September 29, 2004

Darren Buckner
HRSA Grants Management Specialist
5600 Fishers Lane, Room 11A-16
Rockville, MD 20857

Dear Mr. Buckner:

Enclosed is a copy of the Year 2 interim report for the Alabama State Planning Grant (SPG), # 1 P09 OA 00045-01.

If you have any questions, please contact me (fshinbaum@adph.state.al.us or 334/ 206-5568).

Sincerely,

Fern M. Shinbaum, R.N., M.S.N.
Project Director
Alabama State Planning Grant

Enclosure
cc: Judy Humphrey
Myisha Patterson

Alabama State Planning Grant

Interim Report – Year 2
September 29, 2004

Executive Summary

Data Collection Activities:

Statewide 7,200 household telephone survey in Year 1
Eight focus groups with consumers and employers Year 1
Secondary data reviews in Year 1 and Year 2
Economic modeling of selected health insurance options in Year 2

Policy options selected to increase health insurance coverage in the state:

Of the 14 options that would offer health insurance coverage to uninsured populations in Alabama, the following four options were subjected to economic modeling by the project's contractor, The Lewin Group (an additional fifth option was modeled [Medicaid Buy-In] at the request of the project's core advisory committee:

1931 Medicaid Expansion – This would raise the Medicaid income eligibility level for non-pregnant adults from its current level of approximately 13% FPL.

HIFA Medicaid Waiver - This option would provide coverage to uninsured parents of Medicaid and CHIP enrollees as well as childless adults.

Full Cost Buy-In like Local Government – This option would establish a program modeled after the local government program currently administered by the AL State Employees Insurance Board. Following the economic modeling of this option, the project no longer considers this to be a viable option for expanding coverage to the uninsured.

HIPP Medicaid Waiver – This option would expand Medicaid's current Health Insurance Premium Payment Program.

Medicaid Buy-In – This option would allow a buy-in to the Medicaid Program.

Another option which garnered much interest but which had been previously modeled in-house was the option of expanding CHIP to cover the unborn who would be CHIP eligible after delivery.

It should be noted that the state of Alabama is not currently in a position to implement any options to expand coverage. However, the State Planning Grant continues to inform the discussion on the uninsured and develop strategies for coverage which might be implemented in the future should the state be in a position to expand coverage programs and/or implement new programs.

Recommendations for federal and state actions to support state efforts to provide health insurance for the remaining uninsured:

Periodic funding to conduct the telephone survey and analyses as well as the focus group implementation and analyses would assist the state and the federal government in knowing how/if the uninsured population is changing over time. Continued funding of this project would allow additional data analyses and education of employers and employees regarding uninsurance.

Because this project revealed that a significant number of Alabamians are eligible but unenrolled in current programs, work needs to be done to reduce the barriers to their enrollment. The project also highlighted the need for public education and guidance for businesses with regard to insuring the uninsured.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Overall, 11.2% of people in Alabama are uninsured according to the IDEA telephone survey conducted in 2002-2003.

Income:

Alabamians whose family income is less than 134% FPL (Federal Poverty Level) have higher rates of uninsurance. A striking 3 in 10 people below 15% FPL are uninsured, while 3 in 100 people above 300% FPL are without insurance.

Family Income (% FPL)	Uninsurance Rate
<15%	29.8%
15-100%	26.7%
101-133%	20.3%
134-150%	16.3%
151-200%	15.5%
201-250%	8.7%
251-300%	7.5%
>300%	2.8

Age:

Adults ages 25-34 have the highest rate of uninsurance, at 23.1%, compared to he overall state uninsurance rate of 11.2%. A separate analysis shows that the uninsured are statistically much more likely to be between the ages of 19-34 years old, and less likely to be uninsured if they are under 19 or over 64 years of age. This latter finding is most likely attributable to enrollment in Medicaid/CHIP and Medicare programs.

Age	Uninsurance Rate
0 - 5 years	4.3%
6 - 18 years	7.6%
19 -24 years	20.5%
25 –34 years	23.1%
35-54 years	13.0%
55-64 years	11.6%
65 years and over	1.1%

Gender:

The survey did not capture this information.

Family Composition:

Marital Status	Uninsurance Rate
Widowed	6.3%
Married	8.9%
Divorced	15.1%
Separated	20.0%
Living with Partner	34.8%
Single	16.5%

Health Status:

Health Status	Uninsurance Rate
Excellent	6.5%
Very Good	10.0%
Good	12.0%
Fair	19.3%
Poor	21.7%

Employment Status:

Status	Uninsurance Rate
Self-Employed	17.3%
Employed by Someone Else	8.4%
Not Employed/Unemployed Worker	25.7%
Retired	2.2%
Student	14.3%
For Those Who are Employed	
Number of Jobs	
One Job	9.1%
More than one job	11.3%
Hours Worked per Week	
0-10	5.9%
11-20	19.7%
21-30	23.2%
31-39	11.8%
40 hours or more	7.9%
Type of Job	
Permanent	8.4%
Temporary	28.4%
Seasonal	27.8%
Full-time	7.9%
Part-time	15.7%
Size of Employer	
<11 employees	23.3%
11-50 employees	10.3%
>50 employees	4.9%

Availability of private coverage (including offered but not accepted):
Of the total population in Alabama, 53.7% have employer-sponsored coverage and 3.7% have individual coverage. Of the 11.2% who are uninsured, 20.8% are potentially eligible for employer-sponsored coverage.

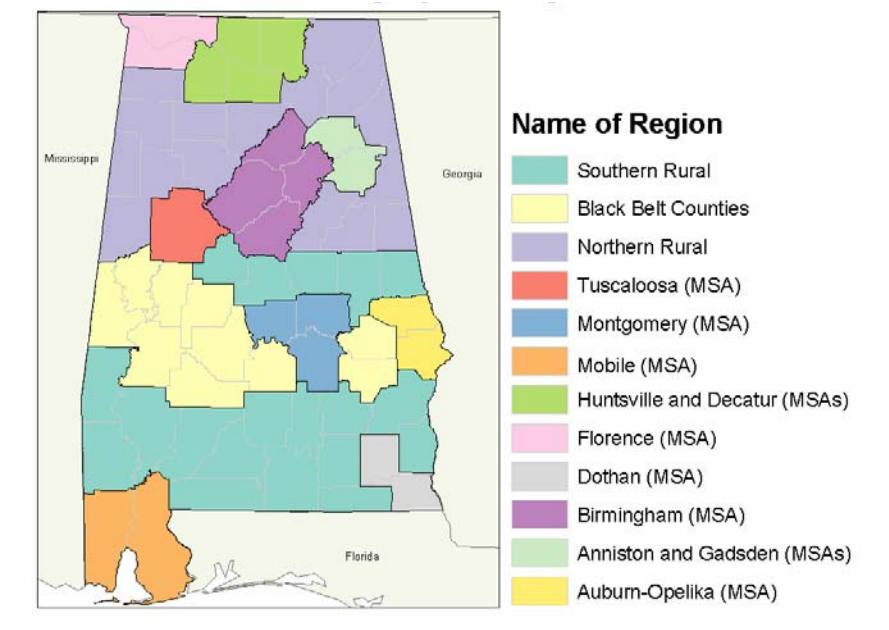
Availability of public coverage:
Of the total population in Alabama, 31.4% are insured under public programs. Of the 11.2% who are uninsured, 16.1% are potentially eligible for coverage under existing public programs.

Race/ethnicity:

Race/ethnicity	Uninsurance Rate
African American/Black	13.2%
American Indian	10.9%
Asian	5.5%
Hispanic*	22.0%
White	10.2%
Other	0.1%

Immigration status:
The survey did not capture this information.

Geographic location (as defined by State)
For the purposes of this project, the state was divided into 12 geographic regions (see map below).



The table on the following page displays Alabama's uninsurance rates by region. People living in rural areas have slightly higher uninsurance rates than those who live in urban areas. Using point-in-time estimates, the areas with the highest levels of uninsurance are the Northern Rural (15.6%) and the Southern Rural (14.9%) regions. By contrast, Birmingham (7.7%) and Florence (8.4%) have the lowest rates of uninsurance among the geographic regions examined in this analysis.

Geographic Region	Uninsurance Rate	Number of uninsured people in the region
Urban	9.7%	239,170
Rural	12.4%	245,697
Anniston	13.0%	21,611
Auburn	10.7%	22,936
Birmingham	7.7%	71,464
Black Belt Counties	10.0%	13,822
Dothan	13.6%	19,384
Florence	8.4%	41,603
Huntsville	13.3%	72,561
Mobile	9.1%	30,422
Montgomery	10.9%	17,992
Northern Rural	15.6%	100,973
Southern Rural	14.9%	27,387
Tuscaloosa	11.8%	59,429
All Regions	11.2%	500,008

Duration of Uninsurance:
Throughout this report, unless otherwise indicated, the analyses refer to the "point-in-time" uninsured.

Definition	Uninsurance Rate
Point-in-Time	11.2%
Uninsured All Year	8.8%
Uninsured Part Year	5.8%
Uninsured at Some Point During Year	14.6%

From the information above it is evident that the following population groups are at the greatest risk for uninsurance:

- Adults ages 19-34 years, especially 25-34 years of age;
- Individuals living in families with incomes of less than 133% FPL, specifically between 15% and 100% FPL;
- Adults with less than a high school education; and,
- Individuals working for firms with less than 10 employees.

The household telephone survey revealed that of the population who have access to employer-sponsored health insurance but who remain uninsured, 61% said that the reason they do not have health insurance is because it is too expensive. When focus group participants were asked to define "affordable health care," the average monthly cost they felt they could afford for comprehensive family health care coverage was approximately $116.

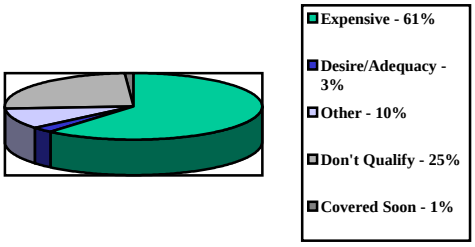
The telephone survey revealed that over three quarters of uninsured people surveyed would be willing to enroll in a public program is they learned that they were eligible. When asked if they would enroll if the programs were free, this figure increased to 86%. These results indicated that the "eligible but not enrolled" group would enroll if they learned more about public programs. The majority of consumers in the focus groups felt that people who receive health care through public programs are treated like "second class citizens." Many participants also feel that patients with private or employer-provided health insurance receive superior care as compared to people with public coverage or no insurance.

The question of why uninsured indibiduals and families disenroll from public programs was not addressed through either surveys or focus groups. However, information from Alabama's CHIP reveals that families who do not seek to renew their children's CHIP coverage even though these children subsequently become uninsured, do not purposely disenroll their children. Rather, the disenrollment is due to oversight.

The most common reason that uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible, according to the telephone survey, is that employer sponsored coverage is too expensive. The overall number of responses to this question was low, so the reasons given are grouped under broad categories described below.

Categories:

Desire/Adequacy (didn't need or want insurance, rarely sick, too much hassle/paperwork, own plan cheaper, benefits don't meet needs, child is covered under school plan)
Covered Soon (expect to be covered soon, after waiting period will be covered)
Don't Qualify (don't work enough hours, not worked long enough, parent not eligible), and
Other (e.g. afraid of doctors, no particular reason, goes to a naturalist, uses walk-in clinics, etc.)



A question concerning responsibility for providing health insurance was posed in focus groups to both uninsured consumers and employers. In consumer groups opinions were diverse among the groups with many indicating the individual, the employer, and the government should share the responsibility. There was no consensus among the groups for preferring to receive coverage through an employer vs. through a governmental program. Hispanics expressed reservations regarding a government administered plan because of concerns over their citizenship/legal status.

When employers were asked the same type of questions, a small majority of employers felt that the workers themselves should be mostly responsible for taking care of their health insurance. At the same time, a larger

majority of employers felt that the state government should play some role in helping to provide coverage to workers. However most did not support the idea of the state making direct payments to workers for their health care. Participants did feel that the state could help hold health care costs down through better regulation of insurance providers and tort reform. Many employers also expressed a need for the state to educate small businesses on the possible benefits (such as tax advantages) of providing health care coverage to employees and to make health care information more readily available to the general public.

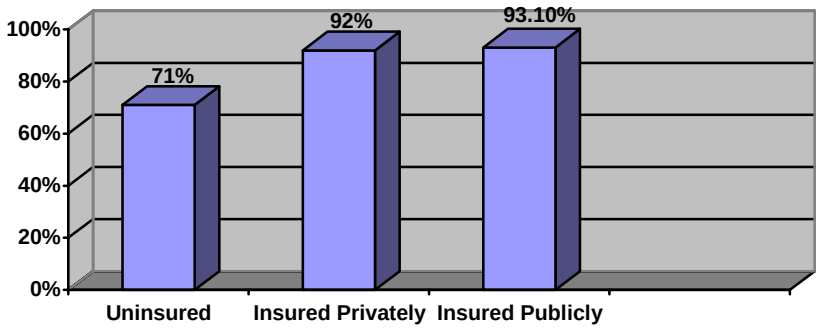
While both consumers and employers perceived cost as the major barrier to obtaining health insurance, the telephone survey and focus groups did reveal other barriers. In consumer focus groups these barriers included: unemployment, not qualifying for private insurance, pre-existing conditions, no coverage available for part-time employees; waiting periods, and coverage not offered through employer. Many of the Hispanic participants indicated that not having the proper INS documentation is a major health care barrier in Alabama.

When employers were asked their opinions concerning the barriers, other than cost, to offering health insurance plans to employees, reasons mentioned were: "younger employees prefer higher pay over insurance coverage," "retired military employees already have coverage," and the administrative cost of providing coverage.

According to focus group data, less than one-half of the uninsured consumers stated they visit a health care provider for regular check-ups and screenings. Additionally, about one-half of the participants felt that all the health care needs of their families were not currently being met.

The chart below (from telephone survey data) shows that the percentage of the uninsured with a regular place to go for medical care is far lower than the percentage of people with insurance from either public or private sources.

Alabamians with a Regular Source of Care by Type of Coverage



A doctor's office is where most people seek medical care, particularly those with private health insurance. Public program enrollees, as well as the uninsured, are likely to use a public health or community clinic. A higher proportion of the uninsured are more likely to use an emergency room than people with either private or public coverage.

Alabama residents use different type of clinics. People who were uninsured were more likely to use a free clinic, as were people who are insured through public programs. People who have private health insurance coverage were more likely to use private clinics.

Source	Type of Insurance		
	Uninsured	Public	Private
Emergency Room	13.5%	2.3%	2.1%
Doctor's Office	58.5%	72.9%	85.7%
Clinic	25.9%	21.2%	10.9%
Other	2.1%	3.6%	1.3%
	100.0%	100.0%	100.0%

Distributions of Clinic types for those with a Regular Source of Care

Source	Type of Insurance		
	Uninsured	Public	Private
Free Clinic	71.0%	44.9%	26.7%
Hospital Clinic	16.3%	24.5%	24.1%
Private Clinic	9.1%	23.7%	45.8%
Other	3.7%	6.9%	3.5%
	100.0%	100.0%	100.0%

According to the telephone survey, dental coverage is held by 3%, 49%, and 77% of uninsured, publicly insured, and privately insured Alabamians, respectively. Following this pattern, the uninsured were the least likely (30%), followed next by the publicly insured (50.4%), and finally by the privately insured (68.7%) to have received dental treatment in the past 12 months. Of those that sought dental care in the past 12 months, the uninsured were twice as likely as the publicly insured and more than three times more likely than the privately insured to experience problems finding a convenient dental office in the past year. The main reasons for not obtaining dental care or having problems finding a dentist, regardless of insurance source, were that they felt they did not need it (40%) or that it was too expensive (22%).

Access to Preventive Dental Care

Insurance Pays for Preventive Dental Care?

YES
3.0%
48.6%
77.0%

NO
97.0%
51.4%
23.0%

Treatment from a dentist in the last 12 months?

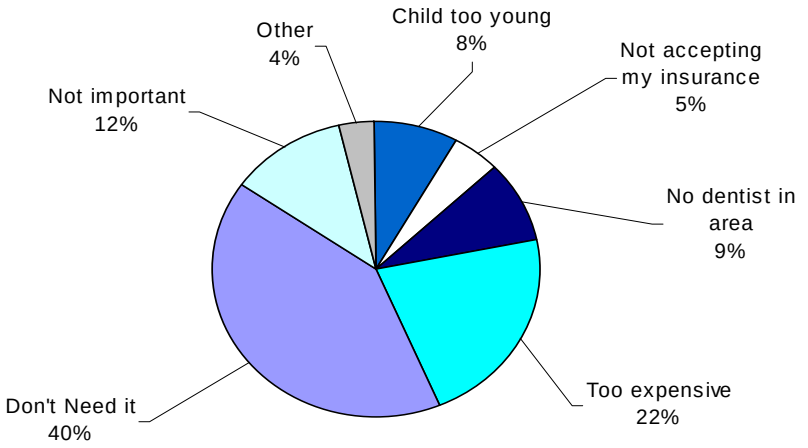
YES
30.0%
50.4%
68.7%

NO
70.0%
49.6%
31.3%

Problem finding a convenient dental office in the last 12 months?

YES
30.3%
15.2%
8.1%

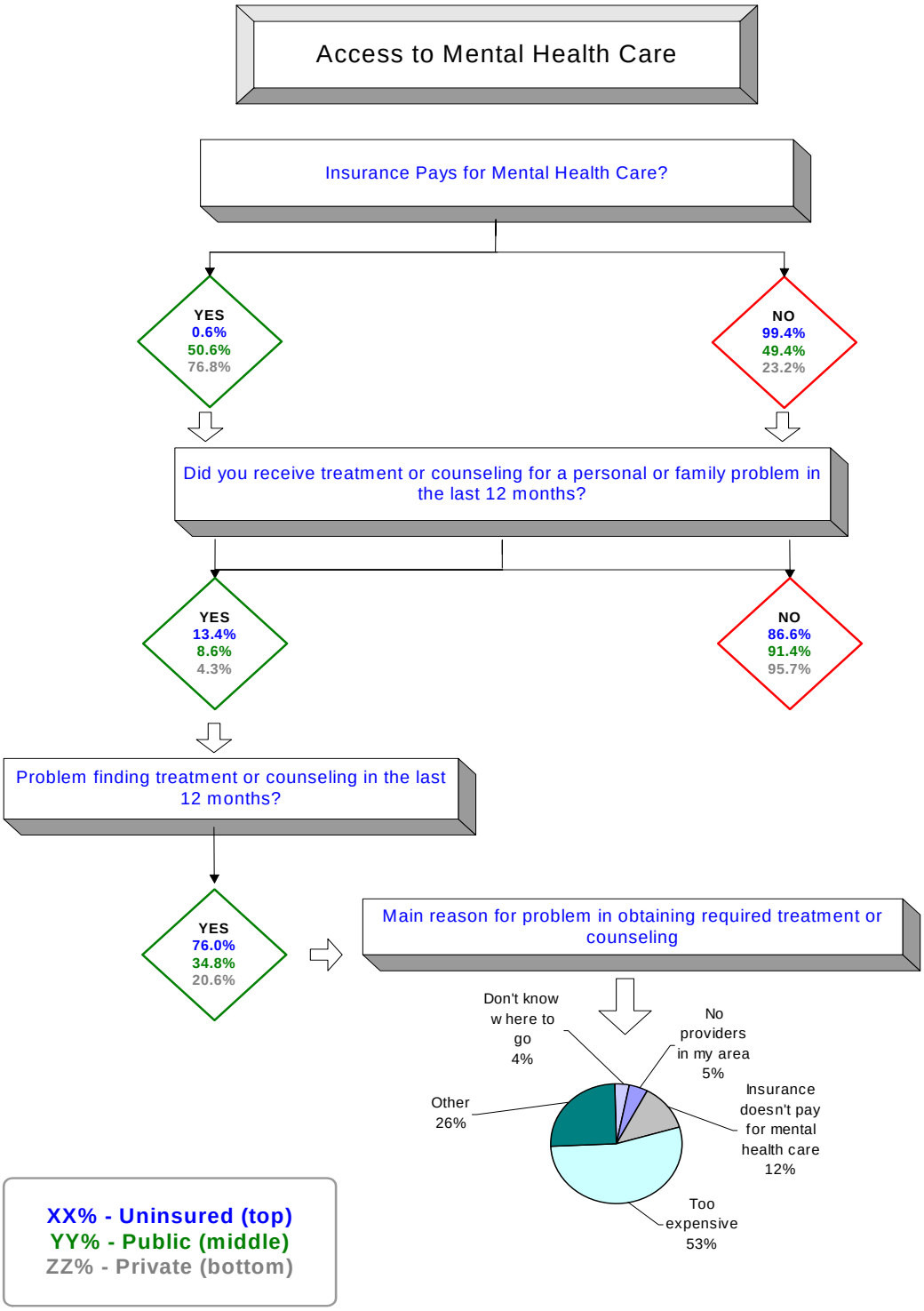
Main reason for not receiving dental care or problem in finding a dentist



XX% - Uninsured (top)
YY% - Public (middle)
ZZ% - Private (bottom)

Over half (57%) of the publicly insured and over three-quarters (77%) of privately insured individuals have mental health care coverage. What was surprising was that few Alabamians seek mental health care and that the uninsured were more likely than the publicly and privately insured to receive treatment or counseling for a personal or family problem in the last 12 months.

Subsequently, the uninsured were also more likely to have a problem finding mental health care in the past year relative to their insured counterparts. Regardless of coverage source, the main reason given for the reported problems obtaining treatment or counseling was cost.



Consumer focus group participants were asked what components of health care cost were most important to those struggling to pay for health care. Participants generally identified the cost of medication as especially troubling. In one group, close to one half of the participants stated that they sometimes borrow prescription medicine from a friend or relative. Other elements of health care cost mentioned frequently were: health insurance premium costs; copays and deductibles; ER visits; and, lab work.

The term underinsured has been defined by the Kaiser Commission on Medicaid and the Uninsured, in the publication, *Underinsured in America: Is Health Coverage Adequate*, as those who have "health insurance but face significant cost sharing or limits on benefits that may affect its usefulness in accessing or paying for needed health services." In Alabama, the problem of underinsurance may be on the rise. According to the telephone survey, approximately 7% of the publicly insured and 11% of the privately insured have forgone care due to cost in the past year, a commonly used measure of underinsurance. This rate is substantially lower than the national rates for the insured obtained by the National Survey on Health Care conducted in 2002 (18% had postponed care they thought they needed). For context, over half of the uninsured report foregoing needed care in the past year.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The table below provides information on the health insurance offer rates by employer characteristics as identified through the telephone survey.

Health Insurance Offer Rates by Selected Employer Characteristics	
	OFFER RATE
Overall rate of employers offering insurance coverage	72.6%
EMPLOYER SIZE	
<11 employees	39.0%
11-50 employees	69.8%
>50 employees	84.1%
INDUSTRY SECTOR	
Arts & entertainment, Recreation, Accommodation & Food Service	57.3%
Educational, Health Care & Social Services	81.5%
Agricultural	58.9%
Construction	64.1%
Manufacturing	82.6%
Transportation, Warehousing	81.3%
Retail	65.1%
Finance	81.7%
Public Administration	74.4%
Business and Personal	52.1%
Professional	77.6%
Other	64.7%
EMPLOYEE INCOME (AS % OF FPL)	
<15%	49.1%
15-100%	35.7%
101-133%	53.7%
134-150%	51.7%
151-200%	70.9%
201-250%	72.2%
251-300%	72.3%
>300%	84.0%
TYPE OF EMPLOYMENT	
Permanent	74.7%
Temporary	34.7%
Seasonal	42.3%
Full-Time	77.2%
Part-Time	55.4%
GEOGRAPHIC LOCATION	
Urban	74.3%
Rural	71.3%

Employer size (including self-employed):
The likelihood that an employer will offer coverage is related to firm size. Only 39.0% of employees working for firms with fewer than eleven employees are offered health care coverage. In larger companies (50+ employees) 84.1% of employees are offered coverage. It is clear from this analysis that there are sizeable differences between the people who are offered health insurance coverage by their employers and those who are not.

Industry Sector
People in the arts and entertainment, recreation, accommodation and food service industries are the least likely to be offered health insurance by their employers. These individuals are likely to be either self-employed or work from small employers, so the coverage findings are consistent with the findings in the paragraph above.

Employee Income Brackets
Employee income is related to the offer of employer-sponsored health insurance. Just over a third of working people earning below the poverty level are offered health insurance coverage. People earning more than 300% FPL are about three times more likely to be working for firms that offer health insurance.

Percentage of Part-Time and Seasonal Workers
Part-time, temporary, and seasonal workers are less likely to be offered coverage than their full-time or permanent counterparts.

Geographic Location
Employers in urban areas are slightly more likely to offer coverage (74.3%) than employers in rural areas of Alabama (71.3%).

Other
People covered by employer-sponsored insurance or public programs are more likely to have dental coverage than those with individual plans or those on public programs. Dental coverage is offered less frequently than prescription drug coverage, except for those with employer-sponsored coverage. Dental coverage is purchased by 0.6% of the uninsured.

Cost
People who have individual coverage are less likely to have deductibles, compared to those with employer-sponsored coverage or public coverage. In general, people with employer-sponsored coverage have lower deductibles than public program enrollees.

Percentage of Employees offered coverage who participate
While available quantitative data does not answer this specific question, the telephone survey did reveal that 53.7% of the people in Alabama have employer-sponsored health coverage and that an additional 20.8% of the uninsured indicated that they were potentially eligible for employer-sponsored insurance.

From summary data gathered from employer focus groups, there was a consensus among small employers that cost was the primary factor in deciding not to offer health insurance coverage to their employees. Other reasons mentions were: “younger employees prefer higher pay over insurance coverage;” “retired military employees already have coverage;” and, “administrative cost.”

According to focus group data, employers generally agreed that those companies offering health care coverage to employees enjoy a distinct advantage when recruiting in the labor market. Further, some participants expressed the belief that companies without employee insurance plans are at a competitive

disadvantage when compared to companies that do offer health insurance. It was noted that health care coverage contributes to the "longevity of employment" and produces a "healthier, more productive" workforce resulting in fewer absences due to illness.

An economic downturn or continued increases in health insurance costs would likely deter small employers from continuing to provide health insurance as a benefit for their employees. It would also deter employers who do not now offer health insurance as a benefit from picking up this option.

The economic modeling, explained in Section 4, applied a crowd-out provision (a waiting period) for employers and/or individuals in the analyses. However a comparison of with and without a waiting period was not made.

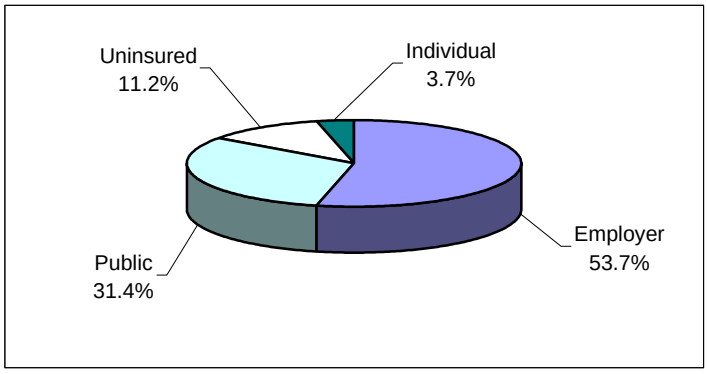
Influences on employers

From December 2002 through July 2003, multi-interest study committees researched various health insurance options which might be applicable in Alabama. Also during this time period a broad based workgroup (which included many of the study committees' members) met to review the work of the study committees and to receive information from the data collection part of the project. In June 2003, the study committees put forth 14 health insurance options for consideration by the project. In July 2003, a large meeting of stakeholders, including employers, in the issue of uninsurance was held to discuss the impact and feasibility of each of these options. Pooling, subsidies, and tax incentives were among the 14 options considered. It was the prevailing thought in the meeting that these options were either not feasible in Alabama or they did not merit consideration in the near future.

Because the bid process for securing a contractor for economic modeling was so successful, the project was able to pay for the modeling totally out of Year 1 carry-over funding. This left much of the supplemental funding for use in developing and distributing materials, for employers and individuals, aimed at explaining the importance of health insurance (including the development of a cost: effectiveness issue brief). During Year 3 of the project, these materials will be distributed and the effect of this type of effort will be evaluated.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Alabama's public health insurance programs have had a significant impact on the uninsurance rate in the state. According to the telephone survey, public programs provide health insurance coverage to 31.4% of the population.



This percentage reflects a large number of children enrolled in the state's CHIP and Medicaid programs. As can be seen in the table on page 1 of this document, the birth to 18 year old age group has the lowest percentage of uninsurance in the state among the state's non-elderly populations.

In furthering the project's understanding of possible insurance options, the grantee contracted with The Lewin Group to perform actuarial and economic analyses of four options. Because of interest shown, by the IDEA Committee in some additional options, The Lewin Group did analyses on three additional options at no charge. The full report of these analyses is in the process of being printed and will be submitted with the Year 3 progress report. The chart below shows a summary comparison of the coverage expansion options that were analyzed. Both other states as well as programs within Alabama were taken into consideration in the analyses. Cost analyses were done using both a private payer reimbursement schedule and the Alabama Medicaid reimbursement schedule.

SUMMARY COMPARISON OF SELECTED COVERAGE EXPANSION ALTERNATIVES

	Number Enrolled	Reduction in Uninsured	Total Program Cost (millions)	Federal Costs (millions)	State Cost (millions)
Medicaid Expansion of Parents (Section 1931)					
Parents Below FPL	67,440	58,760	130.2	$92.2	$38.0
Parents Below 200% FPL	109,200	94,000	$203.5	$144.1	$59.4
Medicaid Expansion for Non-Custodial Adults (HIFA Waiver)					
Non-Custodial Adults Below FPL	169,750	147,190	$396.7	--	$396.7
Non-Custodial Adults Below 200% FPL	259,860	216,790	$625.9	--	$625.9

Medicaid Expansion for all Adults with HIPP Program					
All Adults Below 200% FPL without HIPP	369,060	310,790	$829.4	$144.1	$685.3
All Adults Below 200% FPL with HIPP	369,060	310,790	$7,939.74	$137,624.9	$662,114.5
Create a Medicaid Buy-In Option					
Buy-In Participants	95,180	90,380	--	--	--
Create a Low-Cost Insurance Product Through Reinsurance					
Reinsurance Pool Participants	9,990	9,550	$2.1	--	$2.1
Small Employer Pool Based on State Employees Health Insurance (SEIB) Model					
Pool Participants	15,600	15,600	--	--	--
Medicaid to FPL for All Adults with Medicaid Buy-In					
Adults to 100% FPL	225,990	196,480	$501.8	$87.8	$414.0
Medicaid Buy-In	59,011	56,035	--	--	--
Combined Effect	285,001	252,515	$501.8	$87.8	$414.0

Source: The Lewin Group estimates using the Health Benefits Simulation Model

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

During the first year of the project, Alabama studied many health insurance options and by the end of Year 1, a total of 19 options were put forth as candidates for study during Year 2. Of the 19 options, two pertained to increasing public education and awareness of health insurance options currently available to employers and employees, two pertained to changing the Alabama code to be more aligned with the current health care market and federal legislation, one pertained to changing the Alabama code to reflect a bias in awarding state contracts which would favor businesses that offer health insurance to employees, and 14 would have offered health insurance coverage to uninsured populations in Alabama. The Year 1 Progress Report contained a list of each of the 19 options. If this list is needed again, it is available upon request.

Of the 14 options that would offer health insurance coverage to uninsured populations in Alabama, the following four options were subjected to economic modeling during Year 2:

1931 Medicaid Expansion – This would raise the Medicaid income eligibility level for non-pregnant adults from its current level of approximately 13% FPL. This option offers the state flexibility. The state could use a phased-in expansion, and gradually expand its income limits. The state could determine the income level based on a percentage of the FPL or use a flat income level, such as $1,000/month to determine eligibility. It is not a waiver. With regard to cost, it should draw down federal dollars. Uncompensated care would go down, which is good for rural areas.

HIFA Medicaid Waiver - This option would provide coverage to uninsured parents of Medicaid and CHIP enrollees as well as childless adults. This option could have a positive impact on current Medicaid program coverage. State legislation and CMS approval would be required. Administrative costs could be significant and eligibility would have to be clarified.

Full Cost Buy like Local Government – This option would establish a program modeled after the local government program currently administered by the AL State Employees Insurance Board. This option would preserve coverage in the private market rather than a creation or expansion of a public program. The option would offer a well managed benefit design. It would allow the state to influence access and choice for small employers without creating a new program with large overhead expenses. This option does not address issues for those firms already offering coverage; therefore it would not influence stability of the market.

Mandating take-up thresholds could be administratively burdensome and the economic modeling did not show this option to offer any financial savings for the state.

HIPP Medicaid Waiver – This option would expand Medicaid's current Health Insurance Premium Payment Program. This option could be funded through a 50-50 match with state and federal funds. Uninsured family members may benefit from this premium payment is family coverage is required to enroll the Medicaid recipient.

Another option which garnered much interest but which had been previously modeled in-house was the option of expanding CHIP to cover the unborn who would be CHIP eligible after delivery. During Year 2, the project also modeled Medicaid Buy-In options.

It was recognized, through this project, that a significant portion of Alabama's uninsured are potentially eligible for existing coverage programs (20.8% potentially eligible for employer-sponsored insurance; 16.1% potentially eligible for public programs). During Year 2 and continuing into Year 3, publications containing the statewide analyses of Alabama's uninsurance data were distributed. Further analyses (the development of county-level uninsurance data) however, are needed to inform discussions. In the previous annual report, it was reported that a state referendum on a tax package would be decided on September 9, 2003. This referendum, which could have provided funding to expand current public health insurance programs, did not pass. Because the state expects to face financial shortfalls in the general fund in FY 2005 and possibly beyond, plans to substantially increase enrollment in public programs have are stationary. Because the modeling showed that creating a pool modeled after the State Employees Insurance Board local government health insurance plan offered no financial incentive for implementation.

Supported by the work of this project, *Voices for Alabama's Children*, a statewide advocacy group for children, prepared a grant application to implement the options that pertained to increasing public education and awareness of health insurance options currently available to employers and employees. However, the grant was not funded. Fortunately though, with cost savings from the previous year, the State Planning Grant Project will, in Year 3, develop and distribute distributing materials, for employers and individuals, aimed at explaining the importance of health insurance (including the development of a cost: effectiveness issue brief).

SECTION 5. CONSENSUS BUILDING STRATEGY

The governance structure used in Year 2 consisted of:
(1) Core Decision Making Group: This group was composed of the high level staff within Alabama Department of Public Health, the Alabama Medicaid Agency, and the Alabama Insurance Department, and several advocacy groups. The project used the economic modeling data to educate a cross section of Alabamians who could educate/influence policy makers on the effects of uninsurance and options that could reduce Alabama's uninsurance rate.
This group met on an ad hoc basis. This group provided overall direction and input to the project.
Project Staff: Project staff continued to consist of a project director, data manager, and clerical support.

To date other Year 2 activities have included the maintenance of a website (see Appendix II for the web address), the distribution of 2 publications regarding the uninsured in Alabama, and occasional news articles.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

The data gathered in this project was the first time this type of data had been gathered in Alabama on such a large scale. The fact that the data had been gathered solely from Alabamians and that it had

been gathered so recently, confirmed the fact that Alabama does indeed have an uninsurance problem and it re-energized interest in addressing the problem. The initial sub-state data (data on 12 regions in the state) has been of some use but the small area analyses, to be conducted in Year 3, will be far more useful because they will reveal statistics by county, a geographical division to which more people can relate. While the project initially considered direct collection of data at the county level (before the proposal was submitted), the idea was dismissed due to the high cost and the option of imputing this data from the 7,200 household telephone survey.

While the data supported some long held suppositions about the uninsured, it gave credibility to some of those suppositions as well as enlightenment as to the magnitude of the population eligible for currently available programs. The data also let stakeholders see that no one approach will "fix" the problem of uninsurance in Alabama.

Both quantitative data and qualitative data were important in the process of understanding uninsurance in Alabama. The quantitative data revealed the magnitude of the problem. Quantitative data also confirmed that the state had taken the right approaches with regard to covering children. The qualitative data revealed the interests, abilities, and knowledge deficits that are necessary to both understand the problem as well as develop plans to address it. Both of these types of data were used in researching health insurance options and prioritizing them for study. However, the quantitative data stands out as the most helpful in terms of focusing on which health insurance options to study further.

During Year 2 the two single most important factors in the data analyses process were the analyses and advice provided by The Lewin Group and advice given by previous grantees. Value was added because HRSA provided free consultation to the grantees.

Additional focus groups may need to be held in order to gain additional qualitative data on how best to influence employers in the state.

During Year 1 of the project, the state elected a new governor and experienced several changes in state agency directors. However, this had no adverse effects on the progress of the project. Economic forecasting, which projected declines in state funds however, has made it difficult for the state to contemplate program expansions. This has been especially frustrating since funding for the state agencies that provide current public health insurance programs, is uncertain. However, strong leadership from the State Health Officer and from the Alabama Medicaid Agency and earnest staff in both departments provided a steadying and optimistic balance in the project.

The goals of the project have not changed.
Alabama has applied for a no-cost grant that will allow the project to extrapolate data from the household telephone survey to develop county-level uninsurance data. To the extent that funding will allow, the project will also develop a communications plan that will provide guidance as state officials think and talk about uninsurance in Alabama. The project is planning to continue to have meetings (at least twice in the coming year) of the core workgroup so that stakeholders can remain abreast of the data extrapolations and the communications plan. Updates on project progress will be posted to the project's website which will continue to be maintained.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

No coverage options being studied at this time would require changes in federal law. One option, the HIFA waiver would require a waiver from both Medicaid and SCHIP. Other options, a Medicaid expansion through an increase in the Medicaid 1931 eligibility level, an expansion of the Medicaid HIPP, and Medicaid Buy-In options would require a revision in the Medicaid state plan. The last option, the creation of a small business pool under the operation of the State Employees Insurance Board would probably require a change

in state law. However, because the economic modeling of this option showed no savings to the state or to employers, this option is no longer considered viable.

Periodic funding to conduct the telephone survey and analyses as well as the focus group implementation and analyses would assist the state and the federal government in knowing how/if the uninsured population is changing over time. Continued funding of this project would allow additional data collection, analysis and focus group implementation which would provide input into future policy decisions.

APPENDIX I: BASELINE INFORMATION

Population: 4,486,580

Number and percentage of uninsured (current and trend): According to the project's FY 2003 telephone survey, 11.2% of Alabama's population is uninsured. When applying this percentage to the 2001 population of 4,486,580, it appears that there are 502,497 uninsured Alabamians.

Average age of population: Median age of the population in 2001 was 36.1years.

Percent of population living in poverty (<100%FPL):

Primary industries:
The largest type of employer in Alabama is the micro-employer ($\leq$10 employees).

Number and percent of employers offering coverage: Not obtainable at this time.

Number and percent of self-insured firms: Not obtainable at this time.

Payer mix: Of the total population in Alabama, 53.7% have employer-sponsored coverage and 3.7% have individual coverage.

Provider competition: Not applicable.

Insurance market reforms: To date Alabama has not had any recent insurance market reforms. The largest insurer in the state (insuring 80-95% of the insured lives in AL) is Blue Cross Blue Shield of Alabama.

Eligibility for existing coverage programs (Medicaid/SCHIP/other): Over a third (36.9%) of the uninsured in Alabama have potential access to health care coverage through an employer or a public program.

Use of federal waivers: These have been studied and some Medicaid are being proposed for further study through this project.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

The internet address for this project, a part of the website for the Alabama Department of Public Health, is: www.adph.org/idea.

The Year 1 Progress Report contained a copy of the telephone survey tool and copies of the focus group discussion guides. If these are needed again, they are available upon request.