Mississippi State Planning Grant for the Uninsured

Interim Final Report

submitted to

DHHS & HRSA

September 30, 2005

EXECUTIVE SUMMARY

The State of Mississippi, Office of the Governor, Division of Medicaid applied for and received funding for a Health Resources Services Administration Grant in June 2003. The Division of Medicaid was designated as the lead agency to administer the grant.

The State of Mississippi focused its research on collecting and analyzing data to describe 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 eight goals to direct the state's efforts in this project to include:

1. Develop a comprehensive profile of health insurance coverage and the social, behavioral, economic, and demographic characteristics of the uninsured population in Mississippi, both state-wide 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 healthcare 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 the Department of Human Services, Family and Children Services Division and Chancery Court system for children who are displaced from their families and children who are entitled to benefit from child support payments that should ensure health care insurance coverage.
8. Prepare and distribute specific reports relevant to the findings of each grant component. Prepare and submit to HRSA a final report on the results of the State Planning Grant activities.

The research data was collected using both qualitative and quantitative methods. The overall research was supervised by a Research Coordinator that provides technical assistance to the researchers and the Office of the Governor, Division of Medicaid.

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. The data suggests there is an adverse insurance situation in the State of Mississippi. According to research data, approximately 17% of all household members surveyed were without health insurance and approximately 10% of the households surveyed were households with children under age 19 with no insurance. The State continues to face challenges associated with poor health status of its residents. The problem of un-insurance is exacerbated due to chronic diseases prevalent throughout the State, with those diseases most often treated in facilities as

uncompensated care. Those chronic diseases are diabetes, obesity, high blood pressure, cardiovascular disease and asthma. Children are particularly at risk. Gaps in insurance and treatment are associated with access difficulties, as the State of Mississippi is predominantly rural. Additionally, access and affordability are problems because certain preventative and maintenance care, pharmaceutical, dental, mental health and specialty care are unavailable or are financially unattainable. Another problem is reduced federal support to health care providers, impacting the amount of uncompensated care that can be provided. As with other states, inappropriate use of emergency room facilities is a problem in Mississippi. HRSA research data indicated that those who seek uncompensated care are located throughout the State. The data presents a fairly clear picture that uncompensated care is a significant percentage of patient load for most of the healthcare facilities in the State.

To conduct the research, Mississippi employed a total of four vendors with expertise in collecting and analyzing data in the health related field. There were three private vendors. The Fairman Group conducted focus groups with part-time and low income employees; Nelums and Associates conducted focus groups of CHIP and Medicaid non-renewals to determine what issues prevent their participation in the public health insurance programs; and, PathFinders and Associates conducted personal interviews with insurers and administered a survey with healthcare providers to gain an understanding of the access and utilization issues in the healthcare marketplace.

In addition, the Mississippi Institutions of Higher Learning (IHL) subcontracted with two universities to conduct research. The University of Southern Mississippi collected data from a household survey to develop a comprehensive profile of Mississippi's uninsured and an employer survey about insurance offerings and issues. Mississippi State University profiled the underrepresented population by conducting focus groups with college students and four major ethnic groups in the State to determine the cultural issues unique to the uninsured.

The household survey indicated over half (56%) of those surveyed were eligible for one of the State's public health insurance programs. More than half of the uninsured surveyed are female and forty-two percent forty-two percent are not employed. Nearly 12% have more than one paying job and twenty-five-percent work less than 40 hours a week. Forty-six percent did not seek medical attention because they could not afford it. Most respondents without insurance are Caucasian (54%) or African American (44%).

The focus groups addressed cultural issues of underrepresented populations and indicate the Hispanic population feels having health insurance is very important to them and they did not have the information needed to access programs and make appropriate selection options available through their employers. The African American population stated that their unemployed status made health insurance unaffordable. Many were unaware of community resources and eligibility requirements for Medicaid. They identified an unmet need for surgeries and drugs for chronic conditions.

The focus groups for the low-income and part-time employees corroborate the findings of the underrepresented population. Sixty-nine percent of the participants in the low-income and part-time employee focus groups did not have access to employer sponsored health insurance; more

than half have been uninsured for two or more years. They work in low income industries such as restaurants/food, retail, labor/construction, farming, child care, home health and office/clerical. The respondents reported a need for affordable medical attention for conditions such as asthma, diabetes, hypertension, ulcers, depression, heart disease, hepatitis C and others. Prescription drugs were also noted as cost prohibitive.

Focus groups were conducted for college students, SCHIP non-renewals and social workers, child support workers and Chancery judges to gather information to better understand the issues that affect this group and the groups served by agencies that work on behalf of families and children. All focus group participants expressed that health insurance was important to them, their families and the clients they served; they regarded the Medicaid and SCHIP programs favorably, but expressed that there were systemic barriers to enrollment and reenrollment.

Three hundred employers were surveyed in the State of Mississippi to determine what health insurance options they would support and what issues they had relative to access, affordability and coverage. Data analysis revealed employers are supportive of tax credits, subsides and incentives or support from State/federal sources.

Two hundred sixty-nine health care providers in the State were surveyed to determine current and future insurance and utilization issues that affect health care providers and the marketplace. The list of healthcare providers was composed of all requested hospitals, certified rural health clinics, public health districts and comprehensive/community health centers. Overall, health care providers supported public policies that provide subsidies and tax incentives that would help make insurance more affordable for low-income individuals. They were generally concerned about the funding to offset costs associated with uncompensated care.

To assess the political will to implement specific policy options, personal interviews with key elected health policy makers were conducted. The data indicated support for current public health programs, but there is concern about the continued ability to adequately fund these programs at the current levels.

The State of Mississippi partnered with Mississippi State University, Extension Services and a Community Health Coordinator acted as facilitator to ensure participation of the Blue Ribbon Taskforce members and to build consensus as health policy options were considered. The Blue Ribbon Taskforce is composed of representatives from the Mississippi State Department of Health, Mississippi Department of Human Services, Department of Insurance, Department of Finance and Administration (Office of Insurance), Mississippi Hospital Association, rural health centers, community health centers, key legislative leaders, employers, insurers, faith bases organizations, consumers, and health policy makers. The taskforce meets on a regular basis, with five meeting held to date. This group is responsible for evaluating outcomes of the grant, facilitating consensus building and prioritizing options to reduce the number of uninsured in the State. The Taskforce was active and participatory in the process.

Mississippi officials hope to create an employer/employee insurance subsidy program for small businesses (1-25 employees) that is structured to include greater incentives for wellness/prevention and incentives for business participation. A vendor will be hired to

recommend insurance options and determine the cost for this subsidy program for small employers by the Division of Medicaid. Recommendations for Federal and State actions will be made at the end of the grant period.

Section 1. Summary of Findings: Uninsured Individuals and Families

To obtain information about uninsured individuals and families, a telephone household survey was conducted between the months of November 2003 and April 2004. The Coordinated State Coverage Survey instrument developed by the State Health Access Data Assistance Center (SHADAC) was used as the basis for the Mississippi household survey instrument. The instrument was reviewed by the Blue Ribbon Task Force and several items were added to accommodate the needs of stakeholders. The survey instrument was pilot tested to validate coding and questions that were added by the Blue Ribbon Task Force.

The sample was randomly selected using random digit dialing from a sampling frame of non-elderly households in Mississippi. Seventy-five percent (75%) of the sample was drawn from households with incomes less than $35,000 and twenty-five percent (25%) of the sample was drawn from households with an estimated income between $35,000-75,000. These income criteria were selected to help target the survey to those groups likely to be without health insurance. Since Mississippi is divided into five regions for the Medicaid program, 1500 completed calls were obtained in each of the five regions. This sample size allows for comparison across regions with a sampling error of less than four percent (4%).

The survey was conducted by the University of Southern Mississippi. The Southern Miss survey research lab features an 11 station Computer Assisted Telephone Interviewing (CATI) system using Ci3 WinCATI software, a dedicated server, and one supervisor computer. Interviewers were selected and trained specifically for this project. They were supervised at all times.

The response rates and average length of call is specified in Table I.

Table 1. Response Rates and Call Length
Household Survey

REGION	CALL TIMEFRAME	RESPONSE RATE (%)	AVERAGE LENGTH OF CALL (MINUTES)
1	Nov-Dec 2003	42	9.0
2	Mar-Apr 2004	32	6.0
3	Feb-Mar 2004	34	6.5
4	Feb 2004	29	7.0
5	Jan-Feb 2004	34	8.5

The total number of respondents for the survey was 7620 households. Analysis of the data was conducted using SPSS 11.5. A summary of preliminary findings follows.

1.1 Level of Uninsurance

The survey instrument asks questions about the target respondent and, to a lesser extent, about the members of the household. Nearly 14% of the target respondents did not have insurance or anyone to pay their bills when they go to the doctor or the hospital. Of those target respondents with insurance, 6.1% did not have it for all of the past twelve months. When considering insurance status for all members of the household, over 17% did not have health insurance. For members of the household below age 19, nearly 10% did not have insurance.

The overall level of uninsurance for the State of Mississippi based upon the 2003 data from the Current Population Survey (CPS) is 17.9%.

1.2 Characteristics of the Uninsured

The following information is based on responses from the target respondents who are uninsured and data from CPS.

Income

For the target respondents without insurance, 27% were below 100% of the Federal Poverty Level and 29% were between 100-200% of the Federal Poverty Level. Further breakdown of income levels for the uninsured based upon 2003 CPS data are shown in Table 2.

Table 2. Income Levels and Number of Uninsured
2003 Current Population Survey

INCOME	MISSISSIPPI UNINSURED POPULATION	
	#	%
≤ $9,999	64,428	12.6
$10,000-$19,999	94,590	18.5
$20,000-$29,999	72,708	14.2
$30,000-$39,999	90,767	17.8
$40,000-$49,999	48,855	9.6
$50,000-$59,999	32,033	6.3
$60,000-$69,999	19,729	3.9
$70,000-$79,999	29,872	5.8
$80,000-$80,999	10,894	2.1
$90,000-$99,999	9,503	1.9
≥100,000	37,413	7.3
Total	**510,792**	**100**

Age

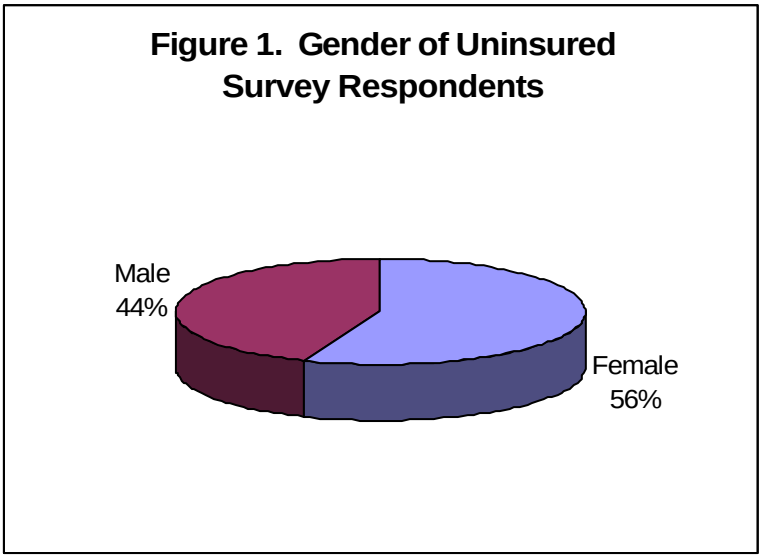
The age of target respondents without insurance ranged from birth to 93 years of age, with a mean age of 38 years and a standard deviation of 16 years. Age in years for the uninsured based upon 2003 CPS data is detailed in Table 3.

Table 3. Age of the Uninsured
2003 Current Population Survey

AGE	MISSISSIPPI UNINSURED POPULATION	
	#	%
1 - 14 years	72,811	14.3
15 - 18 years	23,631	4.6
19 - 44 years	296,503	58.0
45 - 64 years	116,996	22.9
65 years +	851	0.2
Total	510,792	100

Gender

Of the uninsured target respondents, 56% are female and 44% are male.



CPS data indicates 47.3% of the uninsured are female and 52.7% are male as shown in Table 4.

Table 4: Gender of the Uninsured
2003 Current Population Survey

GENDER	MISSISSIPPI UNINSURED POPULATION	
	#	%
Female	241,561	47.3
Male	269,230	52.7
Total	**510,791**	**100**

Family composition

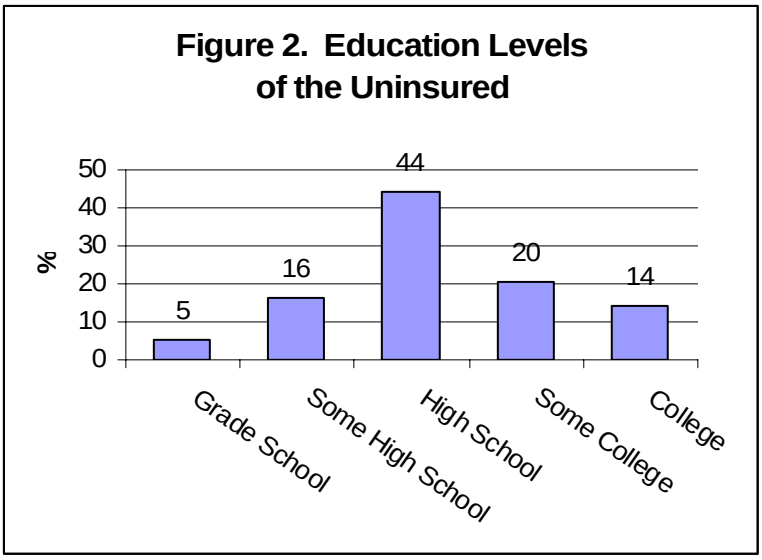
Only 38% of the uninsured target respondents were married. The number of people living in the household ranged from 1-12 with a mean of 2.53 and a standard deviation of 1.5 people. Family composition for the uninsured based upon 2003 CPS data is shown in Table 5.

Table 5. Family Composition of the Uninsured
2003 Current Population Survey

FAMILY COMPOSITION	MISSISSIPPI UNINSURED POPULATION	
	#	%
Husband-wife family	239,873	47.0
Other female head	179,165	35.1
Other male head	91,754	18.0
Total	**510,792**	**100**

Education

Over 65% of respondents had a high school education or less, while 21% did not graduate from high school.



Health status

Of those Mississippi administered surveyed respondents without insurance, 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 check-up in over two years. Of those without insurance, 32% missed work due to illness and nearly 24% missed three or more days of work. Almost 25% rate their health status as fair or poor. Health status for the uninsured based upon 2003 CPS data is shown in Table 6.

Table 6. Health Status for the Uninsured
2003 Current Population Survey

HEALTH STATUS	MISSISSIPPI UNINSURED POPULATION	
	#	%
Excellent	101,167	19.8
Very good	183,427	35.9
good	182,555	35.7
Fair	27,393	5.4
Poor	16,250	3.2
Total	**510,792**	**100**

Employment status

Of those without insurance, 42% are not 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 less than 40 hours/week and 11% are in temporary or seasonal jobs. Many work for smaller employers, with 50% working for employers with less than 25 employees and 33% working for employers with less than 10 employees. Work and employment status for the uninsured based upon 2003 CPS data are shown in Tables 7 and 8.

Table 7. Work Status of the Uninsured
2003 Current Population Survey

WORK STATUS	**MISSISSIPPI UNINSURED POPULATION**	
	#	**%**
At work	274,609	62.7
With job, not at work	6,040	1.4
Unemployed-seek FT	27,728	6.3
Unemployed-seek PT	2,346	0.5
Not in labor force	127,257	29.1
Total	**437,980**	**100**

Table 8. Full and Part Time Status of the Uninsured
2003 Current Population Survey

EMPLOYMENT STATUS	**MISSISSIPPI UNINSURED POPULATION**	
	#	**%**
Part time	252,581	79.3
Full time	65,971	20.7
Total	**318,552**	**100**

The most common employer groups for those without insurance are: retail sales (18%), construction/mining (17%), health care (8%), manufacturing (8%), agriculture (7%), and personal services (7%). Industry sector and employer size information for the uninsured based upon 2003 CPS data is detailed in Table 9 and 10.

Table 9. Industry Sectors of the Uninsured Population
2003 Current Population Survey

INDUSTRY SECTOR	MISSISSIPPI UNINSURED POPULATION	
	#	%
Agriculture, forestry, fishing, and hunting	16,672	3.2
Public administration	5,616	1.1
Information	5,800	1.1
Construction	48,588	9.4
Leisure and hospitality	44,709	8.7
Manufacturing	32,424	6.3
Wholesale and retail trade	50,772	9.8
Mining	6,021	1.2
Not eligible (children or nonworkers)	201,577	39.0
Armed forces	0	0
Other services	30,380	5.9
Education and health services	31,163	6.0
Transportation	15,974	3.1
Financial activities	10,224	2.0
Professional and business services	16,893	3.3
Total	**516,813**	**100**

Table 10. Employer Size of the Uninsured
2003 Current Population Survey

EMPLOYER SIZE	MISSISSIPPI UNINSURED POPULATION	
	#	%
<10 employees	111,564	21.8
10-24 employees	42,848	8.4
25-99 employees	30,379	5.9
100-499 employees	43,123	8.4
500-999 employees	16,912	3.3
≥1000 employees	73,726	14.4
Not employed or child	192,240	37.6
Total	510,792	**100**

Availability of Private Coverage

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 be extended to dependents. Approximately 20% of the employers contribute to the cost of insurance. The primary reasons for not acquiring insurance include (1) cost (52%) and (2) not being eligible due to length of employment, number of hours worked, or health conditions (19%).

Only 8% of the target respondents without insurance had spouses with insurance coverage. Of that 8%, 71% could get insurance for themselves. The most common reason (63%) for not taking advantage of access to insurance is the cost.

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

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 in Table 11.

Table 11. Race of the Uninsured
2003 Current Population Survey

RACE/ETHNICITY	MISSISSIPPI UNINSURED POPULATION	
	#	%
White, non-Hispanic	239,727	46.9
Black, non-Hispanic	235,539	46.1
Hispanic	26,306	5.2
American Indian, non-Hispanic	6,081	1.2
Asian or Pacific Islander, non-Hispanic	3,139	0.6
Other	0	0.0
Total	510,792	100

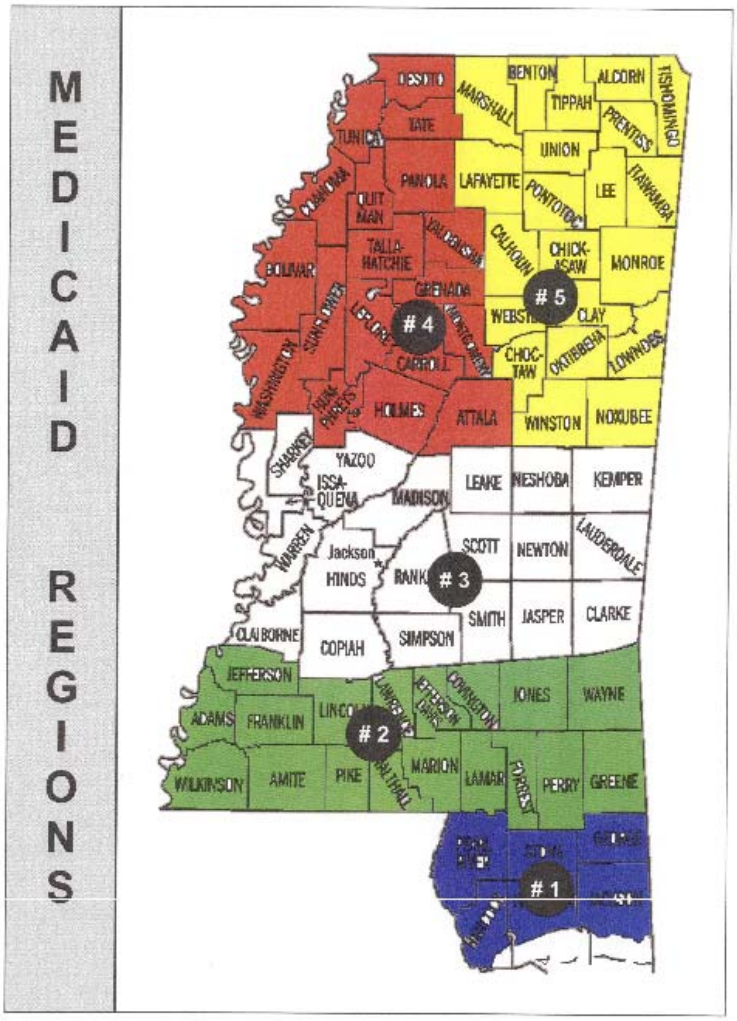
Immigration Status

Immigration status based on CPS 2003 data indicates 95% of the uninsured population in Mississippi is native born.

Geographical Location

The State of Mississippi is divided into five (5) Medicaid Regions. For the purpose of the HRSA Research project these areas were used to collect data. According to the Mississippi household survey data, the uninsurance rates by region from lowest to highest are Regions #1 and Regions #5 have a 17% unisurance rate each; Region #2 have an uninsurance rate of 19% and Regions #3 and #4 has an a rate of 21% each.

A map of the regions is shown below:



1.3 Target Expansion Options

The target group for expansion options was uninsured employees of small business that employed from 1 to 25 employees. The conclusions drawn from the data are about two-thirds of Mississippi's uninsured population(66%) is linked to the workforce through at least one full-time worker; about two-thirds of Mississippi's uninsured population (67%) have incomes at or below 200 percent of the Federal Poverty Level and more that one-third (40%) have incomes at or below 100 percent of poverty and the industries most strongly affected are retail, construction/mining, health care, manufacturing, agriculture and personal services. Thirteen percent of the household survey respondents say that they have 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. These facts were considered most when the parameters were identified for further options to assist small businesses to provide employer based coverage with subsidies.

1.4 - 1.13 Qualitative Research Findings

Several qualitative research projects were included in the overall project to provide additional insights into the health insurance situation in Mississippi.

1.4 What is affordable coverage? How much are the uninsured willing to pay? Uninsured Low Income Workers Can Only Afford Token Premiums and Small Co-Payments

Uninsured Low Income Workers

The Fairman Group conducted focus groups with low income part-time workers in the five Medicaid Regions of the State of Mississippi. Focus group questions about affordable premiums and co-payments generated spirited discussions among participants. Acceptable premiums for full coverage ranged from $25 to $100 for singles and $35 to $150 for families, with those proposing the higher numbers very thinly represented in the groups. The majority supported premiums of $40 to $75 per month.

Participants indicated they could afford to have modest premiums deducted from their checks and juggle other expenses, "robbing Peter to pay Paul" and "finding it somewhere in the budget." Most expressed a willingness to find a way to participate, if at all possible, in paying for affordable medical coverage. One young woman held up a pack of cigarettes and indicated she would sacrifice "These!" to pay for health coverage.

Acceptable co-payments for physician office visits fell in the range of $5- $20, with the majority in the $10 to $20 range. The concept of a sliding scale for co-payments based on a percentage of cost was also supported with one respondent stating, "If they would pay 80%, I would pay 20%."

Proposed co-payments for prescriptions ranged from $2 to $20 with the majority consensus

being $5 to $10. Interestingly, several responding group members felt there should be no co-payment requirements for an emergency room visit. They believe emergency care should be available without financial barriers of any kind. Most other participants agreed $25 to $50 would be appropriate for an emergency room co-payment.

Most participants, given health insurance, would save from hundreds to thousands of dollars per year in prescription costs, physician visits, and emergency room care. Patients with chronic conditions would save the most. These savings could be devoted to premiums and co-payments.

Underrepresented Populations

Mississippi State University conducted focus groups with members of underrepresented populations and noted there were wide differences in responses within and among the groups regarding the amount they were willing to pay monthly for health insurance.

African American participants' responses ranged from "I can't afford to pay anything" to $40 - $60 per month. In one African American group, a discussion ensued between men and women in which some men stated they could not pay anything or could not pay the amounts suggested by the women, and some women stated that the men could if they tried: "You could go outside and pick up cans and get $50 or $60 a month."

Asian American participants indicated they would be willing to pay $20 - $100 per month for insurance. This was a similar response from one of the Native American groups who said they would be willing to pay $20 - $80 per month. The other Native American group's response had a much wider range, but with the caveat that "it depends on the type of coverage:" $1 - $360 per month.

Hispanic American participants spoke of amounts based on percentages of their income, such as 5% to 10% of income. Others indicated a willingness to pay $20 to $50 per month. One participant said that, "it would depend on how many people in the family work."

Asian American participants did not differentiate between their thoughts on fair co-payments for a doctor office visit, a prescription, or an emergency room visit. For all three of these medical services, they suggested $10, $20, and 5% of bill.

African American participants suggested fair co-payments would be $10 - $40 for a doctor visit, $5 - $30 for prescriptions, and $10 - $100 for an emergency room visit.

Because some participants in the Native American groups go to the Choctaw Health Center for doctor office visits and prescriptions, the question was modified so their answers reflected an amount for the entire service received at the hospital as opposed to a co-payment. Amounts ranged from $40 - $180. The other Native American group suggested co-payments for doctor office visits of $5 - $25, but some said that it would depend on the reason for the visit and type of doctor. In this group, fair co-payments for prescriptions were mixed with the amounts they were willing to pay for the doctor visit. Fair co-payments for an emergency room visit ranged from

$25 - $100. (One participant said $500, but it was not clear if she were referring to the entire cost or for a co-payment.)

Hispanic American participants spoke in terms of percentages regarding fair co-payments for health services: 5-10% of the bill for a doctor's visit, 8-25% for prescriptions, and 20-30% for emergency room visits. One from this group stated that, "I would be willing to pay 50% as long as the visit helps," while another countered that he could pay, "nothing because I would have to be covered completely, it would have to cover 100%."

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

Virtually everyone in the low income part-time worker focus groups had heard of Mississippi Medicaid. The majority (58%) had actually applied for Medicaid, either for themselves or their children. Additionally, many were trying to establish disability with the Social Security Administration. Most individuals also had heard of the CHIP; however, there was considerable confusion about the difference between CHIP and regular Medicaid.

Women generally understood they can get Medicaid while pregnant, but coverage for the mother will expire when the infant reached two months of age. Many people who are unable to work but had not been able to establish permanent disability believed they should be able to get Medicaid in order to access care. The one exception was a 38 year-old heart patient who said, "I have never applied for food stamps or anything. It's too personal. You want to stand on your own."

Some frustration was expressed by participants in focus groups of low-income part-time workers about the Division of Medicaid's policies. At one session a young woman who had applied for Medicaid reported, "They were taking so long, they ran out of time. I have to go back and apply again for me and my son . . . he hasn't got it yet." Several respondents also had been turned down for Mississippi Medicaid in the past. The overriding perception of these people is they are caught "between a rock and a hard place" with earnings too high to qualify for Medicaid but unable to afford to purchase private coverage at their family income level. There is also a widespread perception that Medicaid rewards people who refuse to work and punish people who work. "I work every day, I go to school, I am trying to do something with myself, and there is stuff I need that I can't get," said one young woman, a single mother.

Further, there appears to be several misconceptions about Medicaid, e.g., a single adult has to be able to live on less than $400 a month to get Medicaid, a woman can only get it when she's pregnant, and CHIP is better coverage than regular Medicaid. As previously mentioned, TFG ran across several low-income workers who did not know about CHIP or where or how to apply for Medicaid for themselves. However, the majority of participants knew how to apply for Medicaid and CHIP, with only a few exceptions. Existence of the statewide toll free number and

online application forms were mentioned on several occasions. Some participants are not clear on exactly where in the community to apply, but felt it would be easy to call and find out. Overall, parents in the focus groups consistently state they would enroll their children if they were eligible.

1.6 Why **do uninsured individuals and families disenroll from public programs?**

Non-enrollee focus group participants indicate the re-enrollment process involved filling out a form and returning it and the form is easy to obtain (from your eligibility worker at the local "welfare" and/or Medicaid office). One participant indicated, however, the form was complicated and they had to have assistance in completing it. The researchers suspect this individual had literacy problems and acknowledge literacy may be a barrier for many enrollees. Some people may be unwilling to admit not being able to read in a focus group or to an eligibility worker. Participants indicated they understand the income verification process ("you provide them with two check stubs"), but in each group, some participants indicated they were not told and were not aware they would have to re-enroll every year.

Indeed, one of the most consistent group responses to the question about the biggest concerns with the re-enrollment process was not being notified it was time to re-enroll. Being "kicked off" without notification was also a consistent response across groups. Other re-enrollment concerns primarily dealt with complaints about how non re-enrollees were treated by eligibility workers, such as:

- Lack of contact from eligibility workers (failure to return phone calls, etc.)
- Being placed on hold on the telephone for long periods of time when they have questions
- Eligibility workers are rude and unfriendly
- Eligibility workers are not available when they go to office
- Eligibility workers do not listen

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

Low income part-time workers believe that being in a position of having little or no disposable income and only barely meeting basic living expenses makes health insurance premiums out of reach for many —including those with employer-sponsored insurance. Nearly one-third of focus group participants refused employer-sponsored insurance because premiums were too high. There was wide variability in the employee premiums mentioned in the groups, which ranged from a low of $18 per week to a high of $75 dollars per week or more.

The under-represented population's main reasons for not accepting employer health insurance are not being eligible for health benefits (ineligible because of working part-time or not having long enough to qualify) and not having enough money to pay employee portion of benefits. One Hispanic American participant said that he did not accept the insurance because it would limit options for choice in health care.

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

Employers perceive that employees would like them to provide more affordable insurance options. Over 56% of small employers estimate employees could afford to pay $50 per month or less for insurance premiums.

1.9 How likely are individuals to be influenced by:

Availability of Subsidies?

Participants in the part-time, low income groups agreed the source of coverage has little importance. They emphasized the content of the program and completeness of coverage were much more important to them. There were some concerns that a government program could have little choice of provider and additional sentiment that continuity of care is an issue, especially in pediatrics. One mother said t the source of the coverage was not important, but, "I would prefer my (infant) go in to see a private doctor, having the quality care, getting to know one physician instead of going to see a different doctor every time at the clinics." Another participant agreed quality of care was of concern, "On the public program you've got to go to certain doctors and they might not be as good."

Only one participant directly objected to government coverage. She wanted to make it on her own without Food Stamps, Medicaid, or any other form of government assistance.

About one-fourth of focus group members (those who couldn't afford premiums for employer-based coverage) would be most likely to benefit from a subsidy to purchase insurance. The employee's portion of the cost of these plans, as reported by focus group members, ranged from $18-80 per week.

Employers were interested in subsidies to offer insurance coverage. Both daycare and nonprofit organizations said subsidies were a necessity in order for them to provide health insurance coverage for their employees.

Tax credits or other incentives?

Tax credits seem to be a less promising incentive to purchase insurance, given the paycheck-to-paycheck existence of most low-income part-time workers and low tax bracket in which they find themselves. However, any assistance—be it a subsidy, tax credit, or other incentive—would be welcomed by them. Only one worker feels employers should be required to offer insurance. The majority of focus group members feel the source of coverage is unimportant. Employers indicated general support for tax credits related to insurance coverage.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

Employer focus group participants identified lack of choice in selecting a provider, ease of access to free care at University Medical Center and other ER facilities as barriers to purchasing health insurance. In addition, employees may have Medicaid coverage, creating little pressure for employers to provide health insurance. Finally, limited access/coverage provided by cheaper plans presents barriers to purchasing health insurance.

1.11 How are the uninsured getting their medical needs met?

Low income, uninsured workers exhaust all available remedies before seeking care. Participants use a variety of over-the-counter medications, as well as folk remedies such as tobacco on bee stings, 'pine top' tea with lemon and aspirin, or bourbon and honey for a cold, apple cider vinegar in water for high blood pressure, sweet oil from the bible store for an earache, etc. One woman recalled that, as a child, her mother would warm "Vicks Aid Rub" in the oven and have the children drink it as an effective home remedy for colds and flu.

In most of the focus group sessions, the discussion focused on the determination on the part of uninsured workers NOT to seek professional care until all alternatives were exhausted. There appears to be tendency to self medicate with over-the-counter products or folk remedies that, in some cases, delays treatment of potentially dangerous conditions. One respondent reported, 'I waited nineteen days with a migraine, they did a spinal tap and all, but that bill has not come in yet.' It is apparent if this person had an illness requiring prompt diagnoses and a specific course of therapy, the outcome after such a long delay might have been tragic.

Speaking for the group, a female restaurant worker in her late 20's said, "That's everybody's first instinct, to heal them selves." One of her co-workers added, "If you can't heal yourself, then you suck it up and go to the ER." She corrected herself by saying, "You go to your grandmamma, and then you go to the ER."

The African American groups provided descriptions of home remedies: heat for pain, garlic powder for high blood pressure, vinegar-soaked plaster for arthritis, mustard for high blood pressure, whiskey with lemon and cinnamon for pain and colds, remedies at oriental stores, and prayer and faith for healing. One Hispanic American said, "I am a man, so I can handle it [being sick]."

The Community Health Centers provide an important source of care for many. A number of respondents mentioned the availability of community health centers including Jackson-Hinds Comprehensive Health Center and the Jackson Medical Mall in Jackson, Delta Health Center in Mound Bayou, and Access Family Services in Smithville. These workers complimented the

overall quality and availability of service and the sliding scale used to establish affordable costs for visits.

For some, the emergency room is the only source of care. A large proportion of participants indicated they used the emergency room for care as they lacked a regular source of care. In fact, more than half of low income pat-time participants (54%) indicated on their registration questionnaires they lacked a family doctor. Most (67%) indicated they used the ER, and the largest proportion (40%) made 3 to 5 visits per year for themselves and family members.

Because many physicians demand payment before services are rendered, the ER was perceived by many participants as the only available source of care. They seemed reconciled to receiving bills for huge sums that they wouldn't be able to pay and many were being pursued by collection companies.

The under-represented focus group participants mentioned several specific sources of medical services available for those without insurance. Asian Americans said they went to the local health department. Some Hispanic Americans said they went to the hospital, but one participant warned them not to go to a "private hospital." Others said they did not go anywhere, with one saying, "There is no better way [without insurance]." Some African American participants said they would go to the emergency room [at a hospital], especially if it were for their child. Other African American participants made comments that were similar to those of the Hispanic American participants – they do not go anywhere, they "wait out" the sickness.

1.2 What are the features of an adequate, barebones benefit package?

The recommended features of a barebones benefit package consisted of a list of fourteen benefits:

1. Primary Care, OB/GYN
2. Wellness (Screening, exercise, weight management, nutrition education, dental and visual screenings
3. Medication/Medication therapy management
4. Chronic disease/illness management
5. In-patient hospital
6. Dental
7. Lab/diagnostic
8. Mental health/behavioral health/substance abuse
9. Emergency Care
10. Vision
11. Out-patient
12. End of Life Hospice
13. Specialty
14. Transportation

If services are to be deleted, the recommendation is to cut from the bottom as the services are ranked in priority order.

1.3 How should underinsured be defined? How many of those defined as "insured" are Underinsured?

One question was included in the household survey to address underinsurance. Respondents were asked if there was any time in the last year they did not seek services from a physician due to cost. Those with insurance but felt they could not seek the services from a physician due to cost are defined as "underinsured" in this study. Table 12 identifies perceptions of underinsurance by type of insurance coverage.

Table 12. Perceptions of Underinsurance by Source of Insurance

SOURCE OF INSURANCE	THOSE NOT SEEKING PHYSICIAN CARE DUE TO COST (%)
Medicaid	18.9
SCHIP	18.7
Medicare	18.4
Employer	13.0
Other Employer	12.8
Direct purchase	10.1
Military	1.7
Indiana Health Service	.2

Section 2. Summary of Findings: Employer-Based Coverage

Employers are an important part of any study of insurance needs. To this end, it is important to assess employers' perspectives and concerns about providing insurance and any associated barriers. Because smaller employers are the norm in Mississippi, those employers with less than 50 employees were surveyed to better understand how employers view providing health insurance to their employees. Before the survey was developed, focus groups were conducted with small business owners in three Mississippi cities.

2.1-2.7 Focus Group Results

The purpose of conducting focus groups with small employers was to gather information that could be translated into a more detailed survey. Information of interest included benefit packages that are offered, the health insurance decision-making process, knowledge of public programs, and reactions to public-private partnerships to provide insurance to employees. The three groups and their locations were:

Group 1: 2 - 9 employees (Hattiesburg, MS)
Group 2: 10 -19 employees (Gulfport/Biloxi, MS)
Group 3: 20 - 49 employees (Jackson, MS)

Groups were provided an incentive and food to encourage participation. The following information was collected from each participant:

- Signed Informed Consent
- # of employees
- Type of business: service, retail, wholesale, financial/insurance/real estate, construction, manufacturing, mineral, transportation/communication/utilities, or other
- Average age of employees
- Payment type: hourly only, salaried only, both hourly and salaried
- Turnover rate: less than 25%, 25-49%, 50% or greater
- Types of benefits offered: sick time, vacation time, life insurance, health insurance, other

The results of the focus groups were used to develop the survey used in the studies.

In addition, the following qualitative information was collected during the focus groups.

- Focus Group participants said affordable coverage ranges from $50 per month per employee to up to $100-$150 per month per employee.

- Employers were interested in subsidies to offer insurance coverage . Both daycare and non-profit organizations said subsidies were a necessity in order for them to be able to provide health insurance for their employees.

- Within the focus groups, all employers supported tax credits and incentives. Many of them mentioned these solutions before the focus group question even arose. One focus group member stated, "If there is no tax credit or incentive, providing health insurance becomes just like another tax." One representative from a non-profit organization said that tax credits would not affect them as they are not required to pay taxes because of their status.

- When asked about barriers besides affordability that prevent the purchase of health insurance, reasons cited included: (1) lack of choice in selecting a provider, (2) ease of access to free care at University Medical Center and other ER facilities, (3) employees currently have Medicaid so there's no pressure for the employer to provide health insurance, and (4) limited access/coverage provided by cheaper plans.

- Factors that influence the employer's decision about whether or not to offer coverage include: affordability, employees' interest in having coverage, employee eligibility for health insurance (some employees are currently on Medicaid and would not be willing to pay for health care coverage since they currently receive free care).

Employer Survey Results

Methodology

The survey was developed by using the focus group findings and survey instruments used by other states. The draft instrument was submitted to the Blue Ribbon Task Force (BRTF) for input and revision. The BRTF approved the final survey instrument. (See Attachment I.)

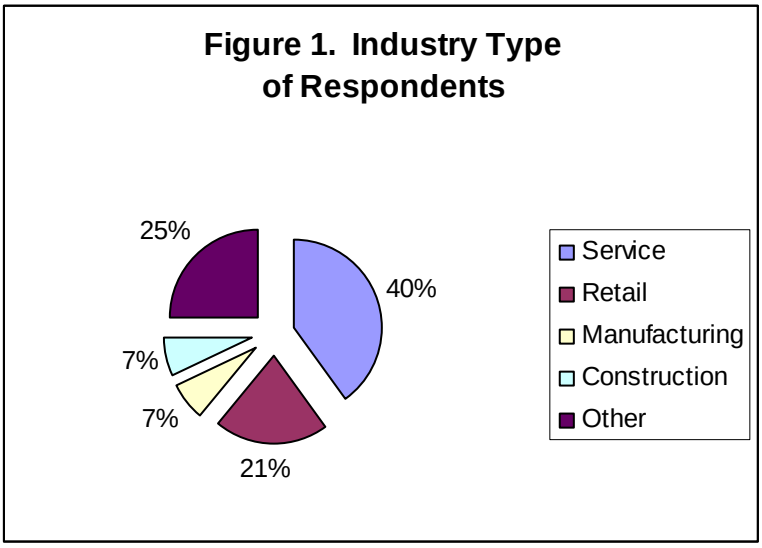
The survey was conducted by The University of Southern Mississippi. Interviewers were selected and trained specifically for this project. The survey research lab features an 11 station Computer Assisted Telephone Interviewing (CATI) system using Ci3 WinCATI software, a dedicated server, and one supervisor computer. Staff pilot tested the survey in the Hattiesburg area to validate coding and phrasing of questions.

The sample was randomly selected from a database provided by the Mississippi Development Authority. The database provided contact information for businesses with less than 50 employees. A sample of 300 completed surveys was targeted in each of the five specified regions (See Attachment II for listing of regions and map). Surveys were mailed to the business address with a cover letter and business reply envelope. Businesses that did not return the survey were contacted via telephone to assist the business owner in completing the survey. Business owners were given the option of having the survey faxed to them.

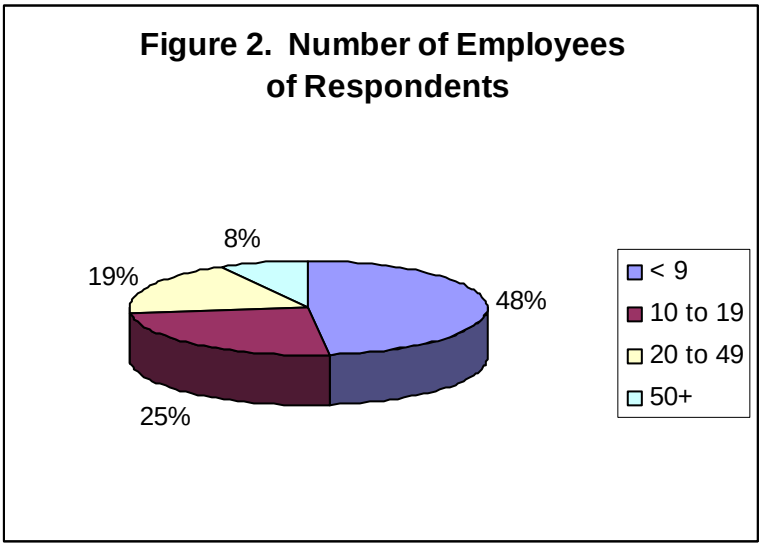
The calls began in June 2003 and continued through September 2004. Initially, 6513 letters were sent to the sample. Most surveys (1296) were completed and returned by mail or fax. Another 334 surveys were completed by phone.

Description of Respondents

Most employers are in the service or retail sectors as illustrated in Figure 1. The "other" category includes small numbers representing transportation, medical, wholesale, financial, religious, entertainment, and mineral industries.



Most respondents had less than 20 employees since the sampling frame focused on small employers. However, the business employee sizes specified by the Mississippi Development Authority were not accurate and 8% of the respondents employed more than 50 people. See Figure 2.

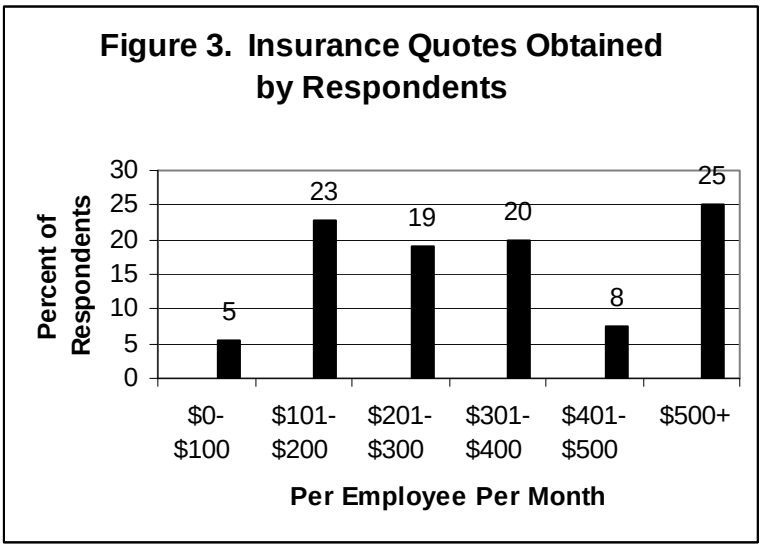


On average, respondents had 8.45 temporary or seasonal employees and 7.55 part-time employees. On average, 8.6 employees earn $7/hour or less and 8.60 employees earn $7-10/hour.

Health Insurance Coverage

Nearly 45% of the respondents do not offer health insurance. When asked why they did not offer insurance coverage, 73% of the respondents said that it was due to cost. Another 17% said that insurance coverage wasn't needed to attract employees and 8% reported high employee turnover rates.

Half of those that don't offer insurance had sought quotes for providing healthcare coverage. Figure 3 details the costs of quotes obtained by respondents. Note that 53% of the respondents received quotes over $300 per employee per month and 25% received quotes over $500 per employee per month.



In contrast, employers do not think the quotes are reasonable with 68% of the respondents reporting they could only afford less than $100 per employee per month for insurance coverage. When asked about what their employees could afford to contribute, 56% said less than $50 per month and 73% said less than $75 per month.

Only 17% of employers have ever directly paid the medical bills of their employees. The voucher concept also is not popular with just over 5% offering employees a voucher or money to purchase health insurance. An overwhelming number (76%) would not pay for health insurance coverage if an employee were eligible for insurance as a dependent under a spouse's plan.

Solutions

The Third Share Health Care Program in Michigan is based on splitting premiums for health insurance three ways with the employer paying 1/3, the worker paying 1/3, and a public program such as Medicaid paying 1/3. Employers were asked if they would be willing to pay $50 per employee per month for such a program. Nearly 65% said they would be willing to participate.

When asked about the likelihood of supporting tax credits, 39% were very likely to support them. Using a 5 point scale with 5 being very likely to support tax credits, the mean rating is 3.57, indicating general support for tax credits related to insurance coverage.

The concept of a purchasing pool was described to survey participants. Using the above 5 point scale, 36% were very likely to join a purchasing pool to improve prices, with a mean score of 3.47.

Section 3. Summary of Findings: Health Care Marketplace (Health Insurers)

The HRSA State Planning Grant research team recognizes the importance of talking with insurers to identify and test specific options and mechanisms to address access, affordability, and coverage. As such, Institution of Higher Learning research affiliates and/or private research vendors conducted personal interviews with public and private insurers to better understand the insurance marketplace and variety, complexity and cost of offering health insurance products. The interview guide was developed based on models identified in other states.

Ten private health insurers were identified based upon their market shares as published in The 2002 Annual Market Share Report by the Mississippi Department of Insurance. The selected private insurers represent 63.3 % of the market share in Mississippi. The public insurers are composed of the Mississippi Medicaid Program, State Children Health Insurance Program and State and School Employees' Health Insurance Plan. These public programs represent 912,304 enrollees. An assessment of personal interview guides and survey models developed by other states such as but not limited to Texas, Kansas, and Illinois was completed. These assessments were used to inform the development of the Personal Interview Guide for management of public and private insurers.

The research goal was to identify current coverage levels and specific options and explore mechanisms supported by insurers to address access, affordability, and coverage. More specifically, the research identified the following issues in the State of Mississippi: (a) current coverage levels in the marketplace, (b) current products offered and all associated costs, (c) opinions and attitudes on current or future options, strategies, and policies, (d) opinions and attitudes on universal coverage and impact, and (e) any other relevant issues to access, affordability and coverage.

The research focused its inquiry on public and private insurers doing business in the state (2003) to better understand the insurance marketplace and the variety, complexity and cost of offering health insurance products. To examine these research issues, the following scope of work was applied:

- A list of key public and private health insurers doing business in the state was identified. The list represented the top 10 private health insurers based on market shares and the three largest public health insurers in the state.

- The methodology for collecting data and information from public and private health insurers was defined and developed. The methodology for collecting data was the administering of a Personal Interview Guide, with the design based upon a review of related literature.

- A draft instrument (Personal Interview Guide) and protocols for contacting potential interviewees and for administering the instrument were developed for collecting data from all public and private health insurers.

- A pretest of the instrument and protocols was conducted with a panel of experts. The comments and feedback from the panel of experts were analyzed and final refinements were made.

- Data were gathered using the instrument and methodology identified above. A review of interview guides of other state models was conducted to discern best practices for designing a Personal Interview Guide for public and private health insurers, including developing appropriate questions.

- A comprehensive analysis of data collected from public and private health insurers' using a Personal Interview Guide was conducted. The analysis also included the consideration of current literature related to the assigned goal and research issues.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

None of the private insurers in the sample offered insurance products for persons of different income levels. However, they reported varying approaches to providing products to persons with pre-existing conditions. Company A indicated although they had certain exclusions on mental illnesses and drug dependency, generally there were no exclusions related to pre-existing conditions. They offer supplemental coverage for some illnesses, such as cancer.

Company B covered persons with pre-existing conditions and there were no special administrative costs or special product offerings or costs to this group.

Company C covered persons with pre-existing conditions, with varying costs and including a 10% administrative cost. Persons with pre-existing conditions who could not be covered by regular group insurance were covered in a comprehensive high-risk health pool. Company D offered persons with pre-existing conditions the same product, with a 10% administrative cost; the cost of the policies were approximately 30% higher. If persons who have pre-existing conditions already have insurance when they seek coverage from Company D, there is no waiting period. If the person does not, they must be enrolled for 12 months before they are able to file claims related to the pre-existing conditions. Company F and Company E provided health insurance for persons with pre-existing conditions with no difference in coverage and costs.

The SCHIP defined "adequate" health insurance as providing comprehensive benefits with both inpatient and outpatient services and full prescription drug coverage. There should also be complementary prevention coverage for individuals. Based on the fact that SCHIP offers comprehensive benefits as well as prevention coverage, it was reported by the interviewee that SCHIP had very adequate health insurance products. The Office of Insurance defined an "adequate" health insurance product as one that protects a person and their family from financial disaster because of high medical bills.

All providers were asked to define an adequate health insurance product and based upon that definition, discuss if the products they offer were adequate products to persons of different income levels. The definitions and answers that follow are in the words of the interviewees:

- Company A – "Basic medical expense coverage that provides deductions which encourage persons to be aware of health."

- Company B – "One that insures that members receive the care they need, for example catastrophic, but is affordable."

- Company C – "Minimum provisions, at affordable costs."

- Company D – "Timely access to primary care without complicated process and access to pharmaceuticals, affordable."

- Company E – "Adequate health insurance is defined by the individual, it is such a subjective term. Adequate products would include well-being and catastrophic coverage, accidental coverage, and some levels of prevention."

- Company F – "Service based on need in the marketplace"

Regardless of the definition that a given company executive gave for adequate insurance, private insurer interviewees felt the products offered in Mississippi were adequate regardless of the types of product.

3.2 What is the variation in benefits among non-groups, small groups, large group and self insured plans?

Most of the private insurer interviewees indicated there are variations in benefits among non-group, small group, large group and self-insured plans beyond the state and federal mandated benefits that apply to all health insurance products since the "content" of the products is based upon employer/employee requests.

3.3 How prevalent are self-insured firms in your state? What impact does that have in the State's marketplace?

The six private health insurance companies which are represented in this analysis are: (a) Blue Cross and Blue Shield of Mississippi, (b) United HealthCare Insurance Company, (c) Mutual of Omaha Insurance Company, (d) Aetna Life Insurance, (e) Trustmark Insurance Company, and (f) Pacific Life & Annuity Company. These insurers comprise approximately 60% of total market share of private insurers in the state (Sources: Mississippi Department of Insurance, Annual Market Share Report for Year Ended 12/31/2002, and Mississippi and Jackson Association of Health Underwriters, November 2003). They provided group and/or major health medical coverage in Mississippi during the 2003 calendar year.

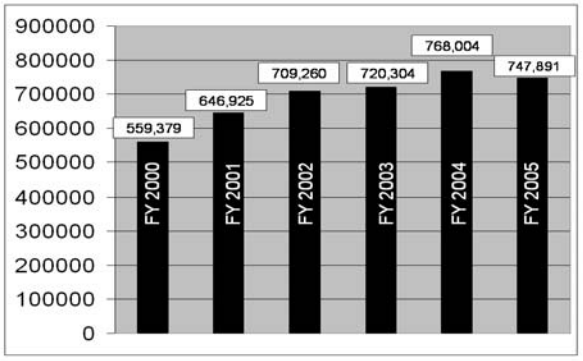
These private insurers offer a variety of products, ranging from individual policies to group policies provided to businesses and individuals. The largest private insurer in the state is Blue Cross Blue Shield of Mississippi. They are only licensed in this state, and held 46.7% of the market share during 2002. They have a partnership with several public insurers including

Medicaid, State Children's Health Insurance Program and State and School Employees' Health Insurance Plan for administration functions. The closest competitor to Blue Cross Blue Shield is United HealthCare Insurance Company at 8.1% of the market share, which includes market share and premiums written by the parent company.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees?

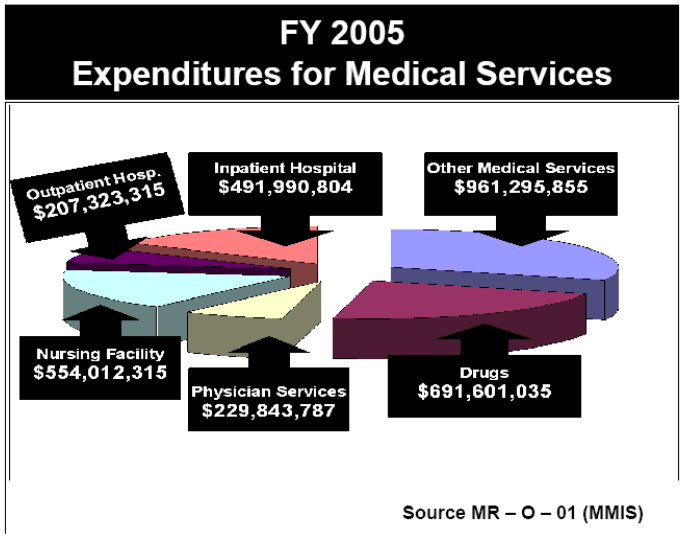
Mississippi did not assess the State's impact on the health care market as a large purchaser. However, the Division of Medicaid through Medicaid and SCHIP, provides coverage to 1 in 4 Mississippians. The following two charts show the total Mississippi Medicaid eligibles and the expenditures related to providing services.

Total Medicaid Certified Eligibles



NOTE: ALL FIGURES AS OF THE LAST DAY OF THE FY.

Source RB411 (MMIS)



3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

The researchers provided each interviewee with a definition for "universal coverage" for the purpose of this study: "providing full access to healthcare for everyone."

The public insurers believe there are some current market trends and/or regulatory policies that impact obtaining universal coverage. Some examples of current market trends impacting universal coverage are: (a) increasing healthcare costs, (b) shrinking healthcare provider market, (c) increasing health care premium rates for consumers, and (d) increasing costs in the delivery of services. There were several ideas for changes in the current regulations: (a) develop regulations that encourage informed decisions by consumers such as when and how to get healthcare, and (b) correct the misalignment in healthcare costs.

The public health insurance providers offered the following suggestions on how the insurance problem can be overcome: (a) a public and private partnership must be forged with key stakeholders such public state agencies, local and state policymakers, private insurance industry, public and private employers, foundations and consumers, and (b) cost sharing could be expanded beyond the traditional contributors (federal and state governments) to include others who are impacted by this issue such as the consumer who might be able to pay a nominal contribution to the cost of their healthcare.

There was only one dissenting opinion as to whether Mississippi can provide universal coverage for all of its citizens. It was felt by the interviewee that Mississippi could not do this in the current environment (political and budgetary) and with the existing tools (staffing and financial

resources). The other interviewees answered yes, if some of the following recommendations are developed and implemented: (a) if public and political wills are nurtured, (b) all stakeholders are willing to "give up a little" for the greater good (providing health care coverage for the uninsured), (c) a culture of personal responsibility is created among consumers, and (d) the creation of public and private partnerships is developed or renewed. All three of the respondents consistently affirmed their opinions throughout the interview, that obtaining universal coverage for all Mississippians would require public and private partnerships.

3.6 How would universal coverage affect the financial status of health plans and providers?

The opinions of the interviewees reflected universal coverage would affect the financial status of health plans they offer and provide. The primary effects would be increased pressure on the budget. An additional effect was universal coverage would negate "cost shifting" because of uncompensated care. One possible positive effect of universal coverage is public insurance such as Medicaid and SCHIP could become secondary insurers for consumers.

3.7 How did the planning process take safety net providers into account?

Mississippi conducted research to better understand current and future insurance and utilization issues affecting healthcare providers and the marketplace. The following issues affecting healthcare for the uninsured were addressed: (a) gaps in terms of insurance and treatment, (b) utilization practices, (c) amount and type of uncompensated care, and (d) any relevant market issues.

Both qualitative and quantitative techniques were used to gather data from November 2003, through 2004. A statewide survey was conducted of healthcare providers. The research team identified and developed a list of healthcare providers composed of all requested hospitals, certified rural health clinics, public health districts and comprehensive/community health centers. This list consisted of 269 healthcare providers representing the above types of providers.

The healthcare providers support public policies which provide subsidies and tax incentives that would help make insurance more affordable for low-income persons. They also favor an expansion of SCHIP and Medicaid to include family coverage. The expansion of all types of health clinic which serve the uninsured was also listed as a positive mechanism for addressing the needs of the uninsured. The healthcare providers thought there ought to be a mechanism which would provide more funding to healthcare facilities providing uncompensated care.

3.8 How would utilization change with universal coverage?

One perspective was that utilization practices would not change in Mississippi under universal coverage given the healthcare environment and the attitudes of consumers toward their healthcare system. Another was that under universal coverage, utilization rates would increase because of greater potential for access and affordability. All interviewees agreed that a consumer educational component would be needed even with a universal coverage approach to healthcare insurance.

3.9 Did you consider the experience of other States with regard to:

Expansion of public coverage?

All three public insurers believed there are some strengths and weakness in expanding the public insurance program. One of the interviewees expressed a concern regarding the state would expand public insurance programs such as Medicaid, SCHIP and the Plan. Some of the strengths identified by the interviewees are: (a) a great cost sharing rate, (b) cost effectiveness given the cost sharing rate, (c) size of the current programs and their efficiency, (d) tremendous bargaining power because of size, (e) competitive pricing compared to other states, and (f) stability and "not going out of business." Three possible major weaknesses in expanding public insurance programs were presented by the interviewees: (a) securing the state match if required, and (b) the need for a long term investment for an entitlement program, and (c) the risk of the program becoming too and decrease the public insurance program bargaining power (reduce competition).

The respondents have mixed opinions about the expansion of pubic programs. Only one company official had no opinion. One indicated that SCHIP had been very successful and stated "We believe there is place for a state high risk pool." One company official mirrored most of the respondents when she stated there is a need to look at best practices and getting the best research done to expand the public programs. Five of the companies indicated funding issues represent the most important component of any decision relative to providing an expansion for public insurance programs.

Public/private partnership?

All three public insurers would support a strategy for Mississippi to expand private, employer-based health insurance coverage by subsidizing employee premiums by allowing them to buy into the program. They justified their opinions by stating that a public and private partnership strategy would be required to expand coverage to employees. One interviewee suggested this approach would allow the state to take advantage of public and private funds and cost sharing, which could result in the state's ability to expand coverage. Another interviewee warned the public sector would need to be sensitive to the administrative costs to the private sector for implementing such a strategy. One interviewee noted increases in the per capita income of individuals in Mississippi would also be important to the implementation of this strategy.

Incentives for employers?

Offering tax credits would help small markets and help more employers afford and offer insurance to employees, in the opinion of the respondents from Company A. Company officials from the other companies with the exception of one, indicated some form of tax-credits for employers would make offering insurance products more feasible for more employers. Five of the six company officials indicated expanding private, employer-based insurance coverage through subsidizing employee premiums by allowing them to buy into a program would be a

good strategy, but officials cautioned that the buy in would work only if supported by federal funding.

All public insurers interviewed favored incentives such as tax credits and "pooling" to help employers offer and afford health insurance. One interviewee suggested individual "prevention and well-being incentives" should also be offered by employers to their employees. Another felt incentives such as tax credits are helpful, but without other strategies these benefits would still be limited because of the challenge of affordability for small employers.

Regulation of the marketplace?

The insurers believed there are current market trends and/or regulatory policies that impact universal coverage, such as increasing healthcare costs, shrinking healthcare provider market, increase in healthcare premium rates for consumers, and increased cost in the delivery of services.

Section 4. Options and Progress in Expanding Coverage

4.1 Coverage Options:

The State of Mississippi has not selected an option to date. The state has identified parameters to develop policy options. Mississippi officials hope to create an employer/employee insurance subsidy program for small businesses (1-25 employees) that is structured to include greater incentives for wellness/prevention and includes incentives for business participation.

4.15 Evaluation

The evaluation piece has not been developed.

4.16 What are the major political and policy considerations that worked in favor of or against the choice. What ultimately brought the state to consensus.

The State of Mississippi has been under considerable financial constraints and had numerous Special Legislative Sessions that were called to address the State budgetary issues. This problem likely has escalated given the anticipated costs to recover from Hurricane Katrina, which affected much of South Mississippi. Our HRSA partners are aware that expanding the Medicaid program was not an option that would receive support from many legislators and the Governor. The group was willing to work within the parameters of offering relief to small employers and low-income employees by providing subsidies/tax credits with some assurance that the State was moving toward a healthier Mississippi. This would not expand public programs and would assist employees to purchase insurance at an affordable cost.

4.18 Which policy options were not considered

The State did not consider any options to expand the current Medicaid program in the State due to fiscal and budgetary constraints.

4.19 How will the state address the eligible but not enrolled in existing programs? Describe the state's efforts to increase enrollment. Describe efforts to collaborate with partners at the county and municipal level.

The State did not consider any options to expand Medicaid coverage to include uninsured parents or other expansions that did not include participation of other sources of funds to subsidize the budget.

Section 5: Consensus Building Strategy

5.1 Governance Structure

The Office of the Governor, Division of Medicaid (DOM) is designated as the lead agency for this project by the Governor. The Division of Medicaid is responsible for the administration of the grant and is to act as the liaison between the other branches of the governance structure.

The Blue Ribbon Taskforce on Health Policy (BRTF) was formed to guide the project and bring together representatives from all constituents. The BRTF consists of representatives from the State Department of Health, Mississippi Department of Human Services, Department of Insurance, Department of Finance and Administration (Office of Insurance), Mississippi Hospital Association, rural health centers, community health centers key legislative leaders, employers, insurers, faith-based organizations, consumers, and health policy leaders.

The Technical Working Group (TWG) was appointed by the BRTF to review and oversee the research projects. Appointments to the TWG were made based upon research expertise, the ability to offer insight on research findings, and the ability to provide oversight on how goals can be accomplished within timeframes. The Technical Working Group reviews the issues and findings prior to submission to the BRTF

All recommendations will be presented to the BRTF. The BRTF then discusses the findings, determines the feasibility, and approves or disapproves the recommendations made by the TWG prior to submission to the Governor.

To date there have been three Blue Ribbon Taskforce meetings and five Technical Working Group meetings.

5.2 Public Input

In addition to the participative nature of the Blue Ribbon Task Force, a number of focus groups were conducted to gain information that will supplement the two quantitative research projects (Household Survey and Employer Survey). These efforts included underrepresented populations, college students, low income workers, insurers, policy makers, and others across the State.

5.3 Public Awareness

The Division of Medicaid Office of the Governor has an agency website that has a Mississippi HRSA grant link. All reports and data collection efforts are located on the website. In addition, issue briefs will be developed and disseminated.

5.4 Policy Environment

The policy environment has not been tested because the options have not been developed or publicized. Realistically, these are challenging times in Mississippi with a slow economy and many demands on the state budget.

As part of the project, Nelums and Associates conducted personal interviews with twelve legislators serving on the Medicaid and Public Health and Human Services Committees in the House of Representative and on the Public Health and Welfare Committee in the Senate. The participants consisted of seven Democrats and four Republicans of which nine were male and two were females. One legislator rejected the invitation to participate.

Participants expressed support for the Medicaid and CHIP programs, were concerned about the ability to fund adequate healthcare coverage. Barriers to support are based on the size and growth of the Medicaid and CHIP budget and the perception of fraud as a significant contributor of rising costs. Most participants were not aware of the three-share program being implemented in other states such as Michigan. Suggestions for building support included education for legislators about the "true needs of Mississippians".

Section 6. Lessons Learned

This section will be address upon completion of the project.

Section 7. Recommendations to the Federal Government

This section will be address upon completion of the project.

APPENDIX II

Links to
Research Findings and Methodologies

This is the HOME page address:
www.dom.state.ms.us

Going down the left side
of the screen,

Select the HRSA link
for supporting vendor reports.