Why Filling the Health Coverage Gap Matters to Older South Carolinians

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EXECUTIVE SUMMARY

Sixty-three thousand low-income, near-elderly (aged 50 to 64) South Carolinians fall into a health coverage gap and lack health insurance. Although living at less than $16,000 annually for a family of one or $22,000 for a family of two and aged 50 to 64, they are not eligible for current public coverages such as Medicaid or Medicare. Most have too little income to be eligible for federal subsidies to purchase private insurance. As South Carolina considers closing the coverage gap for all of South Carolinians at or below 138% of the Federal Poverty Level (FPL), a particularly vulnerable segment of that population is the persons aged 50 to 64, the near elderly, looking towards Medicare eligibility in the future.

Low-income, near-elderly South Carolinians are particularly vulnerable. Many have deteriorating health, accompanied by a growing proportion of their spending going to health coverage, while family wealth and income has declined. Those plagued by chronic or multiple illnesses especially suffer. In some cases, lack of health insurance has pushed them from middle class into low-income.

Coverage up to 138% of the FPL would come with a 100% federal match for health services, declining in SFY2020 to a 90% federal match and generating $2 billion annually in Federal matching funds by SFY2020. Although not without direct state costs, filling the coverage gap would fuel further economic growth through jobs and purchases of goods and services. At the same time, we would be purchasing better health for a particularly vulnerable portion of our population that has given so much to our state.

South Carolina has an important opportunity to close the coverage gap that leaves 63,000 near-elderly, low-income South Carolinians without health coverage. These South Carolinians, our neighbors, friends and family members, are a diverse group. Although many work, especially in strenuous jobs that wear down bodies, others cope with disability or mental illness. Many serve as caregivers, relieving public programs of significant financial burdens.

Lacking health insurance is bad for your health and leads to higher mortality. Lacking coverage leads to inefficient health care choices such as using emergency departments. Lacking health insurance is financially a very risky prospect, leaving people with low income and low wealth at risk of catastrophe from any significant health event. Health coverage provides a buffer against the kind of debt that leads lower-income families to bankruptcy in the face of a major health incident.

A strong business case argues for filling the coverage gap. Many persons now served by our Department of Mental Health using unmatched state dollars could be served with federal-matched funds. Although only a small portion of state Medicaid enrollees is elderly, their health costs, especially in nursing homes and for community long-term care, are a substantial part of South Carolina’s health budget. Improving health among the near elderly saves South Carolina money.

Filling the health coverage gap makes both economic sense and health care sense. It is especially critical for those aged 50 to 64 who have long helped build and support our community.
**Introduction**

Sixty-three thousand low-income, near-elderly (aged 50 to 64) South Carolinians fall into a health coverage gap and lack health insurance. Although living at less than $16,000 annually for a family of one or $22,000 for a family of two and aged 50 to 64, they are not eligible for current public coverages such as Medicaid or Medicare. Most have too little income to be eligible for federal subsidies to purchase private insurance. As South Carolina considers closing the health gap for all of South Carolinians at or below 138% of the Federal Poverty Level (FPL), a particularly vulnerable segment of that population is the persons aged 50 to 64, the near elderly, looking towards Medicare eligibility in the future.

As laid out below, there are strong business and human cases that argue for South Carolina to close the health gap for this group by providing coverage. During recent years they have faced deteriorating health, ever increasing health care costs and, for many, a decline in family wealth and income. Health coverage would provide a buffer against the kind of health care debt that leads lower-income families to bankruptcy. Far too many without insurance delay or avoid care until it is too late.

Coverage up to 138% of the FPL would come with a 100% federal match for health services, declining in SFY2020 to a 90% federal match and generating $2 billion annually in Federal matching funds by SFY2020. Although not without direct state costs, filling the health gap would fuel further economic growth through jobs and purchases of goods and services. At the same time, we would be purchasing better health for a particularly vulnerable portion of our population that has given so much to our state.

**Who Are the 50-64 Uninsured Population in South Carolina?**

South Carolina’s 2013 population included 939,000 citizens aged 50 to 64. Of those, 173,000 live at or below 138% of the FPL. As Figure 1 shows, 63,000 or 37% of low-income, near-elderly citizens lack health coverage. These estimates exclude 9,500 uninsured non-citizens although many may be eligible. (1)
We cannot yet assess the effects of the new Health Care Marketplace on the uninsured near elderly, but the uninsured rate of those ages 50 to 64 declined from 17.5% in 2012 to 16.6% in 2013, although that difference is not significantly different. (2) (3)

Among the near-elderly citizens with insurance, employer coverage accounts for less than one in three (28%) while Medicaid covers 46% and Medicare 33%. One in seven (14%) purchases health coverage privately, although we do not know whether that private coverage meets the minimum standards of coverage now required of a qualified health plan. TRICARE and VA coverage together only applies to 4%.

Among those at or below 138% FPL, uninsured near-elderly citizens are almost evenly divided between males and females. The majority are white (56%) and the remainder predominantly African-American (40%). Six percent are veterans of active military duty, including 11% of males. Thirty-one percent are married, 9% widowed, 29% divorced and 11% separated. One in five (21%) has never married. Eleven percent live in households with their grandchildren. Approximately half are responsible for those grandchildren. (3)

**Employment, Income and Coverage**

Our nation’s health coverage has long been employer-based. For many lower income and near-elderly South Carolinians, employer-based insurance is not a meaningful alternative. Private health coverage is simply unaffordable absent significant subsidies, such as those provided through the Marketplace under the Affordable Care Act.

South Carolina had a seasonally adjusted unemployment rate of 6.3% during August 2014. (4) That is not reported by age. However, near-elderly South Carolinians reported in 2013 an unemployment rate of 9.6%, higher than the reported 8.7% seasonally adjusted overall rate in September 2013. (3) (4)

But for lower-income older South Carolina workers, those numbers are grim. Among those at or below 138% FPL, the unemployment rate was 28%. For the uninsured of that group, the rate was 39%. Half of the uninsured near-elderly at or below 138% FPL are not in the labor force. That is substantially below the 73% among insured low-income near-elderly citizens. One-third
had not worked in the past five years or ever. Forty percent worked within the previous year. (3)

Although older workers generally did better than younger workers during the Great Recession and its aftermath, reemployment for older workers has been especially challenging. “Unemployed adults in their fifties were about a fifth less likely than their counterparts age 25 to 34 to become reemployed each month during the Great Recession.” (5), 3. Moreover, many experienced steep wage losses. (6)

In South Carolina 43% of its eighteen and above citizens’ highest education attainment is a high school degree, GED or equivalent, resulting in a life of low to medium wage jobs that often do not have health coverage. Among those aged 50 to 64, the figures are the same but among low-income near-elderly citizens, 66% had at most a regular high school diploma. (3) By the time they are 50 to 64 they have numerous health issues. During the Great Recession blue collar workers were laid-off and downsized in all occupational areas but most severely in construction, manufacturing, transportation, retail and food preparation and often replaced full time work with part time work. (7) (8)

Only 54% of those 50 to 64 identifying an occupation had health coverage. The five largest occupations for those without health coverage, 56% of the uninsured, are Building and Grounds Cleaning & Maintenance, Production, Construction & Extraction, Sales & Related and Office & Admin Support. These are typically low education and low paying occupations that are often part time work with physical requirements. They do not require workers with skills adaptable to physically less demanding jobs. (3)

The SC Department of Employment and Workforce projects that, from 2012 to 2022, 228,800 new jobs will be added with a nearly 12% increase. The majority will be in low education, low wage work and may not have health coverage. (9)

Disability is common among low-income, near-elderly South Carolina citizens with 42% reporting a disability, 31% among the uninsured. Among those with a disability, 26% are uninsured. Having a disability increases the likelihood of having health coverage through public systems. Of the insured with a disability, 60% are covered by Medicaid and 49% by Medicare. Slightly more than half (55%) of those covered by Medicare report being covered by Medicaid. Among the uninsured, those disabilities, or “difficulties” as they are described by the Census, include “serious difficulty walking or climbing stairs” (15%), “having difficulty remembering, concentrating, or making decision” (11%) and being “blind or having serious difficulty seeing, even when wearing glasses” (10%). (3) (10)
Disability significantly affects the work history of near-elderly, low-income South Carolinians. Some 61% of those with a disability have not worked in the previous five years, compared to 15% who worked in the previous year. Among those without a disability, 44% worked in the past year. (3)

**Home Makers and Caregivers**

Many of the unemployed, underemployed and never employed are homemakers and caregivers.

Unpaid family members provide 80% of long-term care for people with special needs. Filling the health coverage gap is paramount to the uninsured caregiver to help keep families together and avoid costly institutional placements of loved ones. There are approximately 770,000 caregivers in South Carolina. Up to 1.13 million individuals are caring for an adult with limited daily activities at some time during any given year. (11)

Time spent as caregivers increases by age with persons aged 45-64 spending 25 to 26 hours per week giving care. (12) The estimated economic value of this unpaid care to South Carolinians is over $7.4 billion annually. (13) Often, family caregivers do not define themselves as such. They simply identify as mothers, fathers, daughters, sons, siblings, spouses or friends who have an obligation to care for their ailing loved one.

Caregivers suffer loss of wages, health insurance and other job benefits, retirement saving or investing, and Social Security benefits; losses that hold serious consequences for the career caregiver. As Figure 3 shows, “Seven in ten caregivers report making changes such as cutting back on their working hours, changing jobs, stopping work entirely, taking a leave
of absence, or other such changes as a result of their caregiving role (70%)” (14)

Women who are living alone and caring for parents are 2.5 times more likely than non-caregivers to live in poverty in their old age. One reason is they lost an estimated $324,000 in benefits and pensions plus $142,693 in Social Security benefits. (15) In America, 10 million caregivers over the age of 50 lost an estimated $3 trillion in lost wages, pensions, retirement funds and benefits.

Caregivers give back to society and save the state of South Carolina billions of dollars yet, if they do not have health coverage, they cost the state through unpaid hospital bills and often depend on charity or free clinics. According to the Lieutenant Governor’s Office on Aging family caregivers in South Carolina provide 737 million hours annually of free care to their chronically ill, disabled or frail elderly loved ones a year. If these services were paid at a rate of $10.04 an hour the cost would be $29 billion a year. Their average salary would be $659,139 over a lifetime. And even still, South Carolina has a shortage of paid caregivers. Yet, caregivers who are unpaid are often ineligible for health coverage. (16)

Those providing caregiving to persons 50 years or older average between 50 and 64 years of age. Caregivers tend to be lower in income and education than non-caregivers, 20% have a high school education or less. (15)

Caregiving is hard on the caregiver’s health. “Both younger employees (age 18 to 39) and older employees (age 50+) providing care for an older relative were more likely to report fair or poor health in general, and they were significantly more likely to report depression, diabetes, hypertension, or pulmonary disease than non-caregivers of the same age.” (13) Elderly spousal caregivers, with their own history of illness and who are experiencing care-related stress, have a 63 percent higher mortality rate than non-care giving peers. (17)

Taking care of caregivers, by providing them with health coverage, is important to reducing state expenditures on nursing homes. An important driver of nursing home admissions is the loss of the ability of a family caregiver to provide that care. (16)

Health Risks for the 50-64 Population in South Carolinians

South Carolina has much to be proud of in the use of preventive services for adults 50-64, they are ahead of the national average in every screening and vaccination area plus the percentage of binge drinkers is statistically lower than the national average. On the other hand South Carolinians in this age group are far from healthy. Over 66% are overweight and 34% are obese, 29% had no leisure time activity in the last month, 22% smoke, and 50% has high blood pressure. (18) All are above the national average and a long way from the Center for Disease Control (CDC) 2020 targets. (17) The South Carolina State Plan on Aging identifies 8% of those between the ages of 55 and 64 as having at least one difficulty with an activity of daily living. Of those assessed 82% were below the 200% of poverty. (19)
According to the CDC and the American Heart and American Stroke Associations the five most common causes of death in South Carolina are cancer (23%), heart disease (23%), chronic low respiratory disease (6%), strokes (5%), and unintended injuries (5%). (18) In older adults Alzheimer’s disease and diabetes are added to the list plus poor dental care as it contributes to other chronic conditions. (20)

Cancer rates are going down throughout America. Yet it is the leading cause of death in South Carolina. The American Cancer Society reports 26,390 new cases between January and August 2014. (21) In 2011 over 22% of those between the ages of 50-64 died of cancer. (18) South Carolinians aged 50 and above have slightly better cancer rates overall than the US. (22) Uninsured 50 to 64 year olds are significantly more likely to forgo cancer screenings that could reduce both mortality and morbidity. (23), xiii-xiv.

Heart disease accounted for 22% of deaths in 2011, second to cancer. (18) Additionally, South Carolina has the sixth highest rate of strokes in the United States “African Americans are more than 46% more likely to die from a stroke than Caucasians.” Strokes led to nearly 15,000 hospitalizations in 2012. (24)

One of every ten adult South Carolinians had diabetes in 2010. (25) Diabetes prevalence grows dramatically by age especially after age 45. (26) “The number of hospitalizations with diabetes as a primary diagnosis has increased by 13% in the past 10 years and 73% in the past two decades.” (27), 52.

Collectively these chronic conditions cause an unnecessary financial impact on this state’s health system, ability for people to live productive lives and even stay in their homes while aging plus those who are uninsured continue to place an undue financial burden on the state. (28)
Mental Health Considerations

Covering the uninsured mentally ill is a core reason to filling the health coverage gap. Miller and Maududi, in a study for the National Association of State Mental Health Program Directors (NASMHPD) estimate that 114,000 uninsured South Carolinians who would be eligible under a coverage expansion a have a mental health condition, of whom 73,000 “are in serious psychological distress (e.g., severe panic, anxiety, or mood disorders).” Another 68,000, have a substance abuse disorder. More than half (53%) of the uninsured population who would be eligible if South Carolina filled the health coverage gap have a behavioral health condition. (29), 16-20. Nationally, 46% of adults reporting unmet needs in 2009 cited affordability as the reason for not seeking care. (30), 4. Twenty-nine percent of SC Department of Mental Health clients in 2012 were aged 45 to 64. (31), 3. As a NASMHPD study notes: “Among lower-income, nonelderly adults, Medicaid beneficiaries who have a mental illness have a greater opportunity to secure mental health treatment than those who are uninsured and have a mental illness.” (32), iii.

Depression, a type of mood disorder, is the most prevalent type of mental health disorder. Depression can lead to impairment in physical, mental, and social functions in older adults who have lost jobs, are caregivers, lost loved one or suffer from chemical imbalance. Older adults with depression and/or frequent emotional distress visit the doctor or emergency room more often and stay in the hospital longer than those who receive care. (33) Ten percent of adults ages 50 to 64 reported current depression and women report needing extra help from depression during the pre and postmenopausal years. (34)

A key benefit of filling the health coverage gap is that wholly state-funded services can be covered by Medicaid funding, highly subsidized by federal dollars. In 2012, 42% of South Carolina mental health funding came from state sources. Thirty-eight percent of mental health clients were non-Medicaid funded. (31), 2, 11. Filling the gap would reduce that number and reduce pressure on state dollars to fund mental health services.

In addition to the human costs, untreated behavioral health challenges impose significant costs on society. The SC Department of Corrections classifies 14% of its prisoners as mentally ill. (35) Untreated mental health and substance abuse problems lead to higher levels of crime and higher levels of recidivism, among former prisoners. (36) (37)

“Behavioral health issues and substance abuse contribute significantly to frequent ED visits. In one national study, more than half of patients that were frequent users of ED services had a primary or secondary diagnosis of a mental health condition or substance abuse disorder, compared with 12% of non-frequent users.” (38) Filling the health coverage gap would get many of those persons into more stable treatment environments, reducing costly emergency department visits.
Homelessness is exacerbated by mental health and substance abuse problems. National studies have found that 30% of the chronically homeless have mental health problems and 50% have substance abuse problems. (39) Homeless counts in South Carolina’s Midlands have seen significant increases in older (45-64) homeless in recent years. (40)

Untreated mental illness also undermines employment and opportunity. Only 13% of adult mental health consumers aged 21 to 64 in South Carolina were employed. (31) In laying out the business case for investments in behavioral health, NASMHPD notes: “The vast majority of individuals with serious mental illness and/or substance abuse disorders, if appropriately diagnosed and treated, will go on to live full and productive lives. And the return on investment (ROI) is significant.” (41), viii.

Health Impacts of Not Being Insured

For those at or below 138% FPL and near-elderly health care is a luxury and may require difficult decisions. “A negative association between lacking health insurance and health has been well established in hundreds of studies ....” (42), 957. McWilliams and his colleagues report that previously uninsured near-elderly adults who enrolled in Medicare once 65 may have experienced a greater mortality rate than those who had been previously insured. They required more costly and intensive care. “Particularly for those with cardiovascular disease or diabetes, these benefits may be substantial and may partially offset the costs of expanding coverage.” (43), 151; (44).

As Figure 5 illustrates, uninsured South Carolinians are less likely to receive preventive care, are more likely to be hospitalized for preventable conditions, and are more likely to die in the...
hospital than those with insurance. For the uninsured near-elderly consistent provider care is especially important, as they are often not as healthy as those who are insured. Inconsistent care leads to improper or missed diagnoses, incorrect medications, and self-medication such as alcohol or illegal drugs. When chronic conditions are diagnosed, they are less likely to receive follow-up care. The uninsured report higher rates of postponing care or forgoing needed care or prescriptions due to costs compared to those enrolled in Medicaid and other public systems. (45)

One reason that health trajectories for the previously uninsured may not be better after reaching Medicare coverage (46) is that previously uninsured persons use the health care system differently even after they reach Medicare coverage. For example, they are less likely to use in-office physician visits and more likely to use emergency and hospital outpatient departments. That is not so much an argument for not providing coverage as an argument for providing coverage earlier, so that those differences in use can be reduced. As Decker and her colleagues observe: “... both health insurance coverage and other policies that facilitate access to physician services among the previously uninsured may be necessary to substantially alter their use of health care.” (47), 10.

Although Polsky and his cohorts find that gaining Medicare does not lead to better health trajectories for the previously uninsured near-elderly, in a rejoinder to McWilliams they conclude: “More important, however, in the long run is that our work implies that the best answer to preventing premature morbidity and mortality among the uninsured is to ensure that every American has health insurance.” (46), 1428.

South Carolina has systems intended to provide health coverage for the uninsured. Some are direct programs such as Free Clinics (48), Access Health Programs (49), New Horizon Clinics and other day clinics (50), and free dental assistance. (51) South Carolina’s Medicaid agency has expanded coverage for family planning services to cover certain screenings for those up to 194% FPL, but not health care services. (52) (53) Hospitals have charity care programs, although they may be difficult to access. Other programs fill other holes. However, these programs are far from the coordinated systems of care that lead to better health, especially among those with chronic diseases.

Financial Impact of Being Uninsured

Persons aged 50 to 64 are the most likely demographic to forgo good health because of lack of insurance and lack of income yet they are the most likely to lose all financial security if they get sick. In 2012, 49% put off or postponed getting needed healthcare due to cost. And 25% said they went without medical care due to cost. (45)
The near elderly have lost the most earning power of any age group, with their household incomes 10% below what they made when the recovery began. A recent study by economists at Wellesley College found that those who lost their jobs in the few years before becoming eligible for Social Security also lost three years from life expectancy from lack of access to health care. (54)

Health insurance serves not just to buy health care, but also to provide protection against financial ruin in the face of catastrophic health costs. There may be debates over the level of contribution of health debt to personal bankruptcies, but even those who dispute high levels of health-care related bankruptcies concede: “… medical bills are a contributing factor in just 17 percent of personal bankruptcies and … those affected tend to have incomes closer to poverty level than to middle class.” (55), W74. This is precisely the group which would benefit if South Carolina filled the coverage gap.

**Economics of Providing Coverage to Low-Income Near-Elderly**

The debates in South Carolina over covering all non-elderly adults at or below 138% of the Federal Poverty Level have been carried out in no small part around cost and benefit estimates that such coverage would produce.

The South Carolina Department of Health and Human Services commissioned a study of the costs to the Department of the totality of implementation of the Affordable Care Act. (56) Those estimates are driven in no small part by assumptions about the increase in Medicaid enrollment by persons already eligible for Medicaid under then-existing rules rather than providing coverage to those not previously eligible. Milliman estimated a total net cost of $930 million from SFY2014 through SFY2020. The highest net cost in any single year was $268 million in SFY2020. Future years would entail modestly higher costs as the Federal Match rate for the newly covered population declines from 100% (2014 through 2016) to 90% in 2020 and beyond. The SFY2020 estimate covers half a year at 93% and half a year at 90%.

If we focus only on costs of providing coverage to all non-elderly adults at or below 138% FPL, Milliman estimates a net state cost of $570 million over the period SFY2014 through SFY2015. Since South Carolina has not chosen to provide this coverage through SFY2015, a better estimate of net state costs to SCDHHS is the $199 million Milliman estimate for the newly covered population adjusted to the ultimate 90% match rate or $232 million per year. That produces $2 billion in Federal funds, a direct return of 870%.

*Figure 5*
These figures are consistent with recent estimates by Sherry Glied and Stephanie Ma that state funds for the newly covered population in 2022 would be $265 million. (57)

We could quibble with Milliman’s estimates of participation rates but they are not outside the range of the literature and there are no participation estimates yet from states that have provided this coverage to their low income non-elderly adults. (58) In addition, by failing to consider savings from any agencies except the Departments of Corrections and Disability and Special Needs, and especially the Department of Mental Health, from converting clients from state-funded only to Medicaid-funded, Milliman overestimates the costs of providing this coverage. (59)

These figures are for the entire 19-64 age group. Increasing health costs by age means that the near-elderly will use a disproportionate share of health care services and, thus costs. As Figure 6 shows, annual costs of health care for those with commercial insurance at age 64 are 2.42 times as much as at age 41. (60) Applying this age curve to the age distribution among the insured and uninsured in South Carolina, we estimate that approximately 44% of the costs of coverage would relate to the 30% of the age and income eligible population who were aged 50-64. That includes 33% of the insured and 26% of the uninsured.

An analysis which only focuses on the direct costs is lacking. Joseph Von Nessen of the Darla Moore School of Business at the University of South Carolina conducted a study on behalf of the South Carolina Hospital Association finding that: “By 2020, the total annual economic impact of the increase in federal funding due to the ACA Medicaid expansion on the state of South Carolina will total approximately $3.3 billion in economic output, $1.5 billion in labor income, and support nearly 44,000 new jobs for South Carolinians. Approximately one-third of these jobs (15,000) are projected to occur outside of the health care industry due to the economic multiplier effect.” (61) Those estimates recognize that the additional economic activity will generate $106 million in additional state tax revenue, thus lowering the SFY2020 net cost to $95 million.

Any study like this can generate valid critiques. However, no realistic analysis can deny that adding $2 billion annually in federal revenues at a state cost of even $95 million is a significant return on investment, especially if you include the multipliers generated as those expenditures employ people and purchase goods or services.

These analyses do not address long-term state savings from reducing future Medicaid expenditures on elderly South Carolinians. SCDHHS does not break out spending by age in ways that makes figuring total spending on near-elderly or elderly possible. Although elderly South Carolinians make up only 7% of Medicaid enrollees (62), South Carolina’s Department of Health and Human Services is the largest payer of nursing home costs. “Medicaid contracted with 78% of the state’s nursing home facilities and paid for 70% of the people in the facilities” in 2014. (63) For SFY2015, South Carolina budgeted $535 million of a total Medicaid budget of $6.9 billion for nursing home contracts or services of which $119 million was General Fund dollars. Another $155 million ($36 million General Fund match dollars) goes to Community Long Term
Care contracts and services. (64) Especially for the near elderly, expanding coverage in ways that encourages better care for chronic illnesses and changed approaches to medical care promises to reduce future state spending on nursing home and long-term care services and supports.

**Conclusion**

South Carolina has an important opportunity to close the health gap that leaves 63,000 near-elderly, low-income South Carolinians without health coverage. These South Carolinians, our neighbors, friends and family members, are a diverse group. Although many work, especially in strenuous jobs that wear down bodies, others cope with disability or mental illness. Many serve as caregivers, relieving public programs of significant financial burdens.

Low-income, near-elderly South Carolinians are particularly vulnerable. Many have deteriorating health, accompanied by a growing proportion of their spending going to health coverage, while family wealth and income has declined. Those plagued by chronic or multiple illnesses especially suffer. In some cases, lack of health insurance has pushed them from middle class into low-income.

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A strong business case argues for filling the health gap. Many persons now served by our Department of Mental Health using unmatched state dollars could be served with federally matched funds, saving millions for the State. Although only a small portion of state Medicaid enrollees is elderly, their health costs, especially in nursing homes and for community long-term care, are a substantial part of South Carolina’s health budget. Reducing need for those services by improving health among the near elderly saves South Carolina money.

With a federal match rate of 90% for SFY2020 and onward, our economy would have an infusion of funds which would, when used to hire our neighbors and buy goods and services in our communities, drive economic growth. One study suggests annual increases of economic output of $3.3 billion and 44,000 new jobs. Marginal State costs for filling the gap are largely made up by new revenues, replacing state dollar expenditures with matched-dollars and reduced long-term state health expenditures.

Filling the health coverage gap makes both economic sense and health care sense. It is especially critical for those aged 50 to 64 who have long helped build and support our community.
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