INTERIM REPORT

West Virginia State Planning Grant

October 2004

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Executive Summary

During the 2003-2004 extension year, the West Virginia (WV) State Planning Grant (SPG) project continued the data collection, analytic and communication activities needed to develop the comprehensive plan for increasing health insurance levels in the state.

- Telephone surveys were completed with 1,600 households to identify changes in the level of health coverage and the characteristics of the uninsured since the original Healthcare Survey in 2001. Consistent with the expectation that the deteriorating economic conditions boded ill for insurance coverage, the survey found that the rate of uninsurance among non-elderly adults increased from 19.9 percent in 2001 to 21.7 percent in 2003. Preliminary survey results were presented to the SPG's Health Advisory Council in February 2004. (See below).

- Three subcommittees of the project's Health Advisory Council completed deliberations and made recommendations to the Council at the October meeting. The Benefits and Finance Subcommittee's report presented the options recommended for increasing health insurance levels over the short-term and reflected more than year's worth of research, analysis and testimony.

- The Governor used the SPG recommendations to develop his health insurance agenda for the 2004 Legislature. Three bills were enacted to support the expansion of health insurance coverage in the state. They include authorization for a high risk pool, a health benefit plan for small groups that would provide access to less costly coverage, and a plan for a CHIP expansion.

- Six focus groups were conducted in December 2003 to solicit input on two "affordable" benefit designs: an adult basic product for the small group market and a streamlined product ("Individual Health Access Plan") for the individual market.

- The Communication Plan, inaugurated in Year 1, continued to be implemented to keep the uninsured issue on the front burner for state policy makers, the public and other stakeholders. Milestones include:
  - A series of town hall meetings during the summer and fall in Charleston, Wheeling, Morgantown and Parkersburg.
  - Production of a video on the uninsured to be used by local community groups. (scheduled for completion in August).

- Final Reports were prepared for the WV Employer Survey and the Focus Groups with Employers, Uninsured Consumers and Insurance agents conducted in the previous project year. These reports were made available to the public on the project web-site.

- An in-depth background paper exploring the role of the safety net in caring for the uninsured in WV was completed and made available to the HAC. A paper exploring the administrative savings associated with simplified public insurance programs was also prepared.

- The Health Advisory Council (HAC), comprised of more than 100 leaders from key stakeholder groups, continued to meet as a full body and through its subcommittees to guide the planning process and formulate recommendations for expanding coverage. The Governor provided ongoing support to the project, appearing at town hall meetings and incorporating the SPG recommendations into his legislative agenda. The Health Umbrella Group (HUG), comprised of the executives of all State agencies involved in health care, continued to guide the SPG work.

Data Collection Activities: Quantitative Data

Uninsured Individuals and Families. Data from the **WV Healthcare Survey 2001,** conducted prior to the SPG project, have been critical for identifying the target populations for the coverage expansion and have been used extensively. In light of the difficult economic conditions experienced in the state since 2001, the SPG project deemed it important to update the survey to document changes in insurance coverage at least at the statewide level. This would assure that all recommendations were made in light of current circumstances. The SPG requested and received funding for a supplemental survey. Telephone interviews were completed with 1,600 households in December 2003 and January 2004. Analysis of these results show that the overall level of uninsurance in WV increased from 2001 to 2003. Separate reports are in preparation for children, non-elderly adults and older adults and will be completed during the second extension year.

Employers. Analysis of the results from the statewide **WV Employer Survey 2003** was completed during the extension year, and the final report was made available on the project web-site. This telephone survey included more than 500 employers from throughout the state and was conducted from January through March 2003.

Data Collection Activities: Qualitative Research

Six focus groups were conducted in December 2003 to solicit input on two "affordable" benefit designs: an adult basic product for the small group market and a streamlined individual product ("Individual Health Access Plan"). Uninsured low income and self-employed individuals, small business owners not offering health insurance, and agents and brokers participated in the groups. The groups were held in a variety of regions and each had 10-15 participants.

The final report on the qualitative research conducted during year 1 of the project was completed in October and made available on the project web-site. This research, conducted in March 2003, engaged 105 participants in 12 focus groups in 6 communities in different regions of the state. Participants were uninsured consumers, small employers, and agents and brokers. The research was undertaken to better understand the concerns and issues of these groups particularly as they pertain to health insurance.

Additional Data Collection: Secondary Research

Two background papers were prepared during the extension year: "The Impact of the Safety Net on the Uninsured in West Virginia" and "Single Public Programs and Administrative Costs". Analysis was also continued to identify alternative financing sources for public programs.

Summary of Health Insurance Situation in West Virginia

During the period between the initial statewide survey in 2001 and the supplemental survey in 2003, the situation in West Virginia with respect to health insurance worsened. The proportion of non-elderly adults without health insurance increased from 19.9 to 21.7 percent. Even among children, who as a group have enjoyed a high rate of insurance owing to WV's efforts on their behalf, the uninsurance rate increased from 6.6 to 7.7 percent. Uninsured adults are less likely to be employed than they were previously, testifying to the impact of unemployment in the state. The likelihood of being uninsured shifted among regions with the northwest region, including the northern panhandle, now having the highest rate of uninsurance among non-elderly adults.

Small firms, firms with high proportions of low wage workers, those with low proportions of full-time employees and those in the construction and retail industries are the least likely to offer coverage to their employees. The greatest numbers of workers without access to employer-based insurance are employed by the retail and service industries. Among uninsured consumers, cost is the most frequently cited reason for not having insurance, including those instances where an employer offers coverage. The overwhelming reason for a firm's not offering health insurance is also cost. Nonetheless, 18-25 percent of small and midsize employers surveyed in 2003 indicate they would be willing to pay $100 in monthly premiums for this insurance.

Work on Policy Options

The work on option development has been carried out largely by the joint Benefits and Finance Subcommittee of the HAC with staff support from the WVU Institute for Health Policy Research and actuarial and benefits consultants. This work culminated in a series of recommendations to the full HAC in October. Three of the recommendations were embraced by the Governor as policies for immediate action and included in his agenda for the 2004 Legislative session. As result, three bills were passed that would support increased levels of health insurance in the state. They include authorization for a high-risk pool, a public/private partnership around a product for uninsured small groups, and a plan for CHIP expansion. Additional strategies are under consideration by the SPG and will be included in the legislative recommendations for 2005 or form part of the project's final recommendations to be issued in mid 2005.

As part of the options analysis, the Subcommittee designed basic insurance products that would be affordable in the small group and individual markets. Input for these products had been obtained at the focus groups conducted in early 2003. Considerable actuarial work was done during the extension period to assure that the products did not exceed premiums considered "affordable" by the target purchasers. Preliminary designs for these products were included in the recommendations made to the HAC in October. The products were then tested in focus groups in December 2003 and will be available for use with the strategies selected for increasing levels of health insurance in the state.

Attachments

Major events and activities in the 2003-2004 extension year are summarized in Attachment A. Activities and events anticipated for the 2004-2005 extension year are shown in Attachment B.

Section 1. Uninsured Individuals and Families

Data from the WV Healthcare Survey 2003 are still being analyzed. Preliminary data are presented, when available. Otherwise, the data presented are from the WV Healthcare Survey 2001. In any case, data from the 2003 supplemental survey do not allow the detailed estimates afforded by the earlier survey.

Overall Level of Uninsurance

West Virginia experienced a worsening of uninsurance levels between 2001 and 2003. Among adults ages 19-64 uninsurance levels increased from 19.9 percent to 21.7 percent. Even among children, a group that WV had been extraordinarily successful in reaching through public programs, the uninsurance rate climbed from 6.6 percent to 7.6 percent. A total of more than 270,000 persons were uninsured. These declines in coverage are attributable largely to an unfavorable economic climate which saw many job losses and company bankruptcies. In addition, children's participation in public programs appears to have declined.

Virtually all adults age 65 and over have some insurance from Medicare, although more than one-third do not have supplemental coverage or have only Part A. *(WV Healthcare Survey 2003)*. Because of their large burden from pharmaceutical expenses, the SPG had identified the elderly without drug coverage as an underinsured group, worthy of targeting by the project. However, this priority has changed with the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Characteristics of the Uninsured

Age. Non-elderly adults ages 19-64 dominate the uninsured population, accounting for 89 percent of the uninsured in West Virginia. Children ages 0-18 account for 11 percent of the state's uninsured.

Among uninsured adults, the young middle-aged group (ages 26-34) is the most prominent, constituting 27 percent of the total. Among uninsured children, just over half (52 percent) are ages 11 and under; the remaining 48 percent are ages 12-18.

Age	**% of Uninsured Non-Elderly Adults**
All	100%
19-25	17%
26-34	27%
35-44	24%
45-49	10%
50-64	22%

Source: WV Healthcare Survey 2003

Gender. Women make up 53 percent of uninsured non-elderly adults. At ages 19-25 males account for more of the uninsured with the proportion shifting to females at older ages. At ages 50-64, there are 1.75 as many females uninsured as males.

	Both	**Males**	**Females**
All non-elderly uninsured adults	100%	47%*	53%
Ages 19-25	17%	10%	7%
Ages 26-34	27%	13%	14%
Ages 35-44	24%	11%	13%
Ages 45-49	11%	6%	5%
Ages 50-64	22%	8%	14%

** rounding error*
Source: WV Healthcare Survey 2003

Family Composition. Most uninsured adults, 59 percent, are married. Twenty-three percent have never been married, and the remaining 18 percent are either divorced, separated or widowed.

Marital Status	**% of Uninsured**
Married	59%
Divorced	14%
Separated	2%
Widowed	2%
Never married	23%
All	100%

Source: WV Healthcare Survey 2003

Income. The majority of uninsured adults (80 percent) have incomes below $30,000. Only a proportion of those in the lowest income bracket (below $10,000) are currently eligible for public programs. Seventy-five percent of uninsured children are in families with incomes below $30,000. For families of 3 or more, this is below 200 percent of the FPL. Thus many of these children are eligible for public programs at current eligibility levels.

Income	**% Uninsured Adults**	**% Uninsured Children**
Below $10,000	20%	7%
$10,000 to $19,999	35%	36%
$20,000 to $29,999	25%	32%
$30,000 to $39,999	12%	18%
$40,000 to $49,999	4%	6%
$50,000	4%	2%
All incomes	100%	100%*

** rounding error*
Source: WV Healthcare Survey 2003

Race/Ethnicity. The likelihood of being uninsured was slightly higher among African-Americans and other ethnic groups, than it was for the white/non-Hispanic population in 2001.

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

Source: WV Healthcare Survey 2001

However, since WV has a very small minority population, about 5 percent of the total, most of the uninsured population is white/non-Hispanic.

A close-up look at West Virginia's African-American population found disparities between the African-Americans living in Raleigh and Mc Dowell counties, where 22 percent of the state's African-American population lives, and African-Americans in other parts of the state. Uninsurance is higher among non-elderly adults in these counties, 24 percent compared to 18 percent in the rest of the state. On the other hand, the uninsurance rate for African American children in Raleigh and McDowell is more favorable than the rate for African American children elsewhere in the state, 4.5 percent compared to 8.0 percent elsewhere. *(WV Health Care Survey 2001.)*

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

Geographic Location-Regions. Between 2001 and 2003, the severity of the uninsurance problem shifted among the regions of the state. Region 3 (the northwest including the northern panhandle) went from being the region with the most favorable rate (16 percent) to that with the most unfavorable rate (25 percent). This region was disproportionately affected by plant closings and bankruptcies particularly in the steel industry. The uninsurance rates in the other regions remained stable between the surveys.

Region	% Non-Elderly Adults Who Are Uninsured (2001)	% Non-Elderly Adults Who Are Uninsured (2003)
1	22%	22%
2	21%	20%
3	16%	25%
4	20%	20%

Sources: WV Healthcare Survey 2001 and WV Healthcare Survey 2003

Employment Situation. The employed, including those who are self-employed, represent 50 percent of the uninsured non-elderly adults in West Virginia in 2003, nearly 120,000 persons. This is a significant change from 2001 when 61 percent of the uninsured were employed and reflects, among other things, the toll unemployment has taken on West Virginia.

Employment Status	% of Uninsured Non-Elderly Adults (2001)	% of Uninsured Non-Elderly Adults (2003)
Employed	46%	37%
Self-employed	15%	12%
Unemployed	14%	21%
Homemaker	13%	17%
Disabled	6%	9%
Student	4%	4%
Retired	2%	<1%
All groups	100%	100%

Sources: WV Healthcare Survey 2001 and WV Healthcare Survey 2003

Workers most likely to be uninsured are those with temporary or seasonal employment, those working less than 40 hours and those with multiple employers 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%

Source: WV Healthcare Survey 2001
Note: Comparable data are not yet available from the 2003 survey.

Data from the 2001 survey provide further details on the characteristics of the working uninsured. 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 were uninsured in 2001.

The largest numbers of uninsured workers (55 percent) are concentrated in firms of under 50 workers. It is the workers in the small firms of less than 10 workers and in midsize 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 major firms of 100+ workers.

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). *(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 indicate the likelihood of coverage by industry*.)

Duration of Uninsurance. The majority of uninsured adults, 81 percent, are chronically uninsured. They have been uninsured for 1 year or more or have never had coverage. The minority, 15 percent, have been uninsured for less than 1 year.

Among uninsured children, about half have been without coverage for less than 1 year. The other half are chronically uninsured (more than 1 year or never had coverage.)

Length of Time Uninsured	% of Uninsured Adults	% of Uninsured Children
Less than 1 year	15%	46%
More than 1 year or never had insurance	81%	48%
Do not know	4%	6%
Total	100%	100%

Source: WV Healthcare Survey 2003

Health Status and Health Care Situation of the Uninsured. Uninsured adults in 2003 reported their health status to be somewhat less favorable than reported by the uninsured population in 2001. The proportion reporting "excellent" or "very good" health declined, while an increased proportion rated their health as "good" or "fair". The reported health status of uninsured adults tends to be consistently less favorable than that reported by persons with insurance.

The health status of uninsured children was also somewhat less favorable in 2003 than in 2001."Excellent" or "very good" health was reported for a smaller proportion of uninsured children than previously, with a greater proportion having "good" or "fair" health. Almost no uninsured children were characterized as having "poor" or "very poor" health in 2003. Insured children are consistently more likely to report "excellent" or "very good" health than uninsured children.

Health Status	% of Uninsured Adults (2001)	% of Uninsured Adults (2003)		% of Uninsured Children (2001)	% of Uninsured Children (2003)
Excellent or very good	44%	33%		67%	59%
Good or fair	46%	55%		32%	41%
Poor or very poor	11%	11%		1%	0%
All	100%*	100%*		100%	100%

**rounding error*
Sources: WV Healthcare Survey 2001 and WV Healthcare Survey 2003

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).*

In 2001, 39 percent of uninsured adults and 26 percent of uninsured children did not have a regular source for care. Of adults who had a regular source of care, about half received 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).*

By 2003, the percent of uninsured children without a regular source of care increased to 30 percent and uninsured adults without a regular source of care rose to 41 percent. However, the ability to access needed care improved. Only 4 percent of uninsured children reported in 2003 that they did not receive needed care compared to 16 percent who reported they failed to receive needed care in the previous survey. In 2003, uninsured children were also somewhat more likely to have visited a health care provider in the previous six months than they were in 2001, 69 percent of the uninsured children in the 2003 survey compared to 52 percent in the earlier survey.

The situation for uninsured adults, however, worsened. Fifty-one percent of uninsured adults report they are unable to get needed medical care in 2003, an increase from 41 percent in 2001. *(WV Healthcare Surveys 2001 and 2003).*

Availability of Coverage in West Virginia

Enrollment in Public Coverage. At 59 percent, children comprise the majority of participants in income-based public insurance programs (Medicaid and CHIP) in West Virginia. Twenty eight percent of all WV children are on Medicaid or CHIP. Seven percent of adults are on Medicaid. For children, income-based public coverage is currently available up to a family income of 200 percent FPL. Custodial adults are eligible for Medicaid only up to a family income of 29 percent FP, and categorically eligible adults, up to 74 percent FPL.

Age Group/Program	% of Income-Based Public Program Enrollment	% of Age Group in Income-Based Public Program	% of Insured Population in Income-Based Public Program
Children/ Medicaid or CHIP	59%	28%	30%
Adults ages 19-64/ Medicaid	41%	7%	9%

Source: WV Healthcare Survey 2003

Additionally, <1 percent of children and 2 percent of non-elderly adults in WV are covered by Medicare, which does not have an income criterion.

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. The main complaints revolve around eligibility rules and difficulty in locating providers. *(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 in Medicaid).*

Disenrollment from Public Programs. No individuals participating in focus groups indicated they were uninsured because they had disenrolled or been terminated from a public program. One participant expressed concern that his children would lose CHIP if his income increased over the program limit, suggesting that some disenrollments are due to improved economic situations. *(WV Focus Groups 2003 & Benefit Focus Groups 2003).*

Data indicate that a significant proportion of disenrollment from public programs (CHIP and Medicaid) occurs because of failure to recertify. "Churning"---disenrollment then reenrollment--creates gaps in coverage and adds to administrative costs. When public programs are not coordinated (lack "seamlessness") and have overly complex rules, enrollment levels (and overall health insurance levels in the state) are affected. In addition, lack of coordination and administrative complexity add to program costs.

To address the various problems that arise from lack of coordination, West Virginia has already taken a number of steps to integrate Medicaid for children and the Children's Health Insurance Program (CHIP), particularly in the application and renewal processes. For example, an on-line application for both programs has been introduced, and a simplified renewal process for CHIP started December 2003. The adult component of Medicaid, however, is not coordinated with the children's component and has its own requirements and processes.

How the state operates its public insurance programs has a direct bearing on how these programs contribute to the overall level of health insurance in the state. Cognizant of these realities, the SPG project commissioned a background paper on "single public programs", which explores the issues of simplification and seamlessness. While it was understood that these attributes might improve enrollment levels, the Committee was also interested in documenting their impact on administrative costs. This paper, completed in March 2003, will serve as a resource as the Committee prepares its long-term recommendations related to public insurance programs.

Private Coverage. About 82 percent of employed non-elderly adults have employers who offer health insurance. Some 77 percent of employed adults are eligible for employer coverage, and 68 percent of employed adults have employers who offer dependent coverage. *(Note: These figures exclude self-employed individuals).*

Availability of Private Coverage	% of Employed Adults
Employer offers health insurance	82%
Eligible for employer health insurance	77%
Employers offer dependent coverage	68%

Sources: WV Healthcare Survey 2003 and WV Healthcare Survey 2001

Overall, participation in employer-sponsored coverage is fairly high. Almost half of all employers in every size band report that 75 to 100 percent of their employees take company health insurance. For at least 80 percent of companies in every size band, the take-up rate is more than 50 percent. *(WV Employer Survey 2003)*

Employers offering insurance believe the most important reason their employees do not participate is that they already have access to coverage through their spouses. (Reported by 67 percent of offering employers). Cost (reported by 18 percent) was believed to be the second most significant reason. Only 2 percent of employers believe their employees do not participate because they "do not need or want" coverage. *(WV Employer Survey 2003).*

Among uninsured individuals cost is the most important reason for not having insurance, even when coverage is offered through work. *(WV Focus Groups 2003).*

Workers Attitudes toward Employer-Based Insurance. Observations from focus groups suggest that workers look to employers for health insurance coverage. Small business owners emphasize the importance of benefits, including health insurance, in attracting and retaining a reliable workforce. Brokers reiterate the importance of these workforce issues in the coverage decisions made by their small group customers. Responses from uninsured individuals also reveal an expectation that health insurance is linked to the workplace. Focus group participants cite "job loss" as the reason they do not have health insurance. *(WV Focus Groups 2003).* Twenty-two percent of uninsured individuals in WV attribute their uninsured status to "job related factors." *(WV Healthcare Survey 2003).*

Since employer-based insurance involves an employer contribution, the affordable benefit package can be richer than what is offered in the individual market, assuming that the expense to the individual would be the same. Thus in the current environment an individual would be better off with employer-based coverage than what he or she could purchase on his own. However, a change in the current environment—for example, individual tax incentives or a direct public subsidy to the individual—could allow the individual access to a more attractive product on his/her own. The consultants' analysis of these options, however, clearly identified them as the most costly with respect to state general revenue requirements.

Some small employers participating in the focus groups preferred a streamlined individual product to a low cost group product, presumably because of their perceived inability to provide employer-sponsored coverage. *(Benefit Focus Groups 2003).*

The SPG will continue to deliberate the relative merits of employer-based versus individual solutions as it formulates its long-term recommendations; however, the recommended options are likely to be a mix of the two, as they have been to date. (See below).

Underinsurance. Survey data pertaining to kind of coverage (comprehensive, hospital only or dread disease) are being analyzed. However, the SPG believes that most of the insured non-elderly population in West Virginia has comprehensive coverage.

While virtually all older adults age 65 and over have Medicare, not all seniors have comprehensive coverage. Thirty-four percent of older adults have Medicare Parts A and B but no supplement and another 4 percent have only Medicare Part A. About 35 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. However, this situation should be somewhat ameliorated when prescription drug coverage becomes available through Medicare in 2006.

Reasons for Being Uninsured. Uninsured adults (47 percent of survey respondents) are most likely to give the "high cost of premiums, copayments and deductibles" as their reason for being uninsured. Another 22 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. *(WV Healthcare Survey 2003).* 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 appears to 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 not having coverage. *(WV Healthcare Survey 2001).*

Population Groups Important in Developing Targeted Coverage Expansion Options

After a consideration of the data on the characteristics of the uninsured and the availability of coverage in West Virginia, the following were identified as target populations in need of coverage solutions:

Low income working adults. Most uninsured adults in West Virginia are employed (50 percent) and the majority (about 80 percent) are low income and 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 up to 300 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, while 19 percent believed they could pay $100 or more.

Low income Medicare beneficiaries without prescription drug coverage. More than one-third of all seniors do not have drug coverage. This priority has changed, however, since the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Medically uninsurable adults. In the current regulatory environment, these persons cannot obtain coverage in the private market.

Non-custodial adults. This group is not eligible for Medicaid at any income level. The project determined early on that expanding Medicaid to cover non-custodial adults even up to 100 percent 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 as a possible long-term strategy. The project is also looking at the adequacy of the "safety net" for otherwise meeting the health care needs of non-custodial adults.

Developing the Plan for Coverage Expansion

What is Considered "Affordable". Participants in the "Benefits" focus groups, who indicated that their initial focus was on costs rather than benefit design, seemed to gravitate to a price point of about $100 per month. When queried privately, uninsured and self-employed participants indicated that the price of $140 estimated for the streamlined individual product (Individual Health Access Plan) had appeal for them. *(Benefit Focus Groups 2003).*

Uninsured consumers participating in earlier focus groups felt it was very important to have low or zero deductibles and low copayments even if it meant paying a substantially higher premium each month. The premium variations tested ranged from $50 to $100. *(WV Focus Groups 2003).*

Features of an Adequate, Barebones Benefit Package. Guided by the input provided by participants in focus groups conducted in year 1, the project has been working on two affordable benefits packages: one for small groups and one for the individual market. The final products

will be used in conjunction with the recommended strategies for increasing insurance levels in the state.

In these early focus groups, uninsured consumers, employers, and brokers and agents, presented with a 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.

The participants were also asked to indicate their preferences for the plan's financial structure by comparing a lower premium plan with higher deductibles and copayments to a higher premium plan with lower deductibles and copayments. The uninsured consumers overwhelmingly preferred to have a higher monthly premium and pay less out of pocket at the point of service. Small business owners were more mixed in their response. About half were more interested in the low premium product since it would keep their own costs down. They also felt higher out of pocket costs would discourage overuse of services.

The Benefits and Finance Subcommittee worked with actuarial and benefits consultants to develop affordable benefit packages: an adult basic plan for the small group market and a streamlined product (the Individual Health Access Plan) for the individual market. The latter is based on a plan that has been proposed in Arkansas. Details of the benefit designs to date were included in the recommendations presented to the SPG's Health Advisory Council by the Benefits and Finance Subcommittee in October 2003.

Six focus groups were conducted in December 2003 to obtain reactions to the designs. While participants had many questions about the details of the benefits, more than half (57 percent) of the 30 individuals participating indicated that the Individual Health Access Plan had appeal for them, 20 percent indicated it did not and 23 percent were undecided. (Participants were asked to respond privately). Participants also voiced concern about "flexibility", wanting to assure that their specific needs, particularly for medications and physician office visits, were addressed by the coverage. The price of $140 was appealing. Benefits highlights are shown below.

Benefit Highlights: Individual Health Access Plan

Cost-Sharing	**Amount**
Deductible (medical/surgical)	$250
Deductible (drugs)	$75
Service	**Benefits**
Hospital days	7 per year
Outpatient visits	6 per year
Outpatient surgery	1 procedure per year
Maintenance prescriptions	2 per month
Estimated Premium	***$140 month***

The questionnaire used with the individuals and small group owners also explored attitudes toward plan structure and service delivery. About 40 percent of the participants indicated they would be willing to consider a limited benefit plan and another 40 percent would consider an annual benefit limit in order to have an affordable plan. Only 10 percent favored a high cost-

sharing plan with a $10,000 cost-share maximum. The majority of the participants (almost 60 percent) indicated they would accept a plan that uses a limited network.

Potential Influence of Subsidies, Tax Credits or Other Incentives. Based on the experience in other states that have used "state only" funding to provide health insurance coverage to persons in the individual market, West Virginians would respond favorably to a directly subsidized program. As part of its research on potential options for the individual market, the SPG project looked at several states that use "state-only" funding for such programs and found them to be very successful in enrolling their target populations and thus contributing to improved health insurance levels. The programs make a specific benefit package available at no or low cost or may help a low-income person buy coverage in the regular individual market. While some programs include all low-income persons, many focus on a specific segment of the uninsured, individual market. Financing for these programs comes from a variety of sources. These programs succeed in making coverage accessible and affordable. They can be used to target specific groups within the individual market and may be the only recourse for certain segments of this market. The main difficulty is such programs require a substantial financial commitment from the state for the premium subsidies. They also involve program development and ongoing administrative costs.

As part of the research on other states' activities in the individual market, the SPG also examined the potential for tax credits or other incentives. Analysis of this strategy identified both advantages and difficulties.

Advantages

- A tax-based approach leaves the choice of coverage to the individual and builds on the existing tax and insurance systems. It requires neither program development nor a new administrative apparatus. Start-up and administrative costs are low.
- It might be more politically palatable to encourage health insurance through diminished state taxes rather than through an outlay of new funds.

Difficulties

- Tax incentives, whether they are credits or deductions, do not cover a significant portion of the premium. Thus their effectiveness in spurring new insurance purchases is doubtful. A deduction in particular has limited value to a low-income person who may not owe taxes or to a self-employed person who does not show a profit. Even a refundable credit can pose a problem for a low-income person who would need to pay for the insurance up-front and would only receive the credit at the end of the tax year.
- A tax incentive cannot encourage someone to buy insurance when it is not accessible either due to medical underwriting restrictions or high premiums.

The consultants' financial analysis of direct subsidies and tax-related incentives clearly identified them as the most costly options with respect to state general revenue requirements. While they will be addressed in the project's final recommendations, the prospect for these approaches is not encouraging given the state's financial situation.

Section 2: Employer-Based Coverage

The final report from a statewide employer survey was completed October 2003. The survey was fielded January-March 2003 and involved interviews with 500 employers. Preliminary data were provided in the previous Interim Report and are repeated here as appropriate. Benefit Focus Groups, which included small business owners and agents and brokers as participants, were conducted in December 2003. The final report from earlier focus groups became available in October 2003. Preliminary data from these groups were provided in the previous Interim and are repeated here, when relevant.

Characteristics of Companies Offering/Not Offering Coverage

Overall survey results show that the factors most associated with a company's offering health insurance to its employees in rank order are size of company, employee earnings and percentage of full-time employees**.**

Employer Size. Large companies (50-99 employees) and major companies (100 or more employees) are most likely to offer health insurance with 94 percent of the former and 98 percent of the latter doing so. Small companies (4-9 workers) are the least likely to offer health coverage with 52 percent not doing so. This group of non-offerors includes at least 8,000 firms and affects an estimated 20,000+ workers. While a smaller proportion of midsize employers with 10-49 workers (27 percent) do not offer coverage, this is estimated to involve at least 1,000 companies and affect over 20,000 workers. ***Groups under 50 workers were thus identified as a primary target for the coverage expansion strategy.***

Self-employed workers are not part of the small group market in West Virginia. However, data from the Healthcare Survey 2001 indicate that 36 percent of self-employed workers are uninsured.

Size of Company	**% Offering***	**% Not Offering ***	**Total WV Firms****	**Total WV Employees****
Small employers (4-9 workers)	48%	52%		
5-9 workers			*15,475*	*39,975*
Midsize employers (10-49 workers)	73%	27%		
10-19 workers			*3,697*	*46,774*
20 to 99 workers			*2,901*	*105,062*
Large employers (50-99 workers)	94%	6%		
Major employers (100+ workers)	98%	2%	1,803	330,785

**Source: WV Employer Survey 2003*

*** Source: Statistics of U.S. Businesses: 2001, West Virginia – All Industries*

Industry Sector. The construction industry is the least likely to offer health coverage in WV with 62 percent of the firms not doing so. Retail trade follows with 53 percent of firms not offering coverage. The industry most likely to offer coverage is manufacturing with 81 percent of the firms providing coverage.

The impact on insurance levels is, however, a function of the number of firms and workers in the industry. The service industry where a substantial proportion (64 percent) of employers offer coverage, in fact, has the largest number of groups not offering insurance (5,900) because of the tremendous size of the industry. The retail trade industry is second with over 4,000 companies not offering coverage. The service and retail trade industry are first and second respectively in the numbers of workers they employ thus larger numbers of workers are affected, an estimated 82,000 in the service industry and 46,000 in retail trade. ***These industries particularly when they involve small and midsize groups will also be targeted in the expansion initiative through, for example, directed marketing.***

Industry	**# Firms***	**% Firms Not Offering****	**# Not Offering**	**# Workers***	**Est. # Not Offered Insurance**
Construction	4,286	62%	2,657	27,450	17,000
Retail trade	7,713	53%	4,088	87,622	46,000
Agriculture, forestry, fishing	364	49%	178	1,000-2,499	500-1200
Finance & real estate	3,779	47%	1,776	37,583	18,000
Services	16,390	36%	5,900	227,322	82,000
Mining	653	34%	222	19,956	7,000
Wholesale trade	1,800	28%	504	21,631	6,000
Trans., comm., elec., gas, sanit.	3,168	25%	792	51,311	13,000
Manufacturing	1,471	19%	279	72,454	14,0000

** Source: U.S. Census Bureau, County Business Patterns 2001*
*** Source: West Virginia 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.

The propensity of companies with predominantly low wage workers to not offer coverage means that many workers at risk for not having coverage may not be able to afford much in the way of premiums if and when coverage becomes available.

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%

Source: WV Employer Survey 2003

Percentage of Full-Time Vs. Part-Time Workers. The likelihood of offering health insurance in general increases as the percentage of full-time workers in a company increases. Companies with less than 25 percent of their workers full-time are the least like to offer coverage with only 31

percent doing so. Once full-time workers constitute more than 75 percent of a company's workforce, 63-68 percent of the companies offer health insurance. ***These data reiterate the importance of viewing part-time workers as an at risk group for being uninsured.***

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%

Source: 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). ***Special efforts to reach rural employers will need to be made when implementing expansion programs.***

Situation with Employers Who Offer Coverage

Contribution Levels. Sixty-two percent of all companies offering health insurance pay 75 to 100 percent of the "employee only" premium. Among major companies of 100 or more workers, none pay less than 50 percent of the "employee only" premium. Among small companies, 93 percent contribute at least 50 percent and among midsize companies 94 percent do so. ***Overall, these data suggest that when employers offer health insurance, they are willing to contribute at least 50 percent of the cost.***

% of "Employee-Only" Premium Paid by Company

	Any level	Less than 25%	25 to less than 50%	50 to less than 75%	75 to 100%
% of all employers	100%	2%	4%	32%	62%
% of small employers	100%	2%	5%	26%	67%
% of midsize employers	100%*	2%	2%	40%	54%
% of large employers	100%*	7%	7%	20%	67%
% of major employers	100%	0%	0%	47%	53%

** rounding error*
Source: WV Employer Survey 2003

The issue of dependent coverage is important for the many spouses who do not have access to their own employer-based insurance as well as for children. Among the uninsured adults, 17

percent report they are homemakers. *(WV Health Care Survey 2003).* Overall, the percentage contributed by employers for dependent coverage is less than that contributed for the employee. More than half of all companies pay 50 percent or more toward dependent coverage. Among small employers, 64 percent contribute 50 percent or more and among midsize companies, 58 percent pay 50 percent of more of the dependent premium.

% of Dependent Premium Paid by Company

	Any level	**Less than 25%**	**25 to less than 50%**	**50 to less than 75%**	**75 to 100%**
% of small employers	100%*	31%	6%	22%	42%
% of midsize employers	100%*	37%	4%	28%	30%
% of large employers	100%*	27%	7%	20%	47%
% of major employers	100%*	17%	14%	34%	34%

** rounding error*
Source: WV Employer Survey 2003

Large employers (50-99 employees) are the most likely to offer health insurance to retirees with 29 percent doing so followed by major employers (100+ workers) with 26 percent offering coverage. Only 6 percent of small employers and 10 percent of midsize employers do so.

This does not; however, give a full picture of the retiree health insurance situation, since some workers may receive benefits through unions. The United Mine Workers, for example, has a major presence in West Virginia. The likelihood of WV firms offering retiree health insurance appears generally in line with the experience nationally. The issue of retiree health coverage is particularly important for persons ages 50-64 who are likely to have health conditions that would otherwise render them uninsurable.

Percentage of Employees Offered Coverage Who Participate. When coverage is offered, participation appears to be fairly high with almost 50 percent of companies in all size bands reporting a take up rate of 75 percent or more and at least 80 percent of companies reporting a take of 50 percent or more. Workers in small and midsize companies who are offered insurance are no less likely to take it than are workers in larger firms.

Size of Firm	**Any take-up**	**Less than 25%**	**25% to < 50%**	**50% to < 75%**	**75% to 100%**
% of small firms	100%	6%	10%	29%	55%
% of midsize firms	100%*	10%	10%	35%	46%
% of large firms	100%*	12%	6%	25%	56%
% of major firms	100%	11%	5%	35%	49%

**Rounding error*
Source: WV Employer Survey 2003

Reason for Not Taking Employer-Based Coverage. The majority of employers (67 percent) believe that 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 employers believed the main reason their employees do not take coverage is that it is too expensive. Only a very small minority (less than 2 percent) believe employees do not take coverage because they do not need or want it. In general, the same reasons for not taking employer-based coverage prevail among employees in small and midsize firms.

Reason for Not Taking Coverage	% of Small Employers	% of Midsize Employers
Covered by spouse's plan	71%	67%
Covered by some other source	12%	9%
Too expensive/price	15%	22%
Do not need or want	1%	2%
Other	1%	0%
All reasons	100%	100%

Source: WV Employer Survey 2003

Premium Increases. Most employers, regardless of size, who offer coverage report annual premium increases, although the largest employers are somewhat less likely to do so. The survey did not collect data on the size of the increase thus the severity of the burden, particularly among different size companies, is not discernable.

Size of Employer	All Employers	% with Premium Increase	% with No Change	% with Premium Decrease
Small employers	100%	82%	14%	4%
Midsize employers	100%	94%	5%	1%
Large employers	100%	94%	6%	0%
Major employers	100%	72%	23%	5%

Source: WV Employer Survey 2003

Self-insured companies, which tend to be the larger companies, may be in a better position to hold down their cost increases and these may not be as large as those imposed in the small group market. ***Nonetheless, these data suggest the importance of cost containment strategies as part of the overall effort to maintain and increase health insurance levels.***

Responses to Premium Increases. Employers facing premium increases shift more cost to the employees through increased cost-sharing and/or premiums. Some change the plan type or insurance company. *(WV Employer Survey 2003).*

Actions when Facing Premium Increases

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%
Change type of plan	20%	33%	25%	14%
Discontinue coverage for some or all workers	2%	5%	6%	6%

Source: WV Employer Survey 2003
** Exceeds 100% since an employer might take more than one action.*

While only a small proportion of employers discontinues coverage altogether when faced with cost hikes, their workers are at high risk for joining the ranks of the uninsured, thereby eroding any progress made in increasing levels of coverage in the state. Similarly, an increased financial burden on workers in the form of higher premiums may lead to their dropping coverage. If heftier copayments are imposed, they may postpone needed care. One of the stated goals of the SPG is to protect current health insurance levels. To the extent that cost increases jeopardize these levels, cost containment initiatives are an area for SPG concern. ***The formation of a Cost Containment Council is one of the options under consideration for inclusion in the project recommendations. (See below).***

Susceptibility to "Crowd Out". Firms susceptible to "crowd out" include:

- Economically strapped employers who are struggling to keep up with premium increases. Eighty-two percent of small businesses and 94 percent of midsized groups report they face annual premium increases. (*WV Employer Survey 2003)*
- Firms with low income employees who become income eligible for coverage as a result of a public program expansion. While firms with a predominance of low income employees are the least likely to offer health insurance, the 28 percent that do so are at risk for "crowd out".
- Firms providing dependent coverage if the income level for CHIP is raised.

To address potential "crowd" out as well as support the provision of additional dependent coverage, the SPG is exploring the feasibility of a CHIP "buy-in". It would be available for children in families with incomes up to 300 percent FPL, when a parent has employer-based coverage.

Understanding the Non-Offerors

Reasons for 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. Among small groups, 82 percent give "too expensive/cannot afford it" as a reason for not providing coverage and it is the reason indicated by 84 percent of midsize employers.

Reason for Not Offering Coverage	% of Non-Offerors
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%
All reasons	100%

Source: 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).* Among employers with 20 or fewer employees, cost is the greatest barrier to coverage. *(Benefits Focus Groups 2003).*

Amount Willing to Pay. The majority of employers not offering coverage (57 percent) indicate that they are not willing to pay anything or less than $50 toward coverage. Nonetheless, a significant minority (19 percent) indicate they are willing to pay $100 or more. Among small employers (under 10 workers), 18 percent indicate they would be willing to pay $100 or more; among midsize groups, the percent increases to 25 percent. *(WV Employer Survey 2003).* This is consistent with the data from the Benefits Focus Groups where the price point for the employers' contribution was about $100. ***These "willing" companies constitute the target population for an affordable employer-based product.***

$ Willing to Pay	% All Non Offering	% Small Non-Offering	% Midsize Non-Offering
$0 to less than $50	57%	58%	50%
$50 to less than $100	24%	24%	25%
$100 or more	19%	18%	25%
All amounts	100%	100%	100%

Source: WVS Employer Survey 2003

Employer Preferences Regarding Benefit Design and Financial Features. Participants in focus groups, which included small business owners, responded almost uniformly that their initial focus when shopping for coverage is more on cost than the benefit package. Employers, faced with a trade-off between a product with a higher premium and lower cost-sharing and a product with a lower premium and higher cost-sharing, prefer the latter. A lower premium limits their contribution. At the same time, higher cost-sharing can result in more responsible use of services by employees. *(WV Benefits Focus Groups 2003)* Small employers express some concern about a 50 percent minimum premium contribution, although the issue is really a function of the underlying cost of the plan. *(WV Benefits Focus Groups 2003).*

Potential Options for Motivating Employers to Provide or Contribute to Coverage.
Individual or Employer Subsidies: Employer Survey data show 87 percent of employers who do not offer coverage view receiving a premium discount favorably. The majority of small group owners participating in the "Benefits" focus groups indicated they would be interested if coverage assistance was available from the State. *(WV Benefits Focus Groups 2003).*

Additional Tax Incentives: 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 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%	36%
Implementing high-risk pool	55%	31%

Source: 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

The situation in the WV health care marketplace remained essentially unchanged during the 2003-2004 extension year. Research completed and steps taken by SPG to address marketplace related issues are highlighted below.

Situation in the Individual Market

West Virginia residents wishing to purchase coverage on their own face two obstacles:

- Medical underwriting is allowed and coverage may be denied based on health status.
- Premiums will reflect age and health status and as a result may be quite high.

Access to coverage, however, is guaranteed only in two situations. Persons who are federally eligible for portability coverage through the Health Insurance Portability and Accountability Act (HIPAA) are guaranteed a choice of two products from each of the insurers doing business in the individual market. While there is no waiting period for pre-existing conditions and coverage cannot be denied, premiums may be very high. In addition, West Virginia requires HMOs doing business in the individual market to offer an open enrollment period once a year. During this period, the HMO must accept the applicant regardless of health status and also charge the regular approved premium. At this time, however, only one HMO insures in the individual market, and this health plan is licensed only in a handful of counties. Other than these situations, there is no recourse for a person deemed medically uninsurable.

A self-employed individual in West Virginia must purchase insurance through the individual market. As such, he or she is vulnerable to a medical underwriting rejection or exclusion. In a number of states, a similar individual is eligible for coverage under small group regulations, which may make it easier to purchase coverage and at a more affordable price.

A small proportion of the persons with individual coverage hold 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 (sometimes 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).*

About 4-5 percent of the insured West Virginia population is currently covered through the individual market. At the same time, substantial proportions of uninsured adults in West Virginia are potential participants in this market. Particularly prominent among uninsured non-elderly adults who must buy coverage on their own are the unemployed, homemakers and self-employed persons accounting respectively for 21, 17 and 12 percent of uninsured adults. To the extent that employer-sponsored insurance is not available, even those who are employed may be considered individual market customers. It is of particular concern that the proportion of unemployed persons in the uninsured non-elderly adult population grew from 14 percent in 2001 to the current 21 percent. Unemployed persons, trying to meet basic living expenses, have little

likelihood of obtaining health insurance without assistance. Thus the uninsurance problem facing West Virginia has been exacerbated in the last few years.

The SPG project has undertaken the development of a streamlined, affordable product known as the "Individual Health Access Plan" for this market. It also recommended a high risk pool for the medically uninsurable. Legislation authorizing this pool was passed during the 2004 Legislative session.

Situation in the Small Group Market

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. This results in very expensive coverage for some employers. In an unchanged regulatory environment, affordability will continue as a major issue.

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. Cost has been identified as the main factor driving insurance levels; the absence of low cost benefit designs contributes to this situation. ***To address this lack, the SPG has focused on developing an Adult Basic Product for this market.***

Major Players in Health Coverage in West Virginia

Insurers. 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. ***Mountain State has expressed interest in offering the health care plan for uninsured small businesses authorized by the 2004 Legislature. (See below).***

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 state's rural nature and small provider base, there has been little HMO penetration into many areas, particularly in the southern part of the state.

Self-Insuring Firms. About one-third of all WV private sector firms that offer health insurance are self-insured. The self-insurance rate among those with 50 or more workers is 59 percent. Among firms with less than 100 employees, which include small and midsize firms, 12 percent are self-insured.

Self-insured companies are negatively affected by rising health care costs albeit to a lesser degree than those purchasing insurance in the market. They can be more proactive in controlling

expenses by customizing their cost control mechanisms. They are also exempt from providing mandated benefits through ERISA. Legislation enacted during the 2003 legislative session gave the Insurance Commission authority to regulate third party administrators (TPAs), giving the State some indirect control over self-insured employers that are otherwise exempt from state regulation under ERISA.

The SPG has not focused directly on protecting the contribution of self-insured firms to health insurance levels in WV since they are not viewed as a high risk group. Any SPG recommendations around cost containment will be, however, relevant to these firms.

State as Purchaser. 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). PEIA covers 90 percent of its enrollees, almost 200,000 persons, through a preferred provider network which accepts discounted rates. The remaining enrollees are covered through HMO contracts. PEIA has a presence in all 55 counties of WV and is a potential major player for strategies using a public/private partnership. 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***. The recent legislation authorizing health plans for uninsured small groups takes advantage of the state's purchasing power by using the provider reimbursement rates in effect for the Public Employees Insurance Agency.*** (See below) These rates are lower than commercial rates and will result in premiums about 20-25 percent below the commercial market.

Other Factors Affecting Health Care and Coverage

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. ***The SPG is considering recommending the establishment of a Cost Containment Council, which would oversee expenditures in each health care sector and react if a sector exceeded its limits.***

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***.

Role of Safety Net Providers

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. In addition to their contributions to the health care of the non-elderly uninsured, safety net providers play a key role in delivering prescription drugs to the low income elderly who currently do not have any prescription drug coverage through Medicare. Representatives of the safety net health care delivery system have been actively involved in the SPG process through participation in the HAC.

A background paper on the impact of the safety net on the uninsured was completed during the extension year and provides a backdrop for further HAC deliberations and recommendations. Principle findings include:

Primary Care Centers	
Contribution	• Primary care centers serve as an important safety net for the uninsured population in many regions of the state. Overall, 25-35 percent of their users are uninsured.
Shortfall	• A full range of services is not available at the centers thus they are only a partial solution to the dilemma facing the uninsured. Without the financial access afforded by health insurance, the uninsured may not be able to get some needed services.
Free Clinics	
Contribution	• The free clinics leverage tremendous monetary and in-kind contributions to support their work. As such, they attract considerable private resources that might not otherwise make it into the health care system.
Shortfall	• The services available to the users of any free clinic depend on the partner relationships it has in place. For many users, these services may fall short of what would be available under full-fledged insurance coverage.
Community Access Programs (CAP')	
Contribution	• CAPs represent community solutions to the problem of uninsurance and reflect the cooperation and support of many stakeholders.
Shortfall	• Programs are small and limited in their impact.

Final observations in the paper further suggest the contribution of "safety net" providers is not "clear cut".

"While the safety net provides services to people who need them, it is not the same as 'having insurance'. Insurance is the mechanism that provides financial access to specific services as

delineated in a benefit plan. A person relying on the safety net only receives the services available from the safety net provider and is at risk for not receiving all necessary services."

On the other hand:
"*The data available on their patient populations suggest that safety net providers do not serve a representative sample of the uninsured. Significantly, however, they appear to serve populations that may not be targets for public insurance expansions constrained by limited resources and other policy initiatives—for example, single adults without children and the unemployed. Safety net providers may thus fill a niche for which there is no easy replacement".*

These observations and the data presented will provoke discussion as the SPG decides the role the safety net should play in its comprehensive plan for the uninsured.

Impact of Coverage Expansion on Various Stakeholders

The SPG has called upon all stakeholders to bear their fair share of the burden of alleviating the uninsured problem. The Accountability Subcommittee delineated expectations for health plans, providers and consumers:

Health Plans

- Must build an adequate network of in-state providers.
- Should pay reasonable fees in order to recruit a network.
- Should pay promptly, require minimal paperwork and provide a timely appeals process.

Providers

- Should accept the proffered rates keeping mind that the overall level of uncompensated care will be reduced.
- Should submit accurate bills in a timely manner.
- Should be accessible to patients in a reasonable time frame.

Consumers

- Should be expected to pay some reasonable copayments and/or deductibles.

The SPG project looks very favorably at public/private partnerships and anticipates that the private market will be involved in most strategies recommended for coverage expansion. This includes insurance carriers as well as brokers and agents.

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. For example, the new health plan for uninsured small groups uses the PEIA reimbursement which is below commercial rates. While insurers have been invited to participate in this initiative, the potential for profits is limited by the legislation which specifies a minimum anticipated loss ratio of 77 percent for a carrier to request a rate increase.

Section 4: Options and Progress in Expanding Coverage

After considerable analysis and deliberation, the joint Benefits and Finance Subcommittee of the Health Advisory Committee made its recommendations for initial coverage options to the full committee in October 2003. Part and parcel of the options recommendations was the development of affordable benefits packages to be used in conjunction with the selected strategies. An "Adult Basic" product was developed for the small group market and the "Individual Health Access Plan" for the individual market.

The options presented focused on immediate actions that could be taken to increase health insurance levels in the state. They included:

- Employer and employee shared purchase of an adult basic package
- Individual and self-employed purchase of an individual health access plan
- Development of a reinsurance program
- Development of a high-risk pool
- Medicaid expansion for custodial adults to 100 percent FPL
- Staged CHIP program expansion to 250 percent FPL, then 300 percent FPL
- Development of incentives for employers offering health insurance including "preferred status" when competing for state contracts or awards
- Cost containment measures

The strategies under consideration were then presented in a town meeting and feedback, solicited. The Governor embraced three of these of these options in his legislative agenda for 2004. Three bills related to increased health insurance levels were passed. They authorized:

- ***A public/private partnership involving a small employer buy-in to the Public Employees Insurance Agency***
- ***A high-risk pool for HIPAA eligibles and persons deemed medically uninsurable***
- ***A plan for a CHIP expansion to include children in families with incomes from 200 to 300 percent FPL***

In addition, the 2004 legislature extended the authority for the uninsured and underinsured pilot programs which were initiated through the federal Community Access Project (CAP) grants. Two CAP programs provide coverage to uninsured individuals in two separate regions of the state. The Legislature also passed a resolution to undertake a study of the uninsured issue in the state and potential solutions. The SPG project is providing data and analytic support for this study which will be reported at the next Legislative Session.

Health Care Plan for Uninsured Small Groups

This program creates a private insurance program for uninsured small groups with premiums, coverage, and provider reimbursement rates modeled on the state-sponsored PEIA coverage. In 2002, the PEIA received funding from Robert Wood Johnson's State Coverage Initiative Program for a demonstration project to support a small group buy-in to PEIA. SPG embraced this project as a major strategy for improving the levels of insurance coverage among workers and has worked closely with PEIA on the implementation plans for this program including the design of an affordable product (Adult Basic). The legislation, passed in March 2004, provides

the authorization needed for the demonstration and also reflects the SPG's recommendation for a private public partnership for a shared purchase of the Adult Basic Product. The expectation is that the health benefit plans will be available to small groups by January 2005.

Target Population. Employers with 2-50 workers.

Program Administration. As legislated, insurance will be available through private carriers. However, should no carriers elect to participate by July 2005, the PEIA and the Insurance Commissioner may propose to the legislature that the authority to offer this coverage be given to PEIA. Mountain State Blue Cross Blue Shield has indicated interest in participation.

Outreach and Enrollment. Marketing and advertising will be conducted by PEIA with financial support from the State Coverage Initiative grant. Outreach and enrollment functions will be performed by the brokers and agents of the carriers offering the coverage.

Premium-Sharing Requirements. The employer must pay at least 50 percent of the premium with the employee paying the balance.

Premiums. Premium rates for the coverage will parallel PEIA rates for coverage to non-state employees (cities, counties and non-profit organizations). These are 20-25 percent below commercial market premiums.

Benefit Structure including Co-payments and Cost-Sharing. The health plan is patterned after the PEIA product with a deductible, co-payments and coinsurance. The Adult Basic Product, designed by the SPG has a $250 deductible, a co-payment or 20 percent coinsurance for most services and an annual benefit maximum of $13,000. Health plans offered will follow this structure.

Program Rule. A minimum of 75 percent participation of eligible employees is required for a group to enroll. The plan is guaranteed issue with no pre-existing condition limitations. Initially, the product can only be offered to employers that have not offered coverage in the previous six months. The look back period then becomes 12 months.

Projected Costs. Products are exempt from premium taxes. Premiums are expected to be 20-25 percent below commercial market rates.

Financing. All ongoing costs will be covered by the premiums shared by the employers and employees. Premiums will reflect a cap on the insurer's administrative expenses. There will be no costs to the state. Costs for program development are available from a State Coverage Initiative grant award to PEIA in 2002 for development and implementation of the product concept.

Cost Containment Strategies. The health benefit plan will be offered by private insurers or PEIA with the proviso that the PEIA reimbursement schedule be used. Use of this schedule will result in a lower than market premiums and is thus a major cost containment strategy. In addition, insurers offering the health benefit plan may use their customary cost containment strategies.

Should PEIA become involved as the default insurer, the strategies will include negotiated pharmacy rates, preadmission certification, and precertification for selected ambulatory services.

Service Delivery. Insurers offering the health benefit plan must use the existing PEIA networks to deliver services. Reimbursement will be on a fee for service basis using the PEIA schedule. While providers were given the opportunity to opt-out, only a handful of providers have done so.

Quality Assurance. Participating insurers will utilize their customary quality assurance programs.

Interaction with Existing Coverage Programs. The SPG is continuing to explore the potential for a CHIP buy in for children whose parents are covered through the health benefit plan.

"Crowd Out" Avoidance and Monitoring Considerations. A 12 month "look back" is in effect. The authorizing legislation also requires the Commissioner to issue rules to prevent manipulation of the eligibility rules by small employers.

Enrollment Data and Other Information. Enrollment data will be reported by the carriers on a yearly basis.

Program Evaluation. The Legislation provides for a policy advisory committee to advise the commissioner regarding health insurance to the uninsured and the effectiveness of this law. The Commissioner will appoint the committee but the committee must include representatives from labor, the hospital industry, medicine, private business, local government, insurers and the uninsured. Each December, carriers offering health benefit plans must report the number of plans written and the number of covered individuals.

High Risk Pool

The Benefits and Finance Subcommittee recommended that the state explore establishing a high risk pool for individuals who are otherwise uninsurable, following the NAIC model, and investigate the potential for obtaining federal funds to support the effort. Many of the details of the legislation are derived from the SPG recommendations, and these recommendations will serve to guide the development of the operating plan for the pool.

Legislation creating the high risk pool to be known as the "West Virginia Insurance Plan" was passed in March 2004 to take effect July 1, 2004. A federal grant to support development and initial operation was awarded in June. Implementation is currently underway under the direction of the WV Insurance Commission.

Target Population. The target population includes HIPAA eligible individuals, persons eligible for federal health care tax credit under the Trade Adjustment Assistance Reform Act, and individuals not otherwise eligible for health insurance due to pre-existing conditions. The latter must have received a rejection from an insurer or notice that insurance would be provided only at a rate in excess of that charged by the pool. In addition, persons with certain health conditions

may be eligible regardless of whether they have applied for insurance elsewhere. The Board of Directors will identify the eligible conditions. Eligibility for coverage will extend to dependents of eligible persons.

Although it was recognized that high risks pool typically insure only small numbers this was viewed as an important option for those who cannot get insurance elsewhere. West Virginia does not enjoy the robust commercial market that would support the regulatory environment in place in other states (for example, community rating requirements). While guaranteed access to coverage, HIPAA eligible individuals with health conditions face unaffordable premiums. Many of the persons who would qualify for the pool are early retirees who do not have access to employer-based coverage. Based on the experience in other states it is expected that the pool will enroll 1,000-2,000 persons.

Program Administration. The high risk pool is located in the WV Insurance Commission and is a public corporation. A board of directors appointed by the Governor will oversee the program and set rules and parameters, including the identification of eligible medical conditions. Day-to-day operation of the plan will be contracted to a plan administrator who will be responsible for eligibility determination, claims, premium billing and collections, cost containment programs, etc. The plan administrator may be the Public Employees Insurance Agency.

Outreach and Enrollment. The legislation for the pool requires that a program be developed and implemented to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan. These activities are to be detailed in the plan of operation to be prepared by the board.

Benefit Structure including Co-payments and Cost-Sharing. The coverage to be provided is "comprehensive" and will be established by the board subject to the approval of the Commissioner. The benefit levels, deductible, coinsurance factors, exclusions and limitations are to be commensurate with the health insurance provided by representative large employers. There is a six-month waiting period for coverage for pre-existing conditions except HIPAA eligibles. The plan has a life-time benefit cap of $1 million.

Financing. The potential for federal start-up funds made this option particularly attractive. A federal grant of $500,000 for the development and implementation of the pool was awarded in June 2004 by the Center for Medicare and Medicaid Services (CMS). This was followed by a second grant award from CMS of approximately $800,000. Nonetheless, it was necessary for the Legislature to cover the shortfall that is expected when medical costs exceed the maximum allowable premium levels. To this end, the Legislature authorized an assessment on hospitals to be collected by the West Virginia Health Care Authority. Initial revenues from the assessment are estimated at $1.4 million. The Legislature also charged the board of directors with developing recommendations for alternative long-term financing. This report is due to the 2006 Legislature.

Premiums will be assessed on the participants and may be based on age, sex and geographic location. They must be approved by the Insurance Commissioner. Premiums will be derived from a standard risk rate that considers the premium rate charged by other insurers in the

individual market. Rates will be from 125 to 150 percent of the standard risk rate and will depend on actual expenses for claims, administration and other costs.

Cost Containment Strategies. The legislation empowers the Plan to utilize various cost containment strategies including preadmission screening, second surgical opinion, concurrent utilization review, and individual case management. The Plan may also deliver services through preferred provider organizations, HMOs and other limited provider arrangements.

Service Delivery. Service delivery may be through preferred provider organizations, HMOs or a limited provider network.

Quality Assurance. Quality assurance is not specified in the legislation but will be covered in the plan of operation.

Interaction with Existing Coverage Programs. To be eligible for the high risk pool, a person must be denied coverage in the private market or quoted an excessive rate for this coverage. A person may enroll in the pool while waiting to fulfill a "waiting period" requirement imposed by another carrier.

"Crowd Out" Avoidance and Monitoring/Considerations. The legislation specifies that an insurance agent or insurance broker may not refer an individual to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from employer-based coverage.

Enrollment Data and Other Information. Plan enrollment will be reported annually to the Governor and Legislature.

Program Evaluation. The Plan is required by legislation to provide an Annual Report to the Governor, which is also to be filed with the legislature. This will include the activities of the previous year, net written and earned premiums, plan enrollment, administrative expenses and paid and incurred losses.

CHIP Expansion

The Subcommittee recommended extending CHIP to children in families with incomes between 200 and 250 percent FPL. Parents would help cover costs through a premium of $25 per month per child. A recent allotment of federal funds would cover the remainder. Once this expansion was completed and evaluated, consideration should be given to extending the income limit to 300 percent FPL.

Legislation was passed March 2004 instructing the Children's Health Insurance Board to develop a plan to extend participation in the Children's Health Insurance Program to children in families with incomes between 200 and 300 percent of the federal poverty level. (FPL) using a modified benefit plan. Families may be charged a premium and are to contribute 20-25 percent of the cost of coverage with no additional costs to the state. The Board was instructed to study total

program costs including the long term effect on the state budget and provide the findings and recommendations to the Joint Committee on Government and Finance. This plan was to be provided to the legislature in the late summer 2004. Additional legislation will be needed to implement a program expansion.

The details below are from the SPG recommendations which will provide input for the CHIP Board's plan.

Target Population. The initial expansion would extend Child Health Plus to children in families with incomes from 200 percent up to 250 percent of the FPL. An estimated 10,490 children comprise the target population for this expansion. Allowing for non-enrollment and "crowd out", an estimated 1,461-2,247 children would be newly insured as a result of this option. Covering children to 300 percent FPL would add an estimated 12,798 children to the target population. Allowing for non-enrollment and substantial "crowd out" (over 50 percent), this expansion would net 1,579-2,427 newly insured children. Currently, there are 24,000 children participating in CHIP. Thus with the expansion to 250 percent FPL expansion, enrollment would grow about 6-9 percent and with the expansion to 300 percent FPL about another 6-9 percent.

Program Administration. CHIP is administered by the Children's Health Insurance Agency located in the Public Employees Insurance Agency in the Department of Administration. CHIP uses PEIA's third party administrator, benefit plan, network and cost containment strategies.

Outreach and Enrollment. West Virginia has been very successful in enrolling children in CHIP owing to strong state support and an intense-community based marketing effort. Outreach has been very active 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. This same combination of strong state support and effective community-based outreach will be used to reach the populations targeted by the proposed expansions.

Premium-Sharing Requirements. A premium of $25 per child monthly has been considered for the proposed expansion population.

Benefit Structure including Co-payments and Cost-Sharing. The expansion plan has considered an overall contribution from the enrollees of 20-25 percent to cover costs.

Projected Costs The SPG estimated expansion costs under various scenarios. Without a premium, costs to the state for an expansion to 250 percent FPL would be about $2 million and with a premium, just under $1 million. The expansion from 250 to 300 percent FPL would cost

the state about $2.2 million without a premium and just over $1 million with a premium. It was assumed that a premium would result in lower enrollment.

Financing. Financing would continue to be from the federal government (82 percent) and the state (18 percent).

Interaction with Existing Coverage Programs. The SPG has recommended exploration of an employer-based buy in to CHIP for families with incomes up to 300 percent FPL, if a parent has employer-sponsored coverage including the health benefit plan for uninsured small groups

"Crowd Out" Avoidance and Monitoring/Considerations. "Crowd out" experience for the CHIP expansion is expected to be similar to that reported in the literature—about 15-22 percent of enrollees. However, in calculating the number of children who would be newly insured by the program a very high estimate of "crowd out" was used (over 50 percent) in order to not overestimate the impact of this intervention on uninsurance levels.

Additional Work on Options

The HAC will continue its deliberations and review of options in the Fall 2004. Additional recommendations for immediate action will be presented to the 2005 Legislature. The SPG project will issue its comprehensive recommendations at the end of the project. These will lay out the plan for covering all West Virginians through incremental action over a longer time frame.

Options still under consideration for action by the Legislature in 2005 or inclusion in the long-term comprehensive plan include:

Expanding Medicaid to cover custodial parents to 100 percent of FPL. Custodial adults are currently eligible for Medicaid up to 29 percent FPL. Expansion would require an estimated $9 million in state funds. With a waiver that would allow a premium contribution of $25, the state's cost would drop to $5.3 million. The Subcommittee suggested exploring the potential for cost savings through a reduced benefits package under a HIFA waiver. *The target population for this expansion is 25,354 persons. An estimated 8,425-13,952 custodial adults would be newly insured as a result of this strategy.*

Individual purchase of limited benefits plan. This plan would be available to persons who need to purchase coverage on an individual basis. A streamlined benefit package known as the Individual Health Access Plan has been designed with a monthly premium of about $140. As in the small group product, the main strategy for making the product affordable is the use of the PEIA reimbursement schedule. A lock-in of 12 months would be used to prevent enrollees from exhausting their benefits in the early months and then leaving the coverage. Additional actuarial work is needed to finalize this product. Remaining issues include the impact of age and gender rating, possible use of medical underwriting, circumstances when a 12-month look back would not apply, and the need for legislation and/or regulation to support the strategy.

Reinsurance. Using state funds, the state would provide reinsurance to those reaching the annual insurance caps.

Incentives for employers to offer health insurance. The subcommittee deemed that a 40% tax rebate program would cost the state an estimated $58 million and be too costly. As an alternative, the subcommittee is exploring the potential for granting employers who provide health coverage "preferred status" when doing business with the state. Work is underway to further develop this option.

Cost containment council. Under this recommendation, a group with broad representation from throughout the health sector would be established to oversee health care spending in the state. The work would take place as part of the State Health Plan process under the direction of the Health Care Authority. The group would develop annual baseline cost projections for each sector of the health care system. When a sector exceeded projections, the group would react with recommendations. The group would include providers, private insurers, health science schools, regulatory agencies, public insurers, business leaders and consumers.

Faced with the prospect of cutbacks in the existing public programs, the Health Advisory Committee opted not to recommend seeking a HIFA waiver to support a public program expansion at the current time. Instead, the decision was made to invest in additional analysis to identify alternative funding sources for program expansions, an undertaking that had been begun in the first year of the project.

Issues Involved in Expansion Strategies

Attitudes toward Public Programs. There is generally support for public program expansion particularly since a large proportion of the cost is borne by the federal government. However, not everyone sees public program expansions as a panacea. Some feel that people are too proud to participate in these programs. Also, participants often have difficulty finding providers. Other solutions for increasing coverage might meet with more approval.

"Crowd Out". A major issue as income levels for public programs are raised is the prospect of "crowd out". This is especially serious for a CHIP expansion, where children at income levels of 200 to 300 percent FPL are more likely to have private (mostly employer-based) insurance than those at lower income levels. "Crowd out" is a less serious concern for the Medicaid expansion since the maximum income level would be only to 100 percent FPL, and most adults in this group are not likely to already have private coverage.

Private Sector vs. State Involvement. In option development, the role of the state versus the private sector is a recurring issue. The populace appears split on the issue with a leaning toward state involvement. Almost all of the individuals participating in the "Benefits" focus groups did not have concerns about enrolling in an insurance plan run by the state. The reaction of small business owners to state involvement in the uninsured issue was mixed. On the other hand, all of the brokers indicated they would be willing to market a non-traditional plan offered by the state. *(WV Benefit Focus Groups, 2003)*

In authorizing the small group buy-in, the legislature gave preference to the private insurers who have the first opportunity to participate. If they choose not to, a state agency will serve as the

default insurer. The legislation establishing the high risk pool permits the PEIA to serve as the plan administrator, thus the pool could be state-administered.

Other Attitudes. There is a general sentiment that there should be incentives to reward employers who provide health insurance.

Section 5: Consensus Building Strategies

During the 2003-2004 extension year, the SPG project continued to utilize the consensus-building strategies in force from the outset.

The governance and organizational structure for the SPG is designed to represent a broad spectrum of stakeholders and is a major strategy for consensus building. 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 Health Advisory Council (HAC), comprised of more than 100 leaders of constituent organizations, provides 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. A large, diverse Health Advisory Council is viewed as a major strategy for assuring broad consensus on the recommendations of the SPG.

The HAC conducts its work through four Subcommittees that meet monthly or more often. Initially, the HAC utilized five subcommittees; the Benefits and Finance subcommittees were subsequently merged in recognition of their overlapping concerns. The full HAC meets quarterly and is guided by a Steering Committee that includes the co-chairs of the Subcommittees.

The Governor lent his support throughout the 2003-2004 extension year, playing a lead role in public meetings and including SPG recommendations in his agenda for the 2004 Legislative Session. The Governor's involvement is expected to similarly garner support for legislation in the 2005 session and for the project's final recommendations.

Legislative representation is included on the HAC and its Steering Committee. Members of the legislature and their staffs were invited to attend the HAC mid-winter meeting in Charleston prior to the 2004 legislative session. They will be invited to this year's mid-winter meeting in anticipation of the 2005 Legislative Session.

The SPG project used town hall meetings, policy forums, focus groups and surveys to obtain input from the public and key constituencies during the 2003-2004 extension year. The project continued to publicize its work to assure that the uninsured remained a front burner issue in the state.

- Five town hall meetings were held in the Summer and Fall of 2003 at locations throughout the state. The Governor was showcased in three of them, and his participation was viewed as key for rallying the support of key constituencies for the SPG recommendations. An experienced WV Public Relations Consultant ensured that the Governor's involvement was fully leveraged.

- Once the initial recommendations for increasing health insurance levels were presented to the HAC, an additional town hall meeting was convened to solicit feedback on the options under consideration.

- Six focus groups, each with 10-15 participants, were conducted with uninsured consumers, small business employers and brokers and agents to solicit their reaction to two benefits designs intended to provide affordable alternatives for the small group and individual markets.

- The WV Health Care Survey 2003 conducted 1,600 interviews to update the state-level data available from the 2001 survey. The survey documented the current situation with levels of health insurance, characteristics of the uninsured and experiences with health care delivery.

- A statewide prayer breakfast sponsored by the WV Council of Churches as well as town hall appearances by the Governor had been planned for national "Cover the Uninsured" week. However, because this week coincided with elections in West Virginia, which were expected to dominate the media, the scheduled activities were postponed. It then became clear that would not be possible to generate cooperation and media interest without the momentum provided by the national initiative, thus WV's "Cover the Uninsured" week activities were ultimately cancelled for 2004.

- Project materials, including research reports and issue briefs, continue to be made available to the public on the Internet at www.wvhealthpolicy.org.

Section 6: Lessons Learned and Recommendations to Other States

Policy Planning Process

West Virginia has continued to find its approach to the planning process conducive to achieving the SPG objective—an effective plan for increasing health insurance levels in the state.

Careful Scheduling. Timing the initial recommendations for expanding coverage just before the 2004 Legislative section provided a momentum for inclusion in the Governor's legislative agenda and action by the legislature. As a result, three bills were passed that will impact the levels of health insurance in the state. The next wave of recommendations will be similarly timed for consideration by the 2005 Legislature.

Hearing All Sides. Involving a broad coalition of stakeholders through the Health Advisory Council, sponsoring town hall meetings and conducting focus groups and surveys has assured that various points of view are heard and reflected in recommended actions. For example, it is necessary to draw a careful balance between private and state involvement in proposed solutions. Many stakeholders look suspiciously at a state run health plan. The options in place so far involve a mix of private and state players. While the West Virginia Health Care Plan (high risk pool) is state run, commercial insurers are the carriers of choice for the health plans to be offered to the uninsured small groups.

Collecting Additional Data. Changes in the state's economy prompted the Healthcare Survey 2003, intended to document any changes in health insurance coverage on the state level. This was to assure that the SPG deliberations and recommendations were based on up-to-date information. This survey substantiated the fears. The worsening economic landscape was taking its toll on the level of health insurance coverage in the state. The SPG had recognized early on that, while its mission was to improve health insurance levels in the state, achieving this goal involved not only extending coverage to the previously uninsured but making sure that those with insurance did not lose it.

The new data drew attention to the burden of uninsurance on one group in particular–the 50-64 age group. As a result, WV requested funding for additional survey work to take a closer look at the circumstances of this "early retiree" group. Data analysis has thus proven useful for identifying additional focused data collection efforts that will feed into and strengthen the final recommendations.

Respecting Fiscal Constraints. Serious deficits 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. Initial recommendations for policy interventions were made keeping these revenue constraints in mind. An analysis of other states' experiences with revenue-generation is underway. A background paper completed in the Spring explored the relationship between "single public programs" and administrative costs, and will serve as a backdrop for the SPG recommendations relative to public programs.

Other Observation

As has been noted, West Virginia deemed it appropriate to postpone the state's activities originally scheduled for national "Cover the Uninsured" Week. The national initiative coincided with elections in West Virginia, which promised to dominate media attention. However, without the momentum from the national initiative, it became impossible to re-schedule the events and generate the necessary publicity, thus West Virginia did not observe a "Cover the Uninsured" week during 2004. The SPG project would suggest that organizers of national initiatives consider the calendars of the various states when scheduling their initiatives as other states may also have been similarly affected.

Section 7: Recommendations to the Federal Government

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

Attachment A

Major Events/Activities in 2003-04 (First Extension Year)*

Time Period	Event/Activity
Summer & Fall 03	Town hall meetings in Charleston, Morgantown, Parkersburg and Wheeling (5 meetings in all)
Fall 03	Final report from the **West Virginia Employer Survey, 2003** completed. (October)
	Final report from the **West Virginia Focus Groups 2003** completed. *"An Evaluation of Health Insurance and Health Insurance Options in West Virginia: A Qualitative Study of Employers, Uninsured Consumers and Insurance Agents."*
	Accountability, Joint Benefits and Finance, and Communications Subcommittee recommendations presented to the Health Advisory Council (October 15). Options analysis and recommendations. Presentation of affordable benefit designs for small group and individual market.
	Meeting #4 full Health Advisory Council. Recommendations for policy options for presentation to the 2004 legislature. (October)
Winter 03-04	Six focus groups conducted to solicit input on "affordable" benefit designs. (December)
	Governor incorporates SPG recommendations in agenda for 2004 Legislative session.
	Meeting #5 full Health Advisory Council. Briefing for legislators and staff.
	WV Health Care Survey, 2003 conducted through telephone interviews with 1,600 households (December & January)
	Additional Report from the **WV Health Care Survey 2001**. *"An Analysis of West Virginia's Minority Health Issues: Black Americans"* (January)
	HAC Presentation on the **WV Healthcare Survey, 2003**: A Preliminary Assessment of Changes in Healthcare and Health Insurance in WV since 2001. (February)

	Legislation enacted authorizing high risk pool, health benefits plans for uninsured small groups, and plan for cost neutral expansion of CHIP eligibility. (March)
Spring 04**	Final Report from the **Benefits Focus Groups, 2003.** *"WV Health Insurance Focus Group Report: An Evaluation of the Individual Health Access Plan and Adult Basic Benefit Plan by Individuals, the Self-Employed, Small Business Owners and Insurance Industry Representatives".*
	Background paper on *"'Single Public Programs' and Administrative Costs".* (March)
	Background paper on *"The Impact of the Safety Net on the Uninsured in West Virginia".* (April)
	Federal grant awarded to support development and implementation of high risk pool. (June)
Ongoing 03-04	Media and public relations campaign and related informational materials.
	Interface with Multi-State Integrated Database.

***** While shaded events are not conducted directly by the SPG project, they represent milestones that are direct outgrowths of the SPG process.

****** "Covering the Uninsured Week", originally scheduled for March 04, was cancelled due to conflicting media priorities.

Attachment B

Major Events/Activities for 2004-005 (Second Extension Year)*

Date	Event/Activity
Summer 04	Preliminary Analysis of **WV Health Care Survey, 2003.** Non-Elderly Adults, Children and Elderly Reports (July)
	Video on uninsured for use by local community groups (August)
	Study to support CHIP expansion of children in families with incomes to 250% FPL sent to legislature by the Children's Health Insurance Board. (September)
Fall 04	Continued analysis of alternative funding resources to support proposed coverage expansions.
	Data and analytic support for Legislative study on the uninsurance problem in West Virginia and feasible solutions (to be presented to the 2005 Legislature).
	Meeting of full Health Advisory Council. Consideration of options for recommendation to the 2005 Legislature; review of feedback from Governor's town hall meetings.
Winter 04-05	Completion of data analysis and final reports from the **WV Health Care Survey, 2003**.
	2005 Legislative Session including consideration of SPG recommendations.
Spring 05	Meeting of full Health Advisory Council. Final recommendations and comprehensive plan for increasing health insurance levels.
	Preparation of Final Report for project (for completion in October).
Ongoing 04-05	Media and public relations campaign and related informational materials.
	Interface with Multi-State Integrated Database.

***** While shaded events are not conducted directly by the SPG project, they represent milestones that will be direct outgrowths of the SPG process.

Appendix I

Baseline Information	
Population	1,801,354 *U.S. Census Bureau, 2003 (est.)*
Number and percentage of uninsured (current and trend)	***Current*** In 2003, 21.7 percent of non-elderly adults ages 19-64 were uninsured. The percent of uninsured children ages 0-18 was 7.6 percent. Uninsured adults numbered 235,392; uninsured children, 30,884. ***Trend*** State specific data collected in 2001 found an uninsurance rate of 19.9 percent among uninsured adults and a rate of 6.6 percent among children. Thus the uninsurance rate has increased since the baseline survey.
Average age of population	38.9 years (median age) *U.S. Census Bureau, 2000*
Percent of population living in poverty (<100 percent FPL)	17.9% *U.S. Census Bureau, 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): 34% Employers (incl. State and Federal Government): 50% Individuals: 3% Uninsured: 14% *Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 CPS.*

Baseline Information	
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.
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, 2003. A Preliminary Assessment of Changes in Healthcare & Health Insurance in WV since 2001 (Slide Presentation)

II B An Analysis of West Virginia's Minority Health Issues: Black Americans Report

Employer-Based Coverage

II C West Virginia Employer Survey Report (October 2003)

Qualitative Research

II D An Evaluation of Health Insurance and Health Insurance Options in West Virginia: A Qualitative Study of Employers, Uninsured Consumers and Insurance Agents (October 2003)

II E The WV Health Insurance Focus Group Report: An Evaluation of the Individual Health Access Plan and Adult Basic Benefit Plan by Individuals, the Self-Employed, Small Business Owners and Insurance Industry Representatives (March 2004)

Health Care Marketplace

II F "Single Public Programs and Administrative Costs" (March 2004)

II G "Impact of Safety Net Providers on the Uninsured in West Virginia" (April 2004)

Options and Progress in Expanding Coverage

II H Closing the Gap: Insuring the Uninsured in West Virginia. October 15th Health Advisory Council Subcommittee Recommendations. Accountability Subcommittee, Joint Benefits & Finance Subcommittee and Communications Subcommittee.

Consensus-Building Strategies

II I Sample Agenda: Town Hall Meeting