Georgia Pilot Planning Grant for the Uninsured

Final Report to the U.S. Department of Health and Human Services and H.R.S.A.

State of Georgia

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EXECUTIVE SUMMARY

The state of Georgia was the recipient of an initial HRSA State Planning Grant for the Uninsured in FY2002. That work was extended to and completed in FY2004. Georgia was also the recipient of a Pilot Planning Grant in FY2004 that was extended through FY2006. Georgia received a final Planning Grant for the Uninsured in FY2005. Originally awarded through August 31 2006, the project received a no-cost extension and will conclude February 28 2007 with a final report submitted no later than March 31 2007. The Georgia Health Policy Center (GHPC), at Georgia State University's Andrew Young School of Policy Studies, is charged with leading Georgia's efforts under direction of the Governor's Office of Planning and Budget.

Grant activities resulted in the collection and subsequent understanding of information from across the state that identified the uninsured population in a way that had never been done. Based on that information, the engagement of key stakeholders, including the public, created consensus around the common values that Georgians hold regarding the uninsured – the provision of insurance to the working uninsured and uncovered children. With this in mind, modeling of more targeted approaches to these populations (and in particular those related to the working uninsured) resulted in Georgia determining what combination of options would create the greatest opportunity for success.

One of the most significant accomplishments made possible through the original grant was the creation of a Georgia-specific dataset on the uninsured. The State never before had the opportunity to compare rates of uninsured and employer sponsored health care coverage by region, nor did the state ever have the opportunity to look at self-reported health status by county. To do this, the team simultaneously collected data from multiple sources to comprehensively research the availability of health insurance, employee health benefits, Georgians' health care values and attitudes and their opinions on the accessibility and affordability of health insurance, and the attitudes and opinions of key Georgia decision-makers.

The data collection process also included the evaluation of information from secondary sources, including information from the Current Population Survey (CPS), the Medical Expenditure Panel Insurance Component (MEPS-IC), the Behavioral Risk Factor Surveillance Survey (BRFSS), County Business Patterns (CBP), and policy and opinion papers from a variety of sources.

Consensus was reached that any solution adopted, whether public or private, must be:

- Multi-pronged, or part of a broader set of solutions;
- Incremental, or able to be implemented in discrete steps;
- Based on partnerships between public and private entities;
- Financially flexible in the face of changing economies;
- Accountable for preventive care that would generate long term savings; and,
- Based on shared responsibility among individuals, providers, government and business.

Georgia's Pilot Planning Grant contains four distinct areas of work: an update of the employer benefits survey conducted in 2002 – 2003 as part of the original Planning Grant work; a study of incidence of uncompensated care intended to give both state policy makers and local

communities a better sense of the trade-offs they face in assessing plans to expand access to health care services to the uninsured; focus groups and community conversations with local employers, employees, and leaders to inform the selection of community-based coverage models; and, four community-level pilot planning activities designed to create public-private coverage partnerships between small employers currently not offering employment based coverage to their employers and state or local government.

All grant activities are complete. Based on focus group findings, input from community stakeholders, and new information provided by the 2004 Employer Benefits Survey, all of the community pilot sites except Atlanta chose to pursue a three-share model of coverage as successfully implemented in Muskegon Michigan. They have created sub-committees within their planning structures to work on the various design elements that must be decided prior to going live with a coverage product.

The Georgia Governor's Office has pledged its support through its Health and Human Services policy office to consider the inclusion of support for the three-share efforts in any Medicaid waiver or Deficit Reduction Act Plan Amendment that might be considered as part of Medicaid Transformation. Further support has been requested through Congressman Nathan Deal's office. Representative Deal chairs the committee that will consider the Communities Building Access Act introduced in June by Representative Pete Hoekstra of Michigan. The Act would provide direct support to states in the creation of three-share coverage plans.

In March 2006, the three communities designing three-share programs submitted applications to the Healthcare Georgia Foundation to continue Pilot Planning work beyond the term of the HRSA grant. In June, each community was awarded $145,000 over two years to conduct actuarial analyses and marketing outreach to further refine their products and to gain additional partnership that might contribute to the third share.

Based on the input from the focus groups, Atlanta chose a different path. The Planning Committee, after reviewing the information, thought that it reflected a "disconnect" between employers and insurers insofar as knowledge and understanding of insurance products already being sold in the market. Further, it appeared from these conversations that the level of "willingness to pay" expressed by employers and employees exceeded the cost of most small business products that were already available in the market.

The Committee discussed the possibility of incorporating consumer education and marketing in the design of the pilot and questioned the need to create a totally new product in light of the findings from the group discussions. In an effort to clarify the perceived lack of awareness about available small business products, the Committee invited brokers and representatives from the Georgia Association of Health Underwriters to weigh in on the matter in the spring of 2006. The brokers confirmed that there were relatively affordable insurance products in the marketplace and explained that most brokers did not view the small business market as a priority, given the relatively small return on the investment of their time.

The Planning Committee, after considering focus group conversations and feedback from brokers, determined that there was no need for the development of another small business health

insurance product and recommended that a concerted effort be made to pilot an approach that would link small businesses to products that were already available in the marketplace. The Committee has set about the establishment of a Consortium that will provide oversight for the next phase of work. The Committee considered the Pilot Planning period to be the first of three distinct phases of related work. These are:

Phase I – Pilot Planning
Phase II – Development of Marketing Plan
Phase III - Pilot Implementation

Because the state of Georgia has benefited greatly from the ability to examine its uninsured from a sub-state level, the single greatest recommendation to the federal government would be to either continue to make resources available to states to continue the kind of data collection and analysis made possible by the grant or incorporate sufficient cell sizes into current data collection activities in order for states to create sub-state analyses from national data.

SECTION 1: UNINSURED INDIVIDUALS AND FAMILIES

QUANTITATIVE FINDINGS

Georgia is home to more than 8.5 million people. The FY02 SPG Population Survey revealed that about 13 percent of the population under age 65, or about 1 million people in Georgia age 64 and younger, were currently uninsured at the time of the survey in fall 2002. Sixty-eight percent of non-elderly Georgians had employer-sponsored or individual private coverage, and 21 percent had some type of public coverage, such as Medicaid, Medicare, or PeachCare. The 2002 survey also showed that 16 percent of all Georgians, or 18 percent of the non-elderly, experienced a spell without insurance during the previous year, and about nine percent of the non-elderly population lacked coverage for the entire year. Thus, about half of those experiencing a gap in coverage were chronically uninsured.

In order to provide the most up-to-date estimates of the number of uninsured Georgians, the Planning Grant Team has tabulated March 2004 Current Population Survey (CPS)[1] data to contrast with data collected from the FY02 SPG activities. Statements referring to those tabulations are identified throughout this section in italics.

Tabulations of March 2006 CPS data show that 19 percent of the Georgia population overall, and 21 percent of the non-elderly population are currently uninsured.

According to the FY02 SPG Population Survey, children (0 to 18) made 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 was 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 had experienced some lapse in coverage during the previous 12 months, and about one-quarter was 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 (15 percent) or were uninsured at any point in time (13 percent) was substantially lower.

Young men (ages 18 to 24) were much more likely to be chronically uninsured than females (23 versus ten percent). Women, as they approach retirement age (ages 55 to 64), were significantly more likely to experience a lapse in coverage (20 versus ten percent) or to be chronically uninsured than men (ten versus five percent). 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.

The more recent tabulations of the March 2006 CPS show that 10 percent of males under age 18 and 13 percent of females under 18 are currently uninsured. Rates increase to 42 percent for

[1] Because of large standard errors inherent in CPS data, CPS tabulation results are not directly comparable to data collected through the HRSA State Planning Grant; however, they do provide a general indication of the direction rates of insurance coverage are moving in Georgia.

men and 31 percent for women in the 18 to 24 age group. Rates then fall to 30 percent for men and decrease to 24 percent for women in the 25 to 44 age group, and fall further to 17 percent of men and 16 percent of women in the 45 to 64 age group.

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. Per the FY02 SPG Population Survey, twenty-two percent of the uninsured lived 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 had incomes between 100 percent and 300 percent of the FPL. Individuals living in families with incomes below the poverty level comprised about 12.5 percent of the non-elderly population but 22.5 percent of uninsured Georgians.

March 2006 CPS data show that 51 percent of Georgia's uninsured residents have family incomes at or below 200 percent of FPL. Thirty-one percent of the uninsured have family incomes between 200 and 399 percent of FPL, and 18 percent of Georgia's uninsured residents have family incomes at or above 400 percent FPL.

Despite the low income of many of Georgia's uninsured residents, only 22 percent of the currently uninsured reported in FY02 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 were opposed to public coverage or the stigma attached to public programs. Ninety percent of the currently uninsured reported that they would enroll in a public program if eligible, and 95 percent reported they would enroll in a public program if they were eligible and would incur no expense associated with enrollment.

According to the FY02 SPG Population Survey, of those Georgians without health insurance, at least 68 percent worked or were the dependent of someone who works. However, those working fewer than 30 hours per week and their dependents were more than twice as likely as other Georgians to be uninsured, experience a spell without coverage, or be chronically uninsured. Among those who worked or were in a family headed by someone who worked in a permanent position, less than ten percent were currently uninsured. However, among those working or in a family headed by those who worked in non-permanent employment, the rate increased to 41 percent for temporary and 34 percent for seasonal employment.

March 2006 CPS data tabulations show that 71 percent of Georgia's uninsured residents work full-time all year or are the dependent of someone who works.

Insurance coverage is also related to the size of the firm in which an individual works. Twenty-five percent of those who worked for, or were the dependent of someone who works for, firms with between two and ten employees - and 29 percent of those in single person firms - were uninsured according to the FY02 SPG Population Survey. Almost one out of three individuals without coverage was employed by firms with fewer than 25 employees or had a primary wage earner working in such a firm.

The 2006 March CPS tabulations demonstrate that the rates have shifted somewhat. Thirty-nine percent of workers in firms with ten or fewer employees are now uninsured. Twenty percent of

workers (or dependents of workers) in firms with between ten and 24 workers are uninsured, and even 14 percent of workers in firms with 1000 employees or more are uninsured.

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 being chronically uninsured, Hispanics are almost twice as likely as either of these groups to be uninsured for the entire year. Our FY02 findings suggest that minorities are not enrolling in public programs and private plans at the same rates as non-minorities.

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 were uninsured in FY02 as compared with 11 percent uninsured in all urban areas and only ten percent in metropolitan Atlanta, where half the state's population resides. In some rural regions, the likelihood of being uninsured is over 20 percent.

From Georgia's 2002 Household Survey, we know the uninsured are more likely to report their health status as fair or poor (17 percent vs. ten 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 not have had a routine checkup in the past two years (37 percent vs. ten 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. ten 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 2005, the United Health Foundation ranked Georgia 41st in deaths from heart disease, 44th in infant mortality, 24th in deaths from cancer, and 41st in premature deaths overall.

QUALITATIVE FINDINGS

The aspects of the American health care system most valued by the focus group participants in this research include high quality care coupled with the availability of advanced technology, choice of doctor and insurance plans, easy accessibility to physicians, hospitals and other health care services, the peace of mind that comes from having insurance coverage, and the safety-net programs that provide health care to children, the elderly, disabled and indigent. It is important to note, however, that when asked what they liked best about the American health care system, quite a few participants could think of nothing positive to say. Although such comments were spread throughout the focus groups, this reaction was most prevalent among those with low-to-middle incomes, who are more strongly impacted by the financial burden of health insurance premiums and represent a greater percentage of the uninsured.

Additionally, whether discussing quality of care, advanced technology, choice, or accessibility, participants consistently added qualifiers such as "for those who can afford it," "if you have the money," and "for those who can pay for it" to indicate that they were aware that the attributes they personally value are not available to all.

High Quality Care and Advanced Technology

Georgians are in total agreement that Americans have access to the highest quality health care in the world, if they have the money to pay for it. They appreciate the caliber of physicians who practice in our country and the high standards that have been set for the delivery of health care services. A Savannah man described the abilities of American doctors as "incredible;" a Smyrna man called the quality of medicine in the United States "superior to anywhere else in the world;" and a Rome man believes that Americans are "blessed with very excellent medical care."

A key component of high quality care is the advanced technology available to Americans. Generally, participants offered few specifics about what they thought to be advanced technology, stating only that America has "the best health care technology in the world," and that "resources are limitless." A Dunwoody man did elaborate on emergency services, saying "If you need to be airlifted, helicopters come flying in, pluck you up, and fly you across the state to get you to the unit where you can be handled best. It really seems to me that when there's a catastrophe, real miracles can be worked." But outside this example, references to technology were largely expressed in generic, all-encompassing terminology.

Choice

Despite – or perhaps as a result of – having experienced limits placed on their choice of doctors through managed care plans, Georgians still place a high priority on the ability to choose their own doctor, as evidenced by the following comments:

Dunwoody man:	"Freedom of choice means that even in the world of managed care, which is not wonderful; you have the choice of a number of doctors in each specialty. That's better than no choice at all."
Roswell woman:	"I believe we do have choices, even though we don't like in-network and out-of-network. We certainly can find the person who can do the best job of us."
Watkinsville man:	"I have a relative choice between a better doctor or worse doctor based on how they treat me."
Macon man:	"I have the freedom to choose a provider, more or less."

Choice of health insurance coverage was also mentioned by many as a positive attribute of our health care system. A Hinesville man noted, "I like the fact that there is diversification of the plans. Employers can shop around and find different plans that are more suitable for their employees." A Marietta woman agreed, saying, "Companies do provide you with a choice between high options and an HMO. You're not just stuck with the one thing they have."

Accessibility
In respect to the accessibility of health care in the United States, a Jonesboro man said, "We have the availability to see a doctor when we want. If we need specialized care, we don't have to wait. If you need testing, you can get it the next day." Participants expressed similar sentiments throughout the focus groups, indicating how important ready access to doctors, hospitals and advanced technology is to them.

Access to specialists is of particular importance, as indicated by the Toccoa woman who simply said, "If you need a certain type of doctor, you can always find one." Portability of coverage across the country is also appreciated. A Columbus man commented, "You can go with a card from Columbus, Georgia and if you're in Washington state, you can get admitted to the hospital with a broken leg and know that it's going to be taken care of." Yet, these Georgians know that access is also dependent on financial resources as explained by the Atlanta man who said, "I like that I do live in America and that when I get sick, I'm able to get the necessary care I need. There's one thing about America, if you have the money, they will see you."

Peace of Mind from Having Insurance Coverage
Knowing that they are covered for routine health care and catastrophic illnesses provides great comfort to insured participants. Other than quality of care, having insurance was most often included in participants' lists of what they like best about health care. Fathers in Albany and Marietta described similar feelings about the peace of mind that comes with having insurance. One said, "I have the security of knowing that my family will be covered for any medical problem." The other repeated this thought when he replied, "The security that health care coverage can give you when you have a family."

Participants are especially grateful for having insurance partially or completely paid for by their employers. A Jonesboro man spoke for many when he said, "I like the fact that we have the opportunity to be covered on the job." And a Griffin man extolled the benefits of working for a large company, boasting that, "If you are working for a big company, you don't have to worry about paying your insurance. I don't have to pay for my insurance for the rest of my life, so I like that."

Further, low co-payments that are part of many insurance plans afford maximum levels of access to physicians and health care services to those covered. Numerous remarks indicated that co-payments have eased the financial weight of having to pay full fees for prescriptions or doctor's visits. Representative comments verify these sentiments:

Savannah woman:	"With your insurance, you don't have to worry about whether you have the money because you can pay whatever your co-pay is and go."
Watkinsville man:	"I like knowing that I've got insurance. If my kids are not feeling good then I can take them to the doctor. It costs me $15 to be safe."

Atlanta woman: "I used to hate to go to the doctor because it just got to be so expensive. Now, I just have to pay $15."

Safety Net Programs

Programs that provide a safety net for children, the elderly, disabled and indigent rank among the positive aspects of the health care system most often mentioned during the focus groups. Medicare and Medicaid are viewed as programs essential for ensuring that the most vulnerable Americans are assured access to health care. In response to the question about what he like bests about the health care system, a Patterson man responded, "I like being able to qualify for Medicare the best." And, a Hinesville woman's only positive was that "at least low income and elderly people have something instead of nothing" because of the Medicaid and Medicare programs. PeachCare received glowing comments from participants both through hearsay and first hand experience with the program. As one Augusta mother put it, "PeachCare helps me out a lot with my daughter because she suffers from allergies, and she has other illnesses too. I think it's great."

Participants are fervent in their belief that those who are suffering should be treated and appreciate that emergency rooms are required to administer care to anyone in need regardless of their ability to pay. An Atlanta woman noted, "I like the fact that if you go to the hospital you can be seen by a doctor when you absolutely need to see one." Such a mechanism for providing necessary care to all is seen as an essential component of a humane health care system.

Concerns about the Rising Cost of Health Care

If a single issue could be said to drive Georgians' conversations about America's health care system, it would be frustrations and alarm with the seemingly unending escalation of health care costs – both of health care services and insurance premiums. Georgians are united in their belief that health care costs are out of control and use words such as "outrageous," "extremely expensive," "out of proportion," "staggering," "criminal," "skyrocketing" "ridiculous," and "unaffordable" to describe the unacceptable burden they are forced to bear. Participants related numerous personal stories to illustrate their concerns; following is a sampling of comments heard across the state in every focus group:

Smyrna man: "My mother died from cancer. She was diagnosed in February and died in May. Over those few months her medical costs were almost $200,000."

Griffin woman: "My health insurance is almost $500 a month just for me. That's higher than my car payment and my house payment and all of my utilities. Just for health care. Just in case I get sick and have to go to the hospital."

Albany woman: "My husband's surgery cost $60,000. They would send bills for this and that. The insurance company would say, 'Well, we only pay this and that.' It took me two years to clear up that $60,000. I'm still trying to build my savings back up. It almost took the whole family down."

Augusta man: "I looked over the bill that we paid for being in the hospital, and we're paying thousands of dollars a day. We're paying a lot of money for basically staying in a hotel. I don't necessarily see that we're getting what we're paying for."

Ft. Benning woman: "My mom's retired and she has to pay over $100 a month for her blood pressure medicine, for just 30 pills. She can't afford it."

Patterson man: "It's costing me so much. By the time I pay my Medicare supplemental and my wife's insurance, I'm paying right at $700 a month for insurance. And, I'm on a fixed income."

Macon woman: "It's almost funny. My sister had a kidney transplant. You get these bills and you see $60,000 for one day for the ICU and all of the medications. We just laughed at the bill. I thought, no one could possibly pay this."

Participants strongly believe that only those fortunate enough to have coverage through an employer can afford health insurance, and many who have employer coverage are quick to acknowledge that they could not afford to purchase insurance on their own. A Watkinsville woman noted, "I have insurance where I work but if something were to happen, and I lost my job and I didn't have insurance, I couldn't afford it, not with my salary." At the same time, those who are covered questioned how they would pay for a major illness if they were uninsured. "My wife had brain surgery, and when you let somebody do $50,000 or $60,000 worth of whittling on our brain, you're glad for every penny you ever spent on insurance. I'd still be paying on the bill all these years later. There's no way we could do without it," related a man in Wrightsville. A Dunwoody man mused, "My two boys were born healthy, but still we probably couldn't have afforded their being born if we didn't have health insurance."

While appreciative of their employer-based coverage, many are still annoyed with yearly increases that offset any pay raises they might have earned. They see rising health care costs as preventing them from making any financial gains in their lives. A Hinesville woman explained, "Every time we get a cost of living raise, the following January our insurance goes up. So, they recoup everything that they gave us with the cost of living raise." A Wrightsville woman echoed, "If they give us a raise this year, our insurance goes right up about the time they give us the raise. That needs to stop. You never see the raise you got because the insurance goes up, and you don't have a choice in the matter."

Participants believe the cost of health insurance should be more stable and complain about constantly rising insurance premiums. A Stone Mountain woman showed her exasperation when she said, "I can't seem to get a policy that doesn't go up within a year. I mean three months into it, and it's already going up. I seems like it could at least stay the same for a year." A man in Dunwoody expressed a similar sentiment. He said, "I'm kind of sour as far as insurance is concerned because they constantly reel you in with an initially reasonable price. Then, every single year without fail, they raise you until you end up changing again. I don't like change."

Many Georgians are also feeling the pinch of having to pay their share of insurance premiums as well as meet co-payments for doctors' visits and prescription drugs. The pervasiveness of this concern is illustrated by the following comments:

Smyrna Man: "You know I'm very healthy but I still pay $80 a week out of my pocket for coverage for my family. I still have a co-pay of $20 a visit. I have two small boys, and they're at the doctor all the time. It adds up."

Wrightsville woman: "My son has speech therapy. He goes two days a week. Every time I have to make a co-payment. So, I pay my premium every month and then I pay $40 a week for him to go to speech therapy."

Toccoa man: "Originally, our co-pay was $10, and they raised it to $20 without even asking the employees. You have to pay $20 every time you go to the pharmacist. And that's on top of what we have to pay for our premiums."

Columbus woman: "My health insurance is going up and then I have to meet the deductible. That's $300."

Those with pre-existing conditions find it particularly difficult to afford health insurance when not part of an employer's group policy. A Roswell man indicated that he had to pay $2300 per month to cover his family due to his wife's illness. A woman in Toccoa who has had breast cancer and thyroid surgery told the focus group, "I really feel like that was the reason my insurance was canceled. They couldn't cancel me as long as I was paying the policy, which was already more than I could afford. So they adjusted it up to a point where there was no way I could do it."

A Fort Benning man voiced the feelings of many about the cost of insurance premiums by saying, "When you start throwing in dental and eye care, you're looking at $500 to $600 a month coming out of your pay check. That could put food on the table, clothing on your back, maybe even pay for a college education. You can't afford it because you've got health care coming out."

Why Health Care Costs Are So High

Although a number of factors were identified as contributing to the rising cost of health care, the issues that dominated the conversations across the State were greed, malpractice law suits, advanced technology and paying for care for the uninsured.

Greed

Georgians in the focus groups primarily contribute escalating costs to the greed of those within the health care system. In Roswell, a man said, "There's a lot of greed on the part of the insurance companies, the medical providers and the consumer too." In Savannah, a woman stated, "I think the insurance companies want to get rich. I think the hospitals want to get rich."

In Norcross, a woman offered this explanation: "I think its capitalism, free enterprise, the thing that makes America great. I'll get as much as I'm allowed to get. That's greed." In Rome, a man added, "Greed on the part of the doctors, hospitals and pharmaceutical companies. Those are the three primaries. They're each in a war of one-upmanship in trying to see who one can have the car, the best house, the best clothes, the best this and that for themselves." In Wrightsville, a woman bemoaned, "I just think it's more of a money-making racket than (it is) health care;" and in Patterson, a man asserted, "The whole medical profession, doctors and hospitals, is nothing but a rip off. The reason insurance is so high is because the hospitals and the whole profession are ripping the insurance companies off." In Ft. Benning a man plainly said, "I think health care has moved from taking care of people to taking care of pockets."

Pharmaceutical companies are viewed as among the greediest in the health care system, with the high cost of medications being a topic of discussion in every focus group. They describe drug companies as having a "stronghold" over health care and of being the epitome of "corporate corruption." Additionally, pharmaceutical companies are accused of over-inflating prices, spending too much money marketing drugs to doctors and advertising them in the media, and blocking the use of generic drugs. A Norcross woman was vehement when she said, "I don't buy all this whining and crying about how much it takes to develop drugs. Sure it does initially, but for how many years? You know the amount of money they have. All you have to do is look at the books. It's just criminal. We're all being exploited." A Smyrna man wondered about the high cost of blood pressure medications, saying, "These are some drugs that have been on the market for such a long time. So, why do they cost so much?" A woman in Marietta who had worked in a doctor's office was clearly unhappy with how drug company representatives conduct business. She told the group, "They take out the whole nursing staff and the doctors. They go to these nice restaurants. And the kickbacks are major. It's just amazing how much money they spend for entertainment, and that cost is being passed on to your prescriptions."

Participants are concerned about the health impact on their elderly relatives and friends who cannot afford the high cost of prescription drugs, and some participants told of not being able to pay for their own medications. A woman in Patterson related her dilemma, saying, "I put off going and getting my medicines as long as I can. I'll even half my medicine to keep from having to go as often as I need to go. It's very expensive, and with the deductibles, you have to spend a lot before it even kicks in. I don't understand why it's so expensive."

In addition, Georgians who attended these focus groups believe there is a fundamental problem when Americans can go to foreign countries and purchase drugs developed and made in America at substantially cheaper prices. A Roswell man lamented, "It's a sad thing that you can go outside your own country for the same drug and pay less for it." A Norcross man added, "Something that's a sore point with me is that we have friends who winter in Brownsville, Texas. They go to Mexico for their medications because it's so much cheaper. Why do we have to put people through this?" A Savannah man noted, "Clearly drug companies charge more here because we can afford to pay more here. We are subsidizing other countries."

To many, the practice of fixed rates paid by Medicare and negotiated by insurance companies with preferred providers is seen as evidence that doctors and hospitals are overcharging patients. These participants contend that this practice proves that those in the medical profession over-

inflate prices; they question the fairness of charging patients different prices for the same services based on the payment structure of the patient. A Patterson man asked, "You have to use a certain doctor, and you pay them a certain amount. So, the doctor charges you $65 for that office visit. Well, then in the next column, it has where they have written off $25 because the insurance company only allowed so much. Why don't they charge that amount to start with? I don't understand it." A Griffin woman agreed, saying, "The Medicare program will only pay the doctor $500 but he's going to charge me $1,000. Charges are so over-inflated, and none of it's real. If a doctor's services are only worth $500, then charge that. It doesn't make sense." A woman in Augusta wondered, "Sometimes they negotiate with the insurance company and they come down. Why didn't they come down in the first place?" Additionally, a few believe that the practice of negotiated rates results in higher costs for the working uninsured. A man from Rome explained, "I think one reason for the high cost is the deals that they have with the insurance companies. The insurance companies agree to pay a lesser amount. I think they are making up for it on people who don't have insurance." In Savannah a woman commented that "people who don't' have insurance coverage are subsidizing the people who do."

These concerns about escalating costs and the greed of those in the health system led some participants to call for more regulation of the health system, specifically placing caps on prices charged by doctors and hospitals. They made the following comments on the prospects of regulating prices:

Norcross woman:	"I think if we cap the drugs, that would eliminate a lot of the cost right there."
Toccoa woman:	"I think there should be a cap on what they can charge because they might charge you one thing and me another for the very same thing. There really should be a limit to what a doctor can charge."
Ft. Benning woman:	"They need to regulate what's going on in health care as far as the drugs, the equipment and the services."

A Norcross man may have best summarized the feelings of his fellow Georgians about the perceived greed of those within the health care system when he said, "You can't put a price tag on your health. The insurance companies and pharmaceutical companies are set up to inflate the cost and to exploit the American public. They're not just ripping off the U. S. They're ripping off the world. These companies know that people will pay any amount of money to get better."

Malpractice Law Suits

Frivolous malpractice law suits were of widespread concern to participants in every focus group, and they are well aware of the impact such law suits have on health care costs due to increased malpractice insurance rates paid by doctors and hospitals. A Norcross woman said, "I feel like everything has gotten so out of hand with insurance because of law suits and that type of thing. I think that's why our insurance goes up and up." Participants blame consumers who file such suits as well as lawyers who aggressively seek malpractice cases. In Albany, a man complained that "ambulance chasers find any cotton picking, little bitty thing" to sue over, and a Dunwoody man shared this view, stating, "I think that trial lawyers are undermining a lot of things in the

United States because punitive damages have just gone out of sight." In Marietta, a man suggested that costs are increasing because "one little thing goes wrong and they want to sue you for $20 million."

While participants are unanimous in their appreciation of the problems caused by frivolous law suits, they are not of one mind about placing caps on financial awards for malpractice. Some readily support regulating the amount that can be awarded but others are concerned that such limits would harm those who have been true victims of malpractice. Clearly, there was no consensus toward solution in this area.

Those who support limits on malpractice awards offered these comments:

Roswell man: "I think that people should be reasonable. There needs to be some kind of reasonable cap."

Griffin man: "There's got to be a line somewhere. I really think that suing for a million dollars just because you can sue is wrong. Just because the court system is screwed up doesn't mean that you have to screw up the medical system. I guess what I'm saying is that I think a cap is necessary."

Columbus man: "How can you put a value on a life if someone has died? I think there's just a reasonable amount of money that you say, 'Here's what we can give you, and I'm sorry.' So, yeah I think lawsuits should be limited."

Those who cautioned against setting caps said:

Augusta woman: "Some of these people in these professions do think that they are God, but they're not. They are entitled to their mistakes but they've got to remember that they have the kind of job that a mistake could cost somebody their life or permanent disablement."

Columbus man: "I'm not sure that limits are a good idea. It all depends on the circumstances. If some one is really hurt, they deserve to be compensated."

Technology

Advanced technology is also seen as a major factor in rising health care costs. Both in terms of the cost of developing the sophisticated equipment and the training costs and salaries of the technicians required to operate these devices. In addition, participants believe that consumer demand for access to such technology plays a significant role in increasing costs, as does the competitiveness that leads every health facility to want the newest and best "new thing" available. A Macon man observed, "One reason costs are so high is because of our obsession with cutting edge technology. We all want the latest and greatest, and it costs a lot of money." A man in Watkinsville commented, "Technology can be our downfall because everybody wants

all of these things that cost an arm and a leg. But, who do you say 'no' to? Therefore, it's just kind of a continual thing." Regarding the sharing of technology, a Roswell man noted, "There's no easy way for medical practitioners to share, so each has to have the latest and coolest piece of equipment."

Paying for the Indigent and the Uninsured

Participants recognize that low-income Georgians without insurance cannot afford to pay the cost of the health care services they receive. Therefore, doctors and hospitals recoup the cost of caring for indigent patients by increasing their charges for paying patients, notably, those with private health insurance. A Stone Mountain woman clarified, "It makes it harder on those that are covered because doctors raise the price to cover those who don't have insurance. So, we have to pay higher premiums." Women in Albany and Atlanta concurred. One said, "I feel like the doctors and hospitals are overcharging insurance companies so they can make up for the people that come in without insurance;" and the other added, "There are a lot of people who don't have insurance, and the people that do have insurance have to take care of the people who don't."

Managed Care

Complaints about the limits and restrictions on their 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 setting in an office reading a chart can't."

According to participants, doctor-patient relationships have deteriorated due to the pressures doctors face in meeting the financial expectations of the plan managers. Across all Social Groups, participants protested against managed care policies that impact their relationships with doctors and make them feel like a number instead of a patient who needs individualized care. They said:

Jonesboro woman: "You're just another number, just another patient. I guess it's because you don't stay long enough with a particular doctor to develop a relationship, because your health insurance coverage changes. So, that doctor/patient relationship is not established."

Rome woman: "Now, it's an assembly line. The more they see, the more money they make at the end of the day."

Albany man: "It seems like they get you on an assembly line. They just say, 'Well, you're just another person who's not going to be cared for."

Augusta woman: "The doctors are under so much pressure that they tend to be less attentive to the patient than they used to be."

Atlanta woman: "Sometimes I don't think they care; I mean that from the bottom of my heart. They have something that's more important. You're not important. So, the caring of the patient from the doctor is not as high."

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.

The "hassle factor" in dealing with insurance bureaucracies generated heated discussions in several focus groups. Participants shared story after story of their attempts to get clarification on coverage, straighten out billing errors, or obtain pre-approvals for treatments and surgeries. A

Watkinsville man provided a humorous analogy when he said, "It's unbearable. You spend half a day arguing with them and then you have to do it again two or three days later or a month later. I'd rather spend the whole week with my kids by myself than deal with it!" A Macon man described an elaborate computer spread sheet he uses to track bills for his family's medical expenses; and a Roswell woman grumbled, "You have to fight and fight and fight. If you're persistent enough you can get it approved, but it gives you such a headache."

Often, bureaucratic mix-ups have meant significant out-of-pocket costs for participants, as illustrated by the following stories:

Marietta man: "We got pre-approved, and they still didn't cover it. We fought and fought that until three years later; we ended up paying for every bit of it."

Wrightsville woman: "I got a letter saying to go ahead and have the study done, but (now) they won't pay for it. So I have to pay $3000 for a sleep study that the insurance company should have paid."

Macon man: "Its three years since my daughter was born, and they still haven't paid all of the bills from her birth. I'm moving out of the state, so in the next month I'll end up paying that bill because I've got to get done with it and move. I'll pay it even though I know that I don't owe it.

An Emerging Debate over the Benefit of Insurance Coverage

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."

Like the Dunwoody man who maintains insurance for his wife's protection, participants with families, particularly those with children, place a higher priority on having health insurance than do those who are without children or are single. A Smyrna man said, "Your children and your wife are paramount in your life. Above all you want to make sure that they're healthy. So you

will adjust your life to make sure they're covered." Those who have chronic illnesses also see the importance in maintaining health coverage. A Rome woman noted, "It's a priority for me because I have diabetes and high blood pressure."

Some participants have weighed the relative costs of paying for services versus paying for health insurance and have chosen not to be covered. Note the similarities in the comments made by participants in several different focus groups:

Stone Mountain woman:	"For $300 a month, I go to the doctor once a year. I can just pay the doctor the $300; I can pay $300 every month or $300 once a year."
Augusta woman:	"I visit a doctor every six months. I can pay $200-$300 for the doctor's visit, or I can pay the same amount every month for insurance. It's basically cheaper for me to just pay the doctor."
Atlanta man:	"Fortunately, I haven't had any major illnesses, so it's more affordable for me to pay for treatments as I need them."
Marietta woman:	"I sat down and looked at all of my payroll stubs and looked at all the months that I paid for insurance. I only go for an annual check up, and I could just pay that out of my pocket. I think of the thousands of dollars I paid and got nothing back. It's like giving money away."
Hinesville woman:	"We decided that we didn't want it because my husband and I don't go to the doctor that much, and it's so expensive."

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 question of ensuring access to care for all Georgians is the issue in which those in the more affluent Social Group included in this study hold strikingly different points of view from Georgians comprising all other Social Groups. While the vast majority of Georgians are united in their conviction that all Georgians should get the health care they need, the more affluent are clearly less persuaded.

Attitudes of the More Affluent

Defining "Need"

The most affluent Georgians included in this study take a different stance from all others on the issue of access to health care for all Georgians, and whether Georgia should develop a plan to make affordable health insurance available to everyone. While most of the more affluent are in philosophical agreement that all Georgians should get the health care they need, they have a narrow concept of what constitutes "need." They are in full support of someone in the midst of a health crisis receiving emergency care regardless of ability to pay, but they are less sure that society should underwrite the cost of assuring that everyone in Georgia have access to other types of health services. A man explained his definition of "need" this way: "If someone walks into the emergency room, and they need medical care that's life-or-death, they're going to get it. I think it should be immediate need. It's not a Pap smear. It's not a general check up or things like that." Another man explained his viewpoint, saying, "If somebody needs to have a heart transplant or somebody needs a liver transplant, who qualifies for that? I just think it's a ridiculous idea to think that everyone will get all the health care they need. I don't think it's that way in life. You don't get what you need, and life's not fair." Another man added, "You might as well be asking, 'What do we do with hungry people?' Well, some hungry people are going to starve to death, and some people who need health care aren't going to get it. That's just the way it is."

The Burden of Cost

Their views on this issue are largely influenced by the belief that they will be required to carry a disproportionate share of the financial burden for expanding access to health care for all. In reaction to a suggestion that everyone contribute according to their ability to pay to support a system of health care for all, a woman was almost outraged when she said, "I don't think that's possible, because those people aren't going to be able to contribute. What will happen is that they'll have to pay $10, but I'll have to pay $100." Another woman agreed that broadening access to health care would be unfair to people like her. She defended her position by saying, "We've all chosen to go to work so that if our spouses need something like hypertension medicine, we can provide it for them." Another woman shared this sentiment when she said, "I think in a perfect world everyone would have the availability of health care, but I do feel that we work for what we get and those who are harder in pursuit of that may (also) have the right to have the perks."

Those in this Social Group are not convinced that making affordable insurance available to all Georgians is the appropriate approach to take in addressing escalating health care costs. Rather, they believe this type of program would only cost them more. One woman explained, "Right now, if you don't have insurance, and you can't afford it, it's true that it's hard to get routine care. But, if you have something seriously wrong, you can go and get treatment and all of us pay for it. I think we would pay more if we had to pay for insurance for everyone." Further, some in this grouping suggest that providing insurance for all Georgians would be a waste of money because many of those who are currently uninsured are not responsible enough to benefit from the coverage being provided. A man put his views in plain words: "Routine medical care requires people to be responsible and diligent about going to get checked. They aren't the kind of people who have that sort of responsibility most of the time. The kinds of people that you

would aim that toward aren't the kind of people who give a crap about it." Finally, these participants cite the failed attempt by the Clinton administration to provide universal health insurance as evidence that Americans do not support such a plan. A man was sarcastic when he said, "That was proposed at one time by a woman (named) Hillary-something; her name escapes me. There was this huge revolt against it by the people. I don't think the sentiment has changed that much."

Attitudes of Most Georgians

In stark contrast to these views, Georgians in all other Social Groups represented in this study – and thus, represented among Georgia's citizenry at all levels – are of one mind in their concurrence that all Georgians should get the health care they need. Their comments, which abound throughout, show the breadth and scope of this support:

Stone Mountain woman: "Not only all Georgians, but I think all Americans (should get the care they need)."

Savanna woman: "I think everybody is entitled to good health care regardless of what your income is."

Jonesboro man: "I think it's really our duty (to provide health care for all Georgians). It's just the right thing to do."

Toccoa man: "I think everyone should have equal access to the best care."

Norcross man: "I think it should be a right, not a privilege."

Griffin man: "Not only should they get the health care they need, they should be treated just like anyone else when they go and see if they can get it."

Macon woman: "Even if they have to give it to them for free (they should get it)."

Watkinsville man: "I would like to see that happen, but a lot of Georgians can't afford it at the cost it is *now*. Yes, I believe that all Georgians should have it."

Albany woman: "Whether it's a doctor or a hospital, if people need it, they should be entitled to it."

Columbus man: "Everybody is entitled to it."

Augusta woman: Everyone in American should get the health care they need."

Hinesville man: "I think that not only each Georgian, but each American, should have the health care that they need."

Wrightsville man: "I think all Georgians and all Americans should get the health care they need."

Patterson man: "I agree 100 percent. I believe that everybody should be able to get health care, everybody."

Belief in Access to Care for All Georgians

Belief in access to health care for all is an issue that elicits strong emotion in many Georgians. They question the fairness of our current system and cannot understand how a country like America can accept a system that leaves so many people uninsured. A Fort Benning man declared, "In the United States, we have a gross national product large enough that we can afford to take care of those who can't take care of themselves." A Jonesboro man questioned, "We're busy doing things everywhere else in the world, so why can't we take care of the folks in Georgia? We're shipping goods to other countries but we won't help some little kid or some lady that needs to go to the doctor for a cold." A man in Watkinsville espoused his views, saying, "My opinion about health care is that any nation that continues to justify public schooling and public transit and national defense and all those different programs by which we all benefit, cannot justify our current health care system." And, an Augusta woman said, "The fact that someone could get refused the care that could save their life because they are uninsured boggles the mind. It's just unbearable to me because of all the abilities we have in this country."

"Need" Versus "Want"

Although their support for access to care for all Georgians is obviously strong, this is not to say that these Georgians support unlimited access, nor do they lack reservations about implementing a system to provide universal coverage. Like those in the more affluent Social Group, many want emphasis placed on care that is "needed;" however, their definition of "need" is clearly less restrictive, with most broadening this concept beyond life-saving treatments to include routine doctor's visits and prescription drugs, as well as most treatments and procedures recommended by a physician to improve a person's health. An Albany man would include "anything that affects your quality of life" in his definition of need. Participants are worried that some would abuse a system that provides all Georgians the health care they need and want to screen for "hypochondriacs that go to the doctor for every little thing" and make a clear distinction between what is truly needed versus what is "wanted." A Watkinsville woman noted, "We sometimes have a want, but it's not a need."

Shared Responsibility

In addition, with few comments to the contrary, these participants do not want anyone to get their health care or health insurance for free, and they would oppose any system that did not require everyone to make a contribution. A Macon man affirmed this view when he said, "If they're not doing anything to compensate for their health care, I'm not just going to hand it to somebody." An Augusta woman said, "I agree that everyone should get health care but I would also say that everyone ought to contribute to the cause." Across Georgia, participants embraced the fairness of a sliding scale payment system, as a man in Rome suggested when he said, "Make health care available so that people can contribute according to their ability, because there are those who can contribute more and there are those who can contribute less." According to these participants, the requirement to pay is not only fair but also makes people place a higher value on their

coverage and enables them to feel better about themselves. A Watkinsville man alleged, "I think we cherish those things that we have to put something into." An Atlanta man shared his feelings this way, saying, "I would rather pay for something than have somebody give me something. I feel better, and I'm contributing. People don't look down on me so bad. I'd rather do that, work for it or whatever else I had to do."

Care for Working Georgians

These Georgians also hold a strong conviction that anyone who works should be insured, and that those who work should take priority in any system that provides coverage for all. Their comments imply that access to insurance coverage should be a reward for working. They said:

Savannah man:	"I think you should be covered because you're working."
Jonesboro man:	"I think people who work should have insurance even if the state has to pay it for them."
Watkinsville man:	"No one who works for a living should be without health care; that's the bottom line."
Patterson man:	"I think everyone who is working is entitled to health care, even if they just make minimum wage."

Views about Undocumented Immigrants

Providing health care for undocumented immigrants arose as an issue in a number of focus groups. The frequency and tone of the comments made about providing health care for those who do not pay taxes and are considered to be in this country illegally indicates that some Georgians hold intense resentments toward this population. Their comments show their frustrations:

Savannah man:	"I'm saying a taxpaying citizen, not a freeloader, (should get coverage). We have people from Mexico that come over here and make $15,000 and $20,000 a year and take that money back home. I don't believe that I should have to pay for them to get taken care of."
Toccoa man:	"We have been here all of our lives, paying state and federal taxes. But if you get sick, they won't help you. Somebody comes across the border, they get anything they want. It's bad."
Patterson man:	"We are surrounded by Mexicans. They come in and they take the jobs. I feel sorry for them but I don't think they ought to use up our system."

Rome man: "Georgia has a large immigrant population that's forcing our government to provide health care to them. A lot of our services are going to people who aren't paying for the system."

A Comprehensive Plan for Citizens

It is not surprising, given their views on access to care for all Georgians, that participants would ardently support a plan for providing affordable insurance for those who are uninsured. They place a high priority on providing coverage for those who are most vulnerable, such as children, the elderly, and those with mental and physical disabilities, and recognize that such programs as Medicare, Medicaid, and PeachCare are in place and are serving the needs of these populations.

Consequently, they recommend that any new program be aimed at helping those who are currently left out of the system, particularly the working uninsured, those who have lost jobs, and people who have been denied coverage due to pre-existing conditions. Ultimately, however, they contend that all citizens who need affordable health coverage should be included. Coverage through such a plan, they say, should be comprehensive, including preventive care, but should also have reasonable limits to control costs. Participants are resolute in their conviction that an increased emphasis on prevention will help to reduce health care costs in the long term. A Macon man stressed this point when he said, "Until we convert our entire culture to preventive health care, away from corrective health care, it will continue to cost too much." A Smyrna woman concurred, saying: "If you can do some preventive stuff, you can probably stop some of the big expenses that may occur down the road." In Jonesboro, another woman added, "I think the big thing is preventive. If you do as much as you can to keep yourself healthy, the cost will go down." Participants not only want prevention to be an integral part of any new program developed for covering the uninsured but also call for enhanced coverage of preventive services in their own health plans.

During the focus group discussions, participants were asked to consider a list of options for providing access to health care for all Georgians. These options varied in their approach to solving the problem of the uninsured, and all are options that have been under consideration at one time or another by numerous government entities and policymakers. The options include:

- Free or reduced cost care
- Individual insurance pools
- Employer insurance pools
- Employer tax credits
- Personal tax incentives
- Individual subsidies
- Employer subsidies
- Expansion of the Medicaid program
- Buy-in to the Medicaid or PeachCare programs
- Employer mandates to provide coverage
- Universal health insurance coverage

Without being told specific details about the implementation of any of the eleven options, focus group participants were asked to indicate whether or not they could support the option as a

general direction for expanding insurance coverage in Georgia. Their conversations reveal that Georgians are willing to explore a wide range of options for solving the problem of the uninsured. While some gained widespread appeal, no one option emerged as a complete and ideal solution; participants felt that each option, on its own, was inadequate to fully addressing the scope and complexity of the problem. Instead, their conversations suggest that it will take a combination of options to provide health coverage for all Georgians.

With few exceptions, Georgians in all Social Groups showed equivalent levels of support for the various options presented to them. In most cases, in every Social Group some participants supported, and some rejected, each of the options under consideration, and their arguments for and against each option tended to be consistent across all social groupings. Overall, those in the higher income Social Groups tended toward stronger support of options concentrated in the private sector, while those in the lower income Social Groups were more receptive to options that call for greater government involvement.

The discussions around these options for covering the uninsured demonstrate that Georgians retain the same values around health care that were identified by Georgia Health Decisions in the 1993 report *Georgians Speak Out on Healthcare*.; namely, that any solution to providing access to health care for all Georgians must take into account their concerns about quality of care, fairness, affordability, choice, and shared responsibility – not only of individuals, but by employers, insurance companies, providers and government, as well.

Free or Reduced Cost Care

At first, a sizeable majority of focus group participants supported the option of free or reduced cost care through a system of free clinics, their overriding interest being in providing "poor people" a place to get affordable health care. Participants presume that free clinics would be more convenient, offering patients an easier and faster means for accessing care. An Albany man explained, "You would be able to go to a clinic and get a physical, or a flu shot, or things that you wouldn't normally get if you had to always go to a doctor's office. You wouldn't need an appointment; you could just walk in." Others thought clinics would improve access to care in rural areas. A Clayton man said, "If you have a centralized place, it's convenient for more people. I think it would really help the people in rural areas." A few had the sense that uninsured patients would receive better care in these clinics because the clinic doctors would not be overly concerned about making money. A Marietta woman explained, "I feel like the doctors that would work in the clinics would really care about health care because they certainly wouldn't be there for the money. I would feel like I was getting care from someone that really likes what he's doing, not what he's making." Others thought that free clinics would improve the health of the uninsured by providing more preventive care. A woman from Savannah commented, "I think people that don't feel like they can afford to go to the doctor would go to these clinics, and their illnesses won't be as bad as they would've been had they waited for months."

As participants' conversations progressed through the challenges of implementing a statewide system of free clinics, support for this option diminished noticeably, with their main concerns centering on the cost of maintaining such a system and compromising the quality of care. Many agreed with the Fort Benning woman who insisted that the "start-up costs would be huge." A

woman from Watkinsville added, "You can't duplicate all of the technology. In other words, we want everything for everybody everywhere and the technology is the expensive part of it." A Griffin man recognized that funding the clinics would fall on the shoulders of Georgia's taxpayers. He bemoaned, "Taxes would have to be raised so high, it probably wouldn't be feasible." However, most participants' apprehensions were focused on the quality of care that would be received in such a free-clinic system. They said:

Hinesville Woman: "Is the care provided in the clinic going to be as good as it is for those who can pay for their care? I'm saying it's a bad idea."

Atlanta Woman: "People may not get the specialists that they need."

Griffin Man: "I'm a veteran, and I've been to the Veteran's Hospital and I know what it's like to go in there. It's miserable. It's an all-day affair just to go see a doctor for five minutes, and that's what every clinic in the state would end up being like. It's just not feasible in my opinion."

Hinesville Man: "My question is, what if you've got this guy who is right out of medical school, and he doesn't have a practice; he's green in the medical field. Is [the clinic] going to be his transition place? Is the clinic going to be a 'puppy farm' for these guys to get their experience?"

Some participants did offer ideas for addressing the problems of funding and quality. A man from Dunwoody proposed that "all doctors who greatly benefit from the health care system donate a certain amount of time per year to work in a reduced-fee clinic." A Fort Benning woman offered a similar comment: "We have students going to medical school who have federal loans. If they go out and work in these clinics for an amount of time, part of your loan could be forgiven." A man from Atlanta felt that, with technology and specialized clinics, concerns about access could be addressed. He offered, "With computers and technology, the clinics could all be in one system. So if one clinic had a specialist and someone needed to get there, they would be able to talk to each other and get people in touch with the specialist. They would have a connected body of people working in a system chained together."

Insurance Pools

Both employer- and individual-based insurance pools received firm endorsements from Georgians in all Social Groups, gaining appeal from the fact that the availability of coverage would be expanded while simultaneously preserving many of the aspects that participants value about the American health care system. For example, with regard to the value Georgians place on individual freedom of choice, an insurance pool system would allow both individuals and employers to retain the option to participate, as well as decide which components of an insurance package would best suit their particular needs. At the same time, a larger pool would bring down costs, and thus, more people would have the opportunity to purchase affordable health insurance.

Participants in the higher income Social Groups supported the concept of insurance pools for slightly different reasons than those in the lower income groupings. Because these Georgians attribute a high degree of significance to competition and the free market system, they prefer solutions, such as insurance pools, that arise from the private sector. It is not surprising then, that they also showed a preference for employer-based pools, not only because such pools would positively impact the greatest number of those who are uninsured, but at the same time would encourage entrepreneurship and incentivize more small employers to provide coverage to remain competitive. Initially, support for insurance pools among these groupings was based on the absence of a government subsidy of the program. However, after further discussion, participants began to accept the idea of a partial government subsidy, but only if government involvement was kept to a minimum.

Insurance pools were equally popular among those in lower income Social Groups; but unlike those in higher income groupings, these participants appreciated different aspects of the pool concept and tended to favor individual-based pools as a means of preserving choice while providing affordable coverage. The sentiment voiced in one participant's comment was heard in every discussion about insurance pools: "I like the (individual) pool because that way no one would be left out, and everybody would be covered."

Although they like the idea of insurance pools, some participants were skeptical about a government-sponsored program. While they understand that the program must have government involvement in order to be feasible, their comments illustrate their uneasiness with this concept. A Fort Benning man said, "I worry if the government's hands are in it; you're looking at a large amount of money and you run the risk of them tapping into it like they have with Social Security." A Macon woman added, "The state (government) doesn't have a proven track record of being able to manage money, and here we are trying to get them to manage insurance money."

Individual Insurance Pools

Individual insurance pools received solid approval among all Social Groups for several reasons:

- Health insurance would be more affordable for individuals and families
- All of the uninsured would have access to individual insurance pools, even those who are unemployed
- Individuals and families would maintain control and could make choices about coverage that best suits their personal needs
- Everyone would contribute toward their own coverage

In general, Georgians feel individual insurance pools would have a significant impact in increasing coverage by providing affordable insurance. Participants believe that the very design of insurance pools would dictate affordable coverage because of the large number of people who would enroll in the plans. A man from Dunwoody saw the advantage of insurance pools when he remarked, "What's so hard about insurance is bringing together some kind of group that will be attractive to an insurance company. So the government or the state could be the agent that brings together the group that makes it large enough to be attractive to the insurance underwriters." An Augusta woman noted, "It would bring the cost of insurance down, just like

it does for those of us that are working. It would bring it down for everybody. Insurance is just cheaper when it's in a pool."

When individual pools were preferred over employer pools, it was because individual pools would provide everyone, even the unemployed, an opportunity to purchase coverage. Participants are concerned about the many Georgians who have lost their jobs during the recent economic downturn and do not want them to be left without access to affordable health insurance. A woman from Toccoa explained, "If you had to choose, it would be the individual pool, because a lot of people who don't have insurance don't work, and covering them is what's important. It goes back to everybody having a chance."

Additionally, some expressed a preference for individual- over employer-based pools because of issues of control. These participants believe that it is preferable for individuals, rather than their employers, to choose their insurance plans. One Atlanta man said, "Well, with the individual pools, the person has a choice depending upon their family needs or their own needs. I like that." And a Patterson man insisted, "I still go back to letting me purchase what the heck I want to purchase for my own reasons, that I can afford." Others indicated their preference for individual pools based on their distrust of employers' motivations and handling of control, as explained by a Fort Benning man: "I wouldn't like the employer pool because employers can then jack up the cost of insurance, whereas if it's an individual thing, you have more control over it. If you start letting corporations or 'Big Brother' into your business, then you know they're going to charge you; but if it's left to the individual, then the individual has more control over it." An Albany man echoed this viewpoint saying, "I guess I'm not employer-friendly. I don't think they (employers) need tax dollars to buy into it."

Most important, individual insurance pools respond to Georgians' desire that everyone contribute toward their own care. A Griffin man's comments support this view. He said, "Everybody would be paying their own way, whether it was a little or a lot. They would feel better about themselves, even if they were giving only $5.00 a month." A man from Augusta expressed the same feelings, saying, "Everyone is going to pay for it. When people are buying into it, they help bring down their own costs and everybody else's. It doesn't seem like a complete handout. You have to pay a little bit, but you have affordable health care."

Employer Insurance Pools

Employer insurance pools were popular for many of the same reasons as individual pools: access to more affordable coverage, availability of choice, and the requirement that everyone contribute. But for many, the greatest appeal of the employer insurance pool is that it maintains the traditional source of insurance through employers. A Macon man's comments explain: "We are conditioned to think that insurance should come from the employer in our culture. And this is appealing because it helps all employers offer insurance. I don't know if it's the best answer, but it fits in with the mold of how we view insurance."

Participants see employer pools as a mechanism for substantially lowering the numbers of the working uninsured. A man in Roswell said, "I'm for employer pools because the largest (most prevalent) employers of people are small companies who can't afford (to provide) insurance. So you would reach the most number of people who are working." According to participants,

employer pools could also serve as an incentive to small business owners to offer insurance coverage in order to remain competitive in attracting employees. Another Roswell man noted, "It would embarrass those employers who didn't offer coverage because there would be so many more of them offering it, that the ones who didn't would be ostracized."

As with individual pools, employer pools are seen as a way to preserve choice and control, but this time for the small business owner. A Dunwoody man explained, "It allows the individual employers to have some sense of control. If they (employees) want more coverage, they can go outside the pool, and the employer can buy only what his employees need." Others like the fact that under this option, the cost of insurance would be spread among the employer, the employee, and the state. A Macon woman, remarked, "I like this one because it seems to spread the cost out. It's partially funded by tax and partially funded by the employer."

Finally, some favor employer pools because they suspect that this form would be easier to administer than individual pools. A Stone Mountain man shared the following: "I think it's easier to regulate the relatively small number of employers than all of the employees. It would require a much bigger bureaucracy to see that an individual insurance pool was being utilized the way it was intended."

A few participants did not support employer insurance pools because they feel that tax credits would be a better option to incentivize small business owners. As a Smyrna woman explained, "I think that if the employer can provide some type of insurance, then he doesn't need to buy into a state thing. I think he should be given tax credits when he provides insurance."

Tax Credits and Tax Incentives

A few participants did not support employer insurance pools, favoring tax credits as a better option for small business owners. A Smyrna woman was one of them; she said, "I think that if the employer can provide some type of insurance, then he doesn't need to buy into a state thing. I think he should be given tax credits when he provides insurance."

However, while tax credits for both small employers and individuals were a popular concept, neither option was embraced as being effective in making measurable reductions in the ranks of the uninsured. Instead, all would agree with the Augusta man who said, "I think it would make it affordable for some people. I think it would make some people (motivate some people to) buy insurance, but I don't think that it will solve the problem."

Employer Tax Credits

While employer tax credits initially received concurrent support from a large portion of focus group attendees, further discussion indicted their skepticism that this option would serve to get more Georgians insurance coverage. Participants recognized that a tax credit for employers would not guarantee that insurance would be any more affordable for their employees. A woman in Savannah expressed the following: "The issue that comes to mind is that employers might offer insurance if they had tax incentives (to do so), but that doesn't mean that the employee is going to purchase it. Again, what we're trying to accomplish is having more people insured. That leaves a big loophole." A Stone Mountain woman stated, "I don't think that getting a tax credit will make the employer any more generous with their employees."

However, some participants see a beneficial effect of providing tax credits that extends beyond that of covering the uninsured. They cite the potential for stimulating the state's economy by providing an incentive for businesses to relocate to the state. A Roswell woman talked about the possible benefits for Georgia: "I think it would help the state with employment, because employers will come here if there's a tax credit. Maybe it's not just tax credits to small businesses, but tax credits for all employers who employ people below a certain threshold and then offer them insurance. That kind of tax incentive would also draw larger employers to the state."

Individual Tax Incentives

As with employer tax credits, participants support the idea of individual tax incentives, but do see them as an option for reducing the number of uninsured Georgians for two reasons. First, outside an actual reduction in cost, individuals would still be required to pay significant monthly premiums for their insurance coverage; consequently, it would remain out of reach for most Georgians. Second, most questioned whether Georgians who are already strapped would apply the money toward gaining coverage rather than to more pressing family financial matters. A Toccoa woman exclaimed, "If a person makes $15,000 a year, they still couldn't pay $500 a month for insurance even if they had a tax credit." A woman from Hinesville expressed similar cynicism: "That's not a good way to go because the people who can't afford insurance are still faced with $550 a month for an insurance payment. True, it's going to look lovely at the end of the year, but you've got to budget for 12 months in the meantime."

Finally, other participants felt that individual tax incentives would have little impact because the uninsured and working poor do not pay enough taxes to receive any assistance from the tax credit. An Augusta man reminded the group: "The people who need the credit don't pay many taxes. Those are the people who need money, so the tax relief isn't going to do them a whole lot of good." A man from Fort Benning added, "For the individual, the amount that you're going to get back is not going to be very large. Especially when you consider that the average individual who would be looking at this option isn't making enough money and isn't paying enough taxes to really make this worth his while."

Employer and Individual Subsidies

Employer and individual subsidies were the least popular of all options presented for consideration to focus group participants, with less than a third indicating any level of support for either approach. Throughout the conversations around subsidies, a consistent theme of caution and distrust emerged, at times attributed to individuals' motivations but more often directed toward employers and the government. For the most part, subsidies were seen as a "hand-out" and an unreliable solution to the problem of covering the uninsured, for the simple fact that there could be no way to monitor whether the money was used as intended; i.e., for the purchase or provision of insurance coverage. Georgians place a high value on shared responsibility; these participants voiced strong objections to taking responsibility away from the individual and do not want to give something for nothing. Most would agree with the Roswell man who declared, "Subsidies have been a disaster every time they've been tried."

Individual Subsidies
Participants offered several reasons for their lack of interest in individual subsidies:

- The potential for rampant abuse
- "Sky-high" administrative costs
- The stigma that would be attached to those who apply for such a program

Primarily, Georgians do not trust that those who would qualify for a subsidy would use the money for purchasing health insurance. The prevalence of comments on this topic shows their level of distrust:

Norcross woman:	"To me, it's the same thing as the man on the street begging for money. When you give him money, you don't know what he's going to spend it on."
Toccoa man:	"A person will put his entire check on beer or a lottery ticket and to heck with everything else. There would be people who would probably do that."
Rome man:	"They'll buy everything else they need first."
Ft. Benning woman:	"Who says they'll use it for insurance anyway."
Wrightsville man:	"I think you're opening a can of worms for abuse that would beat all abuse because people wouldn't buy insurance with it."
Atlanta woman:	"That could be a nightmare. People will use it for (something) other than insurance."

Participants became somewhat more receptive when subsidies were not being paid directly to individuals, but to insurance companies. However, they are still reluctant to embrace this concept for other reasons. They see the administration of a system for providing individual subsides as being extremely costly and a "big mess" to manage. Additionally, they believe the hassle and stigma associated with government programs would discourage many of the working uninsured from taking advantage of the subsidy. A Norcross woman indicated her aversion to this concept when she said, "I wonder if individuals would even use it. All of the bureaucratic part of it, and being identified in the same system of people, I'd rather just do without." A Watkinsville woman was sympathetic when she said, "In order to get it, bless their hearts, the people would have to go through WIC or something else of that sort." Finally, some say subsidies would do little to help, because even with some assistance, the uninsured will still not be able to afford insurance. One Clayton man said: "I don't see how a subsidy would help, if you already don't have the money. The subsidy is only going to be a small portion. It might be $50-$60 and you're still looking at maybe $150 that this person has to come up with out of their own pocket." A Toccoa man questioned, "What happens when you give somebody $100 a month to go buy coverage but it still doesn't meet their needs?"

The few participants who supported subsidies felt this program would help support the most deserving. A woman from Augusta spoke matter-of-factly: "I don't see anything wrong with it. I mean, if the individual can't afford health insurance and has a family and is just starting out, I don't see anything wrong with giving them a subsidy." An Atlanta woman agreed, saying, "I like it because it covers individuals and families. Because now senior citizens and children are taken care of, so for families, it's a good idea."

Employer Subsidies

Georgians were equally distrustful that employers would use subsidies appropriately. A Clayton man questioned, "Is the employer going to put it where it should be and use the money for what it's subsidized for?" And, an Albany participant asserted, "I'm not going to say all companies, but there's that percentage that would say, 'Oh, I've got this money; I'll just stick it in here and nobody will know about it.' Then when it comes time to pay for the insurance, (the employer will say) 'Oh is that what I was supposed to be doing?'" Others have reservations about the quality of coverage that employers would provide under a subsidized program. A Jonesboro woman said, "I'd be afraid that you'd get somebody that wouldn't provide the kind of health insurance for people that the subsidy was supposed to buy. Someone is going to make a profit out there somewhere when they get subsidized."

On the positive side, participants believe that an employer subsidy program would be easier to manage because there would be fewer employers than individuals to scrutinize.

Medicaid Expansion and a Medicaid Buy-In

Most Georgians responded positively to the idea of a Medicaid expansion or buy-in because both options entail working within a system that is currently in place. Participants do not want to "reinvent the wheel" by creating a new government program; instead, they see these options as improving upon an existing system, allowing change to take place more quickly and in a less costly fashion. A Smyrna woman's comments are representative of this general support. She said, "I feel like if we started a whole new plan, you know how the government is: there's going to be a group of people who get together and talk about it for months and then decide how to do it. Medicaid is already in place and should just be made available for more people." A Savannah woman said she likes this option because "the Medicaid system works, but it needs improvement." A woman from Watkinsville offered, "It already has the bureaucracy, and we already know what it costs." And, a Jonesboro woman noted, "It's already there. We don't have to create a whole new set of something."

The idea of a buy-in to Medicaid, or to an equivalent buy-in program such as PeachCare, was much more appealing than a mere expansion of the Medicaid program. Participants felt keenly that some kind of contribution into any kind of subsidized system is important, and therefore, would be preferable to merely expanding the current Medicaid program. One Watkinsville woman commented, "It would make them (program participants) have some responsibility rather than getting it for free." A woman from Savannah concurred, saying, "It all comes down to what the priority is, and do we want to put the responsibility back on the people? (I say) we do; we want them to have responsibility, and some buy-in instead of just giving it to them."

Medicaid Expansion

Georgians viewed an expansion of the Medicaid program as a solution for only those who are medically needy and cannot currently qualify for Medicaid, as well as for those who cannot afford to pay anything for their coverage. An Augusta woman explained, "I like the idea of expanding it for people that don't have anything, like homeless people, or the unemployed who can't work. There are just so many people that don't have jobs and can't do anything about it." Others only wanted the program expanded for those who already qualify for assistance, such as children, the elderly, and the disabled. A Rome woman sees this option as a way of including those who "really need Medicaid but don't qualify for it."

As an aside, discussions about the possibility of a Medicaid expansion led many participants to express their views about the Medicaid program in general. Many hold longstanding convictions that the Medicaid program discourages responsibility and self reliance and provides beneficiaries with poor quality care. A participant from Fort Benning spoke through personal experience when he said, "I've been on Medicaid, and I know it "sucks." Especially in rural areas, you're going to be stuck with substandard care because doctors know they're getting the minimum dollar, so they see you for the minimum amount and then push you out the door."

For many, any expansion of Medicaid would require addressing quality of care and correcting policies that dissuade people from working in order to receive health care. As a reflection of this, a Savannah woman supported an expansion that would include altering the current system to require that recipients work. She said, "It might entice people that get Medicaid now and don't work, to start working. I mean, a lot of people who get that coverage would like to work, but they're afraid they will lose their Medicaid coverage if they do." A Fort Benning woman reasoned that a Medicaid expansion would force policymakers to pay closer attention to the program's flaws. She offered, "Don't you think they're going to regulate the quality of care a little more? If they're expanding it and adding more regulations, then they're going to pay attention to the quality. I would think that would be a priority, and that they would have to set standards."

Medicaid Buy-In

A buy-in to the Medicaid program, or to an equivalent buy-in program such as PeachCare, was the most popular of all the options presented to focus group participants. Several participants supported a program of buy-in because of their current experience and satisfaction with purchasing PeachCare coverage for their children. A Toccoa mother reported, "My children are on PeachCare, and they get top quality care. To me, that's great."

As was mentioned, most Georgians prefer the buy-in concept because they want everyone to contribute to the health care system. Also, participants believe people feel better about themselves when they pay their own way. A Savannah woman said, "Well, there's a dignity issue as well. Even if people are only paying $2.00, there's something important about that." An Atlanta man chimed in, "I like the buying into it. In that way, people won't feel like it's something that's given to them. They're buying into it, and they just feel good."

Many were quick to note, however, that any contribution would have to be affordable in order for the program to address the problems of the uninsured. A woman from Toccoa insisted,

"Only if the cost was low would a buy-in be okay. Nine times out of ten, when you put a price tag on it, it will be out of reach." A Marietta woman bemoaned that with a buy-in, "that's kind of the way it is now, anybody can buy it. I can go buy insurance, if I need it, but I can't afford it. So to me, you're offering something we already have, and unless the payment was extremely low, I still couldn't afford it."

The buy-in option sparked discussions about who should be eligible to buy in, either to Medicaid or PeachCare, and it became clear that Georgians do not want such a program available to everyone. A Smyrna man cautioned, "Someone who doesn't need it shouldn't be able to buy into it. If he sees the chance to save himself some money, he'll buy into the program even if he can afford to pay his premiums through his employer." A man from Augusta suggested, "I think there should be a salary cutoff, because I don't want someone making $60,000 a year getting any of my tax dollars."

Employer Mandates

Less than half of the focus group participants supported the option of mandating employers to provide insurance for their employees, making it one of the least popular options. So many participants rejected this option because they felt mandates would have an overall negative effect on the economy, causing small businesses to close and resulting in pay cuts or employees to losing their jobs altogether. Here are comments from across the state about mandates:

Roswell man:	"That's a good way to watch companies leave Georgia."
Toccoa woman:	"Well, my son has a small business and he employs twelve people. If he were mandated to pay insurance, he couldn't have a business."
Augusta man:	"The guy driving a pick-up truck, who happens to employ somebody sitting in his passenger seat, doesn't have much money as it is. Are we telling him that he has to pay health care for this guy? It would put him out of business."
Stone Mountain man:	"I think it would cause another round of layoffs. I think the way a lot of companies would deal with it is to cut their work force."
Patterson woman:	"I think it would put all of the small businesses out of business because they probably couldn't afford it."
Griffin woman:	"Minimum wage right now is $5 to $6 an hour. If I had to give my employees insurance, I would pay them the lowest amount of money that I could pay them. For employees, it might mean the difference of a dollar an hour, which may be paying the electric bill that week."

This option was also unpopular because Georgians do not like the idea of the government forcing businesses into providing insurance coverage. A Norcross woman expressed that the whole

notion was "un-American," and during the conversation in Watkinsville, a man pointed out, "You own your own business so you don't have to work for somebody who tells you what to do."

Participants that do favor mandates maintain that employers have a responsibility to cover their employees, since employees contribute to the profit margin of the company, and they were ardent in their convictions that employers should be required to provide coverage. They said:

Rome man:	"We have a lot of companies in this state that are making a lot of money off of our labor, and they should give something back to those employees."
Ft. Benning Man:	"It puts the responsibility back in the employer's hands. There used to be a time when people could pretty much say, 'Okay, if I'm going to go to work for this person, I'm going to be here for 20 years. I'm going to have a retirement, I'm going to have health care, my family is going to be taken care of.' And we've gotten away from that. I mean if an employer isn't required to pay for it, then they're not going to pay for it."
Atlanta Woman:	"I've worked for a small business, and I wasn't covered. That was one of the reasons that I left that particular company. When I got sick, there was no insurance for me to pay for my illnesses. I think the small businesses should have to offer it."

Those who supported mandates were quick to add that insurance should be made affordable to employers if they are required to provide it. A Griffin woman explained, "I would say if it were mandated, they should make it affordable. If I were the employer, then I would pay so much and let the employee pay a smaller fee. The state should fix it so that the small businesses could afford to give it." Some see combining mandates with either subsidies or tax credits as a viable approach for providing employers with affordable health insurance for their employees.

Universal Health Insurance Coverage

There is evidence of a marked shift in the public's perceptions about universal health insurance coverage, as characterized by a government-sponsored, single-payer system, when compared to previous research conducted by Georgia Health Decisions, referenced earlier in this report. A decade ago, a staunch and pervasive resistance to universal health coverage blocked any real debate or productive conversation on the topic. At that time, Georgians in all Social Groups immediately and vehemently dismissed the idea, being too distrustful of a system that was not based on competition and free market values.

Although many participants in this current body of research still remained adamantly opposed to such a concept and refused to consider universal health coverage as a viable approach, a significant number expressed a general open-mindedness to the concept that was noticeably absent a decade ago. Participants in these current discussions expressed frustration and distrust of the free market system itself, saying that it has yielded spiraling costs and limits on access to care, as well as larger numbers of uninsured individuals. Because of their frustration with

skyrocketing costs and decreased access, Georgians in these discussions proved to be more open to discussing the possibility of a universal health care coverage system, with a majority of focus group participants saying they would support such an approach. A number of participants made comments similar to a Norcross man, who asked, "I think the question is not whether we want it to happen; I think the question is how it can happen, or what's stopping it from happening?"

During the focus group discussions, the debate on universal health coverage often centered on participants' perceptions of such systems in Canada and Europe. Many participants acknowledged that their comments were based on anecdotal evidence, speculation, and hear-say, with few participants having any first-hand knowledge of these systems; participants who had had first-hand experience tended to be positive in their observations and were more likely to support this option. One man reported, "I've lived in countries that have universal health care, and the tradeoff is that for nonessential services, you wait longer, but everybody can get the essential stuff taken care of. The care was excellent. That experience alone sold me on it." Other focus group participants also shared their positive experiences with universal health systems in other countries:

Albany woman: "It's true that in Canada they pay higher taxes, but we all have to pay taxes. My aunt in Canada had to have a mastectomy, and all she did was see her doctor; he referred her for a second opinion, and within eight days she was in the hospital and had it done. She didn't have a worry in the world."

Norcross man: "I have friends in Canada and England, and they have national health care and they are thrilled with it. They say our politicians are what's stopping it here."

Stone Mountain man: "And no matter what you've heard about how bad Canada's program is, I was born and raised up there and my relatives live up there; Canadians love it."

Hinesville man: "I was stationed in Germany, and everyone in Germany, it doesn't matter what kind of money you make, everybody is insured, no matter what."

As participants shared these experiences, others in the groups wondered what was blocking the process here. A man from Griffin queried, "I just wonder why Canada can do it, and the United States can't. You know, this is one of the richest countries in the world; why can't we take care of our own people?"

However, a number of other participants shared reports of poor quality of care in socialized countries. Even though many of these participants admitted to having little factual evidence, they said the stories they have heard are enough to keep them from supporting a universal health care and coverage option. A Stone Mountain woman revealed, "I guess I said 'no' because I've heard stories of people who needed major health care in countries with socialized medicine, and

they couldn't get it. I don't know how much fact there is to that, but I've heard it." Other negative accounts of health care in socialized systems included:

Jonesboro man: "It's failed miserably wherever it's been done, like in Canada and Europe. It's not a good program…people in emergency situations or who need testing have to wait six months, seven months, eight months, depending on what they need. And, some people die while they're waiting for preventive care."

Griffin man: "There are people from Canada, Germany, France, and England coming here to get quality health care because the doctors here are making $5 million a year and know more than the ones up there making $100,000 a year."

Macon woman: "I have Canadian friends who sometimes have to wait a year just to get open heart surgery or treatment for cancer."

Smyrna Man: "If we look at what we have compared to socialist countries, where their tax rate is 65%, I'm glad to live in America where, even though it's expensive, I'm not spending 65% of my income to pay for socialized medicine."

What appeals most to some Georgians about a universal system is that everyone, despite their financial resources, would have access to the same quality of care. When universal health care was described to a Marietta woman, she announced, "The fact that some big-time corporate gal could go into a doctor's office, and then I, who am middle- to low income, could go in and get the same treatment… that's what I like!" Many said they would value the peace of mind that comes with a universal health care plan, where they could be assured that if they needed care, they could afford to get it. Additionally, those in support of a universal plan speculate that this type of system would be more manageable and user-friendly, and that it would place more emphasis on preventive care. These are some of the many comments participants offered in support of a universal plan of coverage:

Rome woman: "I think if everybody had insurance, everybody would stay healthier and would go to the doctor earlier."

Albany woman: "I love the universal thing, because that way, every individual in Georgia should be able to afford health care. Every individual that needs glasses (or another kind of care) should be able to see, or to hear, or to walk."

Griffin Man: "If it were available to everybody, we would eliminate some of the fraud and mistreatment in the current system."

Savannah Woman: "I think the cost to our health care system would be lower through universal coverage, because we wouldn't face astronomical

	expenditures for the critical care of people who would be seen in the early, preventive stages of their illness, instead of later – in the emergency room."
Toccoa man:	"I sound like I am for socialized medicine and in a way I think I am. Why should the fellow who has a stroke and doesn't have insurance not get the same chance at having surgery?"
Jonesboro man:	"To be perfectly honest, I believe in and support socialized medicine. I prefer it not just in Georgia, but in the whole United States."
Hinesville woman:	"Everyone would be covered; you wouldn't have to worry. If you didn't make but so much money, or if you made a whole lot of money, you'd still be covered."
Patterson man:	"I just feel like it would be the best all around for low-income people all over the state."

Nevertheless, even those who would consider universal health coverage express concerns about higher taxes, increased government involvement in health care, quality of care, and personal responsibility. As with all other options, Georgians wondered where the money would come from to pay for such a system. For one Stone Mountain woman, the idea of increasing taxes to pay for such as system was a distressing thought. She bemoaned, "My taxes are as high as I can stand them already, absolutely as high as I can stand them; so I can't possibly support this idea." Concerns about increased government involvement arose during many of the discussions around universal health care. A participant from Savannah refused to support this approach because it would require government funding, and thereby, would increase government involvement. He offered, "If you're using government funds, they are going to get involved with how the funds are spent, and that's not a good idea." A woman in Roswell warned of the dangers of government control when she said, "If you study socialized medicine, the government administers it pretty much, and there are rules; and when you reach a certain age, they say, 'Here are a list of things that you can no longer have treated.'" The general mistrust of any increased government involvement was summed up by the Albany man who said, "I would think that the worst way that we could do anything, other than have an Army, is through the federal government."

Other participants were concerned that a universal health system would jeopardize the quality of care. An Albany man reasoned, "The overall health of the country may increase, because more folks would get attention, but the quality of that attention probably won't be as great." In Augusta, a woman wondered, "Is it going to be such a monopoly that the quality of care is going to go down?" Still others expressed anxiety over limits to choice, which they fear would be imposed under a universal health plan. A man from Fort Benning, observed, "You've lost your choice as to what type of care you can provide for yourself and your family (under such a plan); you no longer have that option." A Roswell man added, "One of the negative things about universal health insurance would be that someone else is making the decisions."

Again, as incorporated into discussions of other coverage options, Georgians continue to value personal responsibility and want to ensure that everyone contributes to whatever system is in place. Some participants made it clear that for universal health care to be acceptable to them, there would have to be some way to guarantee that if everyone benefits, everyone contributes. A woman from Norcross declared, "I think one of the things that need to be addressed is that no one wants to feel like they're paying for deadbeat people." An Atlanta man compared universal health care with the welfare system when he said, "You're taking responsibility away from the individual, and we as Americans are a capitalist society, where each person has to be responsible. When you go to a universal system, everybody is the same…we don't want to be socialized."

Conversations in the focus groups around universal health care almost always included speculation about how this option would be received in the United States. Though participants themselves were more receptive to talking about it, they did not feel that the greater public would respond the same way. A woman in Savannah was particularly convinced that Americans are not ready for universal health coverage. She declared, "There's probably not one percent of the population that would go along with national health care." Participants admitted that, even though they found universal health care to be a promising option, the general pessimism about such a dramatic change would allow for little opportunity to freely explore the option. One Norcross woman lamented, "I think that logistically it makes sense, but getting it approved, acclimated, getting it put inside the system, that's an entirely different proposition."

A few participants offered theories about why they thought universal health care would be challenging for the United States, feeling that American society and politics would have to undergo a fundamental shift before a universal health system could gain acceptance. A Norcross woman explained, "It doesn't match Americans' way of existing. We're a country who uses the great majority of the world's resources. We sort of relish in that fact, and we would have to give up that way of life to become a country that could have universal health care. It's not going to happen. I think that it goes against what we love about American ideals." A woman from Smyrna shared a similar perspective: "I don't think it's realistic for this country. Our health care system is so money-grabbing that there's no way that they are going to give up their individualism." There is also a sense that the polarizing nature of Washington politics would prevent the adoption of universal health care. A man from Toccoa who favored universal health care remarked, "Being in America, you're going to have a Democrat wanting to do this, and a Republican wanting to do that. But if the government would get together, they could have a wonderful plan. It would be a wonderful thing to have universal care."

Perceiving no end in sight to escalating health care costs, participants across Social Groups fear the inevitable outcome of the current process of events: that health care will soon be unaffordable for all but the most affluent. Throughout the state, Georgians are anxious about their ability to maintain health coverage. A Dunwoody man said of his personal situation, "Originally, I was in a group (of individuals who purchased coverage). Eventually, the people in the group got so old and the policy got so expensive that everybody had to go out on their own. Since then, it's been precarious. I only have catastrophic coverage now." A woman in Toccoa who is looking for insurance, because the small company she works for has dropped their coverage, expressed her desperation when she told the group, "I've exhausted every avenue.

I've called insurance company after insurance company. They'll cover me, but they're saying that they can't say (assure me) that they will keep me. They definitely won't cover any of the medical problems that I've had previously. What good is that going to do me?" An uninsured Watkinsville woman said that she worries all the time about not having insurance, but she simply cannot find coverage that she can afford. A Hinesville woman grumbled, "They don't provide enough affordable health insurance for people who are low income or even middle income. It's making it very difficult for people like me to be able to afford health insurance." A Patterson man said simply, "It's a troubling thing."

Consequently, participants are feeling a growing sense of helplessness in dealing with a health system that many see as accelerating out of control. As he described his concerns about the health system, a Savannah man shook his head and said, "This is just chaos." A Toccoa man complained, "The insurance is socking it to us. We're the fish on the hook, and that's it." In talking about the rising cost of health care, a Wrightsville man wanted to know, "How have we allowed this to happen?" A Dunwoody man said that the system is "ridiculously out of control, "and a Jonesboro man described the system as "flawed." He added, "Something has to get the price down for people to be able to afford insurance." In Rome, a man who frets about people on fixed incomes like himself questioned, "Where does it end?" An Albany man noted, "You've got your politicians, your insurance companies, and your employers and it's just a big mess." In Griffin, a man demanded, "They need to do something. I don't know what, but they definitely need to do something." A Wrightsville man exclaimed, "We've created a monster, and we don't know how to deal with it. That's the problem." And, a Macon woman expressed the feelings of the vast majority when she asserted, "We have a great health care system in this county, but something is broken."

While Georgians are ready for change, they have little expectations that rampant increases in health care costs will be reversed any time soon due to the lack of visible leadership in finding solutions to the problem. A Dunwoody man decried, "There really hasn't been anybody who has stood up and had the courage to tackle this problem like it needs to be tackled." A Norcross man lamented, "I never even hear the subject come up." A Roswell man expressed his anxiety about the lack of concern among health providers: "I'm really worried from a social standpoint about the unhappiness that has to be among those people who are employed but can't afford coverage. The doctors don't seem to care, and the hospitals don't care."

Citing the failure of the Clinton plan for universal coverage in the early 1990s, focus group participants fear that their elected officials now view health care reform as a political pariah, too risky to undertake. A Roswell woman suggested that any one willing to propose substantial changes in health care would be "committing political suicide," and a Jonesboro man called health care the "mud slinging arena" for political candidates. Furthermore, a significant number do not trust their political leaders to follow through on their commitments. A Columbus woman complained, "This one says that, and that one says this. Neither one of them is right, and neither one of them tells the truth." A Toccoa man was exasperated when he said, "They're going to do what they want to do. They don't care about the individual; they care about themselves and their positions." A dejected man in Patterson sighed, "They're going to do what they want to do. Even if we try, we can't win."

Given their low expectations and mistrust of the political process, many call for alternative approaches for developing health care reforms. A Smyrna man believes reform will only be possible if "they can make it a non-partisan issue." Many share that view and like the idea of a multi-faceted panel of Georgians that would work independently of any political influence in seeking solutions. Such a panel would be composed of health care professionals, insurance and health plan managers, business owners, and representatives of the general public. A Columbus woman voiced the hopes of several when she said, "I would want some people like me, a working person who could fully speak for me."

Additionally, participants praised the focus group process that had allowed them to express their opinions, and called for even more public involvement in the process. An Atlanta man proposed, "There needs to be more programs like this, where you're actually talking to individuals around the State of Georgia; the people themselves, not the doctors, not the politicians, but the actual individual people in small groups like this." Ultimately, participants recognize that any solution for bringing down costs and increasing access will require legislative action; and, therefore, the involvement of elected officials.

Regarding the urgent need and their desire for immediacy in addressing the problems of cost and access, participants said:

Dunwoody man:	"I would absolutely support somebody who wanted to take this on."
Toccoa man:	"Let's see this on the next referendum in Georgia and get it done."
Albany man:	"Let's vote the old people out and put the new people in that will do it."
Marietta man:	"I think that it has definitely got to be addressed, and soon."
Augusta woman:	"Let it be whoever can get it done the fastest."
Wrightsville man:	"I would jump on the bandwagon if somebody got one up."

Despite their call for immediate action, all would agree with the Jonesboro man who said, "I think costs are going to get a lot higher before it gets better. It's going to take a lot of work. You're not going to see it overnight." Still, they would take the issue on, and they present an open door for leadership who will go forward with them in seeking the positive change they view to be so gravely needed.

SECTION 2: EMPLOYER-BASED COVERAGE

QUANTITATIVE FINDINGS

While more than 90 percent of Georgians with private health care coverage obtain it through their employer or are dependents of someone who obtains coverage through an employer, there is concern nationwide and in Georgia that the employer sponsored health insurance (ESI) system is eroding. The most recent statistics from the Current Population Survey (CPS), the most frequently cited source on health insurance coverage in the U.S., suggest that 800,000 fewer Americans were covered by a plan linked to an employer in 2005 than in 2004, despite the fact that the under age 65 population grew by more than two million in the same time period.

Therefore, monitoring the rate at which Georgia employers offer health insurance benefits to employees, the cost of that coverage, and the characteristics of firms that offer - and do not offer - coverage is important to policy makers seeking to stabilize the current, private health insurance system so that as many Georgians as possible maintain health insurance coverage. This report summarizes the results of the 2004 survey of Georgia employers undertaken by researchers at Georgia State University to provide useful information about employer sponsored health insurance in the state. The survey is a part of a larger State Pilot Planning Grant supported through the Health Resources and Services Administration. The baseline survey was conducted in the fall of 2002.

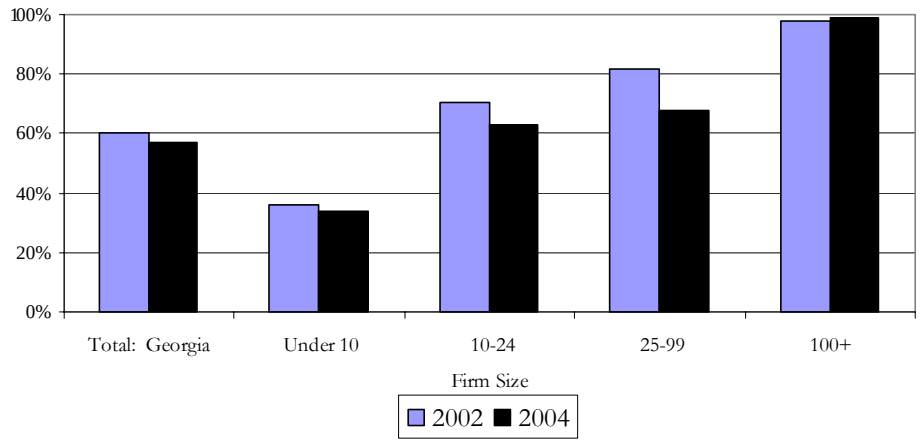
Methods

Information was gathered from a representative sample of the over 150,000 private sector employers in Georgia who employed almost 3.5 million workers during the last quarter of 2003. Over 1,700 Georgia establishments responded to the mailed survey between November 2004 and January 2005. Employers could respond by mail or through a web-based response option. The sample was designed to focus on collecting information about coverage options offered by Georgia's smaller employers – those with fewer than 100 employees. Over 116,000 such establishments in the state employ 1.2 million workers, and it is among these establishments that coverage is declining most rapidly.

Firm Characteristics

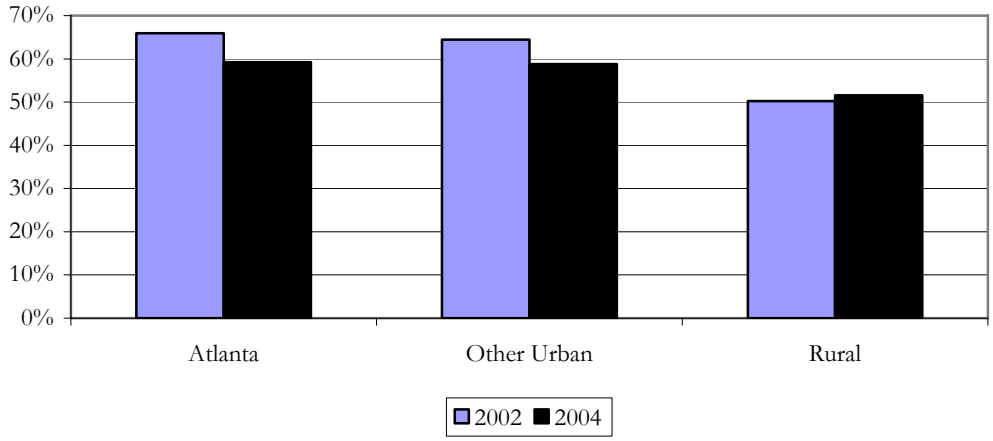
Of Georgia's 151,000 establishments, 57 percent offer at least one health insurance plan to at least some employees. This is down from 60 percent in 2002. As in 2002, it remains true that firm size is the most important predictor of whether or not an establishment offers health insurance to at least some of its employees. While 34 percent of Georgia's smallest establishments offered a plan in 2004, almost all of Georgia's largest firms offer at least one plan. Offer rates remain essentially unchanged among the largest employers in 2004. As Figure 1 demonstrates, the decline in the likelihood of offering coverage is most significant among establishments with 25 to 99 employees, down from 82 to 68 percent in just two years.

Figure 1
Which Georgia Employers Offer Health Care Coverage?



Although rural firms remain less likely to offer a plan than their urban counterparts, the erosion in offer rates in Georgia is focused on urban establishments. In Atlanta, the likelihood that an establishment offers coverage fell by seven percentage points, and in other urban locations the likelihood fell by five percentage points. In rural Georgia, the likelihood that an establishment offers coverage remains essentially unchanged since 2002 (Figure 2).

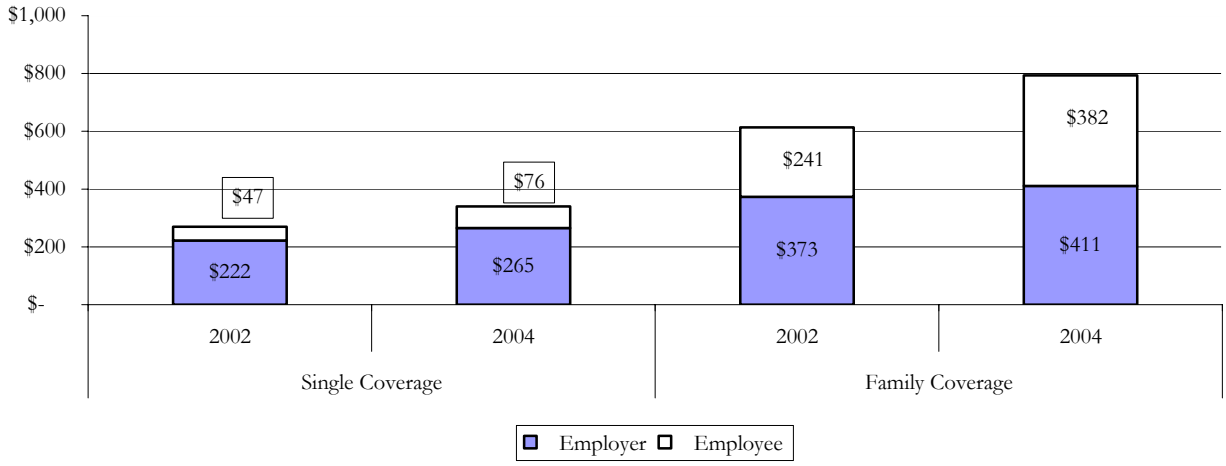
Figure 2
Coverage by Urban and Rural Locale



Plan Cost

Cost is the most frequently cited reason that employers do not offer ESI. Between 2002 and 2004, the total average cost of individual ESI increased 27 percent (12 percent per year), while the cost for family coverage increased 29 percent (14 percent per year). The employee share for either type plan, though, increased 59 percent (26 percent per year), demonstrating that employers are shifting an ever increasing share of the cost of coverage onto employees (Figure 3).

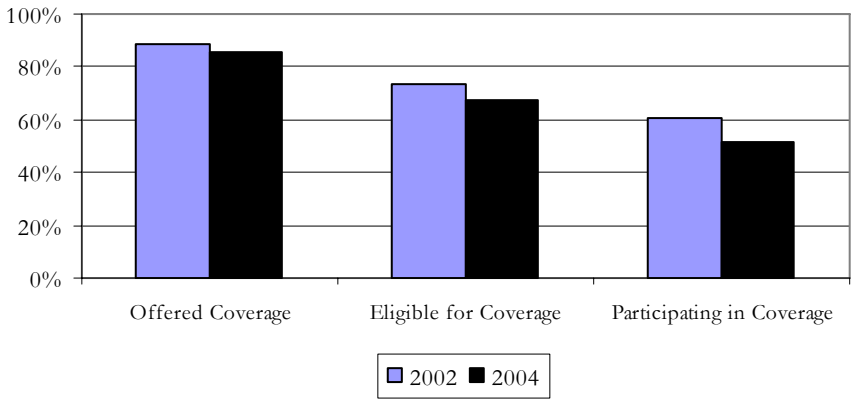
Figure 3
Average Monthly Cost of Coverage: Employer and Employee Share
2002 – 2004



Coverage of Georgia Workers

How does this translate into coverage of Georgia workers? In order to answer this question, we must consider first how many workers are employed at firms that offer coverage. However, not all workers at such firms are actually eligible for coverage, since workers may be excluded from eligibility for a variety of reasons. Many firms exclude part time workers from eligibility for coverage. Firms may also have exclusionary periods that restrict workers from eligibility for coverage during an initial phase of employment. Other workers are ineligible because they are classified as temporary or seasonal workers. Finally, not all workers who are eligible to participate in coverage opt to do so, especially since most coverage is contributory in nature. Given the high number of dual worker families, many workers elect not to participate in an offered plan because they have an alternative source of coverage. However, there is some evidence of an increasing number of workers who elect not to participate in coverage for which they are eligible, choosing to remain uninsured (*Gabel, et al., 2001).*

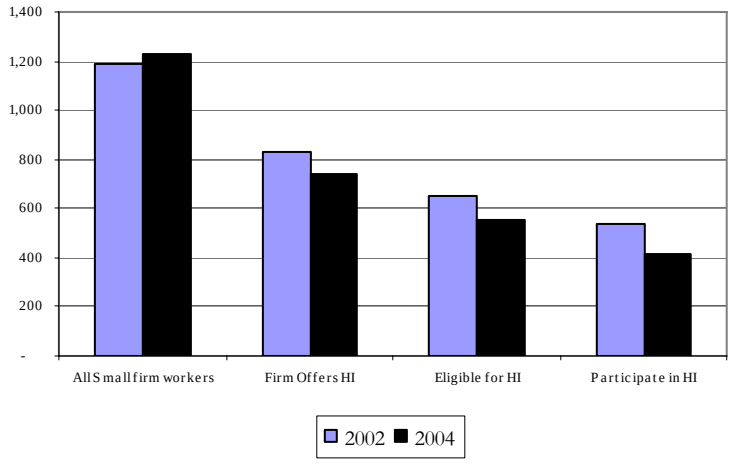
Figure 4
Percent of All Workers Offered, Eligible, and Participating in Coverage



In 2002, 89 percent of all employees worked at establishments that offered health insurance, but by 2004 that share fell to 85 percent of all private sector workers. The combined declines in offer, eligibility, and participation rates reflect 300,000 fewer workers with ESI in their own names. Some of the decline in eligibility results from an increase in the part-time labor force, which is estimated to have grown from over 400,000 to just over 600,000 workers in the two-year period.

When we compare offer, eligibility, and participation between 2002 and 2004 for workers in *small firms* (those with fewer than 100 employees), we see that the decline in coverage has resulted in 117,000 fewer small firm workers with coverage, despite the fact that the small firm work force grew by 47,000 workers in the same time period (Figure 5).

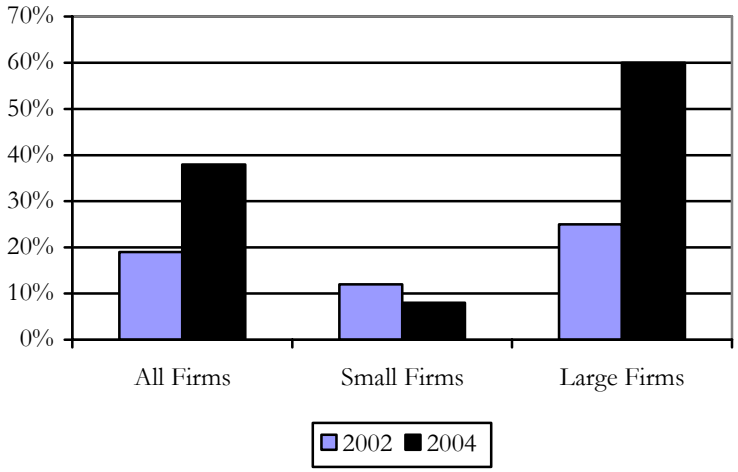
Figure 5
Workers (in 000s) Offered, Eligible, and Participating in ESI among *Small Firm* Workers in Georgia



Part-Time Workers

On average, Georgia employers consider any employee working fewer than 35 hours per-week to be part-time. The percent of part-time workers in firms that offer coverage has remained relatively unchanged from 2002 to 2004; however, the percent of part-time workers in firms where part-time workers are eligible for coverage has actually increased. Further examination, though, reveals that this change is driven by large firms. For part-time employees in small firms, the likelihood that they are eligible for insurance benefits has declined (Figure 6).

Figure 6
Firms Where Health Insurance is offered to Part-time Workers
2002 – 2004

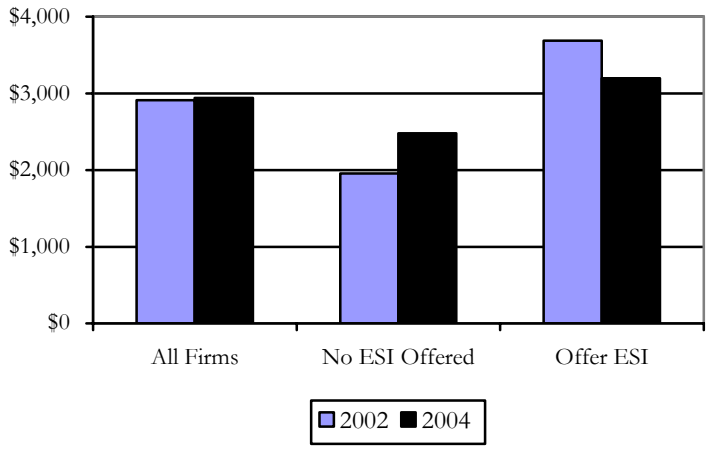


Average Monthly Wages

We measure average monthly wages at the firm as total reported wages divided by total workers employed during the reporting period (3rd quarter 2001 and 2003 respectively). Overall, average wages were relatively stagnant between 2002 and 2004 (Figure 7). Across all firms represented in this study, average wages grew only one percent between 2002 and 2004, while among small firms wages increased an average of five percent (2.3 percent annually). The overall economic conditions, along with an increase in part-time labor, may explain total wage stagnation.

The data reveal a relationship between firms that offer ESI and wage growth. While average wages at firms that do not offer health insurance increased substantially between 2002 and 2004, average wages at firms offering health insurance benefits actually declined over the two-year period of this study. This finding is strong evidence that workers bear the full cost of their employment-based health insurance, regardless of how much of the premium is paid by the employer.

Figure 7
Average Monthly Wages
2002 – 2004



Other Benefits

Among small firms, the declining likelihood that a firm offers health insurance appears to be linked to a slight decline in the offer rates for some other benefits. The likelihood that a worker at a small firm is offered a retirement benefit, life insurance, disability insurance, tuition reimbursement, or an employee assistance program has declined slightly since 2002. On the other hand, the probability that a worker can opt for a flexible work schedule has increased slightly among small firm workers. And, despite the aging of the population and discussion in the popular press of the burden associated with long term care, only three percent of firms offer long-term care insurance, essentially unchanged from 2002.

Holidays, sick leave, or vacation are still the most common benefits offered by small firms that do not offer ESI (70%), though small firms that do offer ESI are still more likely to offer paid holidays, sick leave, or vacation (96%). As in 2002, firms that do not offer ESI are more likely to offer a flexible schedule (32%) than firms that do offer ESI (29%).

Conclusion

The decline in the reported share of firms offering employer sponsored health insurance for at least some of their workers, combined with the decline in the number of workers eligible and participating in offered coverage, are cause for concern. Although some of the workers who are not offered, eligible, or participating in their own employers' plans may have alternative sources of health insurance, some of them are likely to join the growing ranks of the uninsured. Previous research from population surveys has suggested that declines in employer sponsored coverage are primarily attributable to declining take-up rates among workers who are offered coverage. While take-up rates are indeed declining, this research suggests that offer and eligibility losses are equal contributors to the decline in employer sponsored health insurance.

Although this study focuses on employers and their employees, it has implications for all Georgians.

If costs continue to grow at the rate found during this study period, the number of uninsured workers is likely to continue to grow in the future. Of particular concern is the reported increase in the contributions required for family coverage. Employees are paying almost $1,700 more annually for family coverage in 2004 than in 2002. If workers drop family coverage in favor of employee-only coverage or no insurance at all, we will see growing numbers of uninsured Georgians, particularly children. The burden of paying for the cost of caring for these individuals will fall on tax payers through public insurance programs, on those with coverage or who pay out-of-pocket through higher prices for health care services, and on the uninsured themselves who will forgo or delay needed care.

QUALITATIVE FINDINGS

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. These employers characterize the cost of health care as "out of hand," "ridiculous," "out of proportion," "outrageous," "sinful," "astronomical" and "inflated." A Thomson man was blunt in his assessment of the cost of health care when he stated, "You go to be cured, and you walk away feeling raped. It's sad."

Justifying their strong assertions that health care costs are overly inflated, participants cited 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 practice of charging different prices for the same services based on payment structure. Their comments on this type of payment structure included:

Decatur woman: "When I had an MRI, it was about $1200, but the insurance company only paid $500. So, really, their charges are bogus."

Columbus man: "When an insurance company can get their rates down to 30 percent of what it would cost you to walk in there if you had the money to pay for it, then that's out of line."

Albany man: "My wife just had surgery, and she was in the hospital for four days. We got a statement from the hospital that showed that her stay was $15,000, but down on the bottom it said there was a contract adjustment of $8,900. The total they billed the insurance company was $4,800. I wish I had that kind of margin in brick."

Along with their assertions of price inflation on the part of health care providers, these participants criticized insurance companies for being too greedy and profit motivated, and thus, an equal partner in shouldering the blame for escalating costs. A Columbus woman complained, "We've allowed the insurance companies, who are driven by profit and all of that, to just charge whatever. A 40 percent increase in one year is ridiculous! There's no way that (their) costs can go up 40 percent in one year." A man in the same group added, "Insurance in America is one of the most lucrative businesses there is. The insurance companies are always screaming, but they scream by design. Its part of their business plan to make it sound as bad as they can make it, because that's how they're going to continue to make billions of dollars a year." An Albany man

contributed, "Insurance is a huge business. If there's money out there to be made, that's what they're looking to do. They're not going to try to figure out how to make health care affordable to the average guy in America."

These small business owners also 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. Their observations on the cost of caring for the uninsured included:

Dalton man: "When people don't have insurance, they go to some emergency room, which costs ten times more and drives up costs."

Columbus man: "People who don't have insurance can't take preventive measures. They wait until they get sick, and that's driving the cost of health care up."

Albany man: "It costs the hospital to provide for people who cannot, or won't, pay for their medical services. Those of us who are paying for services are paying for those who won't, can't or don't pay."

Participants attributed the rising cost of health care to other factors as well, including:

- Malpractice insurance for doctors and hospitals
- Drug company marketing practices that include entertaining doctors and their office staffs
- Public demand for the highest levels of technology
- Care at the end of life
- Abuse by those uninsured who go to the doctor for minor ailments

While participants were in agreement that malpractice lawsuits and malpractice insurance do contribute to the rising costs of health care, they are not in agreement that monetary awards for malpractice should be capped. Although many expressed a belief that "tort reform is absolutely essential," a few would support the view of the Columbus woman who said, "I don't think you can start setting arbitrary limits on pain and suffering. Only God can do that."

Of note, these business owners contend that the principles of the free market that regulate costs do not apply to health care. As a Decatur participant put it, "The basic laws of the free market don't work in the health industry; when you're sick, you want to be better, and you don't care who makes you that way." A Columbus man agreed, saying, "The problem with the law of supply and demand is that the medical community isn't controlled by that. I can't reduce my demand when I have a 106-degree fever. I can't control that; I have to go, so I have no choice."

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 participants expressed 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 participants likened the relationships that 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 participants would want to do everything possible to make their employees feel secure by providing them with health insurance coverage.

Comments from across the state exemplify the commitment these employers have to those who work for them:

Thomson man:	"We are doing it out of conscience. We offer it to employees because we believe it's something that they benefit from."
Decatur man:	"Our restaurant is like a family. I couldn't imagine those important members of my family going without health insurance."
Dalton man:	"We want to give them that peace of mind. You know, when you work in a small business, you develop a relationship with these people. They're not just a guy in the next cubicle."
Albany woman:	"We've always done it, and I feel like we should do it. I feel like it's almost a moral thing that we should."
Columbus man:	"It's the right thing, and I have peace of mind for them. We care about our employees, all of them."

Given the strength of this conviction, 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, and participants who offer health insurance benefits reported paying from 25 to 100 percent of the premium for their employees, with most opting for some level of cost-sharing. Attitudes about this were varied; while some believe it is important to pay the full premium cost, others were equally adamant that employees should contribute toward the premium in order to maintain an appreciation of the value of the coverage provided. A Columbus employer remarked, "I don't feel like you should give everything to them. I want them to contribute part of it; I want them to actually have something invested in themselves."

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. A Decatur employer acknowledged the overall advantages of offering health insurance by saying, "Paying their health insurance makes them more secure and keeps them around. The benefit outweighs the money I'm spending. I get more from paying for their health insurance than I would get by giving them cash. It's still expensive, but it's a good value."

A second mechanism used to offset the cost of coverage is restricting coverage to certain types of employees or employee groups. Several participants reported 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 give for this discrepancy is that, unlike those in management positions, their lower-income employees cannot – or will not – contribute toward the cost of the premiums. A man in Thomson noted, "Most of these hourly people look at what they can take home, and they aren't really interested in any of the rest of it. But, the people who stay with you over the long haul realize the value of having insurance."

Cited most often as the leading reason employees cannot or do not participate are out-of-pocket costs. A Columbus man explained it this way: "These are $8.00 or $9.00 an hour people, and $300 a month for health insurance is too much for them. They just can't afford it." An Albany man offered a similar analysis, saying, "One of our guys makes $8.50 an hour and has two or three kids. To cover his family would probably be as much as he makes in a month!"

On the other hand, a number of participants expressed considerable frustration with their efforts to offer health benefits to their lower-income employees. Those who had tried to do so often found that their employees would not make even the smallest contribution toward the premium. A Thomson employer commented, "That's what I struggle with. They aren't going to take it, because they can't see that money going toward anything good." A Columbus man added, "If it was $3.50 a week, they wouldn't take it. They just pure and simple don't care." In some cases, participants reported that their minimum wage employees only become interested in having insurance after being diagnosed with an illness. One owner complained, "To be truthful, a great part of them just don't care. They assume that somebody is going to take care of it for them. They go to the emergency room, and it's free. If I have one of them to come and tell me that they want to be on the insurance, I guarantee you that they are about to have an operation, or somebody has told them that they have some problems." An owner of a Mexican restaurant in Dalton provided another perspective on why his staff would not pay for their own insurance. He said, "Most of my employees have come here from Mexico. They work and save money to send to their families. Also, they've never had to pay for insurance before coming here, so they don't understand the importance of having insurance. In Mexico, they get their health care from the government."

In conjunction with these dynamics, the burden of administrative costs to process the paperwork necessary to provide coverage for hourly wage earners is an added encumbrance for these employers. Participants report that those who earn close to minimum wage are often undependable, and a great number of them quit their jobs before they can even qualify for benefits. As an Albany business owner complained, "They'll change jobs and not say anything to you about it at all. They get their paychecks and never come back."

Employers in these focus groups who had made the decision not to offer health insurance coverage did so either because they were financially unable to underwrite the cost, or because employees were covered under a spouse's insurance plan. 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" was just as strong in this group as among participants who provide coverage. It is also significant to note that most of the employers in these focus groups

who do not offer any form of insurance coverage are those who employ fewer than 10 people. In saying, "The premium prices would have to come down or either I would have to be making a lot more money," a Columbus man spoke for most of his fellow small business owners who do not offer health insurance to any of their employees. These participants stated that they simply cannot afford to pay for health insurance for their employees, nor can their employees afford to pay the full premium price themselves.

Those employers who currently do offer health insurance to all or part of their employees share considerable concern about the potential economic impact on their businesses if the cost of insurance premiums continues to rise. Most report experiencing yearly double-digit increases in premium rates ranging from 15 to 45 percent. Employers' first response to such increases is to shop around for lower rates, often resulting in annual changes in insurance providers. A Decatur owner stated, "This is the first time in four years that I've been able to keep the same card in my wallet. And a Columbus man humorously said, "We swap health care insurers like we do our underwear."

In addition to changing insurance companies, these employers report having made other significant changes in response to premium increases, such as reducing or eliminating some covered benefits, increasing employee contributions toward premiums, and increasing deductibles – many times by as much as 100 percent. For a few employers, the consequences of these changes is a decrease in the number of covered employees, as explained by the owner who said, "Every time the rate goes up, the people that are borderline and don't' really care drop off. They drop off if they don't need it, and the ones who need it stay on."

Several participants made comments regarding the effect of an employee's age or sex on their premium rates, noting that younger employees are less expensive to cover, and that coverage for a female employee can cost substantially more than for a male employee of the same age.

Despite rising costs and the paper work associated with providing health insurance, most of these employers do not consider dealing with health insurance to be a major problem for their companies in relation to the other daily concerns faced by a small business owner. When asked about the "hassle factor" associated with health insurance, the majority had a similar response to the Albany woman who said, "Other than the cost, it's low. There are a lot of other things we deal with day-in and day-out that are worse."

Instead, soaring cost seems to stand alone as the single most significant issue that leaves small business owners struggling with their commitment to continue providing coverage for as long as possible. And, concern about the consequences for those who would be left without coverage is the primary reason many of these employers continue to sacrifice financially to maintain their insurance policies. Their comments attest to the strength of their commitment:

Thomson woman: "We tried having everyone get on an individual policy to save some money, but my brother-in-law had a serious heart attack a few years ago, and he would have been immediately dropped."

Columbus man: "I did try to just do away with it and give them the money to get it on their own, but the insurance agent told me that we have some people with pre-existing conditions that can't be insured as individuals."

Albany man: "I can't afford to give it up; I'm a part of the plan."

Decatur man: "I wouldn't dream of taking it away from them. I just couldn't do that.

While most of these small business owners say they philosophically agree with the statement, "All Georgians should get the health care they need," they simultaneously express considerable concerns over the practical implementation of such a statement. Business owners in Thomson and Columbus had similar reactions. One Thomson man said, "It's a catchy little slogan that we can wear around our vests for a day and smile about. The problem comes in how we are going to pay for that need." A Columbus man echoed these sentiments, saying, "The problem with taking a philosophical approach to something is that more often than not, it's just a slogan. Philosophically, I am with you (in agreement), but when it comes right down to it, if it's my dollar that's going to pay for it, then somebody can do without. I have to worry about my family and the folks who work for me." The cost of paying for a system that would provide health care for all Georgians was the primary focus of discussion on this topic in every focus group. In Dalton, a man questioned, "I think everybody should have health care, but at what cost?" In Decatur, another man said, "I have a problem with mandating health care for everyone, because if you say that everyone should get the health care they need, you can't really put a price tag on it."

Complicating access to care for all for these business owners is the difficulty in determining what health care is actually needed. Again, comments concerning need arose in every focus group. Here is a sampling of what was said:

> "All I can think of is that my need is different than your need, and your need is different than his need. The whole thing is that most of the people at this table haven't got the same needs."
>
> "How do you measure need? I guess that's the question."
>
> "What I perceive as my need may not be what you perceive as my need. Somebody has to say, 'You need this, but you don't need that.'"

Many of these business owners believe that the current system of subsidized clinics and emergency rooms already assures that those who have true health care needs are getting the medical services they require. A Decatur man claimed, "You may not be able to get all the health care you want, but if you were dying or if you had a debilitating illness, you would be able to walk in off the street and get help." A Columbus woman agreed, saying, "I don't know of too many people who can't get what they need."

Often in these discussions, the issue of access to health care for all was clouded by participants' perceptions of those on welfare, with some suggesting that those with Medicaid benefits receive better treatment than many who are insured. A Columbus woman noted, "I just get really upset because of the fact that welfare people get better care than I get. They can just go have their babies at whatever doctor they want to and use their Medicaid cards, but I'm being told where to go – and I've worked all my life." Many of these business owners also assert that too many low income workers have chosen to be uninsured and misuse services that are available to them. An Albany man explained, "I've had employees not take our insurance because it would cost them 25% of the premium to have it. Then they just go down there to the emergency room to get treated for a bee sting. They have the attitude, 'If we can't afford to pay, we won't pay.'" A Thomson man complained, "They've got the same right as I have to get out there and put everything on the line and do well, or they can sit back and live off society. The inability to pay a lot of time is pure sorriness." A Decatur man questioned, "How many people choose not to have health insurance because they think it's overpriced but could really pay for it if they quit smoking and spending $6.00 a day on cigarettes?" And a Dalton participant stated, "I believe the government needs to be careful about that (providing health care for all), because somebody will take advantage."

Across the state, small business owners were conflicted about how to control the rising cost of health care and expand health insurance coverage to those who are uninsured. Although most agreed with the Decatur participant who said, "The system is broke and we have to stop and fix it," they were not enthusiastic over any of the potential solutions presented to them and had few suggestions of their own for addressing the problems. They are united, however, in their assertions that their small businesses cannot bear any further tax burden for expanding coverage to the uninsured. In Thomson, a business owner was adamant when he declared, "It's already draining the small business person, and the large industry as well, to pay these enormous health care costs." In Columbus, a man asserted, "I'm really cynical about the solutions on the table, because I think it's just going to be another revenue stream to divert tax dollars that I'm already paying, and it's not going to bring my insurance rates down."

Some participants believe the most feasible approach for expanding coverage is to instigate a federal tax on individuals." In Dalton, a participant offered, "I would say that anybody in here would gladly pay ten cents more for a gallon of gas, if it went to provide everybody health care." Participants in Columbus discussed the advantages to them of having a Federal tax for health care. They said:

First participant:	"I would like to see the Federal government get involved in it, maybe tax everybody's payroll a certain amount and do away with companies paying it."
Second participant:	"Well, I would just as soon they tax my payroll ten percent. Then I don't have to buy insurance for the people that I do."
Third participant:	"It could be a tax like social security tax is now. You're not exempt from it. It would become part of that same tax where everybody that works pays it."

However, small business owners are reluctant to embrace any solution that expands government's role in the administration or regulation of health care, as illustrated by these comments:

Columbus woman:	"I am very much against the state having any more control over anything that my business does."
Thomson man:	"It's been my experience that whatever the government gets involved in, it gets out of control."
Albany woman:	"Government, I don't care whether it's city, county, state or federal, has never been able to do what private enterprise can do for cost efficiency."

In light of their concerns about businesses having to bear the cost for expanded health coverage and their skepticism about government involvement, it is not surprising that the only solution presented to these business owners that received overall support was tax credits for small businesses. All other solutions received mixed reactions; some approaches were universally rejected, while others were embraced by some but not all participants. The following outlines the reactions of these small business owners to each of the solutions presented to them for consideration.

Free or Reduced Care Clinics

This option received very little support from participants, 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

Participants 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 over 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 participants 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. They offered these comments on the subject:

> "If you consider that the greatest percentage of people who have health insurance more than likely have it through a business, and if the business is going to get somewhat of a tax break or tax credit, I think it's a pretty good guess that you're going to have less people fall off the edges than you would if you didn't."
>
> "I think it would get more people insured, because you're going to give a tax break to the employer for providing health insurance. That's something that we have never seen. I would love that. It would be a tremendous incentive to me to keep offering it to my employees."

On the other hand, participants 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. Participants 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 these 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 of these 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."
>
> "I think health care is big enough and important enough that it may take the federal government to do it."
>
> "Somewhere down the road, we have got to work towards universal care and some kind of a method for ensuring quality health care."

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.

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 politicians will result in more of the same for the foreseeable future, as illustrated by their comments:

> "These politicians will mention doing something about health care costs when it's election time, then they don't do anything."
>
> "You go to your legislator or your senator and you tell them how you feel, but you never hear anything from them."
>
> "It just seems life nothing is being done."
>
> "I think the insurance companies have too much of a political lobby to let anything get started."

As small business owners, they feel powerless to influence any of the factors affecting health costs, and most echoed the helplessness of the Thomson man who wondered, "The question is

what do we do? Who do we complain to?" 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. Consequently, they say all they can do is shop around and hope they can find a better deal when they are faced with double-digit increases to their premiums.

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. A Columbus man became passionate when he asserted, "We've got to hold the politicians' feet to the fire and force them to stand up to the doctors, insurance companies and lawyers." Despite their resistance to government involvement, these business owners came to acknowledge that politicians and government will have to play a major role in controlling costs and expanding coverage to the uninsured. And, a Decatur man expressed the sentiments of all when he sighed, "Whatever the solution is, it's going to take a while. It's a long process."

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,[2] more than 60 percent of hospital stays were covered by government payments in 2002, emergency room visits are on the rise, more than $700,000,000 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 and1989, 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.

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

[2] http://www.communityhealth.state.ga.us/

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[3]. 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

[3] As of July 1, 2004.

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 insurance representatives have attempted to create a mechanism for funding the pool – without success. Georgia has yet to enact additional waiver expansions as a means to expand coverage, however the state is examining ways to take advantage of the flexibility the Deficit Reduction Act provides.

SECTION 4: OPTIONS FOR EXPANDING COVERAGE

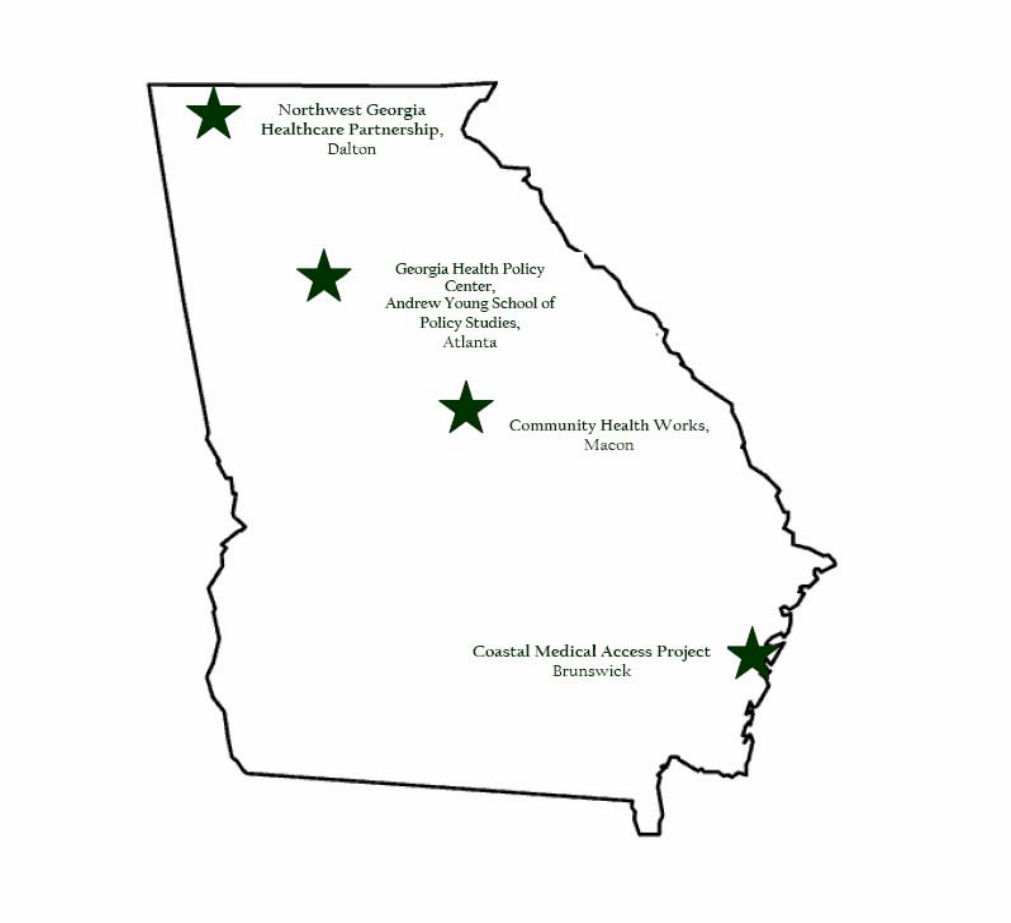
Pilot Planning Grant Activities Fourth Quarter 2004 – Fourth Quarter 2005

Georgia's Pilot Planning Grant design is based on several guiding principles:

1. The acknowledgment of four distinct geographic regions within the state (Atlanta Metro, Other Metro, Rural North, and Rural South) with different populations and different needs.
2. Statewide consensus on focusing on the working uninsured as one of two priority areas.
3. The desire for public-private partnerships rather than purely public program expansion.
4. The power of community to effect change.

Having proven the power of their individual communities to effect change at the community level through prior partnership with the Georgia Health Policy Center, four communities were invited to design tailored community-based approaches to covering the uninsured:

1. **Northwest Georgia Healthcare Partnership** (www.nwgahealthpartners.org) was the previous recipient of a W. K. Kellogg Foundation matching grant and participated in the National Community Care Network Demonstration Program. It operates a Promotoras de Salud (lay health educators) program for the Hispanic community as part of its educational outreach and fosters the growth of the Volunteers in Medicine and Dentistry program operating at the Whitfield County Health Department, the MedBank operating at the Murray and Whitfield County Health Departments, and the Murray County Access Clinic in Chatsworth. It serves Whitfield and Murray counties.
2. **Atlanta Regional Health Forum** (www.arhf.net) is an inclusive, multi-sectoral, results-oriented, nonpartisan coalition operating as a 501(c)(3) nonprofit corporation dedicated to creating healthy local communities which ensure the highest health potential for each person within the ten core county region of metropolitan Atlanta.
3. **Community Health Works** (www.chwg.org) is an enrollment based program for adults, 19 to 64 years old, with incomes under 235% of the Federal Poverty Level. It provides basic primary care, disease-specific benefits, and enhanced case management through a donated care model that includes local physicians, five hospitals, one clinic, two behavioral health clinics, and local county health departments. Community Health Works serves seven counties in central Georgia.
4. **Coastal Medical Access Project** (www.cmapga.org) is a donated care model that provides a three-pronged course of action for those in need - Physician Services, MedBank, and Case Management. CMAP's mission is to provide pharmaceutical assistance, chronic disease case management and free access to primary health care for medically needy residents of Camden, Glynn and McIntosh Counties in Southeast Georgia. This is accomplished through collaboration among the medical community, faith-based organizations, local businesses and volunteers.



In addition, the grant afforded the team the opportunity to re-field the 2002 Employer Benefits Survey. Those results are presented in Section 2.

The communities were first convened at a kick-off meeting November 16, 2004 to familiarize them with project goals, objectives, and strategies. Communities were required to:

- Convene a Working Group
- Hold monthly working meetings
- Gain community input and support
- Determine a coverage model
- Design the coverage model

At the conclusion of the November 16 meeting, each community received a commendation from Governor Perdue for their participation in the Pilot Planning Grant. In the first quarter of 2005, each community held a community forum to gain input from community stakeholders including business owners, providers, and uninsured residents. Several options were presented to stakeholders as possible coverage partnerships: three-share programs, limited coverage plans, and discounted care models.

Discussion questions included:

- What are your general reactions to the opportunity presented for your community by the State Planning Grant?
- What parameters would you place on the project for your community?
- What goals would you set? What outcomes would you hope for?
- What resources are available in your community to draw on in undertaking this initiative?
- Are there any barriers or unique challenges that you might face in this community?
- What reactions do you have about how others have approached this issue?
- Would you want to adapt any of these approaches?
- If so, what parts appeal to you and why?

To facilitate decision-making as to what kind of coverage program to pursue, focus groups were held in the second and third quarters of 2005 in each community with employers and employees at firms that do not offer health care coverage. The reports of the focus groups are presented below to provide insight into emerging thoughts around target eligibility groups, premium sharing, benefits structures, and cost containment strategies.

NORTHWEST GEORGIA HEALTHCARE PARTNERSHIP (DALTON, WHITFIELD, MURRAY COUNTIES)

Introduction

Two focus groups were conducted to gain insights into options for expanding health coverage to the uninsured in northwest Georgia. Eight small business owners participated in a focus group held on May 24, 2005. Nine employees of small businesses participated in the second focus group held on June 9, 2005.

The employers own businesses ranging in size from two to 31 employees. Types of businesses represented include retail stores, restaurant, beauty salon, catering, print shop, non-profit, and daycare.

Both employers and employees were engaged in conversations about their experiences in seeking health coverage and their reactions to three concepts for expanding health coverage in northwest Georgia. The three concepts presented for discussion were:

- A multi-share model based on the three-share program in Muskegon, Michigan
- A discounted provider network
- A limited insurance coverage model

Experiences in Seeking Health Coverage

<u>Employers</u>

Only two of these employers have offered health insurance to their employees in the past, but both have dropped that coverage within the past two years due to rising costs. One employer commented, “It was either make wages or cut out the insurance. It just kept going up and up and

up and up." Concerns about the consequences of yearly premium increases keep most of these employers from considering health benefits for their employees. A man in the group explained, "Last year I looked and saw what it would cost, but then I hear that this year it's going to cost a lot more. So, three years from now the cost of living is going to go up; and by rights, my employees need to get a raise. In the same token, the insurance policies are going to keep going up. Then pretty soon, it's going to be an unmanageable cost." Another employer added his perspective when he said, "My employees can't afford to contribute a whole lot, and I can't contribute a whole lot. So, that's the catch-22."

By far, premium cost is the number one reason employees gave for not having health coverage for employees. However, those in attendance discussed a number of other barriers small businesses face in trying to provide health coverage. The combination of a high employee turnover, relatively low wage scale, and predominately younger workers that is typical of many small businesses such as restaurants and construction companies make it very difficult for their owners to consider the possibility of providing health coverage. The following exchange among two of the employers at the focus group illustrates their dilemma:

First employer: "In the restaurant business, turnover is extremely high. You also have a lot of young people that don't think about the future at all."

Second employer: "Your wage scale is probably like ours. It's not on the high end. It's definitely on the lower pay scale. If they have to contribute even $10 or $20, they're not going to do it because that's the difference between eating and having insurance."

First employer: "And very few young people, especially working as hard as they do in the restaurant business, have real health problems."

A woman in the group believes that a limited insurance market in northwest Georgia adds to the cost of health insurance. She clarified, "We don't have many options to get coverage and actually have providers here in our area. It's very, very limited. We have the one network. You have no choices. You can talk to Blue Cross Blue Shield, but there are no providers in the Dalton area. You have to go to Chattanooga. So we are very limited here, and you're going to pay the price because that's the only thing you can get." A man concurred saying, "She made a good point about the providers. We can provide insurance all day long, but it's not much help if the employee can't go use it."

These employees believe that the inability to offer health coverage impacts their businesses. One female employer worried, "Insurance is a real issue with our staffing concerns. Because we can't afford to provide insurance, we can't always attract employees that we want to be able to hire." A man in the group had similar concerns: "I'm growing, and I have to expand. I need more people; but to attract the right kind of people, I have to offer a benefits package." And, a third employer added, "I've lost several good people that I would like to have work for me because I couldn't offer insurance."

Employees

While all of the small business employees at the focus group are uninsured, all but one have had health insurance in the past through a previous employer. Currently, they have been without coverage from two to twelve years. Additionally, most spouses of the married participants are also uninsured. Almost all have tried to buy insurance but could not find a policy they could afford. The following comments describe their frustrations with these experiences:

Female: "I checked into prices but it was pretty expensive. It was going to be about $400 a month just for me."

Male: "There was one that offered it to my and wife and me, but it was going to be $660 a month for just us two. They had their limitation on what they covered.'

Female: "I got quotes for different levels of coverage, and the cheapest one that I got was about $270 a month. But the deductible was real high and what they would pay was real low."

Female: "I checked with Blue Cross, and you could get it for about $275 a month but it was like a $2,500 or $3,000 deductible and nothing pre-existing, and it would only pay 60 percent."

Participants reported a number of consequences of being without health insurance, including not receiving preventive care and delaying going to the doctor for treatment of acute and chronic illnesses. None have a regular doctor that they see for routine care, and one woman indicated that she had not had a check up in 12 years or a PAP smear in nine years. Another participant stated, "I know how expensive it can be to go the emergency room and most places won't see you without insurance or cash up front. So, I just don't go." A third added, "I need to go to a specialist for my arthritis, but I've been putting it off because I don't have any insurance."

Additionally, several have accumulated large debts when medical emergencies have arisen, as illustrated by the following accounts:

> "I was in the hospital one time, and the hospital bill was $1,000. I still have hospital bills from three or four years ago. I get calls every day, but I just can't afford it."
>
> "I have thousands and thousands of hospital bills, about $5,000. I just got sued last month from people trying to get the hospital bills paid. They said they were going to garnish my wages and all of this stuff. They're taking payments from me now, but its money I don't have. It's frustrating."
>
> "I've been to the emergency room three times because of a car accident. I went and made arrangements, and I give them $100 a month, but it's been hard to pay."

Reactions to Coverage Options
Both employers and employees were presented with three potential options for expanding coverage to the uninsured in northwest Georgia, as described below:

Discounted Provider Network:
In the Discounted Provider Network individuals and/or families are charged an annual fee to enroll in the program. Upon enrollment, they receive a card that provides them financial discounts for the health services they receive. Plan membership provides neither insurance nor coverage for health services, and plan members are financially responsible for all health services they receive. Hospitals, physicians and other health care providers agree to participate in the program and to provide services to plan members at the discounted rate. Plan members only receive the discount when they utilize the services of the local health providers who have agreed to participate.

Limited Insurance Coverage:
This model provides insurance coverage with low maximum yearly limits for employees of small businesses. It is most beneficial for those who need coverage for routine primary care. Plan members must receive services from local hospital, physicians and other health providers who have agreed to participate in the plan

Multi-share Coverage Model:
The multi-share program requires financial participation by the employer and the employee. Their combined contributions may be subsidized by a combination of other funding sources. Those enrolled in the program are provided coverage for health care services but this coverage is not insurance. Hospitals, physicians and other health care providers agree to participate in the program and to provide services to those that are enrolled at a reduced rate. Those enrolled in the program are only covered when they utilize the services of the local health care providers who have agreed to participate. Any health care services received from providers not participating in the plan are not covered. Enrollment is employer based and a median wage for employees is required for eligibility.

Complete descriptions of these options as presented during the employer and employee focus groups are provided as attachments to this report.

During the employer's focus group, the multi-share option was presented first, the discounted provider network second and the limited insurance coverage third. Employees saw the discounted provider network first, the limited insurance coverage second and the multi-share model last.

<u>Reactions to Discounted Provider Network</u>
The discounted provider network had little appeal for either employers or employees, although employers were somewhat more positive than employees. Some employers would consider paying the annual enrollment fee for their employees even tough they do not believe their employees would receive any significant benefit. One employer's reaction was similar to others when he said, "I would pay for it because I want them to know I care, and $120 is not very much. But, I don't think they're getting anything." Employers observed that they have assisted

employees in receiving similar discounts by merely calling the doctor or hospital and asking for it. One employer commented, "You can negotiate with the hospital and physicians. If you say you're paying in cash, you can get a little discount." In responding to this observation, another employer recounted having gotten a 15 percent discount from the hospital when he offered to pay an employee's bill in cash. However, a third employer doubted that such a discount would be provided by pharmacists and felt that the 15 to 25 percent discount offered for prescription drugs would be worth the annual cost of the card. She offered, "This is better than nothing. Certainly, if you have nothing, then just the prescription coverage would help. They could recoup the $120 we initially pay just with the discount with the pharmacy." Others remained unconvinced, with one describing the discounted network as "a band-aid for a hemorrhage" and another requesting "something better."

Employees saw no benefit in the discounted provider network, and no one in the group would consider paying the annual enrollment fee. "I don't think it would help me at all because even at a 10 percent discount for going to the doctor, I would still do the same thing as I'm doing now. I wouldn't go," stated a participated. Another spoke for the whole group when she said, "I say it wouldn't be worth it."

Reactions to Limited Insurance Coverage

While almost all of the employees rejected limited coverage insurance as being viable for them, employers had mixed reactions to this option. One employer's assessment best describes the consensus of the group regarding limited insurance coverage. She said, "This is going to meet a lot of people's needs. It's not my first choice of the options we've seen, but if this were our only choice, I don't think we could turn it down. I think we would offer it." Employers agreed that the limited insurance option is best suited to their single, young, healthy employees with low incomes. "We have a lot of 18, 19, and 20 year olds that do not have any insurance. This is the only thing that I've seen tonight that would truly and genuinely cover a majority of the employees in entry-level positions. To me, $15 a week is something that they could handle," declared one employer. Employers also recognized the constraints of the coverage being offered. One participant observed, "I think this is a one-illness per year type of limitation. It's there to help a little bit, but it's not really much." Other employers quickly eliminated limited insurance coverage as a viable option. One of these employers questioned, "Who is going to pay $40 a week for a possible pay out of $10,000? If something happens, it doesn't take long to get up to $10,000. You'd be better off just putting the money in the bank or taking the risk. I don't see this being any advantage to anybody but the insurance agent." A second noted, "On Plan C, you're getting relatively close to what you're paying for a standard insurance policy, so it would be tough to consider this."

Two of the nine employees indicated that they would consider the limited coverage model, believing it would suit their particular needs. One remarked, "Right now, I don't have anything that covers me and Plan A would work for me. I'm single, and I think I could do $15 a week. Something is better than nothing. If I wind up in the emergency room again, then I'd at least have something to back me up." The other commented, "Plan B looks alright to me, looking at the $10,000 inpatient maximum. I don't anticipated needing anything more than that. If somebody offered that to me, I would probably take it." The remaining seven employees would

not consider purchasing any of the three plans presented in the limited insurance coverage option. Their assessments of this option included:

> "On this prescription drug card, $50 doesn't even come close. It's not really beneficial to me. It would have to be at least $100."
>
> "When I initially looked at it, I thought it would be better than not having anything. But, the more I sit here and think about it; I thought, 'Well, $40 a week is not that much.' But, then I looked at the maximum outpatient per year, and I would be paying more than the maximum outpatient per year for this policy. I think I could put that $40 a week back and have that money in my bank account. Then, I think, 'Why would I need this?'"
>
> "If you went one time, just looking through these numbers, one trip would just about wipe them all out. You'd be through until next year."

Reactions to the Multi-Share Model

Employer and employees, alike, embraced the multi-share concept as their preferred option for expanding health coverage in northwest Georgia even though both have some reservations about the limits of coverage and other issues. In endorsing multi-share they said:

Employer: "My first reaction would be that I would sit down with my employees and say, 'Look, I think I've got a heck of a good deal here and let's look at going with it.' I don't personally see any downside to this."

Employer: "I'm concerned about an employee who has been with me for a long time and doesn't have insurance. It's a good thing that she would have the opportunity to have something like this rather than nothing."

Employer: "This is better than the insurance I have now because I have to meet a deductible."

Employee: "What is so appealing to me is the $20 co-payment. I could afford that. I wouldn't meet a deductible on a health plan. I would know right up front that if I'm not feeling well, or if I needed to get checked out, I only have to pay $20."

Employee: "The no deductible is the kicker. That's what makes it all worth it. It doesn't matter what the premiums are. I mean it does, but the deductible is the thing that makes the biggest difference to me."

Employers and employees identified the geographic limits on coverage to be the biggest drawback to the multi-share option. At least one person in each group has an illness that required treatment by a specialist or hospital in Atlanta or Chattanooga, and their experiences made others consider the consequences of such limited coverage for themselves. Others worried about traveling and being hurt in an accident, resulting in the need for emergency medical treatments that would not be covered. To address these issues, one employer suggested that

multi-share include both catastrophic and accidental insurance policies to supplement the local coverage so that "everybody could make the choice to pay extra to be covered in case they are out of town or in case there is something catastrophic that happens to them."

Although in full support of the multi-share concept, employers questioned the willingness of local health care providers to participate in such a coverage model. One woman was doubtful when she said, "I'm concerned that we may not have enough private doctors who would be willing to opt into this kind of program." Another obstacle to employers offering multi-share coverage, or any insurance, is the threat that some employees currently covered by a spouse's employer might lose their eligibility for that insurance. "My brother-in-law works at Beaulieu and Beaulieu would not cover my sister because she works at the hospital and her employer offers insurance. So, would this force an employee who might have excellent benefits from Shaw or Beaulieu to leave the program and take this," questioned an employer. In addition to the possibility of employees losing their traditional insurance, employers also fretted about incurring the cost of covering them through the multi-share program. One participant in the employer group lamented, "I don't have that cost now, but then all of a sudden I would have that cost."

While employers doubted the willingness of health providers to participate in a multi-share program, the employees do not believe that their own employers would be willing to make a financial contribution toward their coverage. A woman said matter-of-factly, "Well, the first thing is that it requires financial participation by the employer which is why we are all here, because our employers don't offer insurance." Anxious to be able to qualify for coverage, a man asked, "Can this policy not be considered in a way other than a three party? Can it be considered as a two party? If your employer doesn't agree to do this, can it still be considered that you would share it with the part that the government is doing?"

Other suggestions made by employees for improving the multi-share coverage plan included the ability to purchase dental coverage at an additional cost and to include coverage for spouses and families.

Two comments summarize the discussions about multi-share in these focus groups:

Employer: "I think it's a wonderful thing. It would put a big smile on my face."

Employee: "It sounds real good. Sign me up."

Contributions toward Coverage

Having indicated that the multi-share program was their preferred option, employers and employees were asked what financial contribution they could reasonably make toward this coverage.

In order to obtain multi-share coverage, all but one of the participating employers is willing to make a contribution toward coverage for their employees. That employer, who owns a restaurant, believes that the limited insurance coverage option is preferable for his employees and would be willing to contribute toward that coverage for them. Of the other seven, one

employer indicated he would be willing to make a monthly contribution per employee in the amount of $100; two would contribute $90; two others would contribute $60; one would make a $50 contribution and one said $45 per employee would be the most she could afford.

Employees are willing to pay significantly more than there employers for their portion of the multi-share coverage. When asked directly about the maximum they could reasonably contribute monthly, one indicated he would pay as much as $150; two said between $100 and $150; one would pay between $100 and $125; one other said $100; another indicated a willingness to pay between $80 and $100, one said $80, one said between $75 and $80 and the least an employee is able to pay is $75. On average, they would pay an additional $25 to $50 per month for family coverage. For the addition of dental coverage, they would pay between $10 and $25 per month.

Conclusion

These focus groups indicate that the limited insurance coverage and discounted provider network models would have limited appeal for small business owners and their employees. While some employers would be willing to pay the annual enrollment fee for the discounted provider network, they do not feel that their employees would receive significant benefit beyond a reduction in the cost of prescription drugs. On the other hand, employees reject the discounted provider network and see no advantage to enrolling in the program. Limited insurance coverage was seen as an option that would benefit single workers who are young and healthy.

Both groups embraced multi-share coverage as the most viable of the three options presented to them. Employers and employees are willing to seriously consider this coverage and pay their share for participation in the plan. The combined financial contribution that could be expected from employers and employees toward multi-share coverage in northwest Georgia is between $120 and $250 per month.

ATLANTA REGIONAL HEALTH FORUM

Introduction

Two focus groups were conducted to gain insights into options for expanding health coverage to the uninsured in the Atlanta area. Eight small business owners participated in a focus group held on October 18, 2005. Seven employees of these same small businesses participated in the second focus group held on November 3, 2005.

The employers own businesses ranging in size from three to 22 employees, representing a mix of full- and part-time staff. The types of businesses represented include florist and catering, veterinary medicine, commercial and residential lawn care, private dental practice, outsource solutions, residential painting, and consulting.

Both employers and employees were engaged in conversations about their experiences in seeking health coverage and their reactions to three concepts for expanding health coverage in the Atlanta area. The three concepts presented for discussion were:

- *Option 1: Traditional Insurance Coverage model*

- *Option 2: High Deductible Health Plan with a Health Savings Account*
- *Option 3: Multi-Share Model*

Experiences in Seeking Health Coverage

Employers

Only one of these employers had offered health insurance about twenty years ago, as she observed, ". . .before insurance got out of hand, and when you could select your own doctor, and the premiums were somewhat reasonable." The remaining seven participants had all explored providing insurance coverage but had found the cost prohibitive. As one participant, a dentist, said, "I wish I could do it; I have a fairly small practice and just a few loyal employees. At this point, I just can't afford it." One employer's local florist association had attempted to establish group coverage but had been unable to find an agent interested in brokering the coverage for their multi-business group. Another participant has her personal coverage through the national Veterinary Medicine Association but cannot afford the same coverage for her employees. Yet another reported that she had considered converting to an employee leasing business model so that her employees could receive coverage through the leasing company, but the cost would still have been unreasonable in her view.

All of these employers agreed that they would like to provide employee coverage, recognizing that this would help them attract better employees and retain them longer. As one observed, "Anybody who walks in the door is going to want to know if you have a 401K and what your health benefits are." Another reflected, "I lost one of my best employees because she went to where she could get benefits." Premium cost was cited as the primary reason for not being able to provide such coverage. One employer said simply, "Cost is the number one factor." Another added, "If you find something that's affordable, the coverage is poor. It's just terrible."

Other barriers to providing coverage – specifically, insurance "shopping" and plan turnover, along with unpredictable premium hikes due to group health issues – were also at work in these employers' decisions not to provide coverage, as illustrated by their comments:

> "Every year you have to go get another carrier, and another carrier, and another carrier, because they just escalate the rates and it becomes a huge processing issue in changing carriers all the time."

> "The cost is obviously a significant factor, but in addition to that, a lot of small companies are apprehensive that if some of their employees' families have pretty high health problems or issues, then the company might get dinged next year when those premiums increase. So that's part of the reason, our company has been hesitant to offer or subscribe to a health plan. We would rather pay our employees additional dollars a month, but we don't want to offer them health insurance and take it on us."

Employees

Six of the seven employees participating in this research are currently uninsured and have been without coverage from one to seven years. The seventh employee was, at the time of the focus

group, covered under COBRA from previous employment; however, she and a 16-year old son would be joining the ranks of the uninsured when the coverage expires in two months.

Several employees indicated that they had investigated getting insurance coverage, yet most echoed the feelings of the participant who had found the experience "very, very expensive; very, very frustrating." They reported that coverage for themselves would have ranged from approximately $400 to $700 per month and upward. Additionally, a number of these employees recounted having accumulated debts in seeking both routine and emergency medical care. All acknowledged putting off going to the doctor until an emergency arises. One participant stated, "I can't tell you the last time that I've gone to an OB/GYN. A second added, "I've got to go and have a mammogram, but I can't afford it." One frustrated participant, exclaimed, "I don't want to get started on socialized medicine, but I think it's absolutely absurd that this country will allow people to not have medical care if they need it."

At least three of the seven employee participants have considered job changes to secure insurance coverage but have been unsuccessful with that approach. As one participant stated, "I went to another job in a doctor's office for insurance. I took a cut in pay and was driving 38 miles a day. The gas went up and everything, plus it was different. So I just went back to my old job at the florist."

Coverage Options

Both employers and employees were presented three potential options for expanding coverage to the uninsured in the Atlanta area, as described below:

Option 1: Traditional Insurance Coverage

The Traditional Insurance Coverage model, as proposed, would set a monthly premium of $155 and an annual deductible of $2000, wherein beneficiaries could seek routine medical care from a primary care physician at an out-of-pocket co-payment of $40, from a specialist at a co-payment of $50, or through the emergency room at a co-payment of $150, the latter of which would be waived if the emergency visit resulted in a legitimate hospitalization. These co-payments would not go toward meeting the annual deductible; however, this feature would protect plan beneficiaries from paying the full amount for doctors' visits until meeting the deductible, as with traditional plans. When additional services are required above and beyond doctors' visits – such as outpatient tests, hospital admissions, surgery or other procedures – plan beneficiaries would then pay the full cost out-of-pocket until meeting the $2000 annual deductible.

Once the $2000 deductible has been met, a second $2000 co-insurance amount would take effect, wherein beneficiaries would continue with the same out-of-pocket co-payments as described above but would pay only 30% of cost toward additional services until the $2000 co-insurance has been met. Costs for these additional services would be covered at 100% thereafter. Thus, the maximum out-of-pocket cost for the employee would be $4000, in addition to monthly premiums and co-payments.

The plan would also set a separate deductible of $150 for prescription drugs, wherein beneficiaries would pay the full amount until meeting the deductible, then pay $15 or $30 toward

prescriptions thereafter. Plan beneficiaries would be required to seek services within a participating physician network, with no pre-existing condition clauses taking effect.

Option 2: High Deductible Health Plan with a Health Savings Account

This plan model would set a monthly premium of $150 and an annual deductible of $5000, wherein plan beneficiaries would pay 100% of all medical costs up to the deductible with the following exceptions: 1) preventive care services, such as mammograms, colon screenings, would be covered at 100%, and 2) annual physicals would be covered with a nominal co-payment amount of $15. Plan beneficiaries could create a tax-deferred savings account into which they may contribute any amount up to $5000 annually, either individually or as a shared contribution with the employer, and could draw out of this account to pay out-of-pocket medical expenses of any kind. Money deposited in the medical savings account would be rolled over from year-to-year, but could only be used for medical expenses. Plan beneficiaries would be required to seek services within a participating physician network.

Option 3: Multi-Share Model

The Multi-Share Model is not an insurance plan, but rather a coverage model designed after one currently operating in Muskegon, Michigan, which requires financial contributions from the employer and the employee, supplemented by a third portion that is typically tax funding or monies deferred from hospitals that receive indigent care funds. Monthly premiums for the Muskegon plan are $186 with no deductible. Co-payments are $20 for primary care visits, $35 for specialty visits, $50 for urgent care visits and $150 for emergency room visits. Prescription drug co-payments are $7 for generic formulations and 50 percent for non-formulary drugs. Beneficiaries pay 25% for outpatient hospitalization to a maximum of $300 per episode and 25% for inpatient hospitalization to a maximum of $500 per episode.

As with the Michigan model, participation in an Atlanta program would be business-based, and because the plan is tax-subsidized, there would be an income cap on who can qualify, based on an average salary amount for those working in the company. While the plan contains no pre-existing condition clause, beneficiaries with chronic medical conditions would be mandated to participate in a care management program. Services under this option would be provided exclusively by a network of physicians, hospitals and ancillary providers who have agreed to provide care to participating beneficiaries, thus, the network would have inherent geographic restrictions. Services received outside this provider network would not be covered at any level.

Complete descriptions of these options, as presented during the employer and employee focus groups, are provided in Appendix A to this report.

Reactions to Option 1: Traditional Insurance Coverage

Employers

Employers were initially skeptical about this coverage model. While all agreed that the monthly premium amount was attractive and "do-able," they expressed concerns about the deductible and co-insurance amounts, which many described as "steep." One man commented, "From an employer's perspective I like the premium. If I could pay this for my employees, I'd be happy. But if I put myself in their shoes, how would they see this? I don't think they'd be happy

campers. I think this is the paradox we have here." A woman expressed similar sentiments when she said, "An employee would need to put $5000 or $6000 in the bank, if they would – that is the big word, 'If.' I think it's almost to the point that if you pay this much, you hope you would get sick so you'd get some of it back. You'd feel cheated. I really think it's just way, way out of reach."

The concept of a limited provider network was also troublesome to several employers. They noted:

> "The big show-stopper would be the provider network. I guess it's much more of an HMO than a PPO, and we would reject that right out of here."
>
> "From an employer's standpoint, the first thing I looked at was the premium, and I could handle that for three employees. But it has been my experience with HMOs that you have to go to a certain group. I don't
>
> "You know when you get comfortable with a doctor, the first thing they do is change who is in that network. So, you're seeing a doctor that you are comfortable with, and then they change."

Other issues of concern to employers regarding this option included the $150 emergency room co-payment for families with several children and the $40 physician visit co-payment for pregnant women.

Most agreed that coverage with a higher premium and lower deductible would be more appealing for them and their employees. A woman offered, "I would rather see the premiums higher and the deductible less. You're going to have to go for a good many checkups or really be laid up in the hospital to come up with a $4000 deductible." A man concurred when he said, "I agree. I would rather see higher monthly premiums. I think the limit for the deductible should be $1000, maybe $2000."

<u>Employees</u>

Employees were markedly more optimistic about the Traditional Insurance Coverage model than their employers. As with the employer group, participants in the employee group viewed the monthly premium of $155 as attractive and something they could realistically manage. Although most agreed that the annual $4000 out-of-pocket potential expenditure was substantial, they also perceived this as a protective capped amount that would safeguard them against the catastrophic financial burden that can result from a serious or extended health crisis. Several expressed these views in terms of being able to "see light at the end of the tunnel." In addition, most agreed that the co-pay for doctors' visits, while seeming high on a visit-by-visit basis, was likewise financially protective, as demonstrated in these collective observations:

> "I like the monthly premium and having the co-insurance out-of-pocket maximum. Some plans that I've been looking at don't have that; they never pay 100%. You always have to pay 20% to 30%, so if something happened and I did have a hospital stay, I could see the light of day."

"I was thinking the co-pay was a little high, but $155 is great compared to what I've seen."

"The premiums and the prescription drugs and the co-pay are the most appealing. When I go to a regular visit to my doctor, I pay $65. This is $40, so it looks pretty good to me."

"I do like the prescription benefit; I mean, $150 is two prescriptions, depending on what you get. I thought that the deductible was a little high until I got to really thinking about it. Once you go past that $4000, you're pretty much clear sailing."

"It is definitely feasible as far as the monthly payments. The $4000 to me looks good, because if you've been without insurance as long as I have, you want insurance, because if you go to the hospital it could be $100,000."

Only two participants expressed any discomfort with this model. The first participant, a single parent with two children who had had past group coverage with a $15 co-payment and a $25 hospital emergency room co-payment, found the premiums attractive but the out-of-pocket amounts "pricey" in light of her past experience. She stated, "When you're a single parent with two kids, you can't afford to take them to the doctor, let alone get their prescriptions filled. This is expensive to me." The second participant, who found the terms reasonable and liked the $4000 cap on expenses, still expressed some hesitancy stating, "Sometimes your parents tell you that if it glitters it's not always gold, and if it sounds too good to be true then it probably is, but I can't put a finger on it at this moment."

As with the employer group, these employee participants were guarded in their endorsement of the physician/provider network. They would not want to be restricted to a certain facility or a limited physician panel, but given a reasonable amount of choice, they expressed no further reservations.

Reactions to Option 2: High Deductible Health Plan with a Health Savings Account

Employers

Participants in the employer group had mixed reactions to the Medical Savings Account concept. Three participants were in full support of this option; two liked the model but expressed some reservation with regard to gaining employee support; and three preferred the Traditional Insurance Coverage option over this concept.

Those who supported this option cited various reasons: to help the employee more and protect them from devastating costs; to "give something back" to the employee; and to lower their company's tax burden. The following comments explain:

> "I pay $150 a month for just peace of mind. Once I pay the $5000, I know the rest is taken care of. Plus, there's no charge for preventive services, and $15 for preventive care is fine with me."
>
> "Even though there's a large deductible, it's an investment. This is an investment toward their health that is not wasted. A premium is a premium. It just goes whether you use it or not. That's gone. But that $5000 is in an account that can earn some money, and it's tax free. I could talk my employees into it easier once they understood the pretax dollars, because that's so important."
>
> "This is a lot better from an employee's perspective. I think this is a win-win. It would become much easier to attract and retain employees and give something back to them. This is a nest egg, plus if the company puts some money into it, it lowers the company's taxes. Sure, $5000 is a lot of money, but because it's a rollover, plus the amount of coverage, this is real appealing to me."

Participants who preferred the Traditional Insurance Coverage model over this option did so because they liked the idea of the employee being able to receive some coverage after meeting a $2000 annual deductible rather than waiting to meet a $5000 deductible. One employer commented, "I like this plan but I can't see even trying to sell the $5000 deductible to my employees. I am leaning more towards the first plan even though I don't like some of the particulars. Another said, "I probably couldn't talk my people into wanting to lose $1000 by going to the $5000. They're not that interested in savings and tax breaks."

Of interest is that participants in the employer group were intrigued with the savings account concept. They raised a number of logistical questions about ownership and management of the accounts, as well as the tax implications to both themselves and their employees, and they struggled to find ways to combine the benefits of the Traditional Insurance Model; i.e., gaining some coverage with a lower deductible, with the High Deductible Health Plan with a Health Savings Account; i.e., setting aside tax-deferred funds that carry over annually. However, all recognized that the high deductible associated with the savings account option would require a "sell" in order to gain employee support. As one employer stated, "I like this plan, but I could sell the first plan better than the second. Yes, there is a tax advantage, but it would be very difficult to sell."

<u>Employees</u>

In stark contrast, participants in the employee group unilaterally rejected the High Deductible Health Plan with a Health Savings Account based on their perceived inability to accumulate and set aside $5000 to be used exclusively for medical purposes, as demonstrated in this exchange:

Employee A: "I can't save money for a good thing; I know I'm not going to save it for my health."

Employee B: "I was just sitting here thinking, how many women right here have a regular savings account of $5000?"

Employee A: "And for it all to go to health, it just wouldn't work."

Employee B: "The $5000 deductible just blows my mind."

Participants in this group struggled with the perceived value of having such a high deductible amount set aside for catastrophic purposes, yet gaining no immediate benefit. One employee emphatically stated, "It's just not worth it to me. The $5000 deductible just absolutely makes me want to take it and chunk it." A second added, "Even with the tax deferred, the $5000 deductible is not good for me. I have to pay $5000, and I still have to pay $150 a month for the premium."

Although participants indicated they would not turn down this coverage if their employers would be willing to pay the premium, they did not feel that they would receive any benefit as a result of having the coverage. One participant observed, "If they paid the premium and you're putting $150 in your savings, you're still not getting anything on a visit, on a prescription or anything." Trying to be more optimistic, another said, "If it wasn't costing me any more to have this insurance and I got really sick, then at least I would be covered after $5000. But it wouldn't be my choice." Only one participant saw any benefit to establishing a pre-tax savings account for medical purposes. While she said she was "intrigued" by the prospect, she also acknowledged that it would take her a long time to save $5000.

Reactions to Option 3: A Multi-Share Model

Employers

Most employers viewed the Multi-Share Model as ideal for companies with young, healthy employees making modest salaries. The low premium and immediate coverage nature of this option were most appealing. One female employer noted, "For 90 percent of my employees this would be awesome. Most of them are young people; they don't travel much; they're in the Atlanta area. This would be great. They're in that correct wage area. They would be thrilled to pay $20 to go to the doctor." A male employer agreed, saying, "I think this would be an excellent plan. It offers a good prescription plan; I mean $7 for a prescription is excellent."

Their support was not without reservations and some felt this type of coverage would not be appropriate for their companies due to the geographic limitations of the coverage. One offered, "All my employees travel. They're in Denver today, India tomorrow." A second added, "One thing that I don't like about this is that I constantly send employees to different job sites out of the state, and they are there for weeks at a time. So, this really doesn't work in that context."

Other employers expressed reservations with regard to the median income cap. Not only do these participants see salary extremes within the Atlanta area as a whole, but also fairly sizable variances within companies themselves. As one participant observed, "You know, there are companies that have different levels of employees and different salaries, so that one group might fit into it, if you had a salary cap, and then others may not be able to join this group if you count everybody's salary." Another employer elaborated, "I don't think it would work for me because of the cross-section of employees that I have. I don't think I would qualify; I don't think the median wage would work. I get the impression that this is for people who make modest

incomes, and not that my employees are all wealthy, but I have a small office and I don't think I would make the median."

In light of their concerns, these employers presented a number of observations toward addressing the geographic and income restrictions. Their suggestions included incorporating a type of "travel clause" where one would have extended coverage during planned business travel periods and allowing employees who exceed the income cap to participate by paying a higher monthly premium.

Employees

Participants in the employee group were universally in favor of this coverage option with few reservations, even when questioned about their understanding that they would be responsible for any medical expenses incurred outside the coverage network. Their comments regarding a Multi-Share Model included:

> "It appeals to me. It's much better that the other two."
>
> "The co-pays are great, even the 25 percent for the hospitalization per treatment. I like that."
>
> "This package is accommodating to things unknown and unforeseen."
>
> "It sounds very appealing to me."

The only questions raised were regarding whether the provider population would remain fairly stable and not fluctuate from one contract year to the next, and whether patients participating in this plan would be treated differently by participating health professionals.

COMMUNITY HEALTH WORKS (SEVEN MIDDLE GEORGIA COUNTIES)

Introduction

Two focus groups were conducted to gain insights into the viability of implementing a multi-share model for expanding health coverage to the uninsured in central Georgia. Ten small business owners participated in a focus group held on March 29, 2005. Nine of their employees participated in the second focus group held on April 12, 2005. Their businesses are located in Houston, Bibb, Monroe, and Peach counties.

The employers own businesses ranging in size from two to eighteen full-time employees that include retail, health care, service, agriculture and construction companies. None of these employers has ever offered health insurance to their employees, although all but one have health insurance themselves.

Both employers and employees were engaged in conversations about their experiences in seeking health coverage and their reactions to the concept of a multi-share model of health coverage.

Experiences in Seeking Health Coverage

Employers

Although these business owners do not offer health insurance to their employees, most have some employees who do have health insurance, primarily provided through a spouse. However, all but one indicated that they had one or more employees who do not have any form of health coverage. Regardless of the coverage of their current employees, all would like to be able to offer health insurance to those who work for them. Some feel a sense of obligation to their employees, like the man that said, "I really need to give these guys insurance. They deserve it." A second echoed this sentiment when he said, "I grew up there and my grandfather grew up there. Some of these people's families have been with my family for years. It's a close operation, and I would like to be able to offer it to them." All see a direct benefit to their businesses in being able to provide health insurance, as indicated by their many comments:

> "I would like to be able to offer insurance to my employees because I think I could attract better quality employees with health insurance."
>
> "Employee retention would be greatly enhanced with the insurance, as well as the quality of the employees. They would be more loyal to the company."
>
> "My little company is growing. It started out with me and one guy. Now, we have seven employees that are growing into career track jobs. As they mature in the field and have families and kids, it becomes more important for me to provide it. It's going to be a retention problem at some point."
>
> "I'm competing with the bigger companies. For someone to leave those big companies, you have to offer insurance. I don't have anything to offer them."
>
> "It seems to be the number one question when you are interviewing future employees, 'What kind of benefits can you offer me?'"

Almost all have made multiple unsuccessful attempts to find health insurance for their companies. A frustrated owner complained, "Over the eight years we have been in business, I've looked at probably ten different programs. It makes me mad every single time, because what it costs is just ridiculous." Another said, "I've looked numerous times. I have looked and looked at price, and I just gave up." As these comments indicate, the cost of health insurance is the over riding factor that prevents these small business owners from providing coverage for their employees. One woman said, with exasperation, "We have never provided insurance because it is cost prohibitive."

Another, but far less significant barrier, to providing health insurance to employees is the percent participation requirement set by insurance companies. Because these are small businesses with few employees, if one or two are covered through a spouse, it is often difficult to reach the necessary enrollment in the insurance plan. An employer remarked, "It's a problem when some in the office have insurance in another place, then it's difficult to get insurance for those that don't have it."

Employees

Six of the nine employees who attended the focus group, all under the age of 40, do not have health insurance coverage. One woman in her late 50's has a catastrophic health plan with a $5000 deductible and pays $350 a month for that coverage. The other two, both in their mid 40's, have individual coverage that they pay for out of pocket at a cost of over $600 per month. Those who have chosen to purchase insurance for themselves do so because of health issues and fear of losing their assets should they have a serious illness. An insured woman offered, "We're the third generation in our house that is 100 years old. We never want to lose the house, so we made a decision that we don't want to have to go bankrupt because of medical bills. So, we give up a lot of stuff for the insurance."

Three of the six who are currently uninsured have had health insurance in the past, and three have never been insured. Like their employers, most have tried unsuccessfully to purchase their own coverage but cite the cost of care as the primary barrier in obtaining insurance, as illustrated by this exchange between three participants:

Man: "I just didn't have the money that they wanted for a monthly premium, and the coverage didn't sound that great. The least expensive thing they had was too expensive."

First Woman: "The prices are just unbelievable for what they want to give you; and with the money that I make, it's just not possible."

Second Woman: "Depending on what kind of coverage you're looking for, you're looking at $300 plus a month. That's almost a whole paycheck for me. There's no way that I could live just to have insurance."

Like employers, employees see negative consequences of not having insurance. They describe putting off going to the doctor, forgoing primary care, worrying about what will happened to them should they get sick, and then accumulating large debts when they do. One woman told of having a $5000 debt as a result of having surgery while uninsured. Another young woman worried that the same thing would happen to her. She fretted, "Everybody in the family has cancer. You just think, 'What if that happens to me? How am I going to pay for it?' Just take me out back and shoot me because I can't afford it." When asked if he received annual physicals and other preventive services, one man replied, "No, I haven't done any of that. If there's anything there, I guess I'll just die." Still others fear that they will be forced to give up their jobs should they become seriously in order to obtain needed health services. One woman related this story to the others in the group:

> "The guys that I work with that are uninsured have to quit work to get taken care of if they have serious illness. We have had three that had cancer, and they just can't work with that. They just stopped working so that they could qualify for something. That's the only way they could get treatment. It's so bad."

Reactions to the Multi-Share Concept of Health Coverage

Both employers and employees had guarded first reactions to the multi-share model of coverage. Their initial responses tended to focus on what would not be offered to them through this type of coverage rather than what would be made available. They commented:

Employer: "Are you saying if we're traveling and we have a car accident, then we would not be covered?"

Employer: "What happens if you have to be transferred to another hospital? Say you have to have a heart transplant. That's not going to happen down here. You're going to have to go to Emory or St. Joseph's."

Employer: "Does it control who you have the opportunity to go see?"

Employee: "Well, if you had an accident somewhere beside here, you would be SOL."

Employee: "I would be unhappy about giving up my preferred provider if she didn't choose to participate."

Employee: "If something is going to happen when you're on the road, what good does it do you to have it if you can't use it?"

After some discussion, however, employers and employees concluded that most often they would be within the covered region when they needed health services. An employer reasoned, "Most of the time if your employees get sick, they're going to be treated locally." An employee followed the same logic when she said, "I stay home most of the time, so I'm thinking this is where I would be the majority of the time."

However that did not dissuade many of the employees of their reservations about the multi-share approach, as can be seen by these comments:

> "If they could come up with something better, even if you had to pay a little bit more, I would rather have it."
>
> "I would consider it, but I would also be willing to pay more for something that would cover you wherever you go."
>
> "That wouldn't stop me from getting it, but I would pay a little more so that I could have coverage no matter where I went."

After some discussion, almost all of the employers and employees who attended the two focus groups came to the conclusion that a multi-share type of coverage would be "better than having nothing." However, their acceptance comes in the form of a trade off between coverage and affordable cost. An employee concluded, "I would be willing to get something for less money and take that risk." Similarly, an employer commented, "I think it comes down to whether the

cost would offset the risk that you are taking." One employee illustrated the sentiments of employers and employees alike when she said, "It would have to be awfully cost efficient."

Defining Parameters for Multi-Share Coverage

Employers and employees agree that limits on covered services are necessary to keep the cost of coverage affordable. However, both groups identified basic services that must be included in any acceptable plan. These services include:

- Outpatient doctor visits for routine and chronic illnesses
- Outpatient laboratory tests, x-rays, etc
- Hospitalizations
- Preventive care – annual physicals, immunizations, screenings
- Prescription drugs with requirements for generic when available
- Emergency room visits, with restrictions
- Rehabilitation services
- Mental health services, with restrictions

Employers could not agree among themselves on the inclusion of dental, vision or chiropractic care, but they would include ambulance services, home health, and hospice care as necessary basic services. An employer said, "I would probably not include dental, vision and organ transplants on a Volkswagen budget. All of us want to do this, but it's still a matter of money. I think you really need to cover the basics." Employees are willing to forego ambulance services, home health, chiropractic and hospice in order to cover dental and vision care, which they consider to be of more immediate need to them. A male employee commented, "I don't agree with some of the other stuff on here like hospice, but I think vision care is good. There's a lot of use for it. You've only got one pair of eyes. If you lose them, you walk around blind. And your teeth, everybody wants nice teeth." A female in the group responded, "You're thinking more for the now than you are later on. I kind of agree with you. I'm 30. I won't need hospice for another 30 years at least, if not longer than that." The only service that both employers and employees agreed should be excluded is organ transplants.

Employers and employees disagreed on how to include those with pre-existing conditions in the plan. Employers believe unquestionably that those with pre-existing conditions should be included without penalty. While employees agree that those with pre-existing conditions should be covered by the plan, they are more willing to place restrictions on them in order to keep costs down. One female employee suggested a twelve month waiting period, and a male employee wants those with pre-existing conditions to pay more for their coverage.

Employers do not think there should be a deductible included in the plan but want those who are covered to make co-payments when accessing health services. More focused on keeping their monthly payments as low as possible, employees are willing to pay both deductibles and co-payments, as demonstrated by the employee who said, "If it would make insurance more affordable for all of us, I could go for both deductibles and co-pays."

Employers and employees are also in disagreement regarding mandatory disease management for those with chronic diseases. Employers see disease management as a good process for

managing the cost of the plan. However, employees are united in their opposition to mandatory disease management. One man explained his view by saying, "I think that if you have a disease, and you don't want to follow the registry, it's pretty much up to you. I don't know why it would take anybody checking on you to make sure you're doing it."

Both employers and employees are satisfied with the geographic area to be covered by the plan that includes Houston, Bibb, Jones, Twiggs, Monroe and Crawford counties. They also concur that there should be an income limit for those qualifying for the plan. Employees want family size to be a consideration in setting the limit but had few other comments about an income cap. On the other hand, employers were much more engaged in discussing how the income limit should be set, expressing anxiety that an employer's salary could disqualify the rest of the company from being eligible for inclusion in the plan. One employer voiced the concerns of others in the group. He said, "I would be in favor of a cap, if a cap was reasonable. Now what is reasonable is different to everybody. It needs to be inclusive and not overly exclusive. If it was only for folks who make $15,000 or below, then that is not going to serve any of our purposes. So, the cap has to be reasonable."

Although, business owners want assurances that they will be eligible to qualify for the plan, they also do not want their participation to be required. Some are unwilling to give up the insurance they currently have in order to provide this type of coverage for their employees. They also question whether or not employees who currently have traditional insurance coverage would be interested in participating, leading them to suggest that mandatory participation levels would not be feasible for their small businesses. Their skepticism was confirmed in the employee focus group by two of the three covered participants who conveyed reluctance to give up their traditional insurance despite the high cost they are currently paying. One said, "I'm afraid it would run out after the pilot. What is the forecast for this being a permanent program? I'm not concerned about right now. I'm concerned about ten years from now, when I still have to work but can't afford Blue Cross Blue Shield."

Employers and employees alike are apprehensive about accessibility to providers. In order for them to participate in the plan, both want access to a doctor of their choice but will accept some limits on that choice. An employer asserted, "I want to be able to chose who I want, not somebody telling me that I have to go to so-and-so. I can't stand that." Employees concur and especially do not want to be required to see doctors at clinics. A woman articulated this view when she said, "I would be glad to have the program, but I don't want to go to the Medical Center's free clinic and have to wait in line."

Employees indicated a preference for having a non-profit be the administrator of the plan rather than an insurance company or local health system. One participant suggested that an insurance company would make her nervous because "they would start limiting things."

Employers do not want to pay additional taxes to support a multi-share plan in their community but are in favor of current tax dollars being reallocated for this purpose. However, they would consider a local option sales tax but do not believe others in the community would pass such a measure.

Contributions toward Multi-Share Coverage
If presented with a multi-share program that met the parameters discussed, both employees and employers concluded that they would participate in the plan, if it were affordable to them.

In order to obtain this type of coverage for their employees, all but one employer is willing to make a contribution toward coverage for their full-time, permanent employees. Four employers indicated they would be willing to make a monthly contribution per employee in the amount of $100; one would contribute $75; and four said $50 per employee would be the most they could afford.

Prior to being asked about the exact amount they would be willing to pay for multi-share coverage, employees were led in a discussion to identify their perceptions of affordable coverage. The six uninsured participants responded similarly, citing payments equivalent to their monthly phone, cable, and utility bills as being their gauge for what they would be willing to pay for health insurance. The three employees with insurance were willing to make monthly payments for health insurance more in line with a car payment. When asked directly about the maximum they would contribute monthly toward coverage in a multi-share model, three said $50, one said $75, four said $100, and one said $250. On average, they would pay an additional $50 to $75 per month for family coverage.

Conclusion
These focus groups suggest that small business owners and their employees may have an initial reluctance to embrace the concept of a multi-share coverage model in central Georgia. However, when given the opportunity to explore the concept, they conclude that local coverage is better than no coverage at all. Ultimately, they are willing to seriously consider this coverage as long as the cost of the plan offsets their perceived risk of not having traditional health insurance. The combined employer and employee financial contribution that can be expected toward coverage in a multi-share program is between $100 and $200 per month.

Plan Preferences and Contributions toward Coverage

<u>Employers</u>
Participants in the employer group were divided in their plan preferences due to the nature of their individual businesses and their employee composition. Each plan was preferred by some employers and rejected by others, indicating that multiple approaches, rather than a single plan, will be required to meet the needs of the variety of small business employers in this large and diverse geographic area.

When asked what they could realistically afford to contribute toward any of the three coverage options, employers responded with a range of $150 to $300 per employee per month. Within this range, four participants indicated they could pay $200 to $250, two could only pay a maximum of $200, one could realistically contribute $150 but would consider $200, and one would be willing to contribute $300. One of the four participants in the $200 to $250 category stated that he would do so only in the context of the tax incentive presented by the High Deductible Health Plan with a Health Savings Account option, and without this tax incentive he would be willing to pay only $150.

Employees

Employees were far more consistent in their preferences. All but one employee ranked the Multi-Share Model as their preferred option, followed by Traditional Insurance Coverage and then the High Deductible Health Plan with a Health Savings Account. The one employee who did not rank Multi-Share as her first choice did not believe her company would qualify to participate due to the median income cap. She, therefore, selected the Traditional Insurance Coverage as her first option.

Employees indicated they could afford to pay $120 to $200 per month for individual coverage. Within this range, one participant each would contribute $120, $125, $130 or $200, and three would contribute $175. All of the seven employees participating in this group stated that they would take the coverage offered them if either the Multi-Share Model or the Traditional Insurance Coverage model were put into place.

Conclusion

Throughout these focus groups, employers and employees alike felt the premiums of each plan were very reasonable and affordable, in contrast to the premium costs on the current market, which are considered excessive and out of reach. Likewise, both groups concur that while they understand the need for a provider network, they would want to see a reasonable level of choice in any of the three options offered.

Most of the employers viewed the $2000 deductible and $2000 co-insurance amounts of the Traditional Insurance Coverage model as steep and would prefer a higher premium in exchange for a lower deductible. Several strongly favored the High Deductible Health Plan with a Health Savings Account option which they viewed as being best for their employees and themselves, and saw it as a way to capitalize on tax-deferred benefits and "give something back" to their employees. All believed, however, that this option would require a "sell" to gain employee support. Of interest is that the employees flatly rejected this option, which would seem to confirm that belief as correct.

Of further interest is that the employees did not share the skepticism of employers when considering the Traditional Insurance Coverage model in option one. While they agreed that $4000 is a lot of money, they also recognized that paying $40 for a doctor's visit is less than the full price they pay now while uninsured, and that a capped hospitalization rate, no matter how high, is far better than being held fully responsible for a catastrophic medical bill that could devastate their family finances.

More contrast was seen in discussions about the Multi-Share Model, with employers again being more skeptical largely due to the geographic stipulations that would place employees at risk when outside the Atlanta area, along with uncertain median income restrictions. The employers felt that this option would be suitable for young, healthy employee groups who would not be traveling a great deal. The employees, on the other hand, favored this option unilaterally as providing coverage from the outset. Even when pressed for a response, they did not express concern about not being covered outside the geographic area.

These collective dynamics would indicate that in the complex urban environment presented by the Atlanta area, coupled with the dichotomy of salary ranges that can be present within single companies, several plans may be required to meet the needs of the uninsured in the Atlanta area. Further, the benefits and risks of the plan(s) offered should be clearly communicated to ensure that potential participants will make well-informed choices.

COASTAL MEDICAL ACCESS PROJECT (CAMDEN, GLYNN AND MCINTOSH COUNTIES)

Introduction

Two focus groups were conducted to gain insights into the viability of implementing a multi-share model for expanding health coverage to the uninsured in southeast Georgia. Fourteen small business owners participated in a focus group held on May 16, 2005. Eleven of their employees participated in the second focus group held on May 26, 2005. Their businesses are located in Glynn, Camden, and McIntosh counties.

The employers own businesses ranging in size from zero to thirty full-time employees. Two have only themselves and a partner, and another has only one part-time employee. They include retail, service, restaurant, real estate, construction related companies, and non-profit organizations. None of these employers offers health insurance to their employees, although most have health insurance themselves through a spouse's coverage or private policies. Only three are uninsured, as are their spouses. The number of uninsured employees represented by this group ranges from none to twenty-nine.

Both employers and employees were engaged in conversations about their experiences in seeking health coverage and their reactions to the concept of a multi-share model of health coverage.

Experiences in Seeking Health Coverage

<u>Employers</u>

Although these business owners do not offer health insurance to their employees, most have some employees who do have health insurance, primarily provided through a spouse. However, all but one indicated that they had one or more employees who do not have any form of health coverage. Regardless of the coverage of their current employees, all would like to be able to offer health insurance to those who work for them.

Employers see a direct benefit to their businesses in being able to offer health insurance, such as keeping employees healthier. One employer remarked, "I hate it when I know that people are not going to the doctor who should be going. I mean it's real evident. That's hazardous for them and potentially for me." A second added, "Some of them get sick and they lay out. If they had insurance they could go to the doctor, get fixed and come back to work." Additionally, offering insurance would assist employers in hiring and retaining employees longer. An employer reported, "I could have had a great full-time guy, but he had to go somewhere where he got insurance." Another said, "I've lost a couple that wouldn't stay because I didn't have insurance on them." Small business owners are particularly concerned about employees who are older and those raising families that have been with them for a period of time. They feel these are the

employees who will benefit from and appreciate the opportunity to have health insurance, as reflected by the following comments:

> "I've done better with older employees so it's a shame that it's harder to get them insurance."
>
> "I'm still going to have floating positions all the time, but my more mature ones would really like to have insurance."
>
> "Older, responsible adults are the ones that are really looking forward to getting insurance."
>
> "I have some young ones who have families, and if I had insurance, they'd probably stay."
>
> "I have about six right now that have stayed with me for five or six years. I would love to be able to offer them insurance."

The employers that attended the focus group have experienced many unsuccessful attempts to find health insurance for their employees. Cost of health insurance is the over-riding factor that prevents them from providing coverage. A frustrated owner complained, "I looked at several sources, one through a printer's association, another small business association, and then an independent, and it was just too expensive. It just didn't work." One participant echoed the sentiments of all the other business owners when he simply said, "The cost of the insurance is just too expensive."

However, participants also indicated that they face other barriers in being able to provide insurance for their employees. Several have businesses, such as restaurants and construction companies, with low-wage workers that turn over regularly. Owners of these businesses do not believe their employees appreciate the value of having health insurance, as one explained, "None of them own their homes. They may or may not have cars. They don't have anything to lose. If they get sick, they go to the emergency room. They're not worried about paying the hospital, because there's nothing that they can take from them."

Other owners are deterred by employees that have pre-existing conditions. An employer explained his dilemma, "We have one key employee that we're trying to get insurance for. We promised him that if he would come on board we'd do it. As it turned out, he has a whole laundry list of health problems, and nobody will insure him." The time consumed in administering an insurance program for employees is another obstacle for these business owners. One woman complained about the burden of paperwork, saying, "Everything that's involved in that with the hospitals, with the doctors, with the insurance companies, with the employees, on, and on, and on. I mean it's a lot of paperwork." A man concurred, saying: "It falls on you as a small business owner to manage your own plan, even if you go to a group insurance. My background is in health care before I bought the print shop, and I actually know the lingo, and I have a hard time with it. I don't have time to manage it."

Small business owners also feel that the mandate to provide workers compensation insurance adds to the problem, as this conversation illustrates:

First Man: "I think that another thing some of the employees look at is the fact that they're covered by workmen's comp."

Second Man: "That's what ours do, too. You're overlapping there."

First Man: "So therefore, why should they spend x-amount of dollars buying insurance coverage when they are covered by workmen's comp?"

Second Man: "And it's horrendously expensive."

Third Man: "It seems like the insurance companies have forced people to gamble with their health, because you have to hope that your injury or your illness occurs at work so you can get workers comp – which puts a whole other burden on the owner of the company."

Another obstacle to employers offering health insurance is the threat that some employees currently covered by a spouse's employer might lose their eligibility for that insurance. An owner explained, "There's a little quirk that's happening now. Other companies have figured out that they're paying for the spouses that work at another company. So, now if you offer insurance even though that person doesn't take it because they can get a better deal with their spouse's company, the spouse's company is getting to the point to where they will say, 'Well, you have health insurance, therefore you can't have it through us.'" Another questioned, "Do I offer a lesser amount of coverage, but the spouse can get better coverage through their employer? It's almost like a shell game."

<u>Employees</u>

None of the employees who attended the focus group currently have health insurance coverage. Some have lost coverage fairly recently, but most have been without coverage for six to ten years or all their lives. Like their employers, many have tried unsuccessfully to purchase their own coverage and cite the cost of care as the primary barrier in obtaining insurance. They bemoaned:

> "It is outrageous. I can't afford it."
>
> "I'm a diabetic with high cholesterol. I can't even shop for insurance."
>
> "I looked one day and I got so aggravated, and after that I have never looked for it again. I just pray that I don't get sick."
>
> "It was $400 to $600 a month and I just can't do it."
>
> "You can forget Blue Cross/Blue Shield for folks like us. It's just impossible."

"I haven't actually ever gone to a company or anything like that. With what I make, I really couldn't pay for it."

Like employers, employees see negative consequences of not having insurance. They describe putting off going to the doctor, self-medicating with over-the-counter medications, forgoing primary care, worrying about what will happened to them should they get sick, and then accumulating large debts when they do. One woman noted, "If I can't pay cash for it, I don't get it unless I save the money up for it." Another told of amassing a very large debt as a result of having multiple surgeries while uninsured. She lamented, "I have no credit whatsoever. That say that hospital bills don't matter, but in the long run, they really, really do."

Reactions to the Multi-Share Concept of Health Coverage

Both employers and employees reacted positively to the multi-share model of coverage.
Even understanding that coverage would be limited to local health care providers, they considered the model as a "step in the right direction." They are interested in an opportunity to have any type of coverage for the "every day things" such as strep throat, sinus infections, check-ups, etc. "because right now they don't have anything." They commented:

Employer: "I think it would be helpful. Most of the people that I hire are young people who might have minor things. I think that would be attractive to them to know that they can go somewhere and get some help for a lower cost, but obviously let them know up front that it's not catastrophic."

Employer: "I think that it's more crucial that you are at least giving them some basic care that they deserve. I guess in doing that you are taking some of the burden off of the health care system and the emergency room."

Employer: "It's a step in the right direction. It's obviously not going to be a panacea for everything, but I think it's an intriguing thought."

Employee: "That is the closest thing to insurance. That would help out a lot."

Employee: "It's certainly better than what we have now."

Some employees were initially concerned that a gatekeeper system would force them to consult a primary care physician before seeing a specialist and require them to make two co-pays. "We should have the choice to go straight to that doctor instead of going here to be told to go there. You want to go directly to him, because you know that's where you're going to go in the long run," one woman asserted. On the other hand, employees thought that case management would be beneficial, with one saying: "I think it would be a selling point." Employers were in unanimous agreement with mandated case management, believing such services would help to lower overall health care costs. One employer stated, "I think for a condition like diabetes or any kind of chronic condition, case management is a must."

Employees asked a number of questions about such issues as whether spouses would qualify for coverage, if they would have to pay more if they became seriously ill, if new employees would

be covered, and whether coverage would cease if they quit their job. However, most concluded that "the concept sounds good, it's just the details."

Defining Parameters for Multi-Share Coverage

Employers and employees agree that limits on covered services are necessary to keep the cost of coverage affordable. However, both groups identified basic services that must be included in any acceptable plan. These services include:

- Outpatient doctor visits for routine and chronic illnesses
- Outpatient laboratory tests, x-rays, etc
- Preventive care
- Prescription drugs
- Emergency room visits, with for instances of life and limb
- Hospitalizations
- Home health services, with limit on number of visits
- Mental health services, with restrictions

Citing the possibility of abuse of coverage, employers would exclude ambulance services, hospice, rehabilitation services, and organ transplants, but they would include dental with an emphasis on prevention, vision, and chiropractic care. In expressing his reservations about rehabilitation services, one employer explained, "How long do we have to carry this through once someone has been in the hospital? I mean there has to be a limit to it somewhere, whether it's two months, three months, there has to be a limit to it. I can't afford it, and I don't think anybody in here can afford to just keep carrying somebody month after month after month." A woman agreed, saying, "The bottom line is keeping the costs down."

Employees are willing to forego chiropractic, dental and vision services; they would include hospice and ambulance services for acute emergencies, but they are undecided about organ transplants. As one woman said, "Well basically I think we are looking for catastrophic coverage."

Chiropractic care, included by employers and excluded by employees, elicited much discussion in both groups, as indicated by these comments:

Employer: "To be honest with you, it's a cheaper form than a lot of other care. It's almost preventive in some nature, and I would cover it."

Employer: "I could say possibly with a doctor recommendation. I know they work together sometime."

Employee: "I kind of look at it like a luxury thing."

Employee: "We also have to remember when it comes to the chiropractor that if we've got a back injury or something that is the result of an injury at work, that's coming out of worker's comp and it's not going to come under this."

Both groups agreed that those with pre-existing conditions should be included without penalty but with case management mandatory for those with chronic conditions.

Initially employers wanted no restrictions placed on qualifying for multi-share coverage. "If you can pay, you can play," one woman explained. After some discussion, they acknowledged that an average income limit would be necessary due to the subsidy being provided for the coverage. However, they were not able to decide on what the upper income limit should be.

Contributions toward Multi-Share Coverage

If presented with a multi-share program that met the parameters discussed, both employees and employers concluded that they would participate in the plan, if it were affordable to them. Employers who are currently uninsured were interested in being included in the coverage, while those with current insurance would be unwilling to switch to the multi-share plan for themselves. One woman employer replied, "My husband has great insurance, so the answer is no." Another added, "Because I travel, I would be afraid."

In order to obtain this type of coverage for their employees, all employers would be willing to make a contribution toward coverage for their full-time, permanent employees. Three employers indicated they would be willing to make a monthly contribution per employee in the amount of $100; two would contribute $75; one could contribute $60 – $70; and six said $50 per employee would be the most they could afford. One estimated that he could contribute $25 - $50, while one set the limit at $25. Most employers want spouses to be able to receive coverage also, but would not contribute toward that coverage.

After hearing the discussions of the multi-share program, all but one of the employees indicated that they would participate in such a program. The one who was hesitant said that she preferred to investigate a medical savings account for the immediate future. When asked directly about the maximum they would contribute monthly toward coverage in a multi-share model, one said $60, one said $75, three said $80, and six said $100. On average, they would pay an additional $50 per month for family coverage.

Conclusion

These focus groups suggest that small business owners and their employees want more details, but are overall supportive of the concept of a multi-share coverage model in southeast Georgia. They consider this coverage as a step in the right direction for assuring that working Georgians receive the basic health care they need. The combined employer and employee financial contribution that can be expected toward coverage in a multi-share program is between $85 and $200 per month.

Pilot Planning Grant Activities Fourth Quarter 2005 – Third Quarter 2006

Based on focus group findings, input from community stakeholders, and new information provided by the 2004 Employer Benefits Survey, all of the community pilot sites except Atlanta chose to pursue a three-share model of coverage as successfully implemented in Muskegon Michigan. They have created sub-committees within their planning structures to work on the various design elements that must be decided prior to going live with a coverage product.

The Georgia Governor's Office has pledged its support through its Health and Human Services policy office to consider the inclusion of support for the three-share efforts in any Medicaid waiver or Deficit Reduction Act Plan Amendment that might be considered as part of Medicaid Transformation. Further support has been requested through Congressman Nathan Deal's office. Representative Deal chairs the committee that will consider the Communities Building Access Act introduced in June by Representative Pete Hoekstra of Michigan. The Act would provide direct support to states in the creation of three-share coverage plans.

The communities have used the following questions to guide their work moving forward:

1. How is the option aligned with the Network's mission?
2. What are the costs of the options being considered?
3. What are the benefits of the options being considered? (What is the expected (predicted) community Return on Investment?)
4. What are the required administrative structures (data systems, enrollment, billing, etc.) and how will they be addressed?
5. How will the plan be marketed, and what will that marketing cost?
6. What is the likely take up rate for the option(s) being considered?
7. Is the option sustainable over time?
8. How is the option aligned with national and state activities/priorities/resources?
9. How does the option support local providers?
10. Will those who will be impacted by the option or whose participation is essential for success (i.e. small employers, uninsured workers, providers) support the option as being developed?
11. How will the option being considered affect costs for current providers?
    a. Hospitals
    b. Safety net providers
12. How will the option being considered affect cost and access to care for the *uninsured*?
13. How will the option being considered affect cost and access to care for the *insured* population?
14. How will the option being considered affect the health status of the local population?
15. How should the option be "packaged" in order to be successfully marketed?

Each community created a draft plan of benefits tailored to their individual preferences. The following tables describe each community's benefit plan.

Northwest Georgia Healthcare Partnership

Services		Included?
1.	Doctor/ Health Professional A. Choose any doctor/ health professional OR B. Choice of doctor/health professional is limited	NO YES
2.	Preventive care (prenatal, routine physical exams and screenings, immunizations)	YES – With Limits
3.	Outpatient Laboratory Test and X-rays	YES - Basic
4.	Prescription Drugs A. Unrestricted OR B. Restricted (for example, mandatory generics, when available)	NO YES
5.	Organ Transplants	NO
6.	Dental Care	NO
7.	Vision Care	NO – Unless medically indicated.
8.	Mental Health Treatment	NO
9.	Substance Abuse Treatment (drugs, alcohol, etc.)	NO
10.	Chiropractic Care	NO
11.	Hospital Care A. Routine hospital care for non-terminal illnesses If you choose A, you may add: B. Hospital care for persons with terminal illness. (expected to live no more then 6 months)	YES NO
12.	Long Term Care At home or in a nursing home	NO
13.	Skilled Home Health Care	Leaning NO, but need more info.
14.	Hospice Care	Leaning NO, but need more info.
15.	Other	NO

Community Health Works

Services to be covered

1. **Doctor/ Health Professional**
    - Limited choice
    - Provider network should be adequately broad enough
    - Should include more than just physicians

2. **Preventive Care**
    - Limited options (might involve using safety net providers- GDPH)
    - Options should based on best practices and clinical guidelines
    - Should not include prenatal visits if client is Medicaid eligible
    - Immunization for high risk populations should not be included

3. **Outpatient Lab Tests and X-rays**

    - High cost investigations to meet prequalification (authorization) and clinical guidelines
    - Should guarantee cost efficiency in network's choice of lab/x-ray facility
    - Standardization to prevent inappropriate use

4. **Prescription Drugs**
    - Therapeutic Formulary based approach with the mandatory dispensing of generics when available
    - Use cost sharing mechanisms such as co-payments
    - Should utilize PBM services to gain discounts benefit

5. **Dental Care**
    - Significant limitations on benefit. To cover:
        - Cleanings
        - Fillings
        - Extractions
    - Should set annual maximum benefit

6. **Hospital Care** (nature of benefit undecided)

- *Suggestion A – Routine Hospital care for non- terminal illness is offered with Skilled home health and Hospice Care*
- *Suggestion B – Hospital care would include persons with terminal illnesses and Skilled home health and Hospice Care would not be offered*
    - Limit number of inpatient days
    - Use case rates and not charges in computations
    - Use cost sharing mechanisms

Services to be Covered (Unsure)

1. **Mental Health /Substance abuse treatment** (seen as inextricably linked)
    - To partner with community mental health system already in place
    - Use of case management
    - Should allow for medical management (hospitalization) and counseling
    - Limits on inpatient and outpatient benefit
    - Significant limits with the imposition of a lifetime maximum in cases of substance abuse

2. **Vision Care**
    - Might be just an add on benefit
    - Specialized cases – e.g. Diabetes
    - Significant limitations on benefit
    - To cover only basic eye exams

3. **Therapeutic Care**
    - Chemotherapy
    - Radiotherapy
    - Dialysis
    - Physical, Speech and Occupational Therapy

Services Not to be Covered

- Chiropractic
- Organ Transplant
- Long-term care

Coastal Medical Access Project

Services		Included?
1.	Doctor/ Health Professional B. Choose any doctor/ health professional OR B. Choice of doctor/health professional is limited	 YES
2.	Preventive care (prenatal, routine physical exams and screenings, immunizations)	YES
3.	Outpatient Laboratory Test and X-rays	YES, with pre-authorization for high-cost procedures
4.	Prescription Drugs A. Unrestricted OR B. Restricted (for example, mandatory generics, when available)	 YES
5.	Organ Transplants	NO
6.	Dental Care	NO
7.	Vision Care	NO
8.	Mental Health Treatment	NO
9.	Substance Abuse Treatment (drugs, alcohol, etc.)	NO
10.	Chiropractic Care	NO
11.	Hospital Care B. Routine hospital care for non-terminal illnesses If you choose A, you may add: B. Hospital care for persons with terminal illness. (expected to live no more then 6 months)	YES YES
12.	Long Term Care At home or in a nursing home	NO
13.	Skilled Home Health Care	NO
14.	Hospice Care	NO
15.	Other	

Each community has agreed that mandatory disease management will be an integral piece of the coverage program in order to manage costs and improve health.

In March 2006, the three communities designing three-share programs submitted applications to the Healthcare Georgia Foundation to continue Pilot Planning work beyond the term of the HRSA grant. In June, each community was awarded $145,000 over two years to conduct

actuarial analyses and marketing outreach to further refine their products and to gain additional partnership that might contribute to the third share.

Based on the input from the focus groups, Atlanta chose a different path. The Planning Committee, after reviewing the information, thought that it reflected a "disconnect" between employers and insurers insofar as knowledge and understanding of insurance products already being sold in the market. Further, it appeared from these conversations that the level of "willingness to pay" expressed by employers and employees exceeded the cost of most small business products that were already available in the market.

The Committee discussed the possibility of incorporating consumer education and marketing in the design of the pilot and questioned the need to create a totally new product in light of the findings from the group discussions. In an effort to clarify the perceived lack of awareness about available small business products, the Committee invited brokers and representatives from the Georgia Association of Health Underwriters to weigh in on the matter in the spring of 2006. The brokers confirmed that there were relatively affordable insurance products in the marketplace and explained that most brokers did not view the small business market as a priority, given the relatively small return on the investment of their time.

The Planning Committee, after considering focus group conversations and feedback from brokers, determined that there was no need for the development of another small business health insurance product and recommended that a concerted effort be made to pilot an approach that would link small businesses to products that were already available in the marketplace. The Committee has set about the establishment of a Consortium that will provide oversight for the next phase of work. The Committee considered the Pilot Planning period to be the first of three distinct phases of related work. These are:

Phase I – Pilot Planning
Phase II – Development of Marketing Plan
Phase III - Pilot Implementation

As of August 2006, Consortium members have been identified and The Atlanta Regional Health Forum has applied for private sector funding to assist the group in developing its Marketing Plan over the next six months.

Purpose of the Consortium

- To bridge the gap between health insurers and small businesses (employers and employees) as it relates to the awareness of products presently available. This would include increasing the public understanding of:
    - access;
    - pricing; and
    - language/jargon (e.g. HSAs, deductibles, co-pays etc.)
- Establish a protocol that clearly and simply defines available health insurance products
- Increase the coverage levels of small businesses workers in Atlanta

Functions of Consortium

- Design a new distribution channel
- Design and test educational tools
- Create marketing plan and budget
- Test the vision of Planning Committee
- Impact state level policy
    - underwriting guidelines
    - rules on participation levels
    - waiting period
- Standardize plans that are to be offered to small businesses via the Consortium

Consortium Membership

Skill Sets

- Educational/Marketing expertise
- Project memory
- Insurance Market knowledge
- Underwriting knowledge/experience
- Legal expertise

Personnel - Representation from:

- Independent Brokers
- Planning Committee members
- Georgia Association of Health Underwriters
- National Federation of Independent Businesses
- Dekalb and Fulton Chambers of Commerce
- Georgia Department of Insurance
- Georgia Association of Health Plans

SECTION 5: CONSENSUS BUILDING STRATEGY

Governance Structure

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 continued to work with the project team. This committee was first chaired by Trey Childress, Policy Advisor to Governor Perdue, and then by Abel Ortiz, Governor Perdue's Policy Advisor for Health and Human Services, 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 was charged with the responsibility of helping to guide the remainder of the grant activities in keeping with state budget priorities and providing recommendations to the Governor with respect to strategies for reducing the number of uninsured Georgians. The appointment and functional responsibility of this group remains in effect. The Planning Grant Team continues to brief and solicit input from the original members of the Governor's Action Group.

Consensus was reached in Georgia that any solution adopted, whether public or private, must be:

- Multi-pronged, or part of a broader set of solutions;
- Incremental, or able to be implemented in discrete steps;
- Based on partnerships between public and private entities;
- Financially flexible in the face of changing economies;
- Accountable for preventive care that would generate long term savings; and,
- Based on shared responsibility among individuals, providers, government, and business.

Georgia continues to strategically examine what solutions will make sense for the state and its residents in consideration of the fluid economy. From the beginning of the process, there has been considerable interest in consensus building at the community level.

Consensus Building Strategy

Consensus building activities and the provision of technical assistance to key stakeholder groups included:

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, committed their support to the work of the grant in a 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 was 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 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 into 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.*

September 2004
The State Planning Grant Team embarked on its Pilot Planning Grant effort to create public-private coverage expansion partnerships in Four Georgia Communities: Dalton, Atlanta, Macon, and Brunswick. All but Atlanta chose to design a multi-share coverage program as described in Section 5. The multi-share concept gained greater visibility with the introduction of H.R. 5171, *The Communities Building Access Act* in April 2006 by Congressman Pete Hoekstra and potential future support through introduction of HR 5864, *The Health Partnership Through Creative Federalism Act.*

SECTION 6: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

State-specific data were critical to the decision-making process. The current availability of CPS data are not sufficient to provide the detail necessary to support efforts that are tailored to specific regions. With the state-specific data, we were able to discern that while both north and south rural Georgia have similar rates of uninsured, citizens in north Georgia access public programs less frequently than their southern counterparts – even though they may be eligible for public coverage. The state-specific data also highlighted the relatively high rates of uninsurance in females age 55 to 64 – at that time three times the rate of their male counterparts. Throughout the Pilot Planning Grant process, organizations external to the project team have requested county-specific data on the uninsured to support various efforts.

Qualitative research – particularly the focus group work – provided a level of detail that could not be obtained from the quantitative data. For example, how Georgians view the uninsured and their opinions about how to address coverage for the uninsured could not be derived from the quantitative data.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Although all data collection activities were critical to developing a new depth of understanding about Georgia's uninsured residents, from a purely cost-benefit perspective, the employer benefits survey was perhaps the most effective relative to resources expensed. The employer survey was fielded in-house by the Project Team. The survey was mailed and included two follow-up postcard reminders, one re-mailing, and telephone follow-up. Responses could be returned by U.S. mail, FAX, or through the Internet. Analyses revealed those firms that answered via the Internet were statistically different from the firms that responded by mail or FAX.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

N/A

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

As cited above, the employer benefits survey was mailed and included two follow-up postcard reminders, one re-mailing, and telephone follow-up. For the initial focus group work, the Claritas® PRIZM clustering system ensured that qualitative data were collected from a full

range of socio-economic groups and allowed us to target the employees of firms that specifically did not offer health insurance.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

After data collection was complete, it became clear that end users desired to see the data analyzed along racial and ethnic lines, including undocumented immigrants. This may be taken into consideration should the state re-field surveys in the future.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the state proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The state has not proposed changes to health care programs as a direct result of the HRSA planning effort, but information from the planning effort has directly informed health programs – and economic development programs - throughout state government, and a compilation of the project's findings are regularly consulted by the Governor's Health and Human Services policy office.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Key lessons resulting from the HRSA planning effort concerning the insurance market included:

- *The decline in the reported share of firms offering employer sponsored health insurance for at least some of their workers, combined with the decline in the number of workers eligible and participating in offered coverage, are cause for concern.*
- *Previous research from population surveys has suggested that declines in employer sponsored coverage are primarily attributable to declining take-up rates among workers who are offered coverage. While take-up rates are indeed declining, our research suggests that offer and eligibility losses are equal contributors to the decline in employer sponsored health insurance.*
- *If costs continue to grow at the rate found during this study period, the number of uninsured workers is likely to continue to grow in the future.*
- *Of particular concern is the reported increase in the contributions required for family coverage.*
- *If workers drop family coverage in favor of employee-only coverage or no insurance at all, we will see growing numbers of uninsured Georgians, particularly children.*
- *The burden of paying for the cost of caring for these individuals will fall on tax payers through public insurance programs, on those with coverage or who pay out-of-pocket through higher prices for health care services, and on the uninsured themselves who will forgo or delay needed care.*

Key lessons resulting from the HRSA planning effort concerning the employer community included:

- *Small business owners share a universal concern over escalating health care costs and attribute rising costs to combination of factors.*
- *Small business owners who provide health 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.*
- *While they may philosophically agree that all Georgians should get the health care they need, small business owners believe it is an impractical goal to implement.*
- *The fear of having to pay more business taxes make small business owners reluctant to support any program for expanding coverage for the uninsured.*
- *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.*

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

- *Be clear from the beginning about the type and level of state support that will be provided to the work. Clear understanding from the outset during the Georgia work avoided any unreasonable expectations.*
- *Be as inclusive as possible as to stakeholder input, with a specific emphasis on community-level input.*
- *Engage neutral partners such as a research university that can manage much of the analytic requirements.*

6.9 How did your State's political and economic environment change during the course of your grant?

During the course of the 2004 Pilot Planning Grant, the state's political control continued to evolve toward the Republican Party as the Georgia House created a Republican majority for the first time in many years. Soon after Georgia received its first HRSA State Planning Grant in 2002, the state elected its first Republican Governor in over 100 years. Governor Perdue inherited a state budget deficit of over $600 million. In the past four years, that deficit has been turned into a surplus as a result of an improved economic climate and state budget controls.

6.10 How did your project goals change during the grant period?

N/A

6.11 What will be the next steps of this effort once the grant comes to a close?

Three of the four pilot sites will continue their planning work with funds from the Healthcare Georgia Foundation toward implementation in 2008. The Atlanta group plans to embark on a

partnership among the insurance industry, brokers, and employers to provide the information small business owners need to purchase commercial coverage for their employees. This is based on research that indicated products already existed in the Atlanta market based on what employers and employees were willing to contribute to their own coverage.

The Georgia Health Policy Center has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens. The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing analysis, community-level coverage development, key findings dissemination, and grassroots policy development. The GHPC is currently working to identify funding to support such an ongoing decision-making capacity.

SECTION 7: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

N/A

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

N/A

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

While CPS estimates provide helpful state level information, assistance with estimates at the sub-state level will improve policy formulation within states.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

Ongoing capacity to track the uninsured at a sub-state level, including the changing characteristics of the uninsured might be encouraged. Ongoing tracking of health insurance markets at the sub-state level would also be helpful.

SECTION 8: OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY
(Please provide as many concrete examples as possible)

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership etc.

Data collected through the grant activity will continue to inform decision-making on many levels, and the need for good, state-relevant data is recognized as a priority. Although the state's budgetary environment has improved, much of the currently projected surplus will be used to repay the state's rainy day fund.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

Georgia continues to evaluate a range of options and is particularly interested in options that leverage the private sector. The most feasible direction leverages the private sector.

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

Three of the four pilot sites will continue their planning work with funds from the Healthcare Georgia Foundation toward an implementation in 2008. The Atlanta group plans to embark on a partnership among the insurance industry, brokers, and employers to provide the information small business owners need to purchase commercial coverage for their employees. This is based on research that indicated products already existed in the Atlanta market based on what employers and employees were willing to contribute to their own coverage.

The Georgia Health Policy Center has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens. The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing analysis, community-level coverage development, key findings dissemination, and grassroots policy development. The GHPC is currently working to identify funding to support such an ongoing decision-making capacity.

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

No.

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

N/A

8.6 Concretely, what was the value of the funding data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

State-specific data were critical to the decision-making process. The current availability of CPS data are not sufficient to provide the detail necessary to support efforts that are tailored to particular regions of the state. With the state-specific data, we were able to discern that while both north and south rural Georgia have similar rates of uninsured, it was demonstrated that citizens in north Georgia access public programs less frequently than their southern counterparts – even though they may be eligible for public coverage. The state-specific data also highlighted the relatively high rates of uninsurance in females age 55 to 64 – at that time three times the rate of their male counterparts. Throughout the Pilot Planning Grant process, groups external to the project team have requested county-specific data on the uninsured to support various efforts.

The team, going forward, hopes to secure support to re-field the employer and provider surveys every three years in order to account for changes in observed trends.

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

After data collection was complete, it became clear that end users desired to see the data analyzed along racial and ethnic lines, including undocumented immigrants. This may be taken into consideration should the state re-field the survey in the future.

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

N/A

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

The Governor's Advisory Group may be discontinued, but consultation will still be sought from the Project team by the Governor's Policy Office for Health and Human Services and the Department of Planning and Budget.

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

N/A

8.11 Please comment on how helpful the site visit, availability to talk/email with Academy Health staff, and general technical assistance of Academy Health was to your project?

The ability to consult with Academy Health staff provided insight into useful ideas being considered in other states that might have been helpful to Georgia's work. The site visit brought credibility to the communities as they went back to their work groups and built their coalitions.

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

The SPG grantee meetings were extremely helpful in providing a national context against which the state work was occurring. The Project Team felt as though it were on the cutting edge of important, national policy decisions that might affect work at the state level. The meetings were also an invaluable networking opportunity to study other states' efforts.

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

SHADAC was helpful during the population survey work in consulting with the Project Team on survey question design and response weighting during analysis.

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

N/A

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

N/A

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via:

a. Data collection - e.g. surveys, focus groups, etc.

The Georgia Health Policy Center has designed a five-year plan that will provide Georgia with ongoing decision-making capacity in its efforts to reduce the number of its uninsured citizens. The plan includes sequences of employer surveys, population surveys, and statewide focus groups every three years in addition to ongoing analysis, community-level coverage development, key findings dissemination, and grassroots policy development. The GHPC is currently working to identify funding to support such an ongoing decision-making capacity.

b. Data analysis – e.g. modeling, actuarial analysis

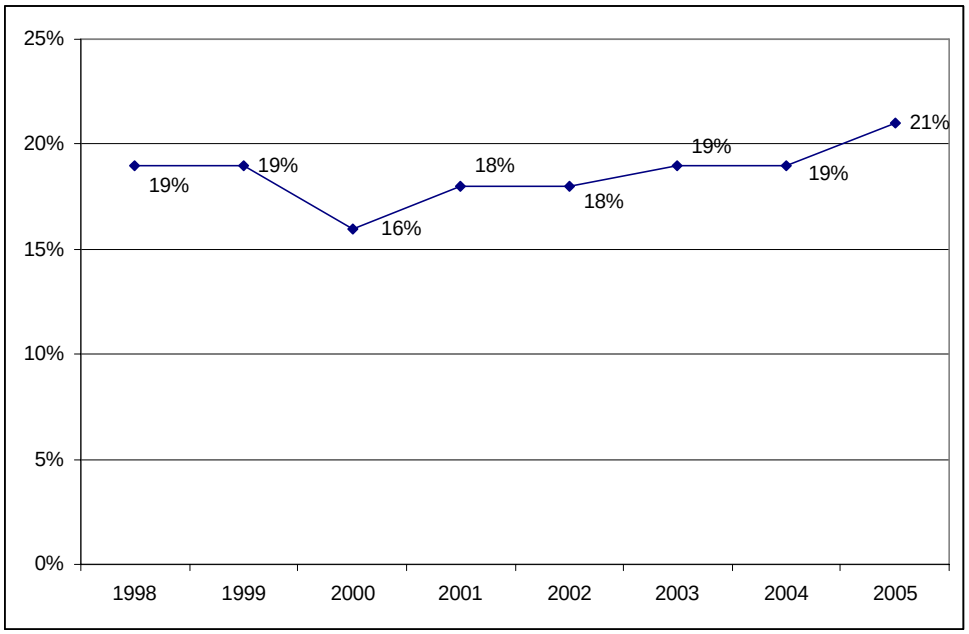
The SPG program has highlighted the analytic capacity of local university resources that are regularly called upon to provide analyses to the Governor's Office and legislative and other study committees.

c. Political understanding/education

The SPG program has fostered relationship building between university-based researchers and members of the Executive and Legislative branches.

APPENDIX I: BASELINE INFORMATION

Population: 8,990,277 total (March 2006 CPS)
Number and percentage of uninsured (current and trend): 1,709,416; 19.0% (March 2006 CPS)



Source: Tabulations of the March 2006 supplement to the Census Bureau's Current Population Survey; Ketsche and Custer, 2006.

Average age of population: 34.3 (Median - 2005 American Community Survey)
Percent of population living in poverty (<100% FPL): 14.4% (2005 American Community Survey)
Primary industries: manufacturing, retail, health care (2002 Economic census)
Number and percent of employers offering coverage: 86,070; 57%
Number and percent of self-insured firms: N/A
Payer mix: N/A
Provider competition: N/a
Insurance market reforms: N/A
Eligibility for existing coverage programs (Medicaid/SCHIP/other):

Medicaid: See http://dch.georgia.gov/00/channel_title/0,2094,31446711_31945377,00.html
SCHIP:

Family Size	1	2	3	4
Monthly Income Level	$1,920	$2,585	$3,252	$3,917
Annual Income Level	$23,030	$31,020	$39,010	$47,000

- For each additional family member, add $668 per month or $8,016 per year.

- Income amounts are based on 235 percent of the Federal Poverty Guidelines as of 2006.
- PeachCare accepts self-declaration of income. However, new and renewing accounts are randomly selected for documentation of income. Eligibility is dependent on the successful completion of this documentation.
- State employees are not eligible for PeachCare for Kids due to federal restrictions established for the State Children's Health Insurance Program (SCHIP).

Use of Federal waivers:
See http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

All research findings may be found at:

http://www2.gsu.edu/~wwwghp/coveragepublications.htm

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

Option considered	Target Population	Estimated Number of People Served	Status of approval	Status of implementation	If implemented, most recent estimate within the federal fiscal year (Oct.1 – Sept 30) of number people served.
1. Three-share program in three Georgia communities	Low-wage workers in small businesses	Not yet operational	N/A	All communities are in first year of implementation: performing actuarial and marketing analyses	N/A