Program Narrative

Current Status of Health Insurance Coverage in West Virginia

The State of West Virginia has been fortunate in having, since January 2001, an administration led by a Governor who, from the beginning, established healthcare as a major priority. He began by convening his appointees who share responsibility for the state's healthcare policy, regulation, and service programs into a Health Umbrella Group (HUG). He charged the HUG to develop strategies that would achieve his vision of providing health coverage for every citizen, beginning with those most in need: the state's children, low-income working families, and prescription drugs and preventive care for low income seniors. In addition, he set forth his expectations that they would work together to improve the system of healthcare delivery for all West Virginians. The Governor has met consistently with this group on a monthly basis to both learn about and endorse their individual and shared projects and to receive reports on their progress.

As a first step, the HUG contracted with the West Virginia University Institute for Health Policy Research (Institute) to provide research, planning assistance, and meeting support as necessary. An early HUG undertaking was a telephone survey of approximately 16,500 West Virginia households to provide information about health insurance, use of the healthcare services system, and the circumstances of the lives of the uninsured population. The size of the survey was sufficiently large to allow data reliable to the county level. This West Virginia Healthcare Survey 2001 was funded jointly by a Robert Wood Johnson Foundation State Coverage Initiatives (SCI) planning grant and the Authority, which houses the state's health planning component. In 2003, with funding from a Health Resources and Services Administration State Planning Grant Continuation grant (WVSPG2), the Institute was able to do a second statewide West Virginia Healthcare Survey 2003 (2003 Survey), reliable to the four geographic areas of the state. These two recent surveys are able to provide a profile of the state's uninsured, as well as changes in their circumstances within the last two years. These surveys are of real benefit in helping the state's policy-makers understand both the nature of the problem and its impact on West Virginia's citizens.

Access to Health Insurance Coverage

To fully understand changing circumstances among the state's uninsured, it is important to know that we are among a relatively small number of states that lost population in the 2000 Census, and have continued that trend in succeeding years. Between 2001 and 2003, our population declined by 50,249 – 2.8 percent across all age groups. The largest percentage loss (5 percent) was among our children, 0 to18 years of age. The other major loss (4.8 percent) was the loss of employment by working age adults (30,456 jobs for those adults 19 to 64). It should be noted that even though we lost 9,927 older adults ages 65 and up, West Virginia now has the largest proportion of that population in the nation.

The 2003 Survey showed an increase of one percent in the rate of uninsurance among children, from 6.6 percent to 7.6 percent (30,884), still well below the national average for this age group. The major insurers for this population are public programs (Medicaid and CHIP) at 27.9 percent, private employers (40.9 percent), and the WV Public Employees Insurance Program (PEIA) at 14.6 percent. Between the two years, the largest decreases were in the public programs and private employers, and the largest increase was in PEIA.

The most troubling change was that the greatest increase in children's uninsurance was for those ages 0 to 35 months. The biggest decrease was for teenagers, probably a result of a significant increase in outreach to that population by the CHIP program. A total of 74.5 percent of uninsured children were from households with incomes below $30,000, a 17 percent increase for low-income children over 2001. In looking at children's use of the healthcare system, there was a 16 percent increase in uninsured children who had no usual place for care, although there was a substantial drop in the number of children that did not get needed medical care (from 15.7 to 4.4 percent). Parents' perceptions of their children's health status dropped 11.5 percent in the excellent to very good category, compared to a 2.7 percent decrease for insured children. Finally, in 2001, fewer uninsured than insured children were diagnosed with a chronic health condition or disability. But in 2003, the circumstance was reversed. There was a 66 percent increase in the number of uninsured children so diagnosed.

For non-elderly or working-age adults (19 through 64 years of age), on any given day, there was an 8 percent increase in the number of uninsured to 237,562 (out of a total 1,084,757 persons in that age group). Again, the losses were in private employer insurance, self-purchased insurance, and Medicaid. There were some gains in PEIA. In 2001, 61.1 percent of working-age adults were employed. In 2003, that percent had dropped to 49.2, and there was a 49 percent increase in the number of unemployed uninsured individuals. There was not much change in the income level of the uninsured, it was 80 percent at below $30,000 in 2003, just one percent higher than in 2001. Unlike children, there was little change in the number of working-age adults that had no usual place for care (39.4 percent and 41.0 percent in 2001 and 2003, respectively), but there was a 22.8 percent increase (to 50.7 percent) in adults that did not get needed medical care. The reason given by 87.6 percent was its cost. In terms of general health status, the uninsured shifts were significant: in the excellent to very good range, the percentages dropped from 43.5 in 2001 to 32.7 in 2003. From 2001 to 2003, there was a 37 percent increase in the percent of non-elderly adults diagnosed with a chronic health condition or disability, although this increase was not as large as it was among children. In 2001, over half the adults felt that paying for healthcare expenses not covered by insurance was a heavy to very heavy burden. By 2003, this had grown to 70 percent.

Finally, while the state's older adults (ages 65 and up) all have Medicare insurance, 34.8 percent of them did not have prescription drug coverage in 2003, and 8 percent did not fill all of their prescriptions. When asked, "why not?" 39.9 percent listed cost as the primary reason, a decrease from the 51.9 percent who gave that reason in 2001. The major difference in access to healthcare services for older adults is related strongly to the issue of supplemental insurance. Those 37.4 percent of older adults that did not supplement Medicare were less likely to have a usual place for care, less likely to get needed medical care, less likely to have an overnight hospital stay, and 73 percent of them found healthcare costs a burden. Nearly one third (32.1 percent) of Medicare only adults paid over $100 a month for prescription drugs.

Current Delivery System

As one of the most rural states in the country, West Virginia is a state primarily served by a fee-for-service healthcare delivery system and indemnity insurers. It is one of fourteen states with managed care penetration rates at 10 percent or lower. In West Virginia, much of that 10 percent is driven by the 51.15 percent of the Medicaid population which is required to join either an

MCO or a Primary Care Case Management (PCCM) plan. Another 20.5 percent of Medicare beneficiaries also participate in Medicare approved HMOs. The Insurance Commission's latest survey (2002) shows that Mountain State Blue Cross and Blue Shield has a 32.7 percent market share (including its PPO product), followed by the two HMOs at 12.5l percent and 12.04 percent. Only two other insurers have a market share higher than 1.5 percent, although there are literally hundreds of health insurers that register and offer health insurance products in the state. A new HMO, Unicare, has been licensed here during the past year to provide services to Medicaid's children and pregnant women. One of the factors working against full risk is that our mountainous geography, with low population density and few providers, makes risk contracting difficult to support. All or part of each of West Virginia's 55 counties is designated as a medically underserved area. In this environment, access to care, even with insurance, can be difficult. Throughout the state, critical access hospitals, small community hospitals, federally qualified health centers, rural health clinics, public health departments, and free clinics constitute the fabric of the healthcare system providing access to care for these underserved rural populations.

The free clinic system alone has grown from one clinic to 13 clinics in the last two decades, serving over 50,000 uninsured patients in a total of 221,000 encounters and dispensing over 486,000 prescriptions to the uninsured and Medicare beneficiaries without drug coverage. In FY2003, free clinics' services were valued at $77 million, with pharmaceuticals adding another $53 million to that total. Equally important are the state's primary care centers, serving 75,049 uninsured individuals in 2002, 34.4 percent of their total patients.

The public program participation rate for children and non-elderly adults in Medicaid is 13.9 percent. For children it is 27.9 percent, well over one out of every four. On the other hand, the non-elderly adult participation rate is 7.3 percent. This differential reflects the more generous income eligibility standards for children. The adult income standard is a fixed dollar amount set in legislation at 31percent of the FPL in 1997. West Virginia's CHIP program serves children to 200 percent of the FPL, and enrollment has reached 23,000. Those least likely to be enrolled are children, ages 12 and older, whose household income exceeds 150 percent of the FPL. The third public program is the state's employer-based PEIA, covering state, county, and local governments, boards of education, and state-owned universities and colleges – a total of more than 12 percent of the state's population. PEIA has played a major role in efforts to expand health insurance in the state and will be discussed further in the section on efforts to expand coverage in the state.

Thanks to the interest of the Governor, the HUG, and the federal SPG program, West Virginia has been able to learn a great deal about its uninsured, the diversity of their circumstances, the state's health insurance market, employer-based coverage, and even employers who do not provide employee health insurance and their reasons for not doing so. We have, for instance, developed a far better picture of employer-based health insurance from the employer's point-of-view. From a survey of 500 state employers, we have come to understand that 41 percent of WV employers belong to the services industry category and employ 40.9 percent of private sector workers. About 66 percent of our employers have less than ten employees, but the ten percent of employers that have 50 or more employees account for 60 percent of the state's workforce. The firms least likely to offer health insurance are those that fall into the low wage category, employ

ten or fewer workers, and have workforces with less than 25 percent full-time employees. Most companies that do offer insurance pay 50 percent of more of employee only premiums, and more than half of them pay 50 percent of dependent coverage as well. About 80 percent of non-offering employers cited cost as the primary reason for not providing health insurance, even though 59.7 percent of them believe it is very important that employees and their families have health insurance. The majority of small employers (those with fewer than 50 workers) believed they could not afford to pay more than $50 toward the cost of monthly employee premiums.

Additional Data Required

From the surveys, focus groups, and studies of our delivery system and its characteristics – all of which have given us the big picture – we have become aware that behind that big picture, we also have access to a myriad of information about special populations and circumstances. We recognize that the needs of the uninsured may best be served by drilling down into segments of the population which might not be apparent in our broader reports. It is for this reason that we believe we need to focus in detail and develop a profile of target population which require tailored solutions to meet their unique needs. That type of focused research on the population aged 50 to 64 is what we are proposing to accomplish with this grant application.

In addition, financial analyses of the burden of costs on the resources of the uninsured and the resources of the healthcare delivery system and other stakeholders are needed to begin to clarify the costs associated with doing nothing as we move into an ever increasing round of overall rising healthcare costs. These analyses are essential to a realistic incremental strategy to expand healthcare coverage to the remainder of the state's uninsured populations.

Earlier Efforts to Reduce the Number of Uninsured Residents

West Virginia has been involved "in earnest" with efforts to provide affordable healthcare for its citizens since the mid 1980s when the legislature created a "permanent" interim legislative "Committee on Uncompensated Care and Medicaid Expenditures." Its work included not only recommending Medicaid expansions exceeding the federal requirements, but finding the revenue sources to fund them. When the Committee began its work, the Medicaid standard of need for all beneficiaries was 31 percent of the FPL.

By 1990, all children below age seven were covered at 133 percent of the FPL, and pregnant women and infants were covered at 150 percent of the FPL. In 1994, all children's coverage was increased to 133 percent of the FPL in legislation that included a phase-in schedule to move to 200 percent. The implementation of that schedule was superceded by the passage of the federal State Children's Health Insurance Program. Despite its poor economic status, the state has always succeeded in providing essential health coverage to a substantial proportion of its children in need.

In 1991, at the request of the Governor, the legislature established a Health Care Planning Commission to look at healthcare service delivery and methods to finance care for all citizens. The Commission spent 18 months gathering information, looking at options, and soliciting public and stakeholder input. Its December 1992 report was a comprehensive outline of recommendations for change. The impact of this ambitious report, however, was quickly obscured by anticipation of legislation at the federal level.

WV CHIP was enacted July 1, 1998 and was implemented in three phases. WV followed a CHIP policy of incremental expansion, broadening the eligibility criteria to offer the program to more and more children. Phase I consisted of a Medicaid expansion for older children from 100 percent of the FPL to 133 percent of the FPL. Phase II introduced a private insurance CHIP model with an income eligibility limit of 150 percent of the FPL for all children. In 2000, the legislature placed the entire CHIP program under the administration of PEIA. It uses an expanded version of the PEIA benefit packages and the PEIA fee-for-service delivery network, with preferred providers expanded to include school-based health centers and other safety net providers that are used by low-income children. In 2000, CHIP eligibility was raised from 150 percent of the FPL to 200 percent of the FPL. The next year WVCHIP was ranked 13 out of 51 programs for the percentage increase in enrollment. During the 2004 legislative session, as recommended by the SPG HAC, a bill was submitted and passed to allow the CHIP Board to move coverage to 250 percent of the FPL, as permitted by its available funding.

In the late 1980s, when other states were undertaking insurance market reforms, the legislature passed a bill to create a catastrophic health insurance program in the private market and to regulate cost increases in the small group market. These bills were never implemented. When HIPAA was passed in 1996, the state adopted the federal fall back position, where eligible individuals are guaranteed the right to buy individual health coverage from insurers selling in West Virginia, but in West Virginia they may be charged premiums based on their risk rating status. As a result, portability insurance carries very high premiums and participation is negligible.

When Governor Wise began his administration in 2001 and created the HUG, he put in place a mechanism that not only resulted in the WVSPG initiative focused on the Governor's goals related to the uninsured, but also to work with a number of other initiatives that have built coalitions and begun improvements in the quality and access to healthcare in West Virginia. To mention a few:

- An analysis of the individual and small group insurance market in West Virginia in order to begin to understand its strengths and weaknesses within the state, beginning the first ever collection of market-based data to track changes in the private markets
- Collaboration on a single claims processing system and organization which will correlate and simplify the administrative processes required from the state's payers to the benefit of the provider community, currently beginning implementation in the Medicaid program
- Development of a common benefit manager contract for all prescriptions drugs purchased through the state's healthcare programs
- Coordination of provider payment rates to maximize benefits to both the provider community and the state's payers
- Initiation of a school-based health services study that has resulted in a Governor's task force to focus on changes that will provide coordinated care between schools and their communities' local providers
- Implementation of a single state 211 number to respond to questions and provide resource information for beneficiaries and clients of the state's health and welfare agencies

- Development of programs to integrate mental health and oral health into the primary care services of the state's safety net providers
- An analysis of combining the public programs administratively to provide savings that could be used for insurance expansions
- Creation of a business roundtable to explore attitudes toward health insurance as a precursor to private-public partnerships
- The major household survey which was described earlier
- A study of the four Community Access Program grants (CAP) to identify those that might be replicable in other communities within the state
- Most recently, the Governor has established an initiative on the Boomer generation which will hold a summit in early fall to discuss the needs of this population as it grows more dominant in our state – with access to healthcare as its first goal

The major successes include having the Governor propose three of the WVSPG (HAC) recommendations for health insurance expansion to the 2004 legislature. That body not only passed all three, it added its own resolution to commit to expansion through an interim committee study of other options and opportunities to be considered. Another success was the creation of the WVSPG HAC, a group of stakeholders from all across the state who have worked together and provided strong community and political support to the issue of expanding healthcare insurance. A Business Summit in the summer of 2003 drew over 200 business and labor leaders to hear national speakers and the Governor point out the importance of health insurance to state and local economies and to economic development itself. As a result of last year's Cover the Uninsured Week, the state's largest daily newspapers ran a series of seven full-page feature articles in order to put a face on uninsured West Virginians. Another success is the development and growth of what has become a very successful prescription drug care program for seniors – the Golden Mountaineer Card. And, finally, the Governor has been personally involved in going door-to-door to enroll CHIP kids, calling attention to the need for community involvement, and bully pulpiting that program from 16,000 to 23,000 children.

Barriers to Progress/Implementation

In terms of its barriers, the WVSPG process still must face a lack of financial resources, as the state's general revenue funds remain stagnant at best, with poor economic indices and limitations on new concepts of resources to tap. Finding and earmarking funds for program expansion requires public support and consensus building. That makes it doubly important to keep healthcare insurance on the "front burner" so to speak. While the WVSPG process has been able to build considerable "will" for healthcare expansion, it must still concern itself with the "way" side of the equation.

Additionally, the concept that healthcare is an important ingredient, and even solution, in the state's needed economic development must be one that is brought home to communities, businesses, and labor leaders. A strong communications effort that accomplishes that, and that begins to focus attention on populations that have not been generally considered "needy," is important to assuring the successful continuation of the WVSPG process.

Progress on SPG Program Funded Activities

2002 Original SPG Planning Grant

The WVSPG process began in 2002 with a State Planning Grant award and continued in 2003 with a Supplemental Grant award. We were very fortunate in having strong support for health insurance expansions from a Governor who was committed to the project and was willing to lend his active involvement in the plans we had proposed. Understanding the importance of creating a broad base of support for expanding health insurance to uninsured West Virginians, the original 2002 grant proposed only agreed to convene the first meeting of this Health Advisory Council (HAC), but also to issue the letters of invitation to membership. With this kind of gubernatorial support, the HAC members not only signed on, but they have participated enthusiastically throughout the two years. They have provided an important link back to their communities and peer organizations that has helped to develop statewide WVSPG support for expanding health insurance in the state. Representing as they do business, labor, consumers, education, healthcare providers, community and county government, the legislature, and advocacy, their unity on WVSPG proposals has been one of our most significant accomplishments. Three of the HAC's proposed health insurance expansions became law in the 2004 session of the WV legislature. Their ability to develop proposals that balanced the needs of the uninsured with the reality of scarce general revenues and community resources was the catalyst for the progress WVSPG has made. We are pleased that they will continue to support us through another year of work.

In addition to establishing the HAC, in 2002, WVSPG worked with HRSA's communication consultant to develop a plan that led to our participation in Cover the Uninsured Week. As a result, the largest daily newspaper in the state initiated a series of articles, beginning with WVSPG and its activities and continuing with seven additional stories on various impacts of West Virginia's high rate of uninsurance on individuals, providers, communities, employers – putting a face on real people who were willing to share their stories about the problems of uninsurance.

In data collection, we focus on learning more about the state's employers and their circumstances – both those that do offer and those that don't. We conducted a survey of 500 employers to obtain information about size, type of industry, wage levels, and much more. We complemented that with a series of focus groups of employers and employees to develop a better understanding of their perceptions and feelings about health insurance and the impact uninsurance has on their and their communities' lives and circumstances. The results were part of the information presented at a 2003 WVSPG Business Summit attended by over 200 individuals and co-sponsored by Blue Cross/Blue Shield, WV AFL-CIO, WV Business Roundtable, WV Chamber of Commerce, and the WV Hospital Association. A more detailed description of the progress achieved under the original WVSPG was documented in our application in 2003 for a Supplemental Grant. That description is attached as Appendix A.

Three activities were not completed during that period. One was the development of a HIFA waiver. While some members of the HAC and the Institute staff, as well as the Lewin Group consultants, continued an interest in the development of a HIFA waiver for the state's Medicaid program, when it became evident at the beginning of 2003 that Medicaid was facing a possible shortfall of $195 million in state matching revenues, the HUG felt it was politically infeasible to propose expanding coverage to additional populations while convincing the legislature to raise taxes to cover the shortfall. This wisdom prevailed and the HIFA waiver was put on the back

burner. It is problematic whether or not this task can be completed since a waiver prepared for submission in 2004 would have a short shelf life in terms of its estimates for both participation and financing. Nevertheless, this task will be completed as a concept paper by the consultant, identifying the population to be served, with estimates of enrollment and costs. The expected expense of this contract work is $28,519.

Two was the documentation of the HAC's final health insurance expansion recommendations, which was not complete until late October 2003. That set of recommendations has now been documented.

Three was the Secretary's final report, which was not appropriate when a no-cost extension was granted. Instead, an interim report was submitted in the summer of 2003.

2003 Supplemental Grant

The new activities proposed in the 2003 Supplemental grant application included the expansion of the HAC to include (1) a subcommittee of consumers, focusing on consumer issues in the state's healthcare system; (2) additional staff and logistics work occasioned by the Governor's participation in local town halls; (3) providing leadership to West Virginia's 2004 Cover the Uninsured Week activities; (4) preparation of a 30-minute video of the Business Summit to be distributed and used for local community events and meetings; (5) preparation of reports on other states' innovative funding mechanisms and successful cost containment approaches; (6) update information related to the state's uninsured through a follow-up survey on uninsurance, assessing changes in both the numbers and the circumstances of West Virginia's uninsured; (7) documentation of final recommendations; (8) completion of the HIFA waiver application if approved; and (9) preparation of the Secretary's final report.

The budget for this array of requests exceeded the HRSA amount available, so an updated list of work that could be performed within the allotted funds included the following: (1) staffing and logistics for the Governor's participation in three town halls during the fall of 2003; (2) conducting the 2003 Survey of 1600 households statewide to measure the increases in uninsurance and assess its impact on the state's citizens; (3) providing leadership for Cover the Uninsured Week 2004; (4) preparing the video for use by local community groups and (5) the Secretary's final report. It was understood that the Lewin Group would also develop the HIFA waiver, if approved, and document the final recommendations when they are completed. Progress made during the supplemental period is now three quarters complete, and has had mixed results.

The HAC had an additional meeting in late summer, and its subcommittees continued to work. At the October meeting, the accountability subcommittee made its report, which was adopted by the HAC and will be included in the final report. The finance/benefits subcommittee met every other week during the months prior to October to have its recommendations ready for presentation. They were strongly supported by the Lewin Group in being able to test a variety of plans and benefit packages that would meet the premium pricing feedback received in the employer focus groups and the Employer Survey. They completed preliminary recommendations by the October meeting and approved their recommendations before the end of

2003. It was from these recommendations that the Governor chose his three proposals for legislation which were successfully passed.

The commitment of the HAC members to reach consensus from stakeholders who often sat on opposite sides of the table was truly impressive. In the end, Blue Cross agreed to become a private partner in the PEIA expansion for small business employers, reducing its administrative percentage in exchange for using the PEIA provider payment mechanism to produce a lower-cost product for the small group marketplace. That product is being implemented for a January 1 start date. The hospitals agreed to pay an assessment to provide the high-risk pool reserve funds for its first two years, understanding that they would benefit most from that program's reduction of uninsured patients. That program is also being implemented for a January 1 start date.

The Governor's enthusiastic participation in three town halls helped to engage the record crowds he was able to draw, and each session was followed by a longer than average question, answer, and discussion period, the press coverage was excellent, and it helped to keep uninsurance on the front burner.

The Lewin Group, Institute staff, and the original 2001 Survey contractor gave priority to getting 2003 Survey in the field in early winter, so that staff would have the time to do initial analyses on the change in rates of uninsurance and its impact on health status and use of the healthcare delivery system. This information was provided in draft to the February 2004 HAC meeting and shared with the press, legislature, and the general public. A more detailed final report is coming out this month. There were no surprises, since everyone knew that major West Virginia employers were being closed by the impact of foreign competition in industries such as steel, glass, and metal fabrication. Working-age West Virginians lost over 30,000 jobs between the two surveys. In addition, the survey's documentation of changes in the circumstances of laid-off workers brought attention to the dilemma of older workers who suddenly lost their connection to employment benefits.

In midwinter, the HUG asked the WVSPG chairs if it would be possible to field a second set of focus groups to test out the benefit packages being proposed in the HAC recommendations. With money provided by the Authority, a series of eight focus groups were conducted to test the benefit concepts, the reaction to the PEIA public/private partnership, and – again – pricing issues related to employer/employee premium contributions. Institute staff provided analyses from the focus group results and prepared a report that was shared with the HUG and will be released in hard copy during the summer

Cover the Uninsured Week has been a difficult proposition. Working with last year's partners, we had built our schedule around the Governor (as we did last year) in order to obtain the greatest press coverage of its events. When we began working in earnest in January, we suddenly recognized that the new week chosen for 2004 began the day before our state's primary election. It would be impossible to get media coverage either to let people know about upcoming events or following them, as news reporters recounted and rehashed the election results from Tuesday. The Governor's staff and our own media consultant were not enthusiastic about our ability to do anything meaningful. At the February HUG meeting with the Governor, he suggested that West Virginia have its own Cover the Uninsured Week in the summer. The

result is that we may have one or two events, but the impact will not meet our original expectation.

The final task to be accomplished is to produce the video for local community organizations. We are in the process of getting vendor bids and it should be ready for use by the time summer vacations are over and community organizations began their fall meetings. We will use it to undertake the revised communications program should we be awarded either a Continuation Limited Competition Grant and/or a Pilot Planning Limited Competition Grant.

The expected expense of the remaining communications and final reporting efforts will be $63,193.

Statement of Project Goals

The overall mission of the WVSPG initiative has been, and continues to be, ensuring that every resident has access to affordable health insurance. This Continuation Limited Competition Grant and/or Pilot Planning Limited Competition Grant will be directed at the following major goals.

Goal 1. Undertake the necessary data analyses that document healthcare coverage needs and costs for uninsured West Virginians, aged 50 to 64.

In the first two years, much of the WVSPG planning work focused on children, their parents, and employer-based insurance. This project will use existing WVSPG data, national data sets, and interviews with community leaders to develop a detailed picture of uninsured West Virginians, aged 50 to 64, their use of the healthcare system, and other circumstances of their lives. It will research the latest literature related to benefit options, coverage plans, and funding resources for the uninsured. Focus groups of the targeted population will document the health insurance issues and concerns of the individuals themselves. Staff will also work with financial consultants to identify the costs of care for this population and estimate the amount of those costs currently covered by the healthcare system's existing finance mechanisms.

Goal 2. Develop a communications program that brings attention to the issues of the target population and explains the benefits of a pilot demonstration to provide coverage for this population.

Working with the Authority and a local media consultant, WVSPG will develop and implement a communications plan that will "put a face" on those uninsured citizens aged 50 to 64. This will document their healthcare needs and the burden this places on them and on the healthcare system. It will also describe options that could fill their coverage needs and show the financial benefits and consequences to both the individuals served, their communities, and the state. The focal audiences of this plan will be local community leaders, the provider community, the general public, and the Interim Study Committee (ISC) of the WV legislature.

Goal 3. Develop a plan to (a) provide the best option(s) for the target population that meets its need for affordability and spreads the risk equitably across the delivery system stakeholders and (b) demonstrate the financial feasibility and sustainability of this health coverage expansion model in both rural and urban settings of West Virginia.

WVSPG's Health Advisory Council (HAC) will be asked to consider new and old options and benefit concepts within the context of the data related to the target population and advise and

recommend those they believe most equitably balance the needs and resource capacity of the population to be served and their costs to the delivery system. Using its knowledge of the state's communities and their resources, as well as other public and private funding capacities, the HAC will work with the assistance of WVSPG staff and consultants to develop a model health insurance expansion that describes the benefits covered and cost sharing required, the development of a local/regional provider network, marketing concepts recommended, and the product's financing mechanisms. The recommendations will also include a financing plan to support the demonstrations of this model an urban and a rural area of the state

Goal 4. Create a process to evaluate and measure the impact of the pilot demonstration on the targeted population's health outcomes and use of health services, on the health care delivery system, and on the reduction of the state's uninsured in order to enable the demonstration to serve as a model for other states.
WVSPG staff will design an evaluation plan to monitor and evaluate the pilot demonstration's outcomes when it is implemented. Evaluation measures will look at beneficiary participation, health status and satisfaction, provider participation experience, reduction of the community's/region's uncompensated care costs, the long-range sustainability, and other factors essential to the pilot's success. It will provide its findings to communities throughout the state, to the WV legislature, and to the general public. These findings will also be made available to other states for their use in adopting and/or adapting the pilot to their own delivery system circumstances.

Goal 5. Provide a Secretary's report that includes all of the West Virginia SPG activities.
The HAC will review its past work, as well as any additional concepts staff research identifies. Working with staff and the financial contractors, they will complete their recommendations for a strategic health insurance plan for all the state's people, with plans and benefits, their costs, their targeted participants, and priorities for their implementation. These recommendations will be provided to the HUG and the Governor for their review and final decision. WVSPG staff will then prepare a report for the Secretary that includes the data analyses and reports and presentations from all the WVSPG activities, including the plan of the incremental strategies that have and will continue to move the issues of the coverage for the uninsured forward in the State of West Virginia.

As was noted in the Project Abstract, Goals 1, pared-down versions of 2 and 3, and 5 will be undertaken if a Continuation Limited Competition Grant is awarded. All goals will be undertaken if the Pilot Planning Limited Competition Grant is awarded.

Project Description
The State of West Virginia is proposing a new project emphasis for this SPG Continuation and/or Pilot Planning Grant. WVSPG will use the 2001 and 2003 Surveys to document the uninsured status of older West Virginians, aged 50 to 64, further explore the range of the health circumstances and costs these individuals are encountering, develop an affordable option to meet their healthcare needs, and plan a model demonstration of this solution, including the resources to fund that demonstration in two areas of the state.

In the past two years, WVSPG has become more aware of the systemic problems that older non-Medicare individuals are encountering, as several major industrial plants in the northern panhandle and Ohio River valley began to fail. Wheeling Pitt Steel, Weirton Steel, Bethlehem Steel, and Specialty Metals are all examples of plants that are now part of industrial bankruptcies. The northwestern quadrant of the state, where three of them are located, has gone from having the lowest uninsurance rate in West Virginia in 2001 (15.8 percent of non-elderly adults were uninsured) to being the region with the highest uninsurance rate (25.1 percent of non-elderly adults were uninsured) in 2003.

While the provisions the Trade Assistance Act of 2002 (TAA) are available to mitigate the financial hardship of these individuals, it is far from a solution for many of them. A specific example illustrates the kind of problems uninsureds may encounter: at a town hall in Wheeling, we heard from a woman and her husband. He worked past the age of 65, and when his employer went bankrupt and closed, he lost his job and his family insurance, but he had Medicare. That makes him ineligible for TAA health premium assistance, and leaves his wife (age 57) without health insurance. At her age, and as a diabetic, her individual policy is costing them over $1,300 a month. They are lucky – they had saved for retirement. But they are desperately looking for a less expensive insurance policy, knowing that their retirement dollars will be severely depleted by the time the wife reaches Medicare status.

The failure of these major employers (and many smaller employers in this and other parts of the state as well) has called more attention to the importance of health insurance for older non-Medicare citizens. Many in this age range have lost their connection to employer-based insurance for a variety of other causes – divorce, death, chronic poor health, or retirement. In West Virginia, the 50 to 64 year old population represents 19.6 percent of our state's population (344,947) and 19 percent of our uninsured citizens. The majority of these uninsureds are women (64 percent) who, because of their age, any significant health problems they may have, and incomes below $30,000 (87 percent), cannot afford health insurance on the individual market. Finding options to help these older baby boomers find affordable coverage is a social responsibility that we cannot ignore. It is a first step that we must take as West Virginia's population more rapidly becomes the oldest in the nation. Additionally, because we know that other states are experiencing the same issue with their older citizens, we believe that solutions successfully developed and tested in this state can serve as models for the nation.

The actions required to successfully complete this Continuation and/or Pilot Planning Grant are described in the tasks below.

Task 1: Data Collection and Analysis

Using existing data – the 2001 and 2003 Surveys, Trade Assistance Act (TAA) data from the Bureau of Employment Programs (BEP), and the Insurance Commissioner's de-identified customer service files, Institute staff will document the demographics, geographic location, health status and use, economic, family and employment circumstances, and other relevant information to provide a complete profile of the target population. The survey data will also show how that profile has changed from 2001 to 2003. BEP file data will allow analyses of the numbers, location, age, and family status of TAA-eligible individuals that are in the target group in order to help estimate their impact on increases in the uninsured and mitigation provided by

the HCTC tax credits program. Finally, the Commissioner's de-identified files will be used specifically to provide "case study" descriptions of circumstances which have caused individuals in this age group to bring their concerns to the Insurance Commission. Based on this information, Institute staff will create both a hard copy report and a PowerPoint presentation descriptive of this group of uninsured individuals and, to the extent possible, characterize the nature of their reasons for being uninsured.

Institute staff will undertake literature reviews on participation and outcomes of both states' high-risk pools that are HIPAA- and TAA-eligible and other programs that states may have undertaken to serve their older uninsured populations. It will also search the literature at the national level to identify articles related to research undertaken and concepts developed which would contribute to the development of health insurance options that could meet the need of all, or some substantive segment, of this population. It will also update the research that has previously been done on the options and opportunities that are being undertaken by other states to expand health insurance to assure that the final plan will reflect the most current and workable models and plans.

In the area of financing, WVSPG staff will search the literature and activity reports that provide the latest information about financing mechanisms. It will also search for public and private sources of funding for innovative solutions and model demonstrations.

PILOT PROJECT: Institute staff will undertake two qualitative data collection activities. As a first step, Institute staff will survey the activities of all state SPG's to collect qualitative information and instruments used in the wide variety of qualitative data collection the states have undertaken. From this base, an interview guide will be developed and key informant interviews will be conducted with community leaders in seven West Virginia communities to identify the severity and impact of the problem of uninsurance among older adults from a community perspective. Aside from a division of urban and rural, the communities will be chosen to represent areas where uninsurance among the target population is highest or has increased substantially between 2001 and 2003 due to industry bankruptcy, industry outsourcing, or industry downsizing. Community leadership will include public health, clinic and hospital administrators, individual providers, the faith community, senior center directors, local business persons, and government officials. The purpose of these interviews is to document the community perspective related to the problem of older uninsureds within the community and/or the county setting, its negative impact on both the individuals and the community's health and social service providers, and how and with what resources the community may be dealing with the problem.

A discussion guide, based on those of other SPG states, will be developed to conduct focus groups of uninsured older West Virginians within these same communities. The purpose of this data gathering will be to identify the perspective of the uninsured, the reasons for their uninsurance, and the impact of not having health insurance on both their use of health services and (from their perception) their health status. They will discuss the services they believe are most important, where they get them when they are needed, how they pay for them, and what services they forgo even when they would be helped by receiving them. Focus group members will also be asked about their ability to get and pay for health insurance, who advises them on the

issue, and the kind of insurance they would be able to afford, and any suggestions they have about "fixing" their problem.

Participants in both the key informant interviews and focus groups will be given an informed consent related to their willingness to allow the project the use of de-identified comments, stories, and generalized histories to assist WVSPG in personalizing individual circumstances (but not individuals) in issue briefs and in its focus group reports.

The focus group participants will be recruited from those seven areas represented by the community leaders (i.e., key informants) using outreach tools suggested by them (e.g., newspaper ads, bulletins posted in barber shops or beauty parlors, announcements through area churches, etc.). Participants will be paid at the rate $50. Institute staff will be responsible for all facets of focus group activities, including recruitment, logistics, conducting the groups, analyzing the data, and preparing the reports and issue briefs. The HAC will recommend which regions of the state in which to implement the pilot projects, based on the information gleaned through the key informant interviews and the focus groups.

WVSPG will contract with the State Health Access Data Assistance Center (SHADAC) to work with Institute staff and the Authority, as the state's data repository, to estimate the types of services and costs incurred by the target population's use of the healthcare delivery system. In addition, SHADAC will work with experienced national researchers to quantify the cost of care for the uninsured, identifying not only what is being spent, but also who is picking up the bill. The purpose of this second analysis is to identify the resources that are already in the healthcare system and potentially available to assist in paying for expanded health insurance coverage[1]

Action Steps

- Analyze the data of the 2001 and 2003 Surveys, specifically related to uninsureds aged 50 to 64, to create a comprehensive profile of the population, measure the changes in that profile during the two years, and compare the experience and circumstances of the population with that of their insured peers
- Analyze the BEP data to identify and report the target population's characteristics and participation as HCTC-eligibles
- Analyze the Insurance Commissioner's de-identified consumer service case files to develop "case studies" and numbers of common complaint circumstances to develop a report that will provide a human element to the issues involved
- Undertake literature reviews of state activity and national concepts and ideas related to insuring older uninsured adults

PILOT PROJECT

- Conduct a literature review of survey instruments used for community leader interviews and uninsured focus groups
- Develop WV community-appropriate questionnaires for leadership interviews
- Develop WV target population discussion guides for aged 50 to 64 community-level focus groups

[1] Jack Hadley and John Holahan, The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

- Solicit the HAC to identify the communities and community leaders to be interviewed, make individual contacts, and schedule and conduct interviews
- With assistance from community leaders, identify participants for focus groups, contact and schedule participants, handle group logistics and documentation needs, arrange payment mechanism, conduct groups and eliminate all individual identifiers from data for Institute staff analyses
- Complete all analyses, compile results, and prepare both overall and synthesized reports, as appropriate
- Contract with SHADAC to provide expertise in developing a report on the types of services used by the targeted population and estimated costs of those services to the healthcare delivery system, and to identify the system resources that are already in the healthcare system that assist in covering the costs of the uninsured

It should be noted that only the analyses of existing data and the literature searches and the reports from those activities will be done if a Continuation Limited Competition Grant is awarded.

Anticipated Results

WVSPG will have a broad range of information to support decision-making related to the economic, social, and healthcare needs of the target population. This information, along with utilization and financial data, will provide sufficient knowledge to allow the HAC, the HUG, and the administration to understand the nature and needs of the uninsured population, their impact on the healthcare delivery system, our communities, and the state in order to make meaningful and effective recommendations about solutions that will expand their opportunities for health insurance coverage.

During the process, information gaps will be identified and additional data analyses and/or collections required will be accomplished. From this base, refinements of health insurance options can begin, communicating the face of older uninsured West Virginians can be undertaken, financial resources can be estimated and developed, possible pilot demonstration sites may be recommended, and concepts for measurable outcomes for improvement can begin to be understood.

Responsible Agencies/Individuals

The Institute will be responsible for the following tasks: analyzing data related to the profile of the target population, literature reviews, the survey of the qualitative data instruments used in interviews/focus groups by other SPG grantees, developing the WV leadership interview and focus group questionnaires/guidelines, choosing the communities where qualitative data will be gathered, conducting the community leader interviews, conducting of the focus groups, analyzing and reporting the results of the leadership interviews and the focus groups, and preparing reports on all data collection activities for the HAC and other publics, when appropriate. The Institute will work with SHADAC, as a contractor, to provide analyses related to the healthcare costs of the uninsured and the resources that are currently being used to pay for their care within existing healthcare delivery system resources. The Institute will prepare all reports for the HUG, HAC, and other public audiences, as appropriate.

Collaboration

The HUG and the HAC (through its Steering Committee) will be kept apprised of both the data collection efforts and the results at each step in that process. They will have an opportunity to review and comment on all data collection instruments, as well as the chance to review draft reports as they are being prepared. In addition, the final drafts of all reports will be shared with all HAC and HUG members to ensure that their comments and concerns are heard and accommodated in the final versions (even if as dissensions).

Timetable

The data collection and analysis efforts will span five months. Prior to award of grant, the SHADAC contract will be discussed and detailed so that the contract award can be made in one month.

The analyses of existing data will begin in month 1 and continue through month 3. Drafts of the findings reports will begin in month 3 and completed early in month 4. The drafts will be circulated for comment in month 4, and final drafts will be completed by the end of month 5.

The literature search will begin in month 2 and continue through month 3. Drafts of findings reports will be prepared in month 4 and circulated for comment. Reports will be put in final form by the end of month 5.

The interview and focus group survey of states' instruments will be done in month 1, with the respective designed instruments completed in month 2. The HAC will be solicited to recommend communities for interviews and focus groups in month 2, and Institute staff will conduct the community leader interviews in month three. The focus group logistics and participants will all be completed and identified by the end of month 3. The focus groups will be conducted in month 4 and the data will be analyzed and reports of both will be completed in month 5.

Task 2. Communication Strategy/Public Information Campaign

The WVSPG had strong consultation support for its original communication plan from HRSA's contractor, American Institutes of Research (AIR). It included working with the first Cover the Uninsured Week in the state, conducting a series of public meetings in which the Governor and other state health officials participated, a statewide Business Leadership Summit, sponsored by both the Governor and statewide provider, business, labor and insurer organizations, and summer Town Halls that allowed the "messages" of the Business Summit (e.g., the severity of the problem in our state and its negative impact on business and economic development) to be presented to community audiences. During this time, a contract was developed with a local media relations consultant to assure the focus of the messages and to facilitate press attention related to these efforts.

With a new program focus for WVSPG3, we will revisit the our original communications strategy, what worked and what was not as successful, and develop a strategy that continues our efforts to "put a face" on those who are uninsured, particularly among the target population – West Virginians between the ages of 50 and 64, many of whom who have worked and provided leadership to their communities and its organizations, and now, perhaps through circumstances

beyond their control, have lost a connection to employment-based health insurance coverage. The plan will also include completing the Business Summit video that depicts the problems of the uninsured in West Virginia more broadly. These were proposed in WVSPG2 to be made available to local civic and other community organizations for community meetings. The local media relations consultant, WVSPG leadership, and the Institute staff will develop components of this updated communication plan for review and recommendation by the HAC at its initial meeting.

The goal of this updated campaign will be to celebrate the achievements of the work that the Administration and the Legislature have already accomplished and to keep the subject of the uninsured "on the front burner," so to speak. While data from the 2001 Survey indicate that most people value health insurance for their families (95 percent of respondents think it is very important) and all West Virginians (91 percent believe that all of us should have access to coverage), it will nevertheless be important to keep building public awareness of the issue and to encourage participation in the debate in order to secure broad support for the necessary public and/or community funding for expansions going forward. In this regard, SPG is fortunate that the Governor maintains his interest in making comprehensive health coverage a subject for his public appearances.

In addition, by a resolution of the 2004 Legislature, the legislative Interim Study Committee (ISC) has been charged with a study of the uninsured and preparing a report for the 2005 Legislature. WVSPG has been asked to provide its information and expertise to assist in this study. WVSPG will work with Legislative Services staff (LSS) to provide its information in reports and presentations that respond to the resolution's specifications (the resolution is attached as Appendix A), as well as to members' questions and concerns. WVSPG sees this as an excellent opportunity to increase the legislative leadership's knowledge of the interaction between the uninsured, their health status, their use of the healthcare system, and the resulting costs to the individuals, their communities, and the state. LSS has asked us to provide a logical issue framework upon which they can base monthly agendas, as well as to make six to seven presentations based on WVSPG information and analyses. Because this is such an important opportunity to improve legislative members' knowledge about the complex interactions between uninsured West Virginians and their impact on public and private health programs and services, the revised communications strategy will include working with LSS to support the needs of this legislative undertaking. The tasks this activity will require are the time it takes for WVSPG PIs to develop and work through a framework of issue presentations which will become an agenda for the meetings of the ISC and for Institute staff to create the presentations which will be made at each of the monthly meetings designated for WVSPG presentations. It will also require attendance at these presentations by Institute staff to make sure that the issues and concerns of the ISC members are captured and responded to between monthly meetings

This task will be undertaken if either a Continuation and/or Pilot Planning Grant is awarded, with the relatively small differences noted in the task narrative above.

<u>Action Steps</u>

- Contract with the media consultant who provided expertise for this task in 2003 to work with the HAC communications subcommittee to revise the communication plan for 2004/2005
- Set communications goals, identifying the types of audiences to be reached, and aggressively promote staff availability for making presentations in local communities
- Review updated survey information and create presentations to use with various stakeholder interest groups
- Identify one Institute staff member who has primary responsibility for managing contracts related to communications and outreach
- Contact radio and television talk show hosts and offer to conduct discussions of the uninsureds or participate in call-in shows on the subject
- Develop an e-mail list serve to disseminate issue briefs, report summaries, and presentation materials and to invite queries and comments
- WVSPG PIs will work with legislative services to develop and work through a framework of issue presentations that will serve as an agenda for WVSPG/ISC meetings
- Institute staff will prepare legislative presentations and circulates them for approval of the HUG
- WVSPG's PIs will give presentations at designated monthly ISC meetings
- Institute staff will support these presentations by attending and making note of member inquiries and concerns that need to be addressed between meetings

Anticipated Results

The completion of this task will result in a communications strategy and campaign, the latter to begin in the second quarter of the grant year, directed at a variety of audiences, including the general public, the stakeholder community, and the West Virginia legislature.

Responsible Agencies/Individuals

The development and implementation of the communications strategy will be led by Institute staff, with advice and counsel from the HAC communications subcommittee. Expert assistance will be sought from the consultant on the logistics and planning for the Governor's appearances and in designing the presentations and other materials. The WVSPG PIs will lead the efforts on the legislative study.

Collaboration

While the development of the communications strategy will be the responsibility of the Institute and the HAC subcommittee, the proposed plan will be reviewed and approved by the HUG. As such, all relevant state agencies will have the opportunity to provide input into this activity. In addition, all HAC members will be invited to offer suggestions and to solicit opportunities for information presentations in their communities.

Timetable

Work related to the legislative presentations will be completed during months 0 and 1, beginning with information already developed by WVSPG. If the Pilot Planning Limited Competition Grant is awarded, a presentation related to that project will be developed in month 2. The communications plan will be developed during the first month and reviewed by the HAC communications subcommittee in month two. After any necessary revisions, a final version will

be circulated to the HUG for approval. The e-mail list serve will be put together in month one using existing Institute contacts. In month two, its first communication will include a solicitation for e-mail membership lists and/or to encourage the recipient to send WVSPG communications on to their membership. Institute staff will track and report on inquiries, responses, and all communications requests and activities, using its expanding e-mail capacity for this function.

Task 3. Decision-Making Process

The Health Advisory Committee (HAC) has provided excellent service to the WVSPG effort. It is made up of leaders from the various delivery system stakeholders, as well as business and industry, labor, farm bureau/extension services, economic and community development organizations, and patient advocacy associations. They have worked together to provide the administration with a package of expansion concepts that balanced the "goods" between access to healthcare for populations in need and the necessary additional costs to public and private revenues. Many members of the group have expressed their interest and willingness to continue with new tasks. Its purpose, as before, will be to provide advice, representation, and a mechanism for communication and input from their various impacted constituencies.

When the new grant is awarded, the HAC Steering Committee (made up of the subcommittee chairs, the Steering Committee Chair, and project leadership) will be convened, advised of the new grant, and asked to review the tasks and provide any advice it may have on the conduct of the grant. Subcommittee structure will be discussed, suggesting that the group be divided into subcommittees dealing with (a) benefits and financing of health insurance options, (b) communications related to the SPG process, (c) community and resource development for the pilot demonstration, and (d) developing an evaluation for the pilot demonstration. It will also be asked to advise on how to divide the membership among the new subcommittee designations.

Once those decisions are made, Institute staff will draft specific subcommittee charges related to the grant's requirements, member preference can be determined and assignments made, and, as necessary, initial tasks can be accomplished. A proposed schedule of meetings, which integrates the work of the subcommittees and meetings of the whole HAC with other WVSPG tasks that need to be accomplished, will be provided and Institute staff will be assigned to provide each subcommittee with necessary meeting and communication support. Face-to-face meetings of the entire HAC will not begin until the grant's second quarter in order to allow time for other preliminary tasks to be accomplished. However, members will receive information about the project through a variety of dissemination vehicles, including e-mail and the WVSPG website, to bring them on board at the start of the project year and keep them apprised of what is occurring. The HAC Steering Committee will meet routinely to provide advice and assistance with the work of the first 5 months.

The HAC will have two tasks to accomplish. The first will be to review, deliberate on information provided, reach consensus on actions to be proposed, set priorities, and provide recommendations on the proposed pilot demonstration plan to the HUG, which is the decision-making body for WVSPG. The second will be to make recommendations and set priorities for health insurance expansions with which they have already worked, as well as new expansions which Institute staff or consultants may propose, to complete the state's comprehensive strategy for incrementally providing health insurance opportunities for all West Virginians. Should the

continuation grant be awarded, they will accomplish only the second task. Should the pilot planning grant be awarded, they will accomplish both tasks.

WVSPG's HAC has established its effectiveness as a planning body that can focus on the needs of the state and its citizens, bringing the spirit of consensus to a diverse group of often opinionated leaders. We firmly believe that it will serve this continuation and pilot planning proposal equally well. Since a substantial commitment of time is required on the part of HAC members, stipends will be offered to help support participation at meetings and travel will be paid at the state government rates.

It should be noted that should the Continuation Limited Competition Grant be awarded, the work of the HAC could continue to involve both of these tasks, although the first task would be limited to the development of a concept for a pilot demonstration without sufficient information for more specific plans and recommendations. The second task would be completed as described. Should the Pilot Planning Grant be awarded, both tasks would be fully completed.

Action Steps

- Hold an initial meeting of the HAC Steering Committee to provide advice on the new project task, to make decisions about setting up new subcommittees and timelines, to suggest subcommittee chair appointments, and to advise on the most effective strategies to get the HAC process underway again
- Provide HAC members with a copy of the grant and letter of award for their review and comment
- Secure the commitment of those who intend be active throughout this grant year
- Secure the commitment of the HAC chair for this grant year
- Secure commitment from HUG members to serve as resources for the work of the HAC and its subcommittees
- Develop a timeline that integrates all grant tasks for HUG and HAC members' information
- Prepare subcommittee charges and staff assignments
- Secure subcommittee leadership (co-chairs) who will also constitute an updated HAC Steering Committee
- Review and revise (if necessary) the deliberative decision-making process
- Provide support and necessary information to all subcommittee meetings and work
- Maintain regular communication with HAC members about the grant tasks and activities that are underway
- Convene and support the first and subsequent meetings of the HAC
- Provide documentation on all HAC activities/actions, along with its recommendations to the HUG

Anticipated Results

It is expected that, as in the first two years, the HAC will produce specific realistic recommendations for an additional option(s) to provide affordable health insurance to older non-Medicare West Virginians. In addition, the HAC will revisit its previous recommendations and review new and old options which it did not recommend in 2003 in order to agree on those plans and benefit packages which they believe will best fill the gaps in the comprehensive plan for

health insurance coverage opportunities to all the state's uninsured individuals. Their recommendations for the final plan will include their priorities, based on the state's need for an incremental strategy that continues the philosophy of the Governor's original charge to provide health care coverage, beginning with those most in need.

Responsible Agencies/Individuals

The Institute will handle all logistics, as well as information and communication needs and materials required for the effective operation of the HAC. Meetings of the whole HAC or its subcommittees will be supported by Institute staff and have a member of the HUG that will serve as a resource. Co-chairs of the subcommittees will form the HAC Steering Committee, the organization that assures individual subcommittee work is integrated and communicated between meetings of the whole. The Chair of the HAC leads the organization and acts as its spokesperson when necessary.

Collaboration

The HAC itself is the vehicle for collaboration within the WVSPG process, and one of its implicit purposes, as stated earlier, is to ensure that the work of WVSPG is fully informed by the various constituencies represented on the HAC, with those HAC members, in turn, keeping their constituencies informed about the work and the deliberations of the organization.

Timetable

The first meeting of the HAC as a whole under the new grant will take place in its second quarter, allowing time for data collection and analyses of costs to occur in the first five months (September to January). Beginning in February 2005, it will meet quarterly. Each subcommittee's meeting schedule will be decided by the needs of its individual charge. It is anticipated that the agenda for the second quarter February HAC meeting will include presentations by experts on the data and analyses completed in the first five months, following which HAC subcommittees will meet to identify additional questions/information needed and begin to interact with the experts and the data in relation to their specific tasks. Between the second and third quarter meetings, the subcommittees, experts, and staff will develop their individual recommendations to move the project goals forward, and in month 9, the Institute staff will integrate the individual subcommittees' work into a plan for the whole. This work will constitute the agenda for the June HAC meeting, giving opportunity for comments, revisions, and additional suggestions. A final draft will be circulated to the members and shared with the HUG and the administration. At the June meeting, the subcommittees will also begin work on recommendations for the final Secretary's report, reviewing the options, and requesting additional information needed to make progress on this task. Between the third and fourth quarters, subcommittees and staff will review options and make their recommendations. In month 11, staff will combine this work into a draft plan for the Secretary. This draft will constitute the agenda for the August HAC meeting, again giving the group as a whole opportunity to comment, revise, and suggest additions. Following this final meeting, the HAC's recommendations will be submitted to the HUG and the administration for their final approval and, following that, inclusion in the Secretary's final report.

Task 4. Develop an Evaluation Plan That Measures the Impact of the Pilot Demonstration on the Target Population and Other Stakeholders

The planning for the pilot project must include a plan for evaluating its implementation and its outcomes. Institute staff will work with the HAC evaluation subcommittee to educate and inform them about the various evaluation methodologies, both qualitative and quantitative, and appropriate indicators that could reasonably be used to describe the pilot successes/shortcomings. Staff will then facilitate discussion among committee members around what the group specifically would want included in the plan (e.g., which components of the pilot project should be evaluated, definitions of what constitutes success, specific methodologies to employ, a timeline such that information can be provided to enable the organizing body to "fine-tune" the project as it is being implemented, etc.). At this point, discussions around availability of data, administrative feasibility and costs, and other limiting issues will also take place.

Based on this discussion, Institute staff will develop a tentative evaluation plan(s) for the subcommittee's review. Reactions from stakeholders will also be solicited. Staff will revise the plan based on the reactions of both the subcommittee and stakeholders. This revised plan will be circulated to the entire HAC membership. Following that review and comment, the revised evaluation piece will be added to the final pilot demonstration plan.

The aim of such broad-based input into the development of the evaluation plan is to assure that the final product meets the needs of the leadership and can be achieved within the constraints of available finances.

If the Continuation Limited Competition Grant is awarded, this task will not be undertaken.

Action Steps

- Institute staff will prepare a summary presentation on evaluation, its purpose, uses, methods, measures, and other concepts necessary for subcommittee members to understand their task, providing examples relevant to the specific project
- Staff will facilitate discussion by subcommittee members related to evaluating the pilot project, including the outcomes and processes that should be measured for a reasonable and timely demonstration of the pilot's success/shortcomings, as well as methods, measures, and their usefulness and feasibility
- Institute staff will draft an evaluation plan(s) reflecting the subcommittee's deliberations for their review
- Staff will revise the plan(s) based on their review and solicit reactions and comments from various stakeholders
- Staff will report the stakeholders' reactions to the subcommittee, which – at this time – will make its recommendations for the evaluation design for the pilot demonstration plan
- Staff will prepare a draft plan for circulation, review and comment by all members of the HAC
- Staff will incorporate the final evaluation strategy into the pilot demonstration plan

Anticipated Results

The aim of such broad-based input into the development of the evaluation plan is to assure that the final product meets the needs of the leadership and can be achieved within the constraints of available finances. In addition, estimates will be provided of the numbers of uninsured to be

covered through expansions that are currently underway as well as those additional expansions included the in final state plan for covering all of West Virginia's uninsured.

Responsible Agencies/Individuals
Institute staff will be responsible for providing guidance, information, and assistance to the subcommittee members as they work through this essential task. Staff will also support communications and logistics for subcommittee meetings, as well as follow-up on actions taken and decisions made. Recommendations will be made by subcommittee members and members of the HAC as a whole.

Collaboration
In addition to involving all of the HAC members, this process will assure that stakeholders impacted by the subcommittee's recommendations will have had the opportunity to make their issues and concerns, if any, known to staff and subcommittee members.

Timetable
The subcommittee will begin its general deliberations at the February HAC meeting and will complete its work and its recommendations at the August HAC meeting.

Task 5. Provide a Final Report to the Secretary of WVSPG's Comprehensive Plan and All Activities Undertaken in Its Development
At the conclusion of the continuation and/or the pilot planning process, a final report will be prepared for presentation to the Secretary of the U.S. Department of Health and Human Services. The final report will detail plans the state proposes for the incremental expansion of healthcare insurance opportunities to meet the needs of its citizens and strike a workable balance between individual populations' affordability and financing costs from both the public and private sectors. It will further describe the uninsured populations to be served, expansion options, the needed partnerships for success, and a possible implementation timeline which must, of necessity, depend on the availability of financing. The report will also summarize the WVSPG activities, findings and deliberations. Its attachments will include documentation of all the activities undertaken. Finally, it will assess the progress of the first expansions undertaken with WVSPG support and any others that are proposed.

Action Steps
- Institute staff will prepare a draft report and, following its circulation to the HAC (described above), it will be submitted to the HUG for review and comment.
- Institute staff will incorporate the HUG's comments and provide a final report to HUG members and the Governor for approval and/or recommended revision.
- The final report will be prepared, all documentation will be appended, and the final report will be given to the Governor for his submission to the Secretary.

Anticipated Results
The result of this process will be a final report that documents the plans, information, and activities of the WVSPG process and provides information and description of research and activities that will be useful to other states and the federal government. In addition, estimates

will be provided of the number of uninsured to be covered through the expansion currently underway as well as those additional expansions included in the final report.

Since it is anticipated that the pilot work will only take place in a few West Virginia communities and the fact that those communities will not be identified until the focus groups have been completed, the exact reduction in the number of uninsured for the project is unknown at this time. However, if the pilot project were implemented statewide, the potential reduction in the number of uninsured of the target population would be 50,980 individuals or 15.7 percent of the total WV population ages 50 to 64.

Responsible Agencies/Individuals

The Institute staff and the co-PIs will be responsible for the drafts and final version of the report to the Secretary.

Collaboration

Both the HAC, representing stakeholders, and the HUG will review, comment, and recommend/approve the final report for submission to the Governor.

Timetable

This task will be completed at the end of the project.

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
1. Data Collection and Analysis				
Analyze the data of the 2001 and 2003 surveys, specifically related to uninsured adults aged 50 to 64	September 2004 through January 2005.	Institute Staff HAC & SC	WVSPG will have a comprehensive profile of the target population.	Report of profile and PowerPoint presentation given to HAC and HUG in February meeting.
Analyze the BEP data	September 2004 through December 2004.	Institute Staff HAC & SC	WVSPG will have information on the target population's characteristics and participation as HCTC eligibles.	Report to HUG and HAC at February meeting.
Analyze the Insurance Commissioner's de-identified consumer service case files	September 2004 through December 2004.	Institute Staff HAC SC	WVSPG will have "case studies" of common complaint circumstances that will provide a human element to the issues involved.	Report to HUG and HAC at February meeting.
Undertake the literature researches of state activity and national concepts and ideas related to insuring older uninsured adults.	October through December 2004	Institute Staff HAC SC	WVSPG will be informed about other states' and national ideas related to insuring older uninsured adults.	Report and PowerPoint presentation to HAC at February meeting.
Contract with SHADAC to provide expertise in developing a report on the health services used by the target population and estimated costs of those services to the healthcare delivery system	September 2004 through January 2005	SHADAC Contractors Institute Staff HAC SC	WVSPG will have information related to health services used by the target population and the costs of those services to the healthcare delivery system	Report and PowerPoint presentation to HAC at February meeting.
Document financial resources currently expended by all stakeholders in delivery system for care of the uninsured.	September 2004 through January 2005	SHADAC Institute Staff	The estimated costs of WV public and private resources expended for healthcare for the uninsured will be quantified for stakeholders (including the uninsured) in the system	Report and PowerPoint presentation to the HAC at the February meeting.
Research instruments and guidelines for key informant interviews and focus groups.	September 2004	Institute Staff	Model instruments available for review and analysis of appropriateness for WVSPG	Analysis of instruments for WVSPG use
Develop WV community appropriate questionnaires for leadership interviews.	October 2004	Institute Staff HAC SC	WVSPG appropriate key informant interview guidelines and focus group discussion guides prepared.	Guidelines and discussion guides will be available for WVSPG use.
Solicit the HAC to recommend communities and leadership to be interviewed	October 2004	Institute Staff HAC SC	Recommendations received and considered in relation to uninsured demographics	Communities chosen interviews and focus groups

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
Key informants contacted and interviews are scheduled and conducted	November 2004	Institute Staff	WVSPG will have knowledge of community perspectives of the severity and impact of older uninsured adults on community healthcare	Report for February HAC
Identify participants for focus groups, contact and schedule participants, handle group logistics and documentation needs, and arrange payment mechanism	November 2004	Institute Staff	Preparations for focus groups will be completed with schedules, participants, and other details accounted for and documented	Focus group plans, schedules, etc. completed
Conduct focus groups	December 2004	Institute Staff	All focus groups will have met and discussions recorded	Data will be available for analysis
Transcribe focus group results, complete analyses & prepare results - both overall and synthesized reports as appropriate.	January 2004	Transcription contractor Institute Staff	Information related to the target population's experiences, health status, and use of services will be analyzed to allow for a better understanding of their needs and circumstances	Reports from focus groups will be available for the February HAC meeting.
2. Communications Strategy/Public Information Campaign				
Contract with a Media Consultant	September 2004	Authority	Contract negotiated and signed	Consultant on board and working with WVSPG
Assign Institute staff responsible for communications activities	September 2004	Institute Director	Single focus to handle all communications contacts, documentation, logistics, and reports	Staff reports on communications activities as needed, but no less than monthly
Review 2002/2003 communications plan and meet with Communications subcommittee for revision and recommendations	October 2004	Institute Staff Authority Media Consultant	Discussion of communications goals, target audiences and methods are informed by Communications subcommittee input	Minutes of Communications subcommittee meeting
Revise communications plan and circulate to Communications subcommittee for comment	October 2004	Institute Staff Media Consultant	Communications plan drafted and recommended revisions made	Final Communications plan completed
Presentation preparation	December 2004 through January 2005	Institute Staff HAC SC	Reports of data collection activities edited in final form and PowerPoint presentations prepared	Materials ready for February HAC meeting.
Develop radio and television talk show opportunities	October 2004 and continuing	Institute Staff Media Consultant	Scheduled presentations/ participation in talk shows and panels to discuss WVSPG and	Schedule of events and monthly reports on contacts and results

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
		HAC	uninsured issues	
Develop an e-mail list serve to receive issue briefs, report summaries, presentation materials and to invite queries and comments.	September and October 2004	Institute Staff	List serve communications on regular and monthly basis to growing audience	Monthly reports and increase audience from 120 HAC members to 1,000 interested individuals
Develop and work through a framework of issue presentations that will serve as an agenda for SPG/ISC meetings.	September and October 2004	Co-PIs	Approval of legislative staff on agenda recommendations	Report to HUG on agenda and ISC meetings scheduled
Prepare the legislative presentations and circulate them for approval of the HUG.	September 2004	Institute Staff	Materials for ISC including PowerPoint presentations and handouts based on previous 2002 and 2003 work	Materials completed
Give presentations at designated monthly ISC meetings.	September 2004 through February 2005	Co-PIs	ISC will be fully informed of WVSPG findings on the uninsured	Recommendations from ISC to 2005 legislature reflect WVSPG report
Attend and make note of member inquiries and concerns that need to be addressed between meetings.	September 2004 through February 2005	Institute Staff	WVSPG staff timely respond to legislative queries and concerns	Recommendations from ISC to 2005 legislature reflect WVSPG report
3. Decision- Making Process				
Provide HAC members with a copy of the grant and letter of award	September 2004	Institute Staff	HAC informed of WVSPG plans	Comments received from the HAC
Hold an initial meeting of the HAC Steering Committee to provide advice on the new project task, to make decisions about setting up new subcommittees and timelines, to suggest subcommittee chairs appointments and to advise on the most effective strategies to get the HAC process underway again	October 2004 through November 2004	Institute Staff HAC SC	HAC structure will be revised to meet the needs of WVSPG3. Leadership will be in place and the full HAC will be informed of its roles for the coming year.	Minutes of meetings, communications to HAC, and commitments to serve in leadership positions

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
Secure the commitment of those who intend to be active through this grant year. Secure subcommittee leadership (co-chairs) who will also constitute an updated HAC Steering Committee.	October 2004 through November 2004	Institute Staff	HAC members will view new tasks positively and Steering Committee will be in place	Commitments of –participation from members
Secure the commitment of the HAC chair for this grant year.	October 2004	Co-PIs	Chair will continue to work with HAC	Chair will continue to communicate WVSPG activities to the HAC and moderate discussions and decisions on the plan activities
Secure the commitment of HUG members to serve as resources for the work of the HAC and its subcommittees.	September 2004	Co-PIs HUG	Commitments made along with agency staff support assignments	Rosters of state agency support contacts
Develop a timeline that integrates all grant tasks for their information.	October 2004	Institute Staff	Presentation of timeline at October HUG meeting	HUG's approval of timeline
Prepare subcommittee charges and staff assignments.	October 2004	Institute Staff HUG HAC SC	New subcommittee assignments will have been reviewed, approved, and are ready for circulation to the HAC	Subcommittee tasks & activities will be coordinated and meeting will be effectively carried-out with involvement of all subcommittee members
Review and revise (if necessary) the deliberative decision making process.	October 2004 through November 2004	Institute Staff HAC SC	Decision-making process revised and affirmed by the Steering Committee	Process documented and ready for February presentation
Provide support and necessary information to all subcommittee meetings and work.	October 2004 through August 2005	Institute Staff	Subcommittees are supported as: (1) they focus on their new charge and specific recommendations therefore, will discuss issues and concerns, review drafts and report their specific work and recommendations and (2) will review and recommend on the final plan for WV	Subcommittee meeting minutes and monthly reports at the June and August HAC meetings
Maintain regular communication with HAC members about the grant tasks and activities that are underway.	October 2004 through August 2005	Institute Staff	Monthly HAC reports will revitalize member interest in WVSPG and improve knowledge	HAC feedback on monthly reports and strong participation at meetings
Convene and support the first and subsequent meetings of the	January 2005 through August 2005	Institute Staff	HAC participation is well-informed, productive, and enthusiastic	Evaluation of each of the three HAC meetings

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
HAC.				
Integrate all subcommittee work into draft pilot demonstration plan described in narrative	May 2005	Institute Staff HAC SC HUG	Draft Pilot Demonstration document has been reviewed by the Steering Committee and HUG and circulated to HAC members prior to June HAC meeting	Draft Pilot Demonstration document and circulation memo – presentation for June HAC meeting and HAC final recommendations
Options report that details WVSPG coverage options considered, as well as options identified through data collection	May 2005	Institute Staff HAC SC HUG	Report which has been reviewed and commented on by HAAC SC and HUG as basis for decisions on final WV plan at August HAC meeting, circulated to members prior to June HAC meeting	Options report and circulation memo – presentation at June HAC meeting
Final pilot demonstration plan prepared	July 2005	Institute Staff	Final plan with HAC comments from June meeting incorporated, given to the HUG and Governor	Final plan and cover letters to Governor and circulated to HAC at August meeting
Draft of WV's comprehensive coverage plan, including HAC input from the June HAC meeting	July 2005	Institute Staff HAC SC HUG	Draft comprehensive plan, reviewed by HAC SC, HUG, and circulated to HAC membership prior to August HAC meeting	Draft plan documentation and circulation memo – presentation for August meeting
Final comprehensive plan prepared	August 2005	Institute Staff HAC SC HUG	Final comprehensive plan circulated and approved by HAC SC and HUG, then given to the Governor	Final comprehensive coverage plan and cover letters to the Governor
Provide documentation on all HAC activities/ actions, along with its recommendations to the HUG.	October 2004 and continuing	Institute Staff	Monthly reports on HAC activities and input/recommendations to the HUG	Minutes of HUG meetings and reports and relevant actions or decisions made
4. Develop Evaluation Design for Pilot Plan				
Prepare a summary presentation on evaluation for subcommittees	January 2005	Institute Staff	Presentation will prepare subcommittee members for reasonable participation in its task	Presentation at February subcommittee meeting
Discuss evaluation concepts and identify any additional information members would find useful.	February 2005	Institute Staff HAC Evaluation Subcommittee	Additional information required is identified and provided to subcommittee	Documented communication of additional requested information
Subcommittee meets to discuss and provide input on evaluation methods and measures, as needed	March 2005 through May 2005	Institute Staff HAC Evaluation Subcommittee	A draft plan of evaluation developed by staff that reflects subcommittee input as well as concepts of staff paper	Draft plan, process , and discussions reported for June HAC meeting

Project Management Matrix				
ACTION STEPS	**TIMETABLE**	**RESPONSIBLE PARTIES**	**ANTICIPATED RESULTS**	**EVALUATION/ MEASUREMENTS**
Solicit various stakeholders reactions and comments through interviews and/or questionnaires	July 2005	Institute Staff	Reactions of stakeholders to draft evaluation plan will provide real world assessment of its usefulness and feasibility	Report documenting comments for subcommittee
Report the stakeholders' reaction to subcommittee which – at this time – will make its recommendations for the evaluation design	July 2005	Institute Staff HAC Evaluation Subcommittee	Final evaluation plan documented and circulated to HAC and HUG	Evaluation plan completed for incorporation into pilot plan
5. Provide a Final Report to the Secretary of WVSPG's Comprehensive Plan and All Activities Undertaken in Its Development				
Incorporate final plans into WVSPG report that includes all activities, reports, and presentations and further documents plan recommendations on uninsured to be served, partnerships and resources necessary for success, incremental expansion and timeline estimates	August 2005	Institute Staff HUG	Final plan for circulation to HUG for comments	Minutes of HUG meeting, comments received
Incorporate the HUG's comments and provide a final report to HUG members and the Governor for approval and/or recommended revision.	August 2005	Institute Staff HUG	Final report which has been revised and approved by the HUG and Governor	Final report document
The final report will be prepared, all documentation will be appended, and the final report will be given to the Governor for his submission to the Secretary.	August 2005	Institute Staff HUG Governor's Office	Final report document and all attachments given to Governor with cover letters to the Secretary	Circulation of final report to HAC members with letter of thanks from the Governor

C. Governance

The Governor of WV continues to be fully committed to expanding health insurance coverage to all West Virginians and has appointed the WV Health Care Authority (Authority), the state planning agency, as the lead organization for the state's WVSPG project. Since it has a small staff with an already full set of responsibilities, the Authority has partnered with the Institute to serve as the "managing partner" for the WVSPG, with the Chair of the Authority and the Executive Director of the Institute acting as co-Principal Investigators.

The Authority and the Institute have worked closely with the Health Umbrella Group (HUG), created by Governor Wise to address the issue of the uninsured in WV. With high-level participation from the executive levels of all state agencies involved in healthcare, the HUG is charged with expanding health insurance for all of the state's citizens, beginning with those most in need. The Institute provides staff support to the HUG and has undertaken its efforts on the uninsured, including the West Virginia Healthcare Survey 2001. The Chair of the Authority is a member of the HUG.

The Authority, the Institute, and the HUG have been assisted in the WVSPG process by a Health Advisory Council (HAC) that is broadly representative of all stakeholders to the project. The HAC's role is advisory. The WVSPG activities are administered by a project management team described below under "Project Management". The HAC is facilitated by a Steering Committee and is chaired by a former member of the West Virginia legislature.

Role of Lead Organization in Coordinating the Project

The Authority is an autonomous agency within the Department of Health and Human Resources with statutory responsibility for a variety of health planning, regulatory and data activities. With broad responsibility for the state of the healthcare system in WV, the Authority is unencumbered by a narrow programmatic perspective. An experienced leader of a number of interagency efforts for state government, the Authority is well suited to provide policy direction to an effort that will bring together multiple constituencies for a single purpose. The Authority will extend the existing contract with the Institute to continue its role as "managing partner."

The Executive Director of the Institute will be responsible for the administrative oversight of the WVSPG, assisted by the Institute's leadership and the Project Coordinator. In this role, she will be responsible for the smooth and timely progress of the tasks being undertaken, the resolution of problems and barriers which may arise, the timeliness and effectiveness of contracting, hiring and other operating functions, and the timeliness and quality of all products produced and activities undertaken by the WVSPG.

The Authority will provide the budget officer, who will be responsible for overseeing expenditures and ensuring accountability and who, as the contract officer, will assure the timely and complete communication required by the Health Resources and Services Administration.

Composition and Decision-Making Structure

All decision-making authority related to the WVSPG resides in the HUG. The HUG is aided in its work by the HAC, comprised of stakeholders drawn from business and labor, community and provider organizations, and consumers, who provide advice and analysis and serve as a vehicle

for communication between the project and the stakeholder communities. The HAC carries out its work through a subcommittee structure, with staff support provided by the Institute.

At the beginning of the WVSPG process, the Authority and Institute specified a formal structure for deliberations and decision-making, which takes into full consideration recommendations of the HAC and the decision-making responsibility of the HUG. The process for informal and formal communication between the HAC and the HUG is carried by the co-PIs and the Institute staff.

The co-Principal Investigators from the Authority and the Institute manage the process for decision-making which includes meetings of senior project staff, regular monthly meetings of the HUG, interim meeting staff assignments, monthly meetings and reports by the HUG with the Governor, and regular meetings of the HAC. The co-Principal Investigators also manage the HUG approved structure, subcommittee assignments, reporting mechanisms of the HAC, and act as spokespersons for the grant and its undertakings.

Participation of State Agencies, the Legislature, and Other Key Public & Private Groups
Relevant state agencies are involved in the process, either through membership in the HUG or the HAC. The legislature receives regular briefings from HUG members on the proceedings of the grant activities. During this specific grant year, specific support for a legislation study resolution will increase interaction with and information to the West Virginia legislature. Additionally, the planning effort represents the formal collaboration of business, the healthcare provider community, consumer groups, and researchers. All key constituencies are involved in the process through their inclusion in the HAC.

Health Umbrella Group: Since its initiation by the Governor, the HUG has begun a number of data collection efforts on the uninsured including the two complete statewide household surveys and other data collection activities. Recognizing the need for more coalition building with the private sector (particularly employers), the HUG participated in a Business Roundtable in June 2003 in order to examine health and health insurance issues in the state. The HUG has embraced its mission to expand health insurance coverage energetically. The WVSPG momentum already created gives a significant jump-start to the additional proposed planning effort that will build on a foundation already in place.

Health Advisory Council (HAC): The HAC was created with broad representation from the private and public sectors and includes representatives from business and labor, WV communities, healthcare delivery systems, uninsured consumer groups, legislative staff, and government agencies. Over 100 persons comprise the council. The HAC has successfully used a subcommittee structure to carry out its work over the last two years of WVSPG activities. The specific subcommittees for this initiative are dependent upon which application is successful, the Continuation Limited Competition Grant or the Pilot Planning Competition Grant. Regardless, each subcommittee will continue to be staffed by an Institute staff member, with the co-PIs attending as many meetings as possible due to the sheer number of meetings.

Project Management

The grant is administered through a management team made up of the Chair of the Authority and the Executive Director of the Institute as co-chairs, the Governor's HUG Chair, the Authority fiscal officer, and the Institute's senior leadership. This group will continue to determine the strategies and assignments for implementing the WVSPG and will meet as needed to assure that strategies and assignments are on schedule.

Accounting Process

The Authority will continue to provide a budget officer for the WVSPG with responsibility for overseeing expenditures and ensuring accountability. A separate account will continue to be maintained for the WVSPG project, and will be subject to special and other audits to assure that funds are being expended appropriately. All contractual/consultant agreements will be with the Authority and will be contracted in compliance with state guidelines. Sub-recipient monitoring will be ongoing to provide reasonable assurance that the sub-recipients administer federal awards in compliance with federal requirements.

	Role	**Continuation Grant Effort**	**Pilot Project Effort**
WV Health Care Authority			
Sonia Chambers	Co-Principal Investigator	10% (In-Kind)	10% (In-Kind)
Carol Haugen	Project Director	5% (In-Kind)	5% (In-Kind)
Jeff Bush	Chief Financial Officer	25% (In-Kind)	25% (In-Kind)
WVU Institute for Health Policy Research			
Sally K. Richardson	Co-Principal Investigator	15%	20%
Johnna Beane	Project Coordinator/ Research Associate	30%	50%
Gail Bellamy	Director of Community Studies	10%	30%
Jiexin Liu	Senior Research Analyst	10%	15%
Melissa McCormick	Research Associate/Analyst	30%	50%
TBN (incumbent Heather Starsick)	Research Associate/Communications Specialist	40%	100%

Grant Monitoring Plan and Report to the Department

The WVSPG will use its Project Management Matrix as the tool against which to measure its progress and its successful completion on the tasks. The Institute has a bi-weekly staff meeting and during the period of the Continuation Limited Competition Grant and/or Pilot Planning Limited Competition Grant, the status of WVSPG tasks will be a regular agenda item. In addition, WVSPG will make regular reports to the HAC Steering Committee and at monthly HUG meetings, as has been its practice in past award periods.

For reports to the Department, WVSPG will obtain the Department's report format and any instructions in order to comply with all data requests and deadlines specified by the Department. It will participate in any Department activities, such as meetings of grantees, and be responsive to requests for information from other grantee states. At the end of the grant period, it will, in a timely manner, complete and provide its plan for state insurance expansions and coverage and a summation of its findings and activities in a report to the Secretary.

Appendix A: Section from 2003 Supplemental Grant Application

Project Progress Report to Date

Phase 1: Planning Process

Input for WVSPG planning comes from the HAC, a leadership body of more than 100 stakeholders. Its charter, structure, process, and membership were developed by the management team and approved by the HUG. The original proposal anticipated a more modest sized group that met frequently and worked in subcommittees only for specific inquiries or issues. It quickly became apparent that interest in the grant was very strong and that the WVSPG would be better served by a much larger constituency leadership group, with five subcommittees working between meetings on broad issue areas.

The HAC, therefore, meets quarterly as a whole to receive the results of state-based research on the uninsured, the workforce and the employment base, health insurance expansion options, other states' SPG activities, national trends, and other concerns and issues relevant to the purposes of the WVSPG.

HAC subcommittees focus on areas integral to making choices and recommendations about feasible solutions for the state. They meet monthly, or more often, to discuss what is known and what needs to be known about their issues and arrive at recommendations for the HAC as a whole. The subcommittee co-chairs, along with the chairs of the legislature's health committees, serve as a steering committee. A retired legislator chairs the HAC.

In November 2002, Governor Wise sent letters of invitation to potential HAC members to both join the Council and attend its first meeting for which he was the opening speaker. This meeting was used to provide HAC members with basic information about the state's uninsured and their circumstances, as well as national briefings on relevant financial and program trends and other states' SPG activities.

The steering committee meets monthly to connect the work of the subcommittees and assure that work is focused on the HAC charge and on two short-term project goals which steering committee developed. These goals are (1) maintaining the State's public insurance programs' enrollments, and (2) reducing the number of uninsured non-elderly adult (ages 19 through 64) by 50% within five years. It is the committee's belief that meeting these goals is feasible and that doing so will create the impetus for achieving the Governor's long-term strategy to incrementally expand health insurance to all West Virginians.

Additional meetings in February and June 2003 have focused on the state's current health insurance markets, broad options that are working for small businesses in other states, the initial results of the WVSPG employer research initiatives, specific state-based options presented by WVSPG consultants, and obtaining input on local communications public meetings planned for the summer and fall.

The fourth meeting is planned for October 2003, and will be the forum for feedback from the local public meetings, the consultants' report on state-based health insurance models with their targeted populations and costs, and the recommendations of the subcommittees. Using an iterative process, HAC members will be asked to provide their initial assessment of each option's and recommendation's suitability for the state, as well as ranking them for inclusion in the WVSPG plan.

Phase 2: Communications

The WVSPG Management Team had strong consultation support from HRSA's communication contractor, American Institutes of Research (AIR). An October 2002 meeting focused on identifying WVSPG's "generic" communications needs and outlining strategies to meet them. This outline was shared with the HAC's communication subcommittee in February. The subcommittee recommended that WVSPG take full advantage of identifying itself with Covering the Uninsured Week. Staff served on the planning committee and provided lead responsibility for media coverage and for planning, logistics, and presentations for two events in which the Governor agreed to participate. Staff also prepared issue briefs, using the Health Insurance Survey data, for distribution at all the week's events, as well as a state logo for the materials that were prepared.

An important result of this work was a decision by the *Charleston Gazette*, the newspaper with the largest statewide circulation, to field a team of reporters to research the state's uninsured issues and produce a summer-long series of reports that would "put a face" on the problem and call attention to the work of WVSPG. The series, "Everyone at Risk, the Uninsured in West Virginia," began in mid-June with three major stories. It continues with intermittent articles on the paper's weekly "Health Watch" page, and its July feature article will be based on the WVSPG employer survey results.

In March, the communications subcommittee, the Management Team, and Institute staff spent a second day with the AIR consultants laying out a communications plan for the remainder of the grant. It has been greatly enhanced by the commitment of the Governor to participate in five or six meetings in the fall, encouraging stakeholder leadership to support the grant's initial recommendations. Following this meeting, a final communications plan was reviewed and approved by the HAC subcommittee, and a contract was signed with an experienced West Virginia media relations consultant to manage the plan's implementation and assure that the benefit of the Governor's personal support is fully realized.

The first "opportunity" of the plan was a Business Leadership Summit, using funds remaining from the earlier RWJ SCI Planning Grant extended for this purpose. Again, the Governor lent his name to the event, invited the participants, and gave the closing address. The June 2003 event was also co-sponsored by Mountain State Blue Cross/Blue Shield, WV AFL-CIO, WV Business Roundtable, WV Chamber of Commerce, WV Hospital Association, and the WVU Bureau of Business and Economic Research. Its purpose was to engage the state's business and labor leaders in understanding both the severity of the state's problem and its negative impact on the state's business climate and economic development. The theme developed for this Summit – Closing the Gap, Insuring the Uninsured in West Virginia – has become the "brand" name for

WVSPG. Attendees heard Larry Lewin, Bill Lindsey and John Shiels discuss the impact of uninsurance on the national, state, and local economies, insurance from a small business perspective, feasible insurance expansion options for West Virginia, and the Governor's challenge to them to become active partners in supporting the state's need to expand health care insurance.

During the summer, the messages of this Summit will be given around the state in public meetings conducted by WVSPG leadership. The State RWJ SCI Demonstration grant that expands the PEIA to provide health insurance for small businesses employees will be included as one of the options. In the area of communications, these two efforts will be coordinated, and often combined, to assure the consistency of the messages, to strengthen awareness of the problem and to include the PEIA demonstration in the discussion of feasible solutions. The HUG also intends to prepare an application for Trade Act 2002 high-risk pool funds. This expansion option will also be included in the options discussed. This ability to bring a range of private, state, and federal funding resources to the task of building the state's health insurance solutions is one of the strengths of WVSPG and the administration's HUG approach.

Phase 3: Data Collection and Analysis

The WVSPG Management Team contracted all external data and research activities with a single consultant, The Lewin Group (Group). The specific tasks of Phase 3 were divided between the Institute's contract (specified in the grant application), the Group and a local researcher, with the Institute acting as manager for all activities.

When the Group's contract was in place, work immediately began on the employer survey and the employer/employee/insurance agent focus groups. Working with SHADAC and other states' employer survey models, the Group and the Institute developed and field tested the survey and proceeded into the field in January 2003. The survey of 500+ West Virginia employers was completed in March, and the data were transferred to the Institute for analysis. The initial findings were presented to the HAC at its June meeting. Additional analyses will be made available to the general public through a *Charleston Gazette* feature article on small business and insurance, a series of WVSPG issue briefs to other state dailies, local weeklies, and radio news rooms, through editorial boards dialogues, and in the town hall meeting presentations.

The second research activity was a series of 12 focus groups with small business employers, uninsured employees, and insurance agents SHADAC again provided questionnaires used by other states, and conversations with specific states gave a broader understanding of what produced the most useful response. The participant screens and the discussion guides were developed by the Group and Institute staff. The actual focus groups were held in March. The transcripts were sent to the Institute for analysis and the findings were presented at the June HAC meeting. These results will also be included in the presentations throughout the summer and fall.

As outlined in WVSPG's request for a no cost extension, the Institute partnered with the state's Community Voices project and the Healthy Kids Coalition to conduct four outreach focus groups to identify issues related to marketing and enrollment of the state programs' insureds. These were based on a discussion guide (and screening questionnaire) developed by the Federal DHHS

Office of the Assistant Secretary for Planning and Evaluation. These groups were completed in May, and the Institute has the transcripts for analysis which will be completed this summer.

The Institute has also worked with a local consultant to review the research literature related to expansions in small business insurance and in the individual insurance market. These are now complete and are being made available on the WVSPG website and to members of the HAC. This research contractor has two tasks underway: the outline of the program's interim report to the Secretary, which will be sent to HRSA by July 31, and a description and evaluation of the state's four CAP grant programs and the work of its 12 free clinics.

Phase 4: Option Development

The Group has provided lead responsibility for analyzing and developing feasible options related to HIFA waivers and other public program expansions. It is also reviewing other states' models of small business and individual market options. In addition to its presentations to the HAC meeting and the Business Summit, it has provided Institute staff with analyses of models, benefits and costs for the work of the benefit and finance subcommittees. These two subcommittees are now meeting jointly to reach agreement on benefit packages that can both serve the needs of and be attractive to the targeted populations.

In addition to the options already presented at the Business Summit, it is expected that the HIFA waiver will be fully fleshed out this summer, along with the SCI Demonstration Grant PEIA option and the Trade Act High Risk Pool mentioned earlier. All of this work will be part of the public presentations discussed earlier in Phase 2. In addition, it is anticipated that, at a minimum, fully developed benefits, pricing, and financial models of the three named options will be needed to document proposals which may be made to the 2004 legislative session.

Two final tasks described in the WVSPG application that are still to be completed by the Group are recommendations about the effectiveness and efficiency of moving towards a single program administration for the state's existing public programs and the preparation of a final report of all models' costs, target populations and estimates of insurance take up and uninsured reductions for those long-term options that have been recommended and approved by the HAC and the HUG.

Once the final recommendations, both short- and long-term, have been documented and presented to the HAC for their consideration and action, a series of interviews will be conducted with 12 to 16 key informants around the state. Working with the Group, an interview guideline will be developed, and, using candidates recommended by the HUG, interviewees will be selected and Institute staff and/or the local researcher will conduct the interviews. Their purpose will be to obtain a better measure of the strength and depth of support for the insurance expansions coming from the HAC recommendations. This information will be critical to the HUG as it begins its own deliberations about choices and recommendations for specific expansion options in both near-term proposals and long-range strategies.

Phase 5: Recommendations

The process of making recommendations has essentially been woven into the fabric of much of the work already described. A key measure of success for this phase is that each of the final recommendations initiated from the HAC, refined by the HUG and given to the Governor, is fully documented, well articulated in a manner that is clear but not simplistic, can be supported by realistic financing mechanisms, has the capacity to reduce the actual numbers of uninsured in the state, and has the strength of a majority of the stakeholders behind it. At every step along the way, these are the primary goals of each activity. The litmus test for each will be how well it contributes to these ultimate requirements.

In order to measure WVSPG progress along the way, various methods have been used to obtain feedback from meeting evaluations, from pre and post questionnaires to look for changes in values and understandings and from comment cards at every meeting to allow anonymous input into the process, the product, and the proposals. These feedback efforts will continue at each of the summer public meetings. The feedback results will be provided at the fall HAC meeting. At that meeting, the use of an audience response system to allow instantaneous feedback from anonymous choices is being considered. The project staff continues to search for opportunities and substantive methods to make sure that the WVSPG recommendations have the benefit of as much input and authentic deliberation as is feasible.

Phase 6: Final Report

WVSPG, having received a no cost extension, is already in the process of preparing an interim report to deliver to the Secretary by July 31, 2003. This is being done with the assistance of a local researcher. We will also continue to make quarterly reports during the period of the extension and a final report to the Secretary at the end of the extended grant period.

Appendix A

HOUSE CONCURRENT RESOLUTION NO. 37

(By Mr. Speaker, Mr. Kiss and Delegates Foster,
Long, Perdue and Leach)

Requesting the Joint Committee on Government and Finance to appoint a select committee to conduct a study to determine the most appropriate mechanisms to reach the goal of providing all citizens of the State of West Virginia with comprehensive, quality and affordable health care.

Whereas, It is a goal of the Legislature to see that all citizens of the State have comprehensive quality and affordable health care; and

Whereas, The cost of health care is growing at a faster rate than any other area of service; and

Whereas, It is estimated that by the year 2008 a basic family health insurance policy in West Virginia may cost at least sixteen thousand dollars making it unaffordable for a majority of the residents of the State; and

Whereas, The current health care system encourages cost shifting to the citizens who are least able to afford the cost; and

Whereas, Twenty percent of the residents of West Virginia between nineteen and sixty-four go without insurance at some time during the year; and

Whereas, Those that need these services the most have the largest economic, social and educational barriers and are ultimately least able to access the health-care system; and

Whereas, The uninsured lose their health and die prematurely; and

Whereas, Uninsured children lose opportunity to develop normally and achieve educationally due to medical conditions going untreated; and

Whereas, Families lose their peace of mind because they live with the uncertainty and anxiety of the medical and financial consequences of a serious illness or injury; and

Whereas, Communities are at risk of losing health care capacity because high rates of uninsured can cause hospitals to reduce services, health providers to move out of the community and cuts in public health programs due to the burden of providing care to those who cannot pay; and

Whereas, Because the system is flawed and does not provide basic health care services to all, the consequences include unnecessary visits to the emergency room, more serious disease outcomes due to lack of early intervention and huge financial burdens to all the citizens of West Virginia; therefore, be it

Resolved by the Legislature of West Virginia:

That the Joint Committee on Government and Finance is hereby requested to study the various mechanisms for reaching the goal that the Legislature has established to provide comprehensive, quality and affordable health care to all of its citizens; and, be it

Further Resolved, That the committee shall report to the Legislature its findings, conclusions and recommendations, together with drafts of any legislation necessary to effectuate its recommendations, no later than the first day of January, two thousand five; and, be it

Further Resolved, That the expenses necessary to conduct the study and to prepare appropriate reports, recommendations and proposed legislation be paid from legislative appropriations to the Joint Committee on Government and Finance.