Palmetto State of Health

2015-2017 Study

LEAGUE OF WOMEN VOTERS®
OF SOUTH CAROLINA

PREPARING FOR HEALTH CARE CONSENSUS

At the LWVSC Convention on April 26th, 2015 delegates voted to conduct a Study (2015-17) of healthcare in support of development of state-level positions for advocacy. Since our needs and experience with healthcare may be vastly different a series of *Healthcare Conversations* around the state were held and coordinated by members of the Healthcare Caucus which met at the Convention.

WHAT IS THE REASON FOR THIS STUDY?

a. 1,000-1,300 South Carolinians will die in the coming year due to a failure to expand Medicaid services. The governor has vowed never to expand the program.
b. The state remains medically underserved with fragmented care. Unlike some issues advocated by the League, healthcare touches every citizen in the most personal way.
c. Medical care costs continue to climb faster that wages. The current trajectory is unsustainable. Current plans, including the ACA, will not arrest soaring prices.
d. Repeated assaults on reproductive rights, in the form of "personhood" and "TRAP" legislation, continually threaten to interject politicians between patients and doctor

HEALTHCARE CONVERSATIONS

Board member and healthcare specialist David Ball led a series of "healthcare conversations" across the state to prepare for this study and help to identify relevant questions. Summaries of these meetings are on our website, www.lwvsc.org.

HOW DOES OUR LEAGUE PARTICIPATE?

- Let your members know as soon as possible that they will be participating in a statewide consensus to help formulate a state-level position on health care issues. Informative articles in the VOTER will help, drawing on the supporting materials provided and other resources. You may also want to include the consensus questions in your VOTER.
- Recruit a resource person from within or outside the League to review these materials and be available at your meeting to provide background information and answer questions. There are also reports from the focus groups of League members around the state on the LWVSC website.
- Schedule a meeting of members to respond to the consensus questions. A brief preliminary presentation on the historical timeline of the Medicaid expansion controversy would be helped (see attached materials). Most of the time, however, should be spent on reviewing background materials and responding to the questions.
- Be sure everyone has a chance to speak and that minority views are not only treated with respect but also reflected in the consensus report.
- Identify an experienced League member to facilitate the consensus process and a recorder to take notes, so that the two of them can prepare a consensus report to send to state board by ***March 1, 2017.***

CONSENSUS QUESTIONS/RESPONSE FORM

1. Do you support expanded health insurance covered for uninsured South Carolinians??

   __Yes __No __No consensus

   If yes, which of the following are your priorities? (Check all that apply)

   __covering low income individuals

   __basic health care

   __mental health care

   __access to health care in rural areas

   __prescription drug coverage

   __co-pays based on income

   __children

   __Other (_____)

   If no, what are your concerns?

   __cost

   __other (_____)

Comments:

2. Should the state of South Carolina take responsibility for proving at least basic health care to its citizens through

   __a) Medicaid expansion

   __b) developing its own plan

   __c) encouraging insurers to offer more affordable options

__d) Other (_____)

__e) None of the above

Comments:

3. Should the League support efforts to address lifestyle health issues such as obesity and tobacco use by (check all that apply)

   __ supporting policies to address food deserts, nutritional education and physical activity

   __discouraging the use of tobacco products

   __Other (_____)

Comments:

4. How important is it for the League affirm its commitment to reproductive rights, including family planning, access to abortion and sex education?

   __very important

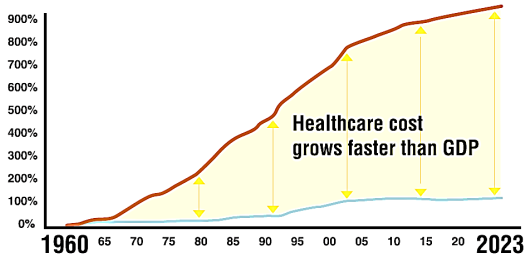
   __somewhat important

   __not important

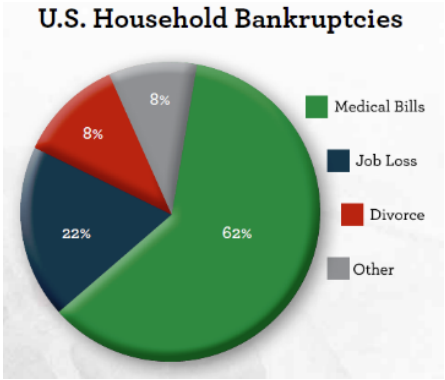
Comments:

Background for Questions 1 and 2: The Importance of Insurance

Traditionally, the role of insurance is to offset economic risk. By contributing affordable premiums to a pool of enrollees some kinds of insurance spread the risk of a catastrophic expense. This is how flood or car insurance works. Health care insurance is different, because it covers routine as well as catastrophic health care expenditures, with varying degrees of cost-sharing between the insurer and the patient. Health Care is also different because of the perception that health care is a right that should not be denied because of inability to pay, and because the government is a major provider of health care insurance coverage through Medicare, Medicaid, CHIP (Children's Health Insurance Program), and the military.



The way we pay for medical care has profoundly impacted the healthcare system. People will take (or decline to switch) a job because of health insurance coverage. Patients will see a particular provider or facility solely because it is in or out of network. Doctors will modify their treatment plans or prescribe alternate drugs based on what the insurance company will cover. Patients will delay or forgo seeking care because they can't afford it. Families are forced to choose between filling prescriptions and buying food. Medical related bills now account for more personal bankruptcies than credit cards or student loans. Three out of four who declared bankruptcy for medical bills had health insurance.



When the Obama administration sought to improve health insurance through the Affordable Care Act (ACA /aka Obamacare) South Carolina resisted. Legislation was even proposed to "nullify" federal law and state employees were forbidden to serve as Navigators (health insurance counselors) or use state property to help South Carolinians sign up for health insurance.

Our state refused to set up an insurance exchange for a number of reasons. On one hand, the Governor's health care committee found that "federal subsidies are solely a federal concern in which the state has no compelling interest" while later in their report saying "It is recommended that the state move forward with a plan to retain control over any marketplace reforms in South Carolina." The committee also concluded that inaction was a good idea due to "uncertainty as to how the Supreme Court might rule next summer should it choose to hear challenges to ACA as well as what changes national elections might bring." The committee also noted that "The only organization capable of implementing the requirements of a state based exchange is the South Carolina Department of Health and Human Services." Since the department's resources were "fully committed now to serving approximately 900,000 persons" the state

would then have to incur the cost of serving an additional 500,000 to 600,000 who would become eligible under Medicaid expansion. (A summary of the committee's recommendations is included in these consensus materials.)

When the Supreme Court upheld the constitutionality of Obamacare, it left open to states the option to expand Medicaid to the poor. Currently, the federal government pays 70% while the state pays the remaining 30% for residents who make less than 62% of the Federal Poverty Level (FPL). The ACA plan would bring all states up to 138% of FPL by paying 100% for the first three years. In later years, the state would assume a small percentage through 2020 when the state match would be 10%.

The Governor promised that "We will not expand Medicaid on President Obama's watch. We will not expand Medicaid ever." Yet the challenge did not go away. Rural medical centers like the one in her home town (Bamberg) closed because of unfunded care. An offer from the South Carolina Hospital Association (SCHA) to "eat" the 10% match the state would eventually have to pay did not change this position.

The state League, in concert with AARP, the United Way, SC Appleseed, and faith-based groups, has pushed for Medicaid expansion. CloseTheGap.SC has identified 197,000 South Carolinians who fall in a gap between 62% of the FPL and the 100% required to receive federal insurance premium support.

The LWVUS health care position calls for a real answer to integrated, quality care with universal access and true cost containment in a Single Payer system. Most other industrialized nations have adopted single payer systems and have found them to be both effective and efficient. The US, with a patchwork of government programs, job-based insurance, and private plans, is ranked 37th for health care outcomes care but pays twice as much per person as any other nation.

Insurance coverage can be divided into two groups. Half of the population has employer-based policies (42% large employer and 8% small employer). The rest depend on Medicare (15%), Medicaid (13%), Individual (4%), or other public (2%). Sixteen percent are Uninsured. In South Carolina's large group segment the largest insurer has 67% of the market with three other companies with at least a 5% share. In the small group market, five of the 131 insurers authorized to write policies control 90% of the business. Since the 1990s, competition in the state has declined 79%.

The Director of the SC Department of Insurance reported that under the ACA consumers "should plan for premiums to increase significantly". "Overall, we expect to see average rates increase by 50-70% in the individual market and 10-20% in the small group market." The Department was able to narrow down the estimated rate change over current rate for a comparable health insurance product to between 2% and 162%. According to the Kaiser Foundation the proposed 2017 increases for the health care premiums in the South Carolina Exchange are 14.36% for Blue Choice and 14.74% for Blue Cross & Blue Shield. In 2016 the premiums increased 8.89% for Blue Choice and 8.66% for Blue Cross & Blue Shield. United Health Care and Coventry (Aetna) exit the South Carolina health exchange market at the end of 2016. During 2016 enrollment using the exchange was 10% higher than 2015.

The median household income in South Carolina dropped 11 percent between 2007 and 2014 according to a new report from the Joint Economic Committee in the U.S. Congress. South Carolina's inflation adjusted median household income declined from $50,500 before the recession in 2007 to $44,900 in 2014. For the country as a whole, median household income dropped 6 percent over the same period, from $57,400 in 2007 to 53,700 in 2014. In South Carolina State employee health plan spending increased 6% from 2011 to 2013. The table below indicates the 2013 monthly premiums (average) for a South Carolina State employee.

	Total Premium ($)	Employer Contribution	Employee Contribution
Single SC	408	311	97
Single US	570	502	68
Family SC	851	616	235

Average annual premiums for private employer-based insurance 2013 (Average)

	Employee Contribution ($)	Employer Contribution
Single SC	1,137	4,289
Single US	1,170	4,401
Family SC	4,482	11,024
Family US	4,421	11,608

Background for Consensus Questions 1and 2:

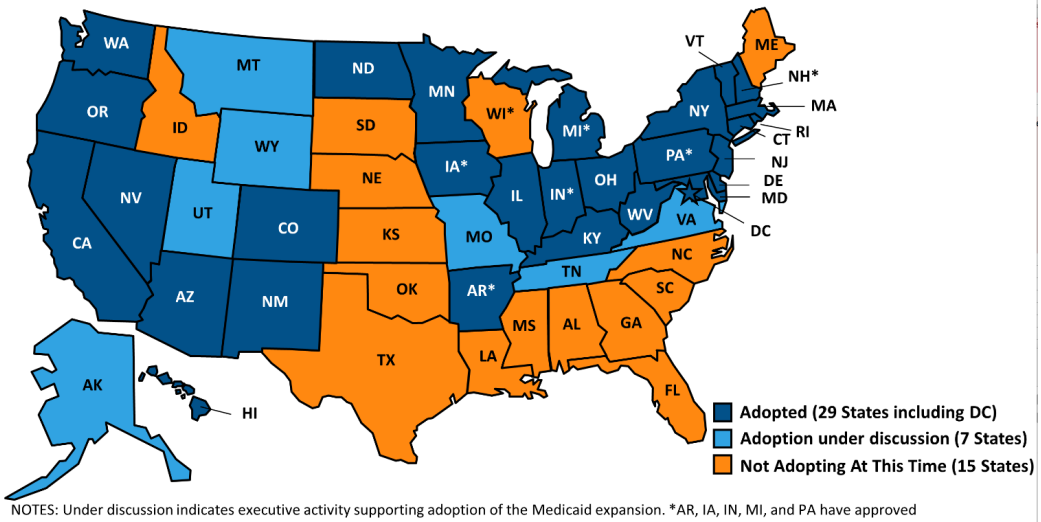
An Overview of Actions Taken by State Lawmakers Regarding the Medicaid Expansion

Feb 13, 2015 Kaiser Foundation

As enacted, the Affordable Care Act (ACA) broadened Medicaid's role, making it the foundation of coverage for nearly all low-income Americans with incomes up to 138 percent of the federal poverty level (FPL) ($16,242 per year for an individual in 2015). However, the Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For those that expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016. The federal share gradually phases down to 90 percent in 2020, where it remains well above traditional federal medical assistance percentage (FMAP) rates. As of January 2015, 29 states (including the District of Columbia) adopted the Medicaid expansion, though debate continues in other states.[1] (Figure 1) State lawmakers have had different responses to the Medicaid expansion. While it does not cover how every state has enacted the Medicaid expansion, this fact sheet highlights some of the different actions state lawmakers have taken in response to the Medicaid expansion. Each state's circumstances are unique; the actions taken by one state may not apply to another state's circumstances.

Figure 1

Over half of states have adopted the Medicaid expansion while discussion continues in others.



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, and PA have approved Section 1115 waivers. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. Coverage under the PA waiver has gone into effect, but the newly-elected governor may opt for a state plan amendment. Coverage began in all states January 1, 2014 except for: MI (4/1/14), NH (8/15/14), PA (1/1/15) and IN (2/1/15.)
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 27, 2015.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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Overview of the Processes Required to Adopt the Medicaid Expansion

Medicaid is a jointly-operated program; state Medicaid agencies must work with Federal partners to adopt the Medicaid expansion. The relationship between the state Medicaid agencies and the Centers for Medicare and Medicaid Services (CMS), the federal agency administering the Medicaid program, is governed by a document called a Medicaid state plan. A Medicaid state plan describes how each state will operate its program, which is submitted to and approved by CMS. To make a change in its Medicaid program, such as adopting the Medicaid expansion, the state Medicaid agency must submit and receive CMS approval of either a state plan amendment (SPA), which is used to make program changes that are allowed under current law, or less commonly a waiver request, which is negotiated agreement involving changes to the operation of the state's program that are not allowed under federal Medicaid law.[2] (Figure 2) To date, 24 of the 29 states that have adopted the Medicaid expansion have done so through filing a SPA; only five states have received Section 1115 waiver approval to implement the ACA Medicaid expansion.[3]

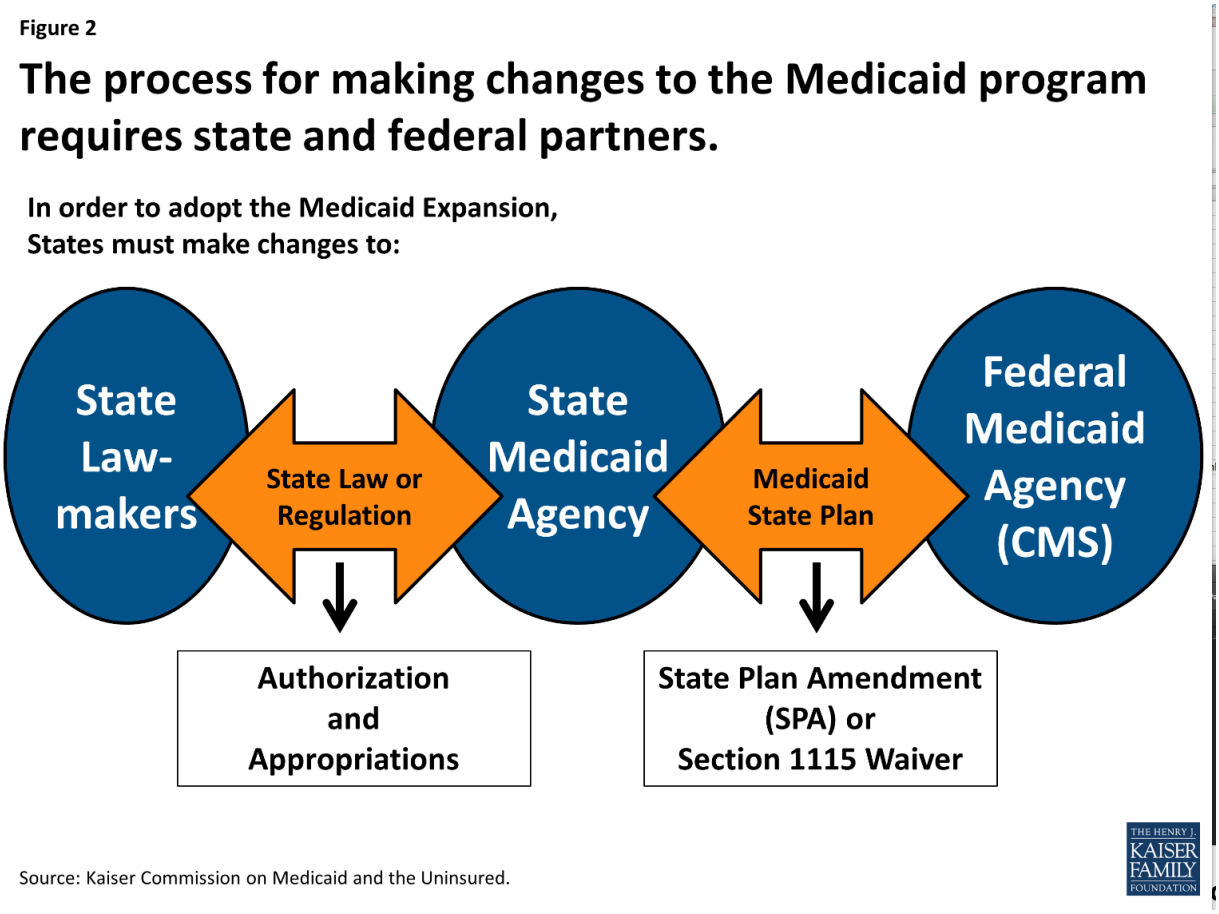


Figure 2: The process for making changes to the Medicaid program requires state and federal partners.

However, before working with federal partners, state Medicaid agencies often must work with state lawmakers to obtain authorization and appropriations before implementing the Medicaid expansion. (Figure 2) In order to make changes to Medicaid policy, such as expanding eligibility under the Medicaid expansion, states must work with lawmakers (governors and/or legislatures) to make changes to either state laws and/or state regulations. Each state has different rules about which kinds of Medicaid policy changes, if any, can be authorized through changes in regulation (and therefore by agencies at the direction of the governor) or must be made through changes to state law or statute (and therefore require legislative approval.) For example, some states require state legislative action before state plan amendments or Section 1115 waiver requests can be submitted by the state Medicaid agency to CMS for federal approval and others do not. States also vary on whether legislative action is required to authorize changes to Medicaid benefits, cost-sharing and other types of Medicaid policy changes.[4] This varies, at least in part, on how the Medicaid program was incorporated into state statute when the state originally enacted the program decades ago and the changes to rules and regulations enacted in the years since. In addition to authorization, state Medicaid agencies must also work with state lawmakers to obtain appropriations to fund the Medicaid policy change(s). Some states require legislative action to appropriate federal dollars as well as state dollars; others do not.

Examples of State Lawmaker Responses to Medicaid Expansion

State lawmakers play a key role in determining if and how their state may adopt the Medicaid expansion. Both Republican and Democratic state lawmakers have responded in differing ways to the Medicaid expansion; responses have also changed over time. The following sections walk through some of the different ways state lawmakers have responded to the Medicaid expansion.

Standard Legislative Process

Many of the states that have adopted the Medicaid expansion have done so through the standard legislative process – legislation was passed authorizing the Medicaid expansion (either through a stand-alone bill or as part of budget legislation.) For example, Minnesota[5] and Maryland[6] passed legislation during their 2013 regular legislative sessions to enact the Medicaid expansion. Other states, such as New York[7] and New Mexico[8], included the Medicaid expansion as part of budget bills passed in 2013. In each of these states, the Governor and legislature supported the Medicaid expansion. The standard legislative process has also worked in some states where adopting the Medicaid expansion was initially supported by one branch but not the other. For example, in Arizona, Governor Brewer strongly supported adopting the Medicaid expansion; after lobbying legislators and building public support, legislators passed the state's budget with the Medicaid expansion.[9]

While Section 1115 waivers require additional steps to obtain federal approval, the legislative process remains largely the same at the state level. The majority of states that have adopted the Medicaid expansion to date have done so within federal rules and options to receive the associated enhanced federal matching funds for newly eligible, in other words, through SPAs. However, a limited number of states have obtained or are seeking approval through Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law.[10] While Section 1115 waivers require additional steps to obtain federal approval, the process at the state level may be largely the same at the state level as if the state were adopting the expansion through a SPA. For example, lawmakers in Iowa, New Hampshire and Michigan approved legislation adopting the Medicaid expansion through their standard legislative process. While the legislation outlined their alternative Medicaid expansion requests and conditioned approval on federal waiver approval within a set timeframe, the legislatures delegated development and submission of the final waiver proposal to the state Medicaid agencies. More recently, governors in some states, such as Utah and Tennessee, have instead started negotiations with CMS officials to develop a waiver proposal that is likely to be approved at the federal level. Once a preliminary agreement in principle has been reached, these governors have now started working with their legislatures to obtain their approval before formally submitting the request to CMS.

One branch of government can stop adoption of the Medicaid expansion. State Lawmakers have differed on their support or opposition to the Medicaid expansion. In states such as Missouri and Virginia, Governors Nixon and McAuliffe have also both expressed strong support for the Medicaid expansion, initiating statewide campaigns for adoption of the expansion in their respective states. However, each of these Governors has faced strong opposition from their respective state legislatures; Medicaid expansion has not been adopted in either state at this time. Sometimes, even one body of the state legislature has stopped passage of state legislation adopting the Medicaid expansion. For example, in Florida, Governor Rick Scott announced his

support of adopting the Medicaid expansion in February 2013.[11] The Senate passed legislation that adopted an alternative Medicaid expansion proposal; however, strong opposition in the House of Representatives prevented final passage of the legislation. [12] In other cases, governor opposition to adoption of the expansion has prevented action. For example, in Maine, the legislature has passed multiple bills authorizing the Medicaid expansion, but each has been vetoed by Governor LePage; override votes have fallen short of the two-thirds majority vote needed each time.[13]

Some states have enacted laws prohibiting Medicaid expansion without legislative approval. While most states have adopted the Medicaid expansion after agreement has been reached by both governors and state legislatures, some legislatures have sought to ensure that legislative approval is required before adoption of the Medicaid expansion can take effect. In March 2013, Governor McCrory of North Carolina signed legislation that prevented any department, agency or institution of the state from expanding eligibility under the ACA Medicaid expansion in North Carolina unless directed to do so by the General Assembly.[14] Similar stand-alone legislation was also passed in other states such as Georgia[15] and Tennessee.[16] Legislatures in other states, such as Virginia, have included language requiring legislative approval before implementing the Medicaid expansion in state budgets.[17] Similar legislation that would prohibit the Governor or executive agencies from implementing the Medicaid expansion without legislative approval is under consideration in Montana.[18]

Alternative Processes

In a few select cases, the Medicaid expansion has been adopted through executive action. While enactment of the Medicaid expansion involved the legislature in most states, at least two states enacted the Medicaid expansion through executive order – Kentucky and West Virginia. In May 2013, Governor Beshear of Kentucky and Governor Tomblin of West Virginia issued executive orders enacting the Medicaid expansion in their states.

The need to appropriate federal funds has also raised some challenges in states seeking adoption of the Medicaid expansion. As part of state budget processes, some states require that all funding be appropriated, including that from federal funds. For example, after the Arkansas legislature approved authorizing language for the Medicaid expansion (the Private Option)[19], the state legislature also had to pass legislation to appropriate the federal dollars that fund the Private Option; all appropriations in Arkansas require a three-fourths majority vote in each chamber, a higher threshold than in most states. [20] Other states delegate appropriation authority in select cases to other government bodies. For example, in Ohio, some spending decisions are delegated to the state's Controlling Board. The role of the board is to "provide a mechanism for handling limited day-to-day adjustments needed in the state budget," without requiring the full legislature to meet; over time its role has been also to provide greater legislative oversight of executive action.[21] After Ohio's budget for SFYs 2014-2016 passed in June 2013 without appropriations for the Medicaid expansion, the Ohio Medicaid Director submitted a request that the Controlling Board approve the appropriation of federal funds for the Medicaid expansion. The Controlling Board approved the appropriation in October 2013.[22]

Some states have passed legislation that created taskforces or study groups to further examine the issue of Medicaid expansion and make a recommendation to the legislature. For example, as part of a compromise deal reached by the Governor and the legislature in 2013, Virginia established the Medicaid Innovation and Reform Commission (MIRC); this committee was charged with monitoring the development of Medicaid reform proposals, such as the expansion of managed care among others. If the MIRC determined that specific Medicaid cost-reduction and efficiency benchmarks had been met, it could then vote to implement the Medicaid expansion.[23] However, the committee was later eliminated as part of the FY 2015-2016 budget passed the following year. Additional legislation establishing study groups or taskforces to examine the Medicaid expansion and broader Medicaid reforms has previously been enacted in a number of states, such as Wyoming; this taskforce recently recommended the SHARE plan, an alternative Medicaid expansion proposal. As in other states, the recommendation of the taskforce is not binding and still requires legislative approval in addition to Governor support before being adopted.

In a few instances, state lawmaker actions adopting the Medicaid expansion have been challenged in court. For example, the executive orders adopting the Medicaid expansion and enacting the state's Marketplace – kynect – in Kentucky were challenged in court. Eventually the judge upheld the executive order based on existing state law that gave the Secretary of Health and Family Services authority "to take advantage of all federal funds that may be available for medical assistance…the secretary…may by regulation comply with any requirement that maybe imposed or opportunity that may be presented by federal law."[24] A court case has also been brought in Arizona, where state legislators are challenging the budget legislation that enacted the Medicaid expansion. Part of this legislation called for the implementation of a new hospital provider fee to fund state costs of the Medicaid expansion. According to the plaintiffs, which include the State Senate President, Senator Biggs, the fee is a tax, which under Arizona's constitution, requires two-thirds majority to approve as opposed to the simple majority that approved the legislation. After the State Supreme Court ruled that the plaintiffs had standing to bring the lawsuit, the case has been referred back to Maricopa County Superior Court.[25]

While discussed in some states, no state has included a ballot initiative on the adoption of the Medicaid expansion. For example, in Montana, supporters of the Medicaid expansion sought to include a ballot initiative on the state's 2014 ballot. If approved by voters in the state, it would have expanded eligibility under the Medicaid expansion; additional legislative action would have been needed to appropriate the funding. However, the initiative failed to collect enough signatures and was not included on the ballot.[26]

Conclusion

State lawmaker responses to the Medicaid expansion have differed across states. Most states adopted the Medicaid expansion through the standard legislative process after gaining the support of both branches of state government; however a few states have adopted the Medicaid expansion through alternative processes. Each state's circumstances are unique; the actions taken by one state may not apply to another state's circumstances.

Endnotes omitted in the interests of space. They can be found on the Kaiser Foundation website.

Determinants of Health

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.

The determinants of health include:

- Social and economic environment, physical environment, and the person's individual characteristics and behaviors. The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors, and many others:

- Income and social status – higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.

- Education – low education levels are linked with poor health, more stress and lower self-confidence.

- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.

- Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions.

- Social support networks – greater support from families, friends and communities is linked to better health.

- Culture - customs and traditions, and the beliefs of the family and community all affect health.

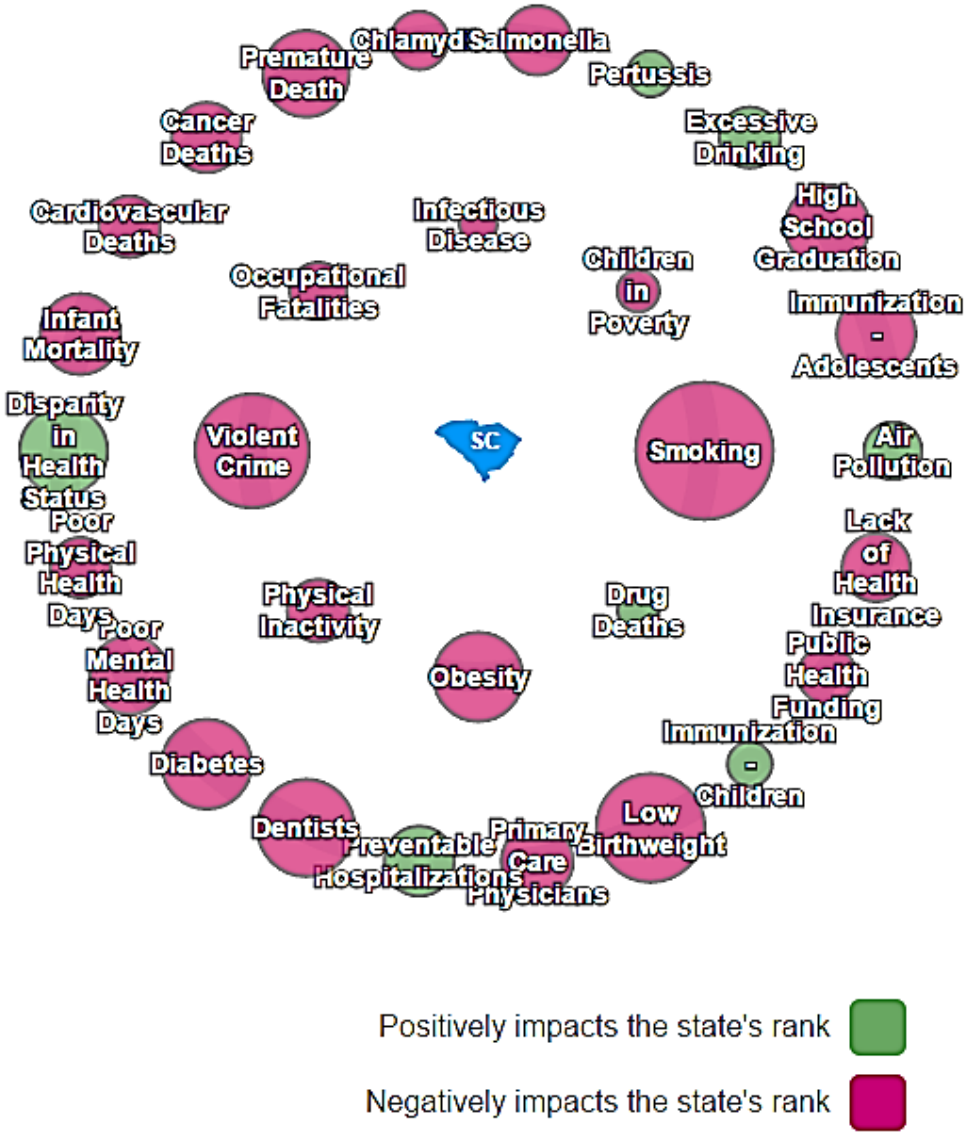
- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.

- Personal behavior and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.

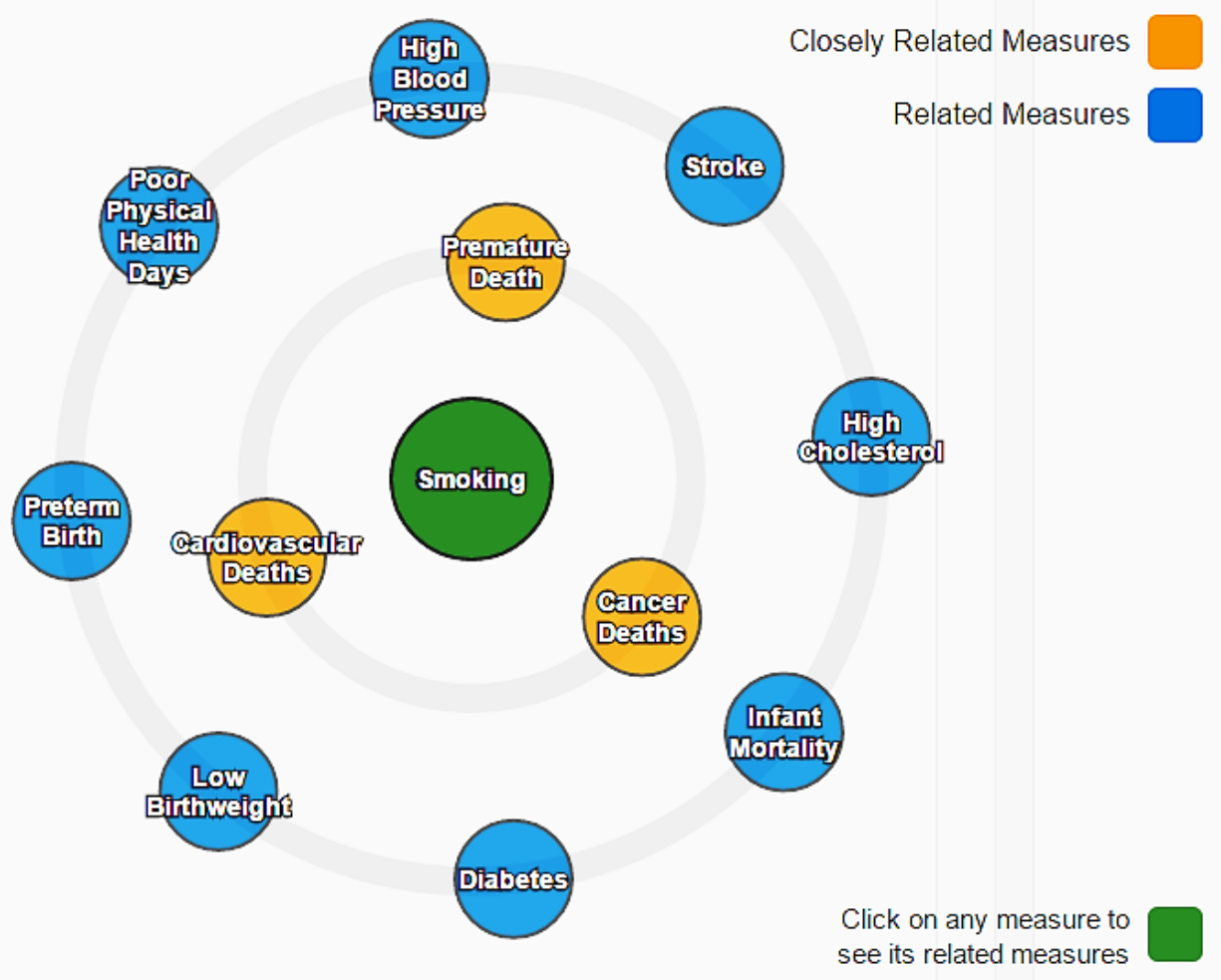
- Health services - access and use of services that prevent & treat disease influences health.

- Gender - Men and women suffer from different types of diseases at different ages.

CHALLENGES TO WELLNESS IN SOUTH CAROLINA

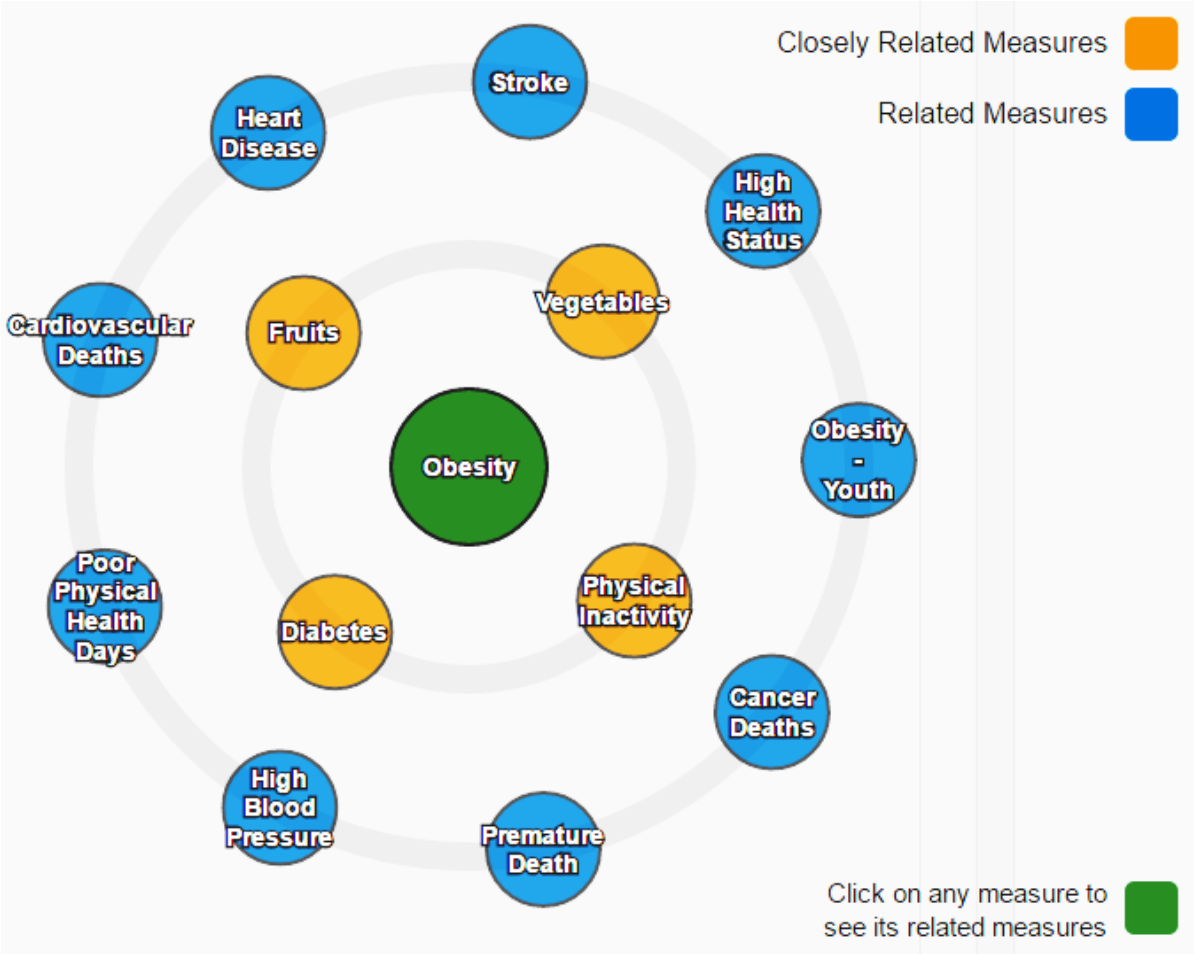


Americanshealthrankings.org does a nice job of distilling statewide health data and then converting it pictorially to better appreciate interrelationships. Here more than two dozen metrics, both positive and negative, are shown with circle size relative to magnitude. Compared to other states South Carolina does better than most in “Disparity in Health”, “Preventable Hospitalization”, and “Excessive Drinking”. On the other hand, we are worse than average for “Dentists”, “Smoking”, “Diabetes” and “Obesity”.



The measures are interrelated. Smoking, for example, not only causes cancer but also leads to an increase in heart disease and cardiovascular deaths. This means when we neglect one aspect of our health we drag ourselves and our community down in other ways. Not only do we suffer but we become less productive (we can't work we narrow the tax base) and become a burden on our families and the community at large.

The reverse is also true. When we quit smoking closely related measures also decline. There are less Premature Deaths, Cardiovascular Deaths, and Cancer Deaths. Think of the toll that smoking exacts. Not only is it expensive but neck, throat and lung cancer are among the worst diseases to get. Those around smokers often get asthma and bronchitis. Usually children with respiratory conditions in homes where parents smoke are sick from second hand smoke.



Americans are overweight. In 1990 a resident of Colorado had an average Body Mass Index (BMI) of less than 7%. A South Carolinian was likely to be twice that at 14%. No state was over 15%. In 2015 no state was under 15%. Colorado, the best in the nation, stands at 21% and South Carolina, 41st in the nation for the Obesity index, is over 32%.

Obesity has consequences. The devastating implications of high blood pressure and diabetes are made much worse when patients are overweight. In many cases, just paying attention to diet and exercise can delay onset of significant disease or eliminate the need for medication.

Tackling obesity will require a multi-pronged approach. We need playgrounds and bike trails, and sidewalks. We must identify food deserts and eliminate them. Pay attention to our diet and support local farmers markets. Take out added salt and keep track of hemoglobin A1C in those prone to blood sugar problems.

Background for Consensus Question 3

1. Cigarette smoking causes more than 480,000 deaths each year in the United States. This is nearly one in five deaths. More than 10 times as many U.S. citizens have died prematurely from

cigarette smoking than have died in all the wars fought by the United States during its history. Smoking is bad for your health. Overall, people who dip or chew get about the same amount of nicotine as regular smokers. They also get at least 30 chemicals that are known to cause cancer.

Nearly 500 brands and 7,700 flavors of e-cigarettes are on the market and none of them have been evaluated by the FDA. We don't know for sure what's in them. Studies have found toxic chemicals, including an ingredient used in antifreeze and formaldehyde in e-cigarettes. Because the FDA doesn't regulate these products, there aren't requirements around ingredient disclosure, warning labels or youth access restrictions. With aggressive industry tactics such as cartoon characters and candy flavors including bubble gum, fruit loops, chocolate and strawberry, it's no surprise studies show a dramatic increase in kids using e-cigarettes. For the first time ever, teens are smoking e-cigarettes more than traditional cigarettes.

2. In the U.S., among adults under the age of 70, obesity is second only to tobacco in the number of deaths it causes each year. Like tobacco, obesity causes or is closely linked with a large number of health conditions, including heart disease, stroke, diabetes, high blood pressure, unhealthy cholesterol, asthma, sleep apnea, gallstones, kidney stones, infertility, and as many as 11 types of cancers, including leukemia, breast, and colon cancer. No less real are the social and emotional effects of obesity, including discrimination, lower wages, lower quality of life and a likely susceptibility to depression.

   Access to fresh fruits and vegetables is a key component to good health and well-being. Individuals who have access to supermarkets in general tend to have healthier diets and are at lower risk of chronic disease such as diabetes. The distance traveled to food stores is an independent predictor of Body Mass Index (BMI). There are approximately 11.5 million low-income people living in areas that are more than 1 mile from a supermarket. Food deserts are correlated with many poor health outcomes.

   It has been shown that participation in regular physical activity reduces the risk of coronary heart disease and stroke, diabetes, hypertension, colon cancer, breast cancer and depression. Additionally, physical activity is a key determinant of energy expenditure, and thus is fundamental to energy balance and weight control.

Background for Consensus Question 4

There is little South Carolina likes to legislate more than abortion. While it is true that there are 69 bills to make guns more available (Firearms Freedom Act, Firearms Liberty Act, Second Amendment Preservation Act, etc.), they are debating 19 abortion bills ((Defund the Abortion Industry, Human Heartbeat Protection Act, Pain-Capable Unborn Child Protection Act, Unborn Infants Dignity Act, Personhood Act of South Carolina, etc.). Some make it crime to get a legal abortion, others make it a crime for a doctor to perform a legal abortion. Others make it illegal to use birth control.

The overwhelming majority of women in the United States use a method of contraception during their reproductive years. The average woman who wants two children will spend five years trying to become or be pregnant and over 20 years trying to avoid pregnancy. Of primary importance in allowing women to affirm their whole selves and giving them control over their bodies, thus their

future, is holistic, medically-accurate sexuality education – and, yes, access to affordable contraception and family planning.

Policies that value family planning make financial sense. Teen childbearing costs our country $9.1 billion annually (National Campaign to Prevent Teen Pregnancy) for social services and lost tax revenue. Prevention of unintended pregnancies and concentrating on reproductive health would allow women to become more educated and thus boost our nation's economy.

Contributors to this Study

Dozens of people made important contributions to this two year study. Medical providers, hospital administrators, health care consumers and their families, and concerned citizens throughout the state shared their experiences, preferences, and beliefs. During a series of *Healthcare Conversations*, sponsored by eight local Leagues, members provided invaluable insights about what health and wellness mean to them. Additionally, because these meetings were conducted statewide, a much more diverse picture emerged. Resources in Hilton Head are different in Hilton Head than in Darlington. Access to specialized care and the importance of transportation varies whether the discussion takes place in Clemson or Charleston.

At the South Carolina State Convention in Hilton Head a number of League delegates attended a caucus interest meeting concerning the health care study. Those in attendance included; Sharon Ayling, Ethel Wells, Nancy Finch, Agnes Edwards, Joan Littels, David Ball, Joyce Franklin, Eleanor Hare, Fran Holt, Elizabeth Adams, Dee Woodward, Alison Burke, and Phylis Giglinto.

The Study Committee included; LWV Charleston Area; Nancy Finch and David Ball, LWV Clemson Area; Eleanor Hare and Elizabeth Adams, LWV Darlington Area; Joyce Franklin and Sheila Haney, LWV Columbia Area; Julie Sellers, LWV Sumter Area; Dee Woodward, LWV Hilton Head Island/Bluffton Area; Alison Burke.

Special thanks throughout the study to Dr. Anne Osborne Kilpatrick, Professor Emeritus of MUSC College of Health Professions.

Additional Resources

Recommendations for new Study

http://www.cdc.gov/cdi/

http://cdnfiles.americashealthrankings.org/SiteFiles/StateSummaries/SC-Health-Summary-2014.pdf

http://www.americashealthrankings.org/SC

Determinants of health

http://www.who.int/hia/evidence/doh/en/

http://www.who.int/topics/health_systems/en/

http://scpronet.com

http://pnhp.org (Physicians for a National Health Plan)

Impact of insurance

http://www.yourconcordtv.org/projects/healthcare-movie/ (The Healthcare Movie)

http://vp.telvue.com/preview?id=T02132&video=264929 (Fix It movie)

Von Nessen, Joseph, Medicaid Expansion in SC. USC Moore School of Business December 2012

SC Hospital Association, SCHA 2013 Medicaid Expansion. February 2013

Challenges to wellness

http://www.theatlantic.com/health/archive/2015/08/the-transportation-barrier/399728/

Brill, Steven, What I Learned From My $190,000 Surgery. Time Jan 15, 2015, 34-43

Reid, T.R. The Healing of America. Penguin Press New York 2009

http://doi.sc.gov/DocumentCenter/View/2534 (Governor's committee on ACA 2011)

http://nyti.ms/1V3cJvC (Drug Goes From $13.50 a Tablet to $750, Overnight)