion on Strategies and Approach**  
John Supra, Facilitator
- V. Approach to Subcommittee Deliverable(s)**
- VI. Other Business**
- VII. Adjourn**

**Minutes**  
**Information Technology Subcommittee**  
July 26, 2011

The July 26, 2011 meeting of the Information Technology Subcommittee was called to order by John Supra, Chairman. Committee members present were Tammie King, Anne Castro, Teresa Arnold, David Patterson, Dr. James Vaught, Sue Berkowitz with Frank Clarke joining the meeting via conference call. Department of Insurance staff present were Gary Thibault and Cathy Cauthen. Department of Health and Human Services staff present was January Stewart. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Ms. King moved that the Agenda be approved as presented. The motion was seconded by Mr. Patterson and unanimously approved. Ms. Berkowitz moved that the July 12, 2011 Meeting Minutes be approved. The motion as seconded by Mr. Patterson and approved.

Mr. Supra presented an overview of the July 21, 2011 South Carolina Health Planning Committee Meeting focusing on the presentation by Dr. Mark Tompkins of the University of South Carolina who spoke on the history of health care reform and various elements of the Affordable Care Act. Mr. Supra also reviewed the IT update he presented at the July 21 meeting.

Mr. Supra led a discussion on strategies and approaches to meet the needs of health marketplaces for South Carolina and the related information technology considerations. The Committee discussed key strategies for health insurance:

- competitive markets
- right information at right time
- increased choices
- lower costs
- increased transparency

The Committee also discussed broader needs for a health marketplace to support increasing health and health outcomes:

- quality information (provider performance information)
- community wellness approaches
- support for payment reform
- improving access

The Committee discussed the needs for information technology systems that both are generally important to modern IT systems and are expected to be critical to a health marketplace for South Carolina. The discussion included:

- service-based
- modular
- scalable
- standards based
- extensible
- interoperable
- integrated
- federated

The committee discussed the importance of an incremental or phased approach, the ability to leverage existing solutions (commercial, other states, other existing in-state systems). Discussion included software as a service, for a monthly fee, citing Charleston based company BenefitFocus as an example. Goals and objectives for the IT system were discussed, that it be a no wrong door approach, and provide a retail like, user centric experience.

The Committee briefly discussed the continuum of approaches from just supporting a marketplace to establishing an insurance exchange. Included in the discussion was Medicaid existing, Medicaid expansion and subsidies in the commercial market. The economic benefits of different business models were discussed as was risk corridors, risk adjustments and reinsurance. The Committee discussed the additional need to determine what components and the related information technology impacts of the portal/Web experience, a health marketplace, the eligibility/enrollment groups, the role of Navigators and IT, and plan certification processes.

Ms. Arnold discussed AARP's publication "State Health Insurance Exchange Websites: A Review, Discussion and Recommendations for Providing Consumers Information about Quality and Performance." She asked that each member be provided a copy.

Ms. Arnold made the moved that the meeting adjourn. The motion was seconded by Ms. Castro and approved.



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**NIKKI R. HALEY**  
Governor

**DAVID BLACK**  
Director of Insurance

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## AGENDA

Information Technology Subcommittee  
South Carolina Health Planning Committee  
August 23, 2011

Room 415, Edgar Brown Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
John Supra, Chairman
- II. Consideration of August 23, 2011 Agenda and July 26, 2011 Minutes**
- III. Continuation of Discussion on Strategies and Approaches**  
John Supra, Facilitator
- IV. Other Business**
- V. Adjourn**

Minutes  
Information Technology Subcommittee  
August 23, 2011

The August 23, 2011 meeting of the Information Technology Subcommittee was called to order by John Supra, Chairman. Committee members present were Tammie King, Anne Castro, David Patterson, Dr. James Vaught, Sue Berkowitz and Tim Ervolina. Department of Insurance staff present were Gary Thibault and Ella Dickerson. Department of Health and Human Services staff present was January Stewart. The meeting's agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Supra welcomed the members and guests present. Mr. Patterson moved that the July 26<sup>th</sup> meeting minutes be approved. The motion was seconded by Dr. Vaught and approved. Ms. Berkowitz moved that the Agenda be approved. The motion was seconded by Mr. Ervoliina and approved.

The group continued the discussion on strategies and approaches. Ms. Castro reviewed her presentation to the Competitiveness and Transparency Subcommittee and Mr. Patterson reviewed his presentation to the South Carolina Health Planning Committee. Ms. Castro informed the group that she has been asked to serve on a Brookings Institute roundtable that will attempt to break down the timeline to make it less intimidating to the states.

Ms. Berkowitz asked if the full committee has taken a stance against a state health exchange. Ms. Castro answered that their conversation was one about options, risks, and how it will affect Medicaid. Ms. Berkowitz asked if the state/federal hybrid model is an option and raised questions regarding public and private payer hubs. Ms. Castro answered with further explanation of the work flow of her design and John Supra added that the exchange is integrating the federal and private insurance markets. Much of the discussion involved how to approach building the support needed to provide better consumer assistance and ensure that it provides the customer experience of a unified system. The operational impact of this type of customer experience must be discussed and should be brought to the full committee.

Mr. Supra informed the group that there are new announcements almost daily from the federal government. He has recently attended conferences centered on exchanges and eligibility systems. These conferences gave some new insight on how to integrate and allocate resources simultaneously. Even states that currently have well integrated systems are struggling with updating eligibility systems within the timelines required.

The group discussed the importance of determining what is required for 2014 and making a business plan that incorporates the necessary state programs. They discussed the difference in the Innovator grants and the Establishment grants noting that Establishment grants do not require the sharing of innovations with other states, or the ability to integrate with other state systems. Innovator grants require both. Mr. Supra gave an update on the progress made by several states.

Ms. Castro noted that in order for proper integration of SNAP/TANF, the system will have to be built as a state and federal integrated model. Mr. Supra agreed that the concept is the reason for the hybrid exchange model option. Ms. Berkowitz stated that the committee needs to think about the navigator issue carefully. Ms. Castro added that the culture of each state will affect the role of the navigators in that state. Mr. Supra stated that the navigator role is an important one and that, for example, kiosks without support are not very helpful.

Mr. Ervolina addressed the group stating that doing nothing is not an option. He added that if it is done right the exchange will save the state millions of dollars in preventing duplication of effort. Ms. Castro added that if federally operated exchange is chosen, the 600 SC Medicaid eligibility workers may lose their jobs. Ms. Berkowitz disagreed stating that CMS is concerned with getting eligible people enrolled and the eligibility workers are essential to that process.

The Subcommittee discussed the technology matrix and the marketplace diagram that were designed in the previous meeting. Mr. Supra stated that the goal is to improve our procedures and policies. He asked for other issues to complete the grid such as pulling together systems that have been independent and governance structure.

Ms. Castro reminded the subcommittee members that neither the federal government nor the states have the ability to create it all. Mr. Supra added that there is still the concern of building an exchange under a regulation set that does not yet exist. He added that the medical community is experiencing many changes simultaneously such as ICD-10 implementation, but those programs should come together in about five years and provide the ability to have payment reform.

Regarding the subcommittee report that will be due at the end of the process, Mr. Supra volunteered to outline the report and assign sections to members in order to have a working draft in a couple of weeks.

There being no further business, the meeting adjourned.



# South Carolina Department of Insurance

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## AGENDA

Information Technology Subcommittee  
South Carolina Health Planning Committee  
September 28, 2011

Room 415, Edgar Brown Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
John Supra, Chairman
- II. Consideration of September 28, 2011 Agenda and August 23, 2011 Minutes**
- III. Continuation of Discussion on Strategies and Approaches  
and Consideration of Report**  
John Supra, Facilitator
- IV. Other Business**
- V. Adjourn**

Minutes  
Information Technology Subcommittee  
September 28, 2011

The September 28, 2011 meeting of the Information Technology Subcommittee was called to order by John Supra, Chairman. Subcommittee members present were Tammie King, David Patterson, Sue Berkowitz, Tim Ervolina and Senator Michael Rose. Will Shrader attended on behalf of Anne Castro. Department of Insurance staff present were Gary Thibault and Ella Dickerson. The meeting's Agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in adherence with the Freedom of Information Act.

Mr. Ervolina moved that the Agenda be approved as presented. The motion was seconded by Mr. Patterson and unanimously approved. Ms. King moved that the August 23, 2011 Meeting Minutes be approved. The motion as seconded by Mr. Patterson and approved.

Mr. Supra briefed the subcommittee on two recent CMS meetings, a regional meeting in Atlanta and a national exchange conference held in Washington, D.C. Generally speaking the discussions encouraged states to come up with ideas and allowed CMS the opportunity to listen to feedback from the states, which seemed to suggest flexibility. Though event attendees were looking for greater clarity on hybrid exchanges, they did not receive it to the degree expected.

Senator Rose attended the Atlanta meeting and stated that he felt the federal government was trying to sell the idea to the states and that no matter how much we try to dress it up the problems of implementation are too great even if everyone had a unified plan from both state and federal point of view.

Mr. Shrader stated that he in general with Mr. Supra's assessment, that the degree of flexibility suggested verbally by CMS may or may not be what is finally published in the regulations. Mr. Supra agreed and noted that the same general feeling was exhibited by other states that were looking for guidance from CMS but did not receive it. Words are very flexible but policies are more rigid. The question before the subcommittee: Where do we find the flexibility and how do we land on it?

Mr. Thibault added that the presentations DC made it clear in that the hybrid model would be a federal exchange, that CMS would be responsible for successful implementation in those states that undertook the partnership. The proposal was for the states and federal government to divide the five core functions: plan management, consumer assistance, eligibility, enrollment and financial management. How the responsibilities would be divided was up to CMS and each state to negotiate. He added that CMS should be coming out with further

regulations later in the year. The federal government seemed to believe the hybrid option was offering added flexibility to the states, but there was disagreement.

Mr. Supra offered his perspective on the five functions stating that the federal government has reserved the policy functions for themselves and left the states with the functions that they have no previous experience operating, in addition to the task of maintaining the infrastructure. Mr. Ervolina commented that it seems that even with the hybrid option we are better off to have a state exchange otherwise we would have to adapt to the federal exchange regardless. Mr. Supra added that the challenge is in how we manage the policy and ensure control of eligibility while at the same time not having to build system after system. How do we do it at lowest cost and risk and how do we leverage it at the right time? The real goal of all of this is to drive health outcomes. He presented his design for an alternative hybrid model. Mr. Supra's model assigned to the states the functions that they already perform while leaving the more complex functions that are new through the ACA to the federal government. This alternative hybrid model allows the consumer to connect with a navigator at several different stages of the process giving the experience certain qualities of case management or a medical home.

Mr. Shrader requested that Mr. Supra share his alternative hybrid design with the federal government, stating that CMS needs to know what the states are looking for as far as flexibility.

Senator Rose added that it makes sense for this committee to be ongoing even after the deadline to develop these ideas. Mr. Supra agreed and stated that even three weeks ago the exchange definitions have changed which speak to this issue. Mr. Patterson stated that we need to establish a consensus vision as stakeholders before we can decide on a model. Senator Rose agreed and stated that the group must also consider what aspects will allow legislation to pass. Mr. Shrader added that South Carolina needs a health policy with the goal of making people healthier. Mr. Patterson agreed and referred to the triple-aim theory.

Mr. Supra, in reference to moving forward with the subcommittee report, suggested that he would draft an outline and that members may add to it as they like. There being no further business, the meeting adjourned.



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## AGENDA

Information Technology Subcommittee  
South Carolina Health Planning Committee  
October 25, 2011

Room 252, Edgar Brown Building  
Columbia, South Carolina  
10:00 am

- I. Call to Order & Welcome**  
John Supra, Chairman
- II. Adoption of Agenda**
- III. Consideration of September 28, 2011 Minutes**
- IV. Consideration of Subcommittee Report**
- V. Other Business**
- VI. Adjourn**

Minutes  
Information Technology Subcommittee  
October 25, 2011

The October 25, 2011 meeting of the Information Technology Subcommittee was called to order by John Supra, Chairman. Subcommittee members present were Anne Castro, Tammie King, David Patterson, Tim Ervolina and Teresa Arnold. Department of Insurance staff present were Gary Thibault, Kim Cox, Director David Black, and Ella Dickerson.

Mr. Patterson moved that the agenda be adopted. The motion was seconded by Teresa Arnold and unanimously approved. Ms. King moved that the minutes of the September 28, 2011 meeting be approved. The motion was seconded by Mr. Patterson and unanimously approved.

Mr. Supra presented the group with an overview of the draft of the committee's report. He noted that he addressed the questions and tasks identified in the executive order specifically. In summary he said that as a group if there were a vote they would lean toward the federal exchange and added that there are also other options. The draft report included tables that mapped the processes of doing nothing versus doing everything.

Ms. Castro asked if is this subcommittee is leaning towards the federal government providing the systems. Mr. Supra clarified that the report suggests for the federal government to provide the technology for the systems that are new and where we do not have the technology. Ms. Castro answered that the subcommittee needs to qualify that statement in the report. Mr. Patterson agreed stating that it should be a joint effort and the state should have control. Ms. Castro agreed and stated that it needs to be controlled by the state and be consumer centric.

Mr. Ervolina added that there would not be a state-based exchange because no matter what we do there is no such thing as a state-based exchange. Ms. Castro stated that the overall flavor could be structured to benefit state of South Carolina. Mr. Patterson agreed but added that we want to retain as much as possible.

Ms. Castro said that the subcommittee's recommendation is really a hybrid because we are taking the best from the federal government and taking the best from the state. Mr. Supra added that we could also reflect on the different rules that have come out around the hybrid. He asked the members to comment on the draft by Friday.

Mr. Supra thanked the group and said that it was a pleasure to serve on the subcommittee with everyone. He stated that the process allowed many ideas to come together. He asked if there were any other comments or questions. Ms. Arnold invited the full committee to an event that Myrtle Beach Nov 14<sup>th</sup> 9-12 about taking charge of your health care.

Information Technology Subcommittee  
October 25, 2011 Minutes

The being no further business, Mr. Ervolina moved to adjourn. The motion was seconded by Mr. Patterson and approved.

## **Information Technology Subcommittee**

### **South Carolina Health Planning Committee**

Presentations received and handouts distributed during subcommittees may be accessed on the South Carolina Health Planning website. Links to each are provided below.

July 12, 2011

None

July 26, 2011

1. [AARP Cronin Report: State Health Insurance Exchange Websites](#)
2. [Technology Matrix](#)
3. [Marketplace Ecosystem](#)

August 23, 2011

1. [State Exchange Model](#)
2. [State Exchange Model Description](#)
3. [Technology Matrix](#)
4. [Marketplace Ecosystem](#)

September 28, 2011

1. [IT Technical Model](#)

October 25, 2011

None

## Appendix E

### Research

- A. Health Insurance in South Carolina: Surveys of the General Public and Key Informants Presentation, 2011 *by*: Dr. Robert Oldendick, Ph.D., University of South Carolina
- B. Cross-Sectional Telephone Survey Results, 2011. Dr. Robert Oldendick, Ph.D., University of South Carolina
- C. The Uninsured in South Carolina: Population Estimates, 2011. Dr. Robert Oldendick, Ph.D., University of South Carolina
- D. Key Informants' Survey Results, 2011. Dr. Robert Oldendick, Ph.D., University of South Carolina
- E. South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study Presentation, 2011 *by*: Dr. Lee Pearson, SC Institute of Medicine and Public Health
- F. South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study Report, 2011
- G. Expanding Insurance Coverage and Stabilizing Rates within the South Carolina Small Group Market, HRSA Planning Grant, 2004
- H. Public Outreach Comments

## Appendix E

### A. Health Insurance in South Carolina: Surveys of the General Public and Key Informants Presentation

# Health Insurance in South Carolina

Presented to the

South Carolina Health Planning Committee

October 10, 2011

Robert W. Oldendick, Ph.D.



## Research Components

- (1) Survey of the General Public
- (2) Focus Groups
- (3) Key Informants Survey



### **Survey of the General Public**

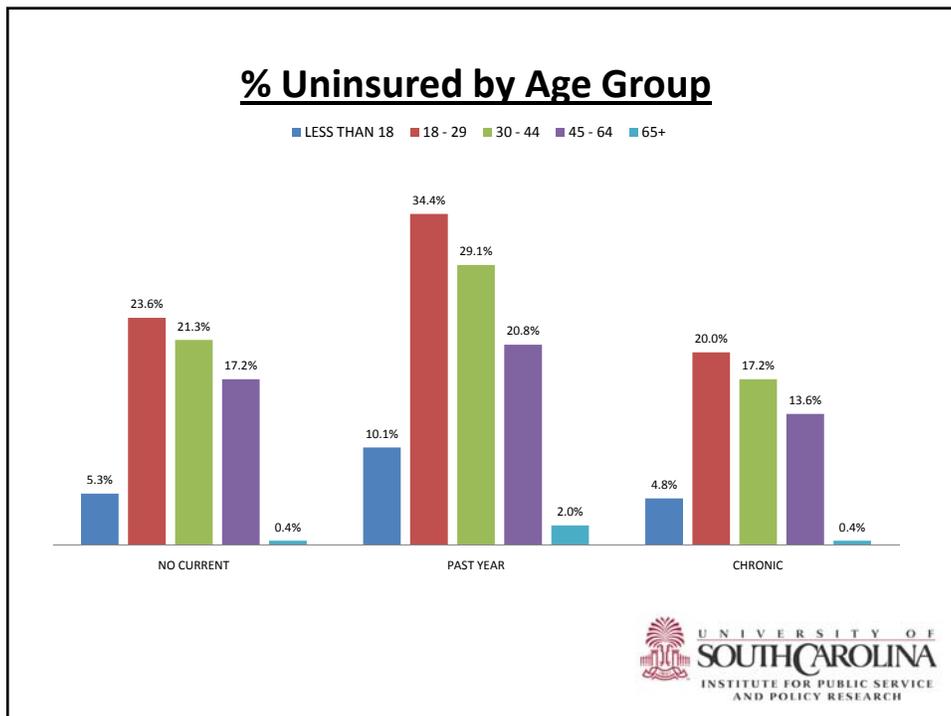
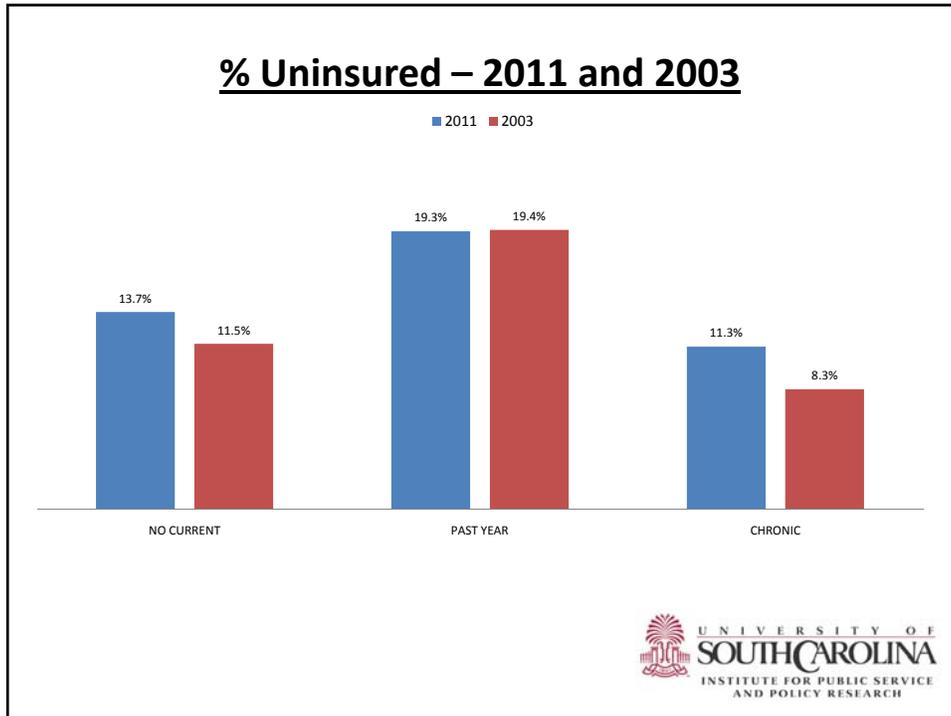
- Telephone survey conducted between June 1 to July 24, 2011
- Interviews completed in 1,649 households, with information collected on 3,843 individuals
- Supplemental sample of 415 households with at least one person without health insurance, representing 601 individuals

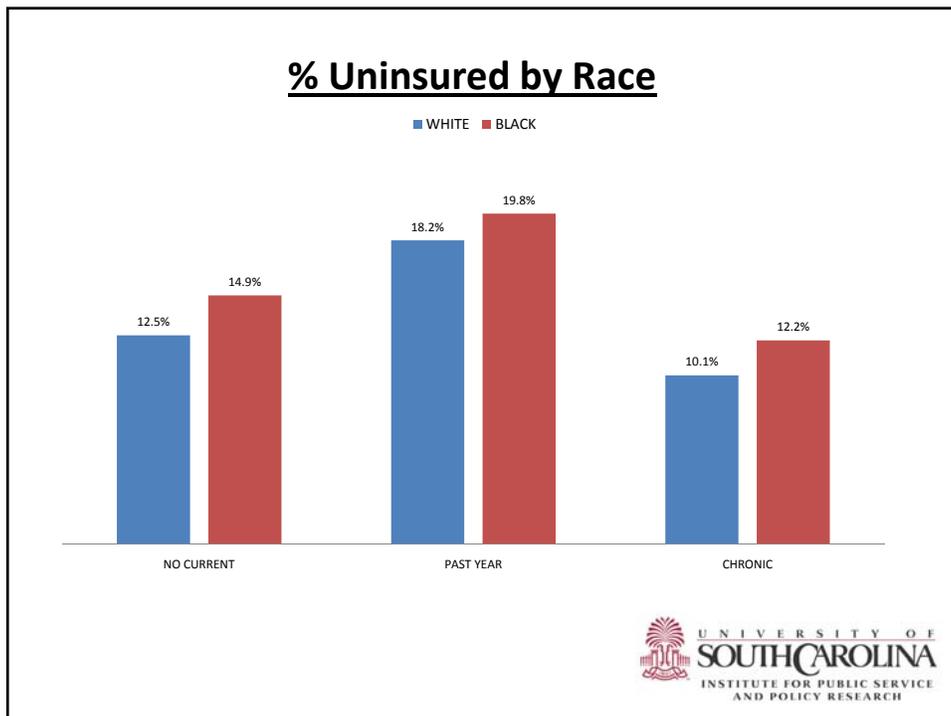
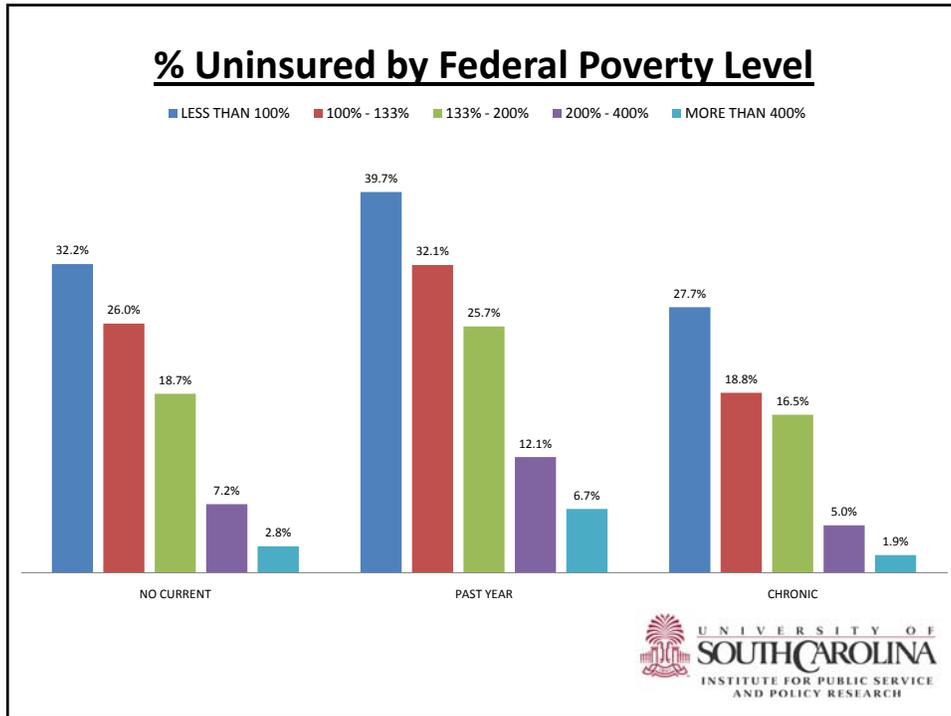


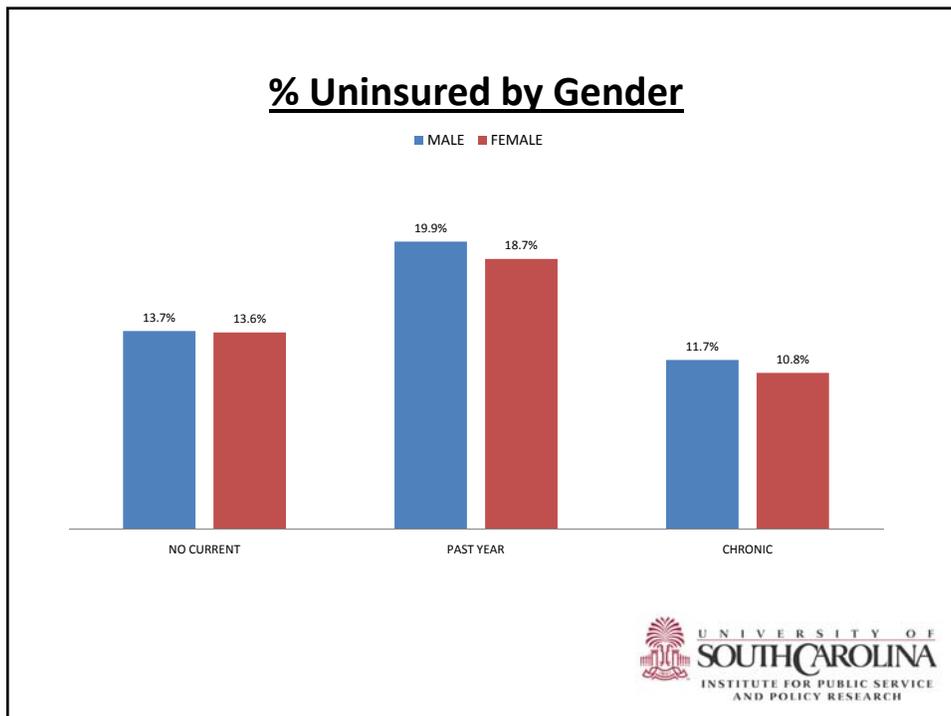
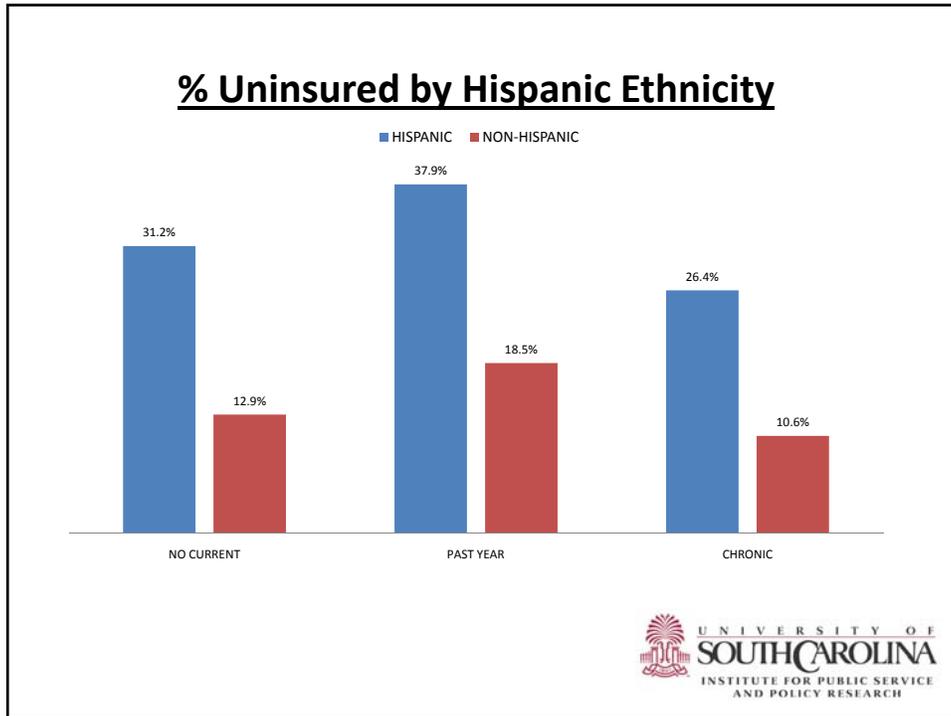
### **Health Insurance Status – 3 Measures**

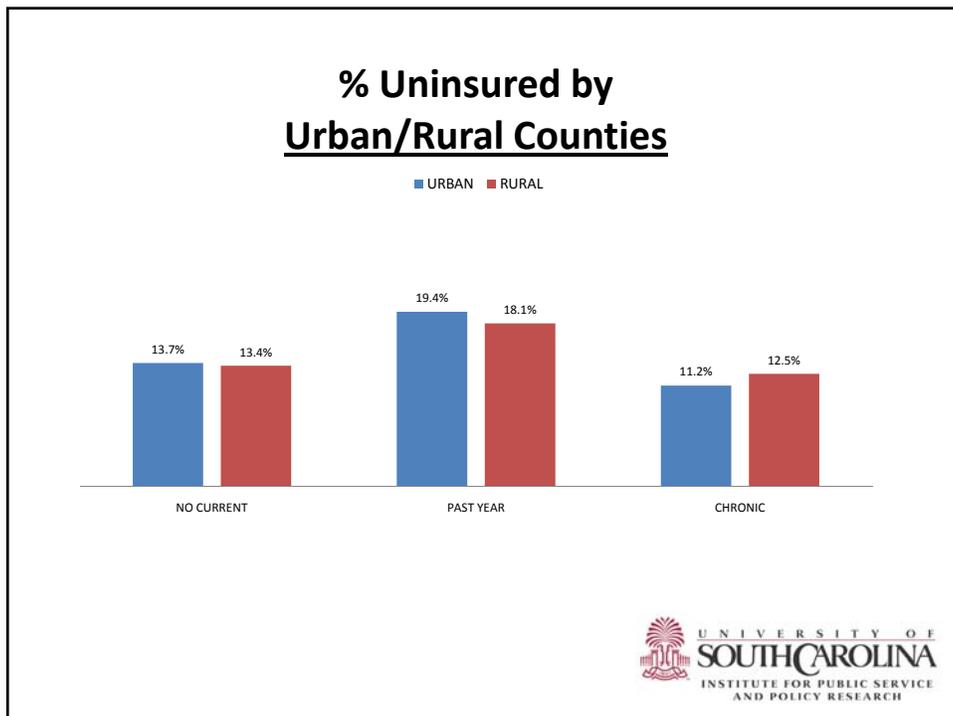
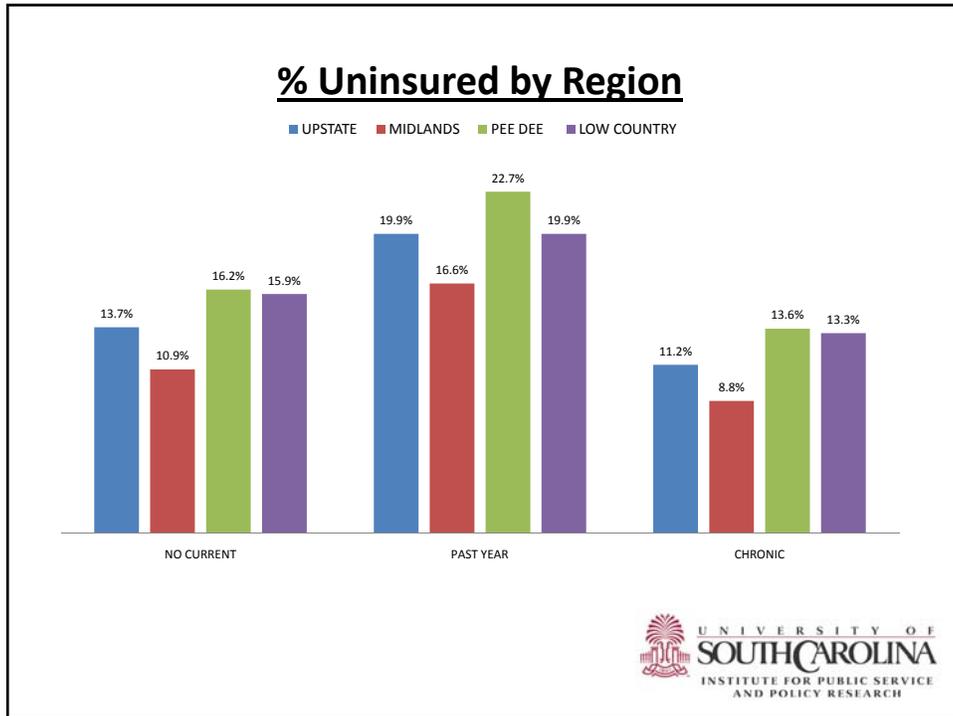
- No health insurance at time of interview  
(No Current)
- Uninsured at some time during the past 12 months  
(Past Year)
- No health insurance during the past year  
(Chronic)

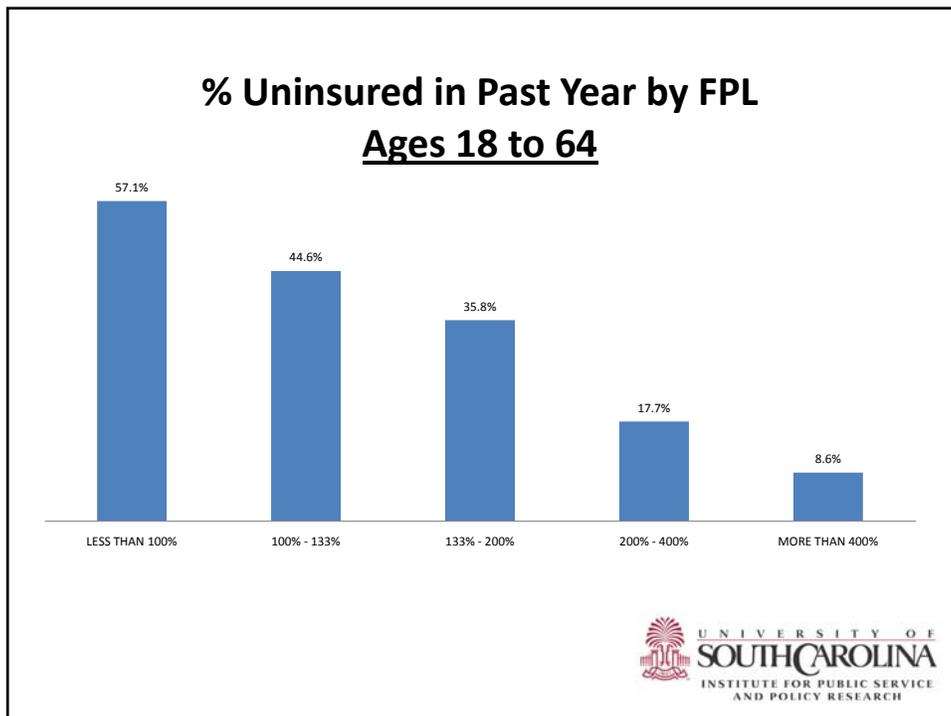
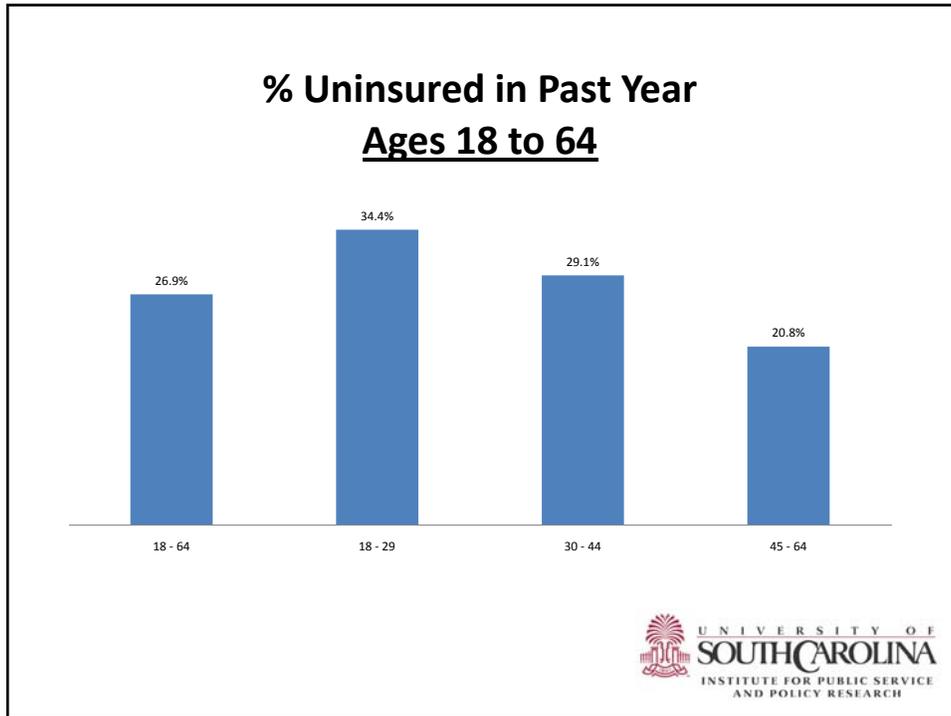


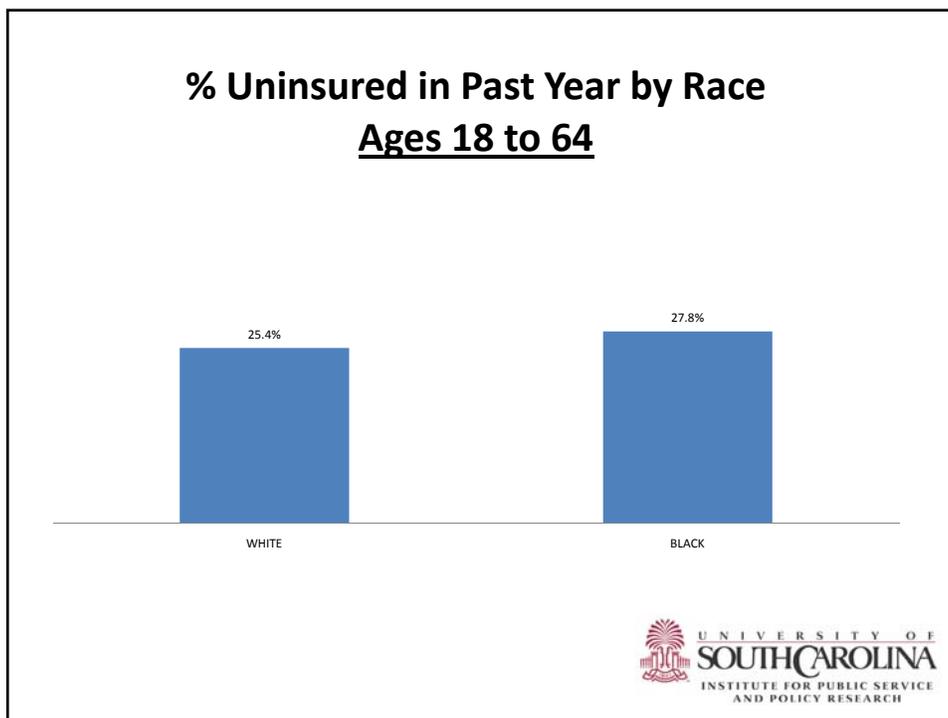
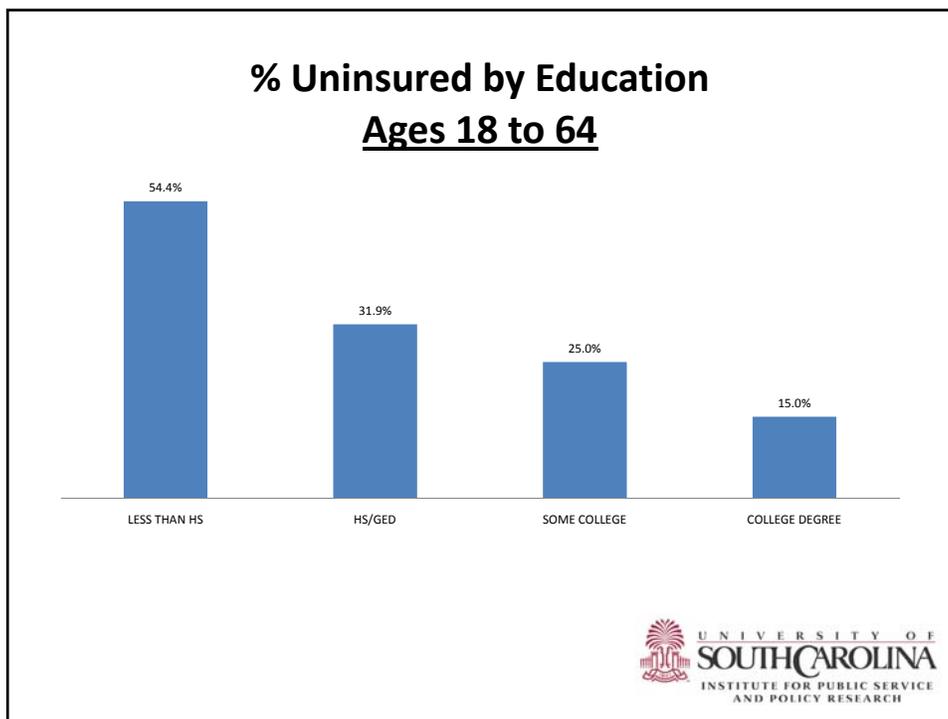


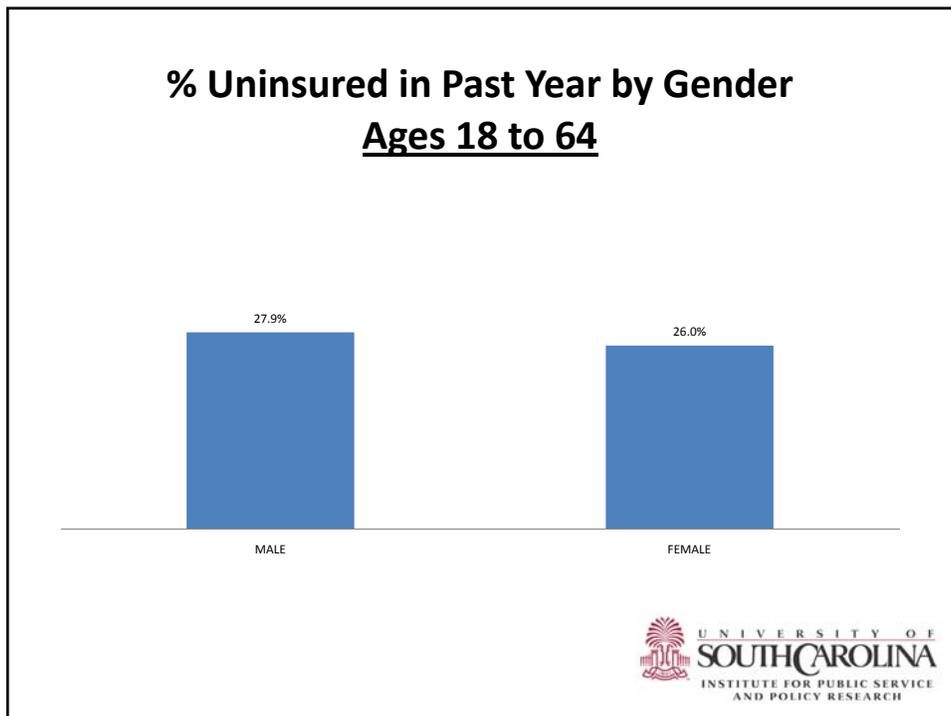
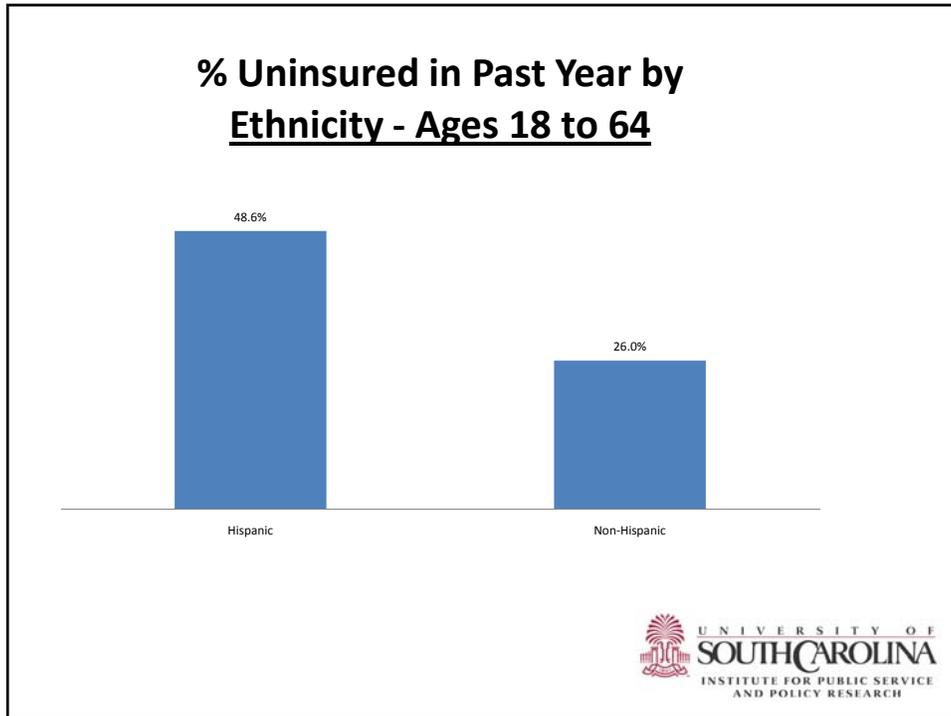


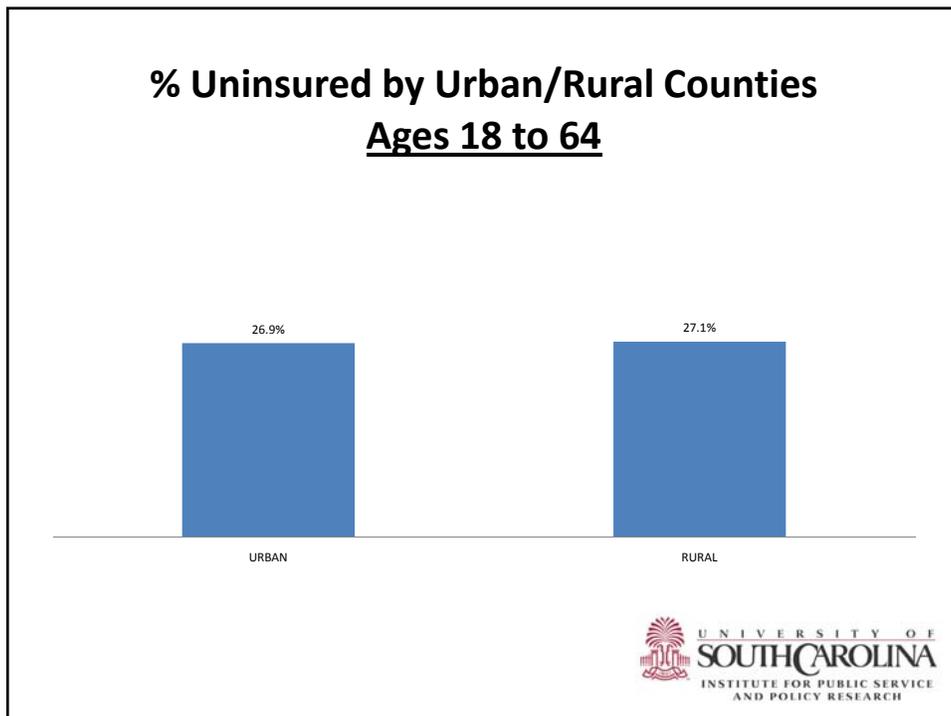
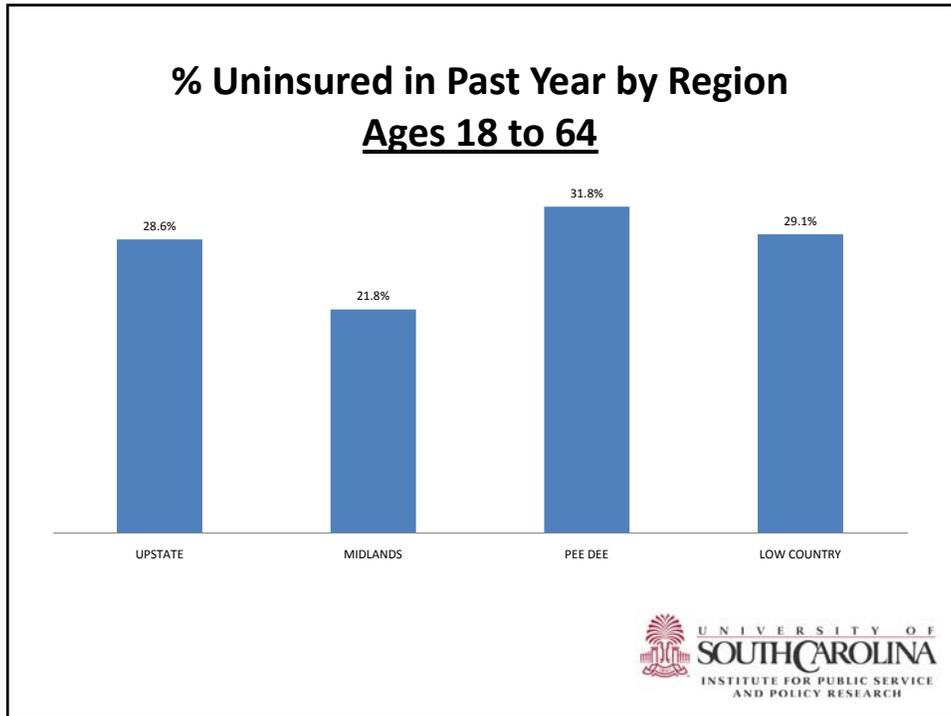


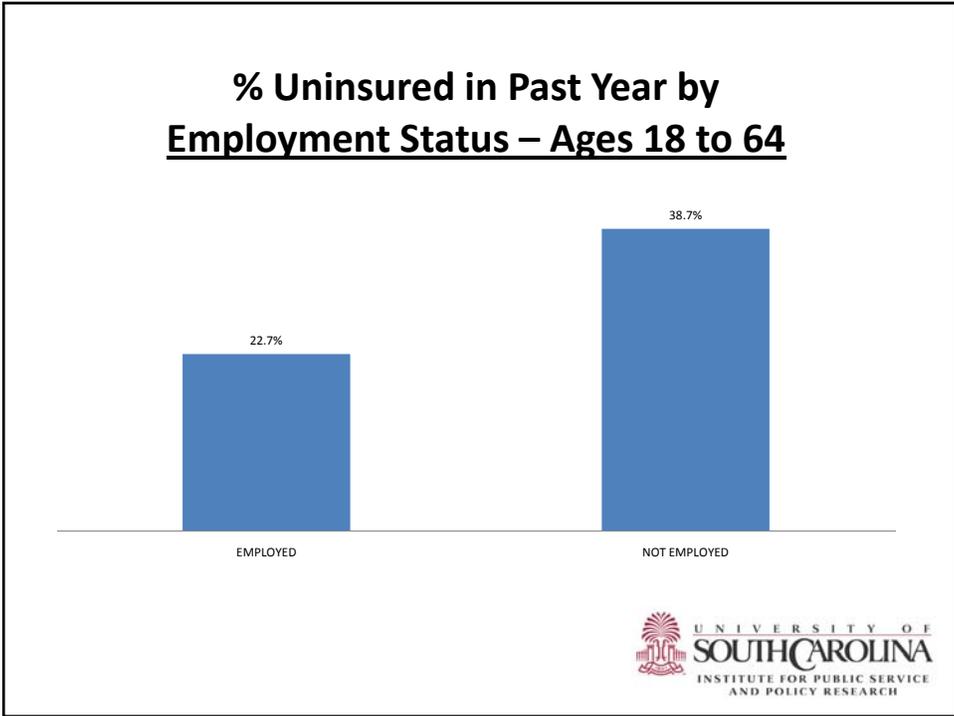












### Reason Not Insured by Employer

- Cannot Afford 38%
- Have Not Worked There Long Enough 17%
- Full-Time Temporary Employee 9%
- Do Not Work Enough Hours in a Week 8%
- Not Eligible 4%



### Uninsured – Ages 18 to 64

Insurance Available through Spouse or Partner's Work

Yes 13%

No 87%



### Reason Not Insured through Spouse's Work Ages 18 to 64

- Cannot Afford 54%
- Expect to Get Own Health Insurance Soon 15%
- Will be Covered After Waiting Period 10%
- Won't Allow Coverage Until Marriage 7%



### Reason Not Purchase Own Health Insurance Ages 18 to 64

- Cannot Afford 81%
- Not Working and Cannot Afford 5%
- Do Not Need Health Insurance 2%
- Expect to Get Insurance Soon 2%
- Not Eligible for Reason Other than Health 2%
- Have Not Looked into It 1%



## Ever Been Given Information on South Carolina Public Insurance Programs

### Uninsured Ages 18 to 64

Yes	31%
No	69%



## Enroll in Public Insurance Program if Eligible at No Cost?

### Uninsured Ages 18 to 64

Yes	97%
No	3%



## Reason Would Not Enroll in Public Insurance Program if Eligible at No Cost

### Uninsured Ages 18 to 64

	<u>N</u>
Does not want government support	10
Do not need health insurance	5
Not worth having	5
Strain on public funds	4
Does not meet needs	1
Was treated poorly before	1
More needy people should get it	1



## Familiarity with Health Insurance Exchanges

	<u>All</u>	<u>Uninsured (18 - 64)</u>
Very familiar	1%	1%
Somewhat familiar	6%	1%
Not too familiar	6%	4%
Not at all familiar	3%	2%
Never heard of	84%	92%



### Internet Use

	<u>All</u>	<u>Uninsured (18 – 64)</u>
Almost every day	57%	49%
4 – 5 days a week	5%	6%
2 – 3 days a week	7%	9%
One day a week or less	11%	10%
Never	20%	26%



### Ever Purchase Insurance Products Over the Internet

	<u>All</u>	<u>Uninsured (18 – 64)</u>
Yes	8%	11%
No	92%	89%



### Importance in Making Health Plan Decisions (% “very important”)

	<u>All</u>	<u>Uninsured (18 – 64)</u>
Provider quality	92%	92%
Benefits	89%	88%
Premiums	78%	86%
Network of available doctors	74%	70%
Yearly out-of-pocket	72%	71%
Deductible	69%	74%
Co-payments	65%	66%



### Key Informants Survey

- Mail survey of individuals with knowledge of health insurance exchanges from different sectors, including large employers, small businesses, health care providers, insurance providers, health care researchers, and non-profit organizations
- Questionnaires were mailed to 125 individuals; 57 completed



### Importance of Exchange Objectives (% “extremely important”)

- Promote and increase competition 62%
- Increase portability and continuity 54%
- Provide cost and quality data 50%
- Driver of quality improvement and cost containment 44%
- Negotiator with health plans 37%
- Help small businesses 32%
- Promote consumer directed plans 31%
- Require additional quality standards 25%

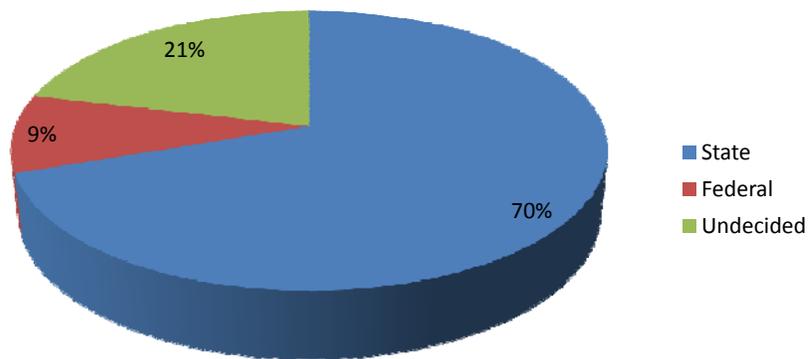


### Importance of *Information* for Consumers (% “extremely important”)

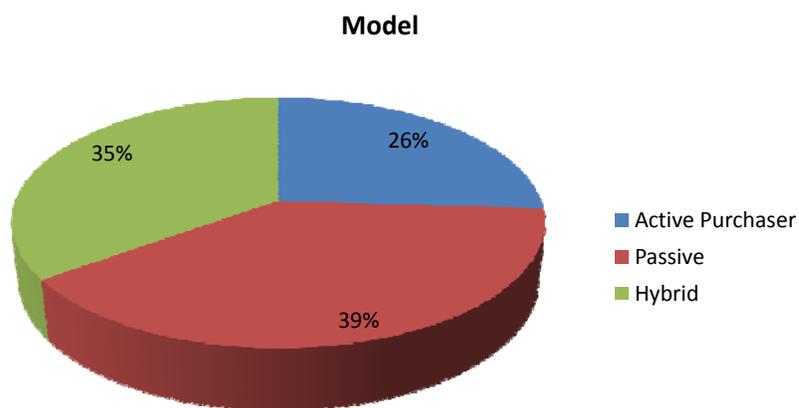
- Premium 87%
- Network of available doctors and facilities 74%
- Co-payments 70%
- Yearly maximum out-of-pocket expenses 67%
- Deductible 66%
- Health plan quality 59%
- Health care provider quality 55%
- Co-insurance 52%



## State or Federal Exchange



## Exchange Business Model



### Administrative Location

- Not-for-profit organization 40%
- Quasi-state agency 31%
- Within existing state agency 25%
- New state agency 4%

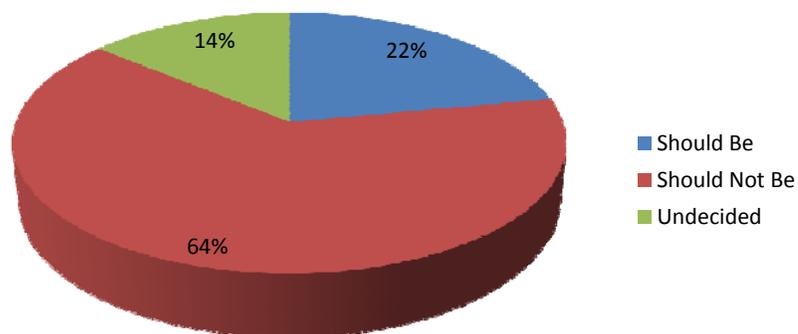


### Exchange Board of Directors

- Board appointed by Governor, Senate, and House 63%
- Exchange should not have Board 10%
- Board appointed by the Governor 4%
- Other 23%



## Pay Board of Directors?



## Exchange Sustainability

- Charge insurers a fee to offer plans 76%
- Increase in current premium tax for all health plans sold in South Carolina 49%
- License fees for Navigators 49%
- Increase in the current premium tax on health plans qualified to be sold on the Exchange 45%
- Charge a fee to small businesses 35%
- Charge fee to join a risk pool 33%
- Charge fee to individuals to use the Exchange 29%
- Issue bonds and borrow money 6%
- Create a new tax 4%



### Limiting Adverse Selection (% “support”)

- Penalties for dropping/enrolling – individual market 86%
- Penalties for dropping/enrolling – small group market 87%
- Limited enrollment periods for the individual market 67%
- Limited enrollment periods for the small group market 63%
- 30 day waiting period for the individual market 55%
- 30 day waiting period for the small group market 53%



### Limiting Adverse Selection Changing Tiers

	<u>Support</u>	<u>Don't Support</u>	<u>Unsure</u>
Allow individuals to move up or down only one benefit level per year	70%	15%	15%
Charge a fee to move up or down a benefit level	46%	33%	21%
Require individuals to lock in to an Exchange benefit level for a multiple year period	23%	60%	17%



### Health Insurance Exchange – Specific Options

	<u>Yes</u>	<u>No</u>	<u>Undecided</u>
• All insurers be required to offer products on the Exchange	38%	39%	23%
• Required to offer plans for both individual and small group markets	80%	16%	4%
• Exchange plans subject to additional requirements for quality and cost of care	46%	28%	26%
• Limited to repricing products only at enrollment/renewal (individual)	93%	4%	4%
• Limited to repricing products only at enrollment/renewal (small group)	95%	2%	4%
• Provide Medicaid vouchers to buy products on the Exchange	60%	18%	21%



### Health Insurance Exchange – Specific Options (2)

	<u>Yes</u>	<u>No</u>	<u>Undecided</u>
• Medicaid providers offer comparable product on the Exchange	54%	29%	16%
• Should South Carolina establish a basic health plan	67%	11%	22%
• Should the Exchange collect premium contributions from individuals and distribute them to health insurers	25%	54%	21%



### Purchasing on the Exchange

- |  |     |
|--|-----|
| (1) Buyers should be able to shop, compare, and purchase plans on the Exchange   | 73% |
| (2) The Exchange should direct customers to the insurers to complete the purchase of the health plan   | 0%  |
| (3) The Exchange should direct customers to a listing of approved (State licensed and certified) Navigators to complete selection and enrollment functions | 20% |
| (4) Undecided  | 7%  |



### Key Informants - Summary

- About 70% of these key informants believe that South Carolina should develop its own Health Insurance Exchange; 10% think that the state should default to the Federal Exchange, and 20% are undecided.
- There is disagreement over the type of purchasing model a State Health Exchange should adopt: approximately 40% prefer a passive clearinghouse model, about 25% favor an active purchaser model, and 35% support some hybrid of the two.



## Key Informants – Summary (2)

- The three objectives for the Exchange that are considered to be most important are promoting and increasing competition among health insurers, increasing portability and continuity of health coverage, and providing cost and quality data on health care providers.
- Administratively, the preference is for the Exchange to be either a not-for-profit organization or a quasi-state agency; a Board should be appointed by the Governor, the Senate, and the House.



## More Information

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Appendix E  
B. Cross-Sectional Telephone Survey Results

## Appendix A

### Cross-Sectional Telephone Survey Results

Data for this study were collected through a telephone sample of households in South Carolina. A dual sampling frame approach, one based on landline telephone exchanges and the second based on cell phone telephone numbers, was used in selecting respondents for this study. For the landline component, respondents to be interviewed were selected from a random sample of households with telephones in the state. Respondents in the cell phone sample were randomly selected from a list of cell phone exchanges in South Carolina. Each of these numbers was called by the survey interviewers. Numbers that were found to be businesses, institutions, not-in-service, or otherwise not assigned were ineligible for the survey. The remaining numbers, when called, resulted in contacts to residences in the landline component and with individuals in the cell phone component.

When contact was made with a residence in the landline component, the interviewer asked to speak with someone 18 years of age or older who could answer questions about health insurance for people living in the household. When contact was made with an individual in the cell phone component, they were asked a series of questions to determine eligibility, including confirming that the number reached was for a cell phone, that the individual who answered was 18 years of age or older, and that they were a resident of South Carolina. If an individual reached on a cell phone also had a landline telephone in their household, they were not interviewed for this study.

The respondent was asked to provide information about health insurance and various background characteristics for all individuals living in the household. Once this information had been collected, a random selection was made of one person in the household and additional information on the use of health care services was collected about this individual. The respondent was also asked a series of questions related to health insurance exchanges and the household's income.

Data were collected from 1,649 households representing 3,843 individuals. This Appendix contains the questionnaire that was used in this study and the weighted frequency counts. Data on health insurance status was collected for all individuals, and these tables are based on the information for 3,843 individuals. Data for questions such as use of health care services were collected only for one randomly selected individual within each household; the results for these questions are based on 1,649 individuals. All data in the tables presented have been weighted so that the characteristics of the individuals for which information is provided match the characteristics of the South Carolina population (2010 Census) on the basis of age, race, and sex.

**South Carolina Health Care Insurance Access and Health Insurance  
Exchange Survey (Field Version)  
University of South Carolina**

**INTRODUCTION:**

"Hello, this is \_\_\_\_\_ calling from the University of South Carolina. This month the University is conducting a confidential study on health and health insurance services in the state, and we'd really appreciate your help and cooperation."

"We are calling for the South Carolina Department of Insurance, and we are not selling anything. The purpose of this study is to identify ways to make health insurance more affordable as well as available to more residents of the state. Your telephone number was chosen scientifically and we would like your help to make the study as accurate as possible. All information will be kept strictly confidential and the results will be reported in summary form, so no individual information will be reported.

"Your cooperation is voluntary. You may stop me at any time, and if there are any questions you would rather not answer, let me know and we will go to the next question. The interview should take approximately 10 to 15 minutes complete.

"First, let me make sure I've dialed the correct phone number ... Is this \_\_\_\_\_?"

"And what county do you live in? RECORD COUNTY : \_\_\_\_\_

"As part of this study we will be asking some questions about HEALTH INSURANCE for people in your household.

S2. Can you answer questions about HEALTH INSURANCE for people in this household?  
1     yes → **GOTO S4**  
2     no

S3. Is another adult available who could answer questions about HEALTH INSURANCE?  
1     yes → **GET PERSON ON PHONE AND GOTO S4**  
2     no → **CALL BACK → Who should I speak with? What is a good time to call back?**  
**GET FIRST NAME OF PERSON WHO CAN SPEAK ABOUT INSURANCE**

S3A \_\_\_\_\_

S4. We will gather information about the insurance status of one household member in detail, but will need some brief information on the other members as well. First, including yourself, how many people currently live or stay in your household, apartment, or mobile home? (PROBE: Include in this number children, foster children, roomers, or housemates not related to you, college students living away while attending college. Do not include people who live or stay at another place most of the time, people in a correctional facility, nursing home, or residential facility, or people in the Armed Forces living somewhere else.) \_\_\_\_\_

S4a. "And what is your age?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

98. DON'T KNOW (PROBE: "Just approximately ...")

S4b. INTERVIEWER – RECORD SEX OF INFORMANT (ASK IF NECESSARY)

1. MALE

2. FEMALE

S5. "And what is the age of the oldest male (other than you) living in the household?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO (OTHER) MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S6. "And what is the age of the next oldest male (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S7. "And what is the age of the next oldest male (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S8. "And what is the age of the next oldest male living in the household?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S9. "And what is the age of the next oldest male (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S10. "And what is the age of the next oldest male (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL MALES LIVING IN HOUSEHOLD --- GO TO S11

98. DON'T KNOW (PROBE: "Just approximately ...")

S11. "And what oldest female (other than you) living in the household ... what is her age?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO (OTHER) FEMALES LIVING IN HOUSEHOLD --- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

S12. "And what is the age of the next oldest female (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL FEMALES LIVING IN HOUSEHOLD -- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

S13. "And what is the age of the next oldest female (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL FEMALES LIVING IN HOUSEHOLD -- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

S14. "And what is the age of the next oldest female (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL FEMALES LIVING IN HOUSEHOLD -- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

S15. "And what is the age of the next oldest female (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL FEMALES LIVING IN HOUSEHOLD -- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

S16. "And what is the age of the next oldest female (living in the household)?"

RECORD AGE: \_\_\_\_\_

96. 96 OR OLDER

97. NO ADDITIONAL FEMALES LIVING IN HOUSEHOLD -- GO TO H0

98. DON'T KNOW (PROBE: "Just approximately ...")

**H0.** "My next questions are about you and your health insurance. I am going to read you a list of different types of health insurance. Please tell me if you CURRENTLY have any of the following.

Do you CURRENTLY have:	Y	N	D K	REF
H1. Medicare? READ IF NECESSARY: Medicare is the health insurance for persons 65 years old and over or persons with disabilities. This is a red, white and blue card. <b>IF YES → GOTO MEDIGAP</b> <b>IF ELSE → GOTO H2</b>	1	2	7	9
* MEDIGAP. Do you have additional insurance to supplement Medicare, such as a self-purchased Medigap policy, or a retiree benefit? <b>*NOTE: MEDIGAP and MEDHMO are SC-specific optional items</b>	1	2	7	9
* MEDHMO. Are you (Is R) enrolled in a Medicare Advantage Plan	1	2	7	9
<b>(DO NOT ASK FOR INDIVIDUALS UNDER AGE 18)</b> H2. A Railroad Retirement Plan?	1	2	7	9
H3. TRICARE, Veteran's Affairs service connected to a disability, military health care or CHAMPUS ?	1	2	7	9
H4. Active Military?	1	2	7	9
H4a. Indian Health Service?	1	2	7	9
H5. Medicaid	1	2	7	9
<b>(ASK ONLY FOR INDIVIDUALS AGE 17 OR YOUNGER)</b> H6. Children's Health Insurance Program, or CHIP (Partners for Healthy Children)?	1	2	7	9
H7a. Insurance through the South Carolina Health Insurance Pool or high risk pool insurance?	1	2	7	9
H7b. Insurance through the Federal High Risk Pool (Pre-existing condition Insurance Plan or PCIP)?	1	2	7	9
<b>(DO NOT ASK FOR INDIVIDUALS UNDER AGE 18)</b> H8. Health insurance through your work or union?	1	2	7	9
H9a. Health insurance through someone else's work or union?	1	2	7	9
H9b. COBRA or small group continuation coverage? <b>PROBE:</b> This is insurance you purchase temporarily through a former employer. You might receive a subsidy for this coverage. <b>IF YES: GO TO H9c</b>	1	2	7	9
H9c. Is this an individual or family policy? 1. Individual policy 2. Family (Covers more than one person) 7. Don't know 9. Refused	1	2	3	4
<b>(DO NOT ASK FOR INDIVIDUALS UNDER AGE 18)</b> H10a. Health insurance <u>bought directly</u> by you?	1	2	7	9

H10b. Is this an individual or family policy? 1. Individual policy 2. Family (Covers more than one person) 7. Don't know 9. Refused	1	2	3	4
H11. Health insurance bought directly by someone else? <b>IF H10 OR H11 YES → GOTO POLICY ELSE GOTO "NOTE" BEFORE H12.</b>	1	2	7	9
POLICY. Is this an individual or family policy? <u>1</u> individual policy <u>2</u> family (covers more than one person) <u>7</u> don't know <u>9</u> refused				

PREM. How much do you (does TARGET) pay each month for your (TARGET's) health insurance premium?  PREM1A. \$ _____ monthly PREM1B. \$ _____ biweekly  7 don't know 9 refused	PREM1C. \$ _____ quarterly PREM1D. \$ _____ semi-annually PREM1E. \$ _____ annually
--	---

DED1. Does your (TARGET'S) health insurance include a deductible? READ IF NECESSARY: A deductible is the amount of money that you have to pay out of your own pocket each year before your insurance will pay for any services. 1 yes → <b>GOTO DED2</b> 2 no → <b>GOTO COPAY</b> 7 don't know → <b>GOTO COPAY</b> 9 refused → <b>GOTO COPAY</b>
DED2. How much is it for your deductible (READ: DO NOT INCLUDE PREMIUM EXPENSES)? \$ _____ 777 don't know 999 refused
COPAY Does your (TARGET'S) health insurance include co- payments, or co-pays, for some services, such as doctor's visits? READ IF NECESSARY: a co-pay is a specified amount of out-of-pocket expenses for health-care services such as doctor visits and prescription drugs that you pay each time the service is rendered. 1 yes 2 no 7 don't know 9 refused

DRUG. Do you (Does TARGET) have insurance that pays for prescription drugs?  
 1 yes  
 2 no  
 7 don't know  
 9 refused

**GOTO H14**

**NOTE: POLICY, PREM, DED1, DED2, COPAY, AND DRUG ARE SC-SPECIFIC OPTIONAL ITEMS ASKED OF ONLY THE INDIVIDUALLY INSURED**

	Y	N	DK	REF
<p><b>NOTE: IF ANSWER TO ANY "H" QUESTIONS IS "YES," GO TO H14.</b></p> <p><b>NOTE: IF ANSWER TO ALL "H" QUESTIONS IS "NO":</b></p> <p>H12. According to the information you provided, you do (TARGET does) not have health insurance coverage. Does anyone else pay for your (TARGET's) bills when you (they) go to a doctor or hospital?</p> <p><b>IF YES → GOTO H13</b>  <b>IF NO/DK/REF → GOTO H15</b></p>	1	2	7	9

**H13. And who is that? (DO NOT READ, SELECT ANSWER)**

- 1 Medicare
- 2 Railroad Retirement Plan
- 3 TRICARE, Veteran’s Affairs service connected to a disability, military health care, or CHAMPUS?
- 4 Active Military
- 5 Medicaid
- 6 CHIP, SCHIP or the Children’s Health Insurance Plan
- 7 South Carolina Health Insurance Pool or high risk pool insurance
- 8 Federal High Risk Pool or pre-existing condition insurance plan (PCIP)
- 9 Health insurance through your (TARGET) work or union
- 10 Health insurance through someone else's work or union
- 11 Health insurance bought directly by you (TARGET)
- 12 Health insurance bought directly by someone else

[NOT CONSIDERED INSURANCE FOR SURVEY, BUT SELECT IF MENTIONED]

- 14 Workers compensation for specific injury/illness
- 15 Employer pays for bills, but not an insurance policy
- 16 Family member pays out of pocket for any bills
- 17 Indian Health Service

**18 No Private or Public Insurance**

**IF 1-12 → GOTO H14**

**IF 14-17, say:**

**“For purposes of this survey, we’ll assume (you do not/TARGET does not) have insurance.”  
THEN GOTO H15**

	<b>Y</b>	<b>N</b>	<b>DK</b>	<b>REF</b>
H14. Was there anytime IN THE PAST 12 MONTHS that you were (TARGET was) not covered by insurance? <b>GOTO CHECK1</b>	1	2	7	9
H15. Have you (Has TARGET) been covered by any health insurance IN THE PAST 12 MONTHS? <b>CONTINUE WITH CHECK1</b>	1	2	7	9

**CHECK1:**

- **IF H14 ASKED AND RESPONDENT/TARGET LESS THAN 18 YEARS OLD, GO TO DENTAL**
- **IF H14 ASKED AND RESPONDENT/TARGET AGE 18 OR OLDER, CONTINUE WITH HHEMP1 AND HHMAR, THEN GO TO DENTAL**
- **IF H15 ASKED AND RESPONDENT/TARGET LESS THAN 18 YEARS OLD, GO TO PARCOV1**
- **IF H15 ASKED AND RESPONDENT/TARGET AGE 18 OR OLDER, CONTINUE**

- HHEMP1. (Are YOU/Is this person) currently:
- 01 self employed or own your business
  - 02 employed by someone
  - 03 an unpaid worker for family business, farm, or home →GOTO HHMAR
  - 04 retired → GOTO HHMAR
  - 05 unemployed, or not working → GOTO HHMAR
  - 06 full-time student (greater than three-fourths time) → GOTO HHMAR
  
  - 07 don't know → GOTO HHMAR
  - 09 refused → GOTO HHMAR

**PROBE: ANSWER FOR THE JOB YOU WORK AT THE MOST HOURS**

- HHMAR. (Are you/Is TARGET person) currently
- 01 married,
  - 02 living with partner,
  - 03 divorced,
  - 04 separated,
  - 05 widowed, or
  - 06 have you never been married
  - 77 don't know
  - 99 refused

**IF H14 ASKED, GO TO DENTAL**  
**IF H15 ASKED, CONTINUE**

## Long Form Items for Uninsured All Year

**IF TARGET AGE IS 18-25 ( $\geq 18$  AND  $\leq 25$ ) → GOTO EVER  
ELSE → GOTO CHECK2**

EVER. Have you (Has TARGET) ever been covered by health insurance?

- 1 yes → **GOTO PRIOR**
- 2 no → **GOTO COV1**
- 7 don't know → **GOTO COV1**
- 9 refused → **GOTO COV1**

PRIOR. Prior to becoming uninsured, what type of insurance did you (TARGET) have? Was that

- 1 Medicare
- 2 some other form of public insurance
- 3 insurance through own or someone else's employer or union
- 4 student health insurance
- 5 insurance bought directly by you/them or by someone else
- 6 Veterans Affairs (VA, TRICARE)
- 10 COBRA
- 11 Other (Probe for type) (SPECIFY)\_\_\_\_\_
- 77 Don't know
- 99 Refused

YOUNG. Was this insurance coverage through (your/TARGET's) parents' or guardian's plan?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

**CHECK2:**

- **IF RESPONDENT'S/TARGET PERSON'S AGE IS LESS THAN 18, GO TO PARCOV1**
- **IF RESPONDENT/TARGET DOES NOT HAVE A PARTNER (WIDOWED; NEVER MARRIED; DON'T KNOW; OR REFUSED TO QUESTION HHMAR) GO TO OWNCOV**
- **ELSE → GOTO COV1**

COV1. Now I'd like to ask a few questions about your (TARGET's) access to insurance ....  
Does (your/TARGET's) spouse or partner have insurance through their work or union?

- 1 yes → **GOTO COV2**
- 2 no → **GOTO COV3**
- 3 spouse/partner does not work → **GOTO OWNCOV**
- 4 no spouse/partner in household or in area → **GOTO OWNCOV**
- 7 don't know → **GOTO COV3**
- 9 refused → **GOTO COV3**

COV2. Could this insurance policy be extended to cover you (TARGET)?

- 1 yes → **GOTO COV5**
- 2 no → **GOTO OWNCOV**
- 7 don't know → **GOTO OWNCOV**
- 9 refused → **GOTO OWNCOV**

COV3. Is your (TARGET's) spouse or partner ELIGIBLE for health insurance through their work or professional association, but chosen not to sign up for it?

- 1 yes → **GOTO COV4**
- 2 no → **GOTO OWNCOV**
- 7 don't know → **GOTO OWNCOV**
- 9 refused → **GOTO OWNCOV**

COV4. If that family member were to sign up for that health insurance, could the policy be extended to cover you (TARGET)?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

**IF COV4 IS ASKED, GOTO OWNCOV**

COV5. What is the main reason (you /TARGET) do not get insurance through that family member?

**PROBE: CAN YOU TELL ME THE PRIMARY REASON YOU DID NOT GET INSURANCE THROUGH THIS FAMILY MEMBER.**

**DO NOT READ. MAP RESPONSE TO RESPONSE CATEGORY. CIRCLE ONE.**

- 1 do not need or want any health insurance
- 2 rarely sick
- 3 too much hassle/paperwork
- 4 could not afford/too expensive
- 5 own plan through work is cheaper/benefits better
- 6 expect to get own health insurance soon
- 7 after waiting period will be covered by family member's policy
- 8 benefit package didn't meet needs
- 9 doubt eligible/rejected because of health condition
- 10 other (specify) \_\_\_\_\_
- 77 don't know
- 99 refused

OWNCOV. What is the main reason (you have not/TARGET has not) bought health insurance on your (their) own?

**DO NOT READ. MAP RESPONSE TO RESPONSE CATEGORY. CIRCLE ONE.**

- 1 do not need or want any health insurance
- 2 rarely sick
- 3 do not know where to begin/where to go
- 4 too much hassle/paperwork
- 5 could not afford/too expensive
- 6 expect to be covered by a health insurance policy shortly
- 7 benefit package didn't meet needs
- 8 not eligible for reason other than health
- 9 doubt eligible/rejected because of a health condition
- 10 other (specify) \_\_\_\_\_
- 77 don't know
- 99 refused

**CHECK3:**

- **IF RESPONDENT'S/TARGET IS NOT EMPLOYED (I.E., ANSWER TO QUESTIOB HHEMP1 IS EQUAL TO OR GREATER THAN CODE 3) GO TO PUB1**
- **ELSE → CONTINUE**

EMPCOV1. Does the firm (you work/TARGET works) for offer health insurance as a benefit to any of its employees?

- 1 yes → **GOTO EMPCOV2**
- 2 no → **GOTO PUB1**
- 7 don't know → **GOTO PUB1**
- 8 NOT applicable, NOT employed → **GOTO PUB1**
- 9 refused → **GOTO PUB1**

EMPCOV2. Can (your/TARGET's) employer coverage be extended to cover dependents?

- 1 yes
- 2 no
- 7 don't know
- 9 refused
- 8 TARGET does NOT have ACCESS to insurance through OWN employer → **GOTO PUB1**

EMPCOV3. Does your (TARGET's) employer contribute to health insurance costs for those employees covered by this benefit?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

EMPCOV4. Why aren't (you/TARGET) included in your employer's group health insurance plan?  
**DO NOT READ. MAP RESPONSE TO RESPONSE. CIRCLE ONE.**

- 1 do not need or want any health insurance
- 2 rarely sick
- 3 too much hassle/paperwork
- 4 could not afford/too expensive
- 5 DO NOT work enough hours in a week
- 6 have NOT worked there long enough
- 7 doubt eligible/rejected because of health condition
- 8 benefit package didn't meet needs
- 10 other (specify) \_\_\_\_\_
- 77 don't know
- 99 refused

**GOTO PUB1**

Now I'd like to ask a few questions about (TARGET's) access to insurance through a parent or guardian.

PARCOV1. Does the firm TARGET's parent or guardian works for offer health insurance as a benefit to any of its employees?

(PROBE: IF ONLY ONE PARENT WORKS, ANSWER FOR THIS PARENT'S EMPLOYER. IF BOTH PARENTS WORK, ANSWER FOR THE PRIMARY WAGE EARNER LIVING IN THE HOUSEHOLD.)

- 1 yes → **GOTO PARCOV2**
- 2 no → **GOTO OWNCOV2**
- 7 don't know → **GOTO OWNCOV2**
- 8 Not Applicable/Parent not employed → **GOTO OWNCOV2**
- 9 refused → **GOTO OWNCOV2**

PARCOV2. Does this employer contribute to health insurance costs for those employees covered by this benefit?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

PARCOV3. Is TARGET's parent/guardian covered under this plan?

- 1 yes → **GOTO PARVOC4**
- 2 no → **GOTO OWNCOV2**
- 7 don't know → **GOTO OWNCOV2**
- 9 refused → **GOTO OWNCOV2**

PARCOV4. Can this coverage be extended to cover dependents?

- 1 yes → **GOTO PARCOV5**
- 2 no → **GOTO OWNCOV2**
- 7 don't know → **GOTO OWNCOV2**
- 9 refused → **GOTO OWNCOV2**

PARCOV5. What is the main reason (TARGET) is not included in this employer's health insurance plan AS A DEPENDENT?

**DO NOT READ. MAP RESPONSE TO RESPONSE. CIRCLE ONE.**

- 1 child doesn't need insurance
- 2 rarely sick
- 3 parent is NOT ELIGIBLE to receive coverage
- 4 child is covered through another adult's employer plan
- 5 too much hassle/paperwork
- 6 could not afford/too expensive
- 7 their benefit package didn't meet this child's needs
- 8 expect this child will be covered by a policy shortly
- 9 child is covered under a school plan
- 10 other (specify) \_\_\_\_\_
- 77 don't know
- 99 refused

OWNCOV2. What is the main reason TARGET's parents or guardian have not bought health insurance for (him/her) on their own?

**DO NOT READ. MAP RESPONSE TO RESPONSE CATEGORY. CIRCLE ONE.**

- 1 don't need or want insurance
- 2 rarely sick
- 3 do not know where to begin/where to go
- 4 too much hassle/paperwork
- 5 could not afford/too expensive
- 6 expect they will be covered by a health insurance policy shortly
- 7 benefit package didn't meet this child's needs
- 8 not eligible for reason other than health
- 9 doubt eligible/rejected because of a health condition
- 10 other (specify) \_\_\_\_\_
- 77 don't know
- 99 refused

**CONTINUE WITH PUB1**

Now I'm going to ask you about public insurance programs available through the state of South Carolina for those who are uninsured.

PUB1. Have you (TARGET/TARGET's parents) ever asked for or been given information about one of the South Carolina public health programs, such as South CarolinaCare, GAMC or Medical Assistance, which is also called Medicaid or PrePaid Medical Assistance Plan (PMAP)?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

PUB2. If you (TARGET) learned you (they) were eligible for health coverage through a public program, would you (TARGET) enroll?

- 1 yes → **GO TO DENTAL**
- 2 no
- 7 don't know
- 9 refused

PUB3. If you (TARGET) learned you (they) were eligible for health coverage through a public program at no cost to you (TARGET) or your family, would you (TARGET) enroll?

- 1 yes → **GOTO DENTAL**
- 2 no → **GOTO PUB4**
- 7 don't know → **GOTO DENTAL**
- 9 refused → **GOTO DENTAL**

PUB4. Please tell me why you (TARGET) would not enroll?  
**INSTRUCTION: RECORD VERBATIM**

DENTAL. Do you (does TARGET) currently have insurance that pays for dental care?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

HSTAT. Would you say your (TARGET's) health, in general, is excellent, very good, good, fair, or poor?

- 1 excellent
- 2 very good
- 3 good
- 4 fair
- 5 poor
- 7 don't know
- 9 refused

HHRACE1. (Are you/Is TARGET person) Hispanic?

- 1 yes
- 2 no
- 9 refused

HHRACE2. What is (your/TARGET person's) race? [MAY SELECT MORE THAN ONE]

**READ AS PROBE. LIST IF NECESSARY. DO NOT RECORD MORE THAN THREE.**

- 01 White
- 02 Black, African-American
- 03 Asian
- 04 American Indian
- 05 Other Pacific Islander
- 06 Some other race? What race is that? \_\_\_\_\_
  
- 77 don't know
- 99 refused

HHEDUC. What is the highest level of education (YOU have/this person has) completed?

- 01 no formal education
- 02 grade school (1 to 8 years)
- 03 some high school (9 to 11 years)
- 04 high school graduate or GED (received a high school equivalency diploma)
- 05 some college/technical or vocational school/training after high school
- 06 college graduate
- 07 postgraduate degree/study
- 77 don't know
- 99 refused

CITIZEN. (Are you/Is TARGET person) a citizen of the United States?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

**NOTE: IF TARGET PERSON IS LESS THAN 18 YEARS OLD, SKIP TO SCREEN**

HHVA. (Are YOU/Is this person) serving on active duty in the U.S. Armed Forces, military reserves, or National Guard?

**(NOTE:** Active duty does not include training for the Reserves or National Guard, but **DOES** include activation, for example, for the Persian Gulf War.

- 1 yes
- 2 no
- 7 don't know
- 9 refused

**SCREEN:** "My next questions are about health insurance for other members of your household. First, I'd like to ask about the (oldest male/oldest female) [other than yourself]?"

**REPEAT QUESTIONS H1 THROUGH HHVA FOR ALL INDIVIDUALS LIVING IN THE HOUSEHOLD.**

**AFTER THIS INSURANCE INFORMATION HAS BEEN COLLECTED FOR ALL HOUSEHOLD MEMBERS, ASK:**

**“My final questions are about the person living in your household who will have the next birthday. Of the people that you have told me about, including yourself, who will have the next birthday. [INTERVIEWER CONFIRM SEX AND AGE OF SELECTED INDIVIDUAL. – CATI → SHOW SCREEN WITH ALL SEXES AND AGES; INTERVIEWERS CONFIRM SEX AND RACE]**

- S10. What is your relationship to TARGET? Are you (his/her) ... (READ 2 THRU 10)
- 1 Self
  - 2 Mother/Stepmother
  - 3 Father/Stepfather
  - 4 Spouse
  - 5 Partner
  - 6 Son/Daughter
  - 7 Sibling/Sister/Brother
  - 8 Grandparent
  - 9 Other relative
  - 10 NON-RELATIVE
  - 77 Other

**READ: The following questions are about "TARGET".**

**IF TARGET AGE >2 YRS → GOTO S11**

**IF TARGET AGE =< 2 YRS → GOTO S12**

S11. How long have you (has TARGET) lived in South Carolina?

S11A. \_\_\_\_\_ # years      S11B. \_\_\_\_\_ # months

7 don't know

9 refused

**(PROBE FOR MONTHS IF LESS THAN 2 YEARS)**

**IF S11 ANSWERED, GO TO USC**

S12. How long has (TARGET's) parents or guardian lived in South Carolina?

S12A. \_\_\_\_\_ years      S12B. \_\_\_\_\_ months

7 don't know

9 refused

**(PROBE FOR MONTHS IF LESS THAN 2 YEARS)**

USC. Is there a regular place that you (TARGET) go for medical care?

- 1 yes
- 2 no → **GOTO WHYNOUSC**
- 7 don't know → **GOTO WHYNOUSC**
- 9 refused → **GOTO WHYNOUSC**

USCKIND. Where does [TARGET usually go/you usually go] for medical care. Is that an:

- 1 emergency room or urgent care center → **GOTO USCPERS**
- 2 clinic → **GOTO CLINIC**
- 3 doctor's office → **GOTO USCPERS**
- 4 or some place else (specify) \_\_\_\_\_ → **GOTO USCPERS**
- 7 don't know → **GOTO CONFID**
- 9 refused → **GOTO CONFID**

CLINIC. Is this clinic a . . .

- 1 public health, community, or free clinic
- 2 hospital outpatient clinic
- 3 private clinic
- 4 Other (please specify) \_\_\_\_\_
- 7 don't know
- 9 refused

USCPERS. Is there a particular health care professional you (TARGET) usually see(s) when you (TARGET) go there?

- 1 yes
- 2 no
- 7 don't know
- 9 refused

MILES How many miles one way do you (TARGET) travel for this care?

\_\_\_ miles (If don't know then probe, using categories)

00. less than one mile

- 91 less than 10 miles
- 92 10 to 24 miles
- 93 25 to 49 miles
- 94 50 to 99 miles
- 95 more than 100 miles

Do you generally receive your healthcare services in states other than SC?

- 1 yes
- 2 no

**GOTO CONFID**

WHYNOUSC. What is the **main** reason you (TARGET) DO NOT have a regular place that you go for health care?

---

---

**DO NOT READ. MAP TO RESPONSE.**

- 1 can't afford it
- 2 DO NOT have health insurance
- 3 rarely get sick
- 4 clinic hours don't fit my schedule
- 5 transportation difficulties
- 6 language barrier
- 7 do not like/trust/believe in doctors
- 8 clinic I used to go to closed
- 9 just moved, DO NOT have a regular place yet
- 10 just switched insurance, DO NOT have regular place yet
- 11 two or more places depending on what's wrong
- 12 other (specify above)
- 77 don't know
- 99 refused

**CHOOSE P: IF PROXY, CHOOSE R: IF NO PROXY:**

CONFID. Please tell me how strongly you agree or disagree with the following statement:

**P:** "I am confident that (TARGET) can get the care she/he needs when she/he needs it."

**R:** "I am confident that I can get the care I need when I need it."

Do you

- 1 Strongly agree
- 2 Agree
- 3 Disagree
- 4 Strongly disagree
- 7 Don't know
- 9 Refused

DOC6M. In the **past twelve months**, how many visits did you (TARGET) make to a doctor's office, outpatient clinic, or any other place for medical care? Do not include overnight hospital stays or emergency room visits.

\_\_\_\_\_ visits

- 77 don't know
- 99 refused

**IF NO VISITS GOTO INPUSE**

DOC3M. In the **past three months**, how many visits did you (TARGET) make to a doctor's office, outpatient clinic, or any other place for medical care? Do not include overnight hospital stays or emergency room visits.

\_\_\_\_ visits

77 don't know

99 refused

INPUSE. During the **past 12 months**, have you (TARGET) been a patient overnight in a hospital?

1 yes → GOTO INPUSE2

2 no → GOTO ERUSE

7 don't know → GOTO ERUSE

9 refused → GOTO ERUSE

INPUSE2. How many times have you (TARGET) been admitted to a hospital DURING THE PAST 12 MONTHS?

\_\_\_\_ times

ERUSE. During the **past 12 months**, have you (TARGET) been to a hospital emergency room?

1 yes

2 no

7 don't know

9 refused

**IF TARGET IS LESS THAN SIX YEARS OLD, GO TO CHECK4**

ABSENCE During the past 12 months, about how many days of school (work) have you (TARGET) missed due to illness or injury?

\_\_\_\_\_ days

**CHECK4: F RESPONDENT/TARGET IS LESS THAN 18 YEARS OLD, GO TO yyy**

HHEMP2. (Do YOU/Does TARGET) have more than one paying job?

- 1 yes
- 2 no
- 3 not employed → **GO TO COUNT**

HOURS. What is the total number of hours usually worked per week?

- \_\_\_\_\_ hours
- 77 don't know
- 99 refused

**CHECK5: IF MORE THAN ONE JOB (HHEMP2 = 1), ASK EMPHRS  
IF HHEMP2 EQUAL 2, GO TO EMPERM**

EMPHRS. For the job you work (TARGET works) at the most hours, what is the total number of hours usually worked per week? \_\_\_\_\_ hours

- 7 don't know
- 9 refused

EMPERM. Is this a permanent, temporary, or seasonal job?

- 1 permanent
- 2 temporary
- 3 seasonal
- 7 don't know
- 9 refused

(Do you/Does TARGET) work for government, a private business or some other type of organization?

- 1 government
- 2 a private business
- 3 other (specify)
- 7 don't know
- 9 refused

ALLSITES. About how many people work for the company your are employed by? Is is (READ CHOICES 1 THRU 5)

- 1 Just one
- 2 Between 2 and 10
- 3 11 and 50
- 4 51 and 100
- 5 more than 100
  
- 7 don't know
- 9 refused

EMPTYTYPE Thinking about the employer you work (TARGET works) for, what industry most closely describes this employer. Is it (READ CHOICES 1 THRU 8)

- 1 Agriculture
- 2 Construction
- 3 Manufacturing
- 4 Retail trade
- 5 Professional and related services
- 6 Government
- 7 Hotel, motel, restaurant or entertainment
- 8 Medical, OR
- 9 Some other industry (SPECIFY)

JOBTENURE: How long have you (has TARGET) been employed in this position?

- 1 less than 1 month
- 2 more than 1 month but less than 6 months
- 3 more than 6 months but less than 1 year
- 4 more than 1 year but less than 5 years
- 5 more than 5 years

HIX1. “Now on the topic of health insurance ... People consider a number of different factors when making decisions about their health plan. I’m going to read several of these, and for each I’d like for you to tell me if this is very important, somewhat important, not too important, or not at all important. First .. “

	<u>Very</u>	<u>Some- what</u>	<u>Not Too</u>	<u>Not at All</u>	<u>DK</u>
a. The premium, that is the cost of the health plan	1	2	3	4	5
b. The types of benefits available	1	2	3	4	5
c. The deductible, or the amount you pay each year before plan benefits begin	1	2	3	4	5
d. Co-payments, or the fixed amount you pay for each office visit or pharmacy prescription filled	1	2	3	4	5
e. The yearly maximum out-of-pocket expenses that you pay	1	2	3	4	5
f. The network of available doctors and facilities	1	2	3	4	5
g. Health care provider quality	1	2	3	4	5

HIX2. “A health insurance exchange is a set of state-regulated and standardized health care plans, from which individuals may purchase health insurance. Have you ever heard of a health insurance exchange?”

1. YES
2. NO OR DON’T KNOW ----- GO TO HIX4

HIX3. “And how familiar are you with the way in which a health insurance exchange operates ... very familiar, somewhat familiar, not too familiar, or not at all familiar?”

1. VERY FAMILIAR
2. SOMEWHAT FAMILIAR
3. NOT TOO FAMILIAR
4. NOT AT ALL FAMILIAR
5. DON’T KNOW (PROBE: “In general ..”)

HIX4. "Do you have access to the Internet in your home?"

1. YES
2. NO OR DON'T KNOW ----- GO TO COUNT

HIX5. "How frequently do you use the Internet ... every day or almost every day, 4 or 5 days per week, 2 or 3 days per week, or one day week or less?"

1. EVERY DAY OR ALMOST EVERY DAY
2. 4 OR 5 DAYS PER WEEK
3. 2 OR 3 DAYS PER WEEK
4. ONE DAY A WEEK OR LESS
5. DON'T KNOW (PROBE: "In general ...")

HIX6. "Do you ever purchase goods or services over the Internet?"

1. YES
2. NO OR DON'T KNOW ----- GO TO COUNT

HIX7. "Have you ever purchased any type of insurance products over the Internet?"

1. YES
2. NO
3. DON'T KNOW (DO NOT PROBE)

Now I am going to ask some questions about your or your family's income. This income information is important because it helps the state understand how to make health care more affordable.

COUNT. How many people live on your or your family's income who CURRENTLY LIVE in the household? (PROBE: DO NOT include any children for which a family member currently pays child support, or any children away attending college or boarding school)

\_\_\_ \_\_\_ people  
77 don't know  
99 refused

**IF COUNT = 1 → GOTO INCOME**

KIDCNT. How many of these people are children under age 21?  
\_\_\_ \_\_\_ children

INCOME. “Is your household income below \_\_\_\_\_?” (THIS QUESTION AND FOLLOW-UPS WILL VARY DEPENDING UPON THE NUMBER OF PEOPLE IN THE HOUSEHOLD.)”

PHONE2. Not counting cell phones, business lines, extension phones, faxes, or modems -- on how many different telephone numbers can your household be reached?

Number \_\_\_\_\_

77 don't know

99 refused

S5. What is your zip code? \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

**END OF SURVEY. THANK YOU FOR YOUR CONTRIBUTION TO THIS IMPORTANT RESEARCH.**

# FREQUENCY COUNTS

## COUNTY OF RESIDENCE

	Frequency	Weighted Percent
ABBEVILLE	17	.4
AIKEN	106	2.8
ALLENDALE	1	.0
ANDERSON	112	2.9
BAMBERG	8	.2
BARNWELL	15	.4
BEAUFORT	123	3.2
BERKELEY	153	4.0
CALHOUN	13	.3
CHARLESTON	239	6.2
CHEROKEE	68	1.8
CHESTER	33	.9
CHESTERFIELD	31	.8
CLARENDON	21	.5
COLLETON	19	.5
DARLINGTON	79	2.1
DILLON	18	.5
DORCHESTOR	88	2.3
EDGEFIELD	30	.8
FAIRFIELD	26	.7
FLORENCE	110	2.9
GEORGETOWN	40	1.0
GREENVILLE	340	8.9
GREENWOOD	53	1.4
HAMPTON	33	.9
HORRY	217	5.7
JASPER	21	.6
KERSHAW	72	1.9
LANCASTER	87	2.3
LAURENS	53	1.4
LEE	21	.5
LEXINGTON	296	7.7
MCCORMICK	2	.1
MARION	17	.5
MARLBORO	23	.6
NEWBERRY	29	.7
OCONEE	98	2.6

ORANGEBURG	68	1.8
PICKENS	74	1.9
RICHLAND	324	8.5
SALUDA	21	.5
SPARTANBURG	263	6.9
SUMTER	90	2.3
UNION	34	.9
WILLIAMSBURG	20	.5
YORK	221	5.8
DO NOT KNOW	14	

**GENDER OF RESPONDENT**

	Frequency	Weighted Percent
MALE	1869	48.6
FEMALE	1974	51.4

**DO YOU CURRENTLY HAVE MEDICARE**

	Frequency	Weighted Percent
YES	698	18.2
NO	3039	79.1
DO NOT KNOW	49	1.3
REFUSED	56	1.4

**HAVE ADDITIONAL INSURANCE TO SUPPLEMENT MEDICARE**

	Frequency	Weighted Percent
YES	392	56.1
NO	287	41.1
DO NOT KNOW	17	2.5
REFUSED	2	.2

**ENROLLED IN A MEDICARE ADVANTAGE PLAN**

	Frequency	Weighted Percent
YES	147	21.0
NO	442	63.3
DO NOT KNOW	108	15.5
REFUSED	2	.2

**INSURANCE THROUGH A RAILROAD RETIREMENT PLAN**

	Frequency	Weighted Percent
YES	45	1.6
NO	2720	95.8
DO NOT KNOW	47	1.7
REFUSED	25	.9

**TRICARE, VETERANS AFFAIRS, OR MILITARY HEALTH CARE**

	Frequency	Weighted Percent
YES	270	7.0
NO	3463	90.1
DO NOT KNOW	52	1.4
REFUSED	58	1.5

**ACTIVE MILITARY HEALTH INSURANCE**

	Frequency	Weighted Percent
YES	67	1.7
NO	3671	95.5
DO NOT KNOW	44	1.1
REFUSED	61	1.6

**INDIAN HEALTH SERVICE**

	Frequency	Weighted Percent
YES	13	.3
NO	3732	97.1
DO NOT KNOW	37	1.0
REFUSED	61	1.6

**DO YOU CURRENTLY HAVE MEDICAID**

	Frequency	Weighted Percent
YES	604	15.7
NO	3112	81.0
DO NOT KNOW	64	1.7
REFUSED	63	1.6

**CHILDREN'S HEALTH INSURANCE PROGRAM**

	Frequency	Weighted Percent
YES	96	9.5
NO	820	81.6
DO NOT KNOW	53	5.3
REFUSED	36	3.6

**INSURANCE THROUGH SC HEALTH INSURANCE POOL**

	Frequency	Weighted Percent
YES	43	1.1
NO	3655	95.1
DO NOT KNOW	82	2.1
REFUSED	63	1.6

**INSURANCE THROUGH FEDERAL HIGH RISK POOL**

	Frequency	Weighted Percent
YES	10	.3
NO	3704	96.4
DO NOT KNOW	65	1.7
REFUSED	63	1.6

**INSURANCE THROUGH OWN WORK OR UNION**

	Frequency	Weighted Percent
YES	985	34.7
NO	1784	62.8
DO NOT KNOW	40	1.4
REFUSED	29	1.0

**INSURANCE THROUGH SOMEONE ELSE'S WORK OR UNION**

	Frequency	Weighted Percent
YES	1013	26.4
NO	2712	70.6
DO NOT KNOW	52	1.4
REFUSED	65	1.7

**INSURANCE THROUGH COBRA**

	Frequency	Weighted Percent
YES	46	1.2
NO	3675	95.6
DO NOT KNOW	58	1.5
REFUSED	64	1.7

**COBRA - INDIVIDUAL OR FAMILY POLICY**

	Frequency	Weighted Percent
INDIVIDUAL POLICY	19	40.5
FAMILY	26	56.2
DO NOT KNOW	2	3.3

**HEALTH INSURANCE BOUGHT DIRECTLY BY R**

	Frequency	Weighted Percent
YES	379	13.3
NO	2375	83.7
DO NOT KNOW	52	1.8
REFUSED	33	1.1

**INDIVIDUAL OR FAMILY POLICY- R BOUGHT INSURANCE**

	Frequency	Weighted Percent
INDIVIDUAL POLICY	265	70.0
FAMILY	111	29.4
DO NOT KNOW	2	.5
REFUSED	1	.1

**INSURANCE BOUGHT DIRECTLY BY SOMEONE ELSE**

	Frequency	Weighted Percent
YES	443	11.5
NO	3269	85.1
DO NOT KNOW	62	1.6
REFUSED	69	1.8

**INDIVIDUAL OR FAMILY POLICY- BOUGHT BY SOMEONE ELSE**

	Frequency	Weighted Percent
INDIVIDUAL POLICY	72	16.2
FAMILY	362	81.7
DO NOT KNOW	8	1.8
REFUSED	1	.3

**DOES PURCHASED INSURANCE INCLUDE A DEDUCTIBLE**

	Frequency	Weighted Percent
YES	581	72.3
NO	134	16.7
DO NOT KNOW	87	10.8
REFUSED	1	.2

**DOES PURCHASED INSURANCE INCLUDE COPAYMENTS**

	Frequency	Weighted Percent
YES	561	69.9
NO	170	21.2
DO NOT KNOW	70	8.7
REFUSED	1	.2

**DOES PURCHASED INSURANCE PAY FOR PRESCRIPTIONS**

	Frequency	Weighted Percent
YES	627	78.1
NO	107	13.3
DO NOT KNOW	69	8.6

**DOES ANYONE ELSE PAY FOR MEDICAL BILLS**

	Frequency	Weighted Percent
YES	125	20.1
NO	393	63.4
DO NOT KNOW	39	6.3
REFUSED	63	10.2

**WHO PAYS FOR MEDICAL BILLS**

	Frequency	Weighted Percent
FAMILY MEMBER PAYS OUT OF POCKET FOR ANY BILLS	119	95.1
NO PRIVATE OR PUBLIC INSURANCE	5	3.9
DO NOT KNOW	1	1.0

**ANYTIME IN PAST 12 MONTHS DID NOT HAVE HEALTH INSURANCE**

	Frequency	Weighted Percent
YES	213	6.6
NO	2976	92.3
DO NOT KNOW	32	1.0
REFUSED	2	.0

**HAD ANY HEALTH INSURANCE IN PAST 12 MONTHS**

	Frequency	Weighted Percent
YES	104	16.7
NO	418	67.5
DO NOT KNOW	37	6.0
REFUSED	61	9.8

**EMPLOYMENT STATUS**

	Frequency	Weighted Percent
SELF EMPLOYED OR OWN YOUR BUSINESS	150	5.3
EMPLOYED BY SOMEONE	1279	45.0
AN UNPAID WORKER FOR A FAMILY BUSINESS	7	.2
RETIRED	602	21.2
UNEMPLOYED OR NOT WORKING	537	18.9
A FULL-TIME STUDENT	194	6.8
DO NOT KNOW	25	.9
REFUSED	44	1.5

### MARITAL STATUS

	Frequency	Weighted Percent
MARRIED	1522	53.6
LIVING WITH A PARTNER	122	4.3
DIVORCED	231	8.1
SEPARATED	62	2.2
WIDOWED	171	6.0
HAVE YOU NEVER BEEN MARRIED	674	23.7
DO NOT KNOW	9	.3
REFUSED	47	1.7

### EVER COVERED BY HEALTH INSURANCE

	Frequency	Weighted Percent
YES	75	66.0
NO	19	16.5
DO NOT KNOW	11	9.8
REFUSED	9	7.7

### TYPE OF INSURANCE PRIOR TO BECOMING UNINSURED

	Frequency	Weighted Percent
MEDICARE	3	3.9
SOME OTHER FORM OF PUBLIC INSURANCE	17	22.2
INSURANCE THROUGH EMPLOYER	28	37.6
INSURANCE BOUGHT DIRECTLY BY YOU OR SOMEONE ELSE	6	7.7
VETERANS AFFAIRS	3	4.0
COBRA	1	1.9
MEDICAID	10	13.1
DO NOT KNOW	7	9.5

**WAS INSURANCE THROUGH PARENT'S/GUARDIAN'S PLAN**

	Frequency	Weighted Percent
YES	52	69.9
NO	18	24.1
DO NOT KNOW	4	6.0

**SPOUSE/PARTNER HAS INSURANCE THROUGH WORK**

	Frequency	Weighted Percent
YES	45	15.4
NO	170	57.9
SPOUSE/PARTNER DOES NOT WORK	24	8.1
NO SPOUSE/PARTNER NOT IN HH OR IN AREA	37	12.6
DO NOT KNOW	14	4.7
REFUSED	4	1.2

**COULD SPOUSE'S INSURANCE BE EXTENDED TO COVER R**

	Frequency	Weighted Percent
YES	21	46.2
NO	18	40.4
DO NOT KNOW	6	13.4

**SPOUSE ELIGIBLE FOR INSURANCE THROUGH WORK, BUT NOT SIGNED UP**

	Frequency	Weighted Percent
YES	18	9.5
NO	144	76.4
DO NOT KNOW	22	11.8
REFUSED	4	2.3

**IF SPOUSE SIGNED UP FOR INSURANCE, COULD IT COVER R**

	Frequency	Weighted Percent
YES	11	60.1
NO	2	11.9
DO NOT KNOW	5	28.0

**MAIN REASON R DID NOT GET INSURANCE THROUGH FAMILY MEMBER**

	Frequency	Weighted Percent
COULD NOT AFFORD/TOO EXPENSIVE	12	56.4
EXPECT TO GET OWN HEALTH INSURANCE SOON	4	16.8
AFTER WAIT PERIOD WILL BE COVERED BY FAM MEMBERS POLICY	2	11.9
WONT ALLOW COVERAGE UNTIL MARRIED	2	8.4
DO NOT KNOW	1	6.5

**MAIN REASON R HAS NOT BOUGHT HEALTH INSURANCE**

	Frequency	Weighted Percent
DO NOT NEED OR WANT ANY HEALTH INSURANCE	5	.9
RARELY SICK	1	.3
DO NOT KNOW WHERE TO BEGIN/WHERE TO GO	1	.2
TOO MUCH HASSLE/PAPERWORK	2	.4
COULD NOT AFFORD/TOO EXPENSIVE	367	69.7
EXPECT TO GET OWN HEALTH INSURANCE SHORTLY	8	1.6
NOT ELIGIBLE FOR REASON OTHER THAN HEALTH	11	2.2
DOUBT ELIGIBLE/REJECTED BECAUSE OF HEALTH CONDITION	4	.7
NOT WORKING AND CANT AFFORD	18	3.3
JUST HAVENT LOOKED INTO IT	5	.9
NOT EMPLOYED LONG ENOUGH TO RECEIVE BENEFITS	3	.6
EMPLOYER DOES NOT OFFER HEALTH INSURANCE	3	.6

DOES NOT WORRY ABOUT HEALTH INSURANCE	2	.4
STUDENT-CANT AFFORD	3	.6
PARENTS JOB DOES NOT OFFER COVERAGE	1	.2
CANCELED PLAN	1	.2
COVERED THROUGH STATE	2	.3
DISABILITY	1	.2
NOT IN SCHOOL	1	.3
HIGH RISK	1	.1
TOO YOUNG AND NOT WORKING	2	.3
SELF-INSURED	1	.2
DO NOT KNOW	43	8.2
REFUSED	41	7.7

**EMPLOYER OFFER INSURANCE AS BENEFIT**

	Frequency	Weighted Percent
YES	85	36.1
NO	115	48.6
NOT APPLICABLE/NOT EMPLOYED	7	3.1
DO NOT KNOW	27	11.6
REFUSED	1	.6

**CAN EMPLOYER COVERAGE BE EXTENDED TO DEPENDENTS**

	Frequency	Weighted Percent
YES	47	55.4
NO	15	17.5
DO NOT HAVE ACCESS TO INSURANCE THRU OWN EMPLOYER	3	3.4
DO NOT KNOW	20	23.8

**EMPLOYER CONTRIBUTE TO INSURANCE COSTS AS BENEFIT**

	Frequency	Weighted Percent
YES	21	25.0
NO	33	40.7
DO NOT KNOW	28	34.4

**WHY R IS NOT INCLUDED IN EMPLOYER'S INSURANCE PLAN**

	Frequency	Weighted Percent
TOO MUCH HASSLE/PAPERWORK	1	1.6
COULD NOT AFFORD/TOO EXPENSIVE	32	39.0
DO NOT WORK ENOUGH HOURS IN A WEEK	5	6.3
HAVE NOT WORKED THERE LONG ENOUGH	14	17.2
FULL TIME TEMPORARY EMPLOYEE	7	8.4
PROCRASTINATION	1	1.0
PLAN TO GET DURING OPEN ENROLLMENT	1	1.0
ONLY PROVIDED FOR MANAGERS	3	3.2
NEW OWNER	1	1.6
SELF INSURED	1	1.6
HAVENT DONE IT	1	1.6
NOT A GOOD PLAN	1	1.0
DO NOT KNOW	14	16.4

**PARENT'S EMPLOYER OFFER HEALTH INSURANCE**

	Frequency	Weighted Percent
YES	25	27.0
NO	24	25.3
NOT APPLICABLE/PARENT NOT EMPLOYED	8	8.9
DO NOT KNOW	4	4.7
REFUSED	32	34.1

**PARENT'S EMPLOYER CONTRIBUTE TO HEALTH INSURANCE COSTS**

	Frequency	Weighted Percent
YES	9	36.3
NO	12	47.1
DO NOT KNOW	4	16.6

**PARENT IS COVERED UNDER EMPLOYER HEALTH PLAN**

	Frequency	Weighted Percent
YES	6	25.1
NO	19	74.9

**PARENT'S EMPLOYERS HEALTH PLAN CAN COVER DEPENDENTS**

	Frequency	Weighted Percent
YES	6	100.0

**MAIN REASON NOT COVERED UNDER PARENT'S PLAN**

	Frequency	Weighted Percent
TOO MUCH HASSLE/PAPERWORK	3	49.9
COULD NOT AFFORD/TOO EXPENSIVE	2	25.9
REFUSED	2	24.2

**MAIN REASON PARENTS HAVE NOT BOUGHT INSURANCE FOR CHILD**

	Frequency	Weighted Percent
COULD NOT AFFORD/TOO EXPENSIVE	42	45.1
BENEFIT PACKAGE DID NOT MEET NEEDS	1	1.4
STARTING ON COBRA SOON	2	1.8
PARENT INTERMITTENTLY EMPLOYED	1	1.5
DO NOT KNOW	12	12.9
REFUSED	35	37.3

**EVER GOTTEN INFORMATION ON SC PUBLIC HEALTH PROGRAMS**

	Frequency	Weighted Percent
YES	116	18.7
NO	371	59.9
DO NOT KNOW	63	10.1
REFUSED	70	11.3

**WOULD ENROLL IN SC HEALTH PROGRAM IF ELIGIBLE**

	Frequency	Weighted Percent
YES	427	68.9
NO	43	6.9
DO NOT KNOW	80	12.9
REFUSED	70	11.3

**WOULD ENROLL IN SC HEALTH PROGRAM IF NO COST**

	Frequency	Weighted Percent
YES	55	28.7
NO	18	9.5
DO NOT KNOW	49	25.5
REFUSED	70	36.3

**WHY R WOULD NOT ENROLL IN SC HEALTH PROGRAM**

	Frequency	Weighted Percent
DOES NOT WANT TO RECEIVE GOVERNMENT SUPPORT	7	35.8
DO NOT NEED HEALTH INSURANCE	1	7.0
GETTING IT THROUGH EMPLOYER	1	7.0
TRYING TO BECOME/OR IS CITIZEN OF ANOTHER COUNTRY	2	11.7
STRAIN ON PUBLIC	7	38.3

**DOES INSURANCE COVER DENTAL CARE**

	Frequency	Weighted Percent
YES	2317	60.3
NO	1348	35.1
DO NOT KNOW	103	2.7
REFUSED	74	1.9

**HEALTH RATING**

	Frequency	Weighted Percent
EXCELLENT	1279	33.3
VERY GOOD	1038	27.0
GOOD	873	22.7
FAIR	394	10.3
POOR	173	4.5
DO NOT KNOW	13	.3
REFUSED	72	1.9

**R - HISPANIC**

	Frequency	Weighted Percent
YES	125	3.2
NO	3621	94.2
DO NOT KNOW	17	.4
REFUSED	80	2.1

**R - WHITE**

	Frequency	Weighted Percent
NOT MENTIONED	1275	33.2
YES	2567	66.8

**R - BLACK/AFRICAN AMERICAN**

	Frequency	Weighted Percent
NOT MENTIONED	2741	71.3
YES	1101	28.7

**R - ASIAN**

	Frequency	Weighted Percent
NOT MENTIONED	3792	98.7
YES	51	1.3

**R - AMERICAN INDIAN**

	Frequency	Weighted Percent
NOT MENTIONED	3790	98.6
YES	52	1.4

**R - NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**

	Frequency	Weighted Percent
NOT MENTIONED	3838	99.9
YES	5	.1

**R - SOME OTHER RACE**

	Frequency	Weighted Percent
NOT MENTIONED	3843	100.0

**R - MORE THAN ONE RACE/MULTIRACIAL**

	Frequency	Weighted Percent
NOT MENTIONED	3681	95.8
YES	162	4.2

**R – REFUSED RACE QUESTION**

	Frequency	Weighted Percent
NOT MENTIONED	3735	97.2
MENTIONED	108	2.8

### LEVEL OF EDUCATION

	Frequency	Weighted Percent
NO FORMAL SCHOOLING	42	1.2
FIRST GRADE	61	1.7
SECOND GRADE	60	1.7
THIRD GRADE	48	1.3
FOURTH GRADE	69	1.9
FIFTH GRADE	67	1.9
SIXTH GRADE	62	1.7
SEVENTH GRADE	64	1.8
EIGHTH GRADE	95	2.7
NINTH GRADE	116	3.3
TENTH GRADE	141	3.9
ELEVENTH GRADE	107	3.0
TWELFTH GRADE	897	25.2
ONE YEAR-COLLEGE	211	5.9
TWO YEARS-COLLEGE	469	13.2
THREE YEARS-COLLEGE	113	3.2
FOUR YEARS-COLLEGE	484	13.6
FIVE YEARS-COLLEGE	38	1.1
SIX YEARS-COLLEGE	171	4.8
SEVEN YEARS-COLLEGE	27	.8
EIGHT YEARS-COLLEGE	41	1.1
NINE YEARS-COLLEGE	7	.2
TEN OR MORE YEARS-COLLEGE	27	.8
GED	30	.8
DO NOT KNOW	60	1.7
9REFUSED	57	1.6

**CITIZEN OF USA**

	Frequency	Weighted Percent
YES	3700	96.3
NO	68	1.8
DO NOT KNOW	1	.0
REFUSED	73	1.9

**ACTIVE MILITARY**

	Frequency	Weighted Percent
YES	29	1.2
NO	2314	97.0
DO NOT KNOW	1	.1
REFUSED	41	1.7

**REGULAR PLACE FOR MEDICAL CARE**

	Frequency	Weighted Percent
YES	1350	81.9
NO	223	13.5
DO NOT KNOW	24	1.4
REFUSED	52	3.2

**WHERE USUALLY GO FOR MEDICAL CARE**

	Frequency	Weighted Percent
EMERGENCY ROOM/URGENT CARE CENTER	83	6.1
CLINIC	90	6.7
DOCTORS OFFICE	1126	83.4
VA	16	1.2
REGIONAL HOSPITAL	1	.1
MILITARY HOSPITAL	7	.5
URGENT CARE CLINIC	5	.3
HOSPITAL (NO SPECIFIC TYPE)	9	.7
CHURCH CLINIC	1	.1
MUSC	2	.1
JUST DONT GO	1	.1

NURSE AT EMPLOYER	1	.1
FAMILY HEALTH CENTER	2	.1
FREE CLINIC	1	.1
DO NOT KNOW	3	.2
REFUSED	2	.1

**TYPE OF CLINIC**

	Frequency	Weighted Percent
PUBLIC HEALTH, COMMUNITY, FREE CLINIC	33	37.3
HOSPITAL OUT-PATIENT CLINIC	13	14.2
PRIVATE CLINIC	27	30.4
VA CLINIC	1	1.3
CAROLINA HEALTH CENTER	0	.3
MUSC	1	.8
AIKEN MEDICAL CENTER	2	2.0
DOCTORS CARE	2	2.7
DO NOT KNOW	10	11.1

**SEES A PARTICULAR HEALTH CARE PROFESSIONAL**

	Frequency	Weighted Percent
YES	1116	82.7
NO	203	15.0
DO NOT KNOW	23	1.7
REFUSED	9	.7

**NUMBER OF MILES TO DOCTOR**

	Frequency	Weighted Percent
TWO MILES OR LESS	148	11.0
3 - 9 MILES	542	40.1
10 - 25 MILES	414	30.6
MORE THAN 25 MILES	227	16.8
DONT KNOW	14	1.0
REFUSED	5	.4

**RECEIVE HEALTH CARE SERVICES OUT OF STATE**

	Frequency	Weighted Percent
YES	95	7.1
NO	1242	92.0
DO NOT KNOW	8	.6
REFUSED	5	.4

**MAIN REASON NO REGULAR PLACE FOR HEALTH CARE**

	Frequency	Weighted Percent
CAN NOT AFFORD IT	31	10.4
DO NOT HAVE HEALTH INSURANCE	19	6.5
RARELY GET SICK	83	27.7
DO NOT LIKE/TRUST/BELIEVE IN DOCTORS	6	2.0
CLINIC I USED TO GO TO IS CLOSED	2	.6
JUST MOVED, DO NOT HAVE A REGULAR PLACE YET	15	4.9
JUST SWITCHED INSURANCE, DO NOT HAVE REGULAR PLACE YET	1	.4
TWO OR MORE PLACES DEPENDING ON WHAT IS WRONG	7	2.4
JUST DID NOT NEED IT/NO MEDICAL PROBLEMS	1	.2
NEVER GOT A FAMILY DOCTOR	1	.4
DISSASTIFIED WITH CARE BY DOCTORS	1	.4

DOCTOR DIED/RETIRED/LEFT AND HAVENT GOTTEN ANOTHER	6	2.0
PRIMARY CARE DOCTOR IS IN ANOTHER STATE	0	.2
DO NOT GO TO THE DOCTOR THAT MUCH	5	1.5
GOES WHERE HE/SHE NEEDS TO GO	5	1.7
JUST DONT	11	3.6
CANT FIND RIGHT PLACE	9	2.8
CANT FIND ONE THAT ACCEPTS MEDICAID	3	.8
USE DIFFERENT KIND OF DOCTOR	1	.3
IN BETWEEN DOCTORS	5	1.6
IN HOSPICE CARE	0	.2
TRAVELS A LOT WITH JOB	2	.5
SOMEONE TAKES HIM/HER	4	1.2
TWO DIFFERENT PLACES BECAUSE HE/SHE IS STUDENT	3	.8
IN SCHOOL	1	.4
NO INSURANCE	1	.4
GOES TO BEST PLACE	1	.2
DO NOT KNOW	24	8.1
REFUSED	52	17.6

**CONFIDENT CAN GET HEALTH CARE WHEN NEEDED**

	Frequency	Weighted Percent
STRONGLY AGREE	794	48.1
AGREE	616	37.3
DISAGREE	120	7.3
STRONGLY DISAGREE	54	3.2
DO NOT KNOW	19	1.2
REFUSED	47	2.9

**NUMBER OF VISITS TO A DOCTOR IN PAST 12 MONTHS**

	Frequency	Weighted Percent
NONE	205	12.4
1 - 3 TIMES	706	42.8
4 - 10 TIMES	488	29.6
MORE THAN 10 TIMES	139	8.4
DONT KNOW	45	2.7
REFUSED	67	4.0

**NUMBER OF VISITS TO A DOCTOR IN PAST 3 MONTHS**

	Frequency	Weighted Percent
NONE	636	38.6
ONCE	465	28.2
2 - 5 TIMES	386	23.4
SIX OR MORE TIMES	63	3.8
DONT KNOW	32	2.0
REFUSED	67	4.0

**STAY OVERNIGHT IN HOSPITAL IN PAST 12 MONTHS**

	Frequency	Weighted Percent
YES	156	9.5
NO	1426	86.5
DO NOT KNOW	7	.4
REFUSED	60	3.7

**NUMBER OF TIMES ADMITTED TO HOSPITAL IN PAST 12 MONTHS**

	Frequency	Weighted Percent
1	101	64.4
2	40	25.3
3	0	.2
5	1	.9
6	1	.7
7	8	4.9
8	1	.8
9	2	1.3
DO NOT KNOW	2	1.2
REFUSED	0	.1

**BEEN TO EMERGENCY ROOM IN PAST 12 MONTHS**

	Frequency	Weighted Percent
YES	331	20.1
NO	1243	75.4
DO NOT KNOW	10	.6
REFUSED	65	4.0

**NUMBER OF DAYS MISSED WORK/SCHOOL IN PAST 12 MONTHS**

	Frequency	Weighted Percent
NONE	538	34.8
1 - 4 DAYS	356	23.0
5 - 10 DAYS	142	9.2
MORE THAN 10 DAYS	75	4.8
DONT KNOW	24	1.6
INDIVIDUAL DOES NOT WORK OR GO TO SCHOOL	351	22.7
REFUSED	61	3.9

**R - MORE THAN ONE PAYING JOB**

	Frequency	Weighted Percent
YES	59	7.1
NO	605	73.2
NOT EMPLOYED/DOES NOT HAVE A JOB	140	16.9
DO NOT KNOW	2	.2
REFUSED	21	2.6

**TOTAL NUMBER OF HOURS USUALLY WORKED PER WEEK**

	Frequency	Weighted Percent
0 - 19 HOURS	52	7.6
20 - 34 HOURS	103	15.0
35 - 40 HOURS	290	42.2
MORE THAN 40 HOURS	203	29.5
DONT KNOW	40	5.8

**PERMANENT, TEMPORARY, OR SEASONAL JOB**

	Frequency	Weighted Percent
PERMAMENT	563	82.0
TEMPORARY	55	8.1
SEASONAL	29	4.2
DO NOT KNOW	13	1.8
REFUSED	27	3.9

**NUMBER OF PEOPLE WORK AT COMPANY**

	Frequency	Weighted Percent
JUST ONE	33	4.8
BETWEEN 2 & 10 PEOPLE	79	11.6
11 TO 50 PEOPLE	89	12.9
51 TO 100 PEOPLE	68	9.9
MORE THAN 100 PEOPLE	351	51.1
DO NOT KNOW	38	5.5
REFUSED	29	4.2

**HOW LONG EMPLOYED IN CURRENT POSITION**

	Frequency	Weighted Percent
LESS THAN 1 MTH	13	1.9
MORE THAN 1 MTH BUT LESS THAN 6 MTHS	57	8.3
MORE THAN 6 MTHS BUT LESS THAN 1 YR	49	7.1
MORE THAN 1 YR BUT LESS THAN 5 YRS	204	29.7
MORE THAN 5 YRS	319	46.4
DO NOT KNOW	14	2.0
REFUSED	32	4.6

**IMPORTANCE OF PREMIUMS IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1160	70.3
SOMEWHAT IMPORTANT	299	18.1
NOT TOO IMPORTANT	51	3.1
NOT AT ALL IMPORTANT	42	2.5
DO NOT KNOW	28	1.7
REFUSED	69	4.2

**IMPORTANCE OF BENEFITS IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1341	81.4
SOMEWHAT IMPORTANT	194	11.8
NOT TOO IMPORTANT	19	1.2
NOT AT ALL IMPORTANT	12	.7
DO NOT KNOW	12	.7
REFUSED	70	4.3

**IMPORTANCE OF DEDUCTIBLE IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1040	63.0
SOMEWHAT IMPORTANT	430	26.1
NOT TOO IMPORTANT	57	3.4
NOT AT ALL IMPORTANT	32	1.9
DO NOT KNOW	19	1.2
REFUSED	71	4.3

**IMPORTANCE OF COPAYMENTS IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	981	59.5
SOMEWHAT IMPORTANT	452	27.4
NOT TOO IMPORTANT	98	5.9
NOT AT ALL IMPORTANT	33	2.0
DO NOT KNOW	14	.8
REFUSED	71	4.3

**IMPORTANCE OF YEARLY MAX OUT OF POCKET IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1115	67.6
SOMEWHAT IMPORTANT	351	21.3
NOT TOO IMPORTANT	60	3.7
NOT AT ALL IMPORTANT	37	2.2
DO NOT KNOW	13	.8
REFUSED	73	4.4

**IMPORTANCE OF NETWORK OF AVAILABLE DOCTORS IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1143	69.3
SOMEWHAT IMPORTANT	339	20.6
NOT TOO IMPORTANT	67	4.0
NOT AT ALL IMPORTANT	18	1.1
DO NOT KNOW	10	.6
REFUSED	72	4.4

**IMPORTANCE OF HEALTH CARE PROVIDER QUALITY IN DECISION**

	Frequency	Weighted Percent
VERY IMPORTANT	1438	87.2
SOMEWHAT IMPORTANT	115	6.9
NOT TOO IMPORTANT	5	.3
NOT AT ALL IMPORTANT	9	.6
DO NOT KNOW	10	.6
REFUSED	72	4.4

**EVER HEARD OF HEALTH INSURANCE EXCHANGE**

	Frequency	Weighted Percent
YES	261	15.8
NO	1297	78.7
DO NOT KNOW	19	1.2
REFUSED	72	4.3

**HOW FAMILIAR ARE YOU WITH HEALTH INSURANCE EXCHANGE**

	Frequency	Weighted Percent
VERY FAMILIAR	17	1.0
SOMEWHAT FAMILIAR	93	5.7
NOT TOO FAMILIAR	108	6.5
NOT AT ALL FAMILIAR	43	2.6
NEVER HEARD OF	1316	79.8
REFUSED	72	4.3

**ACCESS TO INTERNET**

	Frequency	Weighted Percent
YES	1253	76.0
NO OR DO NOT KNOW	324	19.7
REFUSED	72	4.3

**HOW FREQUENTLY DO YOU USE INTERNET**

	Frequency	Weighted Percent
EVERY DAY OR ALMOST EVERY DAY	911	68.8
4 OR 5 DAYS PER WEEK	60	4.6
2 OR 3 DAYS PER WEEK	121	9.2
ONE DAY A WEEK OR LESS	150	11.3
DO NOT KNOW	7	.6
REFUSED	74	5.6

**EVER PURCHASE GOODS OR SERVICES OVER INTERNET**

	Frequency	Weighted Percent
YES	905	68.4
NO OR DO NOT KNOW	344	25.9
REFUSED	76	5.7

**EVER PURCHASE INSURANCE PRODUCTS OVER INTERNET**

	Frequency	Weighted Percent
YES	133	13.6
NO	773	78.8
DO NOT KNOW	1	.1
REFUSED	74	7.6

**NUMBER OF PEOPLE WHO LIVE ON FAMILY'S INCOME**

	Frequency	Weighted Percent
1	200	12.1
2	455	27.6
3	326	19.8
4	314	19.1
5	184	11.2
6	51	3.1
7	11	.7
DO NOT KNOW	13	.8
REFUSED	94	5.7

**NUMBER WHO LIVE ON FAMILY'S INCOME- UNDER 21**

	Frequency	Weighted Percent
NONE/ZERO	506	34.8
1	301	20.8
2	352	24.2
3	164	11.3
4	33	2.3
5	18	1.2
DO NOT KNOW	3	.2
REFUSED	75	5.2

**FEDERAL POVERTY LEVEL**

	Frequency	Weighted Percent
LESS THAN 100% FPL	495	14.4
100 - 133%	284	8.2
134 - 200%	767	22.2
201 - 400%	1000	29.0
MORE THAN 400% FPL	905	26.2
REFUSED	392	

**ANSWERED NO TO ALL INSURANCE QUESTIONS**

	Frequency	Weighted Percent
HAS INSURANCE	3199	86.3
NO INSURANCE	506	13.7

**ANSWERED NO TO ALL QUESTIONS AND UNINSURED IN PAST YEAR**

	Frequency	Weighted Percent
HAS INSURANCE	2991	80.7
NO INSURANCE	715	19.3

**ANSWERED NO TO ALL QUESTIONS AND UNINSURED ALL YEAR**

	Frequency	Weighted Percent
HAS INSURANCE	3288	88.7
NO INSURANCE	417	11.3

## Appendix E

### C. The Uninsured in South Carolina: Population Estimates

### **The Uninsured in South Carolina**

Based on these data, it is estimated that 633,675 individuals did not have health insurance at the time of the interview; 892,695 were without insurance at some point during the past twelve months; and 522,666 have been without health insurance for twelve months or more. The following data provide information on the percentage of different subgroups that were without health insurance in the past twelve months and the estimated number of South Carolinians this represents.

**Uninsured at Any Point during the Past Twelve Months**

	<u>%</u>	<u>Uninsured Estimate</u>	<u>95% Confidence Interval</u>
<b>Total Population</b>	19.3	892,695	804,614 – 980,776
<b><u>Age</u></b>			
Under 18	10.1%	109,127	78,468 – 139,787
18 – 29	34.4	268,603	223,603 – 313,603
30 – 44	29.1	258,690	213,958 – 303,422
45 – 64	20.8	258,590	210,395 – 306,785
65 and older	2.0	12,637	758 – 24,516
<b><u>Race</u></b>			
White	18.2%	556,920	486,643 – 627,197
African-American	19.8	255,555	208,350 – 302,760
Other race	26.4	72,516	48,420 – 96,611
<b><u>Sex</u></b>			
Male	19.9%	447,770	385,557 – 509,983
Female	18.7	444,174	381,853 – 506,495
<b><u>Federal Poverty Level*</u></b>			
Less than 100% FPL	39.7%	245,255	204,663 – 285,848
100% - 125% FPL	32.1	58,219	43,988 – 72,450
126% - 200% FPL	25.7	191,147	155,705 – 226,589
201% - 400% FPL	12.1	189,935	141,494 – 238,376
More than 400% FPL	6.7	93,016	58,576 – 127,458
<b><u>Ethnicity</u></b>			
Hispanic	37.9%	89,323	58,541 – 120,106
Non-Hispanic	18.5	812,091	728,233 – 895,949
<b><u>Region</u></b>			
Upstate	19.9%	238,891	192,892 – 284,890
Midlands	16.6	246,465	202,121 – 290,809
Pee Dee	22.7	197,916	156,658 – 239,174
Lowcountry	19.9	212,592	166,646 – 258,538
<b><u>Urbanicity</u></b>			
Urban	19.4%	783,939	701,745 – 866,133
Rural	18.1	105,784	73,956 – 137,611

**Uninsured at Time of Interview**

	<b><u>%</u></b>	<b><u>Uninsured Estimate</u></b>	<b><u>95% Confidence Interval</u></b>
<b>Total Population</b>	13.7	633,675	555,531 – 711,819
<b><u>Age</u></b>			
Under 18	5.3%	57,265	34,467 – 80,064
18 – 29	23.6	184,274	144,050 – 224,498
30 – 44	21.3	189,351	149,031 – 229,671
45 – 64	17.2	213,834	169,023 – 258,646
65 and older	0.4	2,527	2 – 7,883
<b><u>Race</u></b>			
White	12.5%	382,500	322,285 – 442,715
African-American	14.9	192,312	150,133 – 234,491
Other race	17.4	47,794	27,072 – 68,517
<b><u>Sex</u></b>			
Male	13.7%	308,264	254,684 – 361,843
Female	13.6	323,036	268,247 – 377,825
<b><u>Federal Poverty Level*</u></b>			
Less than 100% FPL	32.3%	199,540	168,035 – 231,045
100% - 125% FPL	26.0	47,156	33,785 – 60,526
126% - 200% FPL	18.7	139,084	107,460 – 170,708
201% - 400% FPL	7.2	113,019	74,630 – 151,409
More than 400% FPL	2.8	38,873	16,155 – 61,590
<b><u>Ethnicity</u></b>			
Hispanic	31.2%	73,533	44,135 – 102,931
Non-Hispanic	12.9	566,269	493,926 – 638,612
<b><u>Region</u></b>			
Upstate	13.7%	164,463	124,846 – 204,079
Midlands	10.9	161,835	124,694 – 198,977
Pee Dee	16.2	141,244	104,953 – 177,535
Lowcountry	15.9	169,860	127,779 – 211,941
<b><u>Urbanicity</u></b>			
Urban	13.7%	553,606	482,150 – 625,063
Rural	13.4	78,315	50,156 – 106,474

**No Insurance at Any Time During Past Year**

	<u>%</u>	<u>Uninsured Estimate</u>	<u>95% Confidence Interval</u>
<b>Total Population</b>	11.3	522,666	452,035 – 593,297
<b><u>Age</u></b>			
Under 18	4.8%	51,863	30,111 – 73,615
18 – 29	20.0	156,165	118,273 – 194,056
30 – 44	17.2	152,903	115,737 – 190,069
45 – 64	13.6	169,078	128,370 – 209,787
65 and older	0.4	2,527	2 – 7,883
<b><u>Race</u></b>			
White	10.1%	309,060	254,190 – 363,930
African-American	12.2	157,463	118,692 – 196,235
Other race	16.8	46,146	25,710 – 66,582
<b><u>Sex</u></b>			
Male	11.7%	263,262	213,191 – 313,332
Female	10.8	256,528	206,909 – 306,148
<b><u>Federal Poverty Level*</u></b>			
Less than 100% FPL	27.7%	171,123	133,996 – 208,250
100% - 125% FPL	18.8	34,097	22,188 – 46,007
126% - 200% FPL	16.5	122,721	92,615 – 152,827
201% - 400% FPL	5.0	78,486	46,115 – 110,856
More than 400% FPL	1.9	26,378	7,585 – 45,171
<b><u>Ethnicity</u></b>			
Hispanic	26.4%	62,220	34,251 – 90,190
Non-Hispanic	10.6	465,306	398,829 – 531,783
<b><u>Region</u></b>			
Upstate	11.2%	134,451	98,115 – 170,788
Midlands	8.8	130,656	96,894 – 164,418
Pee Dee	13.6	118,575	85,206 – 151,944
Lowcountry	13.3	142,084	103,007 – 181,161
<b><u>Urbanicity</u></b>			
Urban	11.2%	452,583	387,033 – 518,134
Rural	11.8	68,964	42,296 – 95,632

\* Note: These data were adjusted to account for the fact that categories of income in the survey classified individuals into categories from 100 – 133% FPL and 134% to 200% FPL, while the data from the Current Population Survey which were used to derive the population estimates uses categories from 100% - 125% FPL, 126 - 149% FPL, and 150% - 200% FPL. The total population represented in the

poverty data is an estimate of the number persons for whom poverty level was determined, which is why this number differs from the total population for other characteristics.

Appendix E  
D. Key Informants' Survey Results

## Appendix B

### Key Informants' Survey Results

The key informants' survey was a mail survey of individuals with knowledge of health insurance exchanges from different sectors, including large employers, small businesses, health care providers, insurance providers, health care researchers, and non-profit organizations. Questionnaires were mailed to 125 individuals; 57 completed were returned.

This Appendix provides the questionnaire used in this study. Within the questionnaire the number of people who gave each response is shown in bold parentheses (**nn**). For example, on the question of how important the objective of promoting and increasing competition among health insurers should be in the formation of a South Carolina Exchange, 33 respondents thought this was extremely important; 9 very important; 8 somewhat important; 2 not too important; and 1 not at all important.

The responses for those question in which respondent wrote in answers, including those "Other" responses for forced-choice questions are provided following the questionnaire.

# SOUTH CAROLINA HEALTH INSURANCE EXCHANGE

## Key Informant Survey

As part of its effort to review the health insurance marketplace and develop recommendations that will improve access to high quality, affordable health insurance, the South Carolina Department of Insurance is seeking input from individuals knowledgeable about the state's health care system. One component of this review involves the potential for establishing a Health Insurance Exchange for the state. Your responses to this survey will assist the Department and the South Carolina Health Planning Committee as they consider the various issues involved in developing such an Exchange.

For each of the following questions, please circle the number that best represents your point of view. If there is any question that you would prefer not to answer, simply leave the answer blank.

1. There are a number of objectives that could be served by a Health Insurance Exchange. For each of the following, please indicate how important you believe each objective should be in the formation of a South Carolina Exchange: (1 = Extremely important; 2 = Very important; 3 = Somewhat important; 4 = Not too important; and 5 = Not at all important).

<i>Objective</i>	Extremely	Very	Some-what	Not too	Not at all
Promote and increase competition among health insurers	(33)	(9)	(8)	(2)	(1)
Serve as a negotiator with health plans to achieve lower prices	(20)	(14)	(9)	(2)	(9)
Be a driver of quality improvement and cost containment in the health insurance marketplace	(24)	(15)	(13)	(2)	(1)
Provide cost and quality data on health care providers to help promote consumerism and increase transparency in the health insurance market place	(28)	(19)	(7)	(0)	(2)
Require additional quality standards based on State health goals (smoking rates, obesity, etc.)	(14)	(20)	(15)	(4)	(3)
Increase the portability and continuity of health coverage	(30)	(13)	(12)	(0)	(1)
Promote consumer directed health plans	(17)	(16)	(14)	(3)	(5)
Help small businesses with administrative functions and minimize the burdens related to offering health insurance	(18)	(22)	(6)	(3)	(7)

2. Please list any other objectives that you believe should be important considerations in the formation of a South Carolina Health Insurance Exchange.

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3. In terms of the health plans offered, do you think that a South Carolina Health Insurance Exchange:

1. Should offer all qualified health plans **(33)**
2. Should allow only a limited number of plans that meet certain criteria to be offered**(23)**
3. Should only meet the minimum federal requirements for an Exchange **(0)**

4. Exchanges have different business models that they can follow, that are described briefly in the choices below. Which model do you think would work best for South Carolina?

1. Active Purchaser – Exchanges can be active purchasers, negotiate with plans and selectively contract with insurers for Exchange products. This model could limit the number of products offered in the Exchange. **(14)**
2. Passive Clearing House – Exchanges can be passive clearing houses where all qualified health carriers can sell their products. Individuals and businesses can shop among these products. This could maximize the number of plans and choices offered on the Exchange. **(21)**
3. Hybrid Model – Exchanges can be a hybrid (Active Purchaser and Passive Clearing House) with some requirements related to quality limiting the plans that offer on the Exchange. **(19)**

4. Other (please specify) **(3)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Please describe any suggestions for strategies you believe South Carolina could employ to increase competition in the health insurance marketplace.

_____
_____
_____
_____
_____

6a. Different types of information are important for consumers to have when making health plan selection decisions. Please rate the importance for consumers of each of the following types of information in making health plan selection decisions, using the following scale:  
 1 = Extremely important; 2 = Very important; 3 = Somewhat important; 4 = Not too important; and 5 = Not at all important.

<i>Information</i>	Extreme	Very	Some- what	Not too	Not at all
Premium	<b>(48)</b>	<b>(7)</b>	<b>(0)</b>	<b>(0)</b>	<b>(0)</b>
Benefit tier (Bronze, Silver, Gold, etc.)	<b>(19)</b>	<b>(22)</b>	<b>(12)</b>	<b>(2)</b>	<b>(0)</b>
Deductible, or the amount of covered expenses the enrollee pays in full each year before plan benefits begin	<b>(37)</b>	<b>(18)</b>	<b>(1)</b>	<b>(0)</b>	<b>(0)</b>
Co-payments, the fixed amounts paid by the enrollee for each office visit or pharmacy prescription filled	<b>(39)</b>	<b>(16)</b>	<b>(1)</b>	<b>(0)</b>	<b>(0)</b>
Co-insurance, a payment for services where the enrollee's share of payment is based on a percentage of total cost	<b>(29)</b>	<b>(24)</b>	<b>(3)</b>	<b>(0)</b>	<b>(0)</b>
Yearly maximum out-of-pocket expenses, the total of deductible, co-payments, and co-insurance that an enrollee could be responsible to pay over a year	<b>(37)</b>	<b>(11)</b>	<b>(5)</b>	<b>(2)</b>	<b>(0)</b>
Health Plan quality (e.g. National Committee for Quality Assurance)	<b>(33)</b>	<b>(12)</b>	<b>(9)</b>	<b>(2)</b>	<b>(0)</b>
Claims denial rate	<b>(12)</b>	<b>(17)</b>	<b>(19)</b>	<b>(8)</b>	<b>(0)</b>
Average cost of specific services	<b>(8)</b>	<b>(25)</b>	<b>(17)</b>	<b>(3)</b>	<b>(2)</b>
Health plan enrollee satisfaction	<b>(20)</b>	<b>(24)</b>	<b>(9)</b>	<b>(2)</b>	<b>(1)</b>
Network of available doctors and facilities	<b>(41)</b>	<b>(11)</b>	<b>(3)</b>	<b>(0)</b>	<b>(0)</b>
Health care provider quality	<b>(31)</b>	<b>(17)</b>	<b>(5)</b>	<b>(3)</b>	<b>(0)</b>
Patient satisfaction by provider	<b>(11)</b>	<b>(30)</b>	<b>(11)</b>	<b>(4)</b>	<b>(0)</b>
Average health care provider appointment wait times	<b>(2)</b>	<b>(23)</b>	<b>(20)</b>	<b>(10)</b>	<b>(1)</b>
Office hours of health care provider	<b>(4)</b>	<b>(18)</b>	<b>(19)</b>	<b>(11)</b>	<b>(3)</b>

6b. Please list any other type of information that you believe it would be important for consumers to have when making health plan selection decisions.

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7. Claims data will need to be made available to the Exchange so that the required risk adjustment functions can be implemented. The Exchange could also use these data to generate public reports on provider or clinic cost and quality. Should the Exchange use the claims data to generate public reports on provider or clinic cost and quality?

- 1. Yes **(40)**
- 2. No **(8)**
- 3. Undecided **(8)**

8. Should the Exchange make provider “report cards” on standard measures – such as quality, affordability, and accessibility – available to Exchange consumers?

- 1. Yes **(44)**
- 2. No **(8)**
- 3. Undecided **(4)**

9. Quality and cost measures or functionality that goes above and beyond the federal Exchange requirements will add additional cost to Exchange operations. This increased cost could be reflected in higher premiums or Exchange fees. What percent premium increase would you be willing to pay to have access to more detailed cost and quality information on providers and plans?

- 1. Not willing to pay any premium increase for cost and quality information that goes beyond the federal requirements **(21)**
- 2. Willing to pay between 0% to 1% premium increase **(13)**
- 3. Willing to pay between 2% to 3% premium increase **(16)**
- 4. Willing to pay between 3% to 4% premium increase **(2)**
- 5. Willing to pay more than 5% premium increase **(2)**

10. Please describe any suggestions you have for quality and cost control initiatives for a South Carolina Health Insurance Exchange.

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11. An Exchange must be self-sufficient by 2015. This means that after 2015 the federal government will not provide funds to support the operation of a State’s Exchange. Which of the following methods should be used in financing South Carolina’s Exchange:

	<u>Should be used</u>	<u>Should not be used</u>	<u>Unsure</u>
a. an increase in the current premium tax on health plans qualified to be sold through the Exchange (South Carolina’s current premium tax is 1.3%)	<b>(24)</b>	<b>(16)</b>	<b>(13)</b>
b. an increase in the current premium tax for all health plans sold in South Carolina	<b>(26)</b>	<b>(16)</b>	<b>(11)</b>
c. issue bonds and borrow money	<b>(3)</b>	<b>(43)</b>	<b>(5)</b>
d. charge license fees for Navigators (those who provide support in the Exchange enrollment process)	<b>(24)</b>	<b>(17)</b>	<b>(8)</b>
e. create a new tax	<b>(2)</b>	<b>(37)</b>	<b>(11)</b>
f. charge insurers a fee to offer plans on the Exchange	<b>(39)</b>	<b>(11)</b>	<b>(1)</b>
g. charge a fee to small businesses to use the Exchange	<b>(18)</b>	<b>(28)</b>	<b>(6)</b>
h. charge a fee to individuals to use the Exchange	<b>(15)</b>	<b>(33)</b>	<b>(3)</b>
i. support the creation of risk pools to purchase insurance and charge a fee to join a risk pool	<b>(17)</b>	<b>(19)</b>	<b>(15)</b>

11j. Are there any other methods that you believe should be used in financing South Carolina’s Exchange? (Please specify):

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12. Should those who provide support in the Exchange health insurance enrollment process, so called Navigators, hold a certification or license to counsel and advise consumers?

- 1. Yes **(46)**
- 2. No **(3)**
- 3. Undecided **(7)**

13. States may establish combined risk pools for the small group market on and off of the Exchange and for the individual market on and off the Exchange. States may also elect to merge the small group and individual markets. This would create one risk pool for individual and small groups on or off the Exchange. If the risk pools are merged, premiums will be the same between the individual and small group market. Should South Carolina merge the current small group and individual markets?
1. Yes **(37)**
  2. No **(10)**
  3. Undecided **(9)**
14. Carriers who offer dental only plans to offer them on an Exchange. Should the potential Exchange offer other stand-alone benefit plans (example: vision plans)?
1. Yes, stand-alone vision plans should be offered **(4)**
  2. Yes, vision, and other stand-alone coverage plans should be offered **(24)**
  3. No, the Exchange should only offer plans with comprehensive coverage that meets the federal essential benefit requirements **(24)**
  4. Undecided **(5)**
15. Should the potential Exchange offer plans only available in specific geographic areas or should all plans offered on the Exchange have the requirement to be available statewide?
1. Plans only available on certain geographic areas should be allowed **(21)**
  2. All plans offered on an Exchange should be available statewide **(30)**
  3. Undecided **(6)**
16. How should open enrollment be conducted in the individual market?
1. Open enrollment should occur once a year **(21)**
  2. Open enrollment should occur twice a year **(14)**
  3. Open enrollment should occur to coincide with the date of birth **(2)**
  4. Open enrollment should be continuous **(18)**
17. The potential Exchange will be a new forum in which to purchase health insurance. Should comprehensive health insurance products continue to be sold in the market outside of the Exchange or should the Exchange be the only place to purchase these products?
1. Both individual and small group health insurance products should be available outside of the Exchange **(37)**
  2. Individual products should be available for purchase only on the Exchange **(3)**
  3. Small group products should be available for purchase only on the Exchange **(0)**
  4. Both individual and small groups products should only be offered **(12)**
  5. Undecided **(4)**

18. Individuals may choose to wait until they become sick to purchase health insurance, which is known in the industry as adverse selection. This would increase premium cost for everyone. Which of the following preventive strategies would you support in the health insurance market to help ensure the affordability of products sold with the Exchange:

	<u>Support</u>	<u>Don't Support</u>	<u>Unsure</u>
a. institute limited enrollment periods for the individual market	<b>(35)</b>	<b>(9)</b>	<b>(8)</b>
b. institute limited enrollment periods for the small group market	<b>(33)</b>	<b>(11)</b>	<b>(8)</b>
c. institute a waiting period of 30 days for covered services for the individual market	<b>(28)</b>	<b>(18)</b>	<b>(5)</b>
d. institute a waiting period of 30 days for covered services for the small group market	<b>(27)</b>	<b>(20)</b>	<b>(4)</b>
e. institute penalties for dropping coverage and then enrolling again when ill for the individual market	<b>(47)</b>	<b>(3)</b>	<b>(5)</b>
f. institute penalties for dropping coverage and then enrolling again when ill for the small group market	<b>(47)</b>	<b>(3)</b>	<b>(4)</b>

19. In addition to adverse selection due to individuals waiting until they become sick to purchase health insurance, there is also the potential for adverse selection between the benefit tiers offered in the Exchange [bronze (60% actuarial value); silver (70% actuarial value); gold (80% actuarial value); and platinum (90% actuarial value)]. If individuals are allowed to change their benefit tier each year, it is likely that the sickest individuals will gravitate to the platinum plans in the Exchange, while the healthiest enrollees will choose the bronze plans. This adverse selection would have the potential to greatly increase the cost of plans in the highest tiers (gold; platinum) relative to plans in the lower tiers (bronze; silver). Which of the following strategies would you support to limit adverse selection between benefit tiers:

	<u>Support</u>	<u>Don't Support</u>	<u>Unsure</u>
a. require individuals to lock in to an Exchange benefit level for a multiple year period	<b>(12)</b>	<b>(31)</b>	<b>(9)</b>
b. allow individuals to move up or down only one benefit level relative to the previous year's benefit level	<b>(38)</b>	<b>(8)</b>	<b>(8)</b>
c. charge a fee to move up or down a benefit level	<b>(24)</b>	<b>(17)</b>	<b>(11)</b>

20. Are there any other preventive strategies that you would support to help ensure the affordability of products sold within South Carolina's Exchange? (Please specify):

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21. If a market for health insurance products exists outside the potential Exchange, it is possible that certain rules (for marketing, benefits, enrollment) governing health plans in this market could be different than the rules for the Exchange. Should rules for insurers be the same for markets inside and outside the Exchange?

1. Yes, the State should ensure that plan requirements are the same for plans both inside and outside the Exchange. **(35)**
2. No, the rules inside and outside the Exchange do not need to be consistent. **(16)**
3. Undecided **(6)**

22. Assuming that a health insurance marketplace exists outside of the Exchange, should health insurers be allowed to offer health plans on the outside market that are not qualified to be sold on the Exchange?

1. Yes, health insurers should be allowed to offer plans that are not qualified to be sold on the Exchange. **(28)**
2. No, health insurers should not be allowed to offer plans that are not qualified to be sold on the Exchange in the outside market. **(23)**
3. Undecided **(5)**

23. Assuming there is a market outside of the Exchange for health insurance, should health insurers be required to sell the plans they offer on the Exchange in the outside market?

1. Yes, health insurers should be required to offer plans sold on the Exchange in the outside market. **(17)**
2. No, health insurers should not be required to offer plans sold on the Exchange in the outside market. **(25)**
3. Undecided **(14)**

24. Should all health insurers who sell small group or individual health plans in the State be required to offer their products on the Exchange?

1. Yes **(21)**
2. No **(22)**
3. Undecided **(13)**

25. Requiring health insurance carriers who offer plans on the potential Exchange to offer plans in both the individual and small group markets could increase the chance that an individual could keep the same coverage if their employment circumstances change. Should health insurers be required to offer Exchange plans for both the individual and small group markets?

1. Yes **(45)**
2. No **(9)**
3. Undecided **(2)**

26. Should all health insurance plans offered on a State Exchange be subject to additional State certification requirements pertaining to quality and cost of care?

1. Yes **(25)**
2. No **(15)**
3. Undecided **(14)**

27. In the individual market, should Exchange plans be limited to repricing their products only at enrollment/renewal?

1. Yes **(52)**
2. No **(2)**
3. Undecided **(2)**

28. In the small group market, should Exchange plans be limited to repricing their products only at enrollment/renewal?

1. Yes **(53)**
2. No **(1)**
3. Undecided **(2)**

29. Should the State provide premium vouchers to Medicaid eligible individuals to buy commercial health coverage products on the Exchange?

1. Yes **(34)**
2. No **(10)**
3. Undecided **(12)**

30. Should Medicaid contracted health plans be required to offer a commercial product with a comparable provider network on the Exchange to aid individual's transitions between Medicaid and Exchange products?

1. Yes **(30)**
2. No **(16)**
3. Undecided **(9)**

31. The Affordable Care Act gives states the ability to operate a "Basic Health Plan" for individuals between 133% and 200% of the federal poverty level (FPL). A state can use 95% of the tax credits and cost sharing subsidies that would have been available to these individuals for Exchange coverage to operate the "Basic Health Plan." Should South Carolina establish a Basic Health Plan?

1. Yes **(37)**
2. No **(6)**
3. Undecided **(12)**

32. Should the Exchange provide the ability to shop, compare, and purchase health plans or should the Exchange only provide comparison data and direct buyers to the individual insurers to complete the purchase of the health plan?

1. Buyers should be able to shop, compare and purchase plans on the Exchange **(41)**
2. The Exchange should direct customers to the insurers to complete the purchase of the health plan **(0)**
3. The Exchange should direct customers to a listing of approved (State licensed and certified) Navigators to complete selection and enrollment functions **(11)**
4. Undecided **(4)**

33. In the individual market, should the Exchange collect premium contributions from individuals and distribute them to health insurers?

1. Yes **(14)**
2. No **(30)**
3. Undecided **(12)**

34. In the individual market, should the Exchange have the functionality to aggregate premium contributions from multiple sources (individuals, part-time employers, subsidy contributions, etc.) and distribute lump sum premium payments to insurers?

1. Yes **(17)**
2. No **(21)**
3. Undecided **(17)**

35. Administratively, where should the Health Insurance Exchange be located?

1. Should be a new state agency **(2)**
  2. Should be located within an existing state agency **(14)**
  3. Should be a quasi-state agency **(17)**
  4. Should be a not-for-profit organization **(22)**
  5. Other (Specify) **(1)** \_\_\_\_\_
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36. Should the Health Insurance Exchange have a Board of Directors and, if so, how should this board be appointed?
1. The Exchange should not have a Board of Directors ----- SKIP TO Q.38 (5)
  2. The Exchange should have a Board of Directors, with members appointed by the Governor (2)
  3. The Exchange should have a Board of Directors, with some members appointed by the Governor, some appointed by the Senate, and some by the House of Representatives (33)
  4. Other (Specify) (12)
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37. If the Health Insurance Exchange has a Board of Directors, should the members of the board be paid or not?
1. Should be paid (11)
  2. Should not be paid (32)
  3. Undecided (7)

38. Another option would be for South Carolina not to develop its own Health Insurance Exchange, but instead default to the Federal Exchange? Should South Carolina develop its own Exchange or default to the Federal Exchange?
1. State should develop its own exchange (39)
  2. Should default to the Federal Exchange (5)
  3. Undecided (12)

39. Which of the following best describes your position:
1. Health care provider (2)
  2. Health care researcher (3)
  3. Hospital administrator (6)
  4. Insurance administrator (6)
  5. Insurance agent (3)
  6. Small Business Employer (less than 100 employees; non-insurance) (4)
  7. Large Business Employer (100 employees or more; non-insurance) (3)
  8. State Government (2)
  9. Not-for-profit organization (17)
  10. Other (Specify) (9)
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**Key Informant Survey**  
Responses to Open-Ended Questions

**Q2. Please list any other objectives that you believe should be important considerations in the formation of a South Carolina Health Insurance Exchange.**

- Be able to link an individual health status via CCD (continuity care document) or a patient summary for a more accurate quote.
- Outreach to low income groups to ensure they can participate.
- Assist in the creation of large purchasing pools to enable individuals/businesses (large and small) to achieve significant purchasing power for lower prices and higher quality.
- The exchange should offer options to those currently found in the private market, but these options should be provided by private insurance carriers. Subsidies should be available for exchange plans and those outside the exchange. Exchange should utilize the current distribution system of professional insurance agents and brokers to represent and explain options to individuals and businesses. Navigators should be licensed.
- (1) All navigators must be licensed insurance professionals who have undergone an Exchange training certification course. (2) Subsidies should be available both inside and outside of the exchange.
- Help the HHS to repeal this blatant takeover of a private industry.
- Level playing field for all insurers; ensure that none of insurers have unfair advantage.
- Regulate contracting practices between payors and providers to prevent market concentration with one or two insurers.
- Educate consumers about how to select the most appropriate plan.
- Provide costs related to possible health care plans; plans are wonderful but costs involved should be paramount.
- Uniform, consistent quality standards and reporting from SC hospitals.
- Ensuring access to all South Carolinians for health coverage.
- Develop and promote consumer accountability and quality standards.
- Rural consumer access.
- Include mental illness in every coverage, preferably on the line of the State Insurance Plan for State Employees.
- Adequate reimbursement for providers
- Establish mechanisms for consumers to provide input on services and quality of services.
- Expanding access to affordable health insurance to South Carolinians without health insurance.
- (1) Strive to minimize the uninsured rate (i.e., convince as many uninsured as possible to buy insurance.) (2) Minimize disruption to the small group market.
- One of the primary purposes of the exchange is to create consumer-focused marketplace that will help connect people to coverage that is appropriate/right for them. Missing among this list is providing a single point of entry for seamless access to both public programs and tax subsidies. Weight should be given to objectives that promote quality and value for consumers and small businesses and contribute to the long-term success of the exchange.

## **Q2 (cont.)**

- Consolidator - batch small groups so they can purchase as large group.
- Key function is to promote competition and to provide good information to buyers that is objective and quantitative in a manner that cuts through the marketing pitch that is now prevalent in purchasing decisions.
- Protect qualified health plans participating in Exchange from adverse selection.
- Bring more/greater choices to marketplace
- (1) Promote involvement of private exchange market in South Carolina. (2) These private exchanges tend to promote consumer directed plans. These exchanges are already up and running with a track record.
- Consumer choice/cost and quality transparency

**Q4. Exchanges have different business models that they can follow, that are described briefly in the choices below. Which model do you think would work best for South Carolina? - OTHER RESPONSES**

- Hybrid; with requirements pertaining to loss ratio and profits, as well as quality.
- Turn it over to the Feds.
- Focus on the consumer shopping experience. This means encouraging competition and choice (similar to Passive Clearing House), but also providing information that easily allows consumers to make informed decisions (e.g. cost, quality, benefit design and network).

**Q5. Please describe any suggestions for strategies you believe South Carolina could employ to increase competition in the health insurance marketplace.**

- Limit the ability of hospitals to restrict market competition through their contracting process with carriers/payors.
- SC, like many states, has one or two major insurers that control the marketplace. SC should encourage other insurers to participate in the SC exchange to maximize competition.
- Invite insurers from outside the SC marketplace to offer plans that could compete with the current carriers in SC. Encourage more carriers to enter the state through the exchange. Eliminate most favored nation clauses in provider/insurer contracts to allow more level playing field in healthcare price negotiations.
- SC could explore the possibility of a common pricing schedule for all carriers at hospitals only. This would allow all carriers the ability to compete on product and efficiency.
- Get out of the way except to encourage more carriers to enter the state
- Provide to consumer examples of comparisons of plans (out of pocket) for different procedures in their regions; informed decision making for all consumers.
- Create a level playing field for insurers by restricting the use of "most favored nation" provisions and limiting the pricing variance charged by hospital systems to various payors. Look to Maryland for their experience in regulating hospital charges.
- Hopefully, consumers will be able to purchase H/W plans from companies doing business in other states. By only allowing in-state companies to control all plans does not serve consumers; this is part of existing problems.
- Eliminate most favored nation clauses in insurance contracts.
- Pooling across state lines.
- Some kind of forum where consumers, businesses can learn about the services and make a decision based on what is convenient for them
- SC could use regulatory clout to structure a more level playing field. One mechanism would be to reduce the predatory pricing and market dominance of BC/BS of SC.
- Focus on developing fair and efficient markets. Rules clearly communicate, apply equally to all health plans. Avoid duplicative regulatory requirements. Minimize administrative complexities for health plans. Utilize national standards for areas such as risk adjustment, quality reporting, accreditation, data feeds, etc.
- (1) Tort Reform; (2) Illegal Alien legislation; (3) Pharmaceutical Reform.
- Limit number of plans to 15 or so. Do not allow navigators to be producers.
- Transparency on cost, quality, network of providers, ease of use, consumer satisfaction, employer satisfaction, physician/hospital satisfaction - all on a website.
- The state should ensure there is a level playing field inside and outside the exchange to mitigate adverse selection and promote a viable exchange marketplace. Strategies include standardizing benefits, regulating all insurance plans equally, requiring all plans to meet the standards for qualified health plans (both inside and outside exchange) and requiring plans to price their products consistently by standardizing important factors such as geographic areas so they do not differ by market or insurer.

## Q5 (cont.)

- An active purchaser. Limiting plan offerings. Require same rules for insurers inside and outside exchange.
- (1) Standardize plans like Medicare supplement has been to facilitate easy comparisons. (2) Limit use of experience rating so plans compete on pro-social factors instead of selection/underwriting.
- A strong exchange will be positive in this regard. Longstanding ties between agents/brokers and insurers provide a drag on competition and to the extent the exchange serves as a credible source for purchasing insurance, that will promote competition.
- Comparison of product offering and prices.
- Limit underwriting restrictions. Require license (HMO) or some other means of testing solvency for all products. Allow benefit flexibility to create price range.
- Until laws are in place to limit consolidated health insurance markets, I do not foresee the real possibility of increasing competition.
- (1) Allow all plans/insurers to participate. (2) Stimulate free market with encouragement of private exchanges. (3) Pursue the elimination of MFN clauses to increase meaningful competition amongst insurers.
- Eliminate most favored nation clauses in provider agreements.
- Use blind rating of the plans so that all insurers are given an equal, unbiased opportunity to participate.

**Q6b. Please list any other type of information that you believe it would be important for consumers to have when making health plan selection decisions.**

- Estimated annual premium and out of pocket costs for a typical: (1) single adult and (2) family under each plan.
- Time allotted by physician to spend time with patient during office visits. Information on coordination with primary care physician when patient is hospitalized.
- (1) Consumer complaints against insurer. (2) Number of lawsuits against insurer. (3) Size of successful awards.
- (1) Ability to care for/see patients with developmental disabilities. (2) Accessibility of building, offices, exam rooms.
- Ratings based on HEDIS measures; rates for prevention services by practice/plan.
- It would be nice for consumers to determine what plans their preferred physician and hospital participate in. Drive the plan selection by provider instead of making the consumer look at each plans network list.
- Coverage exclusions. Provider retention statistics. Programs available to promote health and wellness.
- Billing department of provider- good communication and transparency. Help desk/questions for health plan.
- Portability of plan.
- Transparency, connectivity (communication between providers and billing office).
- Coverage; for example therapies offered, availability of medications, provider availability.
- All information must be easy to understand, user friendly, and created for those who may not have English as a first language or have limited literacy without patronizing the consumer. If translation is done it should be certain to be in appropriate language for different cultures and groups.
- (1) Financial information about health plan (size, financial health, time in business); (2) In network vs. out of network benefits; (3) network access rules (gatekeeper vs. open access).
- Employer satisfaction rate, physician satisfaction rate, hospital satisfaction rate.
- Consumers need the ability to compare health plans in regard to covered benefits and benefit exclusions, premiums and cost-sharing, type of network and related access requirements, and the network of providers. Some of the information here is secondary and associated with choosing providers not plans. How such information gets presented is critical to avoid overwhelming consumers. Secondary information could be presented as click-throughs to more specific insurer/plan or provider information after a consumer has narrowed their choice of specific products.
- A summary measure- grade of cost and quality, including consumer satisfaction.
- (1) Provider satisfaction with plan. (2) Enrollee satisfaction with specific aspects of plan (not just global rating).
- Provider experience and expertise with individuals with disabilities or special health care needs.
- Average change of premium at first renewal.

**Q6b (cont.)**

- Outcome information on common procedures. Availability of doctor accepting new patients. Comparison of service costs among offered plan for ease of selection.
- Price, network, out of pocket (in that order).

**Q10. Please describe any suggestions you have for quality and cost control initiatives for a South Carolina Health Insurance Exchange.**

- There are a number of quality and cost control initiatives across the country, such as NCQA, patient-centered, medical homes (PCMH), pay for performance (P4P), etc. Need to incorporate these things into exchanges.
- Detailed (in plain English) statements (invoices) from health care providers; mediation procedure for complaints by patients who feel over charged for services. Incentives to report provider fraud.
- Use of reimbursement incentives/disincentives for changes in cost and quality.
- Individuals deserve to know the costs of a procedure before having a health care service rendered. Data should be available regarding costs of service comparisons among available providers along with outcomes.
- While I believe that the information is valuable, without better education on what this information means, most consumers will get no value from it. The general public does not understand the relationship between this type of information and the monthly premium costs.
- (1) People should be responsible for managing their own health or have consequences (higher out of pocket). (2) Practitioners and consumers should both benefit from maintaining/improving health.
- The exchange should not be used as a quality and cost control driver for health plans other than certifying that the plans meet the required federal benefit packages for each type of plan.
- Would like to see ordinary consumers have a seat at the table when decisions are being made that will/could affect them.
- Employer participation in plan design elements. Independent supervisory board with representatives from all stake holders. Consistent and uniform quality standards.
- ED co-pays required; charge for no shows; provider report cards share with other providers - not consumers.
- There are plenty of programs that already work well. Copy those.
- Quality and cost control should be built into the offerings of the South Carolina Health Insurance Exchange - not added on as if it would be an additional benefit. Other consumer groups build in quality and control costs before sale not as add-ons to the basics.
- (1) Focus on encouraging increased competition, and providing a shopping experience that allows the consumer to easily compare QHPs and make informed decisions. (2) Ensure that Exchange requirements do not inhibit innovation by health plans (e.g., plan design and network requirements). (3) Focus on minimizing administration costs associated with new capabilities.
- Focus on limited measures each year and incentives to patients and providers based on outcomes.
- The board should have broad authority to pursue evidence based quality and cost control initiatives.

## Q10 (cont.)

- Establish ongoing relationship with health researchers, trading off access to data for assistance in generating cost/quality reports.
- Quality: provide in a clear format hospital performance on NQF measures that are now collected by Medicare; this would be easy and inexpensive but would provide valuable and meaningful information to the public. The exchange could contract with the Budget and Control Board health statistics to measure the same information specific to commercial business; cost control: still to be mainly in realm of insurers and reflected through premium: price: to the extent exchange promotes purchase through price and quality rather than marketing, cost control will be promoted.
- Website to make comments regarding provider standards and cost control ideas. Option to be paperless.
- Determine median costs and calculate an acceptable range for services. Providers charging more without a quality score would then be easily excluded from exchange network.
- Use already well established measurement processes = NCQA and HEDIS. Don't reinvent the wheel.
- Quality must be weighted very heavily to provide an acuity based level of comparison to prevent good, very good, and excellent providers from being ranked below providers who have poor outcomes but may be cheaper and move patients through their office quicker.
- (1) I would temper the drive to increase functionality value from the exchanges if it means increased costs.
- Evidence based medicine compliance reporting by physician or group as determined by credible data.
- Providing consumers quality and cost information will be confusing unless it is shown in relationship to a specific example. Examples of how fictional consumers used the information may be needed as additional information provided on the exchange.

**Q11j. Are there any other methods that you believe should be used in financing South Carolina's Exchange? (Please specify):**

- Charge a fee to insurers when coverage is sold via exchange (much like agent commission) - perhaps 1%.
- Use of general funds for this public purpose.
- The navigators already exist - licensed insurance professionals. Additional training or courses could be offered to those insurance professionals wishing to represent exchange products and part of the course fee could be used to support SC state exchange operation costs.
- Resist the Federal takeover of this industry.
- Look to other states to find models that are fair and seem to work.
- Increase cigarette tax - not a long-term sustainable stream of funding, but may help in the short-run with implementation of a Health Insurance Exchange in South Carolina.
- (1). Fees (or taxes) should be broad based and levied on all health care industry participants who benefit from the exchange (including providers). (2) Consider advertising revenue.
- Limit current premium tax increase as it will be passed on to consumer. Would like to know revenue of current premium tax. Current is 1.3, maybe go up to 1.5
- Support and money offset by savings due to higher quality and lower cost.
- Popular opinion holds that the exchange should be funded by an assessment on ALL insurers, both inside and outside the Exchange. The funds should be dedicated to the exchange (not available to legislators to redirect) on a non-lapsing basis. Some feel that it would be okay to do a general fund appropriation, a new tax, or a fee on providers depending on what is doable in the state and whether the amount being generated is sufficient to run the exchange. Care should be taken in regard to any source of funds to ensure that exchanges are not underfunded during economic downturns.
- General funds support.
- Sell data like ORS does.
- Tax providers.
- The fee on the insurer should be per enrollee and structured in a manner that insurers are not subsidizing Medicaid/SCHIP, that they are not involved in providing. The fee could also be structured in a per claim manner.
- Bonuses from savings generated by the care providers on the exchange providing the best care and highest quality at a reasonable cost.

**Q20. Are there any other preventive strategies that you would support to help ensure the affordability of products sold within South Carolina's Exchange? (Please specify):**

- Wellness programs such as exercise, gym, Weight Watchers, massage, chiropractic care
- Use of incentives/disincentives for obesity and smoking (higher/lower premiums)
- Higher rates for tobacco users. Higher rates for individuals who are +25% above obese. Higher rates for individuals not having a physical at least once a year.
- Requirement of annual physical or 10% premium hike; also higher rates for smokers.
- Make it as difficult as and as unfriendly as possible so Americans would rise up and tell you how much they dislike what has been done.
- If the point of the exchange is to provide affordable health care coverage, then those who are sicker will need the most comprehensive coverage.
- Allow insurers to underwrite a request to move up a tier.
- Develop and implement feasible options to avoid/eliminate adverse selection.
- Require family inclusions in health care decisions - especially for those with mental illness.
- All preventive strategies are ones that should be supported in an insurance product. They, however, do not truly save healthcare dollars. They do improve quality of life, which is important and adds to economic growth.
- NCQA certification of health plans can improve quality as well as lower costs.
- An effective risk adjustment system is one important way to reduce the risk of adverse selection among exchange coverage levels. Also, insurers are required to treat all enrollees in their plans as a single risk pool, and states operating an exchange should make sure this requirement is carried out effectively as insurers price their products.
- Require same plans inside and outside the Exchange. Make provider compensation unrelated to premium inside and outside the Exchange.
- Require companies that sell on the exchange to offer a "bronze" level plan - in fact, a key to the exchange's success is to ensure that persons who are price sensitive when purchasing insurance have access to a variety of bronze level plans.
- Incentives to stop smoking, weight loss, stress reduction, promote healthy lifestyle.
- HRA
- Affordability in the Exchange will be directly linked to a common sense approach in providing health care, that does not ignore existing business principles; i.e., we can't allow a 90 day grace period for those who don't pay premiums and still control cost.
- Price the platinum level of services at a greater band of separation from other lower levels to reduce consumers to only those who can truly afford it. This will prevent switching.

**Q35. Administratively, where should the Health Insurance Exchange be located?**

- Do an RFP and allow public and private organizations to submit proposals.

**Q36. Should the Health Insurance Exchange have a Board of Directors and, if so, how should this board be appointed?**

- The exchange should have a board of directors appointed by the Governor, Senate, Health Plan, Medical Association, and consumer advocate and technology expert/vendor.
- The exchange should have a board of directors with some members appointed by Governor, by Senate, by House, by the Department of Insurance.
- Board of directors - yes; appointed by Senate, House, and possibly 1-2 consumer groups. No appointments by the Governor.
- Some should be selected at large.
- Board of Directors; not appointed by Governor, possibly appointed by Senate, House, and consumer groups.
- I believe in having a Board of Directors, but I am very skeptical of political appointees.
- Board should have strong consumer representation, although individual patients and consumers would be best involved through advisory boards. Those with financial interest in the Exchange should not be on the board, including insurers and providers. Board should be held publicly accountable.
- If located within a non-profit, the board should consist of members of public and private sectors to include legislators and consumers.
- Should have a Board of Directors with 3 appointed by Governor, 3 by Senate, 3 by House; however, 3 members must be primary care providers, 1 member from an FQNC, 1 member from an RHC, 1 member from SCHA. The others at will.
- The board should be composed of industry stakeholders and state DOI, legislature. There should be a staggered schedule where members rotate off board.
- Some appointments by Governor, etc., but some must come from or be consumers, advocates.
- The exchange should have a board of directors as listed above in #3, but also have a couple of members nominated by consumer advocacy groups in healthcare.

**Q40. Please use this page for any other comments that you would like to make concerning the potential establishment of a Health Insurance Exchange in South Carolina.**

- There are several major organizations in the state of South Carolina that can make a health insurance exchange successful. Blue Cross/Blue Shield of SC, Care Core Nation, benefit focus, electronic health network. There is no need to seek outside the state and they will create high paying knowledge based jobs and opportunities for small business.
- Board of Directors members should have no business or family relationship with the health insurance industry.
- Current competition in local markets (by MSA or County) is currently heavily restricted/constrained by hospital contracting processes. Any hospital can effectively render an insurer uncompetitive through uneven costs contracting- giving lower cost contracts to one or two carriers alone. This is a form of trade restraint and should not be allowed.
- When considering those recipients/insured that are higher income Medicaid beneficiaries, they should pay on a sliding scale portion of the premium. Medicaid is like traditional insurance and creates different behaviors/utilization patterns than those individuals who are on Medicaid/Welfare. Incentives should be built in for wellness and prevention.
- Academics have no idea what will work in the business world.
- Keep it simple. Make it easy for people to understand their options. Ensure data on cost and quality are straight forward and include data on quality in supporting people with disabilities. Ensure board of directors includes people who can represent low-income and disability groups.
- Since I prefer a not-for-profit organization to administer the exchange, I would definitely prefer that no one from any state agency be involved. I do believe that healthcare professionals, insurers, and persons with no monetary interest should be part of the decision making. Would also like to see an ombudsman in the mix for issues, etc. Personally, this is a position I would like to be considered for.
- Patient/public education about the new system will be paramount. Providers will need time to re-organize their billing departments.
- First and foremost for me would be making sure that the unique needs of rural SC citizens are taken into account in the development of any health insurance exchange. Access to care issues will be compounded if the Health Insurance Exchange which will likely be developed is too complicated and cumbersome for those rural consumers who will be its end-users.
- I believe that this survey is of questionable value. My understanding about this kind of search for information is that key informants are usually/traditionally interviewed. Although I am knowledgeable about South Carolina, healthcare and professional standards of practices, this survey presumes a sophisticated level of knowledge -- i.e., health care reform, and state insurance regulations which is unrealistic for most of us. I therefore have concerns about how the information will be used after it is tabulated.

#### Q40 (cont.)

- The board should not have any insurers, producers, health care providers or persons with familial or business relationships with those entities. Navigators should be certified but should not be required to have product licenses. Aggressive work in low income communities by Navigators and extensive public communication will be key to success.
- Will be happy to speak with survey sponsors if that would be helpful.
- Minimize level of statewide coverage for individuals and small groups. Community representation on Board. \$90 limit on profit for plans in exchange.
- (1) It is important that we don't cede control of the exchange to HHS. (2) We should consider allowing/encouraging the private exchange industry to function in SC to enhance the free market in our state. (3) Should evaluate some of the obvious trouble spots in the HHS regulations; i.e., 90 day grace period for someone who has not paid premiums. This will quickly create significant problems. (4) The exchange has been seen by many as a natural evolution on the health care industry that was occurring prior to PPACA. As such, it is good to work on exchange if PPACA is somehow overturned.
- It will be important to make the exchange as consumer focused as possible. Therefore, the Board or any other entity heading the exchange needs to be comprised not only of individuals focused analytically on controlling costs, but also looking for quantifiable improvements in healthcare of the various types of consumers within the SC population. Creative solutions, such as the role of IT, in helping with this approach will need to be incorporated.

## Appendix E

### E. South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study Presentation

South Carolina Perspectives on a  
Health Insurance Exchange:  
A Focus Group Research Study

*Presented by:*

Dr. Lee Pearson  
SC Institute of Medicine and Public Health

**Purpose**

To explore the perspectives of key stakeholder groups in regard to health insurance coverage, marketplace considerations and the type of health insurance exchange that South Carolina could have.

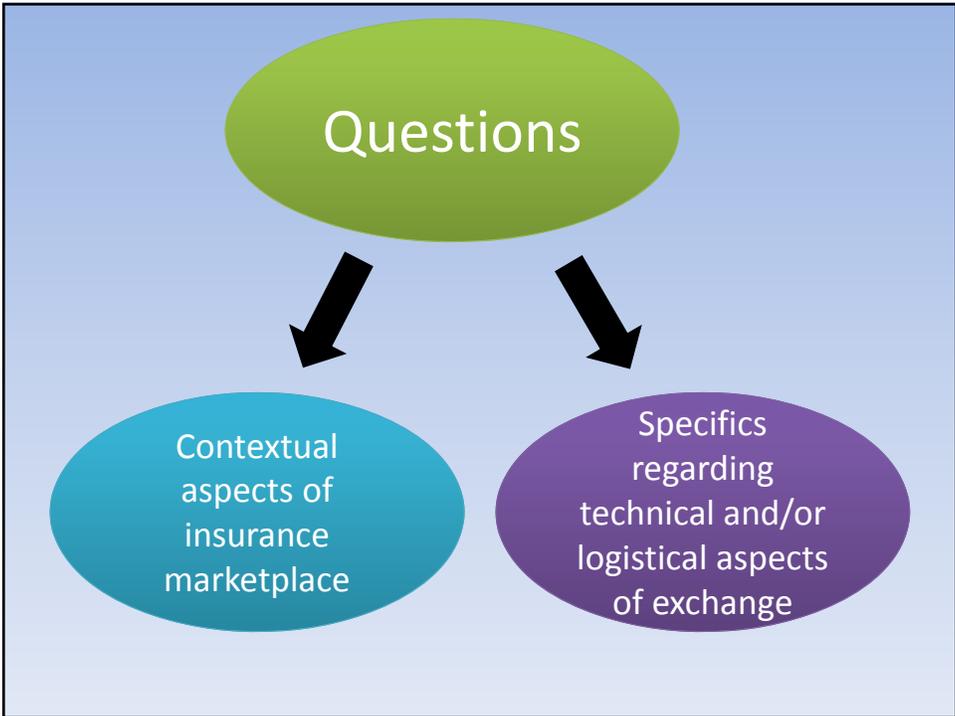
## **Stakeholder Groups**

- Small Business Leaders
- Insurance Agents and Carriers
- Healthcare System Administrators
- Consumer Organization Representatives
- Direct Consumers

## **Methods**

- Six 90-minute focus groups were conducted from July through September 2011
- Structured discussion guides were used with questions tailored to the expertise of each group
- Sessions were digitally (audio) recorded and transcribed verbatim
- Transcripts were reviewed and coded
- Common themes were identified
- Participant statements were included to substantiate each theme

<b>Stakeholder Population</b>	<b>Number of Participants</b>	<b>Session Location</b>
Small Business Leaders (2 groups)	10	Columbia & Charleston
Insurance Agents and Carriers	8	Columbia
Healthcare System Administrators	7	Greenville
Consumer Organization Representatives	5	Columbia
Direct Consumers	11	Greenville



## Themes

- Cost Escalation
- Openness and Information
- Individual/Personal Responsibility
- Competition and Marketplace
- Fostering Innovation

## Overarching Ideas

Introductory Element:

*Theory vs. Practice*

Concluding Element:

*Health Outcomes*

## Cost Escalation

Participants felt that an exchange, intended to increase coverage and create an opportunity to compare plans, would do little to address the underlying issue of the growing cost of healthcare.

*“Neither system right now—the proposed system of the exchange or our current system—is dealing with the cost drivers of healthcare.”*

- Insurance Industry Representative

## Openness and Information

Participants reflected the general confusion and frustration that exists on multiple levels regarding interpreting the costs of both insurance and healthcare services.

*“To read those hospital bills and what the insurance rate was and what the adjusted rate was and what the contractual rate was...it would take a genius to figure that out.”*

- Consumer Organization Representative

## Individual/Personal Responsibility

Participants highlighted the need to promote greater responsibility for both healthcare choices and individual health behaviors.

*“How will people be held accountable for their own health? Those that smoke, that are morbidly obese—they’re the ones that add to the cost of healthcare, and we’re paying for that.”*

- Small Business Leader

## Competition and Marketplace

Participants in most groups expressed a perceived lack of competition in the insurance marketplace.

*“Competition is a concern and despite having put all the large payers essentially on par, other payers have not been able to gain market share.”*

- Healthcare System Representative

## Fostering Innovation

Participants expressed a general desire for something different (as opposed to the current system of coverage options) that they believe should be implemented in an efficient and non-partisan manner.

*“We in South Carolina probably know our people better than the feds probably know us. From the state’s perspective, I think we would be better off doing it [an exchange] ourselves.*

- Healthcare System Representative

## Technical and/or Logistical Aspects

Responses to questions about specific logistical and/or technical questions did not yield sufficient agreement across groups to form a consensus, with one exception:

*There was general agreement that a state-run exchange would be preferable to a federal option.*

## Conclusion

*The specific findings of this study support the need for a broad view of the context of a health insurance exchange and attention to the diverse array of factors—in addition to insurance coverage—that influence the cost and accessibility of healthcare services.*

*If you have questions regarding this research study or the findings presented in our report, please contact the South Carolina Institute of Medicine and Public Health at [info@imph.org](mailto:info@imph.org).*

## Appendix E

### F. South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study Report

# South Carolina Perspectives on a Health Insurance Exchange: A Focus Group Research Study

*This report is based on research conducted by the  
South Carolina Institute of Medicine and Public Health for  
the South Carolina Department of Insurance*

Submitted October 10, 2011

## ABSTRACT

*Perspectives of South Carolinians regarding a health insurance exchange were collected during a series six of focus groups conducted from July through September 2011. Participants included small business leaders, insurance agents and carriers, healthcare system administrators, representatives of consumer organizations, and direct consumers. Each focus group was facilitated by trained research staff based on a structured discussion guide with questions tailored to the specific expertise of each group. A total of 41 participants were involved in this study. Each focus group was audio-recorded, and the verbatim transcripts were coded by members of the research team using descriptive phrases that were analyzed to identify common themes. Five broad themes emerged from across the discussions: cost escalation, openness and information, individual/personal responsibility, competition and marketplace, and fostering innovation. Each theme represents perspectives shared commonly across the various groups and is based on specific statements made by participants. Numerous questions regarding the technical and/or logistical aspects of an exchange yielded input that was inconsistent across participant groups. The results of this research support the need for a broad view of the context of a health insurance exchange and attention to the diverse array of factors—in addition to insurance coverage—that influence the cost and accessibility of healthcare services.*

## INTRODUCTION

The Patient Protection and Affordable Care Act, which became federal law in March 2010, includes a set of specific provisions for the development and implementation of health insurance exchanges at the state level. As each state explores the specifics of these provisions, a critical question is whether states will develop a state-based exchange or default to a federal option. The South Carolina Health Planning Committee was established in March 2011 to assist with the formulation of policy recommendations regarding whether it is feasible for South Carolina to establish a health insurance exchange and, if so, propose a plan for its successful implementation and sustainability.

In an effort to support the work of the Health Planning Committee, the South Carolina Department of Insurance commissioned research on the status of insurance coverage in the state as well as key perspectives on various aspects of a health insurance exchange. As a component of this broader research initiative, the South Carolina Institute of Medicine and Public Health (formerly the South Carolina Public Health Institute) conducted a focus group study among key constituencies to explore their perspectives on health insurance coverage, marketplace considerations and the type of exchange that South Carolina could have. The content of this report reflects the methodology, results and conclusions relevant to this study.

## **METHODS**

Perspectives on health insurance coverage and related considerations were gathered through six 90-minute focus groups conducted from July through September 2011. Each focus group was comprised of individuals representing prescribed stakeholder groups. These groups included small business leaders, insurance agents and carriers, healthcare system administrators, representatives of consumer organizations, and direct consumers. (Note: An effort was made to include frontline healthcare providers, but scheduling demands on those professionals proved to be a significant barrier in convening that group.)

With the exception of the consumer focus group, participants were recruited through individual contacts and referrals. Professional participants were not provided financial incentives for their involvement, but meals were offered to all participants during each focus group session. The consumer group participants each received a \$75 gift card for their involvement. In order to ensure diverse representation of consumers, a marketing firm was engaged to recruit individuals who reflected varied demographics and represented both the insured and under/uninsured populations.

Each focus group was facilitated by trained research staff based on a structured discussion guide with questions tailored to the specific expertise of each group. The discussion portion of each focus group session was digitally (audio) recorded and transcribed verbatim by a professional transcriptionist. A note-taker was also present for each discussion to ensure redundancy in capturing the data.

At the beginning of each focus group, participants were provided with general information about the purpose of the research as well as the format and agenda for the session. Each participant was advised of the optional nature of their involvement and received a written copy of the overview information. Prior

to the guided discussion portion of each focus group, participants were advised that this research was not intended to be a debate about healthcare reform or the legislation itself. Rather, the focus of the discussion would be the component of the law relating to the formation of a health insurance exchange. The focus group protocol also included a verbal and written description of the basic concepts relevant to a health insurance exchange and the essential aspects that would be used to define participation. Core questions relating to development, implementation and governance of exchanges were asked of each group. Broader questions about the insurance marketplace and the healthcare environment were also included for each group and were tailored to the expertise of participants, as needed.

Members of the research team reviewed the transcripts and coded data using descriptive phrases related to the purpose of the study. Each of the researchers completed coding independently and then met together to share results and conduct further analysis. A standard protocol was used to identify salient themes, recurring ideas or language, and patterns of belief. Following general agreement concerning language, perspectives and overarching themes, the research team identified specific statements from the transcripts to support the themes that emerged. Individual themes were reviewed for rigor and then consolidated (where necessary) to eliminate potential redundancy. Themes representing the most common perspectives on the issues discussed across the groups were confirmed, and participant statements were then included to add clarity and demonstrate the strength of the data.

## **RESULTS**

A total of 41 individuals participated in the six focus groups, which were held in Greenville, Columbia and Charleston, SC. Table 1 details the key stakeholder populations engaged, the number of focus group participants, and the geographic location of each session.

Table 1. Focus Group Information

Stakeholder Population	Number of Participants	Session Location
Small Business Leaders (2 groups)	10	Columbia & Charleston
Insurance Agents and Carriers	8	Columbia
Healthcare System Administrators	7	Greenville
Consumer Organization Representatives	5	Columbia
Direct Consumers	11	Greenville

The convenience sample of participants across the various professional groups provided a cross-section of opinions on the topical focus of this research. Varied levels of understanding in regard to the specifics of an insurance exchange allowed for constructive dialogue and a balanced exchange of ideas. Basic information was provided, as needed, to each group regarding the fundamental concepts relative to a health insurance exchange. The sample of direct consumers was recruited by a third-party entity (as described in the Methods section) with strict criteria for diversity—particularly in regard to insurance status.

Each focus group discussion addressed the contextual aspects of the insurance marketplace as well as the specific technical and/or logistical aspects of an exchange. Questions and prompts were designed to effectively promote discussion within each group, emphasizing the need for balanced involvement by all participants. Across the discussion groups, five consistent themes emerged that represent the substance of the qualitative data: *cost escalation, openness and information, individual/personal responsibility, competition and marketplace, and fostering innovation.*

Bridging those specific themes were two overarching ideas that serve as introductory and concluding elements to the results of this research. The introductory element addresses *theory vs. practice* and the concluding element focuses on the broader *health outcomes* of South Carolinians. The introductory element reflected a shared vision among many participants that the theory behind an exchange—specifically the effort to extend health insurance coverage to those who do not have it—is a laudable goal. It is the practical aspects of that effort that concerned a number of participants as evidenced by the following quotes:

*“It’s a good theory in concept of offering everybody insurance, but I don’t know if it [an exchange] is necessarily the right vehicle to do it.”*

Insurance Industry Representative

*“I hear insurance reform, and I agree—it needs to be done. I have yet to understand how; yet to see a plan.”*

Consumer

The first theme that emerged across all groups was that of *cost escalation*. Participants felt that an exchange, while perhaps increasing coverage options and creating an opportunity to compare plans, would do little to address the underlying issue of the cost of healthcare and the fact that those costs are, in part, what drives the cost of health insurance premiums. As examples of this belief, participants in the insurance industry focus group stated:

*“All it [an exchange] does is bring more volume to the problem, which is cost.”*

*“Neither system right now—the proposed system of the exchange or our current system—is dealing with the cost drivers of healthcare.”*

A participant from the small business focus group underscored that concern by stating:

*“We can’t sustain as consumers any more cuts in benefits, and we can’t sustain as employers the cost of what it takes to be insured.”*

The shared concern around cost escalation extended to the impact of high deductible and maximum coverage health plans which are perceived by some as creating burdens for both consumers and healthcare systems, as expressed by a healthcare system administrator:

*“Patients [with high deductible or maximum coverage policies] become, from our perspective, charity patients, and that has a tendency to cause the patient to not seek care until, lots of times, it’s pretty close to too late.”*

Complementing the attention paid to cost concerns is the second theme of *openness and information*. This theme reflects the apparent confusion and frustration that exists on multiple levels regarding the costs of both insurance and healthcare services. The following quotes yield perspective on this issue:

*“To read those hospital bills and what the insurance rate was and what the adjusted rate was and what the contractual rate was...it would take a genius to figure that out.”*

Consumer Organization Representative

*“I don’t know of a soul that I’ve talked to that understands insurance.”*

Consumer

*“You ask people: What does your medication cost? [They will say] ‘It costs me \$20.’ No, that’s the co-pay. What does it cost? If you knew what it costs, it would curl your hair.”*

Small Business Leader

Another concern related to the substance of the previous quote is that individuals are seen by

some as being removed from the true costs of healthcare. A member of the insurance industry focus group indicated that the conceptual design of a health insurance exchange—particularly the provision of premium subsidies—may contribute to that disconnect:

*“The exchange will further remove the consumer from the cost of healthcare.”*

It is that general sentiment that creates a linkage to the theme of *individual/personal responsibility*. A number of participants from across each of the groups highlighted the need for attention to promoting greater responsibility for both healthcare choices and individual health behaviors as reflected in the following quotes:

*“There has to be a cultural change within the society with regard to wellness and accountability—responsibility—and until that begins to take shape, I don’t see anything changing.”*

Insurance Industry Representative

*“How will people be held accountable for their own health? Those that smoke, that are morbidly obese—they’re the ones that add to the cost of healthcare, and we’re paying for that.”*

Small Business Leader

The broader discussion around this particular theme did include recognition by many of the need for targeted guidance and education for those who require the most help in regard to their health practices. This specific concern was expressed by a healthcare system administrator who commented on the potential limitations of an exchange in addressing this need:

*“It’s one thing to have [insurance] coverage, but then how do you use it in a way that manages your health status in the most effective way?”*

The next theme of *competition and marketplace* grew out of the answers to various

contextual questions that were posed to each group. Participants in most groups expressed a perceived lack of competition in the insurance marketplace, as reflected in the following quotes:

*“All roads lead back to one or two companies with the same amount for premiums.”*

Small Business Leader

*“Competition is a concern and despite having put all the large payers essentially on par, other payers have not been able to gain market share.”*

Healthcare System Administrator

*“We do not have enough competition; we do not have enough quality carriers.”*

Small Business Leader

The issue of competition in the state-level marketplace was also seen as a broader national concern:

*“I think the country, as far as that is concerned, needs to open up the market...cross the state lines...open it up, and I think it’ll create a lot of competition.”*

Consumer

Participants from the insurance industry also focused considerable attention on marketplace concerns, expressing particular interest in the impact that an insurance exchange would have on “redefining the marketplace.”

The final theme of *fostering innovation* emerged from a variety of comments regarding the opportunity that exists through any reform effort to explore new ideas and test innovative practices. Participants expressed a general desire for something different (as opposed to the current system of coverage options) that they believe should be implemented in an efficient and non-partisan manner. Many participants pointed to the opportunity that exists to

highlight promising practices across our state and develop a unique, state-based solution that benefits all South Carolinians. The following quote emphasizes that specific point:

*“We in South Carolina probably know our people better than the feds probably know us. From the state’s perspective, I think we would be better off doing it [an exchange] ourselves.”*

Healthcare System Administrator

Related to this theme, a number of participants also presented their belief that current practices and programs should be preserved (where possible) to minimize cost and duplication of effort and maximize potential benefit.

In addition to each of the five broader themes, participants across all groups shared a belief in the need to improve the health and quality of life of South Carolinians. The concluding element of *health outcomes* became a positive focus for all of the groups. As such, they directed attention to the need for healthcare reform efforts to result in improved health statistics and a higher standard for outcomes in regard to both health and quality of life.

The technical and/or logistical questions related to exchange development yielded little consensus. Most participants preferred to focus on contextual issues they found to be more relevant to current considerations. The one area of general agreement was the belief that a state-run exchange would be preferable to a federal option. Aspects of state control and tailoring to meet the unique needs of the state were seen as advantages to a state-administered exchange. Some participants did express concerns around the sustainability and cost of a state exchange, but most participants were still inclined to support a state approach despite those considerations. Discussion around the structural elements of an exchange (e.g., governance, organizational placement) yielded no consensus opinions. Those aspects were seen as further removed from more immediate issues.

## DISCUSSION

Focus groups are a useful tool in the research process in that they allow for detailed and thoughtful exploration of complex topics by targeted stakeholder groups. This discussion-based research approach also allows for diverse opinions to be captured and analyzed in a manner that provides useful information—particularly when considered in the context of complementary research methods. The focus groups conducted as a part of this study provide important perspectives on a health insurance exchange and offer insight into the complexity of this issue. The specific findings generated by this study support the need for a broad view of the context of a health insurance exchange and attention to the diverse array of factors—in addition to insurance coverage—that influence the cost and accessibility of healthcare services. The lack of agreement on most of the technical and/or logistical aspects of an exchange reflect the divergent opinions that continue to exist on key aspects of this issue.

## CONCLUSION

This study aimed to explore the perspectives of key stakeholder groups on the issues of health insurance coverage, marketplace considerations and the type of health insurance exchange that South Carolina could have. The findings from this research highlight the many considerations that should inform any efforts to establish a health insurance exchange at the state level. The technical and/or logistical aspects of developing and implementing an exchange are vital considerations, but the broader context represented by the common themes detailed in this report offers guidance on the more expansive aspects that should be considered as a part of any reform efforts.

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*This research received institutional review board approval from the University of South Carolina.*

*The South Carolina Institute of Medicine and Public Health is an independent convener and research entity established to provide evidenced-based information on issues related to the health of South Carolinians. The Institute is nonpartisan and does not make specific recommendations related to policy considerations. The role of the Institute and its research staff is to provide credible, fact-based information that advances the dialogue on health issues in our state.*

*The research team would like to acknowledge those individuals who participated in this study. By sharing their perspectives and experiences, these individuals have allowed for greater insight into the critical issues relating to the focus of this research.*

*For questions regarding this study or the findings presented in this report, please contact the Institute of Medicine and Public Health at [info@imph.org](mailto:info@imph.org).*

## Appendix E

### G. Expanding Insurance Coverage and Stabilizing Rates within the South Carolina Small Group Market

Full report may be accessed at

<http://www.healthplanning.sc.gov/Documents/Planning%20Overview/Expanding%20Insurance%20Coverage%20and%20Stabilizing%20Rates%20SC%20Small%20Group%20Market%20-%202004.pdf>

## Appendix E

### H. Public Comments

A public comment session was held in Columbia, SC on October 10, 2011. The following comments were received by the South Carolina Health Planning Committee:

Lynn Bailey, Lynn Bailey Associates, noted that the [research] presentation provided percentages, not absolute numbers; questioned whether there were problems with the sample since 400 additional uninsured families were added; and questioned income information provided [by the researcher] regarding federal poverty and family size.

Dr. Ira Williams left the group with a cautionary tale that the efforts to reverse the trend of needless hospital deaths are headed in the wrong direction. He expressed the urgency of addressing the dysfunction of our health care system.

## Appendix F

### Glossary of Health Insurance Terms

## Glossary of Health Insurance Terms

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. Below are definitions for some of the more commonly used terms and how PPACA impacts their use.

### -A-

**Actuarial justification** — The demonstration by an insurer that the premiums collected are reasonable, given the benefits provided under the plan or that the distribution of *premiums* among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. PPACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

**Adjusted community rating** — A way of pricing insurance where *premiums* are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. PPACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

**Annual limit** — Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for *essential benefits* for plan years beginning after Sept. 23, 2010.

### -B-

**Balance billing** — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount. This is known as "balance billing."

### -C-

**CHIP** — The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Like *Medicaid*, it is jointly funded and administered by the states and the federal government. It was originally called the State Children's Health Insurance Program (SCHIP).

**COBRA coverage** — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. Many states have "mini-COBRA" laws that apply to the employees of employers with less than 20 employees.

**Coinsurance** — A percentage of a health care provider's charge for which the patient is financially responsible under the terms of the policy.

**Community rating** — A way of pricing insurance, where every policyholder pays the same premium, regardless of health status, age or other factors.

**Co-Op Plan** — A health insurance plan that will be sold by member-owned and operated non-profit organizations through *Exchanges* when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

**Co-payment** — A flat-dollar amount which a patient must pay when visiting a health care provider.

**Cost-sharing** — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include *deductibles*, *coinsurance* and *co-payments*. *Balance-billed* charges from *out-of-network physicians* are not considered cost-sharing. PPACA prohibits total cost-sharing exceed \$5,950 for an individual and \$11,900 for a family. These amounts will be adjusted annually to reflect the growth of premiums.

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-D-

**Deductible** — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to \$2,000 for policies that cover an individual, and \$4,000 for other policies. These amounts will be adjusted annually to reflect the growth of premiums.

**Disease management** — A broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

-E-

**ERISA** — The Employee Retirement Income Security Act of 1974 (ERISA) is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

**Essential Benefits** — PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of *cost-sharing* that patients must pay for these services.

**Exchange** — PPACA creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing *qualified health insurance plans*. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as *Medicaid* and *CHIP*.

**External review** — The review of a health plan’s determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan. PPACA requires all health plans to provide an external review process that meets minimum standards.

-F-

**Formulary** — The list of drugs covered fully or in part by a health plan.

-G-

**Grandfathered plan** — A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

**Group health plan** — An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

**Guaranteed issue** — A requirement that health insurers sell a health insurance policy to any person who requests coverage. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

**Guaranteed renewability** — A requirement that health insurers renew coverage under a health plan except for failure to pay premium or fraud. *HIPAA* requires that all health insurance be guaranteed renewable.

-H-

**Health Maintenance Organization (HMO)** — A type of managed care organization (health plan) that provides health care coverage through a network of hospitals, doctors and other health care providers. Typically, the HMO only pays for care that is provided from an *in-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

**Health Savings Account (HSA)** — The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a *qualified high deductible health plan (HDHP)* (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses. Additional information about HSAs can be found on the U.S. Treasury Web site: <http://www.treas.gov/offices/public-affairs/hsa/>.

**High Deductible Health Plan (HDHP)** — A type of health insurance plan that, compared to traditional health insurance plans, requires greater *out-of-pocket spending*, although *premiums* may be lower. In 2010, an HSA-qualifying HDHP must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage. The plan must also limit the total amount of out-of-pocket *cost-sharing* for covered benefits each year to \$5,950 for single coverage and \$11,900 for families.

**High risk pool** — A state-subsidized health plan that provides coverage for individuals *with pre-existing health care conditions* who cannot purchase it in the private market. PPACA creates a temporary federal high risk pool program, which may be administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months.

**HIPAA (Health Insurance Portability and Accountability Act of 1996)** — The federal law enacted in 1996 which eased the “job lock” problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to *pre-existing medical conditions*.

**-I-**

**In-Network provider** — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an *HMO* or *PPO*). The provider agrees to the managed care organization’s rules and fee schedules in order to be part of the network and agrees not to *balance bill* patients for amounts beyond the agreed upon fee.

**Individual mandate** — A requirement that everyone maintain health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.

**Individual market** — The market for health insurance coverage offered to individuals other than in connection with a *group health plan*. PPACA makes numerous changes to the rules governing insurers in the individual market.

**Internal review** — The review of the health plan’s determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans to conduct an internal review upon request of the patient or the patient’s representative.

**Interstate compact** — An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be sold in multiple states.

**-J-**

**Job Lock** — The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status.

**-L-**

**Lifetime limit** — Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual’s life. PPACA prohibits lifetime limits on benefits beginning with on Sept. 23, 2010.

**Limited Benefits Plan** — A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

**-M-**

**Mandated benefit** — A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service.

**Medicaid** — A joint state and federal program that provides health care coverage to eligible categories of low-income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for long-term care (such as nursing home care). PPACA extends eligibility for Medicaid to all individuals earning up to \$29,326 for a family of four.

**Medical loss ratio** — The percentage of health insurance *premiums* that are spent by the insurance company on health care services. PPACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. *Small group* and *individual market* plans must devote 80% of premiums to these purposes.

**Medicare** — A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a *Medicare Advantage* plan (Medicare Part C).

**Medicare Advantage** — An option *Medicare* beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an *out-of-network provider* or one outside of the plan’s service area.

**Medicare Supplement (Medigap) Insurance** — Private insurance policies that can be purchased to “fill-in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original *Medicare* (Part A and Part B).

**Multi-state plan** — A plan, created by PPACA and overseen by the U.S. Office of Personnel Management (OPM), that will be available in every state through *Exchanges* beginning in 2014.

-O-

**Open enrollment period** — A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

**Out-of-network provider** — A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization’s network (such as an *HMO* or *PPO*). Depending on the managed care organization’s rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

**Out-of-pocket limit** — An annual limitation on all *cost-sharing* for which patients are responsible under a health insurance plan. This limit does not apply to *premiums*, *balance-billed* charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of \$5,950 per individual and \$11,900 per family, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance *premiums*.

-P-

**Patient Protection and Affordable Care Act (PPACA)** — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

**Pre-existing condition exclusion** — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

**Preferred Provider Organization (PPO)** — A type of managed care organization (health plan) that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an *out-of-network provider*. Depending on the type of coverage you have, state and federal rules govern disputes between enrolled individuals and the plan.

**Premium** — The periodic payment required to keep a policy in force.

**Preventive benefits** — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for preventive benefits without *deductibles*, *co-payments* or *coinsurance*.

-Q-

**Qualified health plan** — A health insurance policy that is sold through an *Exchange*. PPACA requires Exchanges to certify that qualified health plans meet minimum standards contained in the law.

-R-

**Rate review** — Review by insurance regulators of proposed *premiums* and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

**Reinsurance** — Insurance purchased by insurers from other insurers to limit the total loss an insurer would experience in case of a disaster or unexpectedly high claims. PPACA directs states to create temporary reinsurance programs to stabilize their *individual markets* during the implementation of health reform.

**Rescission** — The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a relevant fact.

**Risk adjustment** — A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. PPACA requires states to conduct risk adjustment for all non-*grandfathered* health insurance plans.

**Risk corridor** — A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

-S-

**Self-insured** — *Group health plans* may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

**Small group market** — The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market to those with between 1 and 100 employees.

**Solvency** — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

-U-

**Usual, Customary and Reasonable charge (UCR)** —

The cost associated with a health care service that is consistent with the going rate for identical or similar services within a particular geographic area.

Reimbursement for *out-of-network providers* is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

-W-

**Waiting period** — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. *Premiums* are not collected during this period.

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<sup>42</sup> In litigation against for-profit hospitals, some plaintiffs are adding hospital employees as additional defendants in order to increase the number of non-economic damage caps available. Governmental and charitable hospitals were excluded from the 2005 Tort Reform legislation, as each has its own separate protection under the South Carolina Tort Claims Act and the Uniform Solicitation of Charities Act.