

Georgia State Planning Grant for the Uninsured

Interim 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 Georgia State Planning Grant (SPG), awarded by the Health Services Resources Administration of the U.S. Department of Health and Human Services in the 3rd round of funding to the Governor's Office in July of 2002, was awarded to provide the State of Georgia with the resources to collect the information necessary to plan to substantially reduce or eliminate the number of uninsured in Georgia by increasing geographic and financial access to healthcare.

Georgia has the 11th highest rate of medically uninsured and the 6th highest number of uninsured in the nation with over 1 million Georgians today without any type of health insurance, two-thirds of whom are chronically uninsured. Each year, 1.3 million Georgians are uninsured for 1 month or more and many more of the 8 million citizens of Georgia worry about losing their health insurance. And, the uninsured in Georgia are sicker, less likely to receive routine preventive care such as a cancer screenings, more likely than the insured to utilize expensive emergency rooms, and more likely than those with health insurance to miss work or school, affecting the State's economy and educational system.

During the first twelve months of the SPG process Georgia underwent a change in administration and a plan of action on the uninsured problem had not yet been adopted. However, the data collection supported by the SPG funds has afforded insight into who is uninsured and why in Georgia, what state, federal, local and private options exist for reducing the number of uninsured individuals, and offered the opportunity for dialogue about the role state government should play in implementing those options. If, as a state, Georgia does pursue solutions, it is clear that the complex nature of the problem means that its elimination will require leadership from many sectors acting on multiple solutions over time.

The Role of Data in the Planning Process

The allocation of first year SPG funds heavily emphasized the collection of data to inform the planning process. As a result, Georgia had a unique and important opportunity to simultaneously collect data from multiple sources to look comprehensively at the availability of health insurance, employee health benefits, Georgian's attitudes and opinions on the accessibility and affordability of health insurance and health care, and the attitudes and opinions of key Georgia decision-makers.

Specifically, new data was collected simultaneously through:

1) A Survey of Georgia Households

A random digit dial telephone survey of Georgia households was conducted to provide an accurate estimate of the number of uninsured in Georgia by location, income, and the characteristics of the population that vary with insurance status. The survey gathered information about health insurance status, access to health insurance, type of coverage, health status and access to care, use of services and demographic characteristics of respondents.

2) A Survey of Georgia's Employers

A health benefits survey of randomly selected business establishments in Georgia gathered information about the characteristics of their establishment work force and the benefits available to employees. The sample was designed to be geographically representative of all firm sizes.

3) Focus Groups on Access to Healthcare with Georgia Residents

Using a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System, Georgia Health Decisions, a non-profit health research institution, conducted focus groups to measure Georgian's attitudes and opinions regarding the development of plans to provide access to affordable insurance coverage or to affordable healthcare for all Georgians.

4) Focus Groups with Georgia's Small Employers

In order to assess employer attitudes on health insurance, focus groups with Georgia's independent small employers having between 2 and 50 employees were conducted in, and the small employers recruited from, five geographically separate and economically distinct counties in Georgia.

5) Interviews with Georgia's Key Decision Makers

Interviews were conducted to understand the attitudes and opinions of key leadership in Georgia about health insurance, the uninsured, and access to care. Individuals interviewed were selected based on current position, prior experience, and influence on healthcare related decisions in Georgia and represented the following five professional groups: consumers, employment in the executive branch of state government, insurers, legislators, and providers.

6) Community Listening Sessions

Although not intended to be representative of all Georgia communities, discussions with local officials, providers, insurance agents, local state employees, and social services professionals were held in four Georgia communities to better understand the local challenges in addressing the uninsured issue.

7) Assessment of Georgia's Primary Care Safety Net

An assessment of the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia was conducted to identify affordable primary care services available to an undifferentiated patient.

The data collection and analysis 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), the County Business Patterns (CBP), and policy and opinion papers from a variety of sources.

While the data collection process was viewed by some as unnecessary in light of national data available about the uninsured, the process was extremely valuable in identifying areas where ongoing data collection is needed to continue to monitor the insurance status of Georgians, identifying regional variation within Georgia, engaging various state and federal agencies on the problem, and providing policy-makers and leaders a valid and credible source of qualitative and quantitative information on the uninsured.

Consensus Building and Opportunities to Reduce the Number of Uninsured

The data collected was intended to inform a policy-making process; however, because the State Planning Grant was housed in the Governor's Office, formal efforts to build political consensus on addressing the number of uninsured were placed on hold following the November election to allow the Governor and his staff to have the opportunity to direct and shape the process. Although the grant was awarded to facilitate the creation of state-level policy, there was considerable interest on the community and individual level to proceed, allowing other aspects of the consensus building process, including individual meetings with stakeholders, community listening sessions, and providing the media with relevant information, to continue.

While the policy-making and planning process on the uninsured in Georgia is far from complete, among the lessons learned from stakeholders both inside and outside state government are that any solutions 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
- ? Directed at the uninsured or at risk
- ? Financially flexible in the face of changing economies
- ? Account for preventive care that will generate long term savings
- ? Emphasize cost sharing between individuals, providers, government and business

Recommendations to the Federal Government

Because the State of Georgia has not selected final options for expanding coverage to the uninsured, recommendations to the Federal Government request federal assistance in three areas: 1) Goal Identification, 2) Research and Infrastructure, and 3) Direct Support. However, it is expected that when Georgia's Final Report is submitted, it will contain additional recommendations on the need for specific changes in federal law or policy to increase access to coverage for Georgia's uninsured.

SECTION 1. THE PLANNING GRANT PROCESS- YEAR 1

(Questions 5.1-5.4, 6.5- 6.6, 6.9-6.11)

As most people who work on health care access issues know, there is no “magic bullet” available to reduce the number of medically uninsured; increasing insurance coverage will require time, money, and commitment from many different sectors. And, obtaining those resources will continue to require extensive work to bring together individuals with different interests. For the State of Georgia, recent political and financial developments add a degree of complexity to finding responsible and sustainable solutions to the public health, social, and economic access to care crises.

While there remain no other acceptable choices except to continue to seek ways to increase access to health care and health insurance, the State of Georgia found, as has have other states previously using SPG funds, that more time is needed to complete the planning process for such a significant issue. Georgia has also learned that a strong commitment by the State’s leadership must first be established before planning can take place.

During the first year of the Planning Grant, Georgia made or measured significant progress not in more covered lives but in maintaining the dialogue about the need for access to care, a substantial challenge in Georgia’s current budget environment. To complete the initial planning process will take at least an additional 12 months and after that work is completed, it will be necessary to maintain a continuous cycle of planning and evaluation.

While 1 out of 8 people living in Georgia are still without any type of healthcare coverage, one of the worst rates in the nation, qualitative findings show that almost all Georgians have a sophisticated understanding of how the cost of their care relates to the care others access and most Georgians are seeking leaders who will take on the problem in a way that they were not 10 years ago. Slow economic growth and the resulting increased numbers of families and employers that can no longer afford health insurance coverage has shown a spotlight on the current patchwork of health insurance coverage, but also on the fact that as a result of previous investments in healthcare, there are many talented people in Georgia invested in creating positive change.

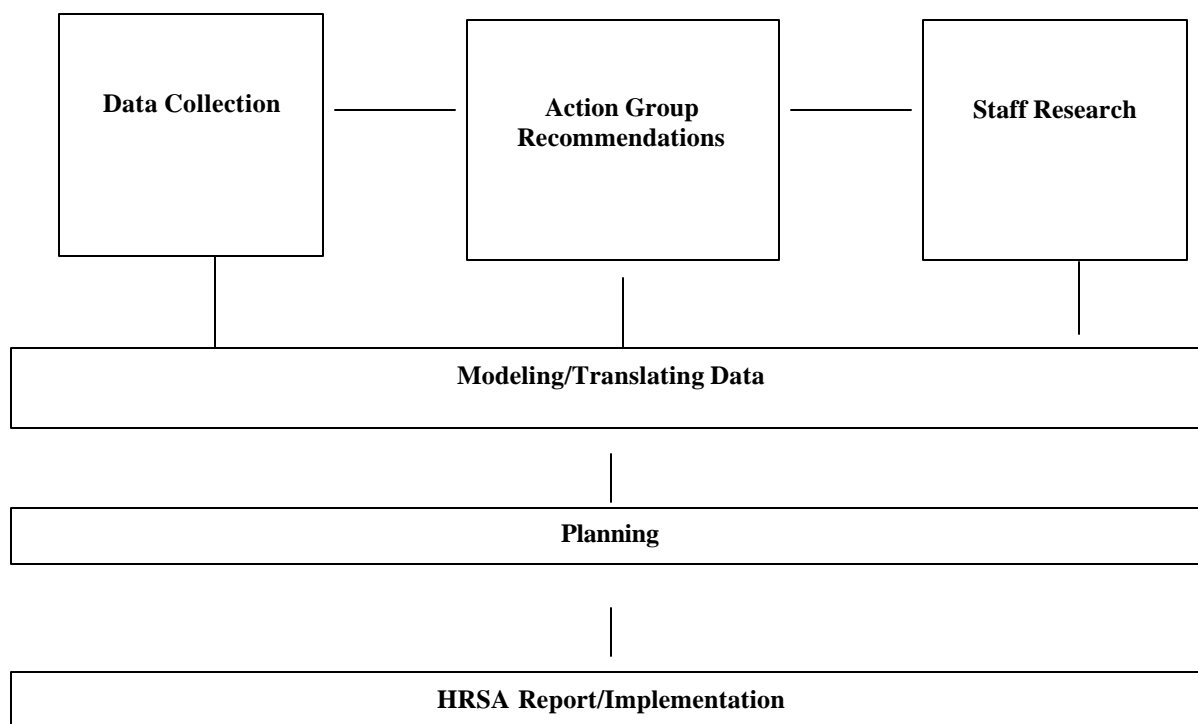
The Planning Grants program provided a unique opportunity for Georgia to take responsibility for creating this change, beginning with the collection of non-partisan, quantitative state-specific information about the scope of the problem and efforts to identify, through qualitative research and consensus building efforts, the characteristics of successful solutions. Essentially, the State Planning Grant funds have offered the State the opportunity to create infrastructure to respond, from a policy perspective, to the changing healthcare marketplace.

Governance Structure

(5.1) To accomplish the extensive planning called for by the SPG funds, the Grant itself had to have a structure that would allow it to work with many entities in the State that would be involved. Originally, this structure was conceptualized as consisting of three parts: 1) the data collection effort, 2) The Governor's Action Group on the Accessibility and Affordability of Health Insurance, and 3) a smaller staff research component that would evaluate prior work in Georgia on the uninsured and current work in other states. These components were intended to result in concepts for solutions that would be incorporated in the econometric modeling, planning and reporting stages of the work.

Policy experts and analysts drawn from state agencies with an interest in the problem of the uninsured were recruited to participate in steering the work of the grant. These included individuals from the Department of Community Health, which administers Georgia's Medicaid and SCHIP programs, the Department of Human Resources, which administers the Georgia Division of Public Health and provides Medicaid and other public program enrollment, the Governor's Office of Planning and Budget, and the Senate Research Office.

Figure 1: Original Governance Structure



In addition, an *Action Group on the Accessibility and Affordability of Insurance* was appointed by Executive Order of former Governor Roy Barnes to provide a venue through which consensus building activities could take place. Members were selected to provide representation by key stakeholder groups, state policy makers and respected academic institutions. Each appointee was assigned to one of three working groups charged with making recommendations concerning

public programs, private sector products, and the gap between public and private coverage. The 27-member panel was chaired by the Consumers' Insurance Advocate with the Commissioner of the Department of Community Health as vice-chair and included individuals from the following entities:

- | | |
|--|---|
| ? Members of the Georgia General Assembly | ? The University of Georgia |
| ? The Georgia Chamber of Commerce | ? Georgia State University |
| ? The Georgia Hospital Association | ? Clark Atlanta University |
| ? The Medical Association of Georgia | ? Morehouse School of Medicine |
| ? The Georgia Nurses' Association | ? Emory University |
| ? The Georgia Association of Health Plans | ? The Georgia Department of Human Resources |
| ? The Georgia Health Underwriters' Association | ? The Georgia Department of Insurance |
| ? Consumer representatives | ? The Georgia Department of Labor |
| ? The Georgia Health Policy Center | |

This structure was in place from the time the Grant was awarded until January of 2003, during which time the funds and process were managed through the Governor's Office of the Consumers' Insurance Advocate under the oversight of the Governor's Policy Director. However, it was considerably impacted by the transition in political leadership when the State elected its first Republican Governor in some 130 years.

In consequence, Governor Barnes' Policy Director, charged with oversight of the Grant, transitioned her responsibilities to Governor Perdue's policy staff. And, soon after his election, in December, Governor-elect Sonny Perdue requested the resignations of all state agency heads. He accepted the resignation of the Consumers' Insurance Advocate, who was also serving as the Chair of the Action Group in March, 2003 and that of the Commissioner of the Department of Community Health, who played a role in the Action Group, on July 1 of this year, effectively drawing to a close efforts by the Grant staff to obtain authorization from Governor Perdue's staff to reconvene or otherwise communicate with the *Action Group*. Although, the Barnes' Executive Order that created the *Action Group* remains in effect and Governor Perdue's staff did consider options to appoint a new group of individuals to a similar committee.

In May of 2003, most of the staff of the Consumers' Insurance Advocate, where the grant was housed, was laid off. In June of 2003, the grant was transferred to the Governor's Office of Planning and Budget. No formal replacement for the *Action Group* has been adopted yet. However, in spite of the challenges associated with formally convening the *Action Group*, informal consensus building activities and research did and does continue and is described more fully in the qualitative findings of this report. The Office of Planning and Budget now plans for the Georgia Health Policy Center to take over almost all of the SPG effort. **(6.10)**

The result has been that the goals of the SPG have been significantly (disrupted), although they have not formally been changed because the SPG staff feels the general goals of the program are not alterable under the terms of the grant award.

Political and Economic Change

(6.9) Even prior to the Grant award, like many other states, Georgia's economy was experiencing strains with which the state has never before had to contend. Georgia is now experiencing record unemployment in key industries including the convention and hospitality trades, telecommunications and technology.

Over the past year, state officials have watched revenue decline continuously. The state's budget deficit for FY 2004 was initially estimated at \$620 million and, although the legislature adopted a "balanced budget" for that fiscal year, ongoing deficits are expected since existing state revenue sources are inadequate to fund major state programs. While Governor Perdue had proposed a slate of new revenue sources, none of these, except for modest increases in the tobacco tax, was approved by the legislature.

Having just emerged from a protracted state legislative session focused on the budget and now beginning a new budget cycle, the Perdue administration has not yet developed a policy regarding access to health care and coverage. A new commission to review the structure, processes and fiscal integrity of state government has been named and may shortly begin to look at healthcare issues. Medicaid cost-containment is expected to be a key focus of that effort, although the exact agenda of that group has not yet been announced. The welfare of children appears to also be a priority of the commission.

Meanwhile, the change in political landscape within the Georgia House and Senate following the November 2002 was equally dramatic. The Georgia Senate became a majority Republican body following that election when four Democratic Senators changed party affiliation. The new majority re-wrote the Rules of the Senate to sharply limit the power of its presiding officer, a Democratic Lieutenant Governor with longstanding interest in health care issues. In the Georgia House, the longest running Speaker in the nation, Thomas B. Murphy, lost his bid for re-election.

These political and financial changes, were historical events that may have set the stage for change in many policy areas, including access to healthcare; they have turned the healthcare focus from incremental increases in access to coverage to fundamental decisions affecting the future of public programs that provide access for millions of Georgians.

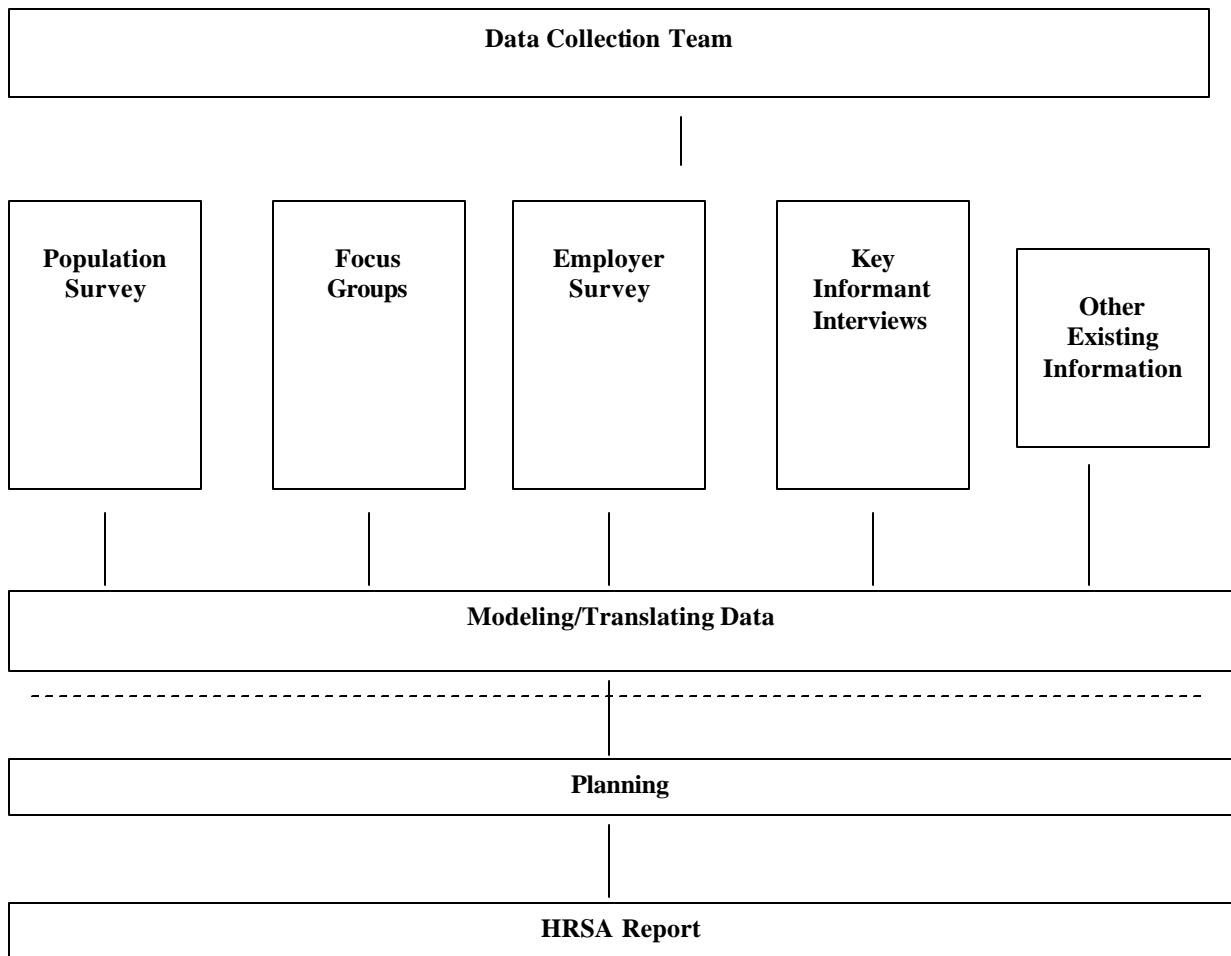
Strategy to Collect Information

These political and economic changes, along with the fact that the Planning Grant award so heavily emphasized data collection, required that the SPG effort in Georgia focus on

informing those with political power on the state and local levels about the scope of the problem and opportunities for change.

The State had never before had the opportunity to compare rates of uninsured and employer sponsored healthcare coverage by region, nor had the state ever had the opportunity to look at self-reported health status by county. To do this, Georgia simultaneously collected data from multiple sources to look comprehensively at the availability of health insurance, employee health benefits information, Georgians' attitudes and opinions on the accessibility and affordability of health insurance and health care, and the attitudes and opinions of key Georgia decision-makers.

Figure 2: The Data Collection Process



The strategy included six data collection activities or methods:

1) Georgia Household Health Insurance Survey

A random digit dial telephone survey of Georgia households was conducted by the University of Minnesota's School of Public Health Survey Research Center between October 2002 and February 2003. The purpose of the survey was to provide an accurate estimate of the number of uninsured in Georgia by location, income, and the characteristics of the population that vary with insurance status. Topics covered in the survey include health insurance status, access to health insurance, type of coverage, health status and access to care, use of services and demographic characteristics of respondents. The design of the survey permitted information about the health insurance status of each individual in the households as well as detailed information collected about a randomly selected target individual in each household.

This is the first broad household survey in the state and the data collection team will require additional research time to fully analyze the results from the survey. Components of the household survey that have yet to be analyzed include but are not limited to:

- ✍ A study of the patterns of coverage within households
- ✍ Analysis of reported levels of cost sharing for those with coverage
- ✍ In depth analysis of the Spanish-language survey within Georgia.
- ✍ A complete analysis of insurance plan characteristics
- ✍ An analysis of the relationship between coverage and health care utilization

2) Georgia Employer Health Benefits Survey

A health benefits survey collecting information from over 1,400 business establishments in Georgia, selected at random based on firm size and location, was performed by Georgia State University between October 2002 and January 2003. The purpose of the survey was to gather information about the characteristics of their establishment work force and the benefits available to employees. The sample for the survey was drawn from the ES202 Firm-level Employment and Address Data, collected by the Georgia Department of Labor, and compiled from the Tax and Wage Report, which is filed quarterly by each Georgia employer covered by unemployment insurance legislation.

3) Georgians on Health Insurance Focus Groups

Between September 2002 and December 2002 twenty-one focus groups were performed by Georgia Health Decisions, a non-profit health research institution to measure Georgian's attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians. The focus groups were conducted using a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System developed by Claritas, Inc., a

recognized marketing company specializing in the identification of neighborhood groupings with similar demographic backgrounds and consumer behavior patterns.

4) Attitudes of Small Georgia Employers on Health Insurance

Between February 2003 and April 2003, five focus groups with Georgia's independent small employers were conducted in the employers' communities. Small employers are those defined as having between two and 50 employees. Because there is no methodology similar to the PRIZM system for employers, the five focus groups were conducted in, and the small employers recruited from, five geographically separate and economically distinct counties in Georgia.

5) Georgia Key Decision Maker Interviews

Interviews with 44 key decision-makers in Georgia were attempted, and 22 were completed, to understand the attitudes and opinions of key leadership in Georgia about health insurance, the uninsured, and access to care. Individuals were selected from the following five professional groups: consumers, employment in the executive branch of state government, insurers, legislators, and providers. Criteria for selection included current position, prior experience, and influence on healthcare related decisions in Georgia.

6) Assessment of Georgia's Primary Care Safety Net

The National Center for Primary Care at Morehouse School of Medicine conducted an assessment of the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia between September 2002 and February 2003. The purpose of the assessment was to identify affordable primary care services available to an undifferentiated patient, rather than isolated categorical programs offering individual services such as mammography or family planning.

Although the analysis of the data is not entirely complete, some of the data is available or being made available to the public (see following sections for a summary of the findings), who are encouraged to request and use the findings for initiatives or education that will help improve access to health insurance. Many requests for small area estimates, or data which reflect a particular local area, from the household survey have been made and filled, particularly for the purpose of applying for funds for Community Health Centers or other federal grants. And, as a result, the grant staff and the Division of Public Health in the Department of Human Resources are working together to make the data available to the public via the internet on that agency's OASIS system. In addition, several requests were made by local entities for detailed technical assistance in finding community-based solutions.

Methods Used to Obtain Input and Build Public Awareness

(5.2) Along with the quantitative research, the planning grant team utilized a range of formal and informal methods to obtain input from the public and key constituency groups. In

addition to the focus group research, which was conducted with the general public, and the key informant interviews, listening sessions were held with community leaders in four Georgia communities and interviews were held with individual stakeholders.

Four listening sessions for community leaders were conducted by Grant staff in localities selected for their geographic and cultural diversity and their relative rankings of aggregate economic strength. Participants were drawn from representatives of the business and economic development communities, healthcare providers, insurers and underwriters, philanthropies, community-based organizations and elected officials. The purpose of the listening sessions was to gauge opinions about the impact of the uninsured at the local level and attitudes about healthcare reform options. (See Section 3 for findings).

Grant staff engaged approximately 20 stakeholders in one-on-one interviews to better identify their key values and concerns about healthcare reform options available to the state. These interviews were helpful in building trust and facilitating on-going collaboration. (See Section 3 for findings).

(5.3) Also, early in the work of the Grant, a web site was created to describe its work, advertise events and post grant findings and reports. Stakeholders enjoy the ease with which the web site allows such sharing of information and documents. However, because the website was designed to reflect the work of the *Action Group* it will have to be redesigned.

Core messages associated with the research findings were made available in two formats—fact sheets produced in an easy-to-read format and supplemented by more detailed reports for those desiring more technical information. Consideration was given to promoting messages that would be understandable to elected officials, key stakeholder groups, researchers and the general public and responsive to their respective areas of concern. Specific activities include:

Public Forums: A series of three public forums were begun contemporaneously with the launch of *Covering the Uninsured Week* to share the findings of research supported by the Grant and to encourage public discussion on these. Each Public Forum was held in an accessible location and was widely advertised directly to stakeholders and legislators as well as the public through the print, radio and television media. The Forums were effective methods of building interest and support for the work of the Grant among stakeholders, legislators and the public. The findings of the Grant, and their implications for Georgia, were the subject of thoughtful reporting in well-circulated media outlets across the state.

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

Fact Sheets: Fact sheets have been distributed at a series of presentations held on research findings, given to Legislators, sent electronically to an extensive mailing list of stakeholders and posted on the Grant website. These include:

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

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

Organizations that participated in interviews or attending the public forums include:

Aetna	Georgia Coalition for Adolescent Pregnancy Prevention
American Diabetes Association	Georgia Department of Labor
Appley Law Firm	Georgia Dept. of Community Affairs
Atlanta Chamber of Commerce	Georgia Dietetic Association
Atlanta Regional Health Forum	Georgia Hospital Association
Blue Cross Blue Shield of Georgia	Georgia House of Representatives
Building Trades	Georgia Insurance Commissioner Office
CARE International	Georgia Medical Care Foundation
ACCG	Georgia Pharmacy Association
Clarke County DFCS	Georgia Primary Health Care Association
Cover the Uninsured Week	Georgia Rural Health Association
Covering Kids and Families	Georgia State University
Employer Relief	Georgians for a Common Sense Health Plan
Families First	Georgians for Healthcare
Family Connection Partnership	GNA
Flex-Corp, Inc.	Grady Hospital
GA Fed. Of Independent Business	GWA
GAHV	GWS
GCDD	Health Access Initiative
Georgia Association for Primary Health Care	Health Students Taking Action Together
Georgia Association of Health Plans	HealthCare Georgia Foundation
Georgia Association of Health Underwriters	Kaiser Permanente
	Love, Douglas & Pope

Medical Association of Georgia
Medical College of Georgia
Mercer School of Medicine
NASW
National Federation of Independent
Businesses
National Mental Health Association
Oakhurst Medical Centers
Public Policy Foundation
Right from the Start Medicaid
Schapiro Research Group
Senator Zell Miller's Office

Service Employees Union International
Shepherd Center Advocacy Office
Southern Pan
St. Joseph's Mercy Medical Care Services
Tenet
The Atlanta Regional Health Forum
The Children's Initiative
The Echols Group
United Way of Central Georgia
University of Georgia
Women's Policy Group

Impact of the SPG on the Policy Environment

(5.4) While the dramatic change in Georgia's economic and political backdrop may slow implementation of any policy options, the Grant has provided the State with a model for a new approach to policy development. The ability to gather State specific information and use those data to model policy options will enable such new or old policies to be assessed in a reasoned and possibly slightly less ideological environment than has previously been the case.

It seems certain that in the long run, Georgia will be benefited by the SPG and the resulting opportunities for building capacity to do research and analysis on the uninsured within the State, along with the opportunity to engage with other states and the federal government. Clearly, the grant will also have added significantly to the body of knowledge about Georgia's uninsured that is available to elected and appointed state officials, the academic community, stakeholder groups and community-based organizations and can be expected to guide continuing efforts to address this issue.

While the State's fiscal crisis severely limits the options for expanding access to care, some of the particular areas the SPG helped to identify clear opportunities for State action that will be reflected in the State Plan included:

- ? Funds available to start or expand Federally Qualified Community Health Centers
- ? The Health Policy Center's Networks for Rural Health Initiative
- ? Trade Adjustment Act-related Tax Credits
- ? CMS grants to develop a HIPAA High Risk Pool
- ? Improved Information for those Seeking Coverage

And, there are many additional public and private opportunities for potential action that, while less clear at present, are being developed and will be considered in the next 12 months of the Grant.

New Project Goals & Next Steps

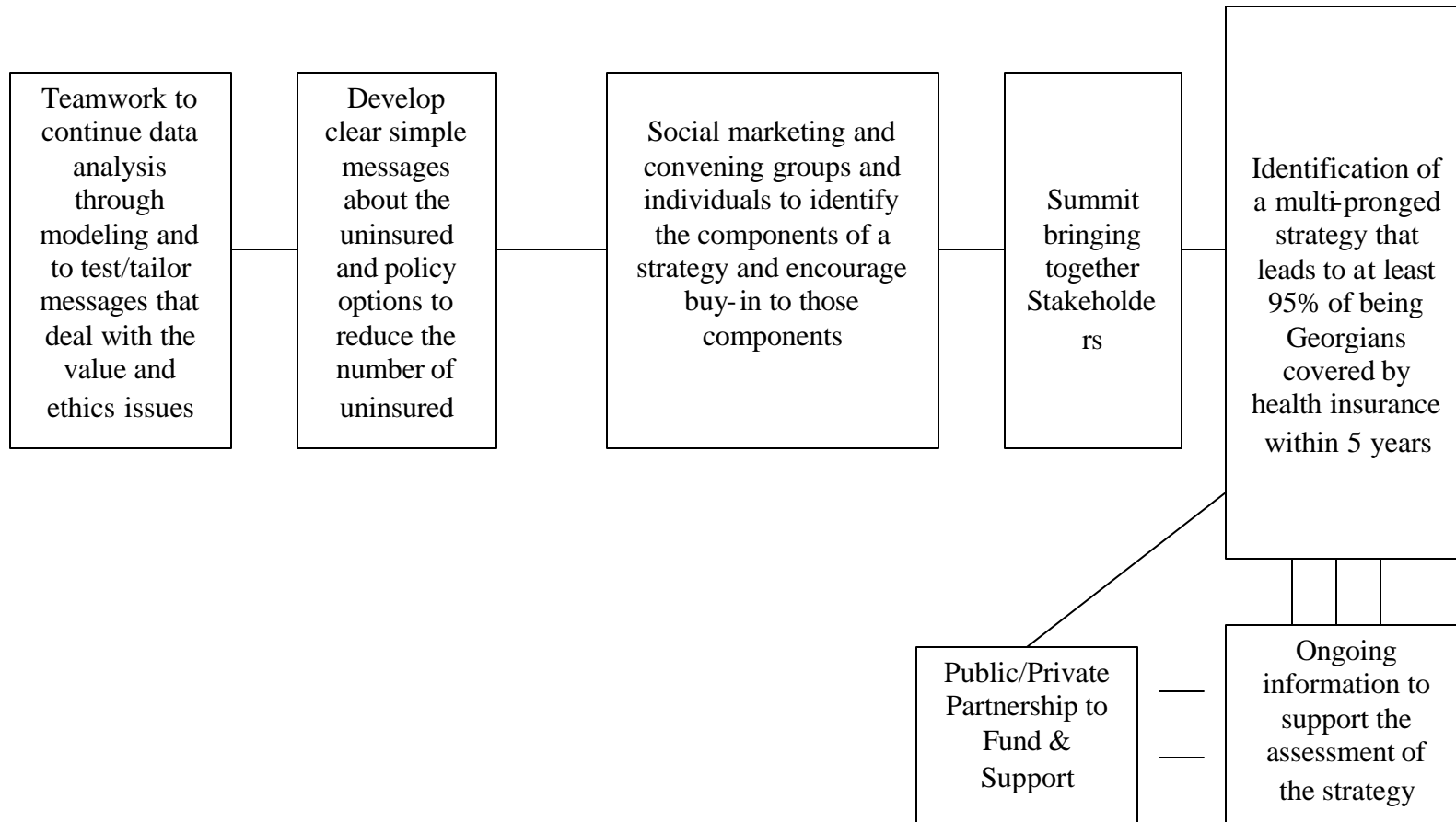
(6.11) Increasing access to health care can seem insurmountable; however, the scope of the problem also means that there are many opportunities to make incremental changes for the better.

To capture these opportunities Georgia has applied for supplemental funds from HRSA to support the second year of the Planning Grant. The new funds and remaining funds from the first year will support three categories of work:

- 1) Completing the quantitative analyses of the data, especially the household survey data and employer survey data, and modeling of coverage initiatives
- 2) Consensus building and education in the form of 12 regional and 1 statewide meetings for stakeholders (no permission has yet been granted by the Governor's Office for State level consensus building and so the effort will focus on combining local efforts), and
- 3) Integration of quantitative analyses and simulation modeling with the output of work by stakeholders in the education and consensus building workshops to create a strategic plan for substantially reducing or eliminating the numbers of uninsured individuals in Georgia. See Figure 2.

(See Application for Supplemental Funds for more details). The greatest challenge facing the SPG and other efforts now is engaging the Governor's Office and those with political authority to develop a cohesive vision concerning access to health care.

Figure 3: Building Public Awareness and Support



SECTION 2. WHO ARE GEORGIA’S UNINSURED INDIVIDUALS AND FAMILIES?

(Questions 1.1-1.3)

Georgia is home to more than 8.3 million people and is the largest state east of the Mississippi River, covering over 157,000 square miles. The state has 159 counties, 529 municipalities, 6 metropolitan areas, and 12 sub-state service delivery regions representing diverse economic and geographic areas of the State. Seventy-eight percent of Georgians are high school graduates, 25% have a bachelor’s degree, and 1.4 million have a disability.¹

The residents of Georgia are younger and more culturally and racially diverse than the nation as a whole; non-Hispanic white individuals make up 62% of population, 28% are black or African American, 7% are foreign born, and 10% speak a language other than English at home.

Table 1: Statewide Population By Age

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

The average age of the population in Georgia is 35.10. The average age varies slightly around the state; the population in Georgia’s metropolitan areas is slightly younger than in the rest of the state. The average age in Atlanta is 34.82, and in all other metropolitan statistical areas are 34.25. In rural areas, the average age is significantly higher, at 36.11 in north rural Georgia and 35.51 in south rural Georgia.

(1.1) About 13% of the population under age 65, or about 1 million people² in Georgia age 64 and younger, are currently uninsured. However, when the 65 and older population is included, the percent without health insurance drops to 12% because Medicare covers 98% of elderly Georgia residents. Sixty eight percent of non-elderly Georgians have employer-sponsored or individual private coverage, and 21% have some type of public coverage, such as Medicaid, Medicare or PeachCare.

¹ Census Quick Facts

² Estimates from the March Supplement to the Current Population Survey (CPS) from 2002, reflecting coverage status for calendar year 2001, are slightly higher than the estimates for the SPG sponsored household survey. The most recent CPS estimate available suggests 1.37 million non-elderly Georgians without coverage during 2001, while the SPG sponsored survey yielded an estimate of 1.01 million currently uncovered Georgians. The differences between the CPS estimates and estimates derived by states using a RDD household survey have been studied by many researchers and have been attributed to differences in survey question design, definition of uninsured, survey administration, and sample selection and size. For a more detailed discussion of the differences please see the July 2001 SHADAC Issue Brief.

Sixteen percent of all Georgians, or 18% of the non-elderly, have experienced a spell of uninsurance during the past year, and about half of them, or 9% of the non-elderly population, lacked coverage for the entire year. Just one third of the currently uninsured Georgians have been covered at some point during the previous 12 months.

The scope of the problem in Georgia is clearly great—the State has the 6th highest number of uninsured and the 11th worst rate of uninsured according to national surveys conducted by the U.S. Census Bureau. And, the many personal and societal impacts of lacking coverage are well documented.³ The question facing the State now is not if there is a problem or how great the problem is, but it is how to reduce the number of Georgians without medical insurance.

(1.2)

Age

There is a relationship between age and insurance status. In Georgia, people of all ages are uninsured; the data show children, young adults, adults, and older adults all may be impacted by lack of access to health insurance. In describing the uninsured in terms of age, it is necessary to look at both the percent of Georgia's total uninsured population made up by each age group to understand how each age group fits into the overall problem, and at the percent within each age group that is uninsured to look at the severity of the problem for that age group.

Table 2: Uninsured Population by Age

Age	Point-in-Time Uninsured Population by Age Group	Percent of Statewide Uninsured Population
Child	144,495	14%
19-24	198,869	19%
25-44	437,534	42%
45-54	131,916	13%
55-64	99,441	9%
65 and older	22,177	2%
TOTAL	1,034,432	99%

Of the State's 1,034,432 uninsured, almost half are between the ages of 25 and 44, in part because 25-44 year olds are the State's largest population group and account just over 2.5 million of the state's 8.5 million residents.

The second largest population group in Georgia, children, make up 14% of the State's uninsured population. This group is more likely to be covered than any other non-elderly group, and just 6% of children are uninsured. This is most likely due to the success of Georgia's S-CHIP program, PeachCare for Kids, without which, the uninsured rate among children would look much like all other non-elderly age groups at about 13%. If all of Georgia's children were

³ See Institute of Medicine access to care reports at www.iom.edu

covered, the percent uninsured in the State would fall from 13% to 10%, significantly improving Georgia's rank among states for covering the population.

Table 3: Types of Uninsurance by Age

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
Statewide	12.1%	7.9%	16.1%
Age of Target			
Child (0-18)	6.2%	3.2%	10.4%
19 to 24	26.5%	16.4%	33.3%
25 to 44	17.1%	12.2%	21.9%
45 to 54	10.7%	7.7%	14.5%
55 to 64	12.8%	7.9%	15.1%
65 and older	2.4%	1.4%	3.4%

After childhood, coverage rates decrease suddenly and then increase with age. Almost one-third of Georgians between the ages of 18 and 24 have experienced some lapse in coverage during the past 12 months and about one quarter of the same age group is uninsured at any given point in time. As compared with those young adults, the percentages of older Georgians between the ages of 55 and 64 who have had either a lapse in coverage in the past twelve months (15%) or are uninsured at any point in time (13%) are substantially lower. However, as is discussed in the next paragraph, some sub-groups of older adults fare better than others.

Sex and Family Composition

Findings about age, however, are complicated by patterns of coverage that are dissimilar between men and women. While men and women are about as likely to be uninsured when all of the age groups are examined together, young men in Georgia are much more likely to be chronically uninsured than their female counterparts. And, women in Georgia, as they get close to retirement age, are significantly more likely to experience a lapse in coverage or to be chronically uninsured than men. In other words, while age is an important factor to consider in targeting expansion options, the options must also account for the different needs and social situations of men and women at different stages of life.

For many women, coverage is linked to the employment status of a spouse. Divorce or early widowhood may leave these women without insurance and without work experience that easily translates into a job with health 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, probably because having two adults in a household offers some couples higher income and greater opportunities to obtain employer sponsored coverage. Those who are single or living with a partner are the most likely to be uninsured.

Table 4: Age and Gender as a Factor in Insurance Status

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
19 to 24 years old			
Men	29%	23%	35%
Women	24%	10%	31%
55 to 64 years old			
Men	6%	5%	10%
Women	18%	10%	20%

Table 5: Sex and Family Composition

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
Sex			
Male	13.0%	9.4%	16.7%
Female	11.2%	6.5%	15.6%
Marital status/own or family head			
Single	20.1%	13.5%	26.2%
Married	8.4%	5.6%	11.7%
Live with Partner	28.0%	20.6%	40.1%
Divorced	14.7%	6.9%	18.5%
Separated	13.3%	6.6%	16.8%
Widowed	9.2%	7.4%	10.4%

Income and Employment Status

Coverage is clearly related to income; the likelihood of being uninsured at any given time, of being uninsured for the whole year, or of experiencing a spell without coverage decreases as income rises. Among those with incomes above 300% of the federal poverty level (FPL), the share of those whose spell without coverage lasts at least a year falls to only one-third when compared to the rate for those with incomes between 201% and 300% and only about one-sixth of the rate among those with incomes less than 100% of the FPL.

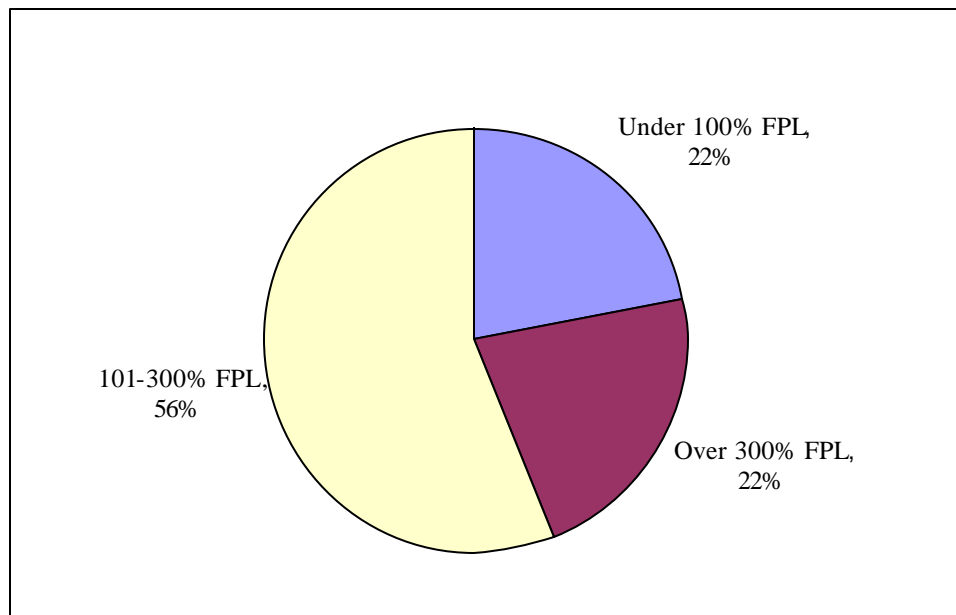
Table 6: Percent of Federal Poverty Level

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
Statewide	12.1%	7.9%	16.1%
Poverty Level			
0 to 100%	24.0%	17.5%	31.5%
101 to 200%	17.4%	11.5%	23.2%
201-300	14.4%	9.7%	17.3%
over 300%	6.0%	3.3%	8.8%

In spite of this relationship between income and coverage, it would be a mistake to interpret this to mean that all uninsured persons in Georgia are low income or all low-income persons are uninsured. Georgians without coverage are still found among the highest income levels. Twenty-two percent, or one-fifth, of the uninsured live in families with incomes at or above three hundred percent of the FPL, or \$55,200 for a family of four per year.

Fifty-six percent of the uninsured have incomes between one hundred percent and three hundred percent of the FPL.

Figure 4: Percentage of Statewide Uninsured Population By Income



About 12.5% of Georgia's population, or 1,071,256 Georgians, are at or below 100% of the FPL. Twenty-two percent of all uninsured Georgians, or about 255,351 people, live in a household under 100% of the FPL, which for a family of four is approximately \$18,400 per year.

All age groups are represented among this poorest group of uninsured.

Table 7: Age of Uninsured Under 100% of FPL

Age	Number of Uninsured Under 100% of FPL	Percent of All Uninsured in Age Group
Child	43,613	30.2%
19-24	47,662	24.0%
25-44	108,342	24.8%
45-54	30,984	23.5%
55-64	24,750	24.9%
65 and older	-	-

Almost 1 out of 3 uninsured children and 1 out of 4 uninsured 19-24 year olds in Georgia live in poverty, however, once again, in terms of sheer numbers; adults represent the largest sub-population of low income uninsured.

However, despite the low incomes of some uninsured Georgians, just 22% of the currently uninsured in Georgia report being previously enrolled in some type of public coverage. Of those who reported being eligible for a public program but declining to enroll, 55% reported they are opposed to public coverage or the stigma attached to public programs. Ninety percent of all the currently uninsured report that they would enroll in a public program if eligible and 95% report they would enroll in a public program if they were eligible and would incur no expense associated with enrollment. In other words, while some Georgians are opposed to public programs, most would enroll in a program if they were eligible, even at their own expense.

Income and employment status are often confused in the health insurance debate; however, many uninsured persons, both low and high income, work, and some work at multiple jobs. Of those 13% of Georgians without health insurance, 68% work or are the dependent of someone who works—over 3 out of 4 uninsured persons. Where these individuals work is also important to their coverage status, a topic which is discussed in more detail in Section 4 of this report.

However, those working fewer than 30 hours per week and their dependents are more than twice as likely as other Georgians to be uninsured, experience a spell without coverage or be chronically uninsured. Among those working or in a family headed by someone working in a permanent position, less than 10% are currently uninsured. However, among those working or in a family headed by those working in non-permanent employment, the uninsurance rate soars to 41% for temporary and 34% for seasonal employment.

While the remaining 32% of the uninsured are either not currently working or are the dependents of someone who is not now working, retirees and students account for 6 of that 32% and other individuals who are not working or not able to work and their dependents account for only 26% of the total uninsured population.

Table 8: Employment Status

Employment status: Own or Family Head	Uninsured Point-In-Time	Uninsured Whole Year	1 Month or More
Self-Employed	23.0%	16.2%	25.3%
Employed	9.4%	5.8%	14.0%
Unpaid Worker	8.2%	5.7%	14.6%
Retired	4.8%	3.4%	6.4%
Unemployed	23.5%	15.9%	28.3%
Student	11.8%	8.6%	15.2%
Hours worked: Own or Family Head			
0 to 10	19.5%	12.6%	20.1%
11 to 20	24.5%	14.5%	31.2%
21 to 30	24.5%	14.3%	32.3%
31 to 40	10.5%	7.0%	15.3%
over 40	7.3%	5.2%	10.9%
Job Type: Own or Family Head			
PERMANENT	9.5%	6.2%	13.5%
TEMPORARY	41.3%	21.2%	54.5%
SEASONAL	33.8%	31.8%	37.5%

Insurance coverage in Georgia is also related to the size of the firm in which an individual works. (See also Section 4). Twenty-five percent of those who work for, or are the dependent of someone who works for, firms with between 2 and 10 employees—and 29% of those in single person firms—are uninsured. Almost 1 out of 3 individuals without coverage are employed by small firms with fewer than 25 employees, or have a primary wage earner working in such a firm.

Table 9: Size of Firm

	Uninsured Point-In-Time	Uninsured Whole Year	1 Month or More
Firm Size: Own or Family Head			
SINGLE PERSON	28.8%	18.2%	32.4%
2 to 10	23.9%	19.0%	27.1%
11 to 24	12.6%	10.4%	20.0%
25 to 50	11.4%	6.5%	18.5%
51 to 100	4.1%	3.1%	11.5%
101 to 500	9.1%	4.9%	12.8%
OVER 500	4.3%	1.9%	8.1%

Race and Ethnicity

Of the 255,351 lowest income uninsured Georgians, 18,000 identify themselves as Hispanic, 119,900 identify themselves as African American or Black, and 5,000 report that they belong to some other minority group.

Table 10: Race and Ethnicity

	Uninsured Point-In-Time	Uninsured Whole Year	Uninsured 1 Month or More
<u>Race /Ethnicity</u>			
White, Non-Hispanic	11.0%	7.7%	13.9%
African American	13.8%	7.9%	19.8%
Hispanic	20.3%	14.7%	28.0%
All other Races	6.7%	3.8%	11.2%
<u>Country of Origin</u>			
US	11.8%	7.9%	15.6%
Europe or Canada	9.1%	5.9%	9.6%
Latin America	31.1%	20.3%	44.9%
Southeast Asia	2.0%		7.9%
All Other	18.4%	7.5%	23.5%

Although the results from the Spanish language survey have yet to be analyzed, we can see from the existing survey data that the likelihood of experiencing a spell of uninsurance is related to race and ethnicity.

African American and especially Hispanic Georgians are more likely than white non-Hispanics to be uninsured at any given time or to experience any spell without coverage. While African American and white non-Hispanic Georgians have similar rates of chronic uninsurance, Hispanics are almost twice as likely as either of these groups to be uninsured for the entire year. Among those respondents who were born in Latin America, the likelihood of being uninsured for a full calendar year is almost three times as high as for Georgians who were born in the United States.

While minorities are more likely than whites to be uninsured, the majority of uninsured in Georgia are white. However, the findings as they related to race and ethnicity, including the fact that the differences hold true at all income levels, do suggest that minorities are not enrolling or being enrolled in public programs and private plans at the same rate non-minorities are enrolling due to cultural or language barriers.

Geography

Rates of insurance coverage vary across the state. A large percent of the population in rural areas, especially south rural Georgia, is uninsured; 17% of Georgians living outside urban areas in the southern half of the state, or 319,388 people, and 16% of north rural Georgians, or 233,517 people, are uninsured as compared with the 11 % uninsured in all urban areas and only 10 %, or 416,456 people, in metropolitan Atlanta, where half the state's population resides. In Macon, 42,048 are uninsured, in Augusta 32,210, Columbus 27,264, Savannah 44,618, and Albany 18,936.

When these statewide variations are considered in terms of the State Service Delivery Regions, Regions 1, 2 and 5 in the northern part of the state, and Region 11 in South Georgia have uninsured rates that are significantly higher than the state mean. The uninsured rate in Region 3, which is comprised largely of the Atlanta metropolitan statistical area, is significantly lower than the state mean.

Table 11: State Service Delivery Region

State Service Delivery Region	Uninsured Point-In-Time	Uninsured Whole Year	1 Month or More
1	14.5%	9.2%	20.3%
2	15.2%	10.4%	19.0%
3	8.3%	5.1%	12.1%
4	10.4%	8.0%	15.4%
5	19.7%	12.6%	23.3%
6	12.0%	8.2%	14.8%
7	12.9%	9.6%	16.2%
8	12.8%	9.6%	17.5%
9	14.1%	10.7%	19.4%
10	13.4%	10.4%	15.9%
11	22.0%	11.6%	27.2%
12	13.9%	8.9%	17.5%

Regions 3 and 4, with the highest rates of coverage in the state, have statistically significantly fewer employees in small firms (25 or less) and Regions 1, 2, 5 and 11, those regions with the highest rates of uninsurance in the state have statistically significantly more employees in small firms when compared to the rest of the state population. Region 11, in particular, has a significantly lower rate of employer sponsored health insurance coverage as compared with the rest of the state, while Regions 1 and 2 have lower rates of enrollment in public programs. And, as previously mentioned, race and age also vary across the state, suggesting that the convergence of a variety of factors contributes to increase numbers of uninsured persons in particular regions.

Health Status

Insurance and health status go hand in hand, with the uninsured reporting poorer health status than the insured. The uninsured in Georgia are more likely to report their health status as fair or

poor (17% vs. 10%) and less likely than all Georgians to report their health status as excellent or very good (52% vs. 63%).

Table 12: Health Status of the Uninsured

	Uninsured Point-In-Time	Uninsured Whole Year	1 Month or More
<u>Health Status</u>			
Excellent	9.6%	6.2%	13.1%
Very Good	10.3%	6.3%	14.1%
Good	14.4%	9.2%	19.1%
Fair	17.5%	13.0%	22.8%
Poor	14.8%	12.4%	19.2%

They are less likely to receive preventive care and more likely to be sicker than the insured. They are almost four times more likely to have not had a routine checkup in the past two years (37% vs. 10%), three times more likely to have never had a routine checkup, and more likely to have missed 6 or more days of work or school in the past year (23% vs. 10%).

The uninsured are also almost half as likely to have seen a doctor in the last 6 months, and more likely to have an emergency room visit in the last 12 months. And, in general, the uninsured in Georgia feel less confident about their ability to obtain healthcare than those with coverage. They are 7.5 times more likely to strongly disagree with a statement that they are able to get the healthcare they need. They are also much less likely to have a usual source of care than the insured population (58% vs. 90%).

Implications

Overall, these data suggest that the uninsured in Georgia are as diverse as the population itself. **(1.3)** While some groups have a greater propensity to be uninsured than others, no group is immune to the risk of losing coverage. This message is important to convey to the public and policy makers as state officials consider the sacrifices that will be necessary to expand coverage to more Georgians.

Statewide, about half of those experiencing a spell without coverage are uninsured for the entire year while the other half are covered for at least part of the year. This ratio holds for most subpopulations studied, although for higher income Georgians spells without coverage are less likely to last for a full year. Solutions for those whose spell without coverage is short may be very different than the solutions that will be viable for the chronically uninsured. One implication of this finding is that more analysis of existing data may help identify the reasons for the episodic gaps in coverage.

While Georgia has made progress in providing coverage to children under PeachCare for Kids, over 6% of Georgia's children remain uninsured. One third of those children reside in families with incomes below the FPL, and over three quarters reside in families with incomes below

200% of the FPL. If all of the children in Georgia with family incomes at levels below 200% of the FPL were enrolled in public programs, fewer than 30,000 children or less than 2% of all children in Georgia would remain uninsured. The transition from childhood to adult status puts Georgians at the highest risk of becoming uninsured. During this period, almost one third of young adults experience at least a spell of uninsurance.

Among adults, as among children, poverty or incomes near poverty are correlated with higher rates of uninsurance. This implies that many uninsured could not purchase a private plan, even if many options for individual purchase were available to them. While expansions of individually purchased coverage might be a viable option for other groups, the poor and near poor are not likely to participate in such plans. On the other hand, 90% of uninsured Georgians would consider participating in public coverage, even if such coverage were contributory in nature.

Adults who work less than full time, at small firms, or temporarily or seasonally are all more likely to be uninsured than those working in permanent, full-time positions for relatively large employers. Nonetheless, most of Georgia's uninsured is in families with a worker. Expanding private coverage to these working Georgians may require collaboration between the private employers and the public sector.

Although it is not possible to determine whether poor health status leads to a lack of coverage or vice versa, it is undeniably true that there is a correlation between being uninsured and assessing one's own health as less than excellent. This implies that, at least for a subpopulation of the uninsured, coverage in the private market may be difficult if not impossible to purchase because of existing health conditions. Expanding coverage to this group may be costly, but current utilization patterns, including higher utilization of hospital emergency rooms, suggests that this group is already imposing a cost on the system. Leaving this group uncovered could result in additional strain on the safety net system in the future, in particular if some of these individuals become sicker over time.

SECTION 3. ATTITUDES AND BELIEFS ABOUT THE UNINSURED IN GEORGIA

(Questions 1.4-1.12, 1.13⁴)

Because improving access to health insurance and health care is in part a matter of public will, understanding the perceptions of a wide range of stakeholders is critical. Given that, three primary data collection methods were used to gather more information about the attitudes and beliefs about the uninsured and the problem of not having health insurance: 1) focus groups with citizens, 2) key informant interviews, and 3) community listening sessions.⁵

The qualitative research undertaken through the SPG was designed to better understand attitudes and beliefs about whether Georgia should move forward in reducing the number of uninsured and, if so, how it should move forward. Unlike other states' focus group research, little information was gained about specific populations or programs (although close analysis of the particular populations or programs will be needed as they relate to solutions), but important themes about solutions were discovered that ran through all of the discussions. Although a few groups did not recognize the problem of the uninsured, the need for leadership and organization, questions about the ability of government to handle the issue, questions of readiness, the overwhelming nature of the problem, and the costs of both fixing and not fixing the problem were all discussed.

Focus Groups with Georgia Residents

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

This effort relied on a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System developed by Claritas, Inc.⁶. The PRIZM System contains 15 Social Groups, each of which contains a population stratum based on degree of urbanization and income level. In Georgia, 10 of the 15 Social Groups each represent 3 percent or more of the total population. While it was determined not to be analytically necessary or financially feasible to sample Social Groups that made up less than 3 percent of the Georgia population, an exception was made to include the Urban Core Social Group, consisting mainly of lower income minorities, due to the possibility that a large number of uninsured Georgians might

⁴ Question 1.13 on the underinsured was not explored in the current research. See Section 8 for support requested from the federal government on this topic.

⁵ Focus groups were also conducted with Georgia's independent small employers, however, because other special interest groups such as providers were not interviewed, the small employer focus groups are reflected in Section 4, where the employer sponsored health insurance market place is described.

⁶ Claritas, Inc. is a recognized marketing company specializing in the identification of neighborhood groupings with similar demographic backgrounds and consumer behavior patterns.

have potentially been included in this Group. Combined, the 11 Social Groups represent 94% of Georgia's population.

The focus groups were conducted in English in the communities identified as meeting the criteria for the Social Group. To ensure validity, two focus groups were conducted for each Social Group in different geographic locations where the PRIZM methodology permitted. The one exception was the Urban Core Social Group, where only one focus group was conducted due to the small size of that population. Participants fitting the description for each Social Group were solicited at random by telephone. Twelve participants per focus group were recruited, with an effort to match the age, race, and gender of the participants to those of the Social Group, and an average of 11 individuals participated in each of the 21 focus groups. Each participant was provided a small stipend and a box meal for their participation. All focus groups were held in the evening hours and all lasted approximately 1.5 hours.

Table 13: Focus Group Participant Demographics

Gender		Total Household Income	
Male	41%	Less than 25,000	24%
Female	59%	26,000-45,000	41%
		46,000-85,000	22%
		Over 85,000	13%
Age		Primary Insurance Coverage	
20-35	27%	Employer Health Insurance	57%
36-55	49%	Individual Health Insurance	6%
Over 55	24%	Medicare	9%
Education		Medicaid	1%
Some High School	6%	Military Health Coverage	11%
High School Diploma	52%	Uninsured	16%
College Degree	42%		

Key Findings

The key findings from the focus groups were:

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

5. Georgians of all income levels feel there is a need for leadership and immediate action to address escalating costs and increasing numbers of uninsured.

Georgians are in total agreement that, for those who can afford it, Americans have access to the highest quality health care in the world; 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 key component to this quality is the availability of the advanced level of technology we enjoy, which offers seemingly limitless opportunity to address medical issues and extend life.

Although recognizing they have made concessions that limit their ability to choose their own doctors, as well as health plans, they place a high priority on the ability to choose their doctors and other health care providers and facilities. They value having ready access to care and not having to wait for long periods for standard procedures or specialty care. Knowing that they are covered for routine health care and catastrophic illnesses provides great peace of mind to those who are insured. And programs, such as Medicare and Medicaid, that provide a safety net for the most vulnerable rank among the positive aspects of the health care system most often mentioned during the focus groups.

But when discussing these attributes, participants also expressed concern that many of the attributes they so highly value are often available to only those who can afford to pay for them. They are troubled about the large and growing number of people who do not have ready access to the highest level of care, namely, Georgia's uninsured.

**What Participants Like About
Health Care:
Quality of Care**

Technology
Ready Access to Care
Choice of Treatment/Health Plan/Physician
Peace of Mind of Insurance
Safety Net Programs

**What Participants Dislike About
Health Care:
Limited Access**

Cost Increases
The Causes of Rising Costs
Managed Care
Cost vs. Benefit of Insurance

If a single issue, however, could drive Georgians' conversations about America's health care system, it would be frustration and alarm over the seemingly unending escalation of health care costs - both of health insurance services and insurance premiums. "Outrageous;" "skyrocketing;" "criminal;" are a few of the words used to describe cost.

Participants attributed the rising cost of health care to many factors, including malpractice lawsuits, development of new technology and the public's demand for it, and paying for care for the indigent and uninsured. However, participants largely see the escalating costs of both health care and insurance premiums as a function of "greed" on the part of insurance companies, drug manufacturers, hospitals, and doctors. Ultimately, Georgians conclude that with costs rising exponentially on one hand, and the ranks of the uninsured increasing on the other, someone must be "getting rich" at their expense.

Georgians also dislike managed care and see it in part as related to the cost issue; they do not like what they perceive as administrative hassles, interference in their relationship with their physicians, and limitations on access to specialists. Participants also perceive that the lower costs they were promised in return for restricted choice and access have not materialized. Within this climate, a disquieting trend emerged with regard to the perceived value of insurance, wherein many Georgians have begun to question the benefit of purchasing insurance coverage due to costs that have reached unacceptable levels. **(1.10)** Aside from individuals with chronic illnesses or children, Georgians of all income levels have started to question the wisdom of having such large portions of their incomes tied up in insurance that they feel is not dependable and ultimately leaves them with additional costs (co-pays and coinsurance) they cannot afford.

A Divide in Opinion on the Uninsured and Access to Care for All

There is a divide between the more affluent Georgians included in this research and all other Georgians on the issue of the uninsured and access to care for all.

(1.11) A small group of more affluent Georgians suggests that the uninsured do not place a high enough value on having insurance to make the sacrifices necessary to provide health coverage for themselves and their families. These higher-income Georgians couch their comments in “us” versus “them” terms and believe that those who are uninsured have adequate access to health care through government-subsidized clinics and hospital emergency rooms. In contrast, all other participants view the uninsured as people like themselves, are sympathetic toward the plight of the uninsured and cite affordability as the main reason people do not have coverage. Further, they believe care disparities exist, in that health professional’s view the uninsured with disdain and do not provide them the same treatment options as those who have coverage.

(1.12) While most of those among the more affluent are in philosophical agreement that all Georgians should get the health care they need, they expressed a narrower concept than other Georgians of what constitutes need, most often limiting need to treatment in emergency situations. Because of this definition and their conviction that such needs are already being met, the more affluent are reluctant to support a program to expand health insurance coverage to all Georgians. Their opinions are influenced largely by the belief that they will be required to carry a disproportionate share of the financial burden for such a system.

In stark contrast, most other Georgians were of one mind in their agreement that everyone should get the health care they need, and this belief often elicited strong emotion. These participants understand the relationship between providing expensive emergency care to the uninsured and increases in their insurance premiums but still questioned the fairness and wisdom of the current system that leaves so many people uninsured. They do not, however, support unlimited access and would oppose any system that did not require everyone to make a financial contribution toward their care, with many suggesting a sliding scale where people pay according to their ability. Further, they strongly assert that anyone who works should be insured and should take priority in any system that provides coverage for all. For some, however, these feelings did not extend to undocumented immigrants.

(1.7, 1.10) Given these views, most Georgians ardently support a plan for providing affordable insurance for those who are uninsured, believing that most people were uninsured because they

could not afford insurance or were too sick to be insured, particularly to the most vulnerable. They recommend that any new program be aimed at helping those who are currently excluded from the system, particularly the working uninsured, those who have lost jobs, and people who have been denied coverage due to pre-existing conditions. Coverage through such a plan should be comprehensive, including preventive care, and should impose reasonable limits to control costs. (1.4) However, it was difficult for Georgians to reach consensus on what is affordable; it seemed to be relative to their income, although the acceptable upper limit ranged somewhere between the equivalent of one utility bill, such as natural gas, for those with lowest incomes, and a mortgage payment for those in the highest income group.

A Call for Solutions

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

Solutions Must Address:

Quality of Care

Fairness

Affordability

Choice

Shared Responsibility

(1.9) Participants were asked to respond to each item on a list of generic solutions to the problem of access to care. The solutions on the list were: 1) A tax funded free or reduced cost care program for the uninsured, 2) Individual insurance pools paid for by participants, 3) Small employer insurance pools, 4) Small employer tax credits, 5) Personal tax incentives, 6) Individual subsidies for those who can not afford insurance, 7) Employer subsidies, 8) Expand Medicaid/PeachCare, 9) Medicaid/PeachCare buy-in, 10) Mandate that employers offer health insurance, and 11) Universal health insurance.

Two options emerged as having the broadest level of appeal: a buy-in to the Medicaid and/or PeachCare programs and the formation of individual- and employer-based insurance pools. While other coverage options were accepted in some measure throughout, none enjoyed the widespread acceptance of these two. The buy-in concept was particularly well received because it would serve a dual purpose: participants thought it would probably lead to improvements in the Medicaid program, and it would encourage shared responsibility with participants. (1.8) Participants liked the employer and individual pools because they believed they would lead to affordability, choice, and shared responsibility between employers, government, and individuals and also because those options maintain the traditional employer-based health insurance system, which many participants found comforting.

(1.5, 1.6) However, while participants liked public programs, they suggested improvements in existing public programs might be critical to the acceptability of using these programs as part of the solutions. Focus group participants felt either they or others fail to enroll in these programs during times of non-emergent need because they:

- ? Are not aware of the programs that are available to them;
- ? Perceive current programs only to be for those on welfare and do not view themselves as likely to be accepted due to their income;
- ? Feel that there is a stigma associated with being enrolled in public programs;
- ? Believe the administrative hassles and lost time at work associated with enrollment issues are too great.

Others stated that either they or someone they knew left the programs because of unpleasant interactions with enrollment workers who they viewed as rude and not helpful in an enrollment process that required extensive paperwork and appointments.

Among the less popular solutions, tax credits for individuals and employers were welcome, but not perceived by participants as something that would alone work to reduce the number of uninsured. Together with subsidies, they felt that it was most likely that individuals would not purchase insurance with the tax credits, but that they would purchase other things unless prevented. Free or reduced cost care would also be welcomed by participants, but they did not feel that quality of care could be maintained in such a system over the long run, nor were they certain it would provide care to everyone in need. Mandating that employers offer insurance was widely rejected because it was felt this would have a negative effect overall on the economy, causing small businesses to close and resulting in pay cuts or employees losing their jobs altogether.

Interestingly, universal health insurance as an option did not elicit the same negative reaction as it did in research conducted by Georgia Health Decisions a decade ago. At that time, Georgians vehemently dismissed the idea, being distrustful of any system that was not based on competition and free market values. While many of the current focus group participants are adamantly opposed to such a concept, a significant number expressed a general open-mindedness to the idea because everyone, despite their financial resources, would have access to the same “quality of care,” this type of system would be more “user-friendly,” and it would place more emphasis on “prevention.” Concerns about higher taxes and increased government involvement in health care, as well as diminished choice and quality, and the sacrifice of personal responsibility are present, but there is a new open-mindedness about this idea.

A Call for Leadership

When asked if they thought Georgia had the leadership to find solutions for the health care system, participants clearly said “No.” They called for leadership to emerge among the state’s health care policy makers and providers, business and insurance industry leaders, and elected officials to stem the tide of soaring costs. Sadly, they hold little expectation that rampant increases in health care costs will be reversed any time soon due to the lack of visible leadership in finding solutions. Citing earlier political failures, particularly failures on the federal level, Georgians fear that their elected officials now view health care reform as a pariah, too risky to

undertake. Participants realize they will not see relief “overnight,” nor do they believe the solutions will be easy. But they are ready to take on the issue because almost all of them see themselves as affected either directly or indirectly by high cost and limited access to care and want their voices on these issues to be heard.

Key Informant Interviews

Key informant interviews were conducted with individuals representing: state administration and the executive branch, consumers, legislators, insurers, and providers. The identity of the informants was kept confidential from all but a few individuals associated with the research; however, the informants included some of the most influential “liberal” and “conservative” decision-makers in the state on healthcare.

Importance of Georgia’s Uninsured

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

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

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

However, some believe this issue is less important to their peers, which is telling given what is arguably a lack of state-level interest on the issue. As one informant summarized, “I think one of the challenges will be getting the political world and [others] aware that it is an important issue and why it is an important issue.”

Impact of Uninsured: Personal, Professional, Community and State

Personal and Professional Impact

Some of the informants are able to relate personal experiences (self, family, friends) to the State problem of the uninsured. As an informant related, “[One of our family members struggles] to keep some [family] members insured [because they] have been laid off recently. They’re [trying] to keep their coverage as long as they can...”

Others provide a professional observation. As one informant explained, “I see the effects of being uninsured. The uninsured typically come into the hospital much sicker than they would if they were insured. ... If you ask any doctor they will tell you it is a mess.”

Other key informants have not been personally confronted with the challenges and barriers related to lack of insurance.

Community and State Impact

Informants report the issue of the uninsured is hitting urban and rural communities harder than the suburban areas. Informants express particular concern for the uninsured in rural communities. One informant summarized, “Needless to say, the health care system is pretty dysfunctional in a lot of ways and particularly when you look at the rural areas of the State. ... Of course there are several reason why it’s difficult to get doctors and nurses to go to rural communities anyway, but one of the major ones is that there is no source of payment. ... If everybody was insured we could focus on the other problems of making the [rural] communities attractive to professionals.”

The impact of the uninsured on the State of Georgia is primarily an issue of economic concern. As one informant explained, “It has created a kind of vicious economic dynamic. ... The uninsured problem means there are more people who need the services but don’t have the dollars ... it has done the opposite, rather than creating health care systems, it’s created these economic systems that don’t fully serve the people. Another informant added, ” I think there is, in the grossest terms, a loss to the economy because of lost school days, lost days of work and just the stress that people are under.”

Another informant provides a detailed account of the number of Georgians who were affected, “When you consider we have about 1.7 million people uninsured or underinsured today in Georgia, you have to look and see how that impacts the quality of life for those individuals. ... 1.7 million out of 8 million is a pretty good percentage, 20% range, you have to stop and ask yourself what kind of quality of life do they have. ... So you have to [ask] yourself, how could life be better in the state of Georgia if we in fact provided a way for health care benefits to every citizen.’

Georgians Most Affected

(1.3, 1.7) The working poor are considered by the key informants to be the segment of the population most affected by being uninsured. As an informant explained, “I think it is the working poor, the people who are out there trying to make a living and are not offered a benefit package through employers or cannot afford what is offered, so they decline.” Other segments impacted by being uninsured include: young adults, immigrants, minorities, and those with illnesses. One informant stressed her concern, “Low income African American males and the Hispanic immigrant population are the two groups that I personally am very worried about ... and of course undocumented individuals are not eligible for any programs.”

Other informants reflected on their opinion that some of the uninsured are so by choice. One such informant related, “Some [of the uninsured]...would rather have a new sofa or cable TV

than purchase insurance. To some extent there are people who make a conscious choice not to have insurance.”

Still other informants are not certain which segment of the population is most affected by this issue. As one informant questioned, “I think probably not the lowest income... I don’t know if there’s any truth to this but I think it probably affects women more... I don’t think I can pin it down.”

What do Georgians deserve?

(1.12) With respect to the minimal level of care that should be available to all Georgians, the most common responses are related to basic primary care, which for some informants included “basic preventive care,” “screening”, “immunizations”, “dental care”, “wellness visits”, “access to hospital visits,” and “necessary prescription drug coverage”.

For others, the minimal level of care is “catastrophic care” that may also include “hospital room stay” and “non-elective surgeries.” And for some, a combination of preventive and catastrophic is seen as most effective. As one informant explained, “I think catastrophic care needs to be provided, and it’s got to cover routine physician care, it’s got to cover hospital care. What we want people to do is make sure they’re maintaining their health. What we don’t want to have is a situation where the coverage is so limited that people don’t seek health care early on and they wait until they are very, very sick.”

However, one informant suggests that the minimal level of care has already been established. According to this informant, “People argue about a [minimal level of care] now, but I think it has already [been] pretty well established. Every program, Medicare, Medicaid, private health insurance has a description of a basic set of benefits that a person is entitled to....”

For others, the question of whether or not health care is a “right” must be addressed before determining what, if any, minimal level of care should be available to all Georgians. As an informant said, “I don’t believe there is a right to health care.”

Other informants disagree. As one informant said, “Health care is a right; it is fundamental to what we do. So it is the responsibility of the government.” Another informant adds, “Government is charged with the health and safety of the population, no question about it. ... We ... are the only industrialized nation in the world whose government has not put in a national health plan. So why in the United State’s should [health care of the] citizens be any other’s responsibility but the Government’s?”

The importance of resolving the issue of whether or not health care is a right is considered an imperative first step before addressing any proposed solutions. As one informant explained, “We have to recognize and really have a debate about what is health care, and is it a right?”

Who pays for Georgia’s uninsured?

Responses vary regarding who bears the cost of the uninsured currently. “Taxpayers”, “physicians,” “hospitals,” and “providers” (private and public) were mentioned most, followed by “the government” (state and federal), “small businesses” and the “general public.” As one

informant explains, “I don’t think when you say who bears the cost that you can point to any one thing.”

Who should pay?

Optimally, several of these informants believe the government, public and private providers, and the general population should share the costs of the uninsured. When asked who should bear the cost of the uninsured, an informant summarized the feelings of many by stating, “All of us.”

Other informants spelled-out precise payment responsibilities. As one informant explained, “The first thing the Government needs to do is create a competitive market price so that the commercial enterprises have the greatest opportunity insuring the greatest number of people...”.

Whose responsibility is it to solve the problem on the uninsured?

In this same vein, informants believe the responsibility to solve this problem relies on combined efforts. As an informant explains, “It has to be solved together. I think it’s going to have to be the State Government, the Federal Government, and the health insurers coming together and working together to try and find solutions for this. No one party can solve it by themselves because it impacts everyone, it impacts employers and individual citizens.” Another informant added, “There may not be a single approach that gets it done....”

Others thought paying for the uninsured is either a public or private sector responsibility. As one informant explained, “ I would like to think that the private sector could play a bigger role....” Another informant gave an opposing view, “It’s [the responsibility of] the policymakers, the government. Government is charged with the health and safety of the population, no question about it.”

What might work?

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

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

What is critical?

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

Affordability for consumers and quality are considered the most critical features of any proposed solution. As one informant summarizes, “Nothing’s any good if people can’t either pay for it or get it. It’s (health care insurance) got to be decent enough coverage that people are getting at least their basic needs met.” Another informant responded, “Quality, followed by affordability” is critical to the solution.

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

What won’t work

Some of the solutions deemed unacceptable are seemingly driven by the special interests that the key informants represent. For instance, those who are in the Consumer group have very different perspectives than those who are in the Insurer group.

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

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

More Information Needed

Informants stated that they needed more information in four key areas:

1. Who Are the Uninsured?

Specifically, informants asked for more information on:

- ? Number of Georgians who are uninsured
- ? Demographics: sex, age, ethnicity, employment and economic status, and geographic location. As one informant expressed, “I would like to know specifically who are the uninsured. ... If we understand them better then we can tailor our solutions to them.”

2. What are the Barriers to Insurance?

Specifically, informants want to know:

- ? How many could afford insurance but choose not to have it versus how many could not afford it. As one informant said, “There are people like me that by choice for a brief period of time because of employment changes, there are people by choice because they would rather spend money on something else. ... Some

people cannot afford it, but some people think they are young and invincible and therefore do not need it.”

- ? Define “affordable health care”
- ? Define “accessible health care”

3. Analysis of Proposed Solutions

Informants want it to be clear:

- ? What other states have successfully done
- ? What are the pros and cons of proposed solutions? As one informant explained, “I think understandability would be important.” “...I think that (study of proposed solutions) would be important as to how far down the road can you provide some level of quality information about down the road costs compared to others (proposed solutions).”
- ? What proposed solutions achieve short- and long-term
- ? Impact of proposed solutions on all constituents (providers, insurers and individuals)
- ? Must show impact of multiple interventions
- ? How the proposed solutions would provide coverage and for whom
- ? Who is paying for the proposed coverage
- ? How many people solutions would cover
- ? What people would get from proposed solutions
- ? Impact proposed solutions would have on free market system

4. Impact of Uninsured on the State

Informants state that to make decisions, they need to know:

- ? Total monies being spent in the State of Georgia on health care
- ? Short- and long-term costs of the uninsured on the State
- ? Proposed solutions’ impact on Georgia’s budget
- ? The cost of doing nothing on the State’s budget
- ? What other programs might suffer if uninsured made a priority

Readiness for Solutions

In spite of the acknowledgment that there is a problem, overall, informants are reluctant to say that Georgia is ready to tackle the problem of the uninsured. As one states, “I don’t think we are collectively, I think there are a number of folks that are very interested....It boils down to resolve that are we all ready to do it, are we all ready to pay more taxes.” Informants appeared to be overwhelmed. As one informant expresses the frustration, “It is hard to keep focused...There’s just not a huge consensus going in one direction.” Other informants are specific about what is needed to encourage Georgia’s readiness. One informant focuses on the need for education. “I think there’s a segment of the population that really doesn’t understand it. ... I think there’s some education that probably has to be done.”

However, all of the informants agreed that any proposed solution must be based on:

- ? Shared Responsibility

- ? Combinations of solutions
- ? Economic feasibility
- ? High quality care
- ? Political feasibility
- ? Geographic sensitivity

Some express hope. As an informant reflects, “I am hopeful, but I am not sure we have the guts to do anything about it.” Another informant states, “I think they (people in Georgia) are becoming increasingly ready on a daily basis.” An informant summarizes, “We need courageous and visionary leadership to put together the solution that can politically be enacted and that will meet the needs that we’re trying to address.”

Listening Sessions with Community Leaders

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

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

Counties are ranked by the OneGeorgia Authority in one of four tiers through reference to each county’s respective unemployment rates, poverty rates, and per capita income. The OneGeorgia Authority was created by the Georgia General Assembly to utilize one third of the state’s tobacco settlement in assisting the state’s most economically challenged areas. OneGeorgia investments are currently targeted toward Tier 1 and 2 counties.

The communities selected as listening session locations were:

Table 14: Community Listening Session Locations

County/City	Geographic Area	OneGeorgia Tier Rank
Hall/Gainesville	NE GA – Service Delivery Region 2	4
Chatham/Savannah	SE GA – Service Delivery Region 12	3
Bibb/Macon	Middle GA – Service Delivery Region 6	2
Dougherty/Albany	SW GA – Service Delivery Region 10	1

To avoid venues that could be seen as significant to one or more representatives of invited stakeholder groups, each *Listening Session* was held in a conference room of an area hotel.

Participants were drawn from representatives of the business and economic development communities, health care providers, insurers and underwriters, philanthropies, community-based organizations and elected officials. Special efforts were made to recruit representatives of minority businesses and health care providers, as well as representatives of organizations that are unique to each of the respective counties in which a *Listening Session* was held.

Each listening session consisted of three basic components. First was a PowerPoint presentation of the results of the Household Population Survey on health insurance coverage patterns in Georgia and within the State Service Delivery Region of each respective *Listening Session* site, followed by a discussion and question-and-answer period on the data. Next, staff facilitated a discussion among participants about the impacts of the uninsured within their community. Third, staff facilitated a discussion among participants on strategies that could be considered to address the problem of the uninsured. Because most participants perceived that the problem of the uninsured is related to health care service delivery issues and coverage costs, solutions to both were proposed.

Findings: Impacts of the Problem of the Uninsured

All of the communities visited were extremely articulate in assessing the impact of the uninsured within their locality and region. Despite the diversity among the localities chosen for *Listening Sessions*, there is great consistency among Georgia communities in their assessment of key impacts of the uninsured. The following is a synopsis of themes that resonated among listening group participants throughout the state.

1) How we got into this mess

All of the communities recognized that the cost of caring for the uninsured is a key component of runaway health care service delivery and insurance coverage costs. Every community specifically referenced the high utilization of emergency rooms by the uninsured as a problem that must be addressed in order to hold down costs. However, communities also associated increased costs with discounts negotiated by large group purchasers, the perception of high profits by insurance companies, new technologies, malpractice liability, consumer demand for “brand name” prescriptions, and ineffective policy at the state and federal levels.

Insurance industry rating and underwriting practices were recognized as both a cause and effect of the problem of caring for the uninsured. Communities believed that within the current market, individuals and small groups are at a particular disadvantage in obtaining quality coverage at an accessible cost. A lack of competition due to a diminishing number of carriers offering insurance products in Georgia was also mentioned as a part of the problem.

Finally, perceived consumer attitudes toward health insurance and primary care services were also identified as contributing factors. Communities say that local consumers often treat health care as an entitlement that will be there when they need it and thus see no need to pay for health insurance. As evidence, participants cited instances in which consumers refused to make even

nominal payments toward low-cost coverage plans, while continuing to purchase cell phones, cable TV, and related goods and services.

2) Impacts on Local Taxpayers

Each of the communities visited are regional hubs and believed that, as such, they bore a disproportionate burden for the care of indigent residents of outlying counties, typically delivered in the emergency rooms of public hospitals. Participants noted that surrounding counties often lack safety net providers due to health care financing and related issues. Some groups noted secondary impacts on local taxpayers, such as law enforcement and jails.

3) Impacts on the Safety Net

For most communities, the health care safety net consists of the local public hospital, the health department, a community health center and/or other voluntary service collaborative, as well as grantors of charitable and philanthropic funds. Every community visited believed that the pressure of caring for the uninsured had frayed the safety net to the point of collapse and, further, that it endangered their ability to address other areas of need. And every *Listening Group* believed that the impending reductions in provider Medicaid reimbursements would irreparably compromise the ability of the safety net to function. One participant lamented that state policymakers had “no clue” how their decisions affect local communities.

4) Impacts upon Economic and Community Vitality

Listening Session groups agreed that the impact of the problem of the uninsured upon community and economic vitality was far-reaching. A lack of access to affordable health coverage was seen as generating increases in community morbidity and mortality rates among all income groups, decreasing potential productivity and overall quality of life.

One community noted that when there are few consumers covered by health insurance in a market area, fewer specialists and quality physicians are attracted to work there and the overall quality of the health care infrastructure declines. The health care infrastructure was perceived, at the same time, as integrally related to economic strength. A weak infrastructure is seen as having a chilling effect on the community’s ability to attract desirable businesses into the area. Thus, local leaders feel that a weakening of the health care infrastructure can set a community on a downward economic spiral.

Listening Session groups did recognize that there has been an unintended positive consequence of the health care crisis. For some communities, the crisis has mobilized health care providers, nonprofit and public organizations to form effective coalitions focused upon achieving positive outcomes for the uninsured. One Session participant even credited the health care crisis with restoring a “sense of community.”

5) Impacts on Employers and the Self-Employed

One *Listening Session* participant stated that there was no practical way that a sole practitioner start-up could succeed without access to a spouse’s group health insurance plan and likely could not afford to provide health insurance benefits to employees. Thus, communities believe that existing health insurance offerings act as a disincentive to economic competition. Each of the groups acknowledged that employers of all sizes are experiencing increasing challenges to their

ability to offer health insurance benefits and speculated that at least some employers would have to drop coverage or lay off employees to remain profitable.

For their part, all insurers and underwriters participating in each of the *Listening Sessions* expressed frustration at their inability to offer coverage products that are affordable to the self-employed and small employers. These participants also expressed concern about how the implementation of new regulations, such as HIPPA privacy requirements, would ultimately affect premiums charged to all employers.

6) Impacts on Individuals and Families with health insurance coverage

Communities believe that when individuals and families have health insurance, it is provided through an employer. The rising cost of the employee share of coverage and services effectively means less take-home pay and less purchasing power within the community. Communities wonder if the cost increases associated with the employee share of group health plans will prompt more individuals and families to drop coverage and join the ranks of the uninsured.

7) Impacts on Individuals and Families without health insurance coverage

Listening session participants noted that individuals with medical conditions and without insurance coverage often remained “locked” in poverty since, without access to care and/or treatment, such individuals have no realistic hope for attaining or maintaining employment. Immigrants who believe, either correctly or incorrectly, that they are ineligible for any public services were seen as particularly vulnerable to “poverty lock.” Communities note that it is only with difficulty that the uninsured are able to access preventive and diagnostic care and when they do, there are frequently no services available to treat identified conditions. Participants noted one instance in which, after a diagnosis of cancer had been made by a safety net provider, there was no treatment available to the indigent cancer patient.

8) Impacts on Children, Youth and Families

Listening Groups’ views about the impacts on children, youth, and families affected by the problem of being uninsured deserves special mention. Communities believe that children and youth without a source of medical coverage suffered academically because instructional time and the ability to learn are impaired by untreated illnesses or medical conditions. One *Session* participant reported that local school health nurses are overwhelmed by the demand for basic preventive, diagnostic, and primary health care among children – roles never envisioned for school health nurses.

Communities also believed that children suffer when parents go without insurance. Participants speculated that the ability of adults with unattended illnesses or medical conditions to effectively parent their children was impaired. In addition, *Session* participants believed that the high cost of insurance served as a significant disincentive to those adults receiving public benefits to achieve economic self-sufficiency through employment.

9) Impacts on Minority, Racial, and Ethnic Groups

Every community visited expressed concern for the health status of resident minority, racial, and ethnic groups, such as African-Americans and Hispanics, and every community believed that there is a significant disparity between the health status of minority and non-minority groups.

Session participants suggested that at least a part of the disparity in health status among minorities was attributable to the lack of cultural sensitivity in which health insurance products, as well as preventive and diagnostic health care services, are promoted.

Findings: Recommended Strategies to Increase Access to Affordable Health care Coverage and Services

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

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

1) State Health Care Planning:

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

The participants of the Savannah/Chatham County *Listening Session* articulated best the thoughts that were voiced in the other communities. The state should coordinate public and private health care resources conceived upon a three-tier “pyramid” model. At the base of the pyramid, public education initiatives and programs should be targeted to all Georgians to facilitate healthy lifestyle choices in avoiding smoking, obesity, and other high-risk conditions. The second tier of the pyramid would address Georgians’ need for preventive health care screenings, laboratory and diagnostic services, primary care, and prescription drug treatments. The top of the pyramid would include the more intensive and higher cost health care treatments and rehabilitation. Proponents of this model believe it would reduce health care costs at the top of the pyramid by preventing and treating illnesses and medical conditions through programs and services available at the first two levels of the pyramid.

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

2) Regional Planning:

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

3) Intergovernmental Cooperation:

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

4) Economic Stimuli:

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

5) Public Programs:

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

- ? Expand PeachCare – or implement a PeachCare look-alike program – to cover adults.
- ? Decrease income limits associated with Medicaid eligibility and simplify the application process. One *Listening Session* participant, an insurance broker, suggested that the state utilize local brokers to enroll eligible individuals into the PeachCare and Medicaid programs.
- ? Implement a basic “bare bones” health plan universally available to all Georgians, subsidized by state and federal dollars. Allow Georgians desiring coverage above the “bare bones” health plan to purchase private supplemental plans.
- ? Leverage federal funds to implement more Community Health Centers in underserved areas.

- ? Implement a disease management system for Georgians with high-risk medical conditions.
- ? Make Indigent Care Trust Fund dollars directly available to physicians that treat indigent patients.
- ? Fund efforts to allow more Georgians to access low-cost or no-cost prescription drugs.
- ? Remove statutory and regulatory barriers to participation in the Medicaid and PeachCare programs by immigrants.
- ? Examine the effect of PPO insurance plans upon safety net and other critical access providers.

6) Access to Health Insurance:

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

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

7) Reduce the Cost of Insurance:

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

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

8) Consumer Education:

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

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

Summary of Qualitative Research Findings

While public support for the sweeping change in the health care system that a single-payer system would bring is significantly higher than was true a decade ago, most Georgians favor an approach to expanding access to affordable services and coverage that builds upon the strengths of existing public programs and private products.

For example, citizens value their ability to access the highest quality of health care in the world and the range of choice among health care providers and coverage plans. Communities value the ability of local governments, providers, businesses, philanthropies, and community-based organizations to craft public/private partnerships that are responsive to local concerns. And state leaders value the modicum of budget predictability that the present system allows.

Do Georgians believe there is adequate access to affordable coverage?

The public, communities, and state leaders universally believe that the current patchwork of coverage products is both costly and inadequate. Particular issues of concern within each group of informants vary. Citizens believe that insurance premiums, co-payments, and deductibles are too expensive and are beginning to question whether the cost of coverage is worth the benefits. Communities feel that more uninsured residents have come to rely on safety net services offered at the local level because coverage by public and private programs is harder to secure. State leaders are concerned about the ability of employers to continue to offer health insurance benefits. However, it is important to note that there is a considerable difference of opinion about what adequate means for certain populations and that among State leaders, in particular, there is a general sense that many of the people who have no coverage do not deserve the same coverage as others.

Factors driving the Uninsured Problem

Cost-shifting generated by the uninsured and discounts negotiated by large group purchasers, along with insurance rating practices, malpractice liability issues, new medical technologies,

prescription drug therapies, and the inappropriate utilization of services by some consumers are among the factors that all informants believe are responsible for the increasing cost of insurance and the decreasing mix of available products. However, the respondent groups diverge on the relative weights attributed to other factors. Citizens are more likely to believe that the excessive profiteering or “greed” by insurers and providers is responsible for the high cost of health care. Communities are more likely to point to ineffective health care policy at the federal and state levels. State leaders are more likely to cite a lack of consensus at legislative and societal levels on whether there is a right to health care and, if so, the extent to which government should facilitate access to coverage and services.

Views on the Uninsured

In some cases, individuals, regardless of the level of importance they placed on finding solutions, seemed to believe things about the uninsured that the statistics do not support. However, all groups believe that the numbers of uninsured are growing and felt the increase is related to the spiraling cost of coverage and care. Citizens are more likely to believe that the uninsured are “people like us” who simply cannot afford to remain in the market. However, wealthier individuals are more likely to feel that the uninsured simply do not place a high enough priority on insurance coverage. Communities see the uninsured as those, like immigrants, who have fallen through the cracks of public programs and cannot obtain private group health coverage plans. State leaders are more likely to see the uninsured as “pockets” of racial and ethnic minorities, undocumented immigrants, and the working poor.

How significant is the problem?

All groups agree that the challenges posed by a lack of accessible and affordable insurance are critical but differ in their assessments of the urgency of addressing those challenges. Citizens overwhelmingly feel that insurance coverage is a basic “kitchen table” issue that is forcing hard choices between health care and other basic needs. They believe that the need for solutions is urgent. Communities see the problem much as an “unfunded mandate” since emergency services must be rendered to those without coverage, despite the lack of revenue to offset the public and private costs of doing so. They believe that without action, every community’s safety net will soon collapse of its own weight. State leaders, on the other hand, believe that the impact of the problem the state should address is the economic impact, particularly for its rural areas. And, state leaders are sharply divided about whether there is a problem with adequate solutions; some are convinced the issue will not ever be addressed at all.

Does Georgia have the public will to address the issue?

All three groups of respondents are unanimous in their view that all stakeholders – insurers, providers, employers, government and consumers– must share responsibility for crafting and implementing strategies to expand access to affordable health coverage. And all agree that an effective solution will require multiple strategies to address this multi-faceted challenge. Other criteria that citizens, communities, and state leaders believe effective solutions should meet include:

- ? Facilitating access to quality health care throughout Georgia,
- ? Upholding fiscal responsibility in its impact on tax dollars,
- ? Ensuring that coverage is affordable to employers and working Georgians,

- ? Encouraging the appropriate utilization of services by consumers,
- ? An emphasis on the prevention and early treatment of costly illnesses and conditions, and
- ? An emphasis on leveraging public/private partnerships

Respondents share the conviction that taking “no action” to address the challenge of accessible and affordable coverage is not a viable option. All are eager for solutions and willing to consider virtually any strategy put forth—including, for the first time, universal coverage. However, no respondent group, particularly state leaders, feel that there is sufficient public will in Georgia to effectively address this issue and manage the trade-offs that will be required to find solutions. Even setting aside the issue of whether state dollars are at stake, many State leaders hold the view that it is not the responsibility of State government to facilitate action on the problem of the uninsured.

Therefore, to move forward, Georgians must achieve consensus on several key issues for which sharp disagreement persists:

- ? The extent to which access to health care should be available to all Georgians.
- ? Whether uninsured Georgians should be provided with primary care, emergency care, or no care at all.
- ? The role of government in subsidizing and/or administering health insurance coverage.

And, as an initial but important step, citizens, communities, providers and state leaders must be educated on the economic impact of the uninsured—the costs to society of continuing on the current path, as well as the potential savings and improved productivity that could result from expanded access to affordable coverage.

SECTION 4. THE STATUS OF THE PRIVATE HEALTH INSURANCE SYSTEM IN GEORGIA

(Questions 2.1-2.7, 3.2, 3.3)

About 5.3 million Georgians are enrolled in private health insurance plans and employer-sponsored healthcare coverage is the predominant source of health insurance for Georgians. Understanding trends in the private and self-funded health insurance marketplace is critical to influencing economic health and employee benefits and to improving access to healthcare.

Background

(2.1) Data from the population survey reveals that about 92% of the 5.3 million privately covered Georgians, or 4.9 million, are enrolled in employer sponsored group health plans. Of those enrolled in group health plans, about 2.5 million get their health insurance directly from their employer while another 2.4 million are enrolled indirectly as the spouse or dependent of a person enrolled in a group plan. The remaining 8%, or approximately 406,000 of the 5.3 million Georgians enrolled in private health insurance plans are enrolled in individual or other non-group coverage.

Of the 5.3 million individuals enrolled in private coverage, a weighted 3.4 individuals responded to questions about their plan type.

Table 15: Plan Type Distribution in the Private Health Insurance Market

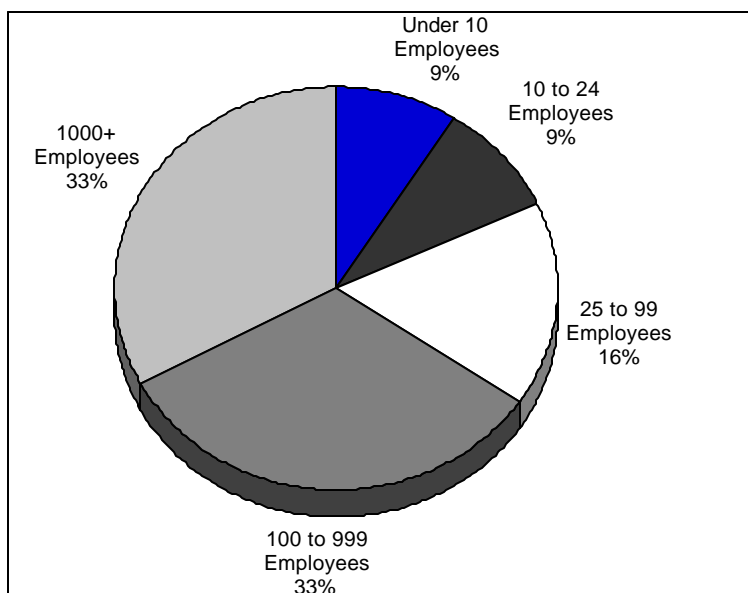
Plan Type⁷	Number Enrolled	% of Respondents
Indemnity or Traditional Plan	373,862	10.7%
Preferred Provider Organization	733,743	21.1%
Point-of-Service	1,313,393	37.8%
Health Maintenance Organization	688,368	19.8%
Unidentified Managed Care Plan	369,479	10.6%

Point-of-service (POS) and preferred provider organizations (PPO) were the most common plan types, followed closely by traditional Health Maintenance Organization (HMOs) plans. Ten percent reported being enrolled in an indemnity plan and another 10% reported being enrolled in a managed care plan but were unsure what kind.

⁷ Respondents were asked whether or not they had a list of providers or a network for obtaining the highest level of coverage, whether they had any coverage for care provided by providers not on the list, and whether they had a primary care physician (PCP) to coordinate their care and make referrals. Respondents reporting no coverage for out-of-network care were classified as enrolled in a health maintenance organization (HMO), while those with out-of-network benefits and a PCP were classified as point-of-service enrollees. Those with a network but no PCP requirements were considered PPO enrollees.

Roughly half of Georgia's 8.5 million residents, or approximately 4 million people, are employed. About 400,000 individuals work for the state or federal government, and 3.6 million work for private or local government establishments with more than one person. Private and local government employers in Georgia account for 108,000 single site establishments and almost 34,000 multi-site firms.⁸

Figure 5: Georgia Workforce By Firm Size



While Georgia's small employers are an important part of the state's economy and almost half (72,000) of the establishments have fewer than 10 employees, only about 9% of the state's labor force, or about 300,000 people work in these smallest establishments. The workforce in Georgia is, in fact, spread relatively evenly among firms of various sizes. Firms of 10-24 workers employ another 10% of the state's workforce. One-third, or over 1.1 million people, of the state's workforce are employed by firms that have 1,000 or more employees and another third by firms consisting of 100-999 employees. Over half of all establishments and employees in Georgia are in the metro-Atlanta area, while 20% of the establishments and 18% of employees are in rural communities.

Data from the employer survey shows that over 3 million Georgians in the private and local government workforce are employed in firms where health insurance is offered, about 2.5 million of those Georgians are eligible to enroll in their employers' coverage plans, and about 80% of those eligible employees actually enroll. These estimates, which result in just over 2 million workers enrolled in privately sponsored employment-based health insurance, are consistent with the results from the population survey because they do not include state and federal workers. The estimates imply that some 400,000 private or local public employees are not offered insurance, 500,000 are not eligible for the plans offered by their employers, and another 500,000 are eligible but not participating in their employer's health benefit plan.

⁸ Although the unit of analysis for the statistics below is the establishment, establishments that are part of multi-site firms are categorized based on the number of employees in the firm rather than the establishment.

Table 16: Employees At Georgia Establishments That Offer EBHI

	Total Employees	No EBHI Offered	EBHI Offered	Employees Eligible	Employees Enrolled
All	3,439,378	399,358	3,040,020	2,560,288	2,023,236
Region					
Atlanta	1,983,106	193,426	1,789,680	1,530,617	1,171,465
Rural					
Georgia	629,957	106,340	523,617	448,085	391,172
Other MSA	826,315	99,593	726,722	581,586	460,599

Firm Size

Firm size, location, and age all affect insurance coverage offered by an employer. The likelihood that a firm will offer coverage to at least some of its employees increases directly with the number of employees at the firm. Only 35% of firms and 39% of employees at firms with fewer than 10 employees offer coverage, while almost all firms with 100 or more employees offer a health plan to at least some employees.

Table 17: Percent of Employees By Firm Size at Georgia Establishments That Offer EBHI

	Total Employees	Percent of employees at establishments not offering	Percent of employees at establishments offering	Percent of employees at establishments with EBHI who are eligible	Take up rate - percent of eligible who enroll
Total:					
Georgia	100%	12%	88%	84%	79%
Firm Size					
By Number Of					
Employees					
Under 10	100%	61%	39%	77%	84%
10-24	100%	28%	72%	80%	77%
25-99	100%	16%	84%	79%	79%
100-999	100%	3%	97%	81%	77%
1,000+	100%	0%	100%	91%	81%

Geographical Location of Firm

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

Table 18: Percent of Employees by Geographic Location at Georgia Establishments That Offer EBHI

	Percent of employees at establishments not offering	Percent of employees at establishments offering	Percent of employees at establishments with EBHI who are eligible	Take up rate - percent of eligible who enroll
All	12%	88%	84%	79%
Region				
Atlanta	10%	90%	86%	77%
Rural				
Georgia	17%	83%	86%	87%
Other MSA	12%	88%	80%	79%

Age of Firm

The likelihood that a firm will offer coverage also increases with the age of the firm. The average age of a firm that offers coverage is 36 years; while the average age of a firm that does not offer coverage are only 16. Older firms also tend to be larger firms. Establishments that have existed for 10 or fewer years employ 19 employees on average, while those in existence for more than 10 years employ an average of almost 200 employees.

Table 19: Average Age of Firms by Firm Size That Offer and Do Not Offer EBHI

	All	Offers EBHI	
		No	Yes
	Years Existence	Years Existence	Years Existence
All	28	16	36
Under 10	17	16	19
10 to 24	21	16	22
25 to 99	29	24	29
100 to 999	44	13	45
1,000 or More	85		85

Industry Sector

The likelihood that an employer will offer coverage varies systematically with the industry in which that employer operates. For example, 58% of the establishments employing 51% of the workers in agriculture, fishing or forestry work do not offer any health insurance benefits. On the other hand, 99% of the workers classified as working in public administration work for an employer that offers health insurance to at least some employees. Workers in the professional services, finance and manufacturing are significantly more likely to be offered health insurance than are the almost one million Georgians working in construction, wholesale or retail trade, or the services industries.

**Table 20: Percent of Firms and Establishments
Offering Health Insurance Benefits by Industry**

	Percent of Establishments Not Offering EBHI	Percent of Establishments Offering EBHI	Percent of Employees at Establishments Not Offering EBHI	Percent of Employees at Establishments Offering EBHI
Agriculture, Fishing or Forestry	58%	42%	51%	49%
Construction	58%	42%	28%	72%
Manufacturing	23%	77%	6%	94%
Transportation	26%	74%	15%	85%
Wholesale or Retail Trade	43%	57%	23%	77%
Finance, Insurance, Investments or Real Estate	39%	61%	8%	92%
Services	56%	44%	25%	75%
Professional Services	32%	68%	7%	93%
Public Administration	6%	94%	1%	99%

There are significant workforce differences, such as wages, the number of part time workers, worker age, tenure, and race which all relate to whether a firm offers healthcare coverage.

Employee Wages

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

At all firm sizes in both rural and urban areas, firms that do not offer coverage have a greater percent of low wage employees than firms that offer coverage (27.5% vs. 13.1%). Not surprisingly then, firms that offer coverage also have a much higher average employee monthly wage than firms that do not offer coverage (\$3,988 vs. \$2,192). In firms with less than 10 employees, the difference in average wage is even more striking; the average employee monthly wage is \$5,311 in firms that do offer coverage, while at those that do not, the average employee monthly wage is \$2,284.

Table 21: Employee Wages and Wage Distribution

	Offer Health Insurance			All	Offer Health Insurance	
	All	No	Yes		No	Yes
	Percent Low Wage Employees	Percent Low Wage Employees	Percent Low Wage Employees	Average Monthly Wages	Average Monthly Wages	Average Monthly Wages
All	18.9%	27.5%	13.1%	\$ 3,255	\$ 2,192	\$ 3,988
Under 10	19.1%	24.8%	8.9%	\$ 3,370	\$ 2,284	\$ 5,311
10 to 24	20.4%	39.8%	13.0%	\$ 3,129	\$ 1,591	\$ 3,731
25 to 99	20.9%	45.8%	16.0%	\$ 3,098	\$ 1,545	\$ 3,406
100 to 999	18.3%	36.2%	17.7%	\$ 2,700	\$ 4,449	\$ 2,632
1000 or More	11.9%		11.9%	\$ 4,575		\$ 4,575

Part-Time Workers

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

Table 22: Percent by Firm Size Categories

	Part-time employees	Part-time employees working for a firm that offers	Part-time employees with eligibility for coverage
Total: Georgia	100%	75%	20%
Firm Size (number employees)			
Under 100	100%	48%	13%
100+	100%	100%	25%

Worker Age, Tenure, and Race

Younger workers are more likely to work in firms that do not offer coverage. Among firms that have between 10 and 99 employees that do not offer health insurance, an average of 16% of employees are under age 25. Among similarly sized firms that offer health insurance benefits, significantly fewer employees are young workers (about 9%).

Table 23: Worker Age By Firm Size

	All	No EBHI Offered	EBHI Offered
	Percent Employees Under Age 25	Percent Employees Under Age 25	Percent Employees Under Age 25
Total: Georgia	10.2%	11.3%	9.6%
Under 10	10.0%	10.5%	9.0%
10-24	10.4%	15.5%	8.6%
25-99	11.7%	17.6%	10.6%
100-999	10.7%	1.0%	11.1%
1,000+	8.3%		8.3%

Table 24: Percent Short-Term Employees in Firms that Offer and Do Not Offer EBHI

	All	Offer Health Insurance	
		No	Yes
	Percent Short-Term Employee	Percent Short-Term Employee	Percent Short-Term Employee
All	17.2%	19.7%	15.7%
Under 10	16.5%	18.3%	13.7%
10 to 24	17.3%	28.4%	13.2%
25 to 99	21.1%	25.7%	20.2%
100 to 999	18.7%	11.6%	18.9%
1,000 or More	12.6%		12.6%

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

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

Cost of Policies

The cost of health insurance, the primary reason employers in Georgia cite as the reason they do not offer healthcare coverage, is rising and affecting rates of coverage. The average annual premium for single person employer sponsored coverage is \$3,228, and the average annual premium for family coverage is \$7,368.

On average, employees at Georgia establishments contribute 17% of the total cost or \$569 per year for single coverage and almost 40% of the total cost or \$2,851 per year for family coverage. Contribution levels appear to be highest for workers at firms between 24 and 99 employees, while workers at the largest firms (>1,000 employees) pay the least for either single or family coverage. Although data for 2002 from the Medical Expenditure Panel Survey (MEPS) are not yet available for comparison, employee contributions for single coverage nationally for 2001 were about 18% of total cost, while family coverage contributions were slightly lower (24%) than the contributions reported by Georgia employers for this survey. At over \$200 per month for family coverage, it is not surprising that a substantial percentage of workers eligible for coverage elect not to participate.

More than 83% of establishments and 79% of employees in Georgia faced an increase in total health plan costs over the past year, while just 4% of establishments and 3% of employees saw a decrease in cost during that same period. It appears that employers are passing some, but not all, of these price increases on to employees. As compared with last year, 15% of establishments report that their employees faced an increase in premiums for individual coverage, 31% report an increase in dependent premiums, 51% report an increase in co-payments, and 43% report an increase in deductibles. On the other hand, plan design appears to be relatively stable, with 86% reporting no change in covered services and 77% reporting no change in choice of providers.

Table 25: Employers Reporting Change in Total Plan Cost

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

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

Nature of Coverage

Firms that offer health insurance typically include hospitalizations, emergency care, and prescription drugs in their packages. Ninety-seven percent of the employer plans surveyed

cover preventive care and mental health-care, while a smaller percentage include dental and eye care coverage (68% and 45%, respectively). These findings are consistent with the fact that state and federal laws require most health plans to cover major medical care but not necessarily mental health, dental, or eye care.

(3.3, 3.2) And, while it is not totally clear exactly how many firms self-insure their coverage, because the data seems to suggest that employers do not understand the difference between fully insured and self-insured, there does not appear to be major differences in these general benefit categories between the two plan types. However, fully-insured and individual coverage sold in the State of Georgia is mandated by law to cover certain conditions or services not mandated by federal law to be covered by self-insured plans.

Many employers (about 30%) who offer health plans are giving their employees a choice of plans. This is particularly true of large employers. Eighty percent of the establishments in Georgia offer a Preferred Provider Organization product, 36% offer a Health Maintenance Organization product, 5% offer a Point of Service product, 14% offer a traditional indemnity plan, 15% offer a special or dread disease policy, 11% offer a non-insurance discount plan, 4% offer a high deductible plan, and 1% offer a voucher for individual coverage. Eleven percent report offering a medical savings account or a flexible spending account to their employees.

Table 26: Benefits Reported Covered Under Any Health Plan Offered

	Employee Coverage		Dependent Coverage	
	Establishments	Employees	Establishments	Employees
Total Offering				
Health Insurance	85,540	3,048,619	85,540	3,048,619
Hospitalization	84,777	3,032,127	78,175	2,923,103
Emergency Room	84,602	3,031,152	78,139	2,921,859
Preventive Care	80,176	2,943,997	75,297	2,854,890
Prescription Drugs	83,305	3,016,910	77,381	2,909,210
Mental Health	78,786	2,949,089	74,263	2,852,539
Dental Care	58,578	2,577,296	56,695	2,508,957
Eye Care	38,760	1,849,387	36,226	1,788,208
	Employee Coverage		Dependent Coverage	
	Establishments	Employees	Establishments	Employees
Offers Health Insurance	100%	100%	100%	100%
Hospitalization	99%	99%	91%	96%
Emergency Room	99%	99%	91%	96%
Preventive Care	94%	97%	88%	94%
Prescription Drugs	97%	99%	90%	95%
Mental Health	92%	97%	87%	94%
Dental Care	68%	85%	66%	82%
Eye Care	45%	61%	42%	59%

Relationship of Healthcare Coverage to Other Employee Benefits

Table 27: Other Benefits Offered by Establishments That Offer and Do Not Offer EBHI

	All	Offers EBHI	
		No	Yes
All	100%	100%	100%
Any Retirement Related Benefits	52%	20%	74%
Life Insurance	48%	3%	78%
Holidays, Sick Leave, or Vacation	85%	73%	94%
Short or Long Term Disability	37%	4%	59%
Employee Assistance Program	15%	2%	24%
Tuition Assistance	18%	4%	27%
Child Care Assistance	6%	3%	8%
Flexible Schedule	27%	31%	25%
Long Term Care Insurance	5%	1%	7%

Firms that offer health insurance coverage are also very likely to offer life insurance, retirement benefits, and short or long term disability benefits to their employees. Firms that do not offer health coverage are likely to only offer paid holidays or vacation as benefits but are significantly more likely than firms that offer coverage to allow a flexible work schedule (31% vs. 25%).

Employers' Decisions to Offer Coverage

Quantitative Findings

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

Table 28: Reasons Cited by Georgia Employers For Not Offering EBHI

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

Employers are also changing carriers frequently. In the past five years, more than 1 out of 3 employees and 1 out of 4 establishments changed health insurance carriers once; 1 out of 3 employees and establishments reported changing carriers two or more times. Only about 1 million Georgians work for a company that has not changed carriers in the past 5 years. Given the large percentage of employers offering a network based plan (see below), this turnover could be disruptive to many employees who might be forced to sever existing doctor/patient relationships.

Table 29: Employer Change of Carriers in Past 5 Years

	Establishments	Employees
Total	85,540	3,048,619
None	32,563	975,141
One time	22,129	1,136,359
Two times	15,265	388,606
Three or more times	12,849	464,375
Missing	2,734	84,138

	Establishments	Employees
None	38%	32%
One time	26%	37%
Two times	18%	13%
Three or more times	15%	15%
Missing	3%	3%

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

Qualitative Findings on Small Independent Employers' Attitudes About Coverage

Focused conversations with small employers, the group least likely to offer coverage and (2.5) probably the most susceptible to crowd out, confirmed the survey findings but also revealed that solving the cost problem and reducing the hassles associated with offering coverage would not necessarily result in greater numbers of employers offering health insurance.

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.

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. It’s 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.

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."

(2.3) 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.

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.

(2.4) 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.

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.

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."

(2.6, 2.7) 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 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. However, small business owners are reluctant to embrace any solution that expands government's role in

the administration or regulation of health care because they feel that approach has not worked well for them in the past.

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

In contrast, some 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.

Summary

Overall, the findings on the status of the private insurance market, which is dominated by employer sponsored health benefits, suggest that Georgia’s small groups, young firms, and the self-employed are the most vulnerable to loss or lack of coverage. Only about 1/3 of these small firms with less than 10 employees offer their employees coverage. Although the workers in these firms make up only 9% of the State’s total workforce, small, independent businesses have historically been an important part of the State’s economy. Among those small businesses, options that reduce costs through tax credits or reduce the “administrative hassles” associated with offering health care are the most popular. However, the size of the small business workforce means, however, that changing the overall numbers of uninsured working adults will mean addressing the cost of coverage. Even among large firms, firms with the greater numbers of low wage workers are the least likely to offer coverage.

SECTION 5. GEORGIA'S HEALTHCARE MARKETPLACE AND PRIMARY CARE SAFETY NET

(Questions 3.4, 3.7)

The State of Georgia's population and geography contribute to a complex healthcare 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 State Department of Community Health,⁹ the most recent data indicates that more than 60% of the hospital stays were covered by government payments, emergency room visits are on the rise, more than \$800,000,000 dollars is spent each year in the State on indigent and charity care, nursing home admissions increased by 30% between 1995 and 2000, and the Department of Community Health reports that the State is facing severe shortages of providers, particularly nurses and pharmacists, over the coming decades. In short, most stakeholders agree that the healthcare marketplace in the State of Georgia, as a whole, when combined with decreasing reimbursements and rising numbers of uninsured, is headed for a major crisis.

However, because the State has a Certificate of Need Program charged with managing provider competition and because other research has indicated that where Georgia falls behind is not in the availability of acute care services, but in the delivery of basic care that has the potential to affect the State's dismal health status rankings, for the purposes of this report, the primary care safety net was identified for further study.

The Primary Care Marketplace

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

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

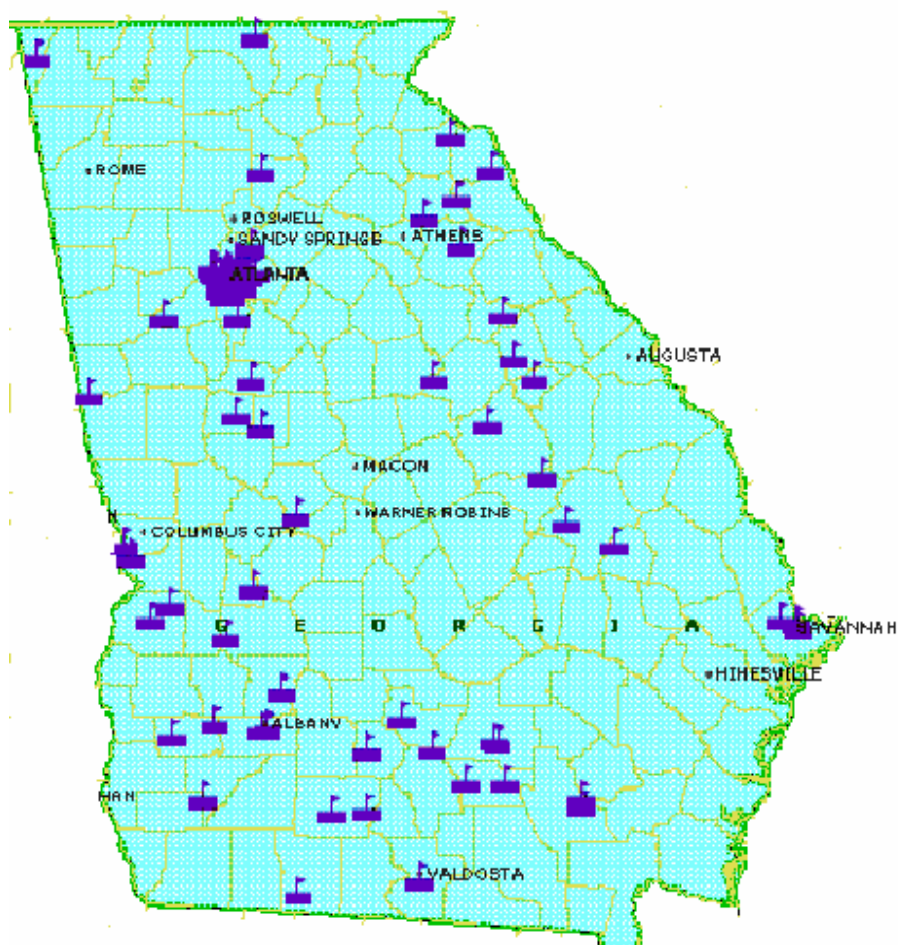
There is no organized, cohesive approach to assuring a primary healthcare safety net for all Georgia communities or citizens. Instead, Georgia's safety net has many layers, with different

⁹ <http://www.communityhealth.state.ga.us/>

governmental agencies and healthcare organizations and individuals providers each offering some primary care services in certain geographic areas to some segments of the population in need. Georgia has a scattered collection of safety net providers consisting of community health centers, county public health clinics, federally qualified community health centers, community mental health centers and hospital based healthcare (public sector and private not-for-profits).

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

Map 2: Locations of Community Health Centers in Georgia



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

Hospital-sponsored Outpatient Clinics or Networks. Public hospitals, such as Grady Health System in Atlanta, offer primary care in outpatient clinics and neighborhood satellites.

Georgia's hospitals also provide some outpatient indigent or charity care and report spending roughly \$1 billion dollars in un-reimbursed costs for hospitalization or uninsured patients.

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

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

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

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

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

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

- 1) **Rural Areas.** Many rural counties have inadequate numbers of primary care physicians, large proportions of the population with no health insurance, struggling hospitals, and no safety net clinic. Thirty-nine counties have been designated as high priority primary care access areas, based on their shortages of health professionals, poverty rates, and excess mortality. As of 1996, there were

101 counties that needed more family physicians, including eight counties with not even one family practitioner. Rural hospitals, which provide supporting infrastructure for primary care, are also in jeopardy. Seven general hospitals closed between 1990 and 1997, five of which were in rural areas. Since that time, significant nursing shortages as well as increasing malpractice insurance costs have created additional threats to the survival of rural hospitals.

- 2) Urban Areas. A plethora of healthcare safety net agencies overlap each other's coverage areas and provide high-volume services, but still have inadequate capacity to serve all the low-income and uninsured patients in need. This may be due in part to the lack of coordination between agencies for allocation of resources and integration of services.
- 3) Suburban Areas. Rapid growth in outer suburbs has brought the healthcare needs of an urban population to communities that did not traditionally require a large safety net infrastructure. The growth of jobs in small businesses and industries that do not offer health benefits to their workers has led to the need for new primary care safety net services.
- 4) Immigrant Populations. Georgia's rapidly growing immigrant populations may face significant language and cultural barriers to care in a system that historically has viewed cultural diversity in terms of black and white. The Hispanic and Latino population has grown by 300% in the past decade and has the highest rates of being uninsured among all ethnic groups in Georgia.
- 5) Georgians with Chronic Illness or Disabilities. Individuals with chronic illnesses or disabilities as well as mental health problems often have primary care needs that go beyond the scope of services provided by public health or primary care safety net clinics. Their needs may include sub-specialist care and sophisticated ancillary services, as well as special transportation or home healthcare and coordination of care between various fragmented service programs.

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

Map 2: Counties with No State, Federal or County Primary Care Safety Net Facility



An estimated 772,947 outpatient primary care safety net visits are being provided to the uninsured each year. This number compares to a projected need of almost 3 million outpatient visits. Thus, Georgia's current safety net is meeting only 25% of the need for adequate primary healthcare. Similarly, roughly 266,533 uninsured person, or one-quarter of Georgia's currently uninsured population and one-third of Georgia's chronically uninsured, are being served by existing safety net providers.

Georgia pays a substantial price for an insufficient primary care safety net, in terms of both human suffering and economic costs. While the total cost is difficult to calculate precisely, a proxy measure is the cost of uncompensated hospital care for the uninsured. In 2000, Georgia spent nearly \$1 billion for indigent care and un-reimbursed services to the uninsured, not including the costs shifted to other patients or the costs in lost productivity.

SECTION 6. OPTIONS FOR CREATING CONSENSUS AND EXPANDING ACCESS TO COVERAGE

(Questions 3.1, 3.5-3.6, 3.8-3.9, 4.1-4.19, 6.7)

Introduction

The State Planning Grant awarded to Georgia has spurred thoughtful conversation among citizens, communities and state leaders on the challenges and options in healthcare policy. However, much remains to be done to reach consensus on solutions and strategies to make coverage accessible to and affordable by every Georgian. A number of recommendations to do this were identified:

- ? The public wants ordinary citizens to have direct participation in developing reform proposals.
- ? Community leaders feel that all stakeholders – insurers, providers, employers, consumers and communities – must work together collaboratively to formulate effective solutions.
- ? State leaders believe that state government should serve as a convener and facilitator of dialogue until consensus is reached and action is possible.
- ? All stakeholders believe the state must identify non-partisan policy priorities that will survive future political transitions and provide a basis for budget priorities.

Translated into State-level action, those recommendations suggest that the following priorities should be adopted:

? **Build a Coordinated Healthcare Policy-Making Infrastructure at the Executive Level.**

Georgia has already made tremendous strides in combining agencies involved in purchasing and planning for healthcare into the Department of Community Health. However, more should be done to integrate and promote interagency state level healthcare policy making within the Executive Branch. Specifically, Georgia needs the capacity to assess and evaluate the nexus between trends in the private health insurance market, self-insured offerings covered by ERISA, and public programs such as Medicaid and public health services and link those findings to fiscal policy. This integration will allow the state to establish both long- and short-term policies aimed at creating savings.

? **Recognize the Link Between Education, Health and Poverty.**

Georgia's youth cannot learn when they have unattended health problems; and without education, Georgia will be unable to compete economically and poverty-stricken areas will remain non-competitive.

- ? **Seek Federal and Other Partnerships to Meet the Health Needs of Georgians.**
The State should adopt a deliberate mission to become a national example in both the public and private markets for health improvement and financing innovations and aggressively seek federal funding to make those innovations possible.
- ? **Promote Individual and Family Responsibility for Health and Health Coverage.**
Mechanisms are needed that promote and reward individual and family responsibility for personal well-being and personal investments in health coverage. Policies that promote personal responsibility will include regulatory changes in the private insurance market, changes in the way public coverage is delivered, the introduction of different cost sharing models, and the creation of financial tools, including tax incentives, that allow individuals and families to manage their own acute and long term care needs and reduce their reliance on public programs.
- ? **Reward Localities That Improve the Health of Their Residents.**
Hospitals, providers, community partnerships, and local governments find that they have competing interests in working to resolve the healthcare access crisis. The State should have clear messages about role expectations and reward the localities that reduce the financial burden on Medicaid and other state programs.
- ? **Ensure the Availability of Care and Functional Assistance for the Disabled and Aged.**
In compliance with the law, the needs of citizens with mental and physical disabilities and Georgia's senior citizens must be met with an emphasis on providing self-directed and non-institutional care when appropriate.
- ? **Coordinate Economic Development and Stabilization Initiatives with Health Initiatives.**
Georgia must respond to the relationship between healthcare resources and coverage programs with economic development initiatives. The relationship between poverty, health, and employment is already well documented yet healthcare considerations are typically not addressed within statewide economic development initiatives or within programs aimed to assist specific communities throughout the state.

Georgia's Plan to Reduce the Uninsured

No option or set of options has been determined be the best approach for Georgia at this time; however, a variety of state-level policy options are the subject of econometric models that will be evaluated in the second year of the SPG through the proposed consensus building model.

At the same time the State is modeling the state-wide policy options and attempting to help elected officials understand the possibilities of each option, the SPG will be pursuing

community-based access to care options, which are essential to a statewide plan to reduce the number of Georgians without coverage.

The statewide options being modeled include **(4.1)**:

- ? A HIPAA compliant high risk pool
- ? Expansion of PeachCare to parents of PeachCare eligible children
- ? Expansion of Medicaid to 100% of the FPL across categories
- ? Increased enrollment of eligible individuals into PeachCare
- ? Increased enrollment of eligible individuals into Medicaid
- ? Small employer tax credits
- ? Individual tax credits
- ? Single-payer healthcare
- ? Status Quo (no changes in state policy)

These options were chosen for modeling based on the experiences of other states and in particular, based on the experience of Minnesota, which has been successful in reaching a high rate of coverage through a series of incremental state actions. **(3.9)** For each statewide expansion option, the following questions will be answered **(4.2-4.19)**:

- ? What is the target eligibility group under the expansion?
- ? How will the program be administered?
- ? How will outreach and enrollment be conducted?
- ? What will the enrollee premium sharing requirements be?
- ? What will the benefits structure be?
- ? What is the projected cost of the coverage expansion?
- ? How will the program be financed?
- ? What strategies to contain costs will be used?
- ? How will services be delivered under the expansion?
- ? What methods for ensuring quality will be used?
- ? How will the coverage program interact with existing coverage programs and state insurance reforms?
- ? How will crowd out be avoided and monitored?
- ? What enrollment data and other information will be collected by the program?
- ? How will the program be evaluated?
- ? What are the political and policy considerations of each option?
- ? What has already been done to implement the selected option?

In particular, with regard to the individual tax credits option, the questions about the adequacy of existing insurance products for those of different income levels and those with pre-existing conditions will be reflected upon. **(3.1)** With regard to the risk pool, lessons about Georgia's insurance market and employer market will be reflected upon. **(6.7)**

In evaluating universal coverage the following questions will particularly be addressed:

- ? What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations? **(3.5)**
- ? How would universal coverage affect the financial status of health plans and providers? **(3.6)**
- ? How would utilization change with universal coverage? **(3.8)**

The plan, in the end, will have 1) a series of state-level policy options prioritized by the order in which they should be implemented and described in terms of the steps to be taken to implement those options, 2) community-level action that will provide “wrap-around” services to those not covered by state-supported coverage, and 3) stakeholder action, including action that insurers, providers, advocates, and elected officials agree to take to move the state towards a decreased number of uninsured.

SECTION 7. PRELIMINARY RECOMMENDATIONS TO THE STATES

(Question 6.1-6.4, 6.6, 6.8)

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

Georgia's Preliminary Recommendations to States

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

In more detail, these recommendations are:

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

(6.1) Although Georgia has not yet completed its planning process; state specific data has been an important part of understanding the problem. The household data, in particular, has yielded information about sub-populations and geographic regions that the state did not have before. It is also expected that the findings from the household survey will see significant use in the General Assembly.

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

The telephone survey used to collect person-level information was very effective. However, the evolving telephone industry will require researchers to revise use of the phone for collection of

household level data as more and more individuals use mobile units exclusively for phone service.

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

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

(6.2) A brief, written survey was an effective tool for gathering general information from a large sample of employers quickly and with minimal costs. The Georgia Employer Survey permitted reply either by mail, by fax, or using a web-based response mechanism. Surprisingly, less than 10 percent of the firms responded electronically by web, and only 10 percent responded using the fax option. The high volume of mailed responses and the systematic differences between firms based on their response mechanism suggests that limiting survey to a single response option may create unintended non-response bias.

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

And, while the method used to collect the employer data was highly effective, the survey would have enjoyed a substantially higher response rate if the cover letter had appeared on letterhead from the State of Georgia's Department of Labor (DOL). Although the response rate was acceptable for academic surveys, the 22% rate lagged significantly behind rates reported for DOL Employee Benefit Surveys administered by other states. Improved cooperation between state agencies, which could have been effectuated by early planning and better communication, would have facilitated this type of collaborative survey administration.

4) Qualitative research was important in identifying stakeholder issues.

Again, although Georgia has not yet engaged in a decision making process, qualitative data has been extremely valuable in identifying needed educational and communication strategies to create an environment in which the policy planning process can move forward.

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

(6.4) Collecting the amount of data Georgia collected in a 6-9 month period required a great deal of planning and organization. It also required persistence in resolving setbacks. For example, our employer survey required two mailings of the survey instrument and one follow up postcard to collect the data. Georgia completed all of the originally proposed data collection activities; however, the hardest part has been translating that data into a usable format for the public and decision-makers.

6) Consider political polling in addition to focus groups, a household survey, key informant interviews, and an employer survey.

(6.3) Although the data collected has been very valuable, credible political polling would also be highly valuable. Through key informant interviews, Georgia's SPG revealed that while many state leaders are somewhat resistant to working toward improving access to health insurance, in part because they fear the public reaction, the public is very accepting of a wide range of solutions and desire leadership on the issue. Polling might have been an excellent source of information for state leaders who are unsure of the public's concerns and desires on access issues.

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

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

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

The SPG funds call for information about the healthcare marketplace to be collected. Because the state is so large, Georgia was unable to fund a full assessment of the healthcare marketplace, the provider markets, the level and number of specialists and hospitals, and long-term care and health insurance markets. We were able to collect data on the primary healthcare marketplace for low income individuals, some hospital discharge data, and some geographic health insurance market data through the various data collection methods, but other states should be aware that market data is very difficult to collect, particularly if information of the state's insurance market regulator and certificate of need regulator has to be requested on a very specific basis.

SECTION 8. PRELIMINARY RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

(Questions 6.5, 7.1- 7.4)

At this time Georgia has not selected any options for covering the uninsured and (7.1, 7.2)) no option has been ruled out because they require changes in Federal law. Recommendations by the State of Georgia therefore relate to the need for federal financial support of current health programs and current efforts to improve the State's ability to sustain its own programs and are only preliminary. Specifically, federal support of the following is needed:

Goal Identification (7.3)

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

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

Research and Infrastructure (7.3)

? **Information Systems Development**

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

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

The federal government should provide ongoing support for the collection of data specific to state-level concerns and needs. Research conducted by the federal government, foundations, and other organizations could be more helpful to states if the surveys were more sensitive to state level concerns, such as terminology and intra-state regional variation. The SPG funds allowed Georgia to collect important information that

is otherwise unavailable, but ongoing data collection will support research on many of the unanswered questions regarding health insurance.

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

? **State-Specific Econometric Modeling**

The state would also benefit from additional support for researcher time to use the employer survey and the household survey to simulate behavioral responses to proposed policies or programs designed to expand coverage. The simulation process requires ongoing dialogue regarding program design and an iterative process of proposal design, estimations of cost and coverage impact, and refinement of proposals based on the output. Each time a new federal health initiative is created, states need the funding to support a quantitative analysis of the impact that initiative will have on its other programs and activities.

? **Regional Collaboration Between States**

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

? **Support Specific Research Questions**

(7.4, 6.5) The State is unable to directly support extensive research on the uninsured at this time. However, some of the questions that require research and that are relevant to policy makers seeking the ensure access to insurance and to health care services where federal assistance would create an impact are:

- ✍ How do employment-based coverage take-up rates differ by location, industry, and other factors in addition to the known effect of premium-sharing?
- ✍ How do worker characteristics influence plan design decision-making by employers?
- ✍ What is the link between individual risk profile and access to health insurance coverage? How does risk influence take up rate, choice between plans, and wage/benefit trade off in employment decisions?

- ✍ How does utilization of different types of health care services vary with the presence of any coverage and with different plan design features?
- ✍ What factors influence participation rates in public programs that vary by region? How does local perception of public programs and community attitude differ between regions?
- ✍ How are the creation of rural health networks and other community-based initiatives impacting health disparities and rates of uninsured in those communities?
- ✍ How will current laws and policies regarding graduate medical education affect health worker shortage areas and the per capita availability of medical care in 10 years? 20 years?
- ✍ What should the definition of under-insured be from a public health perspective (i.e., what level of coverage meets the Healthy People 2010 goals) and what should the definition be from an economic perspective?

Direct Support (7.3)

At this time, because no options have been selected by the State of Georgia, recommendations to the federal government regarding opportunities for directly supporting state innovations to reduce the number of uninsured are minimal. They are:

? Reward States that Reduce Their Number of Uninsured

States that invest state dollars and engage in state level planning to reduce their number of uninsured should be rewarded. In Georgia, somewhere between 10% and 20% of the uninsured are eligible for programs that receive matching federal dollars, but the State is not motivated to enroll those individuals because it can not meet it's share of the dollar obligation. It might remedy this if, for example, the Medicaid and SCHIP matches were based on a sliding scale that increased the match as states covered more eligible individuals. States might take the extra steps necessary to enroll those harder to reach eligible individuals.

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

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

? **Offer Special Financial Assistance to Historically Impoverished Areas to Improve Healthcare Access**

Some states, particularly southern states, still feel the residual affect of the civil unrest that marked the late 1800s and the period from 1950-1975. Communities, and particularly rural communities, struggle to improve access to healthcare because they have little or no experience working together to improve access or writing federal grant applications, and have no financial support to engage in such activities. These communities, therefore, would benefit from grants targeted directly at their particular needs that would later permit them to compete on the same level as, for example, a community in the northeast.

? **Increase the Accessibility of Federal Employees to State Policy-Makers**

It was noted on several occasions during the Planning Grant that it was particularly difficult to arrange meetings with non-grant related federal workers who might have helpful information about strategies to reduce the number of uninsured, such as Community Health Centers, because these workers had to obtain clearance from Washington before joining sharing information. Communication with federal workers on the real issues states are facing will improve the likelihood that innovative partnerships are developed.