

Georgia State Planning Grant for the Uninsured

Final Report to the U.S. Department of Health and Human Services and the Health Resources and Services Administration

State of Georgia



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CONTRIBUTING ORGANIZATIONS

THE GEORGIA STATE GOVERNOR'S OFFICE

THE GOVERNOR'S OFFICE OF PLANNING AND BUDGET

THE GEORGIA HEALTH POLICY CENTER

GEORGIA STATE UNIVERSITY, CENTER FOR INSURANCE RESEARCH

GEORGIA STATE UNIVERSITY, CENTER FOR HEALTH SERVICES RESEARCH

GEORGIA HEALTH DECISIONS

**THE NATIONAL CENTER FOR PRIMARY CARE AT THE
MOREHOUSE SCHOOL OF MEDICINE**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER

GEORGIA DEPARTMENT OF HUMAN RESOURCES

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EXECUTIVE SUMMARY

Current Status of Access to Health Insurance and Efforts to Expand Coverage

Georgia is home to more than 8.5 million people and, according to 2002 Georgia State Planning Grant survey data, 18 percent of the non-elderly, or 1.35 million Georgians, experienced a spell without insurance during the previous year, just over 1 million lacked coverage at the time of the survey, and about 9 percent of the non-elderly population lacked coverage for the entire year. As in other states, a large percentage of the uninsured are either workers or dependents of workers.

Georgia's past efforts to reduce the number of uninsured have been focused on the expansion of public programs. For example, PeachCare for Kids, Georgia's S-CHIP program that covers children up to 235 percent of the federal poverty level, has been very successful in enrolling eligible children. Also, Georgia is the only state to require hospitals to contribute 15 percent of their gross DSH allotment to community-based primary care. This requirement resulted in more than \$63,000,000 in community-based primary care funding for the uninsured in FY04.

Health insurance continues to be an area of concern for the Georgia General Assembly. Information from Georgia's State Planning Grant Process has informed the political debate and will continue to shed light on the policy making process. However, due to continuing budget concerns resulting from the state's slow economic recovery, and in light of a slight contraction in public eligibility for optional groups and a scheduled increase in premiums for PeachCare slated to go into effect on July 1, 2004, state level public expansions are not a viable option for the near future. Therefore, innovative public-private partnerships at the local level are the preferred methods for coverage expansion in the current fiscal environment.

Data Collection Activities

The State of Georgia was funded under the 2002 Planning Grant Program and was approved by HRSA to revise its remaining work plan and spend its remaining \$125,006 on activities that built on the data collection and public engagement work accomplished in FY03.

Georgia Household Health Insurance Survey

Georgia conducted a telephone survey of more than 10,000 households between October 2002 and February 2003. Topics covered in the survey included health insurance status, access to health insurance, type of coverage, health status and access to care, use of services, and demographic characteristics of respondents. The survey, by its design, collected information about the health insurance status of each individual in the household as well as detailed information about a randomly selected target individual in each household.

Georgia Employer Health Benefits Survey

A health benefits survey that collected information from over 1,400 establishments in Georgia (25 percent response rate) was performed by Georgia State University between October 2002 and January 2003. This survey gathered information about the characteristics of the work force and the benefits available to employees. Dr. Pat Ketsche presented results from Georgia's survey at the 2004 Academy Health Annual Research Meeting and has a paper based on the results forthcoming in *Medical Care Research and Review*.

Georgians on Health Insurance Focus Groups

Between September 2002 and December 2002, 21 focus groups (total participation of about 250 individuals) were convened to measure Georgian's attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians. The focus groups were conducted using a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System.

Attitudes of Small Georgia Employers on Health Insurance

Between February 2003 and April 2003, five focus groups with Georgia's independent small employers (total participation of about 50 individuals) were conducted in the employers' communities. During February and March 2004, an additional four focus groups (*new HRSA-approved activity*) were held with small business owners who did not offer health insurance, so as to better understand the barriers that they face in providing coverage for employees.

Georgia Key Decision Maker Interviews

Interviews with 22 key Georgia decision-makers were completed to understand the attitudes and opinions of key leadership in Georgia about health insurance, the uninsured, and access to care. Individuals were selected from the following five professional groups: consumers, employees in the executive branch of state government, insurers, legislators, and providers.

Assessment of Georgia's Primary Care Safety Net

The National Center for Primary Care at Morehouse School of Medicine conducted an assessment of the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia between September 2002 and February 2003. The purpose of the assessment was to identify affordable primary care services.

Community Listening Sessions (Original)

Four listening sessions for community leaders (total participation of about 60 individuals) were conducted by Grant staff in locations selected for their geographic and cultural diversity and their relative rankings of aggregate economic strength. Participants were drawn from representatives of the business and economic development communities, health care providers, insurers and underwriters, philanthropies, community-based organizations, and elected officials.

Dissemination and Coverage Expansion Modeling Activities

Fact Sheets and Reports

Fact sheets were distributed at statewide presentations, provided to and discussed with Legislators, sent electronically to an extensive mailing list of stakeholders, and posted on the grant website. These included:

- 13 fact sheets outlining the findings of the household population survey statewide and for each of the 12 sub-state service delivery regions;
- One report on the methodology of the research conducted under the grant;
- One report on the results of the employer survey;
- One report on the results of the citizen focus groups;

- Two reports on the results of the employer focus groups (Original and Revised); and,
- One report on the results of statewide coverage modeling (Revised)

Additional Reports and Data

Detailed reports of the findings of the employer survey, the focus groups, and the community listening sessions have been distributed through public presentations, the Grant's website, and via e-mail lists. County estimates of the uninsured have been produced and posted on the grant website. Finally, several PowerPoint presentations outlining the work of the grant and key research findings have been posted on the grant web site.

Public Forums

A series of public forums was begun with the launch of *Cover the Uninsured Week 2003* to share the findings supported by the Grant and to encourage public discussion. The findings of the data analysis, and their implications for Georgia, were the subject of thoughtful reporting in well-circulated media outlets (Atlanta Metro, Macon, Augusta, Savannah, and Albany) across the state.

Press Releases

Three press releases were issued statewide to print, radio, and television outlets to coincide with the release of the initial findings of the household population survey, the employer survey, and the results of the series of 21 citizen focus groups.

Modeling

Using Georgia specific data, the Planning Grant Team has engaged in modeling local and national coverage proposals to gauge their impact and costs. In an effort to address the emerging themes of access for the working uninsured and access for uninsured children, the Health care Coverage Project modeled three options - Health Savings Accounts, Tax Credits, and High Risk Pools. The results of this modeling exercise were released in March 2004.

Consensus Building and Policy Development Activities

August 2003

The National Association of Counties (NACo) and the National Council of State Legislators (NCSL) partnered with the Georgia Health Policy Center and the Association County Commissioners of Georgia to host a meeting to examine the issue of the uninsured in Georgia. The organizations together hosted the two-day event in Atlanta. There were nearly 100 participants, including: state legislators, county chairs and commissioners, district health officers, health network directors, conference faculty, representatives from NCSL, and representatives from Kaiser Permanente.

October - December 2003

The House Task Force on Health Insurance Options for Small Businesses and the Working Uninsured, created by the Georgia General Assembly, was a direct result of the August event. This bipartisan Task Force, chaired by Representative Pat Gardner, was supported with information and technical assistance from the Planning Grant Team. During this time, the committee built further consensus by engaging the participation of the Georgia Association of

Health Underwriters in their deliberations as they considered options for expanding coverage, modeled under the planning grant. A report to the House, outlining the recommendations of the committee, was produced by the Planning Grant Team.

December 2003

The Atlanta Regional Health Forum, a multi-disciplinary group (public, private, governmental, corporate, legal, education, business, managed care, community-at-large, etc.) and the Georgia Health Policy Center co-sponsored a meeting of small business executives from the Atlanta region to discuss the data and options coming out of State Planning Grant activities during the year.

April 2004

The Health Care Subcommittee of the Georgia Rural Development Council has been charged by Governor Perdue with the responsibility of making recommendations to the Council on four specific health issues affecting rural communities: tort reform, the working uninsured, the state of rural hospitals, and the role of communities in rural health care and coverage. The group solicited technical assistance from the Georgia Health Policy Center using the findings from the State Planning Grant to inform their discussions.

May 2004

Organizers of Cover the Uninsured Week 2004 activities in Augusta and Savannah and the Annual meeting of Covering Kids and Families in Macon each included presentations by the Georgia Health Policy Center using the findings from the State Planning Grant in forums designed to build support for public policy that will foster expansion of coverage.

May 2004

Given the growing consensus around targeting strategies for the expansion of coverage to the working uninsured, the State Planning Grant Team organized a three-hour pilot discussion with ten business leaders in Albany Georgia. The discussion provided insight to the level of business support for the concept of public/private approaches to the problem of the working uninsured, as well as the potential of approaches to be embraced by larger employers.

Recommendations to States

Georgia's experience with the SPG process has yielded seven specific recommendations to other states engaging in a planning process to reduce their number of uninsured.

- State-specific data are critical to the decision making process.
- A household survey yielded detailed information on un-insurance within specific subgroups of the State population, which helped clarify what could be the most effective coverage expansion options.
- A well-designed employer survey can be a cost effective way to learn about employer benefits behavior.
- Qualitative research was important in identifying stakeholder issues.
- Persistence can be the most effective strategy to improving and completing the data collection.

- The State should be prepared for the planning process to yield ideas for changes in state programs and agencies.
- Collecting information about the State's insurance and health care markets is very different from collecting information about the prevalence of insurance coverage.

Recommendations to the Federal Government

Recommendations to the Federal Government by the State of Georgia relate to the need for federal financial support of current health programs and efforts to improve the State's ability to sustain its existing programs. Specifically, federal support of the following is needed:

- Better define the Healthy People 2010 access goal.
- Support information systems development
- Facilitate collaboration between the states and the federal government on state-specific longitudinal data collection.
- Facilitate state-specific econometric modeling.
- Support regional collaboration between states
- Reward states that reduce their number of uninsured residents.
- Reward states that offer a consumer-friendly private insurance marketplace

SECTION 1

UNINSURED INDIVIDUALS AND FAMILIES

Introduction

Georgia is home to more than 8.5 million people and is the largest state east of the Mississippi River, covering over 157,000 square miles. The state has 159 counties, 529 municipalities, six metropolitan areas, and 12 sub-state service delivery regions representing diverse economic and geographic areas of the State.

The residents of Georgia are younger and more racially diverse than the nation as a whole. While only nine percent of Georgia residents are over 65 years old, over 12 percent of the nation's population is elderly. African Americans comprise almost 29 percent of Georgia's population but only 12 percent of the US population. While Hispanic or Latino persons comprise 12.5 percent of the nation's population and only 5.3 percent of Georgia's population, Georgia has the fastest-growing Latino population in the country, adding nearly 17 percent between July 2000 and July 2002, according to the U.S. Census Bureau. These statistics shape the coverage market within the state, since younger adults and minorities are more likely to be uninsured than are elderly and white non-Hispanic populations.

The Uninsured in Georgia

Table 1, below, shows the coverage status of the total and the non-elderly populations in Georgia during calendar year 2002 based on the household survey conducted under the State Planning Grant.

Table 1
Coverage Status of Georgia Population, 2002

	All Georgians	% of total	Non-Elderly	% of total
Total Population	8,560,310		7,648,552	
Total Private Coverage	5,370,557	63	5,228,663	68
Employment Based Coverage	4,969,960	58	4,871,149	64
Other Private	406,912	5	362,990	5
Total Public Coverage	2,487,701	29	1,631,943	21
Currently uninsured	1,034,436	12	1,012,259	13
Uninsured for 12 months	677,328	8	664,707	9
Uninsured any time past year	1,378,858	16	1,347,580	18

Percentages sum to more than 100 because some individuals report more than one source of coverage.

Sixty-eight percent of non-elderly Georgians have employer-sponsored or individual private coverage, and 21 percent have some type of public coverage, such as Medicaid, Medicare or PeachCare. According to 2002 Georgia SPG survey data, 16 percent of all Georgians, or 18 percent of the non-elderly, experienced a spell without insurance during the previous year, and about half of them, or nine percent of the non-elderly population, lacked coverage for the entire year. Thus, about half of those experiencing a gap in coverage are chronically uninsured.

Characteristics of Georgia's Uninsured

State Planning Grant activities have allowed insights into Georgia's uninsured that were not previously known.

Age

Children (0 to 18) make up 27 percent of the state's non-elderly population but only 14 percent of the State's uninsured population. Children are more likely to be covered than any other non-elderly group, with just six percent of Georgia's children lacking coverage. The low number of uninsured children is most likely due to the success of Georgia's S-CHIP program, PeachCare for Kids. On the other hand, almost one-third of Georgians between the ages of 18 and 24 have experienced some lapse in coverage during the previous 12 months, and about one quarter is uninsured at any given point in time. By comparison, the percentage of Georgians between the ages of 55 and 64 who have had either a lapse in coverage in the past twelve months (15 percent) or are uninsured at any point in time (13 percent) is substantially lower.

Young men (ages 18 to 24) are much more likely to be chronically uninsured than females. Women, as they get close to retirement age (ages 55 to 64), are significantly more likely to experience a lapse in coverage or to be chronically uninsured than men. For many women, coverage is linked to the employment status of a spouse. Divorce or early widowhood may leave these women without insurance benefits. Men and women who are married or living in a family with a married primary wage earner are the most likely to be covered. Those who are single or living with a partner are the most likely to be uninsured.

Income

The likelihood of experiencing a gap in coverage decreases as family income increases. However, a substantial number of the uninsured in Georgia are not low-income. Twenty-two percent of the uninsured live in families with incomes at or above 300 percent of the federal poverty level (FPL), or \$55,200 for a family of four. Fifty-six percent of the uninsured have incomes between one hundred percent and three hundred percent of the FPL. Individuals living in families with incomes below the poverty level comprise about 12.5 percent of the non-elderly population but 22.5 percent of uninsured Georgians.

Race and Ethnicity

African American, and especially Hispanic, Georgians are more likely than white non-Hispanics to be uninsured at any given time or to experience any spell without coverage. While African American and white non-Hispanic Georgians have similar rates of chronic uninsurance, Hispanics are almost twice as likely as either of these groups to be uninsured for the entire year. Our findings suggest that minorities are not enrolling in public programs and private plans at the same rates as non-minorities.

Region

Rates of insurance coverage vary across the state. A large percent of the population in rural areas, especially south rural Georgia, is uninsured; 17 percent of Georgians living outside urban areas in the southern half of the state and 16 percent of north rural Georgians are uninsured as compared with the 11 percent uninsured in all urban areas and only 10 percent in metropolitan

Atlanta, where half the state's population resides. In some rural regions, the likelihood of being uninsured is over 20 percent.

Health Status

From Georgia's original Household Health Insurance Survey (fall 2002), we know the uninsured are more likely to report their health status as fair or poor (17 percent vs. 10 percent) and less likely to report their health status as excellent or very good (52 percent vs. 63 percent). They are less likely to receive preventive care and more likely to be sicker than the insured. They are almost four times more likely to have not had a routine checkup in the past two years (37 percent vs. 10 percent), three times more likely to have never had a routine checkup at all, and more likely to have missed six or more days of work or school in the past year (23 percent vs. 10 percent).

The uninsured are also half as likely to have seen a doctor in the last six months and more likely to have had an emergency room visit in the last 12 months. And, in general, the uninsured feel less confident about their ability to obtain health care than those with coverage. They are 7.5 times more likely to strongly disagree with a statement that they are able to get the health care they need. They are also much less likely to have a usual source of care than the insured population (58 percent vs. 90 percent). These numbers become even more important when one considers that in 2003, the United Health Foundation ranked Georgia thirteenth in deaths from heart disease, seventh in infant mortality, thirtieth in deaths from cancer, and eighth in premature deaths overall.

Target and Special Populations

There is a consensus in Georgia that children and the working uninsured without coverage should be targeted in any effort to expand coverage.

Children

While children comprise the age group most likely to be covered, there are still 241,000 children in Georgia who experienced a gap in coverage at some point in 2002, and 73,000 children who were uninsured for the entire year. One-third of those children reside in families with incomes below the FPL, and over three-quarters reside in families with incomes below 200 percent of the FPL. The transition from childhood to adult status puts Georgians at the highest risk of becoming uninsured. During this period, almost one-third of young adults experience at least a spell of uninsurance.

Children in rural areas were twice as likely as children in metropolitan Atlanta to be uninsured and almost three times as likely to experience a gap in coverage. Children in Georgia who are uninsured are seven times more likely to lack a usual source of care and three times as likely to report using the emergency room as their usual source of care as are children who are insured.

Working Uninsured

Of those Georgians without health insurance, at least 68 percent work or are the dependent of someone who works. However, those working fewer than 30 hours per week and their dependents are more than twice as likely as other Georgians to be uninsured, experience a spell without coverage, or be chronically uninsured. Among those working or in a family headed by

someone working in a permanent position, less than ten percent is currently uninsured. However, among those working or in a family headed by those working in non-permanent employment, the rate increases to 41 percent for temporary and 34 percent for seasonal employment.

Insurance coverage is also related to the size of the firm in which an individual works. Twenty-five percent of those who work for, or are the dependent of someone who works for, firms with between two and ten employees - and 29 percent of those in single person firms - are uninsured. Almost one out of three individuals without coverage is employed by firms with fewer than 25 employees or has a primary wage earner working in such a firm.

What Constitutes Affordable Coverage in Georgia

Information gathered from the focus groups conducted as part of the SPG activities demonstrated how difficult it is for Georgians to reach consensus on what is affordable; it seemed to be relative to income, although the acceptable upper limit ranged somewhere between the equivalent of one utility bill, such as natural gas, for those with lowest incomes, and a mortgage payment for those in the highest income group.

The employer survey revealed that in the group market, the average cost for a plan covering a single worker in 2002 was \$3,382, and employees paid, on average, 17 percent of that cost. Family coverage in the group market cost about \$7,367, with employees contributing an average of 39 percent, or almost \$3,000 annually. Small employers pay at least eight percent more for coverage that is traditionally less comprehensive.

Coverage in the individual market is even more expensive than in the group market. Using the smaller group market rates (that are unlikely to be available in the individual market), family coverage in Georgia will typically constitute 17 percent of the median household income of \$42,433 (Census Quick Facts). Given that the uninsured have substantially lower household incomes than insured populations, it is likely that individual policies to cover an uninsured family in Georgia would cost over 20 percent of the annual household income for many.

Failure to Enroll in Public Programs

Except for children, eligibility for public programs in Georgia is dependent upon both income and other conditions that were not ascertained in our survey. Thus, it is only possible to estimate the propensity of eligible individuals not to enroll for children in the state. All children ages 18 and under living in families with incomes below 235 percent of the FPL are eligible for either Medicaid or PeachCare. We estimate that 80 percent of Georgia's uninsured children, or approximately 115,000 children, are actually eligible for PeachCare or Medicaid but are not enrolled. If all of the children in Georgia with family incomes at levels below 200 percent of the FPL were enrolled in public programs, fewer than 30,000 children, or less than two percent of all children in Georgia, would remain uninsured.

Despite the low income of many of Georgia's uninsured, only 22 percent of the currently uninsured report being previously enrolled in some type of public coverage. Of those who reported being eligible for a public program but declining to enroll, 55 percent reported they are opposed to public coverage or the stigma attached to public programs. Ninety percent of the

currently uninsured report that they would enroll in a public program if eligible, and 95 percent report they would enroll in a public program if they were eligible and would incur no expense associated with enrollment.

Failure to Participate in Employer Sponsored Coverage

There are two sources of information about the failure of employees to participate in employer-sponsored coverage. From the Survey of Georgia Employers, we know that uninsured workers fall into three categories:

- Those who work at an establishment that does not offer any health insurance benefit to any workers (400,000 private sector employees),
- Those who work at an establishment that offers benefits, but are not eligible because of part-time, temporary or seasonal status, or because of an exclusionary period (almost 500,000 private sector employees),
- Those who decline to participate in a plan for which they are eligible (over 500,000 private sector employees).

We know from the household survey that approximately 40 percent of all workers who lack coverage in their own name from an employer are actually covered as a dependent by another worker in the household. However, those declining offered coverage are the most likely to be covered by another plan, while those who work at an establishment not offering any benefits or are ineligible for an offered plan are the most likely to remain uninsured. We estimate that almost 75 percent of uninsured workers and their dependents are not offered or are not eligible for benefits, while 25 percent (or approximately 150,000 uninsured Georgians) lack coverage because of a worker who declined to participate in a plan for which they were eligible. The high cost sharing for family coverage (almost \$3,000 annually in 2002) and lower average family incomes of the working uninsured (11 percent lower) imply that premium sharing contributes to this problem. National data indicate that this group of uninsured workers is growing.

From Statewide Focus Groups: Attitudes on Employer Sponsored Coverage

Complaints about the limits and restrictions on coverage due to managed care plans rank second in Georgians' grievances about the health care system. Their problems with managed care are broad in scope but center on insurance companies, rather than doctors, making decisions about what treatments they can receive, what drugs they can take, and how long they can stay in a hospital. A Savannah woman worried about managed care's impact on the quality of medical care when she said, "I don't think people are getting as good a (quality of) medical care as they should because of insurance companies. I think the insurance companies don't want to have tests done on patients that really need to be done because they don't feel like it's necessary. I think they are taking too much of a responsibility and aren't letting the doctors make the decisions." Another Savannah woman appeared to question the quality of doctors that practice through managed care plans when she said, "A lot of doctors in the managed care programs can't get patients any other way."

Participants have come to accept that having to choose their doctors from lists of preferred providers is an irreversible method for controlling health care costs. Many, particularly those in the urban areas of the State, seem satisfied with the choice of doctors available to them. A

Macon woman commented, “We are fortunate that there are a lot of doctors in our area, and I haven’t had a problem.” But, many more simply dislike having any restrictions placed on them. When a Columbus woman said, “I just feel like if you’re paying that much money, you should be able to go where you choose to go,” she spoke for the large majority of those who attended the focus groups. Even those who say they have sufficient numbers of doctors from which to choose join in the debate over preferred provider lists when this practice causes disruption in an established relationship with a doctor. Most often, this disruption occurs because their employers change health plans in search of more cost-effective coverage. Several related stories similar to the Wrightsville woman who had to change doctors after 19 years when her company switched insurance plans, and the Jonesboro man who complained of having to change doctors every year for the past three years because his employer is constantly seeking less expensive coverage.

Access to specialists presents greater problems due to referral policies established by health plans. A frustrated Jonesboro woman said, “It’s like pulling teeth trying to get them to send me to a specialist. You’ve got to get a referral, and they don’t like to refer you because that’s more money. If it’s going to be more costly, they’ll dodge it at all costs.” And a Griffin man declared, “If your doctor says you need to go to a specialist or have an MRI done, I think it should be done regardless of what the insurance company says because your doctor can detect things that someone sitting in an office reading a chart can’t.”

Those who are enrolled in an HMO voiced the loudest complaints about limits on their choice of doctors, the difficulties they face in accessing services, and the quality of care they receive. A man in Stone Mountain asserted, “HMOs are horrible. It’s like you’re trapped. You have to go to their doctors, and you have to wait forever to get into see the doctor.” In Toccoa, a man passionately stated, “They need to drop the HMO deals. That’s the bottom line because HMOs are what’s killing a lot of people.” “My number one complaint is the attitude of the HMO. They act like they’re doing us a favor, and they’re not. You’re a pig in a poke to them,” griped a Norcross man.

While participants in every Social Group inherently understand the advantages of having health insurance for themselves and their families, there are those who are beginning to question the cost benefit of maintaining their coverage. For participants with higher incomes, having health insurance is viewed as absolutely essential. A Dunwoody man explained, “If you have any money and any possessions you have got to have health insurance. If you have nothing, it’s okay. You don’t have to have it.” And a Griffin man declared, “A major illness would take everything that you ever worked for.” For those in higher income brackets and those who have reached middle age and who have accumulated assets, having health insurance is as much about protecting their savings and possessions as it is about receiving quality health care. Yet, even these individuals are beginning to examine the cost benefit of their insurance coverage. Another Dunwoody man protested, “The insurance premium is our second highest monthly bill. If it wasn’t for my wife, I wouldn’t have it. I would rationalize that I can’t afford it, and I don’t need it. I try not to think about the cost of it. It makes me sick to my stomach to think that I pay that much money.” A man in Macon reiterated this concern by saying, “It’s frustrating because \$12,000 of my salary is tied up into something that I hardly even use. I can’t remember the last time I went to the doctor.”

Even those who maintain their coverage are seriously questioning what benefits they are receiving, as health care costs consume a greater percentage of their income. A Wrightsville woman said, “I never meet my deductible. So all year long, I just pay for nothing.” A man in Columbus added, “Between the co-pays and the deductibles, it’s really expensive and not worth what you get.” A Toccoa man acknowledged the dilemma that many of his peers have faced in making decisions about insurance coverage, saying, “There comes a time when insurance is just too expensive, and you have to risk it.”

The Potential Impact of Subsidies, Tax Credits, or Other Incentives

How can we make insurance more available and affordable to the high percentage of working Georgians who do not currently have coverage – particularly those employed in small businesses? To begin to address this important issue, the Project Team evaluated several options for expanding coverage that are currently being examined at the national level and projected the impact they might have on Georgians. Here we describe three of these options: Health Savings Accounts, Tax Credits, and High-risk Pools.

Health Savings Accounts

Health savings accounts (HSAs) are very similar to individual retirement accounts (IRAs) and medical savings accounts (MSAs). They are set up and “owned” by the employee, who agrees to set aside a percentage of his or her salary to cover certain medical expenses. These expenses typically include:

- Health insurance deductibles
- Co-payments for medical services, prescriptions, or products
- Over-the-counter drugs
- Long-term care insurance, and
- Health insurance premiums during any period of unemployment.

HSAs are available to all individuals, provided they have a health insurance plan with a high annual deductible of at least \$1,000 for individual coverage (or at least \$2,000 for family coverage). Employers can make additional contributions to an employee’s HSA. However, like an IRA, the HSA is portable; if an individual changes jobs or retires, the HSA goes with him or her. In addition, there is no time limit within which employees must spend the funds in their HSAs.

Contributions by an employer are not included in the individual’s taxable income, and contributions by the individual are tax deductible. No taxes are levied on interest and investment earnings generated by the account, or on distributions from the account used to cover qualified medical expenses. Any contributions, however, that are not used to pay for qualified medical expenses are subject to a penalty tax of up to ten percent. Individuals over age 55 may be able to make extra contributions to their HSAs and still enjoy the same tax advantages.

Who would be eligible? Almost all Georgians not covered by Medicaid or Medicare are eligible to create an HSA.

How many would be covered? The number of Georgians covered by the more limited Archer Medical Savings Accounts was quite small. While HSAs have a broader eligibility, it is not clear that they would be any more attractive in the short run. For employers now offering more generous coverage, switching to an HSA may not save them any money in the short run if they want to keep their employee insurance benefits roughly the same. More problematic is whether they would save any money in the long run.

Who would pay? Federal and state revenues would be reduced as some income would become non-taxable through contributions to an HSA. This impact could become quite large over time if the deductible limits on the affiliate insurance plans are not increased to keep pace with medical inflation. To the extent that employers switch to HSAs, some low income and less healthy employees may find that they pay more in the form of out-of-pocket expenses and have reduced access to care.

What is the potential impact? Based on data about the types of health plans offered in Georgia and their respective participation rates, it is likely that less than 100,000 Georgians will elect to use an HSA for their insurance plan in the near future. Over a much longer period of time, if the limits remain stable, the \$1,000 deductible will become much more common and HSAs will look more like traditional insurance. At that point, use of HSAs will be more widespread, although their effectiveness as a cost management tool will be reduced or completely eliminated.

The theory behind HSAs is that they save money by altering consumers' spending habits. Under this theory, consumers faced with the true costs of health care services would become more cost conscious. The reality is that the largest part of an insurer's claims payouts are for high cost cases – episodes of care where the total costs are well beyond the deductible in an HSA plan. Therefore, the cost savings to an employer for switching to an HSA may be minimal. In addition, the best way to reduce high costs, particularly for the chronically ill, is to provide early, frequent access to care. However, because there is no time limit within which HSA contributions must be spent, employees may opt to save these funds for later use rather than spend them in the short term for preventive services. Finally, HSAs are most attractive to healthy, higher income individuals. If employers offer HSAs as an option, they may find that the cost of their more traditional plan rises as healthy employee select HSAs, while employees at higher risk remain in the traditional plan.

Tax Credits

Tax credits are a type of subsidy which would be available to individuals at low income levels. President Bush has proposed a refundable tax credit as part of the Administration's Fiscal Year 2004 budget. This approach gives refundable tax credits of up to \$1,000 to individuals and \$3,000 to families to use in the non-group market or for employer-sponsored coverage. It has been estimated that this plan would insure an estimated three to six million people nationally who currently have no insurance.

One of the issues with a tax credit is that it is a "blunt" instrument: it is difficult or impossible to offer a subsidy to the currently uninsured without offering that same subsidy to similarly situated people who are already covered. As a result, the costs of a tax credit program may be relatively expensive per newly insured individual.

Who would be eligible? All Georgians who live in families with incomes under \$30,000 for individuals and \$60,000 for families are eligible.

How many would be covered? An estimated 126,000 uninsured Georgians would gain coverage. Another 900,000 would benefit directly from the subsidy, although they already have coverage. The subsidy in that case may lead to the purchase of more generous health plans.

Who would pay? The costs would be borne by taxpayers. Conversely, however, increasing coverage may decrease state and local taxpayer burdens if the amounts they have to pay to provide care to the uninsured decreases.

What is the potential impact? The expected impact is depicted in Figure 1.

Figure 1
Projected Cost of Tax Credits

Current Coverage	Number Getting Subsidy	Cost of Subsidy
Uninsured	138,345	\$113,442,629
Private	924,329	\$757,949,780
Total	1,062,674	\$871,392,409

High-risk Pools

High-risk pools are designed to provide coverage to individuals who have been deemed by the insurance industry as “medically uninsurable.” Typically, these individuals have a chronic health condition and have either been rejected for coverage because of that condition or can only get coverage with exclusions or at a higher cost. The pool serves as a risk-spreading mechanism whereby the few high-risk, high cost persons in a market are guaranteed a source from which to purchase insurance, and the purchase is subsidized through some public funds.

Coverage offered through high-risk pools tends to mirror that of individual market plans. Persons who enroll pay more for coverage, but there is a cap on premiums, usually 25-50 percent more than comparable private coverage.¹ Once admitted to a high-risk pool, an individual is guaranteed access to the same set of services as others in the same insurance plan.

States have been experimenting with high-risk pools since 1976, using a variety of structures and funding mechanisms. Premiums paid to pools typically cover about half of the costs, with the balance covered by: state general revenues, specially designated state funds, service charges to hospitals, premium taxes, and/or health insurer assessments that may be based on premiums or the number of covered lives. Successful pools tend to be those that:

- Spread risk and loss equitably to all members.
- Avoid promises of positive return to members from pool operations (since claims will exceed premiums).
- Have a good return from better outcomes of care management (due to integrated techniques and sophisticated predictive models) and cost-effective administration (if systems and staff are tailored to the special needs of the risk pool and its unique population).

Who would be eligible? Eligible individuals are those who were denied coverage from two private insurers, were quoted a rate that was higher than the rate at which they could purchase coverage through the pool, or had a prior diagnosis of a serious chronic illness.

How many would be covered? Approximately 3,400 Georgians who are currently uninsured would receive coverage from the high-risk pool. Although over 5,000 Georgians lack health insurance because they are uninsurable, a portion of them would not participate in the high-risk pool because of its expense. Other states have found that high-risk pools attract about 1 percent of the individual market. In Georgia, the number of individuals who are uninsurable and live in families with incomes above 300 percent of the Federal poverty level is almost equal to 1 percent of Georgia's individual market.

Who would pay? The high-risk pool would be funded by assessing insurers and re-insurers at a rate of \$1 per insured per month. The benefits package (with a \$500 deductible, an 80 percent coinsurance rate, a \$2,000 out-of-pocket maximum, and a \$2 million lifetime maximum benefit) would cost \$5,706 per year for an eligible 50-year-old male – approximately 50 percent more than comparable coverage outside of the high-risk pool.

What is the potential impact? Based on other states' experience, the number of individuals in the pool is likely to grow over the first few years of operation as individuals become aware of its existence. If we assume:

- An assessment of \$1 per insured individual per month;
- Initial coverage of 40 percent of the individual market;
- Enrollment that builds over the first three years, rising ultimately in Year 3 to 80 percent of those eligible with incomes over 300 percent of the Federal Poverty level; and
- Health care cost inflation at levels projected by the Federal Government;

Then we can project:

- A 5-fold increase in enrollees
- A comparable 5-fold increase in premiums, claims and administrative costs
- A relatively stable level of revenue.

Thus, under this scenario (see Figure 2), a high-risk pool in Georgia would potentially be viable and sustainable. While the number of people potentially covered would be small relative to the total number of uninsured in Georgia, these individuals are some of the state's most vulnerable residents. Moreover, the high-risk pool has the potential to help stabilize the individual and small group insurance markets in Georgia and thereby increase access to health insurance coverage for an even larger pool of Georgians.

Figure 2
Five-year Projected Costs for a High-risk Pool

	Year 1	Year 2	Year 3	Year 4	Year 5
Enrollees	850	1,700	3,399	3,875	4,417
Premiums (Millions)	\$6.33	\$12.65	\$25.31	\$28.85	\$32.89
Revenues (Millions)	\$24.75	\$25.74	\$26.77	\$27.85	\$28.96
Administrative Costs	(\$0.32)	(\$0.64)	(\$1.28)	(\$1.33)	(\$1.39)

(Millions)					
Claims (Millions)	(\$11.07)	(\$23.00)	(\$45.99)	(\$50.36)	(\$55.26)
Addition to Reserves* (Millions)	\$19.69	\$14.76	\$4.80	\$5.00	\$5.20
Cumulative Reserves (Millions)	\$19.69	\$34.45	\$39.25	\$44.25	\$49.44

**Ignores interest income*

The goal is not to make health care free for all, nor is it to totally eliminate the number of uninsured individuals. Rather, it is to help Georgians acquire or improve their health insurance coverage. According to the Rand Corporation, which recently studied the effects of five kinds of state experiments to expand health insurance coverageⁱⁱ, a successful approach toward this goal would likely involve:

- Multiple strategies.
- New federal expenditures or innovative public-private approaches to financing. States will be unable to solve the problem of the uninsured on their own.
- Maintaining a strong safety net to ensure that those individuals who remain uninsured (even with substantial public subsidies) will retain access to health care.

Availability of Medical Care to the Uninsured

Between September 2002 and February 2003, the National Center for Primary Care at Morehouse School of Medicine assessed the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia. This assessment identified affordable primary care services available to patients with a broad range of presenting conditions. To ensure that all aspects of the primary care safety net were taken into consideration, a wide variety of sources of information were used. Sources included a survey of district health officers, an information request made to Georgia's Division of Public Health, the Health Resources Services Administration, the State of Georgia's Office of Rural Health, the American Medical Association, the Georgia Hospital Association and the Grady Health System.

To be counted as part of the primary health care safety net, a health center or health care professional must provide the full range of services typically provided in a family physician's office. In other words, the provider must offer services that meet 85-90 percent of the health care needs of patients in all age groups.

There is no organized, cohesive approach to assuring a primary health care safety net for all Georgia communities or citizens. Instead, Georgia's safety net has many layers, with different governmental agencies and health care organizations and individual providers each offering some primary care services in certain geographic areas to some segments of the population in need. Georgia has a scattered collection of safety net providers consisting of community health centers, county public health clinics, federally qualified community health centers, community mental health centers and hospital-based health care (public sector and private not-for-profits).

Community Health Centers: The Health Resources and Services Administration's Bureau of Primary Health care funds 19 Community Health Center organizations in Georgia, whose clinics and satellites comprise a total of 81 primary care delivery sites.

County Health Department Facilities: Georgia's State and county health departments offer many categorical services (family planning, immunizations, etc.) to uninsured and other underserved Georgians, but may also offer more comprehensive primary care services as well.

Hospital-sponsored Outpatient Clinics or Networks: Public hospitals, such as Grady Health System in Atlanta, offer primary care in outpatient clinics and neighborhood satellites. Georgia's hospitals also provide some outpatient indigent or charity care and report spending roughly \$1 billion dollars in un-reimbursed costs for hospitalization or uninsured patients.

Indigent Care Trust Fund/Disproportionate Share Hospital Programs: Hospitals that treat a disproportionate number of Medicaid and other indigent patients qualify to receive federal Disproportionate Share Hospital (DSH) payments through the Medicaid program. The Indigent Care Trust Fund represents the largest component of DSH payments. Fifteen percent of the state's Indigent Care Trust Fund dollars are explicitly awarded to Georgia hospitals specifically for "primary care" programs. Roughly one-fourth of these support programs provide comprehensive primary care services to low-income or uninsured clients.

Private Sector Religious and Charitable Organizations: Some charitable organizations operate full or part-time clinics, often with volunteer physicians and nurses. These clinics are essential in providing services to specific immigrant groups or other underserved populations.

Private Practice Physician Offices: Georgia's physicians and other health care professionals working in private practice often care for uninsured or other underserved patients, but typically can not offer up-front discounted charges or sliding fees for the services they provide.

Community Coalitions and Rural Health Networks: In several Georgia counties, coalitions of community-based organizations and/or health care providers have banded together to provide more structured mechanisms for providing primary health care to the uninsured. Since 1999, the Georgia Health Policy Center and the Office of Rural Health Services, with funding from Georgia's Department of Community Health, has provided technical support for the development of rural health networks. These networks have demonstrated tremendous success in bringing together key stakeholders to achieve coordination of services of patients in need. Though the inclusion of private practitioners they may expand clinical delivery sites. However, they have also demonstrated that their impact will be limited if they do not have the ability to expand capacity in terms of high volume patient care for low-income and uninsured patients.

Emergency Rooms: Individuals who lack access to primary health care to are significantly more likely to seek care in hospital emergency rooms, even for non-emergency conditions. When they do experience medical emergencies, they are less likely than insured patients to be admitted to the hospital for the same level of severity of illness. Even patients who obtain primary health care may have care that is less than optimal.

Despite the number of agencies and organizations providing health care to the uninsured and other underserved populations, the current level of statewide or even regional planning and coordination of services is not sufficient to assure coverage for all Georgians. Five gaping holes preclude Georgia from having one cohesive safety net for the delivery of primary care.

- 1) Rural Areas. Many rural counties have inadequate numbers of primary care physicians, large proportions of the population with no health insurance, struggling hospitals, and no safety net clinic. Thirty-nine counties have been designated as high priority primary care access areas, based on their shortages of health professionals, poverty rates, and excess mortality. As of 1996, there were 101 counties that needed more family physicians, including eight counties with not even one family practitioner. Rural hospitals, which provide supporting infrastructure for primary care, are also in jeopardy. Seven general hospitals closed between 1990 and 1997, five of which were in rural areas. Since that time, significant nursing shortages as well as increasing malpractice insurance costs have created additional threats to the survival of rural hospitals.
- 2) Urban Areas. A plethora of health care safety net agencies overlap each other's coverage areas and provide high-volume services, but still have inadequate capacity to serve all the low-income and uninsured patients in need. This may be due in part to the lack of coordination between agencies for allocation of resources and integration of services.
- 3) Suburban Areas. Rapid growth in outer suburbs has brought the health care needs of an urban population to communities that did not traditionally require a large safety net infrastructure. The growth of jobs in small businesses and industries that do not offer health benefits to their workers has led to the need for new primary care safety net services.
- 4) Immigrant Populations. Georgia's rapidly growing immigrant populations may face significant language and cultural barriers to care in a system that historically has viewed cultural diversity in terms of black and white. The Hispanic and Latino population has grown by 300 percent in the past decade and has the highest rates of being uninsured among all ethnic groups in Georgia.
- 5) Georgians with Chronic Illness or Disabilities. Individuals with chronic illnesses or disabilities as well as mental health problems often have primary care needs that go beyond the scope of services provided by public health or primary care safety net clinics. Their needs may include sub-specialist care and sophisticated ancillary services, as well as special transportation or home health care and coordination of care between various fragmented service programs.

Those categorical gaps translate to geographical gaps. There are many counties in Georgia that do not have a state, federal or local safety net primary care clinic. In these areas, uninsured individuals have no access to providers that will address their basic health care needs on a free or sliding scale basis.

An estimated 772,947 outpatient primary care safety net visits are being provided to the uninsured each year. This number compares to a projected need of almost three million outpatient visits. Thus, Georgia's current safety net is meeting only 25 percent of the need for

adequate primary health care. Similarly, roughly 266,533 uninsured persons, or one-quarter of Georgia's currently uninsured population and one-third of Georgia's chronically uninsured, are being served by existing safety net providers.

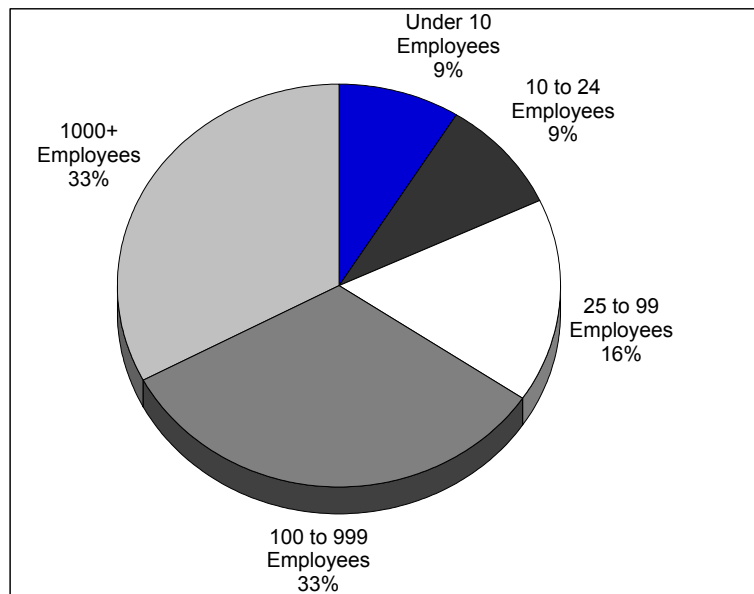
SECTION 2

EMPLOYER BASED COVERAGE

Introduction

Roughly half of Georgia's 8.5 million residents, or approximately four million people, are employed. About 400,000 individuals work for the state or federal government, and 3.6 million work for private or local government establishments with more than one person. Private and local government employers account for 108,000 single site establishments and almost 34,000 multi-site firms.ⁱⁱⁱ

Georgia Workforce by Firm Size



While Georgia's small employers are an important part of the state's economy and almost half (72,000) of the establishments have fewer than ten employees, only about nine percent of the state's labor force, or about 300,000 people, work in these small establishments. One-third of the state's workforce is employed by firms that have 1,000 or more employees and another third by firms consisting of 100-999 employees.

Data from the employer survey show that over three million Georgians in the private and local government workforce are employed in firms where health insurance is offered, about 2.5 million of those Georgians are eligible to enroll in their employers' plans, and about 80 percent of eligible employees actually enroll. These estimates, which result in just over two million workers enrolled in privately sponsored employment-based health insurance, are consistent with the results from the population survey because they do not include state and federal workers. The estimates imply that some 400,000 private or local public employees are not offered insurance, 500,000 are not eligible for the plans offered by their employers, and another 500,000 are eligible but do not participate in their employers' health benefit plans.

Table 2
Employees at Georgia Establishments

	Total Employees	No EBHI Offered	EBHI Offered	Employees Eligible	Employees Enrolled
All	3,439,378	399,358	3,040,020	2,560,288	2,023,236

Characteristics of Firms that Offer and Do Not Offer Coverage

Establishments that offer and do not offer health insurance to employees are quite distinct from one another. Firm size, location, and wages are the most important determinants of whether or not insurance coverage is offered by an employer.

Firm Size

The likelihood that a firm will offer coverage to at least some of its employees increases directly with the number of employees at the firm. Only 39 percent of employees at firms with fewer than ten employees are offered coverage, while almost all firms with 100 or more employees offer a health plan to at least some employees. On the other hand, if eligible for coverage, workers at small firms are the most likely to enroll.

Table 3
Enrollment and Eligibility at Georgia Establishments

Firm Size	% Employees offered	% Employees eligible who enroll
Under 10	39	84
10-24	72	77
25-99	84	79
100+	99	79

Geographic Location of Firm

Establishments in Atlanta are significantly more likely to offer health care coverage to employees than are firms in rural areas. Only 49 percent of establishments employing 83 percent of workers in rural Georgia offer any health care coverage, while 65 percent of Atlanta establishments employing 90 percent of Atlanta's workforce report at least one health plan for their employees. This difference may be due to the wider availability of health insurance products in the Atlanta area.

Employee Wages

The most important distinction between firms that offer and those that do not offer coverage is the average wage paid to employees and the distribution of those wages as measured by the percent of those employees who earn less than \$9 dollars per hour (\$18,000 per year). Among firms with 100 employees or less, those that do not offer health benefits employ about three times as many "low wage" workers as those with some type of employment-based health plan offering.

Among all firms, those that do not offer coverage have a greater percent of low wage employees than firms that offer coverage (27.5 percent vs. 13.1 percent). Not surprisingly then, firms that offer coverage also have a much higher average employee monthly wage than firms that do not offer coverage (\$3,988 vs. \$2,192). In firms with less than ten employees, the difference in average wage is even more striking; the average employee monthly wage is \$5,311 in small firms that offer coverage, while at small firms not offering coverage, the average employee monthly wage is \$2,284.

Worker Age, Tenure, and Race

Younger workers are more likely to work in firms that do not offer coverage. Among firms that have between ten and 99 employees that do not offer health insurance, an average of 16 percent of employees are under age 25. Among similarly sized firms that offer health insurance benefits, significantly fewer employees are young workers (about nine percent).

Turnover and worker tenure are additional factors strongly related to a firm's offer of coverage. For purposes of this study, full-time employees who have worked in a firm for less than one year are classified as short-term workers. Firms that do not offer health insurance coverage employ a greater percent of short-term workers than firms offering coverage (20 percent vs. 16 percent). This suggests that firms not offering coverage have substantially higher worker turnover than do firms with an employment-based health plan.

Firms that do not offer health care coverage report a significantly smaller share of employees who are minorities. Among firms that offer coverage, 26 percent of employees are Hispanic, African American, Asian or American Indian. However, among firms that do not offer coverage, only 19 percent are minorities. Large employers report a greater share of minority employees than do small employers and, as previously noted, are more likely than these small employers to offer health insurance coverage.

Part-Time Workers

Georgia employers generally consider any employee working fewer than 35 hours per week to be part-time. Most Georgia employers (78 percent) do not offer coverage to part-time employees, while 22 percent of Georgia establishments report that part-time employees may be eligible for coverage. Among those firms reporting that they currently employ part-time workers, only 20 percent report that those employees are eligible for private coverage. Just 13 percent of part-time employees in firms of less than 100 employees are eligible for private coverage, while 25 percent of those in firms of more than 100 employees are eligible.

Factors in the Employer's Decision to Offer Coverage

Employers offer coverage in response to the demand of their workers. Higher wage, older, and long-term workers demand coverage, and their employers respond. Firms that offer health insurance coverage are also very likely to offer life insurance, retirement benefits, and short or long-term disability benefits to their employees. Firms that do not offer health coverage are likely to only offer paid holidays or vacation as benefits but are significantly more likely than firms that offer coverage to allow a flexible work schedule.

Employers of all sizes cite a variety of factors in their decisions about offering coverage. In the Georgia Employer Survey, establishments not offering coverage were asked to select from a list up to three reasons why they did not offer coverage.

Table 4
Reasons Cited by Georgia Employers for Not Offering EBHI

	Establishments	Percent of Establishments
Total Establishments not offering EBHI	56,090	
Premiums Too High	42,215	75.3
Employees Covered Elsewhere	21,804	38.9
Employee Turnover Too Great	7,458	13.3
Too Many Low Wage or Minimum Wage Workers	5,984	10.7
Administrative Hassle Too Great	5,884	10.5
Firm Newly Established	4,225	7.5
Employees Don't Want Insurance	3,234	5.8
Firm Can Attract Good Employees Without It	2,820	5.0
Competitors Don't Offer Insurance	2,709	4.8
Other Reason for Not Offering Health Insurance (Group too small, employee participation low, coverage cancelled)	6,220	11.1

About 300,000 Georgia employees work in 47,000 establishments that have never provided health insurance coverage. Of the establishments that do not offer coverage now, 16 percent previously offered coverage. Those 16 percent of establishments that no longer offer coverage employ more than 83,000 employees. Sixty-one percent of those establishments previously offering coverage have dropped coverage since the year 2000, corresponding with changes in the economy.

How Do Employers Decide on Benefit Levels

Firms that offer health insurance typically include hospitalizations, emergency care, and prescription drugs in their packages. Ninety-seven percent of the employer plans surveyed cover preventive care and mental health-care, while a smaller percentage include dental and eye care coverage (68 percent and 45 percent, respectively). These findings are consistent with the fact that state and federal laws require most health plans to cover major medical care but not necessarily mental health, dental, or eye care.

Table 5
Benefits of Firms that Offer

	Employee Coverage		Dependent Coverage	
	Establishments	Employees	Establishments	Employees
Offers Health Insurance	100%	100%	100%	100%
Hospitalization	99%	99%	91%	96%
Emergency Room	99%	99%	91%	96%
Preventive Care	94%	97%	88%	94%
Prescription Drugs	97%	99%	90%	95%
Mental Health	92%	97%	87%	94%
Dental Care	68%	85%	66%	82%
Eye Care	45%	61%	42%	59%

While it is not clear how many firms self-insure their coverage, there does not appear to be major differences in general benefit categories between the two plan types. However, fully insured and individual coverage sold in Georgia are mandated by law to cover certain conditions or services not mandated by federal law.

Many employers (about 30 percent) who offer health plans give their employees a choice of plans. This is particularly true of large employers. Eighty percent of the establishments in Georgia offer a Preferred Provider Organization (PPO) product, 36 percent offer a Health Maintenance Organization (HMO) product, five percent offer a Point of Service product, 14 percent offer a traditional indemnity plan, 15 percent offer a special or dread disease policy, 11 percent offer a non-insurance discount plan, four percent offer a high deductible plan, and 1 percent offer a voucher for individual coverage. Eleven percent of employers report offering a medical savings account or a flexible spending account to their employees.

Employer Response to Economic Downturn or Extensive Cost Increases

The cost of health insurance is rising and affecting rates of coverage. The average annual premium for single person employer sponsored coverage was \$3,228, and the average annual premium for family coverage was \$7,368 in 2002.

On average, employees at Georgia establishments contribute 17 percent of the total cost, or \$569 per year, for single coverage and almost 40 percent of the total cost or \$2,851 per year for family coverage. Contribution levels appear to be highest for workers at firms between 24 and 99 employees, while workers at the largest firms (>1,000 employees) pay the least for either single or family coverage. Employee contributions for single coverage nationally for 2001 were about 18 percent of total cost, while family coverage contributions were slightly lower (24 percent) than the contributions reported by Georgia employers for this survey. At over \$200 per month for family coverage, a substantial percentage of workers eligible for coverage elect not to participate.

More than 83 percent of establishments and 79 percent of employees in Georgia faced an increase in total health plan costs in 2002, while just four percent of establishments and three percent of employees saw a decrease in cost during that same period. It appears that employers are passing some, but not all, of these price increases on to employees. As compared with 2001,

15 percent of establishments reported that their employees faced an increase in premiums for individual coverage, 31 percent reported an increase in dependent premiums, 51 percent reported an increase in co-payments, and 43 percent reported an increase in deductibles in 2002. Plan design appeared to be relatively stable, with 86 percent reporting no change in covered services and 77 percent reporting no change in choice of providers.

Table 6
Employers Reporting Change in Total Plan Cost

	Establishments	Employees
Total	85,540	3,048,619
Report Cost Increase	71,201	2,418,365
Report Cost Decrease	3,736	82,290
Report Cost Constant	6,230	370,244

	Establishments	Employees
Total	100%	100%
Report Cost Increase	83%	79%
Report Cost Decrease	4%	3%
Report Cost Constant	7%	12%

Qualitative Findings of Georgia's Small Business Owners

Five focus groups were conducted during the spring of 2003 to assess small business owners' opinions and attitudes regarding access to health care and expanding health coverage for Georgia's uninsured population. Business owners that do and do not provide health benefits to their employees participated in these discussions. During February and March 2004 an additional four focus groups were held with only small business owners who do not offer health insurance to their employees. The purpose of these discussions was to better understand the barriers that a small business faces in providing coverage for employees. Participants in the nine groups represented businesses with two to 46 employees and included service, manufacturing and retail establishments. Both sets of focus groups were designed and facilitated by Georgia Health Decisions.

Key Findings

The key findings from these focus groups were:

1. Small business owners share a universal concern over escalating health care costs and attribute rising costs to a combination of factors
2. Small business owners who provide coverage for their employees do so because they view their employees as "family" and want them to have the security that comes from being insured. Those that do not provide coverage want to do so but cannot due to the high cost of coverage.

3. The cost of carrying the legally required workers compensation insurance significantly adds to many small employers' inability to provide health insurance.
4. Small employers who do not currently provide insurance say they could pay an average of \$75 to \$100 per employee per month toward health insurance. They believe their employees, for the most part, could pay an average of \$40 to \$75 per month.
5. Small business owners are reluctant to support any method of expanding coverage to the uninsured that would require them to pay more business taxes. However, they would participate in employer purchasing pools in order to expand or lower their cost of coverage. They also support tax credits as a method of enabling them to expand coverage.
6. Small business owners believe the cost of health care and health insurance will continue to rise because there is no leadership to address the problem.

The Rising Cost of Health Care

If a single issue could be said to characterize small business owners' opinions about health care, it would be concerns about escalating costs – both of health care services and health care insurance. Employers characterize the cost of health care as “out of hand,” “ridiculous,” “out of proportion,” “outrageous,” “sinful,” “astronomical,” and “inflated.” Justifying their strong assertions, small business owners cite the practice of rate negotiations among insurance companies and health care providers as a chief contributing factor. Many see this practice as evidence that doctors and hospitals are overcharging patients and question the fairness of charging different prices for the same services based on the payment structure of the patient. Participants also criticize insurance companies for being too greedy and profit motivated, and thus, an equal partner in shouldering the blame for escalating costs. Compounding this picture is the belief among business owners that the principles of the free market that typically regulate costs do not apply to health care.

Small business owners further recognize that the sheer size of Georgia's uninsured population contributes substantially to the high cost of health care for a variety of reasons, namely, that the uninsured most often receive care in emergency rooms, do not seek preventive care, and delay getting treatment until their illnesses are in advanced stages and require more expensive treatments. They attribute the rising cost of health care to other factors as well, including malpractice insurance for doctors and hospitals, the marketing practices of drug companies that include entertaining doctors and their office staffs, the public's demand for the highest levels of technology, the cost of caring for terminally ill patients, and abuse by those uninsured who go to the doctor for minor ailments.

Providing Health Insurance Coverage

The small business owners in these focus groups showed a remarkable degree of consistency in their belief that providing health insurance to employees, at least at some level within the organization, is the “right thing to do.” Whether they are currently doing so or not, almost all express a strong desire to provide coverage to their employees, for a number of reasons. As

small businesses, employees work together in close contact with one another and with the owners, and the relationships are cultivated as “family.” Moreover, employees may be literally among the members of the owner’s personal family. In this light, it is not surprising that these owners want to do everything possible to make their employees feel secure by providing them with health insurance coverage.

The employers who provide insurance also profess that offering benefits such as health insurance helps them to attract and maintain better employees. They stress that employees who are dependable, conscientious, and loyal expect to have health insurance, and that they could not attract this caliber of employee without such benefits. On the other hand, those that cannot afford to provide health coverage related experiences of not being able to hire someone with strong credentials and of losing valuable employees due to lack of coverage.

Small business owners explore every means available to them for making insurance affordable to both themselves and their employees. Employee cost-sharing is the mechanism most often used, but attitudes about this varied. While some believe it is important for them to pay the full premium cost, others are equally adamant that employees should contribute toward the premium in order to maintain an appreciation of the value of the coverage provided.

A second mechanism used to offset the cost of health insurance is restricting coverage to certain types of employees or employee groups. Several business owners report making clear distinctions between those employees they view as essential to the long-term success of their businesses, and other employees. Some of these business owners indicated that they do not extend the health insurance benefits provided to those in management positions to their lower-income workers, who are generally paid by the hour. The primary reason they gave for this discrepancy is that, unlike those in management positions, their lower-income employees cannot afford to contribute toward the cost of the premiums and are often only short-term employees.

Employers who offer health insurance to all or part of their employees share considerable concern about the potential economic impact on their businesses if the costs of insurance premiums continue to rise. Most reported experiencing yearly double-digit increases in premium rate ranging from 15 to 45 percent. Such rate increases leave small business owners struggling with their commitment to provide coverage, but concern for those who would be left without coverage remains the primary reason many of these employers continue to sacrifice financially to maintain their insurance policies.

Barriers to Providing Health Coverage

Employers in these discussions who had made the decision not to offer health insurance did so either because they and their employees were financially unable to underwrite the cost. In no instance, however, was this decision based on an employer’s unwillingness to do so; indeed, the feeling of doing the right thing for the “employee family” is just as strong among employers who do not offer benefits as among those who do. And, almost all of the employers who do not currently offer insurance had sought coverage for their employees within the past two years, but none was able to find a plan that they and their employees could afford.

Although cost is the overriding obstacle, other barriers to obtaining or effectively extending coverage were also identified. One of the more important of these barriers is the reluctance of employees to pay toward their own coverage. Many participants stated that their employees consistently prefer to receive salary increases rather than apply the same amount of money toward health insurance. Business owners who do offer coverage also expressed frustration with their lower-income employees who remain uninsured because they are not willing to contribute toward insurance coverage offered by the company.

The requirement to carry workers compensation insurance also compounds these small employers' inability to provide health insurance. Because of the necessity of having workers compensation insurance, which is often very expensive, these employers cannot afford the additional cost of providing health insurance. In addition, participants report that their uninsured workers have more claims on their workers compensation than do workers who have health insurance - setting up a vicious cycle where an increase in claims results in an increase in premiums for the workers compensation insurance, taking the goal of providing health insurance even further out of reach.

Expanding Coverage

In order for small employers to consider expanding health insurance benefits to their uncovered employees, the cost of insurance will have to be dramatically reduced, or they will have to receive some form of financial assistance. Every employer who attended the focus groups held in the spring of 2004 was willing to make some form of financial contribution toward health insurance for their employees. When asked what monthly contribution per employee they could reasonably make, their responses ranged from \$50 to \$200, with the most common response being between \$75 and \$100. Additionally they believe that with the exception of their very-lowest hourly workers, most of their employees would also be willing to make some level of contribution toward their own health insurance. Again, participants offered a fairly wide range of what they believe their employees would contribute. As could be expected, the variance is attributed to employee salary levels. However, these employers did concur that as a group, most of their employees could reasonably pay between \$40 and \$75 per month for insurance, with the stipulated understanding that low-income hourly workers could not reasonably be expected to make any contribution toward insurance because they have no realistically disposable income.

In discussing what benefits should be included in an insurance plan to make it attractive to both the employers and their employees, participants are willing to have a "bare bones" plan in order to afford coverage for their employees, concluding that an acceptable plan should provide major medical benefits that cover outpatient visits to physicians, hospitalization, prescription drugs (generic when possible) and preventive screenings, and that vision and dental care should not be included, in order to reduce cost.

These business owners expressed a general willingness to buy insurance through an employer's purchasing pool and suggested that the following parameters be incorporated into a purchasing pool program:

- All employees should be eligible for participation, even those with pre-existing conditions.

- Coverage should be provided by reputable insurance companies.
- Yearly price increases should be regulated so that insurance remains affordable.
- A reasonable choice of doctors and hospitals should be included in the network.
- Those who live in rural areas of the state should not have to travel long distances in order to receive covered services.
- Participation in the pool should not create a “paperwork nightmare.”

Participants in all focus groups supported a tax credit as a means of helping them provide health insurance for their employees. Some believe that a tax credit would not only help them as small business owners, but would benefit the state as well.

They are also willing to explore options that would help relieve business owners from bearing the responsibility of providing health coverage for employees. A buy-in to the state Medicaid program received a strong endorsement and the concept of universal health insurance met with more support than expected. While cautious in their support, business owners indicated a willingness to explore the details of such a plan. However some remain adamantly opposed to any form of universal health care, believing that this system would dramatically increase taxes, reduce the quality of health care, eliminate choice, and expand government regulation. Not surprising, the idea of an employer mandate was universally rejected by small business owners.

Climate for Change

These small business owners see no relief in sight to rising health care costs. They believe a lack of leadership from business, health care professionals, and elected officials will result in more of the same for the foreseeable future.

As small business owners, they feel powerless to influence any of the factors affecting health costs. While they would like to play a more active role in finding solutions, most are too emerged in the challenges of being a business owner to be able to address issues that do not directly impact their day-to-day operations. However, most participants agree that change will not happen until businesses band together and demand that something be done to relieve the financial burdens they currently bear. Despite an expressed resistance to government involvement, these business owners came to acknowledge that elected officials and government will have to play a major role in controlling costs and expanding coverage to the uninsured.

SECTION 3

HEALTH CARE MARKETPLACE

The State of Georgia's population and geography contribute to a complex health care marketplace that consists of a mix of public and private hospitals, large and small health insurers, multiple schools of medicine, nursing and allied health, and a wide variety of consumers, all of which either directly or indirectly impact the number of uninsured in Georgia.

According to the Georgia Department of Community Health,^{iv} more than 60 percent of hospital stays were covered by government payments in 2002, emergency room visits are on the rise, more than \$800,000,000 dollars is spent each year in the State on indigent and charity care, nursing home admissions increased by 30 percent between 1995 and 2000, and the State is facing severe shortages of providers, particularly nurses and pharmacists, over the coming decades.

Created in 1999, the Department of Community Health is responsible for the management of Georgia's Medicaid program, the state employee benefits program, and PeachCare program. In all, the agency is responsible for almost 27 percent of all covered lives in Georgia. Because of this, a review of Medicaid and PeachCare developments over the past two decades, in addition to a review of market reforms and developments, will help put Georgia's insurance market characteristics in perspective.

Medicaid and PeachCare

Medicaid has played a critical role in past attempts to reduce the number of uninsured Georgians. Between 1980 and 1989, these efforts consisted of the initiation of 30 enhancements or expansions of the Medicaid program, extending insurance coverage to many previously uninsured residents. Federal Medicaid expansions in the late 1980's and early 1990s were also responsible for large increases in enrollment of children. From 1990 to 1999, 26 additional enhancements or expansions to the Medicaid program were implemented.

In 1990, Georgia established the Indigent Care Trust Fund (ICTF) with federal DSH dollars to expand Medicaid eligibility and services; support rural and other health care providers that serve the medically indigent; and fund primary health care programs for medically indigent Georgians. Georgia is the only state to require hospitals to contribute 15 percent of their gross ICTF allotment to community-based primary care. This requirement was challenged in FY04 in an effort to reduce primary care contributions to the hospitals' net allotments - effectively cutting primary care funding in half. Governor Perdue ultimately required the maintenance of the existing formula - preserving more than \$63,000,000 in community-based primary care funding in FY04.

In November of 1995, the Department of Medical Assistance (then Georgia's Medicaid Administrator) was charged with examining state Medicaid reform. That study, entitled "Directions for Change: Recommendations for Medicaid Reform in Georgia," was prepared by the Georgia Coalition for Health and the Georgia Health Policy Center and financed in part by the Robert W. Woodruff Foundation. The study resulted in a recommendation that disabled individuals who work should have the opportunity to buy-into Medicaid. Mechanisms for

funding such an expansion are still being examined in the larger context of State Planning Grant activities.

During the mid-1990's, two efforts were undertaken in an attempt to reduce Medicaid costs and allow for Medicaid expansion. These efforts were Georgia Better Health care, a primary care case management program still in use today, and a capitated managed care program. Medicaid remains one of the largest shares of the Georgia budget. Including federal contributions, it accounts for approximately one-fifth of state expenditures.

In March 1998, the Georgia State Legislature approved an SCHIP program, PeachCare for Kids, which has been very successful in enrolling eligible children. PeachCare covers children up to 235 percent of the federal poverty level. Enrollment has far exceeded state predictions, with over 178,000 children currently enrolled. However, like many states, Georgia has had to make difficult decisions regarding the State budget. During a special session held in May 2004 to close a budget deficit, the Georgia Legislature passed two changes to Medicaid eligibility and PeachCare premiums. Medicaid eligibility for pregnant women has been reduced from 235 percent of federal poverty level (FPL) to 200 percent FPL^v. Additionally, PeachCare premiums have been changed from \$10 per month individual and \$20 per month multiple children to a sliding scale that caps at \$30 individual and \$70 multiple children. It has been estimated that up to 9,000 women may lose Medicaid coverage because of the change in Medicaid eligibility. Although Medicaid and PeachCare eligibility levels remain above the national norms and particularly above those in the Southeast, the potential repercussions of these changes make the currently proposed work even more critical.

Insurance Market Reforms and Market Developments

In the late 1980's, Georgia passed into law a risk pool mechanism. However, due to uncertain costs, the risk pool remains unfunded. Efforts by the insurance industry to create legislation in the 2004 legislative session to assess one dollar per policy per month on all health insurance policies in the state in order to fund the risk pool did not gain traction due to overall state budget concerns and the time spent on closing a \$65,000,000 budget gap. However, the process did begin to raise the level of awareness, and the insurance industry plans to reintroduce the bill in 2005. With more success, the General Assembly passed a COBRA law in the early 1990's that provides three months of continuation coverage for employees in small firms not subject to federal law.

In the mid-1990s, when many states were undertaking major insurance market reforms, Georgia undertook a series of smaller, but still important, reforms. In 1995, the General Assembly passed a law that limits insurers' ability to deny coverage in the small group market based on pre-existing conditions. Also in 1995, Blue Cross Blue Shield of Georgia began the process of conversion to for-profit status. In response to the conversion, a group of non-profits filed suit and won an 80 million dollar judgment for the public's interest in the conversion. In 1996, the federal HIPAA law was passed, requiring guaranteed issue, renewal, and portability in the group market. Based on the status of the state's insurance market, Georgia chose to implement a HIPAA alternative mechanism rather than guaranteed issue in the individual market. The alternative mechanism provides a combination of conversion and risk assignment for individuals who have exhausted all continuation coverage available to them.

In the late 1990's, a law providing for Health Plan Purchasing Cooperatives was passed. However, for a variety of reasons, cooperative purchasing has yet to catch on in Georgia. A major milestone was achieved in 1999 when the Patient Protection Act was signed into law. While the Patient Protection Act does not provide insurance to the uninsured, it provides a bill of rights for Georgians enrolled in managed care and greatly reduces under-insurance for managed care clients receiving emergency medical attention.

The late 1990s were also marked by the increasing adoption of mandates by the General Assembly. Two mandates were passed in 1998 - HB 1565, which requires insurers to provide coverage for annual Chlamydia screenings, and SB603, which mandates coverage for routine costs associated with clinical trial programs for children who have cancer. Two mandated offerings were also passed in 1998 - HB1086 mandates osteoporosis testing, and SB 55 requires the provision of diabetes treatment, education, and supplies. A mental health parity bill requiring employers with two to 50 employees to offer a minimum mental health benefit with the same annual and lifetime cap for mental illness as for other illnesses was also passed. In 2002, a bill to eliminate mandates in the small group market was introduced for the purpose of reducing the cost of health insurance to small employers and, thus, reduces the number of uninsured; however, the bill did not pass.

States have tried to achieve coverage for the uninsured through many means with varying degrees of success. Several of the more common are SCHIP programs (all 50 states), high-risk pools (31 states), Section 1931 (27 states) and 1915 (16 states) Medicaid waivers, and tax incentives (15 states.) As previously mentioned, Georgia's SCHIP program, PeachCare for Kids, has already exceeded enrollment projections. Georgia has had legislation in place for a statewide high-risk pool since the early 1990's, and, as recently as this past legislative session, insurance representatives attempted to create a mechanism for funding the pool – without success. Georgia has yet to enact additional waiver expansions as a means to expanded coverage, and, in light of the recent economy and the difficulty in closing a state budget deficit, the state is unlikely to consider further public expansions in the near future.

SECTION 4

OPTIONS FOR AND PROGRESS IN EXPANDING COVERAGE

Georgia has been engaged in the Planning Grant process for two years. During that time, various options for coverage expansion have been modeled and presented in a variety of forums. The response from those stakeholder forums has been incorporated in subsequent expansion option iterations and presented for feedback. In this manner, the Project Team has been able to gauge public acceptance of various options and the likelihood that each would garner support.

Free or Reduced Care Clinics

This option received very little support from stakeholders, who cited numerous reasons, in addition to an increased tax burden, for why they did not believe free or reduced care clinics were a viable solution for covering the uninsured. These included:

- Cost of construction and staffing would limit the number of clinics that could be built, making it necessary to pay for the ongoing cost of transportation for those in rural areas to have access to care.
- Doctors who staffed clinics would have to do a large volume of business to make the clinic financially feasible, which would create the potential for fraudulent claims.
- Knowing that they can go to a clinic and get free care would discourage those who are uninsured from trying to buy their own insurance and encourage those who are insured to drop their existing coverage and rely on the free clinics instead.
- The quality of care provided at free clinics would not be as good as that available to those who are insured.
- Those who are uninsured would claim to be discriminated against because they could only go to the free clinic for care.

Insurance Pools

Stakeholders had mixed reactions to both employer- and individual-based insurance pools. A number of these small business owners felt that employer insurance pools would help to reduce their current cost of insurance coverage and favored any approach that would help to alleviate their own financial burden. Also, some employers who do not currently provide insurance thought participation in an employer insurance pool might reduce costs so that they could offer insurance to their employees. A Columbus woman commented, “I only have four employees, and if this is an insurance pool that is set aside to cater to people in small groups, then I would be able to afford to provide insurance coverage for my employees.” A Thomson man volunteered, “If the government is going to help pay for part of it, you bet I’m going to be in it.”

Those who did not like the idea of employer insurance pools were concerned that these pools would result in the creation of a new government agency to oversee the program and increase the paperwork associated with providing health coverage. A Dalton participant explained, “Being a small business with limited hours in a day, you would have to have somebody to process all of the paperwork on a regular basis in addition to the regular accounting, plus running the business to generate income.”

Those who preferred employer pools to individual pools believe that more people would be covered, because too many individuals would opt not to participate if they had to pay the premium themselves. They also expressed doubt that their lower-income employees would be able to keep up with the paperwork required for getting pre-approvals and processing claims.

In contrast, some stakeholders felt that individual pools were a better solution because they would take the onus of providing insurance off the business owner; everyone, including the unemployed, would have an opportunity to buy coverage; insurance would be portable, and individuals would not have to remain in a job merely to maintain their health coverage.

Tax Credits and Tax Incentives

As previously noted, employer tax credits received the strongest support of any of the proposed alternatives. Not only do these employers like the fact that tax credits would reduce their out of pocket cost of providing health insurance, they also suggest that tax credits would provide enough incentive so that some small businesses would decide to offer coverage to their employees.

Stakeholders, however, do not feel that individual tax incentives would decrease the number of uninsured. They again point out the unwillingness of many of their employees to spend any amount of money, no matter how little, on insurance; they note that these employees pay very little tax, and thus the incentive for them would be insignificant. A Decatur man voiced the opinions of many when he said, “If they are only making \$20,000, they’re probably not paying much in taxes anyway. So this one doesn’t look good.”

Employer and Individual Subsidies

Business owners were split on whether or not employer subsidies would be of benefit, but agreed that individual subsidies would not be a feasible approach for covering the uninsured. Those opposed to employer subsidies believe they would result in increased taxes, cost too much to administer, and be open to fraud and abuse. Those in support view tax subsidies similarly to tax incentives, in that they would encourage employers to offer insurance coverage. A Thomson man remarked, “It’s about the same as the tax incentive, but you are actually getting the money to go and buy the premium. I could use that.”

Medicaid Expansion and Medicaid Buy-In

Second to employer tax incentives, a buy-in to Medicaid for adults, in a similar fashion as the PeachCare program for children, received strong support. Stakeholders much preferred the buy-in to an expansion of Medicaid, because they strongly believe everyone should contribute toward their own care as much as possible. A Thomson woman observed, “It does something for their self-respect. I think there are people out there that would pay a small part of it to get coverage. Then at least they feel like they are doing something to help themselves rather than just taking a handout.” Support for a Medicaid buy-in was largely based on the favorable view most participants have of the state’s PeachCare program. They believe the success this program has had in covering children can be expanded to cover their parents as well. An Albany man noted, “PeachCare is a good program, and it comes the closest of being a possibility because it’s working.” Also, participants like that a Medicaid buy-in would not require establishing a new program or agency, and thus, implementation could occur more quickly.

Employer Mandates

The idea of employer mandates was universally rejected by small business owners. Similar comments were heard in every group:

- Thomson man: “I think it would really break down small businesses if you made them do it. I don’t like the idea of telling me that I’ve got to do anything.”
- Decatur man: “There are enough small businesses that are already struggling.”
- Dalton man: “It would kill some of the small businesses that can’t afford to pay for it.”
- Columbus man: “If you mandate stuff, you may drive some people flat out of business. You just can’t do it.”
- Albany woman: “If we want to see a lot of people go out of business, that’s a good way to do it.”

Universal Health Insurance

Despite their apprehensions about more taxes and government involvement, many business owners were somewhat open to the idea of a universal system of health care. While cautious in their support, they indicated a willingness to explore the details of such a plan. They said:

“There’s a lot to be said about it, but again it’s who’s paying for it and where the money will come from. If I’m in a pool of one billion Americans, the chances of the cost of my health care being averaged out are a lot better.”

“I don’t know that it would be a terrible thing. Maybe they would have enough authority or enough power to bring some of these out-of-control costs back in check.”

“Maybe we’re not for it, but I don’t think anybody is against it either.”

“I think the universal health insurance will work if it’s monitored right, so that everybody can get good service.”

“I’m kind of thinking on the good side of universal care, where the state would pay the insurance cost. They would get the burden that we feel.”

However, some remain opposed to any form of universal health care, believing that this system would dramatically increase taxes, reduce the quality of health care, eliminate choice, and expand government regulation.

SECTION 5

CONSENSUS BUILDING STRATEGIES

From the beginning of the SPG process, there has been considerable interest in consensus building at the individual and community levels. In 2002, Governor Roy Barnes appointed an advisory body - the Governor's Action Group on the Accessibility and Affordability of Health Insurance – to review the work of and advise the project team. Representation was sought from the Governor's Office, the Georgia General Assembly, provider associations, key state agencies, the business sector, academia, and consumers.

Governor Sonny Perdue was elected in November 2002, and he appointed a State Planning Grant Advisory Committee that continues to work with the project team, providing unique insight of what contributions are possible from the state. This committee is chaired by Trey Childress, Policy Advisor to Governor Perdue, and includes the Director of Health and Human Services from the Governor's Office of Planning and Budget, the Commissioner of the Department of Community Health, the State Public Health Director, the Director of Life and Health/Managed Care Division of the State Insurance Commissioner's Office, the Director of Georgia's SCHIP program, and members of the Planning Grant Team from Georgia State University's Georgia Health Policy Center, Center for Risk Management Research and Center for Health Services Research.

This group has been charged with the responsibility of helping to guide the remainder of the grant activities in keeping with state budget and providing recommendations to the Governor with respect to strategies for reducing the number of uninsured Georgians. The Planning Grant Team continues to brief and solicit input from the original members of the Governor's Action Group and seeks informal input from the Georgia Coalition for Health Provider's Council, the Georgia Hospital Association, the Atlanta Regional Health Forum, and the Georgia Association of Health Plans. Having learned from its change in gubernatorial administrations during SPG activities, members of the Georgia team consulted with the Mississippi SPG team in 2003 to provide insight into establishing a productive relationship with a new administration.

Consensus building activities have been varied over the past two years, beginning with qualitative data collection (focus groups, community listening sessions, and key informant interviews) and progressing to "organic, grassroots policy development" during which broad stakeholder buy-in was sought. The consensus building activities conducted over the past two years are detailed below.

Georgians on Health Insurance Focus Groups

Between September 2002 and December 2002, 21 focus groups were designed and facilitated by Georgia Health Decisions Inc., a non-profit health research organization, to measure Georgians' attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians.

This effort relied on a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System developed by Claritas, Inc.^{vi} The PRIZM System contains 15 Social Groups, each of which contains a population stratum based on degree of

urbanization and income level. In Georgia, ten of the 15 Social Groups each represent three percent or more of the total population. While it was determined not to be analytically necessary or financially feasible to sample Social Groups that made up less than three percent of the Georgia population, an exception was made to include the Urban Core Social Group, consisting mainly of lower income minorities, due to the possibility that a large number of uninsured Georgians might have potentially been included in this Group. Combined, the 11 Social Groups represent 94 percent of Georgia's population.

The focus groups were conducted in English in the communities identified as meeting the criteria for the Social Group. To ensure validity, two focus groups were conducted for each Social Group in different geographic locations where the PRIZM methodology permitted. The one exception was the Urban Core Social Group, where only one focus group was conducted due to the small size of that population. Participants fitting the description for each Social Group were solicited at random by telephone. Twelve participants per focus group were recruited, with an effort to match the age, race, and gender of the participants to those of the Social Group, and an average of 11 individuals participated in each of the 21 focus groups. Each participant was provided a small stipend and a box meal for their participation.

The key findings from the focus groups were:

1. Georgians are alarmed about the escalating cost of health care and believe greed is a causative factor.
2. While most Georgians agreed with the statement "Everyone should get the health care they need," a small but vocal group of higher income Georgians were less likely to agree.
3. Georgians are beginning to question the cost of having and using insurance coverage versus the perceived benefits of having insurance.
4. Most Georgians are very willing to consider almost any solution to rising costs and the number of uninsured. And, compared with their views in the early 1990s, Georgians are more willing to discuss a universal coverage plan.
5. Georgians of all income levels feel there is a need for leadership and immediate action to address escalating costs and increasing numbers of uninsured.

These focus groups reveal a clear call for solutions to stem the tide of rising cost and lack of access to quality care, and that Georgians are willing to consider a wide range of options for solving the problem of the uninsured. Although no one option emerged as a complete and ideal solution, participants agreed that any approach must take into account their values and concerns with regard to quality of care, fairness, affordability, choice, and shared responsibility among all parties; namely, individuals, employers, insurers, providers and government.

Key Informant Interviews

Key informant interviews were conducted with individuals representing: state administration and the executive branch, consumers, legislators, insurers, and providers. The identity of the informants was kept confidential from all but a few individuals associated with the research;

however, the informants included some of the most influential decision-makers in the state on health care.

Importance of Georgia's Uninsured

Findings indicate that the key informants see the issue of the uninsured, relative to other challenges facing the State, as an important issue. In fact, of those interviewed, two-thirds consider the issue “important” or “very important.” None of the interviewees reported believing the issue is not at all important.

As one key informant stated, “I don’t think there’s much of anything that is more important. You can talk about education, yes it is important, but all the education in the world does not ensure you’re going to have health care, ...I’m not saying we don’t have to focus on education in this State, we certainly do, but one of the pieces of security we must make sure people have is health care.”

Some of the informants report that their “peers” (as defined by each informant) would also rate the issue of the uninsured as an important issue facing the State of Georgia. “My professional peers are all struggling to try to help individuals to seek coverage and help employers to be able to provide coverage that’s affordable to their employees. I think they would all share the same sentiment.”

However, some believe this issue is less important to their peers. As one informant summarized, “I think one of the challenges will be getting the political world and [others] aware that it is an important issue and why it is an important issue.”

Some suggest the need for increased government involvement and leadership. “I think Government has to step up to the plate. ... There has to be some leadership and there has to be one entity driving it and I think it should be the Government because business will not do it and people do not have the voice to do it.” Another informant adds, “I think that if there was some sort of national initiative on the uninsured that would give states more flexibility than we have today to try to deal with the issue, then, I believe that would go a long way towards helping states solve their individual problems.”

Others focus on specific solutions, such as “single payer plans”, “small businesses access to bigger risk pools”, “controlled malpractice rates”, “tort reform” and “maintaining free markets.” As an informant explained, “I think tax and market reforms are where we should start.”

Several suggest a multifaceted approach to improve the uninsured situation. One informant describes the importance of a collective effort, “We have to figure out a way to build some sort of public consensus that is relevant to all of us. “ Another informant states, “The State’s going to have to be the mediator, somebody’s going to have to bring these people (general public, insurance companies, legal professionals, hospitals and physicians) to the table and [get] them [to] all work together.”

Affordability for consumers and quality are considered the most critical features of any proposed solution. As one informant summarizes, “Nothing’s any good if people can’t either pay for it or

get it. It has (health care insurance) got to be decent enough coverage that people are getting at least their basic needs met.” Another informant responded, “Quality, followed by affordability” is critical to the solution.

Others speak of budget responsibility and political approval. As one stated, “[The solution] would have to be financially feasible. It’s got to be politically feasible.” Another informant added, “How are costs going to be controlled in the future? Funding and costs are going to be critical.”

Approaches that some informants offer as potential solutions are not acceptable to others, including mandates (employer and government), single payer plans, and more government involvement. As one informant explains, “We do not need to move toward government involvement. I do not think the Oregon model is appropriate. It is not acceptable to say these conditions are cared for and these are not.” Other informants provide a contrasting view: “Ideally, probably some kind of single payer plan....”

Regardless of the type of approach deemed as “best,” several of the informants feel the “worst approach” is to “do nothing”. When one informant was asked what approach, if any, is not workable, he stated, “The thing that is not an acceptable solution is doing nothing. Providing no care at all is unacceptable.”

Listening Sessions with Community Leaders

Recognizing that policy solutions must ultimately be supported, and in some cases implemented, at the local level, *Listening Sessions* were undertaken to identify the attitudes and opinions of local leaders in diverse communities. Four communities were selected as *Listening Session* locations to elicit the widest possible range of attitudes and opinions. The counties were selected on the basis of their geographic diversity and OneGeorgia Tier ranking.

Geographic regions within Georgia differ from one another culturally as well as by such other variables as population density and growth, racial and ethnic composition, and type(s) of industries. In 1998, the Georgia General Assembly sponsored the creation of 12 state service delivery regions to coordinate the delivery of state services at the regional level and to facilitate community and economic development priorities.

The views of community leaders on strategies to address the health care crisis reflect tremendous consistency, despite the variety of localities visited. Every community expressed the conviction that the need for effective solutions is urgent and time-sensitive. Without swift and effective action at the state and federal levels, *Listening Session* participants feel that their capacity to respond to the crisis will soon be exhausted. Further, participants believed that all stakeholders – insurers, providers, employers, consumers, and communities – must work together collaboratively to formulate effective solutions.

Multiple strategies were offered by *Listening Session* participants to address the challenge of providing accessible and affordable health care. Communities see the problems of health care coverage, access to care, and health care planning as inextricably linked. The solutions generated can be categorized as follows:

1) State Health Care Planning:

Communities believe that there is a fundamental “disconnect” in the manner in which health care services are planned, coordinated, and delivered in Georgia. One *Listening Session* participant complained that the system inappropriately reflects a “medical” model (e.g., health care begins with the onset of an acute illness or condition) rather than a “wellness model” that emphasizes prevention.

Other factors communities believe the state should address in health care planning include a) the need to increase the number of available providers, including providers that share cultural and ethnic identities with residents in the area to be served; b) the need to provide transportation services to enable area residents to access services; c) the need to promote a “best practices” approach to health care service delivery by facilitating collaboration among doctors, hospitals, and other providers; d) the need to alleviate regulatory burdens on providers to the extent possible; and e) the need for better accountability of the use of state funds, including dollars received from the Tobacco Settlement.

2) Regional Planning:

Listening Session participants also identified a need for collaboration among such stakeholders as providers, businesses, counties, insurers, and community-based organizations within each service delivery region to address health care needs. Such collaboration could identify region-specific solutions to health care service and coverage needs, facilitate public/private partnerships to address these, and encourage the effective use of existing resources. Participants noted that the state could support the work of regions in this regard by allocating funding and technical assistance to help replicate programs shown to be effective in other parts of the state or to leverage other resources such as federal funding for Community Health Centers.

3) Intergovernmental Cooperation:

Listening Session participants believed that state and federal policymakers did not fully understand the impact at the community level of their legislative, regulatory, and appropriations decisions relative to health care coverage and services. As a consequence, local leaders feel that the need to “react” to the unintended negative consequences of state and federal policy often precludes their ability to take proactive action. Participants recommended, as a first step, that federal and state policymakers make a concerted effort to understand the pressures on communities and believed that a series of meetings among federal, state, and community leaders could be productive in initiating effective intergovernmental relationships.

4) Economic Stimuli:

Listening Session participants recognized that health insurance coverage and health status are ultimately linked to the state’s economic vitality. Participants recommended that the state strengthen its commitment to educational opportunities to help Georgians attain employment and, thus, access to employer-sponsored health plans. Similarly, participants recommended that small businesses be given incentives to provide insurance benefits. Finally, participants believed that communities achieving health status improvements should be formally recognized for doing so. Such recognition, participants believed, could help attract desirable industry to the market area.

5) Public Programs:

Every *Listening Session* produced recommendations to strengthen and expand existing public programs to cover the uninsured and/or to expand access to care. Key recommendations included:

- Expand PeachCare – or implement a PeachCare look-alike program – to cover adults.
- Decrease income limits associated with Medicaid eligibility and simplify the application process.
- Implement a basic “bare bones” health plan universally available to all Georgians, subsidized by state and federal dollars. Allow Georgians desiring coverage above the “bare bones” health plan to purchase private supplemental plans.
- Leverage federal funds to implement more Community Health Centers in underserved areas.
- Implement a disease management system for Georgians with high-risk medical conditions.
- Make Indigent Care Trust Fund dollars directly available to physicians that treat indigent patients.
- Fund efforts to allow more Georgians to access low-cost or no-cost prescription drugs.
- Remove statutory and regulatory barriers to participation in the Medicaid and PeachCare programs by immigrants.
- Examine the effect of PPO insurance plans upon safety net and other critical access providers.

6) Access to Health Insurance:

The rising cost of health insurance premiums prompted *Listening Group* participants to recommend a number of proposals to put coverage within reach of employers, individuals and families. Key recommendations included:

- Make health insurance fully deductible under the state and federal tax codes for business owners and their families.
- Facilitate buying groups that could negotiate more favorable rates with carriers.
- Fund the High Risk Insurance Pool already authorized by Georgia law.
- Implement state and federal refundable tax credits to help individuals and families and/or employers offset the cost of coverage.
- Review existing fund sources available to the state for health care, including Tobacco Settlement dollars, and redeploy funds associated with ineffective programs to subsidize Georgians who otherwise could not afford health insurance.
- Identify a stable revenue source that could be used to subsidize health insurance.

7) Reduce the Cost of Insurance:

Listening Session participants also believed that there is much state policy makers could do to reduce the cost of health insurance coverage. Key recommendations included:

- Consider mandating that all Georgians carry some basic level of health insurance, just as the state requires for motor vehicle operators. *Listening Session* participants speculated that at least a part of the reason that premium costs remain high is attributable to the proportion of healthy Georgians that do not carry coverage. As a consequence, insurance premiums reflect coverage costs for a sicker population than would otherwise be the case.
- Tort Reform to reduce medical and malpractice costs
- Eliminate the requirement that mandated benefits be included in every insurance product.
- Increase competition in the insurance marketplace by making a variety of lower cost insurance products available.
- Reduce regulatory burdens on insurers to the extent possible. The HIPPA privacy requirements were frequently cited as unnecessarily burdensome.
- Review rating practices to be sure that insurers, including self-funded ERISA plans, are not profiteering excessively.

8) Consumer Education:

Listening Session participants also believed that consumers – the public – have a role in alleviating the health care crisis by being making informed decisions in purchasing health care services and insurance products. Participants believe that too many consumers did not see the value of enrolling in coverage plans, did not seek sufficient preventive and primary health care to forestall more serious conditions - but exhibited a high demand for expensive and unnecessary therapies advertised in the media. Every *Listening Group* specifically recommended that advertising by pharmaceutical companies be prohibited.

In order to help Georgians become better consumers, *Listening Session* participants recommended intensive public education initiatives, delivered in a culturally sensitive manner, to achieve the following objectives: a) enrollment in effective insurance plans, b) enrollment in public programs by eligible Georgians, c) an understanding of consumer rights and responsibilities under private and public coverage plans, d) a reduction in behavioral risk factors such as smoking, e) the appropriate utilization of health care services, and f) the promulgation of locations where care is available to the uninsured, such as Community Health Centers.

Attitudes of Small Georgia Employers on Health Insurance

Between February 2003 and April 2003, five focus groups with Georgia's independent small employers (total participation of about 50 individuals) were conducted in the employers' communities. Small employers are those defined as having between two and 50 employees. Because there was no methodology similar to the PRIZM system for employers, the five focus groups were conducted in, and the small employers recruited from, five geographically separate and economically distinct counties in Georgia. During February and March 2004, an additional four focus groups (*new HRSA-approved activity*) were held with small business owners who did not offer health insurance, so as to better understand the barriers that they face in providing coverage for employees.

Data Analysis and Presentation

With the analysis of the data completed, there have been many opportunities for incorporating the information from it into the public domain to inform decision makers and build consensus. Core messages associated with the research findings were made available in two formats - fact

sheets produced in an easy-to-read format supplemented by more detailed reports for those desiring more technical information. Consideration was given to promoting messages that would be understandable to elected officials, key stakeholder groups, researchers, and the general public.

Specific accomplishments in the use of the data include:

- Development of a project website (www.gsu.edu/%7Ewwwghp/uninsured.htm) allowing access to the most up to date information coming out of the Planning Grant.
- Ongoing responses to multiple requests by local organizations for detailed technical assistance in finding community-based solutions. The public was encouraged to request and use the findings for planning local initiatives that will help improve access to health insurance.
- Many requests for small area estimates have been received, and localized data from the household survey have been used, particularly for the purpose of applying for funding, the establishment of Community Health Centers, or other federal grants. As a result, the grant staff and the Division of Public Health in the Department of Human Resources are working together to make the data available to the public via the Internet on that agency's OASIS system.
- Participation in the Arkansas Multi-State Integrated Database System
- Presentation of results at the 2004 Academy Health Annual Research Meeting and forthcoming publication of results in *Medical Care Research and Review*.

Fact Sheets and Reports

Fact sheets were distributed at statewide presentations, provided to and discussed with Legislators, sent electronically to an extensive mailing list of stakeholders, and posted on the grant website. These include:

- 13 fact sheets outlining the findings of the household population survey statewide and for each of the 12 sub-state service delivery regions;
- One report on the methodology of the research conducted under the grant;
- One report on the results of the employer survey;
- One report on the results of the citizen focus groups;
- Two reports on the results of the employer focus groups (Original and Revised); and,
- One report on the results of statewide coverage modeling (Revised)

Additional Reports and Data

Detailed reports of the findings of the employer survey, the focus groups, and the community listening sessions have been distributed through public presentations, the Grant's website, and via e-mail lists. County-by-county estimates of the uninsured have been produced and posted on the grant website. Finally, several PowerPoint presentations outlining the work of the grant and key research findings have been posted on the grant web site.

Public Forums

A series of public forums was begun with the launch of *Cover the Uninsured Week 2003* to share the findings supported by the Grant and to encourage public discussion. Each Public Forum was

widely advertised directly to stakeholders and legislators, as well as the public through print, radio, and television media. The Forums were effective methods of building interest and support for the work of the Grant among stakeholders, legislators, and the public. The findings of the data analysis, and their implications for Georgia, were the subject of thoughtful reporting in well-circulated media outlets (Atlanta Metro, Macon, Augusta, Savannah, and Albany) across the state.

Press Releases

Three press releases were issued statewide to print, radio, and television outlets to coincide with the release of the initial findings of the household population survey, the employer survey, and the results of the series of 21 citizen focus groups. Each release resulted in statewide television and print media exposure.

Modeling

Using Georgia specific data, the Planning Grant Team has engaged in modeling local and national coverage proposals to gauge their impact and costs. In an effort to address the emerging themes of access for the working uninsured and access for uninsured children, the Health care Coverage Project modeled three options - Health Savings Accounts, Tax Credits, and High Risk Pools. The results of this modeling exercise were released in March 2004.

Year Two Consensus Building

In September 2003, the Georgia State Planning Grant Team was granted a no-cost extension to complete work on current Planning Grant activities and move the grassroots consensus building process forward. Specific activities are detailed below.

August 2003

The National Association of Counties (NACo) and the National Council of State Legislators (NCSL) partnered with the Georgia Health Policy Center and the Association County Commissioners of Georgia to host a meeting to examine the issue of the uninsured in Georgia. The organizations together hosted the two-day event in Atlanta. There were nearly 100 participants, including: state legislators, county chairs and commissioners, district health officers, health network directors, conference faculty, representatives from NCSL, and representatives from Kaiser Permanente.

The data from the State Planning Grant provided the information around which the participants became engaged in attempting to craft solutions to the problem of covering the uninsured. At the end of two days, the group determined that the working uninsured and uninsured children should be the two focus areas going forward. This imparted significant momentum to the process and quickened the formation of a House-appointed task force to further investigate those two priorities.

Impact: Commitment of multi-level leadership to the process; consensus around focusing strategies to cover working uninsured and children.

October - December 2003

The House Task Force on Health Insurance Options for Small Businesses and the Working Uninsured, created by the Georgia General Assembly, was a direct result of the August event. This bipartisan Task Force, chaired by Representative Pat Gardner, was provided with information and technical assistance from the Planning Grant Team. During this time, the committee built further consensus by engaging the participation of the Georgia Association of Health Underwriters in their deliberations as they considered options for expanding coverage, modeled under the planning grant. A report to the House, outlining the recommendations of the committee, was produced by the Planning Grant Team.

Impact: State leaders became engaged; greater consensus around solutions for working uninsured. Legislation put forward to create a mechanism to fund the state's high-risk pool.

December 2003

The Atlanta Regional Health Forum, a multi-disciplinary group (public, private, governmental, corporate, legal, education, business, managed care, community-at-large, etc.) and the Georgia Health Policy Center co-sponsored a meeting of small business executives from the Atlanta region to discuss the data and options coming out of State Planning Grant activities during the year. Vondie Woodbury, of Access Health in Muskegon Michigan, also briefed the group on public/private partnerships. The group was then led through a participatory exercise to arrive at options they individually would be willing to consider. The Forum, with core functions that include disseminating data, shaping views, convening stakeholders, and catalyzing change, has committed their support to the work of the grant in a soon to be published report.

Impact: Metro-Atlanta small business employers committed to the process of finding solutions through public/private partnerships.

April 2004

The Health Care Subcommittee of the Georgia Rural Development Council has been charged by Governor Perdue with the responsibility of making recommendations to the Council on four specific health issues affecting rural communities: tort reform, the working uninsured, the state of rural hospitals, and the role of communities in rural health care and coverage. The group solicited the technical assistance of the Georgia Health Policy Center using the findings from the State Planning Grant to inform their discussions. They have requested additional assistance to further examine the options for covering the working uninsured before making recommendations to the Governor in August 2004.

Impact: Creating consensus on options to cover rural uninsured Georgians.

May 2004

Organizers of Cover the Uninsured Week 2004 activities in Augusta and Savannah and the Annual meeting of Covering Kids and Families in Macon each included presentations by the Georgia Health Policy Center using the findings from the State Planning Grant in forums designed to build support for public policy that will foster expansion of coverage.

Impact: *Further dissemination of the quantitative and qualitative information to community leaders engaged in efforts to expand coverage.*

May 2004

Given the growing consensus around targeting strategies for the expansion of coverage to the working uninsured, the State Planning Grant Team organized a three-hour pilot discussion with ten business leaders in Albany Georgia. The discussion provided insight to the level of business support for the concept of public/private approaches to the problem of the working uninsured, as well as the potential of approaches to be embraced by larger employers.

Impact: *Understanding of business leaders' support and concerns around a public/private partnership models.*

SECTION 6

LESSONS LEARNED AND RECOMMENDATIONS TO THE STATES

Georgia's experience with the SPG process has yielded seven specific recommendations to other states engaging in a planning process to reduce their number of uninsured.

Georgia's Recommendations to States

- State-specific data are critical to the decision making process.
- A household survey yielded detailed information on un-insurance within specific subgroups of the State population, which helped clarify what could be the most effective coverage expansion options.
- A well-designed employer survey can be a cost effective way to learn about employer benefits behavior.
- Qualitative research was important in identifying stakeholder issues.
- Persistence can be the most effective strategy to improving and completing the data collection.
- The State should be prepared for the planning process to yield ideas for changes in state programs and agencies.
- Collecting information about the State's insurance and health care markets is very different from collecting information about the prevalence of insurance coverage.

In more detail, these recommendations are:

1) State specific data is critical the decision making process.

State specific data have been an important part of understanding the problem. The household data, in particular, have yielded information about sub-populations and geographic regions that the state did not have before. It is also expected that the findings from the household survey will see significant use in the General Assembly.

2) A household survey yielded detailed information on un-insurance within specific subgroups of the State population, which helped clarify what could be the most effective coverage expansion options.

The telephone survey used to collect person-level information was very effective. While the data collection team was satisfied with the content collected as part of the household survey, if time and survey administration permitted additional questions, health status indicators such as the presence of a chronic disease or any functional limitations would have provided valuable information about risk-selection that may go undetected in health insurance markets. Although collection of data regarding income and wages is difficult, the analysis of survey responses would be enhanced if worker wages were also collected in addition to total family income.

3) A well-designed employer survey can be a cost effective way to learn about employer benefits behavior.

A brief, written survey was an effective tool for gathering general information from a large sample of employers quickly and with minimal costs. The Georgia Employer Survey permitted reply either by mail, by fax, or using a web-based response mechanism. Surprisingly, less than ten percent of the firms responded electronically by web, and only ten percent responded using the fax option. The high volume of mailed responses and the systematic differences between firms based on their response mechanism suggest that limiting the survey to a single response option may create unintended non-response bias.

Creating a survey instrument in a short period of time is a difficult task. Georgia's instrument was created from the Alaska employer survey instrument. However, the Employee Benefits Consortium work, being conducted by the State of Nebraska and the U.S. Department of Labor, and the other existing state instruments, offer states conducting a first survey an excellent opportunity to utilize an existing instrument. In Georgia's survey, the survey questions regarding employer share, employee share, and the total premium for single and family coverage would be revised to be more specific if the survey were to be administered again.

While the method used to collect the employer data was highly effective, the 22 percent response rate lagged behind rates reported for DOL Employee Benefit Surveys administered by other states.

4) Qualitative research was important in identifying stakeholder issues.

Qualitative data have been extremely valuable in identifying needed educational and communication strategies to create an environment in which the policy planning process can move forward.

5) Persistence can be the most effective strategy to improving and completing data collection.

Collecting the amount of data Georgia collected in a six to nine month period required a great deal of planning and organization. It also required persistence in resolving setbacks. For example, our employer survey required two mailings of the survey instrument and one follow up postcard to collect the data. Georgia completed all of the originally proposed data collection activities; however, the hardest part has been translating that data into a usable format for the public and decision-makers.

6) The State should be prepared for the planning process to yield ideas for changes in state programs and agencies.

While no options have been selected in Georgia, it is likely that some of the recommendations generated by the planning process will call for changes in state programs and agencies. A lack of willingness to accept and participate in the changes decreases the likelihood that policy options will be implemented.

7) Collecting information about the State's insurance and health care markets is very different from collecting information about the prevalence of insurance coverage.

The SPG process calls for information about the health care marketplace to be collected. We were able to collect data on the primary health care marketplace for low income individuals, some hospital discharge data, and some geographic health insurance market data through the various data collection methods, but other states should be aware that market data is very difficult to collect.

SECTION 7

RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

Recommendations to the Federal Government by the State of Georgia relate to the need for federal financial support of current health programs and efforts to improve the State's ability to sustain its existing programs. Specifically, federal support of the following is needed:

- **Better Define the Healthy People 2010 Access Goal**

The federal government should help states identify reasonable and realistic goals; the Healthy People 2010 Goals on Access need more detail and need to be more clearly linked to research findings about the value of coverage. The document states the goal is coverage for 100 percent of the population, and for 96 percent of the population to have access to an ongoing source of primary care. However, if 100 percent of people in a state are covered, but the state still has high infant mortality, large numbers of motor vehicle accident deaths, and low levels of vaccinations, billions of dollars will be spent with little change in overall health status. States need help identifying the kinds of services to which everyone should have access.

- **Information Systems Development**

As states move toward programs that cover the uninsured, information systems are needed that track public programs and private coverage to reduce crowd-out and duplicate coverage. Such systems will also improve the flow of information to decision makers, improve the ease with which the cost-effectiveness of programs is measured, and make it easier to reward communities that take action that improves coverage status.

- **Collaboration Between the States and the Federal Government on State-Specific Longitudinal Data Collection**

The federal government should provide ongoing support for the collection of data specific to state-level concerns and needs. Research conducted by the federal government, foundations, and other organizations could be more helpful to states if the surveys were more sensitive to state level concerns, such as terminology and intra-state regional variation. The SPG process allowed Georgia to collect important information that is otherwise unavailable, but ongoing data collection will support research on many of the unanswered questions regarding health insurance.

Ideally, both the employer and household surveys would be repeated every two years, as the information is outdated quickly and very subject to economic fluctuations. If the data were collected on an ongoing basis, policy makers could be educated to rely on these data for the information needed. Furthermore, stakeholders would be more likely to agree on using the population and employer survey data as an acceptable standard when discussing their various interests if the data collection process were routine and reliable.

- **State-Specific Econometric Modeling**

The state would also benefit from additional support for researcher time to use the employer survey and the household survey to simulate behavioral responses to proposed policies or programs designed to expand coverage. The simulation process requires

ongoing dialogue regarding program design and an iterative process of proposal design, estimations of cost and coverage impact, and refinement of proposals based on the output. Each time a new federal health initiative is created, states need the funding to support a quantitative analysis of the impact that initiative will have on its other programs and activities.

- **Regional Collaboration Between States**

The simultaneous collection of similar data in Alabama, Georgia, and South Carolina suggests the need to aggregate data from these three states for use in analyzing the impact of existing differences in state policy on levels and distribution of coverage. The contiguous nature of the states and some similarities in population demographics would enable us to use these data to isolate state policy variable effects on program enrollment, employer decision making, and use of services. Federal support to facilitate the sharing of data and provide researchers with funded time to complete this analysis would benefit all of the states involved and would provide information applicable to other states as well.

Recommendations to the federal government regarding opportunities for directly supporting state innovations to reduce the number of uninsured are:

- **Reward States that Reduce Their Number of Uninsured**

States that invest state dollars and engage in state level planning to reduce their number of uninsured should be rewarded. In Georgia, somewhere between ten percent and 20 percent of the uninsured are eligible for programs that receive matching federal dollars. Budgetarily, however, there is a disincentive to enrollment in that additional State dollars would be needed to match the federal funds. This might be remedied if, for example, the Medicaid and SCHIP matches were based on a sliding scale that increased the match as states covered more eligible individuals. States might take the extra steps necessary to enroll those harder to reach eligible individuals.

- **Reward States that Offer A Consumer-Friendly Private Insurance Marketplace**

Offer additional financial assistance in the form of grants to states or insurers that offer generous portability and continuation coverage in their private health insurance market. In Georgia, over half of the uninsured are the temporarily uninsured, and could potentially remain insured in a more-consumer friendly marketplace, saving the state and the federal government public program dollars should the health status of these individuals change during the period they would be uninsured.

Appendix A: Georgia Baseline Information

A1. Georgia's Population

The estimated 2003 population of the State of Georgia is **8,560,310**.

A2. Number and Percentage of Uninsured

Thirteen percent of the population under age 65, or about 1 million people in Georgia age 64 and younger, are currently uninsured. In the previous twelve months, 18% of the population of the state was uninsured for one month or more; and 9% were uninsured for the full year.

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
Statewide	12.1%	7.9%	16.1%

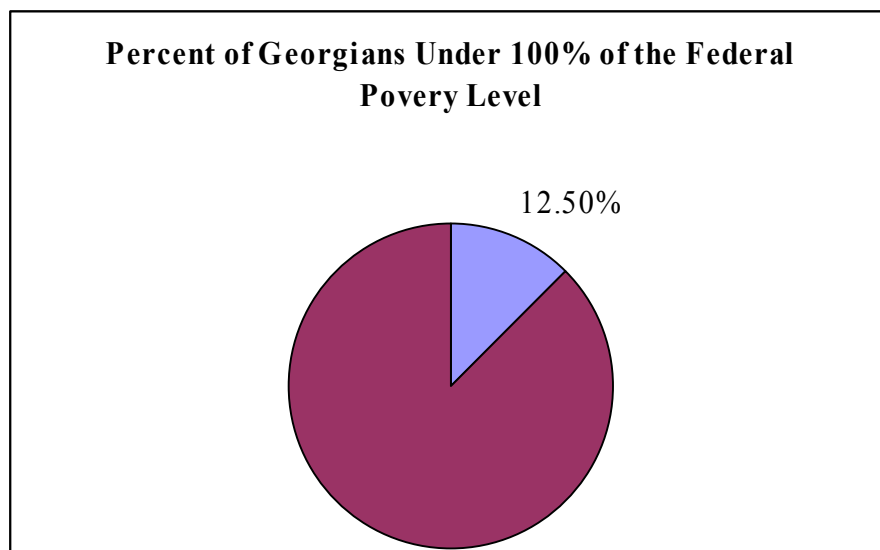
A3. Average Age of Population

The average age is 35.10 years. The average age of the population in Georgia is 35.10. The average age in Atlanta is slightly younger at 34.82, and in all other metropolitan statistical area it is similarly 34.25. The average age in north rural Georgia and south rural Georgia is slightly higher at 36.11 and 35.51 years of age respectively. The difference between rural and urban areas is significant ($p=.01$).

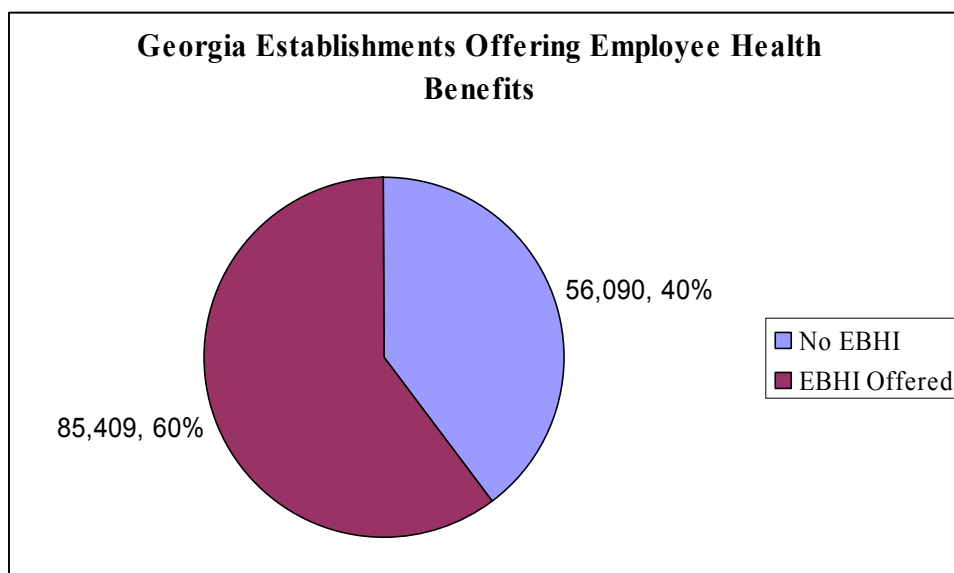
Age	Population	% of Total Population
0-18	2,322,840	27.1%
19-24	751,391	8.8%
25-44	2,564,588	30.0%
45-54	1,232,713	14.4%
55-64	777,021	9.1%
65 +	911,758	10.7%
Total	8,560,310	100%

A4. Percent of Population Living Poverty

Twelve point five percent of Georgia's population, or 1,071,256 Georgians, are at or below 100% of the Federal Poverty Level (FPL). About 75,000 of those 1,071,256 individuals are aged 65 or older; 353,244 are children under age 18; the remaining 925,657 individuals are between the ages of 19 and 64.



A5. Number and Percent of Employers Offering Coverage



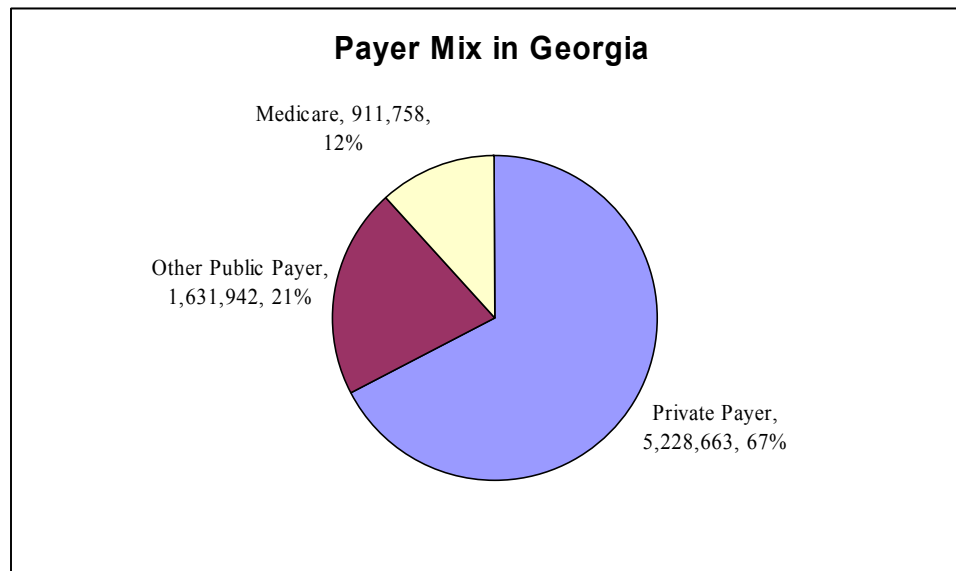
A6. Number and Percent of Self-insured Firms

Insufficient data/ further analysis required.

As part of the written survey of Georgia employers, establishments were asked to indicate whether they were offering a fully insured plan, a self-insured plan, or a union or association plan. Almost eighty percent of the establishments covering two thirds of the employees indicated that they offered a fully insured plan. Many of those

establishments are quite large. Even among the establishments with over one thousand employees, over half indicated that their primary plan was fully insured. This number includes organizations such as local public school systems known to participate in the state-merit system. National data from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC) indicate that almost two thirds of employees are covered by plans that are self-insured. Future analysis will attempt to address the validity of this question and reconcile the results with the MEPS estimates.

A7. Payer Mix



A8. Provider Competition

Provider competition in Georgia is most significant in the metropolitan areas where the providers, particularly hospitals, compete for managed care contracts, particularly in specialty care. However, in much of the rest of the State, there is little competition between insurers and providers, and in some areas, there are an insufficient number of providers, particularly general practitioners. The State has a Certificate of Need program.

A9. Insurance Market Reforms

In the late 1980s Georgia demonstrated its willingness to begin to address the issue of risk-impairment and the uninsured by passing into law a risk pool mechanism. However, due to uncertain costs and political pressure, the risk pool remains without funding. With more success, the General Assembly also passed a "mini"-COBRA law that provides 3 months of continuation coverage for employees in small firms not subject to the federal law.

In the mid-1990s when many states were undertaking major insurance market reforms, Georgia undertook a series of smaller, but still important, independent reforms. In 1995 the General Assembly passed a law that limits insurers' ability to deny coverage in the small group market based on preexisting condition. In 1996, HIPAA was passed requiring guaranteed issue, renewal and portability in the group market. Based on the status of the state's insurance market, Georgia chose to implement a HIPAA alternative mechanism, rather than guaranteed issue in the individual market. The alternative mechanism provides a combination of conversion and risk assignment for individuals who have exhausted all continuation coverage available to them.

In the late 1990's a law providing for Health Plan Purchasing Cooperatives was passed. However, for a variety of reasons, including the lack of small employer interest and public marketing of the concept, cooperative purchasing has yet to catch on in Georgia. The late 1990s in Georgia were also marked by a growing trend toward for-profit insurers. In 1995, Blue Cross Blue Shield of Georgia began the process of conversion to for-profit status. In response to the conversion, a group of non-profits filed suit and won an eighty million dollar judgment for the public's interest in the conversion. A major milestone was achieved when in 1999, the Patient Protection Act, was signed into law. While the patient protection act does not provide insurance to the uninsured, it provided a bill of rights for Georgians enrolled in managed care and did much to reduce under-insurance for persons with managed care receiving emergency medical attention.

The late 1990s were also marked by the increasing adoption of mandates by the General Assembly. Two mandates were passed in 1998. Those included HB 1565, which required insurers to provide coverage for annual Chlamydia screenings, and SB603, which mandated coverage for the routine care costs associated with clinical trial programs for children who have cancer. Two mandated offerings were also passed in 1998, HB1086, to offer osteoporosis testing, and SB 55, to offer diabetes treatment, education and supplies. A mental health parity bill requiring employers with 2 to fifty employees to offer a minimum mental health benefit with the same annual and lifetime cap for mental illness as for other illnesses was also passed. The mandate trend continues to grow with seven mandate bills introduced during the 2002 legislative session. During 2002 and again in 2003, a bill to eliminate mandates in the small group market was introduced. The intention of the bill was to reduce the costs of health insurance to small employer and, thus, reduce the number of uninsured. There is a great deal of uncertainty in the General Assembly about whether reduced regulation will lead with some certainty to reduced costs.

Therefore, health insurance and reform of the marketplace continues to be a major topic of discussion for the Georgia General Assembly. Many health and health insurance related bills, including at least forty-five bills that directly effects the way Georgians receive and use health insurance, were under consideration during the 2002 legislative session and again during the 2003 legislative session, over 50 relating to the health insurance market were introduced.

A10. Primary Industries in Georgia^{vii}

Industry Description	Number of Establishments	Number of Employees	Annual Payroll (\$1,000)	Shipments/Sales/Receipts (\$1,000)
Wholesale trade	(r)1,176	(r)45,687	(r)2,456,822	(r)79,070,673
Wholesale trade	13,978	(r)191,087	7,519,730	(r)163,782,649
Wholesale trade	(r)10,990	(r)135,654	(r)4,680,441	(r)69,922,093
Manufacturing	9,083	533,830	15,534,058	124,526,834
Retail trade	33,073	420,676	6,943,559	72,212,484
Accommodation & foodservices	13,829	274,322	2,695,138	9,689,927
Administrative & support & waste management & remediation services	7,796	273,178	4,887,976	9,839,387
Mining	6,354	233,362	1,441,860	
Health care & social assistance	13,960	173,768	5,158,002	12,065,068
Construction	17,896	163,981	4,687,527	28,587,264
Health care & social assistance	2,028	161,127	4,477,721	11,646,505
Finance & insurance	11,668	153,755	6,005,306	N
Professional, scientific, & technical services	17,810	138,198	5,908,775	15,266,425
Information	3,163	100,656	4,176,545	18,939,188
Transportation & warehousing % % **	4,733	85,109	2,359,434	8,306,254
Other services (except public administration)	11,482	69,422	1,407,547	4,580,693
Real estate & rental & leasing	7,794	47,669	1,308,803	6,912,946
Auxiliaries, exc corp, subsidiary, & regional managing offices	464	27,699	860,109	490,336
Arts, entertainment, & recreation	1,653	23,437	408,877	1,533,747
Utilities	498	21,420	1,053,048	10,729,941
Other services (except public administration)	1,837	13,418	337,651	2,248,189
Wholesale trade	1,812	9,746	382,467	14,789,883
Arts, entertainment, & recreation	381	9,622	150,942	428,664
Educational services	920	5,755	129,930	413,395
Professional, scientific, & technical services	105	1,509	68,802	134,044
Educational services	124	1,376	25,595	74,379

A11. Eligibility for Existing Coverage Programs^{viii}

Medicaid Eligibility Categories

Who Qualifies	Eligibility Categories	Eligibility Requirements	Income Criteria	Additional Criteria	Services Available
Aged, Blind and Disabled	1. SSI Recipients	Aged, blind or disabled adults who receive Supplemental Security Insurance benefits.	Monthly income limit for individuals is \$545 and \$6,540 annually. Resource limits -\$2,000 for individual and \$3,000 for couple, plus \$5,000 for burial expenses.		Eligible for all basic Medicaid benefits.
	2. Former SSI Recipients (Disabled Adult, Children, Widow, Widower, and Pickle).	Some individuals may be eligible for continued Medicaid benefits under certain conditions.		Coverage is based on past receipt of SSI and Social Security, and certain increases in Social Security income that caused the individual to be ineligible for SSI.	Eligible for all basic Medicaid benefits.
	3. Disabled Children-Former SSI	Children who were receiving SSI benefits in August 1996 and lost those benefits because of the change in disability Requirements for children.		These children must continue to meet all other SSI requirements	Eligible for all basic Medicaid benefits.
	4. Nursing Home	Aged, blind or disabled individuals who live in nursing homes and have low income and limited resources.	The income limit is less than 300% of the SSI benefit amount of \$1,635. Effective 01/01/02. Resource limits-\$2,000 for individual and \$4,000 for couple.	After 30 days in a nursing home or other institution, individuals may apply using higher institutionalized income levels. Coverage is retroactive to the date of admission.	Eligible for all basic Medicaid benefits.
	5. Medically Needy	Aged, blind or disabled individuals qualify if income or resources exceed the SSI limits.	Monthly income limit is \$317 or \$3,804 annually. Resource limit is \$2,000 for individual and \$4,000 for couple.	They must use incurred/unpaid medical bills to "spend down" the difference between their excess income and the Medically Needy income limit.	Eligible for all basic Medicaid benefits.
	6. OMB (Qualified Medicare Beneficiary)	Aged or disabled individuals who have Medicare Part A (hospital) insurance.	Income less than 100% of FPL. Monthly gross income limit for individual is \$759 and gross annual income limit is \$9,108. Effective 04/01/02. Monthly gross limit for couple is \$1,015 and gross annual income limit is \$12,180. Resource limits-\$4,000 for individual and \$6,000 for couple, plus \$5,000 for burial expenses.		Medicaid will pay the Medicare premiums (Part A&B), and Medicare coinsurance and deductibles.

7. SLMB (Specified Low-Income Medicare Beneficiaries)	Aged or disabled individuals who are entitled to Medicare Part A.	Income less than 120% of the FPL. Monthly gross income limit for individual is \$906 and gross annual income limit is \$10,872. Effective 04/01/02. Monthly gross income limit for couple is \$1,214 and gross annual income limit is \$14,568. Resource Limits-\$4,000 for individual and \$6,000 for couple, plus \$5,000 for burial expenses.		Medicaid pays only the Part B Medicare insurance premium.
8. Qualified Disabled Working Individuals (QDWI)	Social Security Disability recipients who begin working, exhaust their 48-month trial work period of extended Medicare coverage are eligible in order to continue to receive Medicare coverage.	Income limit is 200% of the FPL. Monthly gross income limit for individual is \$3,039 and gross annual income limit for couple is \$36,468.00 Resource limits-\$4,000 for individual and \$6,000 for couple, plus \$5,000 for burial expenses.		Medicaid pays Medicare Part A premiums.
9. Qualified Medicare Beneficiary-1 (QI-1)	Aged or disabled individuals who are entitled to Medicare Part A.	Income less than 135% of the FPL. Monthly gross income limit for individual is \$1,017 and gross annual income limit is \$12,204. Effective 03/01/02. Monthly gross income limit for couple is \$1,364 and gross annual income limit is \$16,368. Resource limits-\$4,000 for individual and \$6,000 for couple, plus \$5,000 for burial expenses.	QMB-1 is not an entitlement program. Funds for this program are limited and benefits are provided on a first come, first served basis. QMB-1 is scheduled to end in 2002.	Medicaid only pays the Part B Medicare insurance premium.
10. Qualified Medicare Beneficiaries-2 (QI-2)	Aged or disabled individuals who are entitled to Medicare Part A.	Income less than 175% of the FPL. Monthly gross income limit for individual is \$1,313 and gross annual income limit is \$15,756 Effective 03/01/02. Monthly gross income limit for couple is \$1,762 and gross annual income limit is \$21,144. Resource limits-\$4,000 for individual and \$6,000 for couple, plus \$5,000 for burial expenses.	QMB-2 is not an entitlement program. Funds for this program are limited and benefits are provided on a first come, first served basis. QMB-2 is scheduled to end in 2002.	Medicaid pays 1/7 per cent of the amount of the Medicare home health benefit being transferred from Medicare Part A to Medicare Part B.

Pregnant Women and Infants	1. Pregnant Women (Presumptive)	Low income, pregnancy, and citizenship/alien status.	Pregnant women with family income at or below 235% of the FPL.	Based on family income level at or below FPL, they can receive temporary Medicaid under the Presumptive Medicaid Eligibility Program.	Eligible for all basic Medicaid benefits with the exception of inpatient hospital and delivery services.
	2. Pregnant Women (RSM)		Pregnant women with family income at or below 235% of the FPL. There is no resource limit.	Once eligible, these pregnant women remain eligible through two months following the termination of the pregnancy.	Eligible for all basic Medicaid benefits. They are eligible for a full range of medical services.
	3. Pregnant Women Medically Needy	Resources must meet Medically Needy resource limit.	Pregnant women with family income/resources that exceed AFDC limits may be eligible.	There is no "spend down" of resources.	Eligible for all basic Medicaid benefits.
	4. Children (Newborn)	A child born to a woman who is eligible for Medicaid on the day the child is born may be eligible for Medicaid for up to one year. The child must be residing with his/her mother.			Eligible for all basic Medicaid benefits.
Children	1. Children-Right from the Start Medicaid (RSM)	Children through the age of 19.	Family income is at or below the appropriate percentage of the FPL for their age and family size. There are no resource limits for this group.		Eligible for all basic Medicaid benefits.
		Children age 0-1 year.	Family income does not exceed 185% of the FPL for their family size.		
		Children 1-6 years.	Family income does not exceed 135% of the FPL for their family size.		
		Children 6-19 years.	Family income does not exceed 100% of the FPL for their family size.		
	2. Children (Medically Needy)	Children under the age of 18.	Family income/resources that exceed the AFDC limits may be eligible	They must use incurred/unpaid medical bills to "spend down" the difference between their excess income and the Medically Needy income limit. Resources must meet the Medically Needy resources limit. There is no "spend down" of resources.	
	3. Children-Foster Care	Children residing in foster care.	Income and assets are less than the family income limits for the Low Income Families.		Eligible for all basic Medicaid benefits.
	4. Children-Adoption	Children under the age of 18 for whom adoption assistance agreements is in effect.			

Parents and Children	1. Low Income Families	Adults and Children who meet the standards of the old AFDC (Aid to Dependent Children) program.	Gross family income can be no more than 185% of the countable income guideline. All income is included when looking at the gross income. The countable income for the family must be at or below the countable income limit. Resource limit is \$1,000.		Eligible for all basic Medicaid benefits.
	2. Transitional Medicaid	Former Low Income Families who are no longer eligible because their earned income exceeds the income limit.		Families are eligible for up to one year after they go to work.	Eligible for all basic Medicaid benefits.
Hospice		Terminally ill individuals who are not expected to live more than six months may be eligible.	Monthly income limit is \$1,635 and \$19,620 annually. Effective 01/01/02. Resource limit is \$2,000 for individual and \$4,000 for couple.	They must agree to receive Hospice services through a Medicaid participating hospice care provider.	All basic Medicaid services for other illnesses not related to terminal illness.
Breast and Cervical Cancer	Women under the age of 65.	Meet breast and cervical cancer screening requirement. Must be under the age of 65.	No income limit for eligibility. 200% of FPL attached to screening.	Otherwise uninsured.	Eligible for all basic Medicaid benefits.
Immigrants	1. Emergency Medicaid for Aliens	Persons who meet all Medicaid eligibility rules except for citizenship may be eligible for emergency medical services.			

A12. Use of Federal Waivers^{ix}

Name/Program Expiration	Initial Date of Approval
Specialty Service & Population Waivers Under 1115 Authority	
HIV/AIDS - pending	pending
Specialty Service & Population Waivers Under 1915(b) Authority	
MH/MR Preadmission Screening and Annual Review (PASAAR) Program - Approved through April 8, 2003.	02/21/98
General Managed Care & Selective Contracting Waivers Under 1915(b) Authority	
Georgia Better Health Care Program - Approved through December 14, 2002.	07/14/93
Non-emergency Transportation - Approved through January 10, 2004.	09/08/99
Home and Community Based Services Waivers Under 1915(c) Authority	
Georgia HCBS Waiver: Severely Physically Disabled and Traumatic Brain Injury (4170)	08/22/01

APPENDIX B: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

All reports from research findings and related methodologies may be found at:
<http://www.gsu.edu/uninsured.htm>.

ⁱ Abbe Bruce. Using tax credits and state high-risk pools to expand health insurance coverage. Health Affairs October 23, 2002. pp 345-348.

ⁱⁱ Rand Corporation website <http://www.rand.org/publications/randreview/issues/fall2003/reform.htm>.

ⁱⁱⁱ Although the unit of analysis for the statistics below is the establishment, establishments that are part of multi-site firms are categorized based on the number of employees in the firm rather than the establishment.

^{iv} <http://www.communityhealth.state.ga.us/>

^v As of July 1, 2004.

^{vi} Claritas, Inc. is a recognized marketing company specializing in the identification of neighborhood groupings with similar demographic backgrounds and consumer behavior patterns.

^{vii} U.S. Census Bureau 1997 (most recent) Economic Census Quick Facts
http://factfinder.census.gov/servlet/GQRTable?_ts=72971400020

^{viii} Adapted from an internal document created by the Departments of Community Health and Human Resources in 2002.

^{ix} Source: <http://cms.hhs.gov/medicaid/waivers/gawaiver.asp>