STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

September 15, 2006

Mr. Darren Buckner
Grants Management Specialist
HRSA State Planning Grants Program
Bethesda, Maryland 20814

Dear Mr. Buckner:

Thank you for the opportunity to provide a final report on Mississippi's Health Resource Service Administration (HRSA) Planning Grant Fiscal Year 06 continuation grant.

Data collected under the HRSA grant will give us additional information about the profile of the uninsured and provide strategies for the health and policy makers to understand how to address the issues long term.

If you have any questions regarding the final report, please contact Dr. Nycole Campbell-Lewis, Deputy Administrator, at (601) 359-6050.

Sincerely,

Robert L. Robinson
Executive Director

cc: Judy Humphrey, HRSA

HRSA State Planning Grants

Final Report to the Secretary

Executive Summary

The State of Mississippi requested and received a no-cost extension from Health Resource Service Administration through August 2005 and again through August 2006. The Division of Medicaid was designated as the lead agency to administer the grant. The collected data provided information for health and policy makers to craft policies to address gaps in insurance and access to health care services for Mississippi's uninsured.

The State of Mississippi focused its research on collecting and analyzing data to describe the characteristics of the uninsured; designing a program to reduce the uninsured through state, federal, and private partnerships; and designing feasible options for identified population. Mississippi identified the following eight goals to direct the state's efforts in this project:

1. Develop a comprehensive profile of health insurance coverage and the social, behavioral, economic, and demographic characteristics of the uninsured population in Mississippi, both statewide and at regional levels.
2. Identify current coverage levels and specific options and explore mechanisms supported by employers to address access, affordability, and coverage.
3. Identify current coverage levels and specific options and explore mechanisms supported by insurers to address access, affordability and coverage.
4. Understand current and future insurance and utilization issues affecting health-care providers and the marketplace.
5. Interview key health policy makers to assess the political will to implement specific options that build on and enhance public and private programs.
6. Establish a Blue Ribbon Task Force on health policy through the Governor's Office to facilitate collaboration, provide oversight for the project, evaluate and monitor outcomes, and develop options for reducing the number of uninsured citizens in Mississippi.
7. Identify current health coverage levels and explore options and mechanisms supported by other agencies.
8. Prepare and distribute specific reports relevant to the findings of the grant component. Prepare and submit to HRSA a final report on the results of the State Planning Grant activities.

In 2006, the grant allowed Mississippi to secure professional and specialized consulting services to research and recommend proposed options and determine the cost of the proposed options, including potential sources of subsidies given the following parameters: to create an employer/employee insurance subsidy program for small businesses (one to twenty-five employees who do not currently offer insurance) that is structured to include greater incentives for wellness/prevention, as well as incentives for business participation. The State wishes to eliminate the barrier of price to purchasing insurance coverage. Mississippi contracted with the Lewin Group who has expertise in collecting and analyzing data in the health-related field. The

Lewin Group collected and synthesized the data, prepared interim and final reports, and recommended policy options based on the feedback received from the technical workgroup and other sources.

Lewin provided an aggregate impact assessment of the coverage option to include estimates of changes in health care spending, which includes government, private payers, businesses currently providing insurance, businesses currently not providing insurance, and households. The contractor collected specific data and other secondary data on the uninsured.

Goal:

Mississippi's goal is to create an employer/employee insurance subsidy program for small businesses that is structured to include greater incentives for wellness/prevention and incentives for business participation.

Target Population:

Small business employees were identified as the target population that the partners selected to assist in reducing the number of uninsured.

Methods:

The research data was collected through use of both qualitative and quantitative methods. The overall research was supervised by a research coordinator who provided technical assistance to the researchers and the Office of the Governor, Division of Medicaid.

Data Collection

The State conducted regional meetings in eight locations. Some of the meetings had to be cancelled due to low participation by the small business owners and the community-at-large. Each session was facilitated by a consultant with the Mississippi State University Extension Services. The facilitator utilized a structured curriculum and modules and asked regional participants to consider how to decrease the uninsured rate in their respective regions.

The regional members had to assess their strengths, weaknesses, opportunities, and threats in the regions, and the group defined their individual and collective commitment and realities of developing uninsured health policy solutions. Regional members provided options to reduce uninsurance in their regions. Regions had specific target groups that they were interested in developing.

Findings

The State of Mississippi has made tremendous progress in understanding the problems associated with the uninsured in the state through the administration of the HRSA State Planning Grant. Preliminary data suggests that there is an adverse insurance situation in the State of Mississippi. Preliminary data suggests that approximately 17% of Mississippi's residents are without health

insurance. The issue of uninsurance is exacerbated due to the chronic diseases that are prevalent in the state. Those chronic diseases are diabetes, obesity, high blood pressure, cardiovascular disease, and asthma. Data also indicates that children are particularly at risk.

Mississippi attended the State Planning Grant Program Meeting in Arlington, Virginia, in 2003. At that meeting, South Carolina, Connecticut, and New Jersey provided lessons learned from their efforts to close the gaps in health insurance coverage.

Connecticut provided issue briefs to be distributed to the state legislators and emphasized the importance of states' utilizing the skills of communication to build consensus with other partners.

South Carolina encouraged other states to work on the final report on an on-going basis to meet the deadline of funding sources. They recommended that states develop a timeline and hire a facilitator to monitor that the state is on track. South Carolina informed the audience that they didn't get valuable information from utilizing qualitative data, but they were able to draw meaningful conclusions from the data obtained from employers.

New Jersey was in agreement with South Carolina that they didn't have a lot of success with focus groups. However, they commended HRSA on being flexible and providing technical assistance to states if needed.

The State discussed what it learned in designing its plan that could assist other states in seeking to expand coverage to all citizens. The State should also include any recommendations to other states regarding the policy-planning process itself.

Other information that was shared with states included:

- Delaware is looking at establishing a buy-in to their State Employee Insurance Plan.
- Majority of the States are proposing to use the 1/3, 1/3, and 1/3 formula (e.g., federal match, state match, and employee match).
- States need to establish a community network to serve the uninsured.
- States need to provide a tax credit to employers.
- States need to implement educational programs to recruit people to use hospitalization more effectively.
- States should keep their legislators involved in the planning process.

Uninsurance in your State

According to 2000 United States Census figures, Mississippi has a population of 2.8 million people and remains one of the poorest states in the nation. Mississippi receives the largest Federal Medical Assistance Percentage (FMAP) of any state in the union. According to the Current Population Survey, 17% of all of Mississippi's population had no insurance. The majority of Mississippians are between the ages of eighteen and sixty-four. Twenty-seven percent of the population is below eighteen years of age, and approximately 12% is sixty-five years of age or older. In addition, 48% of the population is male and 52% is female.

The 1990 United States Census indicated that in 1989, 20% of Mississippi families lived below the poverty level. The 2000 Census also indicated that 22% of families with related children under eighteen years of age lived below the poverty level in 1999. Mississippi is a rural state, made up of eighty-two counties; only 14% of the square miles are urbanized. Of its eighty-two counties, twenty-one are designated as 100% rural based on rural and urban designations resulting from 2000 Census data.

Characteristics of the Uninsured

Income:

For the target respondents without insurance, 27% were below 100% of the Federal Poverty Level and 29% were between 100% and 200% of the Federal Poverty Level.

Age:

The age of target respondents without insurance ranged from birth to ninety-three years of age, with a mean age of thirty-eight years and a standard deviation of sixteen years. Age in years for the uninsured based upon 2003 CPS data is shown below:

Age 1 to 14 years	72, 811
15 to 18 years	23, 631
19 to 44 years	296,503
45 to 64 years	116,996
65 years and older	85

Gender:

Of the uninsured target respondents, 56% were female and 44% were male. CPS shows that 47.3% of the uninsured were female and 52.7% were male. Gender for the uninsured based upon 2003 CPS data is shown below:

Female	241,561
Male	269,230
Total:	510,791

Family Composition:

Husband-wife family	289,873
Other female-headed household	179,165
Other male-headed household	91,754
Total:	510,792

Health status:

Of survey respondents without insurance in Mississippi, 46% did not seek medical care over the past year because they could not afford it. Those that did seek care went to an emergency room or community clinic. Approximately 40% of those without insurance have not had a routine checkup in over two years. Of those without insurance, 32% missed work due to illness.

Mississippians have poor health status as compared to the residents of other states. The state has high rates of infant mortality, low birth weight infants, heart disease, diabetes, strokes, and accidents.

The majority of the state's physicians, dentists, and other health-care personnel are concentrated in urban areas. The shortage of health-care providers (i.e., nurses and doctors) in rural areas leads to numerous problems in access to primary health care.

Employment status (including seasonal and part-time employment and multiple employers):

Of those without insurance, 42% aren't employed and 10% are self-employed. Nearly 12% of those without insurance have more than one paying job. Approximately 25% of those without insurance work fewer than forty hours/week, and 11% are in temporary or seasonal jobs. Many work for small employers with 50% working for employers with fewer than twenty-five employees and 33% working for employers with fewer than ten employees.

Availability of private coverage (including offered but not accepted):

When asked if the target respondent's employer provided health insurance benefits, 35% responded that they did not. Nearly 13% of the employers did, however, offer insurance that could not be extended to dependents. Approximately 20% of the employers contribute to the cost of insurance. The primary reasons for not acquiring insurance are (1) cost, and (2) not being eligible due to length of employment, number of hours worked, or health conditions. According to the respondents (64%), the most common reason for not taking advantage of access to insurance is that it is too expensive.

Availability of public insurance awareness:

For those without insurance, nearly 44% had never asked about or been given information about public programs such as Medicaid. Nearly 8% of those without insurance would not enroll in a public program even if they were eligible.

Race/Ethnicity:

Most respondents without insurance were either Caucasian (54%) or African American (44%). Race and ethnicity data for the uninsured based upon 2003 CPS data is shown below:

White, non-Hispanic	239,727
Black, non-Hispanic	235,539
Hispanic	26,306
American Indian	6,081
Asian or Pacific Islander	3,139
Total:	510,792

Immigration status:

Immigration status based on CPS 2003 data is shown below:

Native, born in United States	485,071
Native, born in Puerto Rico	0
Native, born abroad of American parents	640
Foreign born, U.S. citizen by naturalization	4,412
Foreign Born, not a U.S. citizen	20,668
Total:	510,791

Source: CPA, 2003.

Focus Group Research Findings

What is affordable coverage? How much are the uninsured willing to pay?

Focus groups were conducted with low-income, part-time workers in the five Medicaid Regions of the State of Mississippi. Acceptable premiums for full coverage ranged from $25 to $100. The majority of the respondents supported premiums of forty dollars to seventy-five dollars per month.

Why do uninsured individuals and families not participate in public programs for which they are eligible?

The majority of the respondents participating in the focus groups had heard of Mississippi Medicaid. The majority (58%) had actually applied for Medicaid, either for themselves or their children. Most respondents also had heard of the State Children's Health Insurance Program (SCHIP).

Why do uninsured individuals and families disenroll from public programs?

Generally, the non-enrollee focus group participants indicated that the re-enrollment process involved filling out a form and returning it. They indicated that the form was easy to obtain from

an eligibility worker at the local office. Participants indicated that they understood the income verification process. Some of the respondents indicated that they were not aware of the re-enrollment process each year.

Why do uninsured individuals and families not participate in employee-sponsored coverage for which they are eligible?

Nearly 1/3 of focus group participants had refused employer-sponsored insurance because premiums were too high. There was wide variability in the employee premiums mentioned in the focus groups, which ranged from a low of eighteen dollars per week to a high of seventy-five dollars per week.

Thirteen percent of the household survey respondents said that they had access to employer-sponsored insurance, but they were not enrolled in the group plans. The reasons for not enrolling were that the plan was too expensive or it was not worth it.

Do workers want their employers to play a role in providing insurance or would some other method be preferable?

This question was not addressed in the research study.

Availability of subisidies:

The respondents concurred that the content of the program and extent of coverage were much more important to them. The respondents were vague in their responses relating to the availability of subsidies.

How are the uninsured getting their medical needs met?

Safety Net-Federal Qualified Health Center provides a sliding scale to the underserved population. Hospitals provide uncompensated care to the uninsured population.

Health Care Marketplace

The Lewin Group conducted phone interviews with the technical workgroup members to understand the insurance marketplace and the feasibility of implementing the policy options. The contractor analyzed options with advantages and disadvantages that will create an employer/employee insurance subsidy program for small businesses. In addition, the contractor analyzed the costs associated with these options-include administrative costs to set up and manage the initiative, the cost to the state such as tax credits, and the estimate of what the premium would be for a limited benefit plan.

Expansions of public coverage:

The Lewin group reviewed three states' models of expanding Medicaid/SCHIP (New York, Indiana, and Alabama).

Public/private partnerships:

PathFinders and The Fairman Group identified policies to help employers provide health insurance to their employees by partnering with public agencies. The model includes the employer paying 1/3, employee paying 1/3, and public programs paying 1/3 of premiums. In addition, the Lewin Group reviewed New York and Michigan models.

Incentives for employers to offer coverage:

According to Center for Applied Research and Evaluation Study, in 2003-2004; 36% of employers surveyed said they would participate in a purchasing pool. The businesses surveyed indicated that subsidizing employee premiums, allowing them to buy into a program, would be a good strategy, but officials were concerned that the buy-in program would only work if supported by federal funding.

Consensus Building Strategy

What was the governance structure used in the planning process and how effective was thedecision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The Mississippi State University Extension Services served as the intermediary to bridge the partners together and to ensure participation of the Blue Ribbon Task Force members. The governance structure is the Office of the Governor, which is designated as the lead agency for the HRSA Planning Grant project.

The Blue Ribbon Task Force (BRTF) was formed to guide the project and bring together stakeholders. The BRTF consists of State Department of Health, Department of Mental Health, Department of Finance & Administration, Department of Human Services, Mississippi Association, Rural Health Centers, faith-based organizations, and coalition members from different advocacy groups.

The technical workgroup was assigned the responsibility for overseeing the timely accomplishments of the HRSA State Planning Grant goals. The TWG reviewed research methodologies and the data collected by the research vendors. The information was distributed to the technical workgroup for review/comment by the contractor, Lewin Group. The interim report by the Lewin Group was circulated to the technical workgroup to review the policy options. The legislators were interviewed to see their perspective on the uninsured.

What methods were used to obtain input from the public and key constituencies (e.g., meetings, policy forums, focus groups, or citizen surveys)?

Qualitative Data Collection/Findings

Policy Makers:

The policy makers were interviewed during the last data gathering on their perspective on providing health care to the uninsured. The Legislature was concerned about the continued financial ability to fund expansion programs at the current levels without additional funding from the federal government and/or private sector.

Health-Care Providers:

The four vendors previously collected qualitative data from the health-care providers in the state. The survey results revealed that, overall, health-care providers were in favor of public policies that provide subsidies and tax incentives that could help make insurance more affordable for low-income individuals. However, they were concerned about the funding to offset cost associated with uncompensated care provided to the uninsured.

Regional Meetings:

Mississippi hosted regional stakeholder meetings. There were five planning stakeholder meetings in Regions 1-5. The purpose of the stakeholder meetings was to encourage the stakeholders to develop the mechanism to fund the policy options to cover the uninsured in their regions. The Division of Medicaid proposed that all stakeholders should consider establishing themselves as a 501(c)3 or identifying a 501(c)3 home base to include their projects.

The Mississippi Center for Nonprofits discussed the pros and cons of establishing as a nonprofit, the procedures, financial encumbrances, and the support that would be provided by the Mississippi Center for Nonprofits. Regions 1 and 2 expressed interest but did not come to an agreement to establish the group as a 501(c)3 or to come under an existing nonprofit agency.

Regions 1 and 2 met on May 10, 2006. The stakeholders elected to develop a small business co-op of insurance products and coordinate existing services through a resource and referral system to decrease uninsurance in their region. Preferred Hospital was the guest speaker at the meeting as they have an insurance product with a group of small employers, consumers, and other interested persons. The group was encouraged to continue to hold meetings to explore their policy options further.

Region 3 proposed to have the stakeholders established as a 501(c)3 or under another organization. There was interest among the stakeholders to establish a Statewide Disaster Call Center.

Region 4 has taken ownership of their project and has elected a chairperson and proceeded to schedule meetings.

Region 5 had low participation at their scheduled meeting. There was only one person in attendance.

Regional Meetings:

The State hosted eight to ten regional meetings throughout the state. The facilitator, Mississippi State Extension Services, utilized different tools to solicit input from the attendees. Regional stakeholders were requested to establish an action plan for small business owners to provide insurance for their employees. The purpose of the meeting was to gather information on the benefit packages that are offered by the small businesses and employers.

Dates of Regional Meetings Held:

April 17, 2006
April 26, 2006
April 28, 2006
May 03, 2006
May 04, 2006
May 10, 2006
May 16, 2006
June 16, 2006

Public Awareness:

The Division of Medicaid Office of the Governor has an agency website that has a Mississippi HRSA Grant Link. In addition, issue briefs will be disseminated with the Office of the Governor, Division of Medicaid Leadership Team and the technical workgroup members.

Next Steps

The State of Mississippi has been under financial constraints and predicts that the outlook is still bleak for 2007. Therefore, the option to implement expansion programs is not feasible and would have difficulty receiving support from the Legislature and the Governor.

Mississippi is reviewing the results of the policy findings to determine the next steps and whether it would be advantageous to request consideration in the upcoming legislative session.

Recommendations/Comments to the Federal Government

1. There is a lot of data available on the uninsured. The challenge for states is how to fund any types of expansion programs due to the budget challenges on the national and state levels.
2. The Federal Government will need to provide federal funding and technical support to states to implement the employer/employee programs.
3. The Federal Government provided a venue for states to share data concerning regional and national practices.
4. The Federal Government provided a central clearinghouse for states to gather data on the uninsured.

5. The State benefited from the federal funding by acquiring data needed on the uinsured.

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible):

Profile of the State of Mississippi:

Population: 2.8 million
Number and percentage of uninsured (current and trend): 17%
Provider competition: Private and Public
Eligibility for existing coverage programs (SCHIP): 100-200% of FPL

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Division of Medicaid Home Page Address:
www.dom.state.ms.us

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

Using the following chart, please list the policy options considered and/or implemented under the HRSA SPG, including original grant and continuation grants. For each policy option described, please include data on a cumulative basis per fiscal year (FY), e.g. FY 2006 starts October 1, 2005 and ends September 30, 2006.

Option considered	Target Population	Estimated Number of People Served	Status of approval (for example waivers submitted or legislation proposed) Please provide month and year when waiver or legislation was proposed and if approved, month and year of approval	Status of implementation (please include month and year program or initiative began)	If implemented, most recent estimate within the federal fiscal year (Oct.1 – Sept 30) of number people served. Please provide the month and date of the point in time estimate provided.
1. Blue Ribbon	Community-At Large	Statewide Coverage	N/A	September, 2003	Quarterly Meetings/Ad Hoc

TaskForce					Basis
2. Policy Options	Technical Workgroup/Health System, Health Providers and Policy Makers	Statewide	N/A	April, 2006	Ad Hoc Meetings
3. Regional Meetings 4. Issue Briefs	Regional Representation/Community At-Large	5 Regions	N/A	April, 2006	Ad Hoc Meetings