Georgia Pilot 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

September 30, 2005

A. Executive Summary

Background and Previous HRSA SPG Accomplishments

The State of Georgia was funded under the 2002 State Planning Grant Program and was approved by HRSA to revise its remaining work plan and spend its remaining $125,006 through August 31, 2004 on activities that built on the data collection and public engagement work accomplished in FY03.

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

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

Georgia Household Health Insurance Survey

The University of Minnesota's School of Public Health Survey Research Center conducted a telephone survey of more than 10,000 Georgia households between October 2002 and February 2003. The survey enabled the modeling 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 included health insurance status, access to health insurance, type of coverage, health status and access to care, use of services, and demographic characteristics of respondents. The survey, by its design, collected information about the health insurance status of each individual in the household as well as detailed information about a randomly selected target individual in each household. In keeping with HRSA's desire to share SPG products with other states, the Georgia survey was used by the state of Alabama as a model in its data collection activities.

Georgia Employer Health Benefits Survey

A health benefits survey that collected information from over 1,400 establishments in Georgia (25 percent response rate) was performed by Georgia State University between October 2002 and January 2003. The survey gathered information about the characteristics of the work force and the benefits available to employees. The survey sample was drawn from 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. The Georgia team consulted with Virginia and Hawaii in modeling their SPG employer surveys after Georgia's. Additionally, Dr. Patricia Ketsche presented results from Georgia's survey at the 2004 Academy Health Annual Research Meeting and published a paper based on the results in *Medical Care Research and Review*.

Georgians on Health Insurance Focus Groups

Between September 2002 and December 2002, 21 focus groups (total participation of 250 individuals) were convened to measure Georgian's attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians. The focus groups were conducted using a scientifically valid population sampling technique known as the PRIZM Population Cluster Identification System. Claritas, Inc., a marketing firm specializing in the identification of neighborhood groupings with similar demographic backgrounds and consumer behavior patterns, developed the system.

Attitudes of Small Georgia Employers on Health Insurance

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

Georgia Key Decision Maker Interviews

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

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.

Community Listening Sessions

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

underwriters, philanthropies, community-based organizations, and elected officials. The purpose of the listening sessions was to gauge opinions about the impact of the uninsured at the local level and attitudes about health care reform options.

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

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

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

Georgia continues to strategically examine what solutions will make sense for the state and its residents in consideration of the fluid economy. From the beginning of the process, there has been considerable interest in consensus building at the community level. State leaders are also now aware of, and fully vested in, the continued work of the grant.

Pilot Grant Activities

Georgia's Pilot Planning Grant, awarded in September 2004, contains four distinct areas of work: an update of the employer benefits survey conducted in 2002 – 2003 as part of the original Planning Grant work; a study of incidence of uncompensated care intended to give both state policy makers and local communities a better sense of the trade-offs they face in assessing plans to expand access to health care services to the uninsured; focus groups and community conversations with local employers, employees, and leaders to inform the selection of community-based coverage models; and, four community-level pilot planning activities designed to create public-private coverage partnerships between small employers currently not offering employment based coverage to their employers and state or local government.

The employer benefits survey is complete, and a report follows on the latest findings. The study of incidence of uncompensated care is also complete, and a report also follows. The model created to determine the incidence of uncompensated care in Georgia is also flexible enough that it will be used to assist the communities in estimating plan design as they complete their coverage plans. The focus groups and community conversations are complete except for the Atlanta community. Detailed reports follow. Community-level activities are complete up to the actual design of the plans chosen by each unique community. Three of the communities have chosen variations of the 3-share model made popular in Muskegon, Michigan.

All communities have had a challenging time determining support for the model beyond employer and employee shares and discounted provider rates. Georgia is currently undergoing mandated changes in the way it operates its disproportionate share hospital (DSH) program, and

support from DSH at this time is not scene as a viable option. The state is also undergoing a Medicaid modernization process. As part of that process, the state is in conversation with CMS as to the feasibility of using employer funds as state match in a modest Medicaid expansion that might provide coverage to the families of PeachCare parents. That same process might be used to match employer funds at the community level to provide an additional share to the funding pool that would provide employer-based insurance through a modified Medicaid expansion. Throughout 2005 – 2006, all communities will continue to work on the development of their plans. Atlanta, after being delayed by a leadership void, continues to work with Kaiser Permanente and the National Federation of Independent Business to design a community-based plan that fills a gap in the marketplace for the working uninsured.

Implementation Status

As the Georgia Pilot Planning Grant has been awarded a one-year no-cost extension to continue work on the project, none of the four coverage pilots have yet been implemented. However, as part of a larger effort by the state to modernize Medicaid, Georgia officials are in conversation with the Centers for Medicare and Medicaid Services as to how a modest Medicaid waiver expansion might be applied to the current work. Specifically, Georgia is exploring with CMS the possibility of federal match of employer contributions to private, employment-based insurance for those small business owners who have not been able to offer coverage to their employees due to cost. In effect, this would create a "third share" among employers, employees, and the federal government. Under a waiver, it is envisioned that working individuals of small firms that meet Medicaid expansion income guidelines would be bought into private coverage with federal dollars. The coverage plan would be tailored to the needs of the local community and would not necessarily include all benefits generally available through the Medicaid program. The state anticipates submitting its initial waiver in early 2006.

Recommendations to the Federal Government and HRSA

As the Georgia Pilot Planning Grant has been awarded a one-year no-cost extension to continue work on the project, comprehensive recommendations have yet to surface. However, at this initial stage, the Planning Grant Team endorses the following:

1. HRSA should consider in its future grant making tying implementation funds to any planning grant effort. Particularly in working with community organizations, local boards are reluctant to raise the hopes of community members in a planning phase without the necessary implementation funds allocated to the project through to fruition.

2. HHS, and particularly CMS, should support a broad range of pilot Medicaid expansion strategies and financing schemes that may not have seemed feasible in the past.

B. Background and Previous HRSA SPG Accomplishments

The State of Georgia was funded under the 2002 State Planning Grant Program and was approved by HRSA to revise its remaining work plan and spend its remaining $125,006 through August 31, 2004 on activities that built on the data collection and public engagement work accomplished in FY03.

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

Grant activities accomplished in the initial funding period (2002 – 2003) and no-cost extension period (2003 – 2004) are summarized below.

1. State Oversight

In 2002, Governor Roy Barnes appointed an advisory body - the Governor's Action Group on the Accessibility and Affordability of Health Insurance – to review the work of and advise the project team. Representation was sought from the Governor's Office, the Georgia General Assembly, provider associations, key state agencies, the business sector, academia, and consumers.

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

This group was charged with the responsibility of helping to guide the remainder of the grant activities in keeping with state budget priorities and providing recommendations to the Governor with respect to strategies for reducing the number of uninsured Georgians. The appointment and functional responsibility of this group remains in effect. The Planning Grant Team continues to brief and solicit input from the original members of the Governor's Action Group and seeks informal input from the Georgia Coalition for Health Provider's Council, the Georgia Hospital Association, the Atlanta Regional Health Forum, and the Georgia Association of Health Plans. Having learned from its change in gubernatorial administrations during SPG activities, members

of the Georgia team consulted with the Mississippi SPG team in 2003 to provide insight into establishing a productive relationship with a new administration.

2. Data Collection, Analysis, and Presentation

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

Georgia Household Health Insurance Survey

The University of Minnesota's School of Public Health Survey Research Center conducted a telephone survey of more than 10,000 Georgia households between October 2002 and February 2003. The survey enabled the modeling 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 included health insurance status, access to health insurance, type of coverage, health status and access to care, use of services, and demographic characteristics of respondents. The survey, by its design, collected information about the health insurance status of each individual in the household as well as detailed information about a randomly selected target individual in each household. In keeping with HRSA's desire to share SPG products with other states, the Georgia survey was used by the state of Alabama as a model in its data collection activities.

Georgia Employer Health Benefits Survey

A health benefits survey that collected information from over 1,400 establishments in Georgia (25 percent response rate) was performed by Georgia State University between October 2002 and January 2003. The survey gathered information about the characteristics of the work force and the benefits available to employees. The survey sample was drawn from 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. The Georgia team consulted with Virginia and Hawaii in modeling their SPG employer surveys after Georgia's. Additionally, Dr. Patricia Ketsche presented results from Georgia's survey at the 2004 Academy Health Annual Research Meeting and published a paper based on the results in *Medical Care Research and Review*.

Georgians on Health Insurance Focus Groups

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

the identification of neighborhood groupings with similar demographic backgrounds and consumer behavior patterns, developed the system.

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

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

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.

Community Listening Sessions
Four listening sessions for community leaders (total participation of 60 individuals) were conducted by Grant staff in locations selected for their geographic and cultural diversity and their relative rankings of aggregate economic strength. Participants were drawn from representatives of the business and economic development communities, health care providers, insurers and underwriters, philanthropies, community-based organizations, and elected officials. The purpose of the listening sessions was to gauge opinions about the impact of the uninsured at the local level and attitudes about health care reform options.

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

Data Analysis and Presentation
With analysis of the data completed, there were many opportunities for incorporating the information from it into the public domain to inform decision makers and build consensus. Core

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

Specific accomplishments in the use of the data included:

- Ongoing responses to multiple requests by local organizations for detailed technical assistance in finding community-based solutions. The public was encouraged to request and use grant findings for planning local initiatives that would help improve access to health insurance.
- Many requests for small area estimates were received, and localized data from the household survey were used, particularly for the purpose of applying for funding, the establishment of Community Health Centers, or other federal grants. As a result, the grant staff and the Division of Public Health in the Department of Human Resources worked together to make the data available to the public via the Internet on that agency's OASIS system.
- Participation in the Arkansas Multi-State Integrated Database System
- Presentation of results at the 2004 Academy Health Annual Research Meeting and a publication of survey results in the August 2005 issue of *Medical Care Research and Review*.

Fact Sheets and Reports

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

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

Additional Reports and Data

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

Public Forums

A series of public forums began with the launch of *Cover the Uninsured Week 2003* to share the findings supported by the Grant and to encourage public discussion. Each Public Forum was widely advertised directly to stakeholders and legislators, as well as the public through print,

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

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

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

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

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

Georgia continues to strategically examine what solutions will make sense for the state and its residents in consideration of the fluid economy. From the beginning of the process, there has been considerable interest in consensus building at the community level. State leaders are also now aware of, and fully vested in, the continued work of the grant.

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

August 2003
The National Association of Counties (NACo) and the National Council of State Legislators (NCSL) partnered with the Georgia Health Policy Center and the Association County Commissioners of Georgia to host a meeting to examine the issue of the uninsured in Georgia. The organizations together hosted the two-day event in Atlanta. There were nearly 100 participants, including: state legislators, county chairs and commissioners, district health officers, health network directors, conference faculty, representatives from NCSL, and representatives from Kaiser Permanente.

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

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

October - December 2003
The House Task Force on Health Insurance Options for Small Businesses and the Working Uninsured, created by the Georgia General Assembly, was a direct result of the August event. This bipartisan Task Force, chaired by Representative Pat Gardner, was provided with information and technical assistance from the Planning Grant Team. During this time, the committee built further consensus by engaging the participation of the Georgia Association of Health Underwriters in their deliberations as they considered options for expanding coverage, modeled under the planning grant. A report to the House, outlining the recommendations of the committee, was produced by the Planning Grant Team.

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

December 2003
The Atlanta Regional Health Forum, a multi-disciplinary group (public, private, governmental, corporate, legal, education, business, managed care, community-at-large, etc.) and the Georgia Health Policy Center co-sponsored a meeting of small business executives from the Atlanta region to discuss the data and options coming out of State Planning Grant activities during the year. Vondie Woodbury, of Access Health in Muskegon Michigan, also briefed the group on public/private partnerships. The group was then led through a participatory exercise to arrive at options they individually would be willing to consider. The Forum, with core functions that include disseminating data, shaping views, convening stakeholders, and catalyzing change, committed their support to the work of the grant in a published report.

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

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

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

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

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

May 2004
Given the growing consensus around targeting strategies for the expansion of coverage to the working uninsured, the State Planning Grant Team organized a three-hour pilot discussion with ten business leaders in Albany Georgia. The discussion provided insight into the level of business support for the concept of public/private approaches to the problem of the working uninsured, as well as the potential of approaches to be embraced by larger employers.

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

C. Pilot Grant Activities
Georgia's Pilot Planning Grant, awarded in September 2004, contains four distinct areas of work: an update of the employer benefits survey conducted in 2002 – 2003 as part of the original Planning Grant work; a study of incidence of uncompensated care intended to give both state policy makers and local communities a better sense of the trade-offs they face in assessing plans to expand access to health care services to the uninsured; focus groups and community conversations with local employers, employees, and leaders to inform the selection of community-based coverage models; and, four community-level pilot planning activities designed to create public-private coverage partnerships between small employers currently not offering employment based coverage to their employers and state or local government.

The employer benefits survey is complete, and a report follows on the latest findings. The study of incidence of uncompensated care is also complete, and a report also follows. The model created to determine the incidence of uncompensated care in Georgia is also flexible enough that it will be used to assist the communities in estimating plan design as they complete their coverage plans. The focus groups and community conversations are complete except for the Atlanta community. Detailed reports follow. Community-level activities are complete up to the actual design of the plans chosen by each unique community. Three of the communities have chosen variations of the 3-share model made popular in Muskegon, Michigan.

All communities have had a challenging time determining support for the model beyond employer and employee shares and discounted provider rates. Georgia is currently undergoing mandated changes in the way it operates its disproportionate share hospital (DSH) program, and support from DSH at this time is not scene as a viable option. The state is also undergoing a

Medicaid modernization process. As part of that process, the state is in conversation with CMS as to the feasibility of using employer funds as state match in a modest Medicaid expansion that might provide coverage to the families of PeachCare parents. That same process might be used to match employer funds at the community level to provide an additional share to the funding pool that would provide employer-based insurance through a modified Medicaid expansion. Throughout 2005 – 2006, all communities will continue to work on the development of their plans. Atlanta, after being delayed by a leadership void, continues to work with Kaiser Permanente and the National Federation of Independent Business to design a community-based plan that fills a gap in the marketplace for the working uninsured.

In addition to the reports below, a color-coded project management matrix is included as Appendix 2. Green shading indicates the task is complete and yellow shading indicates the task is on-track but behind schedule.

1. Employer Benefits Survey

The employer benefits survey was completed in the spring of 2005. A complete report, as well as a summarized report released to the public, is included in Appendix 3: Completed Reports Supported by HRSA Pilot Planning Grant.

2. Study of Incidence of Uncompensated Care

The number of Georgians without health insurance has increased by over 23 percent in the 21st century, increasing from just over 1.1 million in 2000 to almost 1.4 million in 2003. Nationally the number of uninsured has grown from 38 million in 2000 to almost 45 million in 2003. One of the implications of this growth in the uninsured population is that the costs of the care provided to those individuals moves from direct payments from insurers (public or private) to a set of subsidies for care that are difficult to identify. Understanding the incidence of these costs is an important part of crafting a more rational method of financing health care in Georgia.

This project develops a micro-simulation model of the incidence of the costs of health care provided to the uninsured in Georgia. National data are combined with Georgia specific surveys and economic literature to address the following questions:

- Who bears the costs of the uninsured?
- How does the incidence of health care costs change with changes in public and private insurances programs?
- What are the local economic consequences of changes in sources of health care financing?

Methodology

Counting the Uninsured

Population data from The Georgia Healthcare Coverage Project, which surveyed 10,000 Georgians in the fall of 2002 were matched to the March 2004 Supplement to the Census Bureau's Current Population Survey (CPS) to provide estimates of the number of uninsured in Georgia by demographic and geographic characteristics. Estimates of the number of uninsured by county were obtained by estimating the relationship between income and health coverage.

Preliminary estimate of the uninsured by county were then adjusted by county growth since the 2000 census and calibrated to match state totals from the CPS.

Health Insurance in Georgia, 2003

		Percent
Total	7,700,928	100%
Total Private	5,491,623	71%
Employer	5,113,573	66%
Direct	2,697,076	35%
Indirect	2,416,497	31%
Other Private	409,888	5%
Total Public	1,186,725	15%
Medicare	196,962	3%
Medicaid	898,693	12%
SCHIP	239,560	3%
Uninsured	1,397,907	18%

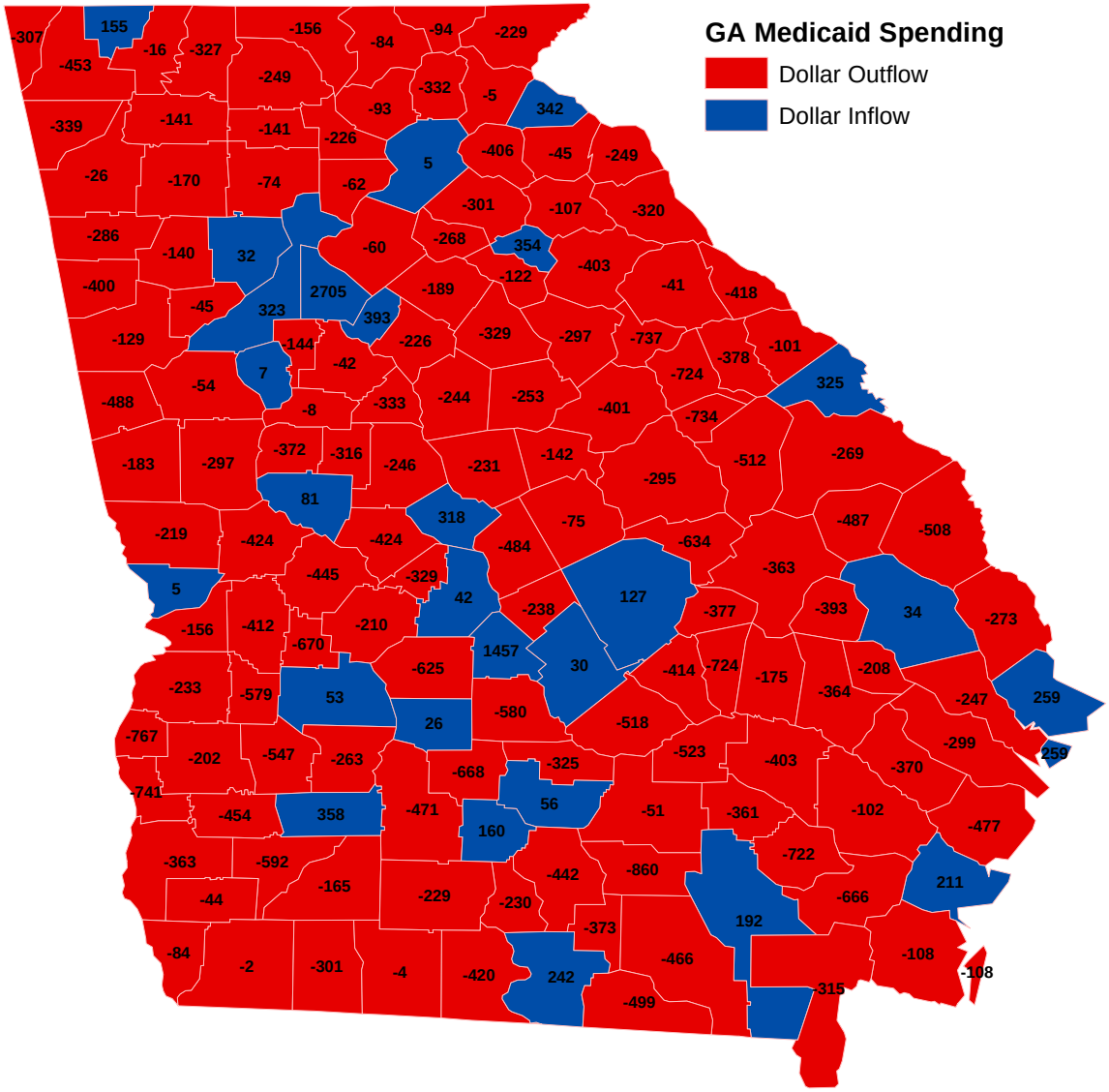
Estimating Uncompensated Care Costs

From the Medical Expenditure Panel Survey (MEPS) for 2002, the amount families spend on health care can be estimated by family income, insurance status, employment status and health status. Estimates of total health expenditures, out of pocket payments, and uncompensated care were obtained and calibrated to match total national health expenditures. These data, which reflect 2002 information, were then inflated by the rate of growth in national health expenditures to create real estimates for 2003.

Georgia Medicaid claims data were used to identify patient flows between counties in Georgia. Previous work on patient flows done to help Georgia communities develop their optimal health care delivery system found that Medicaid patient flows are very similar to uninsured patient flows. Total Medicaid claims for recipients within the county were compared to total Medicaid payments made to providers within the county. Positive numbers indicated that more Medicaid dollars were paid to providers within a county than were accounted for by the county's Medicaid population. These Medicaid patient flows were used to estimate the patient flows for the uninsured in Georgia.

The per-capita uncompensated costs adjusted for income were assigned to the insured and then summed to provide an estimate of total uncompensated care in Georgia. The distribution of those costs across geographic areas in Georgia use Medicaid patient flows.

Georgia Medicaid Dollar Flow Per Capita By County



Estimating Incidence of Uncompensated Care

Uncompensated care costs that were paid by public sources were estimated by totaling public payments made in Georgia for:

- Disproportionate share payments in Medicare and Medicaid
- Indigent Care Trust Fund
- Direct payments to providers
- Direct care (Community Health Centers, etc.)

This total public expenditure was then assumed to be born by individual taxpayers as a percentage of their total tax payments to the Federal, state and local governments.

After subtracting public payments from the total uncompensated care costs, the remainder is assumed to be born by private purchasers of health care services. It is assumed that these costs are part of provider fixed costs. In the long run, these costs increase the costs of services and, therefore, increase both out of pocket payments and insurance premiums. Cost sharing in health care plans and premiums varies by size of the individual's employer (or individual coverage). Larger groups generally have lower premiums and lower cost sharing arrangements. Costs are then allocated by assuming that premiums increase by a per-capita amount of private uncompensated care costs adjusted by elasticity of demand for health insurance.

Estimating Incidence of Changes in Medicaid Eligibility

Medicaid claims data were examined to determine the costs of health care for those individuals eligible for Medicaid under the Right from the Start Program both in total and by county. The policy change modeled was to drop eligibility for Medicaid under that category. The number of newly uninsured as a result of the policy change was estimated by matching those losing Medicaid eligibility with similarly situated individuals and assuming those who leave the Medicaid program have similar sources of coverage.

Costs are estimated by comparing the costs of care for those on Medicaid with those without any source of health insurance coverage. The percentage of those costs that are uncompensated for currently uninsured are applied to the newly uninsured under the policy change.

Results

It is estimated that the uninsured accounted for $1.49 billion in health care services in Georgia in 2003. Of that total $1.2 billion had no identifiable source of payment and is estimated to be uncompensated. Tax payers pay an estimated 49 percent of the costs, while private payers bear the rest of the costs.

Uninsured:	**$297 million**
Taxpayers:	**$586 million**
Other Health Care Consumers:	**$602 million**
Total Costs of Uninsured:	**$1,485 million**

The actual incidence of those costs depends on the economic circumstances of the individual. For example, a family of three earning the median income for Georgia in 2003 would pay almost $800 a year in taxes, premiums, and direct payments for health care services for uncompensated care. A family earning around 200 percent of poverty would pay over $650.

Within Georgia, those costs are not equally distributed. It is estimated that over 16 percent of all uncompensated care costs are incurred in two counties in Georgia: Fulton and DeKalb.

3. Focus Groups with Employers and Employees

Focus groups were conducted in the three pilot site communities of Macon, Brunswick, and Dalton. In each location, one focus group was held with small business employers and one focus group with employees of small businesses. The primary purpose of the focus groups in Macon and Brunswick were to gain insights into how small business owners and employees would accept a multi-share health coverage model. In Dalton, three models were presented to focus group participants for their reactions. The three models were multi-share coverage, discounted provider network and limited insurance coverage. Both the small business owners and employees in Dalton preferred the multi-share coverage model over the other two approaches presented to them.

In all three locations, employers and employees were enthusiastic about the potential for having multi-share coverage available in their communities because such a plan would provide them some access to coverage, even though it would be limited to the geographic area in which they reside. Employers and employees alike expressed frustration with their inability to obtain health insurance which they could afford. Employers feel a sense of responsibility for employees whom they consider essential to the success of their businesses and want to be able to provide them health benefits. Additionally, they are concerned about their ability to attract the quality of employees they need to help expand their businesses if they cannot provide health coverage. In all locations, uninsured employees told of accumulating debt due to a medical emergency.

With few exceptions, both employers and employees indicated that they would strongly consider participating in their community's multi-share plan. They are pleased with the scope of services that would be provided and would even accept a more limited benefits package in order to have affordable coverage. When asked what they would be willing to contribute toward multi-share coverage, employers indicated they could pay between $25 and $100 per employee per month. Employees would pay between $50 and $150 per month.

These focus groups have suggested that small business owners and their employees are overall supportive of the concept of a multi-share coverage model in all three pilot communities and are willing to personally contribute toward that coverage.

Brunswick, Georgia

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

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

three are uninsured, as are their spouses. The number of uninsured employees represented by this group ranges from none to twenty-nine.

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

Experiences in Seeking Health Coverage

Employers

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

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

> "I've done better with older employees so it's a shame that it's harder to get them insurance."
>
> "I'm still going to have floating positions all the time, but my more mature ones would really like to have insurance."
>
> "Older, responsible adults are the ones that are really looking forward to getting insurance."

Other owners are deterred by employees that have pre-existing conditions. An employer explained his dilemma, "We have one key employee that we're trying to get insurance for. We promised him that if he would come on board we'd do it. As it turned out, he has a whole laundry list of health problems, and nobody will insure him." The time consumed in administering an insurance program for employees is another obstacle for these business owners. One woman complained about the burden of paperwork, saying, "Everything that's involved in that with the hospitals, with the doctors, with the insurance companies, with the employees, on, and on, and on. I mean it's a lot of paperwork." A man concurred, saying: "It falls on you as a small business owner to manage your own plan, even if you go to a group insurance. My

background is in health care before I bought the print shop, and I actually know the lingo, and I have a hard time with it. I don't have time to manage it."
Small business owners also feel that the mandate to provide workers compensation insurance adds to the problem, as this conversation illustrates:

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

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

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

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

Employees

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

> "It is outrageous. I can't afford it."
>
> "I'm a diabetic with high cholesterol. I can't even shop for insurance."
>
> "I looked one day and I got so aggravated, and after that I have never looked for it again. I just pray that I don't get sick."

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

Reactions to the Multi-Share Concept of Health Coverage

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

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

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

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

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

Defining Parameters for Multi-Share Coverage

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

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

Citing the possibility of abuse of coverage, employers would exclude ambulance services, hospice, rehabilitation services, and organ transplants, but they would include dental with an emphasis on prevention, vision, and chiropractic care. In expressing his reservations about

rehabilitation services, one employer explained, "How long do we have to carry this through once someone has been in the hospital? I mean there has to be a limit to it somewhere, whether it's two months, three months, there has to be a limit to it. I can't afford it, and I don't think anybody in here can afford to just keep carrying somebody month after month after month." A woman agreed, saying, "The bottom line is keeping the costs down."

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

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

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

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

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

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

Contributions toward Multi-Share Coverage

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

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

After hearing the discussions of the multi-share program, all but one of the employees indicated that they would participate in such a program. The one who was hesitant said that she preferred

to investigate a medical savings account for the immediate future. When asked directly about the maximum they would contribute monthly toward coverage in a multi-share model, one said $60, one said $75, three said $80, and six said $100. On average, they would pay an additional $50 per month for family coverage.

Conclusion

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

Dalton, Georgia

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

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

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

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

Experiences in Seeking Health Coverage

<u>Employers</u>

Only two of these employers have offered health insurance to their employees in the past, but both have dropped that coverage within the past two years due to rising costs. One employer commented, “It was either make wages or cut out the insurance. It just kept going up and up and up and up.” Concerns about the consequences of yearly premium increases keep most of these employers from considering health benefits for their employees. A man in the group explained, “Last year I looked and saw what it would cost, but then I hear that this year it’s going to cost a lot more. So, three years from now the cost of living is going to go up; and by rights, my employees need to get a raise. In the same token, the insurance policies are going to keep going up. Then pretty soon, it’s going to be an unmanageable cost.” Another employer added his perspective when he said, “My employees can’t afford to contribute a whole lot, and I can’t contribute a whole lot. So, that’s the catch-22.”

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

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

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

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

<u>Employees</u>

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

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

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

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

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

> "I was in the hospital one time, and the hospital bill was $1,000. I still have hospital bills from three or four years ago. I get calls every day, but I just can't afford it."

> "I have thousands and thousands of hospital bills, about $5,000. I just got sued last month from people trying to get the hospital bills paid. They said they were going to garnish my wages and all of this stuff. They're taking payments from me now, but its money I don't have. It's frustrating."

Reactions to Coverage Options

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

Discounted Provider Network:

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

Limited Insurance Coverage:

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

Multi-share Coverage Model:

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

<u>Reactions to Discounted Provider Network</u>

The discounted provider network had little appeal for either employers or employees, although employers were somewhat more positive than employees. Some employers would consider

paying the annual enrollment fee for their employees even tough they do not believe their employees would receive any significant benefit. One employer's reaction was similar to others when he said, "I would pay for it because I want them to know I care, and $120 is not very much. But, I don't think they're getting anything." Employers observed that they have assisted employees in receiving similar discounts by merely calling the doctor or hospital and asking for it. One employer commented, "You can negotiate with the hospital and physicians. If you say you're paying in cash, you can get a little discount." In responding to this observation, another employer recounted having gotten a 15 percent discount from the hospital when he offered to pay an employee's bill in cash. However, a third employer doubted that such a discount would be provided by pharmacists and felt that the 15 to 25 percent discount offered for prescription drugs would be worth the annual cost of the card. She offered, "This is better than nothing. Certainly, if you have nothing, then just the prescription coverage would help. They could recoup the $120 we initially pay just with the discount with the pharmacy." Others remained unconvinced, with one describing the discounted network as "a band-aid for a hemorrhage" and another requesting "something better."

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

Reactions to Limited Insurance Coverage

While almost all of the employees rejected limited coverage insurance as being viable for them, employers had mixed reactions to this option. One employer's assessment best describes the consensus of the group regarding limited insurance coverage. She said, "This is going to meet a lot of people's needs. It's not my first choice of the options we've seen, but if this were our only choice, I don't think we could turn it down. I think we would offer it." Employers agreed that the limited insurance option is best suited to their single, young, healthy employees with low incomes. "We have a lot of 18, 19, and 20 year olds that do not have any insurance. This is the only thing that I've seen tonight that would truly and genuinely cover a majority of the employees in entry-level positions. To me, $15 a week is something that they could handle," declared one employer.

Employers also recognized the constraints of the coverage being offered. One participant observed, "I think this is a one-illness per year type of limitation. It's there to help a little bit, but it's not really much." Other employers quickly eliminated limited insurance coverage as a viable option. One of these employers questioned, "Who is going to pay $40 a week for a possible pay out of $10,000? If something happens, it doesn't take long to get up to $10,000. You'd be better off just putting the money in the bank or taking the risk. I don't see this being any advantage to anybody but the insurance agent." A second noted, "On Plan C, you're getting relatively close to what you're paying for a standard insurance policy, so it would be tough to consider this."

Two of the nine employees indicated that they would consider the limited coverage model, believing it would suit their particular needs. One remarked, "Right now, I don't have anything

that covers me and Plan A would work for me. I'm single, and I think I could do $15 a week. Something is better than nothing. If I wind up in the emergency room again, then I'd at least have something to back me up." The other commented, "Plan B looks alright to me, looking at the $10,000 inpatient maximum. I don't anticipated needing anything more than that. If somebody offered that to me, I would probably take it." The remaining seven employees would not consider purchasing any of the three plans presented in the limited insurance coverage option. Their assessments of this option included:

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

Reactions to the Multi-Share Model

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

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

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

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

Employers and employees identified the geographic limits on coverage to be the biggest drawback to the multi-share option. At least one person in each group has an illness that required treatment by a specialist or hospital in Atlanta or Chattanooga, and their experiences made others consider the consequences of such limited coverage for themselves. Others worried about traveling and being hurt in an accident, resulting in the need for emergency medical treatments that would not be covered. To address these issues, one employer suggested that multi-share include both catastrophic and accidental insurance policies to supplement the local coverage so that "everybody could make the choice to pay extra to be covered in case they are out of town or in case there is something catastrophic that happens to them."

Although in full support of the multi-share concept, employers questioned the willingness of local health care providers to participate in such a coverage model. One woman was doubtful

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

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

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

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

Employer: “I think it’s a wonderful thing. It would put a big smile on my face.”

Employee: “It sounds real good. Sign me up.”

Contributions toward Coverage

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

In order to obtain multi-share coverage, all but one of the participating employers is willing to make a contribution toward coverage for their employees. That employer, who owns a restaurant, believes that the limited insurance coverage option is preferable for his employees and would be willing to contribute toward that coverage for them. Of the other seven, one employer indicated he would be willing to make a monthly contribution per employee in the amount of $100; two would contribute $90; two others would contribute $60; one would make a $50 contribution and one said $45 per employee would be the most she could afford.

Employees are willing to pay significantly more than there employers for their portion of the multi-share coverage. When asked directly about the maximum they could reasonably

contribute monthly, one indicated he would pay as much as $150; two said between $100 and $150; one would pay between $100 and $125; one other said $100; another indicated a willingness to pay between $80 and $100, one said $80, one said between $75 and $80 and the least an employee is able to pay is $75. On average, they would pay an additional $25 to $50 per month for family coverage. For the addition of dental coverage, they would pay between $10 and $25 per month.

Conclusion

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

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

Macon, Georgia

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

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

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

Experiences in Seeking Health Coverage

<u>Employers</u>

Although these business owners do not offer health insurance to their employees, most have some employees who do have health insurance, primarily provided through a spouse. However, all but one indicated that they had one or more employees who do not have any form of health coverage. Regardless of the coverage of their current employees, all would like to be able to offer health insurance to those who work for them. Some feel a sense of obligation to their employees, like the man that said, “I really need to give these guys insurance. They deserve it.”

A second echoed this sentiment when he said, "I grew up there and my grandfather grew up there. Some of these people's families have been with my family for years. It's a close operation, and I would like to be able to offer it to them." All see a direct benefit to their businesses in being able to provide health insurance, as indicated by their many comments:

> "I would like to be able to offer insurance to my employees because I think I could attract better quality employees with health insurance."
>
> "Employee retention would be greatly enhanced with the insurance, as well as the quality of the employees. They would be more loyal to the company."
>
> "My little company is growing. It started out with me and one guy. Now, we have seven employees that are growing into career track jobs. As they mature in the field and have families and kids, it becomes more important for me to provide it. It's going to be a retention problem at some point."

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

<u>Employees</u>

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

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

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

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

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

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

Reactions to the Multi-Share Concept of Health Coverage

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

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

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

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

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

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

> "If they could come up with something better, even if you had to pay a little bit more, I would rather have it."
>
> "I would consider it, but I would also be willing to pay more for something that would cover you wherever you go."

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

Defining Parameters for Multi-Share Coverage

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

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

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

Employers and employees disagreed on how to include those with pre-existing conditions in the plan. Employers believe unquestionably that those with pre-existing conditions should be included without penalty. While employees agree that those with pre-existing conditions should be covered by the plan, they are more willing to place restrictions on them in order to keep costs

down. One female employee suggested a twelve month waiting period, and a male employee wants those with pre-existing conditions to pay more for their coverage.

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

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

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

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

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

when she said, “I would be glad to have the program, but I don’t want to go to the Medical Center’s free clinic and have to wait in line.”

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

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

Contributions toward Multi-Share Coverage

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

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

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

Conclusion

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

4. Community-level Pilot Planning

The Planning Grant Team has three objectives in working with four pilot planning communities: recruiting the communities, providers, and employees, assisting the community coalitions in determining the coverage partnership model, and assisting in the design of the chosen model. Through the Georgia Health Policy Center’s experience working with communities, patterns of

what works and what is not successful in transforming community health systems have been observed and documented. The Keys to Success© and their characteristics are:

1. **Clear Vision and Intent**

    - Active, effective leadership in three areas: Governing Boards, Clinical Services, and Management.
    - Access and health status programs driven by needs and assets. These programs are based on a clear understanding of needs and disparities, goals, and health system assets and needs.
    - "Win/win" partnerships involving a collaborative balance of control and power with value created for all.
    - Services and products that are strategic and require each party's investment of time and resources.
    - Urban members supporting rural health systems in sustaining the broadest appropriate range of local services; rural partners coordinating with regional systems to have access to a wider range of services.

2. **Culture of Caring**

    - "Whole Patient Care" supported by an integrated delivery system that works to improve patient care and quality of life.
    - Patients treated holistically.
    - A broad range of services included as system elements.
    - Mutually agreed upon quality of care standards.

3. **Communications and Campaigning**

    - Stakeholder support and participation.
    - Effective communication and advocacy.
    - Pacing events and celebrations of accomplishments.
    - Internal and external marketing.

4. **Sustainability Based on Demonstrated Value**

    - Infrastructure supporting mission.
    - Network striving to remain relevant over the long term.
    - Sustainability documented through financial return and increased investment.
    - Social and financial return on a community's investment as revealed by activity and impact.

5. **Technical Assistance and Benchmarking**

    - External facilitation performed by credible and neutral providers.
    - Use of a broad array of tools.

- Relationships built on constant contacts.
- Technical assistance provided by the right people at the right time.

Based on these Keys to Success©, the GHPC also developed a series of Milestones© which communities must meet to develop a fully organized community health system.

Community Decision to Partner	• Initiate local and regional conversations with community members and providers • Utilize external facilitation including mediation and conflict resolution • Integrate relevant data for informed, local decision-making • Garner commitment to change the health care system
Critical Partnerships	• Build relationships among primary, secondary and tertiary care providers as well as a wide range of community stakeholders • Identify relevant data and integrate for informed decision-making • Utilize external facilitation, including mediation and conflict resolution
Clear Intent	• Analyze health statistics and identify priority health needs • Utilize external facilitation to solicit community perceptions and needs • Facilitate community work groups to develop program details • Study national and state best practices • Develop Strategic Plan incorporating keys to success for network development, network best practices, and basic principles for win/win rural-regional partnerships
Business Plan	• Develop sustainability strategies based on sound business principles • Utilize feasibility studies in development of programs • Develop comprehensive business plan to serve as a road map and a tool for engaging investors

System Building	• Create organizational structure which suits the goals and vision of the network • Utilize external facilitation including mediation and conflict resolution • Develop tools for improved enrollment, screening and assessment • Create state and local data collection processes to support program evaluation • Involve end-users of evaluation data
Services Delivery	• Develop Critical Quality Assurance and Program Improvement programs • Assist "ramp up" and "pilot" planning
Results Measured	• Analyze evaluation data collected and document value created by the system • Summarize and present results • Communicate outcomes to key audiences
Expansion or Expansion Planned	• Identify replication opportunities • Create replication plans • Serve as neutral facilitation for successful replication
Replication or Expansion Initiated	• Evaluate replication process • Successfully implement replication process
Sustainability	• Ensure that relevant network activities are sustained • Monitor and evaluate plan's long-term effectiveness

The GHPC and SPG team members chose communities with which the Health Policy Center had long-standing relationships. Beyond the scope of the State Planning Grant, Health Policy Center personnel have been assigned as technical assistance team leaders to these communities since 2002, and most of these communities have successfully achieved the Milestones© stated above and have organizational characteristics that model the Keys to Success. The four communities are outlined below:

Coastal Medical Access Project

In 2001, leading citizens in Georgia's three coastal counties of Camden, Glynn, and McIntosh became concerned about the health care access of their populations because of business downsizing and immigrant influx. Recognizing the need to provide medical access to the more than 22,000 underserved and uninsured residents in the three-county community, they successfully competed for an *Access Georgia Rural Health Matching Grant* in late 2001 and formed the Coastal Medical Access Project (CMAP).

Coastal Medical Access Project, or CMAP, was founded in 2002 by these concerned citizens committed to ensuring quality health care for area residents who are without access to health care, other than the local emergency room. Over the past two years, CMAP has developed an innovative, fully integrated approach to meeting these health care needs. CMAP provides three

distinct but coordinated services in the tri-county area of Glynn, McIntosh, and Camden counties of southeast Georgia.

- MedBank, to provide access to free pharmaceuticals
- Access to medical service through free clinics
- Chronic disease case management

Northwest Georgia Healthcare Partnership

The Northwest Georgia Healthcare Partnership is a not-for-profit, tax-exempt organization serving Murray and Whitfield Counties since 1992. The Healthcare Partnership views itself as going beyond programming and research to include roles of coach, catalyst, convener, and facilitator. The Partnership's mission is to develop and support cooperation and collaboration between health care providers, business, industry, payers, consumers, social organizations, government, educators and the community for the purpose of improving the health of all through the efficient, effective, and caring use of resources. Their mission is to develop and support cooperation and collaboration among health care providers, business, industry, payers, social organizations, government, educators and the community for the purpose of improving the health of all through the efficient, effective, and caring use of resources. The goals of the Partnership are to:

- Improve the overall health status of the community while controlling costs
- Improve accessibility to health care
- Promote high quality health care
- Empower local citizens to shape health care in our community

Atlanta Regional Health Forum

The Atlanta Regional Health Forum (ARHF) is a 501(c) (3) nonprofit organization that functions as an inclusive, nonpartisan coalition dedicated to creating healthy local communities within the ten core counties of metropolitan Atlanta. By virtue of its mission and operation, ARHF functions primarily in a role of convening stakeholders of health and does not provide direct medical services.

The vision of the Atlanta Regional Health Forum is to:

- Leverage community assets and health research resources
- Integrate health into planning
- Frame issues and agendas for health
- Engage communities in participatory processes to effect change

Membership is multi-sectoral (public, private, governmental, corporate, legal, education, business, managed care, community-at-large, etc.), and four established working committees allow the Forum to work toward its goal of transforming the health of the Atlanta region by encouraging, enabling, and empowering communities and individuals to achieve their fullest health potential.

Community Health Works

Community Health Works (CHW) was created in the fall of 1999. In recognition of the fragmented, costly, and inefficient way that uninsured residents were accessing care, MedCen Community Health Foundation convened physicians, community, and health care

leaders from across Bibb and six contiguous counties of Georgia (Crawford, Houston, Jones, Monroe, Peach and Twiggs), to plan for a greater collective effort in addressing the issue.

Out of that initial meeting grew a regional collaborative representing physicians, behavioral health organizations, county governments, hospitals, public health and Family Connections, committed to a regional and integrated response. Today, CHW is a non-profit network of 55 physicians, 1 clinic, 5 safety net hospitals, 2 regional behavioral health providers, district and county health services, local Family Connections, and several county governments.

Born out of the realization that people often need the services of different parts of the health care system to receive full care and a vision of better health care for all people through communities working together, CHW's partners work to cooperatively and more effectively realign health care resources and assure coordinated access to a full continuum of outpatient-focused care for the uninsured. The focus of the network has been, and continues to be, the four most costly high-risk diseases in the region: hypertension, heart disease, diabetes, and depression.

Community Summaries

Most importantly for this initiative, the boards and members of these organizations contain representatives from physicians, hospitals, allied health professionals, Chambers of Commerce and other businesses, the faith community, school systems, public health, and other local government. All of the organizations have strong ties to the community and have successfully completed a wide variety of health initiatives prior to the award of the Pilot Planning Grant. By containing representation from health care providers and local business, each organization has avenues with which to invite larger representation into the project.

Board members and staff in all of the pilot communities have enthusiastically supported this process and remain generally eager to participate in the initiative. The community-based service organizations: CHW, CMAP, and NGHP have completed community asset mapping exercises which provided the GHPC with information and an understanding of the resources available in the community. Forums hosted by ARHF have also provided information about the needs of the uninsured in the Atlanta region. By receiving support from the boards of these community-based organizations, SPG team members felt that there was a significant amount of readiness to act. ARHF, CHW, CMAP, and NGHP all have established governance structures that support organized decision-making through a Board of Directors, relationships with local employers through established Board relationships and community engagement, and relationships with local providers through successful, local health initiatives.

Each community was presented with a range of coverage options at the initial community conversation. CHW, CMAP and NGHP staff worked with the GHPC to invite and organize an initial meeting where a wide range of local stakeholders, along with providers and employers, were represented. GHPC staff worked to determine a range of suitable coverage options that matched with each community's uninsured data, local attributes, and the organization's interests.

Coastal Medical Access Project

CMAP held its first State Planning Grant related "kick-off" meeting on January 21, 2005 in Brunswick, Georgia. Approximately 24 individuals were in attendance including representation

from health care providers, local business, education, local government, and local philanthropic organizations. In addition to an explanation regarding the project and its potential impact on the four county service area, Vondie Woodbury with the Muskegon, Michigan Community Health Project was in attendance. She shared the story of her local three-share model, lessons learned, and provided to CMAP materials related to the project. She also spent a significant amount of time answering the questions of the community members that were in attendance.

In a subsequent meeting in February, Beverly Tyler, with Georgia Health Decisions, facilitated a community conversation to help this group reach consensus that the pilot project in CMAP's service area (Glynn, Camden, and McIntosh counties) should be a multi-share approach where employers, employees, and the community share in paying the coverage for low-income, uninsured workers.

On March 11, 2005 a planning group was brought together by CMAP and supported by GHPC and Georgia Health Decisions. These individuals were presented with a variety of coverage options which matched the needs of their community. Those in attendance reached consensus that the HRSA State Health Planning Grant pilot program in Southeast Georgia should be based on a multi-share approach focused on small employers with CMAP as the governing organization. The area to be served by the initiative should include the five counties of Glynn, McIntosh, Brantley, Camden, and Charlton. Based on these decisions, the groups developed a list of expectations for what the model should look like, barriers and challenges to successful implementation, and opportunities/resources available in the community. These included:

EXPECTATIONS

- Stable financing
- Efficiency and easy administration
- Directed towards those most in need

BARRIERS/CHALLENGES

- Lack of understanding with employer/employee communities
- Stable financing availability
- Infrastructure requirements for managing the plan
- Marketing challenges

OPPORTUNITIES/RESOURCES

- Current strength of CMAP
- Current provider network of concerned physicians and hospitals
- Existing network of churches, businesses, public health department, professional and trade organizations that can be used to spread the word about the plan
- Linkages with other HRSA Planning Grant communities that are also developing multi-share models

Based on these conversations, focus groups with small business employers and employees were organized with leadership from Georgia Health Decisions staff. Frank Selgrath, CMAP Executive Director, requested that no additional work be completed towards this initiative after focus group completion until agreement from the state is given regarding obtaining a third share.

Northwest Georgia Healthcare Partnership
NGHP held its first State Planning Grant meeting on January 26, 2005. Eight community members were in attendance and were invited to comprise the planning group for this project. These individuals represented local hospitals, health care providers, business, insurance, and local government. At this meeting, Beverly Tyler facilitated a community conversation to help this group reach consensus that the pilot project in Whitfield and Murray counties should be a multi-share approach where employers, employees, and the community share in paying the coverage for low-income, uninsured workers. This approach would utilize locally available services through the existing Medical Access Clinic and would be available to local businesses and their uninsured employees.

Expectations, barriers and challenges, and local opportunities were also developed by the planning committee. Highlights of these include:

EXPECTATIONS
- Realistic plan
- Disease case management must be a component
- Education is key!

BARRIERS
- Language and cultural differences
- Limited financial resources
- Attitudes and understanding of uninsured

OPPORTUNITIES
- Current infrastructure
- Strong business community and employer interest

Although the multi-share option was initially chosen, NGHP has worked along with its core team of committee members to determine if this is an appropriate choice. They have been working with a local insurer to determine the amount of reimbursement providers would be willing to receive if they participated in the multi-share option. The committee explored the idea of a discount plan in which a network of local providers would be willing to accept reduced rates from plan members. The committee has also explored the idea of a limited benefit plan. Both of these options were presented to local employers and employees in focus groups conducted by Georgia Health Decisions. However, only the multi-share coverage model was deemed acceptable by those participating in the focus groups.

The NGHP planning committee continues to meet and is working towards developing the basic design of a multi-share option that would work for their committee. GHPC staff continues to support these efforts by providing technical support and resource materials as requested. They are working towards developing a third share that is local versus waiting on state financial support.

Community Health Works

The first facilitated community conversation with the Steering Committee took place at the Macon Camber of Commerce on January 28, 2005. This followed a presentation of the grant's aims and objectives to the Board of Community Health Works in early December. A diverse 16 member planning group, made up of providers, local government officials, community advocates, and employers were in attendance. They were briefed on the status of the uninsured in their region before commencing discussions on the principles that would guide the design of a coverage model.

Though multiple options were presented and examined, by the end of the meeting, there was consensus among the group that the region's pilot program ought to be a multi-share public/private partnership model directed at the working uninsured. Some consideration was given to beginning this model in the two most populous counties (Bibb and Houston) during the planning phase, but this was later reconsidered, and all seven counties presently served by the organization are invited to participate.

The group determined that following this meeting, next steps would include:

- Getting pertinent information from communities that have successfully designed and implemented this type of model,
- Setting up work groups that would begin to further define the different elements of the model,
- Identifying the employer and employee communities for focus group attention.

Vondie Woodbury from the Muskegon Community Health Project was consulted and provided information on the 3-Share model. Summaries of other programs and models used throughout the country were also presented to the group in subsequent meetings and by electronic dissemination.

On March 25 and April 12, Georgia Health Decisions carried out listening sessions with employer and employee focus groups respectively. From these conversations it became clear that both groups were willing to participate in the pilot, though there were reservations about the sustainability of the plan, the potential third share, and a declared non-interest in any plan that would likely fold after a year or two of operation.

The Steering Committee began the process of appointing sub-groups to work on various elements of the pilot plan in May 2005. These plan elements included: Benefit Design, Marketing, Provider Relations, Financing, and Governance. Greg Dent, President and CEO of Community Health Works, also began dialogue with local hospitals about forging potential partnerships with the state in an effort to identify sustainable financing for the program.

Over the last two months, a clearer picture of the limits on the potential use of the state's DSH funds has emerged. Further, the state has begun thinking through the possibilities of an 1115 HIFA waiver as it undergoes changes to Medicaid. This has resulted in some deceleration in the design of the pilot as the group awaits the continued commitment of the state to the process.

Atlanta Regional Health Forum

The first meeting of the Pilot Planning Group of the Atlanta Regional Health Forum occurred in December 2004 and served to provide background information about the project. The initial group included ARHF Board members, a representative from an Atlanta based health plan, and members of the Latino community. The group began the process of examining the data on Atlanta's uninsured and identified other stakeholders whose engagement would be necessary for the success of the process.

The Forum, led by Dr. William "Buck" Baker, hosted the second meeting of the SPG Pilot Planning Group on January 24, 2005. Cecelia Galvez from the Hispanic Healthcare Coalition and Maurice Maddux of Diversified Health Solutions, an executive officer of Diversified Health Solutions - a discount medical benefits plan, provided information for the group to consider in designing a model to cover more uninsured residents of the metro Atlanta region. The group was also made aware that as a consequence of the first meeting, Remedios Gomez-Arnau (Consul General of Mexico) and Evonne Yancey of Kaiser Permanente had been in discussion about the health plan recognizing the Matricula Consular - an identification card issued by the Mexican Consulate.

Among the initial group, some felt that the issue of Latino health in the metro Atlanta area was one that needed to be the focus of the plan. While recognizing the importance of that issue, there were, however, reservations from others about the need for a broader base of constituents in a city of Atlanta's size and demographics. In subsequent meetings on March 7 and 29, 2005, it was agreed that the group would subdivide to give attention to two different approaches to expanding coverage.

One group would work with the Hispanic Health Coalition and other interested parties to address the needs of uninsured Latino workers while the other group would focus on the development of the pilot plan that would have as its emphasis a modification of a small group insurance product offered to workers of small businesses in combination with HSAs.

Over the last three months, there have been regular meetings of the second group, which includes representatives from Kaiser Permanente, the National Federation of Independent Business, the Georgia Public Policy Foundation, and local providers. They have agreed in concept to a plan that incorporates a "multi-legged" approach to covering the working uninsured at small firms, (i.e. <50 employees) in Fulton and DeKalb counties, inclusive of the city of Atlanta. The pilot will feature an insurance product or products designed as a *demonstration* that will, where possible, incorporate and leverage federally endorsed initiatives. The design of the pilot will also be informed by national best practices and policies. Potential partners will include Grady Memorial and other metropolitan hospitals (Northside, Piedmont, DeKalb Medical Center), State and local government, insurance carrier(s), employers, employees, and other non-hospital providers.

Georgia Health Decisions will shortly conduct focus group discussions with employees and employers in the two counties. This information is expected to help feed the design of the coverage product that will be tested prior to implementation.

D. Implementation Status

As the Georgia Pilot Planning Grant has been awarded a one-year no-cost extension to continue work on the project, none of the four coverage pilots have yet been implemented. However, as part of a larger effort by the state to modernize Medicaid, Georgia officials are in conversation with the Centers for Medicare and Medicaid Services as to how a modest Medicaid waiver expansion might be applied to the current work. Specifically, Georgia is exploring with CMS the possibility of federal match of employer contributions to private, employment-based insurance for those small business owners who have not been able to offer coverage to their employees due to cost. In effect, this would create a "third share" among employers, employees, and the federal government. Under a waiver, it is envisioned that working individuals of small firms that meet Medicaid expansion income guidelines would be bought into private coverage with federal dollars. The coverage plan would be tailored to the needs of the local community and would not necessarily include all benefits generally available through the Medicaid program. The state anticipates submitting its initial waiver in early 2006.

E. Recommendations to the Federal Government and HRSA

As the Georgia Pilot Planning Grant has been awarded a one-year no-cost extension to continue work on the project, comprehensive recommendations have yet to surface. However, at this initial stage, the Planning Grant Team endorses the following:

1. HRSA should consider in its future grant making tying implementation funds to any planning grant effort. Particularly in working with community organizations, local boards are reluctant to raise the hopes of community members in a planning phase without the necessary implementation funds allocated to the project through to fruition.

2. HHS, and particularly CMS, should support a broad range of pilot Medicaid expansion strategies and financing schemes that may not have seemed feasible in the past.

F. Appendix 1: Summary of Policy Options

Option Considered	Target Population	Estimated Number of People Served	Status of Approval	Status of Implementation	Most Recent Estimate of Number Served
1. HB 320 - High Risk Pool Legislation	5,000+ individuals who are medically uninsurable	Est. 3,400	Substitute version signed by Gov. Perdue May 10, 2005,	Bill created a high-risk pool commission to determine funding, take-up, etc. and to report to Governor by December 15, 2005	N/A
2. Insurance Mandates (SB 174)	Employees of small businesses that cannot afford to offer fully mandated insurance benefits	Estimated to apply to one-fourth of the population	Signed by Governor Perdue May 10, 2005	Final version protected many mandates for babies, screenings, and specific diseases	N/A
3. Volunteers in Medicine Act (HB 166)	Uninsured residents under 200% FPL and Medicaid recipients receiving care from volunteer providers	Approx. 42% of 1,600,000 uninsured residents	Signed by Governor Perdue May 10, 2005	Volunteer providers offered state liability coverage as of July 1, 2005	N/A
4. Premium support for families of Peach care children	Uninsured parents of PeachCare children	79,025 families of PeachCare children	Under consideration	Under consideration	N/A
5. Medicaid Waiver – Medicaid Modernization	Est. 200,000 employees of small businesses not offered insurance	N/A	In development stage	In development stage	N/A

G. Appendix 2: Project Management Matrix

Pilot Planning Limited Competition Grant				
Comprehensive Oversight Activities				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Quarterly Meeting with Governor's State Planning Grant Advisory Committee	Quarterly beginning October 2004	Governor's Advisory Committee, Office of Planning and Budget (OPB), Georgia Health Policy Center (GHPC), Robinson College of Business (RCB)	Guidance on planned activities	Meeting held and feedback/guidance incorporated into project
Monthly Project Team Meeting	October 2004 - July 2005	OPB, GHPC, RCB	Tasks and schedules reviewed and adjusted, if necessary	11 monthly meetings completed
Community Steering Committee Meetings	November 2004-August 2005	GHPC, Community Steering Committees	Pilot planning activities completed	11 monthly meetings completed
Joint Meeting for Pilot Sites	October 2004	GHPC, Community Steering Committees	Alignment of community coverage goals, SPG goals, and state budgetary goals	Joint meeting held
Task 1: Employer Survey Design and Administration				
Prepare Survey Instruments	September 1-September 15, 2004	RCB, GHPC	Finalized Survey Instruments	Survey Forms Ready for Distribution on 9/15/2004
Determine Sampling Frame	September 1-September 15	RCB and Georgia Department of Labor	Sample of 7,500 Firms	Mailing list ready for distribution on 9/15/2004
Field Survey	October 1-November 15	RCB	Survey administered as described in narrative	2,000 completed surveys
Collect Data	October 1 – December 1	RCB	Input and process returned surveys	Analysis file created
Clean Data	December 1-January 1	RCB	Cleaned survey data merged with original data base and weighted for analysis	Analysis file finalized
Analyze Community Site Data	January 1-January 15	RCB	Data available to Pilot Site Communities for demand projections	Pilot site report
Analyze Statewide Data	January 1-February 15	RCB	Bi-variate and multivariate analysis of employer coverage in Georgia	Tabular data available for team review
Write Report	February 15 to April 1	RCB and GHPC	Written report of Employer Survey results available to policy and business audiences throughout the state	Report written by May 15

Disseminate Report	April 15 to July 30	RCB and GHPC	Report widely disseminated	Number of reports distributed statewide
Task 2: Study of Incidence of Uncompensated Care				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Estimate Health Care Utilization and Costs for Uninsured Georgians	October 1 to October 31	RCB	Tabular report on utilization of uninsured by characteristics (age, sex, work status, location)	Tables completed
Estimate Effect of Uncompensated Care on Provider Charges	October 15 to November 15	RCB	Tabular report on cost impact of the uninsured by provider type	Tables completed
Examine the Incidence of Charges by Type of Insurance Coverage	November 15 to December 15	RCB	Tabular report on cost shifting	Tables completed
Review of Tax Incidence Literature	September 1 to October 30	GHPC, RCB	Summary of literature review	Literature review completed
Cost Incidence Modeling	December 15 to March 30	RCB	Models used to assess changes in cost to various populations for proposed interventions	Modeling results included in modeling report
Pilot Site Modeling and Educational Activities	February 1 to March 30	RCB and GHPC	Models used to assess Pilot site planning proposals and to educate local leaders on fiscal impact of proposals	Number of community education meetings in which models are used
Write Report	April 1 to May 15	GHPC, RCB	Report written	Report written by May 15
Disseminate Report	May 1 to July 30	GHPC	Report widely disseminated	Number of reports distributed statewide
Task 3: Focus Groups with Business Leaders				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Refine Agenda and Materials	October 2004	GHD	Refine agenda and materials based on result of pilot session held in May 2004	Meeting agenda and materials complete
Identify Communities	October 2004	GHD	Achieve geographic diversity in communities	Communities for listening tour identified
Get Commitment from Leaders of the Chambers of Commerce	October 2004	GHD	Chambers of Commerce co-sponsor listening session	Agreements from Chambers to assist with listening sessions
Recruit 10 to 12 Business Leaders for Each 3-hour Listening Session	October - November 2004	GHD	10 business leaders in each community agree to participate in listening session	Business leaders participate in listening sessions

Conduct Listening Sessions	November 2004	GHD	Recommendations for covering the uninsured are received from business leaders attending the listening sessions	4 listening session are held across the state
Prepare Report	December 2004	GHD	Report presents findings from 5 listening sessions	Report is complete
Disseminate Report	January 2005	GHPC	Policy makers are informed of recommendations made by business leaders	Findings are presented to policy leaders and report is made available
Task 4: Recruit Community Collaboratives, Providers, and Employers				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Identify Resources	October 1- October 31, 2004	GHPC	Description of community assets and readiness to act	Report to team
Establish Governance Structure	October 1- October 31, 2004	GHPC and Communities	A collaboration of community leaders	Formal planning structure
Establish Employer Relationships	November 1 - December 31, 2004	GHPC and Communities	Employers eager to be part of the community plan	Sufficient numbers of employers to enact the plan
Establish Provider Relationships	November 1 - December 31, 2004	GHPC and Communities	A range of providers are part of the community plan	Sufficient numbers of providers to enact the plan
Task 5: Focus Groups with Employers and Employees				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Develop Discussion Guides	October 2004	GHD	Key issues to be discussed in employer and employee focus group are understood	Discussion guides for employer and employee focus groups are complete
Identify and Recruit Focus Group Participants	October - November 2004	GHD	10 small business owners and 10 uninsured workers per pilot site community agree to attend focus groups	Business owners and uninsured workers attend focus group
Coordinate schedule and meeting logistics	October - November 2004	GHD	Facilities and caterers are confirmed for all focus groups	Focus groups are held
Facilitate and Record Discussions	November 2004	GHD	Insights from small business owners and uninsured workers are provided for structuring the public/private partnership in each pilot community	4 focus groups with small business owners and 4 focus groups with uninsured workers are held

Transcribe and Analyze Transcripts and Prepare a Report of the Findings	December 2004	GHD	Insights from small businesses and uninsured workers in each pilot community are used in structuring that area's program	Summary reports of findings from each pilot community are complete
Disseminate Report	January 2005	GHPC	Pilot communities have findings to help structure programs that will appeal to small business owners and uninsured workers	Findings are presented and report is made available
Task 6: Determine Partnership Model With the Community Collaborative				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Presentation of Available Options to Community Collaborative	November - December 2004	Communities, RCB, GHPC	Communities are knowledgeable of options	Presentation meetings with communities are held
Facilitated Evaluation of Community Options	November - December 2004	Communities, RCB, GHPC	Communities understand the pros and cons of available options	Facilitated meetings with communities are held
Determination of Community Options	November - December 2004	Communities, RCB, GHPC	Communities choose the coverage option best for them	Coverage option is decided on
Task 7: Coverage Design				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Market Analysis	November 2004 - February 28, 2005	RCB, GHPC	Description of target population's ability to pay, demand and resources	Series of reports for team and community
Benefit Design	March 1, 2005 - May 15, 2005	GHPC, Communities	Integration of market analysis-community resources and needs	Plan Design description
Plan Pricing	March 1, 2005 - May 15, 2005	Communities, RCB, GHPC	Actuarial interactive work with Communities	Pricing report for each community
Reimbursement Rates	March 1, 2005 - May 15, 2005	Communities, RCB, GHPC	Interactive work with Communities, actuarial analysis, and providers	Rate structures set for each community
Project Utilization Rates	April 1- May 15, 2005	RCB, GHPC	Final actuarial report based on plan design	Utilization rates set for each community
Prepare Report	June 2005	RCB, GHPC	Completed report of community experiences	Report ready for distribution
Disseminate Report	July 2005	GHPC	Report widely distributed	Report distributed statewide and to all Planning Grant States

Task 8: Final Report				
	Timetable	**Responsible Agency or Individual**	**Anticipated Results**	**Measurement**
Prepare Draft Report	June - July 2005	OPB, GHPC	Draft report to the Secretary completed	Draft reviewed by all team members
Final Project Team Meeting	August 2005	OPB, GHPC, RCB	Final tasks and schedules reviewed and adjusted, if necessary	Final monthly meetings completed
Prepare Final Report	August 2005	OPB, GHPC	Final report to the Secretary completed	Final report completed
Submit Final Report	August 2005	OPB	Final report forwarded to Secretary	Receipt of report by HRSA

H. Appendix 3: Completed Reports Supported by HRSA Pilot Planning Grant

Employer Sponsored Coverage in Georgia 2002 – 2004

The Georgia Healthcare Coverage Project

Patricia Ketsche, Ph.D.
Institute of Health Administration
Robinson College of Business
Georgia State University

Glenn M. Landers, MBA, MHA
Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University

Introduction

While more than 90 percent of Georgians with private health care coverage obtain it through their employer or are dependents of someone who obtains coverage through an employer, there is concern nationwide and in Georgia that the employer sponsored health insurance (ESI) system is eroding. The most recent statistics from the Current Population Survey (CPS), the most frequently cited source of information on health insurance coverage in the U.S., suggest that almost two million fewer Americans were covered by a plan linked to an employer in 2003 than in 2002, despite the fact that the under age 65 population grew by two million in the same time period.

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

Methods

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

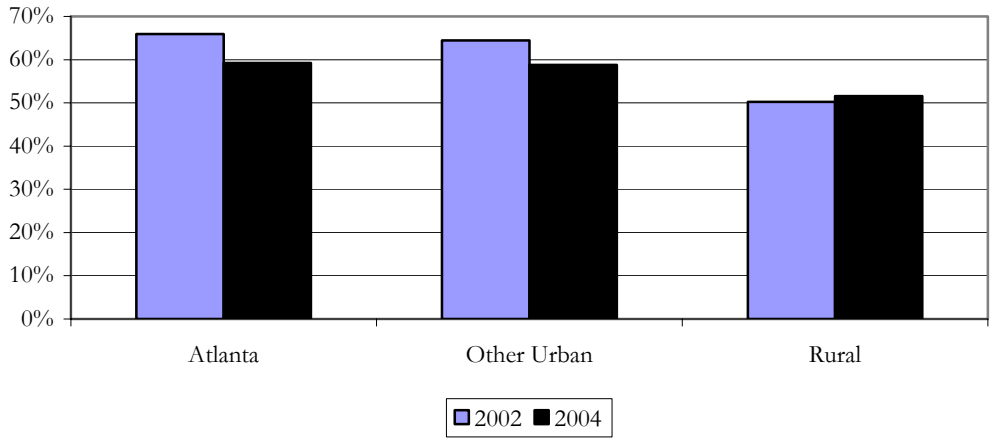
Firm Characteristics

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

Figure 1
Which Georgia Employers Offer Health Care Coverage?

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

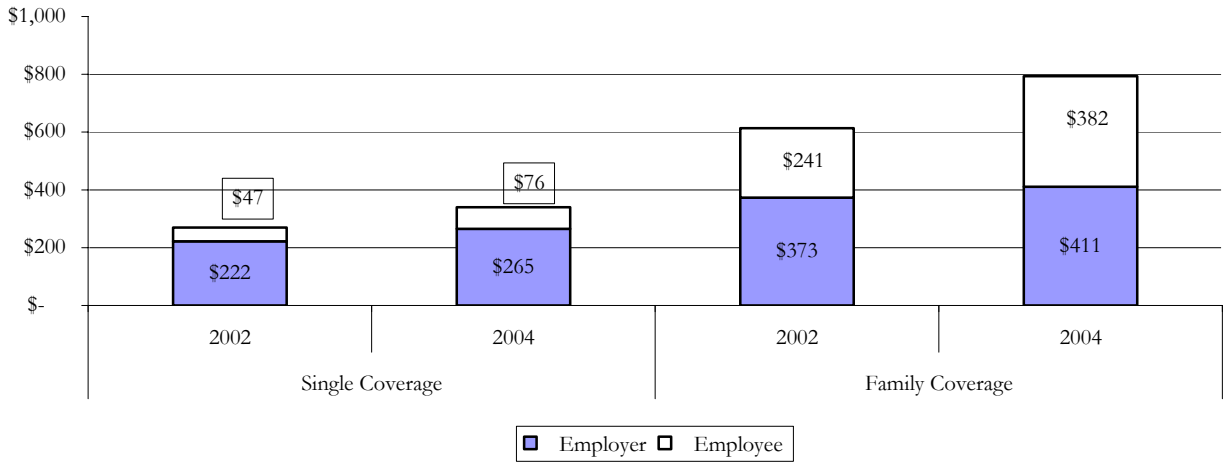
Figure 2
Coverage by Urban and Rural Locale



Plan Cost

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

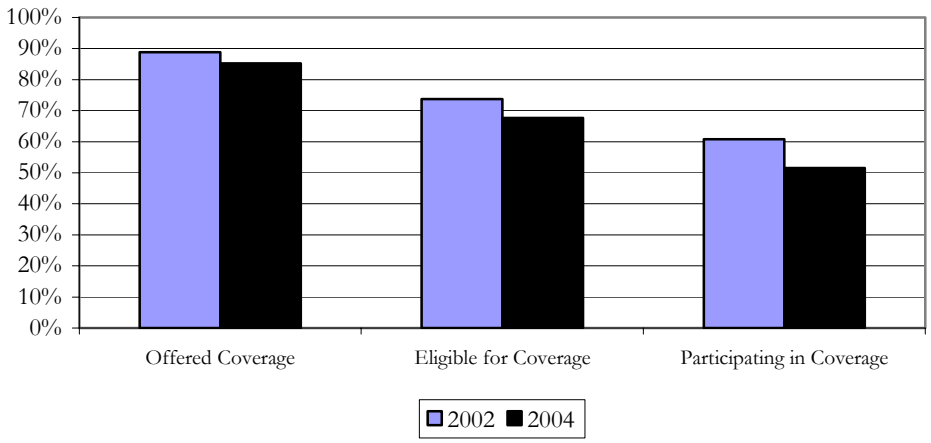
Figure 3
Average Monthly Cost of Coverage: Employer and Employee Share
2002 – 2004



Coverage of Georgia Workers

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

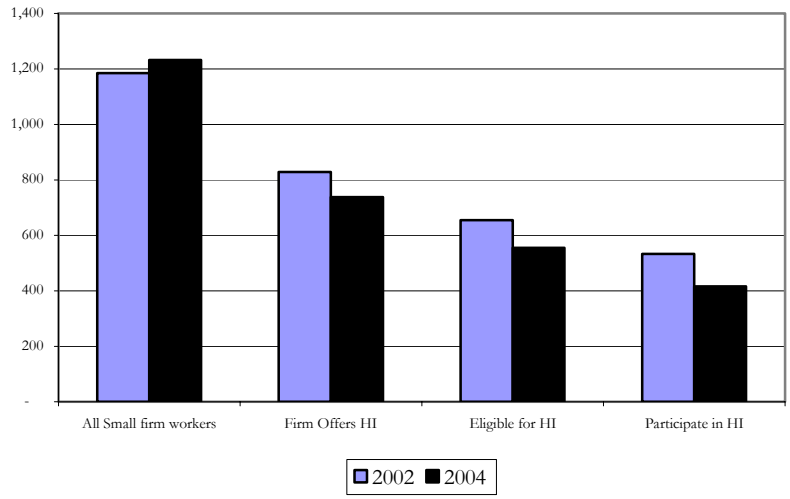
Figure 4
Percent of All Workers Offered, Eligible, and Participating in Coverage



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

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

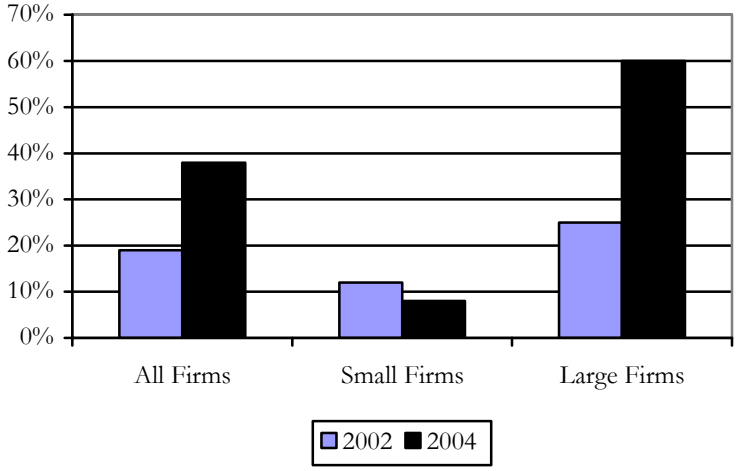
Figure 5
Workers (in 000s) Offered, Eligible, and Participating in ESI among *Small Firm* Workers in Georgia



Part-Time Workers

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

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

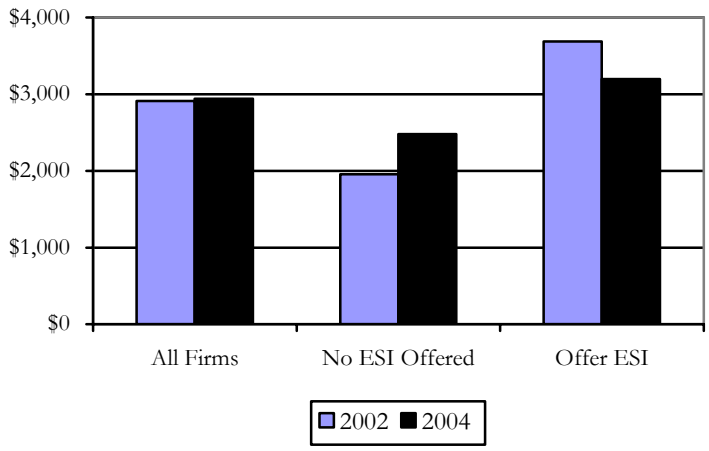


Average Monthly Wages

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

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

Figure 7
Average Monthly Wages
2002 – 2004



Other Benefits

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

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

Conclusion

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

Although this study focuses on employers and their employees, it has implications for all Georgians. If costs continue to grow at the rate found during this study period, the number of uninsured workers is likely to continue to grow in the future. Of particular concern is the reported increase in

the contributions required for family coverage. Employees are paying almost $1,700 more annually for family coverage in 2004 than in 2002. If workers drop family coverage in favor of employee-only coverage or no insurance at all, we will see growing numbers of uninsured Georgians, particularly children. The burden of paying for the cost of caring for these individuals will fall on tax payers through public insurance programs, on those with coverage or who pay out-of-pocket through higher prices for health care services, and on the uninsured themselves who will forgo or delay needed care.

GEORGIA HEALTHCARE COVERAGE PROJECT

2004 Georgia Employer Health Benefits Survey

While more than 90 percent of Georgians with private health care coverage obtain it through their employer or are dependents of someone who obtains coverage through an employer, there is concern nationwide and in Georgia that the employer sponsored health insurance (ESI) system is eroding. The most recent statistics from the Current Population Survey (CPS), the most frequently cited source of information on health insurance coverage in the U.S., suggest that almost two million fewer Americans were covered by a plan linked to an employer in 2003 than in 2002, despite the fact that the under age 65 population grew by two million in the same time period.

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

Figure 1.
Which Georgia Employers Offer Health Coverage?

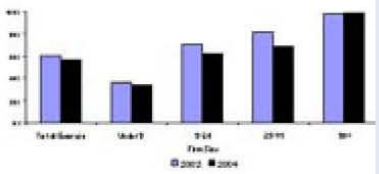
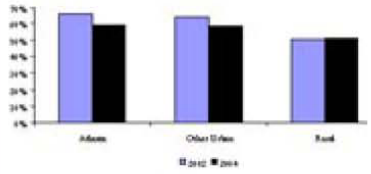


Figure 2.
Coverage by Urban and Rural Locale



Firm Characteristics

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

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

GEORGIA HEALTHCARE COVERAGE PROJECT

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

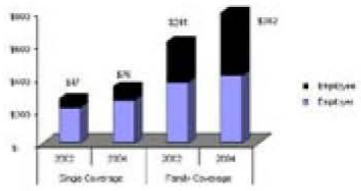


Figure 4.
Percent of All Workers Offered, Eligible, and Participating in Coverage

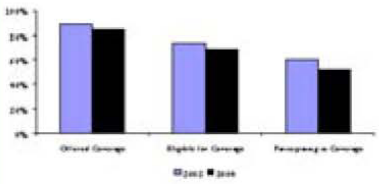
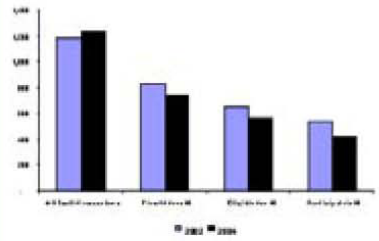


Figure 5.
Workers (in 000s) Offered, Eligible, and Participating in ESI among *Small Firm* Workers in Georgia



Plan Cost

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

Coverage of Georgia Workers

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

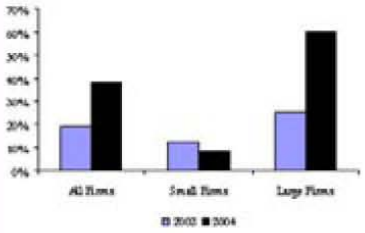
In 2002, 89 percent of all employees worked at establishments that offered health insurance, but by 2004 that share fell to 85 percent of all private sector workers (Figure 4). The combined declines in offer, eligibility, and participation rates reflect 300,000 fewer workers with ESI in their own names. Some of the decline in eligibility results from an increase in the part-time labor force, which is estimated to have grown from over 400,000 to just over 600,000 workers in the two-year period.

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

Part-Time Workers

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

Figure 6.
Firms Where Health Insurance is Offered to Part-Time Workers 2002-2004

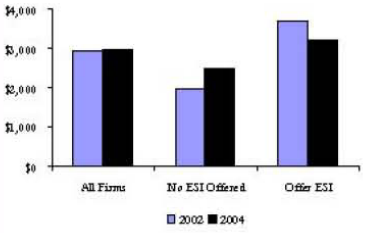


Average Monthly Wages

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

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

Figure 7.
Average Monthly Wages 2002-2004



Other Benefits:

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

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

GEORGIA HEALTHCARE COVERAGE PROJECT

Conclusion

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

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

About the State Planning Grant

Georgia is one of only nine states selected for a federal grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services to design pilot programs that make health insurance more available and affordable throughout the state. This pilot planning grant allows four communities across the state to develop public/private partnerships that support the power of community and positively impact the number of uninsured in their region. Four communities - Dalton, Brunswick, Macon and Atlanta – are selected for pilot planning and programming. These communities are chosen because of their proven success in using the power of community to improve health through their successful safety net collaboratives.

Survey Methods

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

For more information, please contact: the Georgia Health Policy Center at (404) 463-9337

Funded by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services