INTERIM REPORT

West Virginia State Planning Grant

September 2003

Table of Contents

Executive Summary

Overview

The West Virginia (WV) State Planning Grant (SPG) project completed a number of major activities during its first year, which ended June 30, 2003.

? A Health Advisory Council (HAC), comprised of more than 100 leaders from key stakeholder groups, was constituted to guide the planning process and formulate recommendations for expanding coverage.

? More than 500 employers were surveyed to obtain baseline data on the extent and characteristics of employer-based coverage in the state and the attitudes of employers toward the provision of health insurance to their workers and the issue of the uninsurance in general.

? Small employers, uninsured consumers, and insurance agents and brokers were engaged as participants in 12 focus groups to explore their attitudes towards health insurance and potential solutions for the expansion of health insurance coverage.

? A formal Communication Plan was developed and implemented to assure that the public and various constituents were kept apprised of the work of the project and that the issue of the uninsured was kept in the public eye.

? A Business Leadership Summit, sponsored by the Governor, the SPG and a number of major stakeholders, brought together more than 200 representatives of the business community for a day long seminar exploring the importance of health insurance to the state's economy and options for expanding health insurance coverage to all West Virginians.

? SPG staff played a leadership role in organizing events for the statewide "Covering the Uninsured" Week in March. The media attention to the issue of the uninsured continued through a series of articles "Putting a Face on the Uninsured" published by **The Charleston Gazette**, the leading daily in West Virginia.

? The SPG project contracted with a major national consulting firm to conduct in-depth analyses of a broad range of options for expanding health insurance coverage.

This work has taken place under the guidance of the Health Umbrella Group (HUG), comprised of the executives of all State agencies involved in health care. The HUG, charged by the Governor with planning an incremental approach to health insurance coverage of all West Virginians, provided the impetus for the SPG application. The WV Health Care Authority (HCA) is the lead organization and the contractor for the SPG. The HCA has a contract with the West Virginia University Institute for Health Policy Research (Institute) to provide research, analytic and management support.

The WVSPG has articulated two major short-term goals for its work:

? To assure that the current levels of coverage in WV's public and private health care programs are maintained.

? To develop an incremental plan that makes affordable quality coverage available to all West Virginians and reduces by half the non-elderly adult uninsured rate from 20 percent to 10 percent within five years.

The final recommendations will also include long-term strategies for incrementally extending coverage to all uninsured West Virginians.

Data Collection Activities: Quantitative Data

Uninsured Individuals and Families. West Virginia began the SPG project with an arsenal of data on the uninsured collected in the West Virginia Healthcare Survey 2001 with funding from the Robert Wood Johnson Foundation through a State Coverage Initiatives (SCI) planning grant. This telephone survey, designed to provide county level data on the uninsured, included some 16,493 households throughout West Virginia and affords a detailed picture of the characteristics of the uninsured.

Analyses of these data have continued as part of the SPG project. Reports on four target populations (children, non-elderly adults, older adults and working adults) have been published by the Institute. These reports have been shared with the HAC membership. An overview of the survey results was also presented at the first full HAC meeting in November 2002.

Employers. More than 500 employers participated in the statewide telephone survey conducted January through March 2003. Interviews were conducted with the person in the firm most knowledgeable about health care benefits. Employers with 4 or more workers formed the target population. The survey sample was stratified by size then drawn proportionately by region and industry with an oversampling of large employers to ensure adequate representation. Taylor Nelson Sofres Intersearch fielded the survey. An initial report was presented to the HAC at the June 2003 meeting. Institute staff will complete the analysis in Year 2 of the project.

Data Collection Activities: Qualitative Research

Uninsured consumers, small employers, and insurance agents and brokers were engaged as participants in 12 focus groups in 6 cities in different regions of the state to explore their attitudes towards health insurance and potential solutions for coverage expansion. The focus groups were conducted for the SPG by Lake, Snell, Perry and Associates during March 2003 and involved 105 participants.

Four groups were conducted exclusively with uninsured consumers who were non-elderly adults with annual household incomes below $40,000 per year. Participants represented a mix of race, gender, marital status and employment/industry status. Six of the groups were conducted with

small employers (3 to 50 workers) with low wage workers (at least 25 percent earning $8.50 an hour or less) with a mix of industries represented. The remaining two groups were conducted with brokers and agents who had least 25 percent of their business in health insurance. A preliminary analysis of the focus group results was presented at the June 2003 HAC meeting. Institute staff will complete the final report during Year 2.

Summary of Health Insurance Situation in West Virginia

While West Virginia has been extremely successful in insuring its children (the uninsurance rate has been reduced to 6.6 percent), almost one in five non-elderly adults, 19.9 percent, do not have insurance with 61.1 percent of these adults employed. *(WV Healthcare Survey 2001).* Small firms, those in the construction and retail industries, firms with high proportions of low wage workers, and those with low proportions of full-time employees are the least likely to offer coverage. *(WV Employer Survey 2003).* Among uninsured consumers, cost is the most frequently cited reason for not having insurance, including those instances where an employer offers coverage. *(WV Focus Groups 2003 & WV Healthcare Survey 2001).*

Data Collection: Literature Reviews and Other Secondary Research

In addition to primary research, the SPG supported a number of secondary research efforts that resulted in monographs and slide presentations. As background for its work on option development, the WVSPG commissioned two syntheses of the literature: "State Activities Related to Employer-Sponsored Insurance" and "State Activities Related to Individual Health Insurance". Another report summarized the HIFA waivers obtained by other states to expand their public programs.

An initial analysis of the health care marketplace was presented to the HAC at the February 2003 meeting in a slide presentation, entitled "Current Coverage Available in West Virginia". A Consultant, contracted under a separate initiative, analyzed the individual and small group markets in WV and market reform efforts elsewhere to identify strategies suitable for the state. This report was reviewed and considered by the HUG and HAC.

Presentations prepared for the SPG by national experts during the course of the first year included:

"HRSA State Planning Grants, A National Perspective" (Vickie Gates, Robert Wood Johnson Foundation's State Coverage Initiatives Program)

"Health Care Cost Increases: How Do States Cope in a Changing Health Care Marketplace" (Vernon Smith, Health Management Associates)

"Approaches to Expanding Employer-Sponsored Health Insurance: Learning from Experience" (John Shiels, The Lewin Group)

"Employer-Sponsored Health Plans Trends and Their Implications" (William Lindsay, Benefit Management and Design, Inc.)

"42 Million Uninsured—Does It Matter?" (Lawrence S. Lewin, Executive Consultant)

In addition, an analysis of a buy-in option to the state employees' plan, prepared under a different contract, became available during the grant year and was utilized by the project.

Work on Policy Options

The SPG contracted with a national consulting firm, the Lewin Group, to conduct in-depth analyses of a wide range of policy options for expanding insurance coverage. This work has been in full swing since Fall 2003 and has continued into Year 2. A preliminary assessment of the cost and impact of the options under consideration was presented at the Business Leadership Summit in June. Specific recommendations for maintaining current levels of health insurance and reducing the level of uninsurance among uninsured adults by 50 percent in five years will be made in the Fall in Year 2 and submitted to the Governor for approval and legislative action during the 2004 legislative session. Additional strategies for eventually extending health insurance coverage to all West Virginians will be identified and included in the project's final recommendations at the end of Year 2.

Options under consideration for immediate action include:

? **Public program expansions including the potential use of a HIFA waiver.** Custodial adults with incomes to 100 percent of the Federal Poverty Level (FPL) are the primary target population.

? **Medicaid buy-in for employers with low wage workers and for individuals.**

? **Public-private partnerships including a small employer buy-in to the Public Employees Insurance Agency.**

? **High-risk pool**

? **Employer and/or individual tax credit**

? **Indirect subsidies through State-financed reinsurance**

? **Low-cost health insurance product for the private market**

The Benefits and Finance Subcommittees of the HAC are also working with the Lewin Group to finalize the designs and pricing for affordable benefit packages. A preventive plan, an adult basic package and a streamlined benefits package for adults are under development. The focus groups conducted during Year 1 provided guidance for this work, and the designs will be further tested in focus groups planned for Year 2 in cooperation with the small employer buy-in demonstration. (See below). The final decision on benefit packages will be made in Year 2.

Formation of the Health Advisory Council

A major undertaking in the initial months of the project was the formation of the Health Advisory Council (HAC), comprised of more than 100 leaders from stakeholder organizations, to advise and provide input to the planning process. The charter, structure, process and membership of the HAC were developed by the management team and approved by the Health Umbrella Group. The Governor personally invited all potential members to participate. HAC membership includes key staff from many state agencies involved in health care, provider representatives, employers, legislative staff and health care advocates.

To better conduct its work, the HAC was structured into five Subcommittees-- Finance, Benefits, Communications, Accountability and Delivery System. These Subcommittees meet monthly or more often to carry out their charges. The full HAC meets quarterly and is guided by a Steering Committee that includes the co-chairs of the Subcommittees. Staff support to the HAC is provided by the Institute and the HCA.

Communication Plan

A formal Communication Plan for the project was developed with the assistance of Consultants from the American Institutes of Research and adopted by the Communication Subcommittee of the HAC. Central to this plan are a series of town hall meetings and business roundtables hosted by the Governor. A local Public Relations Consultant was contracted to oversee the implementation of the plan and ensure that the Governor's participation is fully leveraged. The "nuts and bolts" of the Communication Plan involves a steady stream of press releases, publications and events to keep the work of the project in the public spotlight and build support for solutions to the uninsured issue. A major event in Year 1 was the Business Leadership Summit in June. The name created for that Summit "Closing the Gap" became the "brand" name for the SPG project.

Multi-State Integrated Database

The WVSPG is a participant in the Multi-State Integrated Database (MSID) and worked with the Arkansas Center for Health Improvement to incorporate its household and employer survey data into the MSID during Year 1. As a participant, WV enjoys facilitated access to WV-specific data included in the national databases that form part of the MSID.

Attachments

Major events and activities during Year 1 are summarized in Attachment A. Activities and events anticipated for Year 2 are shown in Attachment B.

Section 1. Summary of Findings: Uninsured Individuals and Families

1.1 Overall Level of Uninsurance

At any time, 16.2 percent of the non-elderly West Virginia population is uninsured. There are, however, wide differences based on age. As a result of successful outreach to uninsured children eligible for Medicaid and the Children's Health Insurance Program (CHIP) the uninsured level among WV children through age 18 is 6.6 percent, a level well below the national average. Among non-elderly adults ages 19 through 64, who have little access to public programs, the uninsurance rate is 19.9 percent. Virtually all elderly adults ages 65 and over have some insurance owing to Medicare. However, the SPG project considers those who do not have prescription drug coverage, at least 33 percent of the total, to be underinsured.

1.2 Characteristics of the Uninsured

Income:

More than 75% of the uninsured non-elderly population have a family income below $30,000. For families of 3 or more, this is below 200% of the FPL.

Income	% of Uninsured Ages 0-64
Below $10,000	17%
$10,000 to $19,999	34%
$20,000 to $29,999	26%
$30,000 to $39,999	12%
$40,000 to $49,999	4%
$50,000	7%
All incomes	100%

Source: WV Healthcare Survey 2001

Age:

Non-elderly adults ages 19-64 account for almost 90 % of the uninsured population, a total of almost 220,000 persons. Young adults ages 19-25 years account for 23% of the uninsured and are the least likely to have coverage with an uninsurance rate of 34%. Forty-two percent of the uninsured (over 100,000 persons) are ages 26 to 44.

Age	% of Uninsured
0-18	11%
19-25	23%
26-44	42%
45-64	24%
All non-elderly	100%

Source: WV Healthcare Survey 2001

Gender:

Women make up 51% of uninsured non-elderly adults. At younger ages, males account for more of the uninsured (54 % of the total at ages 19-25) with the proportion shifting to females as age increases. Women account for 61% of the uninsured at ages 55-64.

Age	Both	Males	Females
All non-elderly	100%	49%	51%
Ages 19-25	100%	54%	46%
Ages 26-34	100%	50%	50%
Ages 35-44	100%	49%	51%
Ages 45-54	100%	47%	53%
Ages 55-64	100%	39%	61%

Source: WV Healthcare Survey 2001

Family Composition:

Most uninsured adults, 52 %, are married. The remaining 48% are divorced, separated, widowed or never married.

Marital Status	% of Uninsured
Married	52%
Divorced	15%
Separated	2%
Widowed	2%
Never married	29%
All	100%

Source: WV Healthcare Survey 2001

Health Status of Uninsured Adults:

While there are not wide differences in health status between uninsured and insured adults, those without insurance are less likely to give very favorable reports of their health ("excellent" or "very good") than their insured counterparts (44% compared to 55%). They are also more likely to report less than good health ("fair", "poor" or "very poor", 26% compared to 20% of the insured.

Health Status	% of Uninsured Adults	% of Insured Adults
Excellent	20%	27%
Very good	24%	28%
Good	30%	25%
Fair	16%	12%
Poor	8%	6%
Very poor	2%	2%
All	100%	100%

Source: WV Healthcare Survey 2001

Health Status of Uninsured Children:

Uninsured children are less likely to be in "excellent" or "very good" health than are insured children (67% compared to 72%). "Fair" to "very poor" health seems to characterize uninsured and insured children fairly equally.

Health Status	% of Uninsured Children	% of Insured Children
Excellent	45%	48%
Very good	22%	24%
Good	23%	20%
Fair	8%	6%
Poor	<1%	2%
Very poor	1%	<1%
All	100%	100%

Source: WV Healthcare Survey 2001

Employment Status:

Employed persons, including the self-employed, represent 61% of the uninsured non-elderly adults in West Virginia for a total of over 130,000 persons.

Employment Status	% of Uninsured Non-Elderly Adults
Employed	46%
Self-employed	15%
Unemployed	14%
Homemaker	13%
Disabled	6%
Student	4%
Retired	2%
All groups	100%

Source: WV Healthcare Survey 2001

Category of Worker:

Workers most likely to be uninsured are those with temporary or seasonal employment, those working less than 40 hours and those working two or more jobs.

Category of Worker	Likelihood of Being Uninsured	Category of Worker	Likelihood of Being Uninsured
Permanent	12%	Working 40+ hours	12%
Temporary	42%	Working less than 40 hours	32%
Seasonal	42%		
Other	24%	Two or more jobs	19%
		One job	16%

WV Healthcare Survey 2001

Availability of Private Coverage (Including Offered But Not Accepted):

About 83% of employed non-elderly adults have employers who offer health insurance. Some 78% of employed adults are eligible for employer coverage, and 68% of employed adults have employers who offer dependent coverage. *(Note: These figures exclude self-employed individuals. The uninsurance rate for this group is 36%.)*

About half of all firms offering coverage, regardless of size, report their take-up for coverage to be 75-100%. *(WV Employer Survey 2003)*

Availability of Private Coverage	% of Employed Adults
Employer offers health insurance	83%
Eligible for employer health insurance	78%
Employers offer dependent coverage	68%

WV Healthcare Survey 2001

Availability of Public Coverage:
Together Medicaid and CHIP cover 17 percent of the insured population under 65 years of age. The majority of participants in these public programs (61 percent) are children. Thirty percent of WV children are on Medicaid or CHIP; only 7 percent of adults are in a public program.

Age Group/Program	# in Public Program*	% of Insured Population in Public Program	% of Public Program Enrollment	% of Age Group in Public Program
Children on Medicaid	112,716	28%	52%	26%
Children on CHIP	18,737	5%	9%	4%
Adults ages 19-64 on Medicaid	82,495	9%	39%	7%
All persons ages 0-64 in public programs	213,948	17%	100%	14%

WV Healthcare Survey 2001

** Since these data were collected in 2001, the numbers of children participating in Medicaid and CHIP have increased.*

Race/Ethnicity:

The likelihood of being uninsured is slightly higher among African-Americans and other ethnic groups, than it is for the white/non-Hispanic population. However, since WV has a very small minority population, about 5% of the total, most of the uninsured population is white/non-Hispanic.

Race/Ethnicity	% Uninsured
White/non-Hispanic	20%
African-American	22%
Other	22%

Source: WV Healthcare Survey 2001

Immigration Status. These data were not collected as immigration status is not a significant factor for the WV population.

Geographic Location - Public Health Districts and Counties:

Among non-elderly adults, the uninsurance rate is highest in Public Health Region IV in the very rural southeastern part of the state, where more than 25% are uninsured and lowest in Region VI, the northern panhandle, where the uninsurance rate is 15%. Twelve out of 55 counties have an uninsurance rate above 25%.

Uninsurance rates are highest in the most rural areas of the state, where employers are less likely to offer insurance than those in more urban areas.

Public Health Region	% Uninsured Non-Elderly Adults
I	22%
II	22%
III	19%
IV	25%
V	17%
VI	15%
VII	22%
VIII	17%

Source: WV Healthcare Survey 2001

Duration of Uninsurance for Adults:

The majority of uninsured adults, 72%, are chronically uninsured (more than one year) and another 9% have never had insurance. A minority, 16%, has been uninsured for less than 1 year.

Length of Time Uninsured	% of Uninsured Adults
Less than 1 year	16%
1-5 years	36%
More than 5 less than 10 years	17%
More than 10 less than 15 yrs.	7%
More than 15 years	12%
Never had health insurance	9%
Do not know	3%
Total	100%

WV Healthcare Survey 2001

Duration of Uninsurance for Children:

Fifty-five percent of uninsured children have not had coverage for a year or more and an additional 8% have never had insurance.

Time Uninsured	% of Unins. Children
0-6 months	30%
7-12 months	3%
13-24 months	15%
Between 2 and 5 years	21%
More than 5 years	19%
Never had insurance	8%
Do not know	4%
Total	100%

WV Healthcare Survey 2001

Other (s): Uninsured Workers

More than three-quarters of uninsured workers have incomes below $30,000. This suggests that most of these have limited ability to pay for health insurance coverage. In 11 counties, more than 25 percent of the workers are uninsured.

The largest numbers of uninsured workers (55 percent) are concentrated in small firms of under 50 workers. It is also the workers in the micro firms of less than 10 workers and in other small firms of 10 to 49 workers who are the most likely to be uninsured with rates of 34 percent and 28 percent respectively. However, there are substantial numbers of workers without health insurance (24 percent of all working uninsured) in large firms of over 100.

The largest concentrations of the uninsured are in the restaurant/food services industry (14 percent), construction and home repair (11 percent) and health care (11 percent). *(WV Healthcare Survey 2001). (Note: These data reflect the concentrations of workers in the various industries rather than the likelihood that the employers in the industry offer coverage. The data provided below in "Section 2: Employers" indicate the likelihood of coverage by industry*.)

1.3 Population Groups Important in Developing Targeted Coverage Expansion Options

The following have been identified as target populations in need of coverage solutions:

Low income working adults. Most uninsured adults in West Virginia are employed (61 percent) and the majority (an estimated 77 percent) are low income thus have limited resources for health insurance.

Parents of children on Medicaid and CHIP to at least 100 percent FPL. Currently, eligibility for Medicaid is limited to custodial adults with incomes below 29 percent FPL.

Children to 250 percent FPL. Children are currently covered in public programs to 200 percent FPL.

Workers in small businesses that cannot afford to offer coverage or that believe the cost of coverage is too high. Fifty-five percent of uninsured workers are in small firms. Eighty-one percent of small employers participating in the Employer Survey indicated their price range for insurance was $0 to less than $100. Nineteen percent believed they could pay $100 or more.

Low income Medicare beneficiaries without prescription drug coverage. About one-third of all seniors do not have drug coverage.

Medically uninsurable adults, persons who cannot obtain coverage in the private market because of their health status.

Non-custodial adults. This group is not eligible for Medicaid at any income level. The project has already determined that expanding Medicaid to cover non-custodial adults even up to 100% FPL would be unaffordable given the State's current financial situation. The potential for a Medicaid buy-in for employed persons in this group either through direct purchase or through the employer is under consideration. The project is also looking at the adequacy of the "safety net" for otherwise meeting the health care needs of non-custodial adults.

1.4 Affordable Coverage

Uninsured consumers participating in the focus groups felt it was very important to have low or zero deductibles even if it meant paying a substantially higher premium each month. They also preferred lower copayments. The premium variations tested ranged from $50 to $100. The project will officially test various premium levels for affordability once the work on affordable benefits designs has been completed. (See below).

1.5 Failure to Participate in Public Programs

Uninsured consumers by and large look favorably at public programs. Stigma does not appear to be an issue in WV. *(West Virginia Focus Groups 2003).*

The main reason parents whose children are presumably eligible do not apply for CHIP is that they have not heard of the program (31 percent). The second most important reason is that they

do not think their child is qualified (19 percent). A small proportion, 5 percent, believes it is too hard to enroll and 3 percent do not want a government program. *(WV Healthcare Survey 2001). (Note: As has been found to be true in similar surveys, parents participating in this survey underreported their children's participation in Medicaid, thus valid conclusions cannot be drawn regarding their reasons for not participating).*

1.10 Barriers Other than Affordability That Prevent the Purchase of Health Insurance

While uninsured persons (46 percent of Survey respondents) are most likely to give the "high cost of premiums, copayments and deductibles" as their reason for being uninsured, 23 percent point to job-related factors including unemployment (which may also be a cost issue) or not being offered or eligible for employment-based coverage as their reason for being uninsured. These responses suggest that many uninsured workers look to their jobs for coverage. The review of the WV health care marketplace below shows that direct purchase is not an option either because the coverage is too costly and/or not available through the individual market.

In WV, persons with health problems seeking to buy insurance in the individual market may be rated based on health status or denied coverage completely unless they are HIPAA eligible. Even so, the premiums for portability coverage under HIPAA are not regulated and tend to be higher than the regular individual market.

Thus while only a small group of uninsured adults participating in the Survey (2 percent) report they lack coverage because of a health problem, many of those reporting "high cost" as their reason for being uninsured may have health status as a contributing factor (if their health status results in a higher premium). Thus the lack of rating restrictions in the individual health insurance market in WV may be an important barrier to the purchase of health insurance.

The attitude that they are healthy, the ability to self-insure and the availability of free care are factors for 2 percent of the uninsured. *(WV Healthcare Survey 2001).*

1.11 How the Uninsured Get Their Medical Needs Met

The uninsured in West Virginia deal with their medical needs in a variety of ways. Some uninsured consumers treat themselves with over-the-counter medications, seeking care only when self-medication fails or the situation deteriorates. Others seek care from the outset, knowing they will get a reduced rate or that they can make a payment arrangement. *(WV Focus Groups 2003).*

Thirty-nine percent of uninsured adults and 26 percent of uninsured children do not have a regular source for care. Of adults who do have a regular source of care, about half receive their regular care at a physician's office with 24 percent relying on a community health center, 11 percent on hospital outpatient clinics, 7 percent on the emergency room and 2 percent on free clinics. *(WV Healthcare Survey 2001).*

And there are the people who simply do not get the care they need. Insight into their plight was provided by the series on the uninsured run by **The Charleston Gazette** starting in June 2003:

Vernon DeLung, 41, a veteran electrician, has severe joint pain, but can't afford the medicine that would give him relief.

> *"I live on Tylenol and ibuprofen," he said. "Some days, I hurt from my nose to my toes. I try not to think about what could happen. When I think about the future, I think about getting up and going to work."*

A few years ago, he got a staph infection on his leg. His doctor told him he might lose his leg if he didn't go in the hospital. "We didn't have money for that," he said. He kept going to work and checked with the doctor every other day.

Or the case of Cynthia Ray, a Fairmont resident who has cysts on her kidneys.

> *"A month ago, I went to my doctor. He still insists I have an MRI, and I still can't afford it. But we still make sure I'm alive, that I'm not going to keel over."*

Source: The Charleston Gazette, June15, 2003, Kate Long, "On the Edge, Health Insurance Prices May Double: This Affects Everybody".

1.12 Features of an Adequate, Barebones Benefit Package

In the Focus Groups conducted for the SPG project, uninsured consumers, employers, and brokers and agents, presented with a long list of potential benefits, all viewed hospital coverage as the most important feature of a health plan. They also concurred that the three other most important benefits are prescription drugs, doctor visits, and specialty care, although they did not rank them in the same order. Guided by the input provided by the focus group participants, the project is developing several affordable benefits packages including a basic package for adults, a streamlined adult package and a product incorporating preventive services.

1.13 Definition of Underinsurance

The West Virginia Healthcare Survey 2001 defined underinsured as having a dread disease or hospital only policy. Five percent of the non-elderly population and 7 percent of children were found to have such limited benefit policies.

While virtually all older adults age 65 and over have Medicare, not all seniors have comprehensive coverage. Thirty-two percent of older adults have Medicare Parts A and B but no supplement and another 5 percent have only Medicare Part A. About 33 percent of seniors have no prescription drug coverage.

The SPG does not consider underinsurance to be a significant issue except for seniors who lack prescription drug coverage. This group has been identified as a target population for option development.

Section 2. Summary of Findings: Employer-Based Coverage

2.1 Characteristics of Firms Offering, Not Offering Coverage

Note: Data from the West Virginia Employer Survey 2003 and WV Focus Groups 2003 continue to be analyzed. The results presented here should be viewed as preliminary. The final analyses will be completed in Year 2.

Employer Size (Including Self-Employed): The smallest companies (4-9 workers) are the least likely to offer health coverage with about 52 percent not doing so. Self-employed workers are not part of the small group market in West Virginia and were not included in the Employer Survey. However, data from the Healthcare Survey 2001 indicate that 36 percent of self-employed workers are uninsured.

Size of Company	% Offering	% Not Offering
4-9 employees	48%	52%
10-49 employees	73%	27%
50-99 employees	94%	6%
100 or more employees	98%	2%

WV Employer Survey 2003

Industry Sector: The construction industry is the least likely to offer health coverage in WV followed by retail trade. The manufacturing industry is the most likely to offer coverage.

Industry	% Offering	% Not Offering
Construction	38%	62%
Retail trade	47%	53%
Agriculture, forestry, fishing	51%	49%
Finance & real estate	53%	47%
Services	64%	36%
Mining	66%	34%
Wholesale trade	72%	28%
Trans., comm., elec., gas, sanit.	75%	25%
Manufacturing	81%	19%

WV Employer Survey 2003

Employee Income Brackets: Companies with a majority of low-wage employees (less than $15,000) are the least likely to offer coverage. In general, as the wage level improves a company is more likely to offer coverage, although the situation is less straightforward with companies at higher wage levels.

Employee Earning level	% Offering	% Not Offering
Low wage--majority earn <$15,000	28%	72%
Moderate low wage—majority earn between $15,000 & $25,000	59%	41%
Moderate wage—1/2 earn between $15,000 & $25,000 ; 1/2 earn > $25,000	82%	18%
High wage—majority earn > $25,000	78%	22%

WV Employer Survey 2003

Percentage of Full-Time Vs. Part-Time Workers: The smaller the proportion of full-time employees in its workforce, the less likely a company is to offer health care coverage. Of companies that have fewer than 25 percent of their employees working full-time, 69 percent do not offer health coverage.

Percentage of Full-time Workers	% Offering	% Not Offering
Less than 25%	31%	69%
25 to less than 50%	50%	50%
50 to less than 75%	47%	53%
75 to less than 90%	68%	32%
90 to 100%	63%	37%

WV Employer Survey 2003

Geographic Location: West Virginia is a predominantly rural state with only one city with a population in excess of 50,000. Employers in rural areas with small populations under 10,000 are less likely to offer coverage to their employees than those in more urbanized settings (47 percent compared to 66 percent).

Size of Location	% Offering	% Not Offering
Population under 10,000	47%	53%
Population 10,000 and over	66%	34%

WV Employer Survey 2003

Employers Offering Coverage

Level of Contribution: More than half of all companies, with no distinction based on size, pay 75 to 100 percent of the "employee only" premium. Among the largest companies of 100 or more workers, none pay less than 50 percent of the "employee only" premium. Among companies in other size bands, some contribute less than 50 percent but there is not a strong correlation between size of company and percentage contribution. The percent of dependent premium paid by the company also does not show a strong correlation with company size. *(WV Employer Survey 2003).*

Percentage of Employees Offered Coverage Who Participate: More than 75 percent of companies, regardless of size, report that more than 50 percent of the employees take company health insurance.

Size of Firm	Less than 25% take-up	25% to less than 50% take-up	50% to less than 75% take-up	75% to 100% take-up
Less than 10	6%	10%	29%	55%
10-49 workers	10%	10%	35%	46%
50 to 99 workers	12%	6%	25%	56%
100 or more	11%	5%	35%	49%

WV Employer Survey 2003

According to employers, the most frequent reason an employee does not take coverage when it is offered is that he or she is covered by a spouse's plan. About one-fifth of the employees who do not take coverage do not do so because it is too expensive. A very small minority does not need or want coverage. *(WV Employer Survey 2003).*

2.2 Reasons for Offering/Not Offering Coverage

The data from the Employer Survey indicate that cost is by far the most important reason for not offering coverage indicated by 81% of the employers not offering coverage.

Reason for Not Offering Coverage	% of Total Employers Not Offering
Too expensive/cannot afford it	81%
Employees have coverage through other plans	9%
Insufficient profit margin	3%
Employees do not demand it	2%
Not interested in purchasing it	2%
High employee turnover	2%
Employees do not want to pay their share	1%
Administrative hassles	<1%

WV Employer Survey 2003

Employers participating in the Focus Groups also overwhelmingly cited cost as the primary factor in deciding whether or not to offer coverage. Some fear that if they begin to offer coverage they will only to have to drop it months later when premiums become unaffordable. Brokers and agents reiterated a similar message—costs are the most significant factor affecting a small firm's ability to offer insurance. According to brokers and agents, the main reason employers offer health insurance is to attract and retain workers. Another reason is that the owners themselves want insurance. *(WV Focus Groups 2003).*

Amount Willing to Pay. Forty-one percent of employers not offering coverage indicate that they are not willing to pay anything toward coverage. Another 16 percent are only willing to contribute less than $50. A significant minority, 19 percent, however, say they would pay $100 or more.

Amount Willing to Pay	% of Employers Not Offering Coverage
Nothing	41%
$1 to less than $50	16%
$50 to less than $100	24%
$100 or more	19%
All amounts	100%

WV Employer Survey 2003

2.3 Decision-Making about Premium Contributions, Benefit Package, and Other Features
Data will become available in Year 2 after the affordable benefits packages are tested in focus groups.

2.4 Employer Responses to Economic Downturn or Increasing Costs
Employers not already offering coverage will not begin. Those offering coverage will increase employee contributions or begin to assess whether they will continue to offer coverage. *(WV Focus Groups 2003).* Employers experiencing premium increases shift more cost to the employees. Some change the plan type or health insurance company. A very small proportion discontinues coverage altogether. *(WV Employer Survey 2003).*

Action	Size of Group			
	4 – 9 *	10- 49*	50 – 99 *	100+*
Increase deductibles and/or co-payments	42%	58%	38%	38%
Increase employee premium contributions	25%	33%	33%	40%
Change health insurance companies	16%	24%	19%	21%
Discontinue coverage for some or all workers	2%	5%	6%	6%
Change type of plan	20%	33%	25%	14%

WV Employer Survey 2003

** Exceeds 100% since an employer might take more than one action.*

2.7 Alternatives to Motivate Non-Offering Employers to Provide or Contribute to Coverage
Expansion/Development of Purchasing Alliances: Data not available.

Individual or Employer Subsidies: Employer Survey data show 87 percent of employers who do not offer coverage view receiving a premium discount favorably.

Additional Tax Incentives: Employer Survey data indicate 88 percent of employers who do not offer coverage would find an employer tax credit appealing.

Other Alternatives: A limited benefits plan has some appeal ("very appealing" or "somewhat appealing") to 76 percent of employers not offering insurance who participated in the Survey. Other solutions such as implementing an employer risk pool, buying into a public program and implementing a high-risk pool have less appeal with more respondents indicating they are either "somewhat unappealing or "very unappealing".

Program	% Indicating "Appealing"	% Indicating "Not Appealing"
Receiving employer tax credit	88%	7%
Receiving premium discount	87%	11%
Offering limited benefits	76%	20%
Implementing an employer risk pool	59%	31%
Buying into a public program.	59%	37%
Implementing high-risk pool	55%	31%

WV Employer Survey 2003

Note: The total in favor or against does not equal 100% since those indicating neutrality "neither appeal or not appeal" are not shown.

Section 3. Health Care Marketplace

Information on the health care marketplace was gleaned from a number of sources including, but not limited to, the WV Insurance Commission's 2001 Accident and Health Lines of Business Survey, a slide presentation to the HAC February 2003 entitled "Current Coverage Available in West Virginia", "An Analysis of the Small Group and Individual Insurance Markets in West Virginia" (DRAFT document), the WV Healthcare Survey 2001 and the WV Employer Survey 2003. In addition, the broad representation of major constituent groups in the HAC, including the insurance industry and the provider community, has facilitated the ongoing exchange of information about trends in the marketplace during Subcommittee and other meetings.

3.1 Adequacy of Existing Insurance Products

A small portion of the population holds limited benefits products--"hospital only" or dread disease policies, presumably because these are affordable. There do not appear to be any comprehensive benefit packages available that might be affordable to persons at lower income levels. While catastrophic policies with large deductibles (usually connected to medical savings accounts) have some availability, they do not address the needs of lower income persons who have limited ability to self-insure for primary care. Moreover, uninsured consumers prefer products with low out-of-pocket costs even if it means higher premiums. *(WV Focus Groups 2003).*

WV State law regulates the restrictions placed on pre-existing conditions in the small group market. In addition, WV has adopted the federal fallback position for HIPAA. While persons eligible for portability coverage are guaranteed access to coverage in the individual market, premiums are not regulated and are quite high.

Purchasers in the individual market with pre-existing conditions who do not qualify for portability coverage face the prospect of being rejected outright or having their medical conditions excluded from coverage. Since self-employed individuals in WV must purchase coverage in the individual market, they are vulnerable to a medical underwriting rejection as well. Most companies, regardless of size, impose some limit on pre-existing conditions. *(WV Employer Survey 2003).*

3.2 Variation in Benefits in Different Markets

Most policies sold in WV provide comprehensive coverage; that is, a full range of services is covered subject to a deductible and coinsurance and/or copayments. Limited benefits policies tend to be sold to non-group customers, although overall the proportion of the population with these policies is low (about 5-6 percent). Additional data on benefits variations have not been compiled.

3.3 Self-Insured Firms

Self-insurance is most common among large companies of 100 or more employees where self-insurance is reported by 53 percent of the total. Legislation enacted during the last legislative session gave the Insurance Commission authority to regulate third party administrators (TPAs),

thus giving the State some indirect control over self-insured employers that are otherwise exempt from state regulation under ERISA.

.

3.4 Impact of State as Purchaser of Health Care

The State is a major purchaser of health care covering about one-third of the insured population under age 65 through Medicaid, CHIP and the Public Employees Insurance Agency (PEIA). The State also covers a significant proportion of older adults age 65 and over including PEIA retirees and their dependents and persons who are dually eligible for Medicare and Medicaid.

The State has been focusing on ways to leverage its presence as a major payer through consolidated purchasing including participation in a multi-state prescription drug-purchasing consortium and the use of common reimbursement methodologies for State programs. Recognizing its clout as a purchaser, the State is undertaking a pilot program to provide coverage to small employers through PEIA.

Health Care Purchaser	**% of Insured Population Under 65**
Medicaid	15%
CHIP	2%
State Employees' Plan (PEIA)	16%
Other purchasers	67%
Federal government	*9%*
Private employers	*51%*
Other	*7%*
All purchasers	100%

WV Healthcare Survey 2001

3.5 Impact of Market Trends and Current Regulatory Environment on Coverage Expansion

? West Virginia saw a decline in the number of insurers doing business in both the group and individual markets between 1997 and 2001. While many insurers still do business in the state, most have insignificant market share. Mountain State Blue Cross Blue Shield dominates in both the group and individual markets with 28 percent market share (based on direct premiums written). Other players of import include Carelink Health Plans, Inc. (14 percent market share) and the Health Plan of the Upper Ohio Valley (12 percent market share). Mountain State is viewed as a major stakeholder for the SPG project and serves as a member of the HAC Steering Committee.

? Although only a small number of HMOs are active in WV, they account for 31 percent of covered lives in the group market and 7 percent in the individual market. However, owing to its rural nature and small provider base, there has been little HMO penetration into many areas, particularly in the southern part of the state. PEIA covers 90 percent of its enrollees, almost 200,000 persons, through a preferred provider network with which it negotiates discounts. PEIA has a presence in all 55 counties of WV and is viewed as a potential major

player for a public/private partnership. A demonstration to allow small employers to buy in to PEIA is currently underway with funding from the State Coverage Initiatives.

? Health care costs have been accelerating, growing about 7-9 percent last year. These costs have direct implications for the cost of any benefit packages offered as part of an expansion effort.

? Premium costs continue to rise. A report prepared by Mountain State Blue Cross Blue Shield indicates that family premiums rose by 12 percent from 2000 to 2001. For some small businesses, premiums went up 16 percent from 2001 to 2002 with annual family premiums at almost $10,000. The majority of respondents to the Employer Survey reported they had experienced premium increases. Concerned about the pressure on employers who currently provide coverage, the project articulated maintaining current levels of coverage as a major goal.

? The lack of rate regulation in the individual market contributes to unaffordable coverage for those with health problems as well as those deemed at high risk due to age or other characteristics. While insurers in the small group market are required to use rating bands, premiums still fluctuate widely among small employers and differences may be on a scale of 5:1 or more, resulting in very expensive coverage for some employers. In an unchanged regulatory environment, affordability will continue as a major issue.

3.6 Impact of Expansion Strategies on Health Plans and Providers

The WVSPG project looks very favorably at public/private partnerships and anticipates that the private market will be involved in all strategies recommended for coverage expansion. In general, providers can expect to enjoy a more favorable income stream if previously uninsured patients are covered. However, reimbursement rates for new coverages are likely not to be high.

3.7 Consideration of Safety Net Providers in the Planning Process

Safety net providers are considered the backbone of the health care enterprise throughout rural West Virginia and for some underserved urban populations. They include federally qualified health centers (FQHCs), FQHC-look alikes, rural health clinics and community health centers at more than 250 sites throughout the state, 13 critical access hospitals, 7 community mental health centers, and 13 free clinics. In addition, there are 4 community access programs (CAP) that are focused on developing health systems to serve the uninsured in their catchment areas.

Representatives of the safety net health care delivery system have been actively involved in the SPG process through participation in the HAC. The Finance Subcommittee has already looked at the uncompensated care funds paid to hospitals and the role of the free clinics. The project has commissioned an issue paper on the "safety net" in general and the status and impact of the four CAP programs to be completed during Year 2. The findings will be provided to the Delivery System and Finance Subcommittees and will feed into the HAC deliberations and recommendations.

3.9 Consideration Given to the Experience of Other States Regarding: *Expansions of Public Coverage, Public/Private Partnerships, Incentives for Employers to Offer Coverage, and Regulation of the Market Place*

The WVSPG project has paid considerable attention to the experience of other states and commissioned a number of reports and slide presentations on the activities in other states including two comprehensive syntheses of the literature: "State Activities Related to Employer-Sponsored Insurance" and "State Activities Related to Individual Health Insurance".

The synthesis on employer-sponsored insurance considered public/private partnerships including buy-ins to employer-sponsored coverage using Medicaid, SCHIP and state only funds as well as incentives for employers to offer coverage (premium assistance programs, employer tax incentives, and indirect subsidies such as New York's reinsurance program). The synthesis on the individual market considered expansions of public coverage. Additionally, a separate document was prepared on HIFA waivers in other states as background for exploring the potential for a public program expansion in West Virginia through a HIFA waiver.

Slide presentations at SPG project events included:

"HRSA State Planning Grants, A National Perspective" (Vickie Gates, Robert Wood Johnson Foundation's State Coverage Initiatives Program)

"Health Care Cost Increases: How Do States Cope in a Changing Health Care Marketplace" (Vernon Smith, Health Management Associates).

"Approaches to Expanding Employer-Sponsored Health Insurance: Learning from Experience" (John Shiels, The Lewin Group)

In addition, the SPG project utilized an analysis of the individual and small group markets in WV prepared by a Consultant for an earlier initiative. This document analyzed market reform efforts elsewhere and their suitability to West Virginia.

Section 4. Options for Expanding Coverage

4.1 Expansion Options Under Consideration

The WVSPG project has examined a number of options in detail and expects to make recommendations for initial strategies during the Fall of Year 2 so that they can be presented for legislative action during the 2004 Legislative session in January. These are viewed as the first wave of recommendations for implementation in the near future. One of the primary target populations is low income working adults. These recommendations will be followed by a second set to be issued at the end of the project, which will lay out the plan for covering all West Virginians through incremental action over a longer time frame.

Options under consideration for the initial recommendations include:

? ***Medicaid expansion to low-income custodial adults, including the potential use of a HIFA waiver***

? ***Medicaid buy-in for employers with low wage workers and for individuals***

? ***Public/private partnerships including a small employer buy-in to the Public Employees Insurance Agency***

? ***A high-risk pool for HIPAA eligibles and persons deemed medically uninsurable***

? ***Employer and/or individual tax credits***

? ***Indirect subsidies through State-financed reinsurance***

? ***Low cost heath insurance product for the private market***

In addition, the SPG project has focused on developing affordable benefits packages to be used in conjunction with the selected strategies.

Work on options development has been carried out by the HAC through its Steering Committees and five Subcommittees assisted by the Lewin Group, which is providing the analytic support. A summary of the work to date on feasible options was presented at the Business Leadership Summit in June. (See below.)

Prior to making its final selections, the HAC will consider for each option the size of the target population, the expected take-up rate, the cost to the state and federal government, the outreach and marketing approach, the administrative infrastructure, the service delivery system, particularly the ability to meet the needs of the underserved rural population, potential for cost containment and the impact on the existing marketplace, including crowd out.

Once the initial recommendations are made, focus will be directed at making recommendations for the longer term. To this end, the WVSPG project has requested the Lewin group to analyze the efficiency and effectiveness of moving toward a single public program in West Virginia. A paper on best practices with respect to single public programs has also been commissioned.

4.19 Eligible But Not Enrolled Population/Efforts to Increase Enrollment

Since 2000, CHIP enrollment has grown phenomenally owing to strong state support and an intense community-based marketing effort. The uninsurance rate for children in WV has been halved falling from 12-13 percent to 6.6 percent, and CHIP enrollment has increased by more than 4,000 children. In addition, many children have been added to the Medicaid program as a result of a simplified joint application process, which considers the child for the most appropriate program. The application requirements for the two programs (documentation required, definitions of "household", etc.). have been aligned to lessen the burden on parents as well as on the eligibility workers. The joint application may be downloaded from the WVCHIP Web-Site.

Outreach for CHIP has been intense at the grass roots level with volunteers (including the Governor) going door to door to promote the program. Applications and promotional

information on WVCHIP is available through participating community organizations including hospitals, physician practices, pharmacies, dental offices, pediatric clinics and primary care centers. Businesses and retailers such as discount stores, grocers, convenience stores and fast food restaurants have also assisted in the promotional effort.

WVCHIP works closely with the WV Healthy Kids Coalition to coordinate and jointly participate in outreach activities throughout the state. The Coalition includes numerous community-based organizations including primary care centers, Family Resource Centers, childcare centers and faith-based organizations. WVCHIP also takes advantage of local events such as health fairs, parades and the state's many festivals to promote the program. The SPG project worked with the Coalition and the Community Voices Project on four focus groups that explored outreach and enrollment issues with parents.

This same combination of strong state support and effective community-based outreach will continue to be used to reach the small number of children not yet enrolled in the public programs and to promote the coverage expansion strategies resulting from the SPG project.

Section 5: Consensus Building Strategy

5.1 Governance Structure, Involvement of State Officials and Agencies, Key Constituencies

The Health Umbrella Group (HUG), comprised of the executives of all State agencies involved in health care, serves, with the Governor, as the decision-making body for the project. The membership of the HUG is shown in Attachment C. The WV Health Care Authority (HCA) is the lead organization and the contractor for the project. The Authority has a contract with the West Virginia University Institute for Health Policy Research (Institute) to provide research, analytic and management support. A management team drawn from the HCA, the Institute and the HUG oversees the day-to-day work.

The Health Advisory Council (HAC), comprised of more than 100 leaders of constituent organizations, was established at the outset of the project to advise and provide input to the process. The HAC membership includes key staff from many State agencies involved in health care, provider representatives, employers, legislative staff, health care advocates, local community leaders and other interested parties. The HAC conducts its work through five Subcommittees that meet monthly or more often. They include Finance, Benefits, Communications, Accountability and Delivery Systems. The full HAC meets quarterly and is guided by a Steering Committee that includes the co-chairs of the Subcommittees. The HAC recommendations for expanding health insurance will be sent to the HUG and Governor for approval. The membership of the HAC and their affiliations are provided as Attachment D.

The Governor has lent his support throughout the process, inviting the participation of potential HAC members and playing a lead role in public meetings. His continued participation has helped make the uninsured a "headline" issue in the state. Legislative representation is included on the

HAC and its Steering Committee. Members of the legislature and their staffs will be invited to attend the HAC mid-winter meeting in Charleston during the 2004 legislative session.

5.2 Methods Used to Obtain Input from the Public and Key Constituencies

The WVSPG project has used town hall meetings, policy forums, focus groups and surveys to obtain input from the public and key constituencies. In addition, the members of the Health Advisory Council, drawn from key stakeholder groups, provide input on an ongoing basis.

Critical to the WVSPG process was the development and implementation of a communication strategy to involve the public in the planning process. A Communication Plan was developed with the assistance of the HRSA Consultant, American Institutes of Research, and adopted by the Communication Subcommittee. The mainstay of the plan is a series of town hall meetings to be held throughout the state during Year 2 of the project. The Governor made a commitment to participate in 5-6 of these meetings and his participation is expected to continue to be instrumental in rallying the support of key constituencies for the SPG recommendations. An experienced WV Public Relations Consultant was contracted to manage the implementation of the Plan and to ensure that the Governor's involvement is fully leveraged. Five of these town hall meetings have already taken place.

In June 2003, a Business Leadership Summit, with over 200 participants, offered a major communication platform for the SPG project. This seminar, hosted by the Governor, was a joint effort of a number of key stakeholders: 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. The purpose of the forum was to engage the state's business and labor leaders in understanding the severity of the uninsured problem in WV and its negative impact on the state's business climate and economic development. The theme developed for the Summit --"Closing the Gap, Insuring the Uninsured in West Virginia"-- has become the "brand" name for WVSPG. The Governor invited the participants and gave the closing address challenging participants to become active partners with the State in meeting the health insurance needs of its citizens. National experts were invited to discuss the impact of uninsurance on the national, state, and local economies, issues surrounding insurance for small business and potential options for expanding coverage in West Virginia.

Twelve focus groups were conducted with uninsured consumers, small business employers and brokers and agents to explore their attitudes towards health insurance and preferences with respect to health insurance benefits design and pricing. A total of 105 persons participated. The WV Employer Survey 2003 explored employer attitudes toward health insurance and preferred solutions to the problem of the uninsured and polled over 500 employers.

5. 3 Other Activities to Build Public Awareness and Support

The project took full advantage of "Covering the Uninsured" Week in March 2003 to publicize the SPG and to bring the issue of the uninsured to public attention. SPG staff served on the planning committee and took the lead responsibility for obtaining media coverage and arranging two town hall meetings in which the Governor participated. Using data from the WV Healthcare

Survey 2001, staff prepared issue briefs for distribution at the week's events and designed a logo for use on the materials.

An important outcome of this work was the 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 series of reports that would "put a face" on the problem and call attention to the work of the WVSPG. The series "Everyone at Risk, the Uninsured in West Virginia" began in mid-June with three major stories and continues with intermittent articles.

Project materials, including the reports on the uninsured in WV, issue briefs and other research reports are available to the public on the Internet at www.wvhealthpolicy.org.

5.4 Impact of the Planning Effort on the Policy Environment

Substantial effort has been made to obtain input from various stakeholders throughout the state. The Governor's involvement is also expected to garner support for the final recommendations. The true impact of the project will not be known until the final test—whether or not the recommendations are accepted and embraced by the legislature and the affected stakeholders—This will be discussed in the Final Report.

Section 6. Lessons Learned and Recommendations to States

6.1 Importance of State-Specific Data/Qualitative Research

The small population of West Virginia makes it difficult to estimate the characteristics of its uninsured population and employer-based coverage from regional or national data with a great deal of reliability. The state-specific data available through the population-based and employer survey are particularly important for small area estimates and for characterizing the uninsured and the employer community along more than one variable.

The contribution of the qualitative research to the decision making process will be best assessed once the analysis of the focus groups has been completed and will be discussed in the project's Final Report.

6.3 Data Collection Activities Not Implemented

All data collection activities proposed in the grant application have already been carried out (employer survey, focus groups) or will be carried out (key informant interviews related to project recommendations).

6.4 Effective Data Collection Strategies

A number of strategies were used successfully to assure participation in the Employer Survey and attain the desired sample. First, a letter was sent to each business included in the sample, explaining the purpose of the study and preparing them for the interviewer's call. Upon initial contact with a human resource specialist at each business, the attempt was made to complete the full interview. If the respondent was unavailable, an effort was made to schedule a callback for a specific time.

A systematic method to monitor the sample was employed throughout the study in an attempt to maximize the response rate and reduce non-response bias. In an effort to reduce non-response bias, every sampling unit received a minimum of an original call and up to 5 call backs over six separate interviewing sessions. These attempts varied as to the day of the week (Monday-Friday) and the time of day the call was placed. To assure the unbiased contact of sampling units, the Contractor utilized controlled replicate sampling based on the strict application of accepted sampling theory and procedures. In this manner, sampling personnel randomly subdivided the pool of sampling units in each stratum into mini-samples called replicates. These replicates consisted of independently representative probability samples of the universe in that cell. As data collection progressed, the number of replicates released got smaller. The release of additional replicates only occurred after a substantial number of cases had final dispositions and/or were call-rule exhausted, thereby lowering the number of cases without final contact dispositions at the conclusion of the study. This procedure ensured that only the number of sampling units required to attain the desired number of interviews for each cell were released.

6.5 Additional Data Collection Strategies

Changes in the West Virginia economy since 2001 suggested the need to update the household survey through a supplement. In addition, information gaps have become apparent since the time of the SPG application. Additional funding has been requested for work on a supplemental survey that would be conducted in Year 2.

6.8 Recommendations for Other States on the Planning Process

Flexibility is important for responding to insights gained during the planning process as well as changes in the environment. For example, the WV project team quickly realized that the Health Advisory Council would be more effective for consensus building with a larger membership than originally envisioned. A serious deficit in the State's Medicaid budget underlined the critical importance of identifying solid revenue sources for any expansion as well as measures that could be used to slow cost inflation. As a result of these concerns, a study of other states' experiences with revenue-generation and program restructuring has been proposed for Year 2 and funding to support the study, requested.

While they may promise lower costs, projects should be wary of relying on data collection efforts by nonprofessional personnel. While the WVSPG had not planned on conducting outreach focus groups, an opportunity to collaborate with an advocacy organization presented itself. The plan was to explore attitudes of parents towards various promotional techniques and enrollment processes. For its contribution, the SPG invested staff time in preparing the screener and the discussion guide. However, because volunteers conducted the groups, standard research protocols were not followed in recruiting the participants and managing the discussion. As a result, the data gleaned were not usable by the SPG project.

6.9 Changes in State's Political and Economic Environment

Liberalized international trade resulting from the Trade Act of 2002 has had adverse affects on WV workers and retirees. Facing new economic straits, some companies have eliminated retirement benefits, forcing these workers onto the Pension Benefit Guarantee Corporation.

Many of the retirees and their spouses who have lost health insurance are under 65 and not in good health. They are included in the target population for the high-risk pool option under consideration by the SPG. The proposed supplement to the household survey taken in 2001 would document any change in health insurance levels among retirees and active workers since the original survey.

As noted above, the State's Medicaid crisis prompted new concern about sources of revenue and the need for stronger cost-control measures in public programs.

6.10 Changes in Project Goals

While the expansion of coverage to currently uninsured populations remains a goal of the project, the WVSPG project, concerned about rising health care costs and deteriorating economic conditions, has articulated a second project goal of maintaining the current levels of coverage in public and private health care programs.

Section 7: Recommendations to the Federal Government

This Section will be covered in the project's Final Report.

Attachment A

Major Events/Activities in Year 1*

Date	Event
October 2002	Meeting to develop communication strategy with Communication Consultant, American Institutes of Research
November 2002	Meeting #1 Full Health Advisory Council (HAC), Charleston, WV
January 2003-March 2003	Employer survey (500+ WV employers)
February 2003	Communication Plan presented to Communications Subcommittee of HAC
	Meeting #2 Full HAC, Charleston, WV
March 2003	Covering the Uninsured Week: Town meeting #1 with Governor, Charleston, WV Town meeting #2 with Governor, Wheeling, WV Issue Brief "The Uninsured in West Virginia: Putting a Human Face on the Problem of Uninsurance"
	Communication Plan finalized and adopted. Public Relations Consultant contracted.
	12 focus groups with small business employers, uninsured employees, and insurance agents
May 2003	4 outreach focus groups in partnership with the Community Voices project and the Healthy Kids Coalition
June 2003	Business Leadership Summit, Charleston, WV
	Meeting #3 Full HAC, Flatwoods, WV
	The Charleston Gazette begins series on the uninsured.

Attachment B

Major Events/Activities for Year 2

Date	Event/Activity
Summer 03	Town hall meetings in Charleston, Morgantown, Parkersburg and Wheeling (2 meetings) (Completed)
Fall 03	Additional Town hall meetings
	Issue paper on combined Medicaid/children's health insurance programs
	Issue paper on the role of the safety net
	Final report on the West Virginia Focus Groups
	Completion of data analysis and report on the WV Employer Survey 2003
	HAC Presentation on analysis of short-term expansion options including potential for HIFA waiver with supporting data
	Meeting #4 full HAC: Recommendations for policy options for presentation to the 2004 legislature
	Key informant interviews on options recommendations
Mid-Winter 03-04	Meeting #5 full HAC and Legislative briefing
January-February 04	Analysis of the effectiveness and efficiency of moving to a single, public program in WV
Spring 04	HAC Presentation on all short and long term policy options
Spring 04	Meeting #6 full HAC: Final recommendations for long-term strategies for extending coverage to all West Virginians
April-August 04	Filing of HIFA waiver application, if recommended
July-August 04	Preparation of Final Report for project
Ongoing 03-04	Media and public relations campaign and related informational materials
	Interface with Multi-State Integrated Database

Attachment C

Health Umbrella Group Members

Nancy Atkins, Commissioner, Bureau for Medical Services, DHHR

Johnna Beane, Research Assistant, WVU Institute for Health Policy Research

Fred Boothe, Commissioner, Bureau for Children and Families, DHHR

Gregory Burton, Acting Commissioner, Bureau of Employment Programs

Sharon Carte, Director, Children's Health Insurance Program

Sonia Chambers, Chair, WV Health Care Authority

Jane Cline, Commissioner, WV Insurance Commission

Chris Curtis, Acting Commissioner, Bureau for Public Health

Charles Dunn, Consumer Advocate, WV Insurance Commission

Carol Haugen, Executive Director, WV Health Care Authority

Tamara Lively, Medical Professional Liability Mgr., Board of Risk & Insurance Mgt.

Elizabeth D. Lovas, Assistant to the Governor

Phil Lynch, Deputy Secretary, Department of Health and Human Services

Randy Meyers, Director of Medicaid Managed Care, DHHR

Paul Nusbaum, Secretary, Department of Health and Human Services

Shana Kay Phares, Assistant to the Secretary, DHHR

Sally K. Richardson, Executive Director, WVU Institute for Health Policy Research

Phil Shimer, Deputy Director, Bureau of Employment Programs

Susan Small-Plante, Director of Constituent Services, Office of the Governor

Ann Stottlemyer, Commissioner, Bureau of Senior Services

Tom Susman, Executive Director, Public Employees Insurance Agency

Eugenie Taylor, Acting Commissioner, Bur. for Behavioral Health & Health Facilities

Governor Bob Wise, Governor of the State of West Virginia

Attachment D

Health Advisory Council Members*

Father Thomas Acker, Executive Director, Forward-Southern West Virginia, Beckley

H.M. Agee, Business Development Leader, The Dow Chemical Co., South Charleston

Judy Akers, Executive Director, Mercer, McDowell, Wyoming Mental Health Council, Inc., Princeton

Dr. Kenneth Allen, Wheeling

Paul E. Arbogast, Ernst & Young LLP, Charleston

Randy Atkins, Secretary/Treas. , Teamsters Local 175 Teamsters, Charleston

Honorable Billy Wayne Bailey, Senator, WV Senate, Pineville

Dr. Helen Baker, Professor, WV School of Osteopathic Medicine, Lewisburg

Doug Bentz, Administrator & CEO, Roane General Hospital, Spencer

David Biesemyer, Field Director, UMWA Health and Retirement Funds, Beckley

Jim Bowen, President, WVAFL-CIO, Charleston

Karen Bowling, President & CEO, Raleigh General Hospital, Beckley

Kathie Brown, CEO, Wheeling Health Right, Inc, Wheeling

Roger Bryant, Executive Director, Logan County EMS, Logan

Perry Bryant, Government Relations Specialist, West Virginia Education Association, Charleston

Sally Burchfiel, Clinical Associate, CED-WVU, Morgantown

Honorable Thomas W. Campbell, Delegate, WV House of Delegates, Lewisburg

Jack Canfield, Consultant, Jack Canfield, LLC, Charleston

Joe Carter, President, United Mine Workers of America, Charleston

Health Advisory Council Members*

Ashish Chandra, Assoc. Prof. of Health Care Administration, Marshall University Graduate School, South Charleston, WV

Mary Pearl Compton, Union

Randy Cox, Attorney at Law, Spilman Thomas & Battle, Charleston

Dr. Robert D'Alessandri, Dean, School of Medicine, West Virginia University, Morgantown

Stephen Dexter, CEO, Thomas Hospital, South Charleston

Vicki Douglas, Martinsburg

Fred Earley, Mountain State BlueCross/BlueShield, Parkersburg

John Elliot, CEO, AMFM Inc., Charleston

Donna Evans, Health Educator,WV Health Right, Charleston

Barbara Ferraro, Co-Director, Covenant House Incorporated, Charleston

Gail Foley, GCCF, Families First Council, Greenwood

Ron Forren, Acting Deputy Commissioner, Bureau for Public Health, Charleston

Dr. Albert Gelderman, Family Medical Care, Union

Paul Gilmer, Sr. Vice President, Life Bridge, United Way, Charleston

Richard Graham, CEO, Fairmont General Hospital, Fairmont

Judy Hale, President, West Virginia Federation of Teachers, Charleston

Dr. Clark Hansbarger, Associate Vice President, West Virginia University/Charleston Division, RCB Health Sciences Center, Charleston

Robert Hansen, CEO, Prestera Community Mental Health Center, Huntington

Robert Harman, CEO, Grant Memorial Hospital, Petersburg

Sister M. Jane Harrington SSJ, The Sisters of Saint Joseph Charitable Fund, Parkersburg

Elaine Harris, International Representative, WA-West Virginia Area, Charleston

Health Advisory Council Members*

Hilda Heady, Associate VP Rural Health and RHEP, West Virginia University, Morgantown

Tom Heywood, Attorney At Law, Bowles, Rice, McDavid, Graff & Love, Charleston

Jill Hutchinson, Director, WV Primary Care Association, Charleston

Evan Jenkins, Executive Director, WV State Medical Association, Charleston

Dr. Olen Jones, President, WV School of Osteopathic Medicine, Lewisburg

Tom Jones, President & CEO, WV United Health System, Fairmont

Sam Kapourales, Board Member, HCA, Charleston

Dr. Calvin A. Kent, Dean, Lewis College of Business, Marshall University, Huntington

Julia Kerns, President, WV Assn. of Local Public Health Depts, Grant County Health Department, Petersburg

Honorable Robert Kiss, Speaker, WV House of Delegates, Beckley

Betty Knighton, WV Center for Civic Life, Charleston

Barbara Koster, Nurse, Madison Medical Group, Madison

Sharon Lansdale, Director, Center for Rural Health Development, Dunbar

Honorable Margarette R. Leach, Delegate, WV House of Delegates, Huntington

Ivin Lee, WV Human Rights Commission, Charleston

Richard Mansuetto, Certified Senior Faciliator, Covenant Associates, Corporate Training/Development, Wheeling

Scott McClanahan, Director, Kanawha Valley Senior Services, Charleston

Dennis McCutcheon, RHEP Consortium Board, Lookout

Dr. Douglas McKinney, Physician, Bridgeport

Dr. Charles McKown, Dean, School of Medicine, Marshall University, Huntington

Rose Meredith, Director, Wayne County Senior Services, Wayne

Health Advisory Council Members*

Dr. Gregory Merrick, Schiffler Cancer Center, Wheeling

J. Holmes Morrison, Chairman & CEO, BB&T-West Virginia, Charleston

Jim Mylott, Executive Director, Mid Ohio Valley Regional Planning & Dev. Council, Parkersburg

Alvita Nathaniel, Nurse Practictioner, Private Practice, Princeton

Andy Paterno, President & CEO, Acordia of West Virginia, Charleston

Honorable Don C. Perdue, Delegate, WV House of Delegates, Prichard

Kenny Perdue, Secretary-Treasurer, West Virginia AFL-CIO, Charleston

Dr. Cynthia Persily, Associate Dean, WVU School of Nursing, Robert C. Byrd HSC/Charleston Division, Charleston

Dr. George Pickett, Charleston

Dr. Christopher Plein, Associate Professor, West Virginia University Division of Public Administration, Morgantown

Jennifer Plymale, Director, Robert C. Byrd Rural Health Center, Marshall University, Huntington

Julie Pratt, State Coordinator, Prevent Child Abuse West Virginia, Charleston

Dr. John Prescott, Senior Associate Dean, WVU School of Medicine, President and CEO, University Health Associates, Morgantown

Honorable Roman Prezioso, Senator, WV Senate, Fairmont

Louise Reese, Consultant, Dixon Odom PLLC, Clarksburg

Donna Renner, Director, Marion County Senior Services, Fairmont

Craig Robinson, Summers County ARH, Beckley

Mike Ross, Executive Director, NAMI WV, Charleston

Scott F. Rotruck, President, Morgantown Chamber of Commerce, Morgantown

Health Advisory Council Members*

Sharon Rowe, Director of Communications, Greenbrier Resort, White Sulphur Springs

Robert Rubicky, Director, Benefits & Medical Services, Weirton Steel Corporation, Weirton

James Schneider, Associate Dean for Finance & Administration, Marshall University, Huntington

Walt Shafer, Regional Manager, Pilgrims Pride Poultry, Moorefield

Carol Sharlip, Program Director, American Friends Service Committee, Nitro

Steven Shattls, CEO, Valley Health Systems, Huntington

Greg Smith, CEO, Mountain State Blue Cross/Blue Shield, Parkersburg

Roy Smith,WV State Building Trades, Charleston

Susi Smith, Managing Member, Majesty Consulting, Charleston

Susan Sobkoviak, Gov Relations Director, WV Chapter of NASW, Charleston

Savolia Spottswood, Project Director of Community Health Initiatives, Dunbar

Steven Summer, President, West Virginia Hospital Association, Charleston

Dennis Sutton, CEO, Children's Home Society, Charleston

Josha Sword, Member Benefit Coordinator, WV Federation of Teachers, Charleston

Michael Tierney, Director, Step by Step, Charleston

Nancy Tolliver, Director, WV Community Voices, Higher Education Policy Commission, Charleston

Honorable Earl Ray Tomblin, President, WV Senate, Chapmanville

Nancy Tonkin, President, Tonkin Associates, Charleston

Nancy Tyler, Staff, House Finance Committee, Charleston

Leigh Unites, Manager of Retiree Medical Plans, Dow Chemical, So. Charleston

Dana E. Waldo, President & CEO, West Virginia Roundtable, Charleston

Health Advisory Council Members*

Dr. Robert Walker, Dean, Marshall University School of Medicine, Huntington

Beverly Walter, Vice President, Claude Worthington Benedum Foundation, Pittsburgh, PA

Susan Walter, Director, Shenandoah –Potomac CAP, Martinsburg

Marilyn White, Board Member, HCA, Charleston

Patricia White, Director, WV Health Right, Charleston

Steve White, Director, Affiliated Construction Trades Foundation, Charleston

Robert Whitler, VP of Government and Community Affairs, Charleston Area Medical Center, Charleston

John Wiesendanger, CEO, WV Medical Institute, Inc., Charleston

Dick Wilson, CEO & Chairman, American Benefit Corporation, Huntington

Allison Wood, Director, Women's Commission, Charleston

Phil Wright, CEO, The Health Plan of Upper Ohio Valley, St. Clairsville, OH

Gary Zuckett, Consultant, Health Care for All, Pullman

* All locations are in West Virginia except where indicated otherwise.

Appendix I

Baseline Information	
Population	1,801,916 *U.S. Bureau of Census, 2001 (est.)*
Number and percentage of uninsured (current and trend)	***Current*** 16.2% overall for persons ages 0-64 (320,342 persons) with a wide disparity between non-elderly adults (19.9% for 291,971 persons) and children (6.6% for 28,371 children). ***Trend*** Current data are from the WV Healthcare Survey 2001, and comparable trend data are not yet available. Census data indicate that in 1997, 17.2% of the West Virginia population was uninsured.
Average age of population	38.9 years (median age) *U.S. Bureau of Census, 2000*
Percent of population living in poverty (<100 percent FPL)	17.9% *U.S. Bureau of Census, 1999*
Primary industries	1. Health and social assistance 2. Retail trade 3. Manufacturing *County Business Patterns, 2001*
Number and percent of employers offering coverage	19,688 private sector establishments (55% of the total) offer coverage *MEPS, 2000*
Number and percent of self-insured firms	6,261 private sector establishments that offer coverage self-insure (31.8% of those offering coverage) *MEPS, 2000*
Payer mix	Public Programs (Medicaid, Medicare, CHIP): 31% Employers (incl. State and Federal Government): 52% Individuals: 3% Uninsured: 14% *CPS , 2000-2001 (est)*
Provider competition	Minimal. Most counties (46 out of 55) have one or no hospitals. Many areas of the state are designated as Health Professional Shortage Areas (HPSA's). While some urbanized areas have an adequate physician supply, most areas of the state are underserved.

Baseline Information	
Insurance market reforms	? State COBRA expansion for firms with under 20 workers ? Small group market: pre-existing condition look back limited to 6 months, 12 month limit for duration of pre-existing condition, + or – 30% rating band for underwriting factors, age rating allowed, 65% minimum loss ratio
Eligibility for existing coverage programs (Medicaid, SCHIP, other)	? CHIP: up to 200% FPL ? Medicaid for children: up to 100 to 133% FPL depending on age ? Medicaid for pregnant women: up to 133% FPL ? Medicaid for custodial adults: less than 29% FPL
Use of Federal waivers	West Virginia has two 1915 b waivers—one for a primary care case management program, the other for Medicaid managed care. WV also has a 1915 c waiver for home-based services for the aged and disabled. There are no Section 1115 waivers.

Appendix II

Research Findings and Methodologies (Included on CD)

Uninsured Individuals and Families

II A WV Healthcare Survey 2001: Methodology and Survey Instrument

II B Health Insurance in West Virginia: The Children's Report

II C Health Insurance in West Virginia: The Non-Elderly Adult Report

II D Health Insurance in West Virginia: The Older Adult Report

II E Working Adults and Health Insurance in West Virginia

II F Slide Presentation: 42 Million Uninsured: Does It Matter?

II G Issue Brief "The Uninsured in West Virginia: Putting a Human Face on the Problem of Uninsurance"

Employer-Based Coverage

II H WV Employer Survey 2003: Methodology and Survey Instrument

II I Slide Presentation: West Virginia Employer Survey Results

II J Slide Presentation: Employer-Sponsored Health Plans Trends and Their Implications

Qualitative Research

II K WV Focus Groups: Methodology

II L WV Focus Groups: Screening Questionnaires

II M WV Focus Groups: Discussion Guides

II N Slide Presentation: West Virginia Focus Groups

Health Care Marketplace

II O Slide Presentation: Health Care Cost Increases-- How Do States Cope in a Changing Health Care Marketplace

II P Slide Presentation: Current Coverage Available in West Virginia

Options for Expanding Coverage

II Q Slide Presentation: HRSA State Planning Grants, A National Perspective

II R Literature Review on State Activities Related to Employer-Sponsored Insurance

II S Literature Review on State Activities Related to Individual Health Insurance

II T Slide Presentation: Approaches to Expanding Employer-Sponsored Health Insurance: Learning from Experience

II U Slide Presentation: Options to Expand Insurance Coverage in West Virginia

Consensus-Building Strategy

II V Communication Plan

II W Articles from **The Charleston Gazette** Series on the Uninsured

II X Multi-State Integrated Database: An Overview