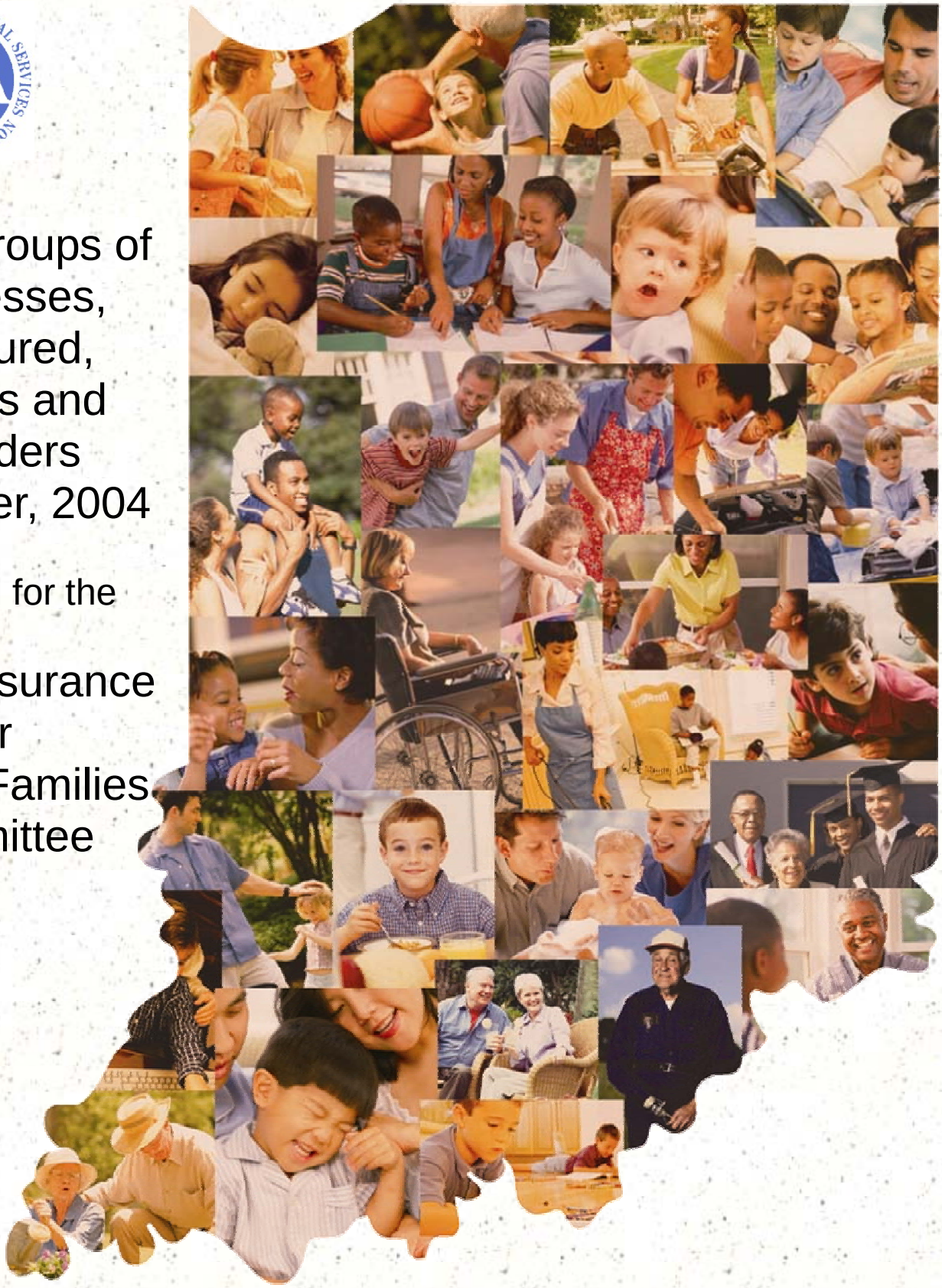
Focus Groups of Businesses, Uninsured, Brokers and Providers November, 2004

prepared for the

Health Insurance for Indiana Families Committee



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FOREWARD

Hoosiers and people around the United States are paying more for health care than ever before. Increases in health care premiums have left some Hoosiers without insurance, underinsured, or on the verge of losing coverage. Employers face double-digit increases in premiums. Rising health care costs undermine the ability of individuals, businesses, and the state to purchase health care coverage.

There are approximately 45 million uninsured Americans. In Indiana, the percentage of Hoosiers without coverage is lower than the national average. The Family and Social Services Administration (FSSA) telephone survey reached more than 10,000 people and showed an uninsured rate of 9.2%. National studies put Indiana's rate at 12.9%. This means more than 600,000 Indiana citizens do not have health insurance.

The face of the uninsured has changed. It includes mostly working families and larger numbers of the middle class. Being uninsured has a great impact on individuals, families, communities and the economic vitality of the state. People without health insurance often have poorer health status, which affects their ability to work. Lack of health insurance is one of the leading causes of personal bankruptcy. Uninsured patients often delay care ultimately receiving costly emergency room treatment. Safety net hospitals and other institutions created to provide care for the indigent are struggling.

With great concern for these issues, the Indiana Family and Social Services Administration (FSSA) competed for and was awarded a $1.1 million State Planning Grant from the Health Resources and Services Administration (HRSA) in July 2002. The grant provided Indiana the opportunity to study its uninsured population and develop viable policy options for providing access to affordable coverage.

The Indiana State Planning Grant work was guided by the Health Insurance for Indiana Families committee, a bi-partisan group that included public and private officials, representatives from small and large businesses, insurers, physicians, hospitals, the Indiana University School of Medicine, safety net providers, and advocates that developed options to address the needs of uninsured Hoosiers.

State Planning Grant funds were used to support data collection to aid committee members in their deliberations. The data collected was unparalleled in its scope and depth in providing information on the uninsured and the Indiana health care system.

The following reports were received by the committee. The contents are not endorsed or recommended by the committee.

I. 10,000 Person Household Survey

Over 10,000 Indiana residents were surveyed between February and April 2003 to understand key characteristics of the uninsured. The survey identified who the uninsured

are, where they live, where they receive care, their age, race, employment and health status.

II. Focus Groups of Businesses, Uninsured, Brokers, and Providers

The purpose of the focus groups was to gain insight from those affected by this issue and to understand the local dynamics of how people access care or experience barriers. Forty-seven focus groups were conducted throughout the state with more than 350 individuals. The stakeholder groups included uninsured and underinsured individuals, physicians, hospital administrators, businesses, insurance brokers, and community groups. They were asked about cost, the consequences of no coverage, what should be in a basic plan, and their experience with government health programs.

III. Assessment of Indiana Health Funding

This report attempts to catalogue the major funding sources, eligibility requirements, and restrictions on funding. It also examines Indiana's current financing mechanisms and outlines additional opportunities for leveraging federal dollars. The report lays out issues that must be considered in determining whether the options presented are feasible.

IV. Safety Net Assessment

This report is intended to broadly identify and assess the major providers of safety net services in Indiana. It reviews the availability of primary, specialty, mental health, hospital and dental health care services and their financing. The information in the report was derived, in part, from the results of a survey of the Indiana Step Ahead Councils, as well as from interviews with the Indiana Primary Health Care Association (IPHCA), the Rural Health Association, and others. The report also discusses the Indiana Medicaid program and its significance to safety net providers.

V. Assessment of National & State Efforts to Address the Uninsured

This report focuses on the variety of options most commonly used by other states to expand health coverage. The report examines public program expansions, health insurance market reforms and initiatives, tax-based reforms, community-based programs, and strengthening the safety net.

VI. Indiana Market Assessment and Drivers of Health Care Costs

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care sector, the economic impact of cost reduction, Indiana's health insurance market, employer coverage, and cost drivers.

VII. Indiana Market Assessment & Drivers of Health Care Costs

A. Indiana's Health Care Sector and Insurance Market: Summary Report

This report examines Indiana's demographic and economic changes that have affected the affordability and structure of private health insurance. The report provides an overview of Indiana's health care market place including its impact on the overall economy. The report compares Indiana to neighboring states and identifies cost drivers.

B. Indiana's Health Care Sector and Economy Report

Understanding the impacts of rising health care costs on the economy is important, but it can be difficult to measure. In this report, health care services are considered as a source of employment. Finally, this report includes two analyses: a simulation of the impacts of rising health care costs in Indiana, and estimation of the possible impact of greater insurance coverage on hospital uncompensated care.

C. Indiana's Health Insurance Market

This report reviews the literature on state regulation of the small group and individual health insurance markets and describes three types of small-group insurance regulation.

D. Employer Sponsored Coverage in Indiana

This report reviews coverage rates overall (including both private- and public-sector workers and their families), as well as rates of employer offer, eligibility and take up. This report considers aspects of employer-based coverage that have cost implications.

E. Factors That Drive Health Care Costs in Indiana

This report examines trends in health care spending in Indiana for various types of services, changes in service utilization and price data. Several factors that may drive cost increases are considered, including changes in demographics, health insurance, service supply, and population health status.

VIII. Actuarial Analysis of Policy Options

This analysis estimates the number of people eligible and enrolling in the program at various income eligibility levels up to 250 percent of the Federal Poverty Level (FPL). The report also estimates the cost of coverage under three alternative benefits packages. The actuarial analysis of alternative benefits packages addresses the selected expansions in eligibility, program costs under alternative benefits packages, minimizing crowd-out, the impact of premium contribution requirements, and buy-in.

ACKNOWLEDGMENTS

The final report of the Health Insurance for Indiana Families represents the work of many individuals who donated their time, expertise, and energy to oversee the data collection efforts and to develop policy recommendations. The committee and subcommittees met monthly for more than two years and their efforts are sincerely appreciated. Additionally, we would like to thank members of the FSSA Technical Assistance Group which included Kathy Moses, Kari Kritenbrink, Joe Shelton, Judy Tonk and Michelle Geller.

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The HIIF Reports and Recommendations Are Online At :

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Report to the Health Insurance for Indiana Families (HIIF) Committee

Voices of the Uninsured Indiana

An assessment from stakeholders affected by those without health insurance in Indiana.

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November 2003

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ACKNOWLEDGEMENTS

This report represents the cumulative work of a great number of people who expended both time and effort to provide input on the very critical issue of the availability and affordability of health insurance. The focus group participants offered their time and opinions on the cost of health insurance, the consequences of not having insurance, and thoughts on what policy makers might consider as they deliberate on options to expand insurance coverage.

The participants came from many different regions and represented many different points of view. It is this diversity of opinion that we believe needs to be evaluated and incorporated in the final recommendations of the Health Insurance for Indiana Families.

Organizing these focus groups required considerable effort by many people. Our thanks go to those organizations who assisted us or allowed us time on their meeting agendas. Those groups include the Indiana Chapter of the National Federation of Small Business, the Indiana Minority Health Coalition, the Indiana State Chamber of Commerce and many local Chambers of Commerce, the Indiana Hospital and Health Association, the Indiana Brokers Association, local Step Ahead Council staff, the Indiana State Medical Association and several of their local representatives, hospital medical staffs, and many community organizations and interested parties who believe that this issue is important and, therefore, supported the efforts in support of this project.

A special thanks goes to Jamalia Brashears who kept track of all the sessions and attended to the many details that are required for a project of this size. Also, thanks to Michelle Geller and Judy Tonk in the Office of Policy and Planning at Family and Social Services and to Cindy Collier, the Director of the Office of Policy and Planning. They made great use of their contacts throughout the state to make sure that we received input from many different viewpoints.

And thanks to the many people who participated. They gave their time freely and we are more knowledgeable as a result. And finally, a special thanks to Debbie Austin and Darla Traylor who edited the presentation materials and the contents of this report.

EXECUTIVE SUMMARY

The Health Insurance for Indiana Families Committee was created to examine the complex issue of providing access to affordable health insurance to Indiana families. By design, this examination includes gathering both qualitative and quantitative information from many different sources.

What are the most important health insurance issues across the State of Indiana?

This report, Voices of the Uninsured in Indiana, represents the qualitative information and is intended to compliment the 10,000 person household survey and the Safety Net Report. It is an assessment of feedback from the stakeholders affected by either those who do not have insurance or by the uninsured or underinsured themselves.

Its purpose is to gain insight into the thoughts and opinions of those affected by this issue and to understand the local dynamics of how people access care or experience barriers to care. It also explores in greater detail the complex nature of the uninsured and stories are told to further emphasize the complexities in finding solutions.

The Process

Forty-seven focus groups were conducted throughout the state with more than 350 individuals. The stakeholder groups included uninsured and underinsured individuals, physicians, hospital administrators, owners and managers in both large and small businesses, insurance brokers, and various community groups focused on developing local solutions.

We asked a range of questions on the cost of coverage, the consequences of not having coverage, what should be in a basic plan, the responsibility for coverage, the experience with government health programs, and finally, we asked the participants their thoughts on how an acceptable program might be structured.

The Regions

For organization and reporting, the state was divided into ten regions. Efforts were made to meet with stakeholder groups in each region. Although there were no dramatic variations between the regions, where there were differences, it could usually be traced to one of three community drivers. These drivers included:

- Economic changes caused by the business climate in a particular region
- Demographic changes caused by an influx of immigrants or by an older, non-working population
- Changes in the healthcare market resulting in either the development of or the need for safety net services

The Findings

The findings are categorized by the broad areas of inquiry. Those areas include:

Coverage: Many people are losing or have lost their insurance due to plant closings and many employers are shifting the increased cost to their employees. The number of uninsured is also increasing because of the growing number of Hispanics who work in service positions or have part-time jobs with businesses that do not provide health insurance.

Costs: Costs are increasing for both large and small businesses. The volatility is particularly difficult for small business and many small business owners are concerned about their ability to continue to offer insurance to the employees. Most are pushing increases to their employees.

Consequences: Everyone agreed that there is a negative impact of not having insurance. People put off seeking health care because of their fear of large bills. By waiting, their condition usually becomes worse.

What should be in a basic plan: Most uninsured individuals want a comprehensive plan and are willing to pay some premium or co-pay. Pharmaceutical benefits were most often cited as important. With other stakeholders, there was no consensus on whether a catastrophic plan would be preferable to a low cost, primary plan.

The safety net system: The feedback revealed that where there is a formal safety net system, that is a clinic, people will use it. If they need to depend on a private primary care physician, the uninsured will most often put off seeking treatment and then use the emergency room as their "safety net." It was also clear that all safety net systems are not created equal. Some are more accessible, more comprehensive, and more responsive to the needs of their clients.

Government programs: Everyone on Hoosier Healthwise for their children were pleased with the program. Providers expressed dissatisfaction with the reimbursement and the bureaucracy. Many providers also indicated they believed that there needed to be increased marketing to ensure that eligible people are enrolled.

Increasing coverage: Many had thoughts about increasing coverage. There was support for a state expansion. Physicians suggested that the state support their efforts with liability and malpractice protection for providing free services in community clinics.

In conclusion, there is consensus that the problem is great but there is no consensus between the groups on either short-term or long-term options. Most people indicated they believed it would take multiple solutions to achieve access to affordable health insurance coverage.

Voices on the Uninsured Population in Indiana

An assessment of feedback from stakeholders affected by those without health insurance in Indiana

BACKGROUND ON THE STATE PLANNING GRANT AWARD

The State of Indiana Family and Social Services Administration (FSSA) was awarded a State Planning Grant (SPG) from the Health Resources and Services Administration (HRSA) in July 2002 in order to assist it in its efforts to examine options to expand coverage for the uninsured. The goal of this project is to analyze key information necessary to consider policy options to address the uninsured in Indiana with the following final report.

FSSA is reconvening the Health Insurance for Indiana Families (HIIF) committee to analyze the feedback gained in this focus group process and to consider potential Indiana state policy recommendations. The HIIF committee is composed of both public and private representatives from small and large business, insurance, physicians, hospitals, the medical school, safety net providers, and consumer advocates to assure a diversity of perspectives when feedback and policy options are considered. FSSA will be convening a Technical Assistance Group (TAG) composed of key state staff from the various state health agencies to participate in the process as well.

State Planning Grants have been awarded to a total of 42 states to assist in the development of plans for providing access to affordable health insurance coverage.

Overall Project Goals

The primary thrust of the SPG was to work in partnership with legislators, key stakeholders, private industry, and the community at large to consider and develop key policy options to address the needs of the approximately 500,000 uninsured Hoosiers. This effort will build upon earlier efforts of the Working Poor Commission, and the Children's Health Policy Board.

The grant funds are to support the data collection effort used to consider policy options for the uninsured which is outlined in the following report. These efforts are designed to assist the state,

legislators, HIIF, and the TAG committees as they consider options to address the uninsured.

Overall, the SPG funds were assigned to do the following tasks. Those marked with an asterisk (*) denote those tasks which the following report supports or addresses:

- Update the Indiana Household Survey on the uninsured. This survey of approximately 10,000 households in Indiana will help quantify the number and characteristics of the uninsured and geographic variation throughout the State. The complete survey results will be available in July 2003.

* Conduct focus groups of small business employers, uninsured communities including those with chronic diseases and priority populations, insurance brokers, and providers throughout Indiana to ascertain perspectives on policy options for the uninsured.

* Conduct key informant interviews of stakeholders.

- Develop a market assessment of the healthcare market place and the insurance industry.

* Conduct an assessment of the Indiana safety net, existing health programs, and funding streams in Indiana.

- Assess various federal options to expand coverage and other State initiatives.

- Develop policy options to address the uninsured in Indiana.

- Provide an actuarial analysis and implementation plans for policy options.

- Assessment at the key drivers of cost in Indiana

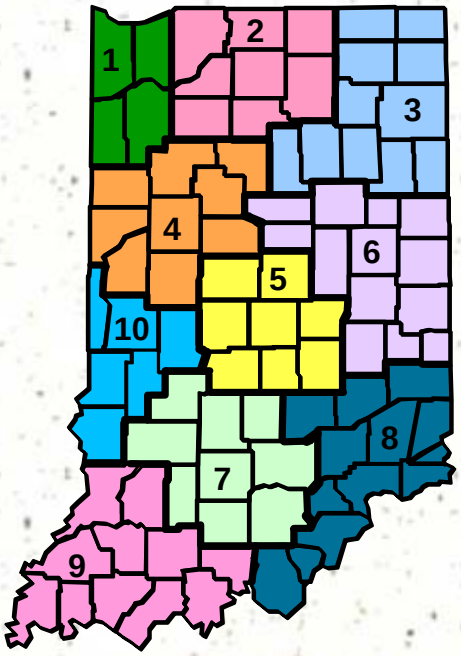
METHODOLOGY OF DATA COLLECTION EFFORT

A significant part of the information gathering process was conducted via a series of approximately 50 focus groups with key stakeholders throughout the state. The focus groups were designed to get a wide range of input including information about their experiences, their frustrations, and their thoughts on potential policy options.

Stakeholder Groups

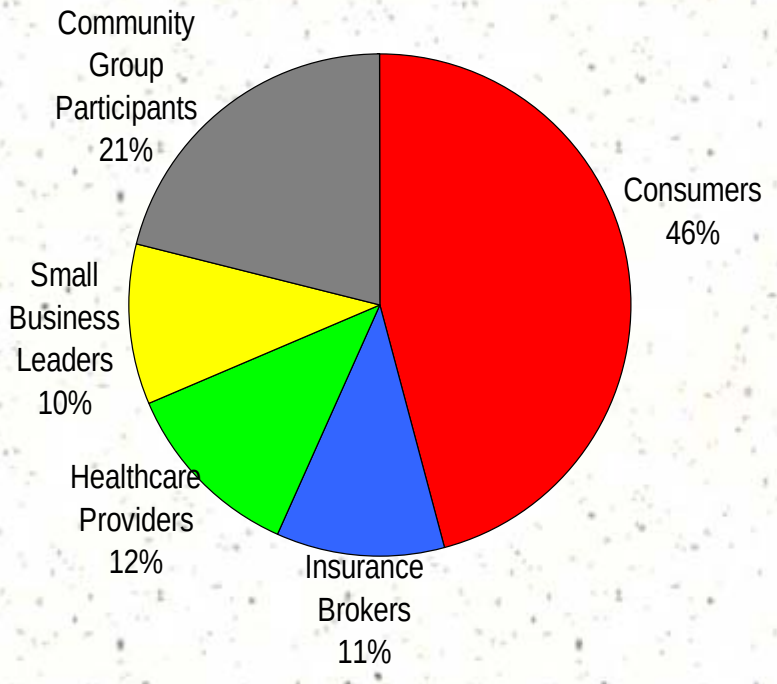
- ***Small business owners*** to determine what barriers or issues they face in providing health insurance for their employees;
- ***Uninsured and underinsured individuals*** to determine where they receive care, how they pay for it, and what their general experience is without insurance;
- ***Healthcare providers including hospitals and physicians*** to determine what issues they face with an increasing number of uninsured individuals using their services;
- ***Insurance brokers*** to determine what they see as the greatest pressures and motivations of businesses in offering health insurance; and
- ***Community groups*** focused on safety net services to get their views on what is in place, what is planned, and what the best model to expand service capacity throughout the state.

In order to ensure any intrastate variations of responses were noted, the state was divided into ten regions as the map illustrates below. The ten regions mirror those regions set by the Indiana State Department of Health for bioterrorism preparedness. Focus group sessions were conducted with each of the stakeholder groups noted above in each one of the ten regions.



Over 350 individuals participated in the focus groups. The following statistics illustrate the scope of attendance to the focus groups by stakeholder group:

- 165 consumers (who were either considered uninsured or severely underinsured)
- 39 insurance brokers
- 43 healthcare providers (including hospital leaders, community mental health center directors, and physicians)
- 37 small business leaders
- 76 people who participate in community groups (these individuals are working in capacities to improve healthcare access in their hometowns and could include social workers, hospital community outreach personnel, community grant administrators, and state government employees)



Background of Focus Group Facilitator

Health Evolutions, Inc. is an Indianapolis-based healthcare consulting firm providing hospital systems, managed care companies, medical groups, state and local governments, post-acute and ancillary providers, and health business entrepreneurs a wide range of skills and experience to help them thrive in a challenging, rapidly changing healthcare environment. Distinguished by the fact that the majority of its consultants have over 15 years of hands-on operational experience within the healthcare industry, Health Evolutions is able to provide its clients with practical, implementable solutions to their business challenges and opportunities.

Input Protocol

Each focus group session was conducted in the home county of the focus group participants. Participants were invited based on their stakeholder membership and where possible we used existing meeting structures. Focus groups lasted approximately one hour and included on average six to ten participants.

Facilitators used similar questionnaires for each stakeholder group. Questionnaires were sometimes given to the participants in advance. On the occasions that there was not enough time to receive responses to every question, participants were invited to submit additional comments to the facilitator after the completion of the focus group.

Description of the Questionnaire

In general, the attendees were all asked to discuss their viewpoints on various aspects of health insurance coverage such as why some people lack sufficient coverage, the personal implications of not having sufficient coverage, and on the state government's potential role on assisting to increase coverage. The following chart illustrates the scope of the questioning between each stakeholder group:

	Consumers	Providers	Community groups	Brokers	Businesses
The Uninsured		X	X		
Coverage	X	X	X	X	X
Costs	X		X	X	X
Consequences	X	X	X		X
Basic Plans				X	X
Locations to Receive Care	X	X	X		
Changes				X	X
Health Care Experience	X				
Government Programs	X	X	X		X
Responsibility for Coverage	X	X	X	X	X
Future	X	X	X	X	X

The questionnaires are in Appendix B.

UNDERSTANDING THE REGIONS

In analyzing the collective responses across stakeholder groups, several similarities and differences became apparent between stakeholders from region to region. While these similarities form the basis for the themes discussed in more detail later in this report, the differences can be generally categorized into three groups which we have defined as "community drivers." These "community drivers" directly affect either the supply or local demand of healthcare services and thus, impact the number of uninsured and the availability of healthcare services in communities across Indiana. These drivers are categorized as:

- Economic changes
- Demographic changes
- Changes in the healthcare market including the availability of safety net services

The following highlights many of these "community drivers" that influenced feedback in the region:

Lake and Porter Counties – This area has been greatly affected by the downsizing and closing of the steel plants. This has left many people without jobs, without insurance, and without many options. Because of the age of many of these people, they do not believe they can start over. Even with the insurance support from the state, they are still faced with no family coverage for their spouses.

Lake County – There have been changes in the hospital market in Lake County. With the sale and/or consolidation of the Ancilla Hospitals, the cost pressures have significantly increased for Gary Methodist and St. Catherine's Hospitals. In addition, while this region has always had a diverse demographic base, there has been a significant increase in the Hispanic population, many of whom have no insurance and are seeking care.

Allen County – There are many people who are without insurance because of the closing of Tokheim, Dana Corporation, and the downsizing of Lincoln Life. Individuals who had very good comprehensive insurance are coming to the end of their COBRA option.

Clark and Jefferson Counties – These counties appear to be well served by a clinic system that has two community clinic sites. Funded originally through a community focus fund grant from the Department of Commerce, it is now supported by the hospital, volunteer physicians, and general community contributions.

Jasper County – Since late 1999, the mega-dairy farms have hired large numbers of Hispanics to work. This has increased the demand on the area healthcare providers. One support system for pregnant women is through the Birthright Program in Rensselaer which supports primary and prenatal services for uninsured pregnant women.

Daviess County – A nurse managed clinic in Washington fills a significant gap in provider availability. For many uninsured, it represents the only major source of primary care.

Decatur County – A free clinic in Greensburg, originally funded through a MCH grant and now supported through donations and volunteer physicians, provides care for the uninsured. There are, however, long wait times to get an appointment.

Vigo County – St. Anne's Clinic provides most of the safety net care in Terre Haute but is only open two days per week. Safety net services are very limited particularly when compared to other communities of similar size.

Clinton County – The county is still largely a farming community. Many are insured through the public sector where one family member can get coverage for everyone in the family. There is a free clinic with limited services for the uninsured.

Vanderburgh County (Evansville) – The uninsured population includes many temporary and part-time workers and most do not qualify for health insurance. Those few that do, can often not afford premiums. A free clinic is available to the uninsured in downtown Evansville.

Boone County (Lebanon) – Predominantly a rural and suburban community with a free clinic that is very popular and well utilized with uninsured residents. A nurse practitioner at the clinic provides a consistent image and source of help/navigation for the local healthcare system.

Steuben County (Angola) – A predominantly rural community with many senior residents who are uninsured. Pride and the stigma attached to public assistance prevent many eligible people from applying for Medicaid. However, many of those on Medicaid have trouble accessing physicians since many local physicians have been reluctant to participate in the program. A weak local economy and a lack of employment opportunities make qualifying for Medicaid a primary focus for many younger residents.

Owen County (Spencer) – Many small companies offer high cost health insurance resulting in a relatively large uninsured population. The local Head Start clinic assists many uninsured families with referrals to providers including other social service agencies. Awareness and coordination with several state programs is enhanced with the Head Start clinic being housed in the same complex as other state agencies.

Hancock County (Greenfield) – There is a significant amount of small business employees and self-employed individuals within this relatively healthy regional economy. Most of these cannot afford adequate coverage thereby creating a sizable uninsured/underinsured population. No free clinic is available which forces those without coverage to access the ER for urgent care and the financial hardship that follows. Access to specialist care is difficult as up front deposits for procedures are unaffordable.

Howard County (Kokomo) – Many local residents have been affected by recent layoffs from the large automotive manufacturers. A safety net for the uninsured is dominated by the Catholic hospital-sponsored free clinic. The clinic is very popular with a quality reputation, but timely access for appointments and specialist physicians is difficult due to heavy patient volumes against a short supply of volunteer physicians. Therefore, the two local hospital ERs experience steady demand from this population.

KEY FINDINGS ACROSS ALL FOCUS GROUPS

The following findings were determined based on their relative high frequency of mention by several focus groups:

Lack of Insurance Coverage

The number of uninsured is growing

- *The relatively poor state of Indiana's economy is accelerating the growing ranks of the uninsured.* As the Indiana manufacturing-based economy has declined, many large businesses have reduced their workforce or closed.

- *The lack of insurance coverage is mainly due to its high costs for both employers to offer and for employees to accept.*

Costs of Health Insurance Coverage

Coverage is not affordable - especially to small employers and their employees

- *Making coverage more affordable is the primary concern for most all stakeholders.* By a large margin, the high cost of healthcare insurance is the main obstacle to increasing coverage through both the employer and individual markets.

- *Premium cost, rate stability, claims service, and provider network are the primary criteria customers use to determine their satisfaction with a health plan.*

- *Employer subsidies for insurance are decreasing.* The economic downturn has greatly exacerbated the need for most employers to limit the healthcare coverage for their employees.

- *The cost of coverage for employees is rising, in part, due to cost shifting.* Most small employers are shifting the increased costs of healthcare coverage to the employee in the form of higher co-pays, higher deductibles, spousal exclusion, and overall reduction in the benefit level in order to keep premium increases more manageable over time.

- *The small business community considers health insurance increasingly unaffordable and an impediment to their companies' growth potential.*

- *A healthy economy will help but not solve the high costs of healthcare.* An economic rebound will greatly help decrease the numbers of the uninsured by making coverage more affordable relative to revenue/income levels, but due to the way healthcare is insured, sold, and utilized, cost will remain the key factor.

The number of employers providing insurance coverage is shrinking in addition to the scope of coverage offered

- *Small businesses health insurance premiums are very sensitive to any changes in their employee's medical history and to healthcare inflation in general and are becoming increasingly unaffordable for employees.* The presence of employer-based insurance

coverage among small businesses is rapidly shrinking because it is unaffordable for both employers to offer and the employees to purchase. Small business premiums are extremely volatile since each small group must spread the expected cost of its high risk cases across its own small pool of employees. While health insurance may be made available to employees, many employees in small businesses choose not to accept/purchase coverage due to its very high cost.

High cost of coverage is affecting hiring practices

- *The real cost of health insurance coverage goes beyond the cost of premiums: it needs to be measured by combining the cost of monthly premiums with co-pays and deductibles.*

- *Health insurance costs are such a budget problem for small business employers that hiring decisions are increasingly being made in favor of younger, single workers without children due to the cost impact a potential employee with a family will have on the company's health insurance premium.*

Consequences of High Costs for Employer

- *Due to large company closings and layoffs, workers are forced to find work with much smaller businesses. As a result, workers are faced with much higher health insurance rates, and are less likely to accept coverage.*

- *Small business employees with insurance coverage are faced with significant co-pays especially for physician office visits, prescription drugs, and laboratory tests. As a result, many uninsured choose to not fill costly prescriptions and do not receive the care they need.*

Emergency rooms and payment plans allow for the uninsured to obtain care.

- *An employee's decision to not accept health insurance coverage from his employer is supported by the availability of the local hospital emergency room to provide needed care and the usual practice of setting up a payment plan to pay the bill.*

What should be the components of a "basic" health plan and how much should it cost?

- *Although most of the uninsured who attended the focus group sessions believe the government should make a "basic" benefits plan available, most all providers, insurance brokers, and small business owners believe the government should not offer such a plan, but rather create incentives for businesses to purchase coverage for their employees and/or require that individuals (not businesses) carry their own health insurance policy.*

- *Uninsured individuals are willing to pay something out of their pocket for health insurance coverage.*

- *Sliding scales are preferable.* While the range of acceptable monthly premium payments is large, all agree that any "basic" health plan must adjust its premium based on income level through a "sliding scale."

- *Primary care is key.* While most people believe a basic plan should first cover primary and preventive care, considerable concern remains over catastrophic expenses that could be incurred.

- *Scope of benefits should focus on preventative care.* For a basic plan, most all providers insisted on including "preventative care." The uninsured wanted preventative care, but also had a particular interest in vision and dental services.

Assessment of the Safety Net: Where Do the Uninsured Go for Care?

Very few of the county "safety net" systems are well-organized. Only a few of these are organized and able to inform and administer several state programs effectively. Of these, only a handful have demonstrated they are proactive enough in securing grant money to improve healthcare service delivery. There is no system to coordinate efforts or document and share best practices.

- *Inconsistent availability of clinics across counties.* The availability and utilization of the "safety net" to address the healthcare needs of the uninsured varies greatly from county to county and, therefore, from region to region. Even the best safety net system has gaps in coverage either because of long wait times or the availability of comprehensive services.

- *Reliance on the clinics.* The uninsured are very reliant upon their local hospital ER, and any free clinics that may exist in the area, for their primary care needs. Without a free clinic in the county, the uninsured are very reluctant to seek care due to the threat of personal bankruptcy or damage to their credit record.

- *Lack of available appointments.* The presence of free clinics varies by county and most cannot serve all of the primary care needs of the uninsured in a timely fashion (long waiting times for appointments, only open a limited number of days).

- *Specialists difficult to access.* The uninsured are finding it difficult to access primary care since appointments are given on the basis of whether one has insurance or not. Access to specialist-based care is virtually impossible since most specialist physicians demand that 100% of the procedure's cost be paid prior to service.

- *Access to physicians serving Medicaid patients.* Providers often opt out of the Medicaid system because they claim the cost of treating "non-compliant" patients is high relative to available reimbursement.

Stakeholder Assessment of the Available Government Programs

Due to its complex nature, broad government insurance programs like Medicaid are not well understood by staff, enrollees, and many providers.

- *Hoosier Healthwise is a positive state program.* The Hoosier Healthwise program for low income children in Medicaid is regarded as a good example of a state government healthcare program.

- *More awareness is needed.* There seems to be a lack of external communication efforts that publicize the existence of state public health programs to potential enrollees. Many of the uninsured populations lack awareness of the many state benefit programs that may be available to them.

- *Medicaid is perceived as complex and slow.* Medicaid is perceived as a very slow and very complex system. Most of the uninsured cannot understand why eligibility decisions take between six months to over a year in some cases. It would appear the system's complexity prevents many state employees from informing recipients of other state programs they may qualify for. Providers opt out of the Medicaid system due to inadequate reimbursement and the costly and time consuming process of Medicaid auditing.

- *Medicaid creates a disincentive to work.* Medicaid's rich benefit package and first dollar coverage creates a large disincentive for those on Medicaid to find work since their health coverage would likely diminish as a result of gaining employment; particularly if the Medicaid recipient was going to work for a small employer.

Recommendations for Increasing Coverage

- *State funded health benefit plan is supported.* There is considerable support for a state funded health benefit plan for the uninsured with a focus on primary and preventative care. There are some stakeholders, including the uninsured, who would pay for their primary care but want protection from catastrophic healthcare expenses.

- *Increase the number of physicians at the clinics.* The supply of physicians to free clinics for the uninsured could be enhanced by the state's efforts to assist them with liability and malpractice

protection given the higher medical risk and the potential litigious nature of this population in general.

- *Consensus between the stakeholders is not apparent.* There is recognition by all stakeholders that the problems of the uninsured are great, but there is little consensus between the groups on either short-term or long-term options.

EMERGENT THEMES BY STAKEHOLDER GROUP

The Uninsured and the Working Poor

"The cost for my family coverage would be approximately $500 per month out of my $16,000 annual salary, or $1,300 per month before taxes."

Region 6 CNA working at a local nursing home

- Cost is the number one obstacle to purchasing insurance because it impinges on other important spending.

- Many of the uninsured do not qualify for the opportunity to purchase insurance coverage due to pre-existing conditions.

- While temporary and part-time work is available, these workers rarely, if ever qualify for health insurance because most employer benefit plans exclude these types of positions from coverage.

"I feel betrayed by a system that on the one hand encouraged me to get help, but turned around and punished me for doing so. I am young and very nervous about the increased stress of not having insurance if I needed it."

Region 4 woman rejected for insurance coverage because of a previous bout with depression

- Most of the uninsured believe that "Healthcare is a right – not a privilege" and are desperate for solutions.

- Access to quality care (appointments and specialists) often requires coverage or 100% payment in advance.

- Due to the scaling back in benefits and increased costs of employer based health insurance, Medicaid has become a sought after benefit plan. It is difficult to qualify for, however, because of strict eligibility guidelines. Once someone qualifies for Medicaid, there may not be a strong incentive to look for employment due to the loss of Medicaid. The Med Works program will alleviate this for some.

"I was denied access for my sick child because I owed money on a previous bill."

Region 7 mother

- Free clinics, if locally available, are heavily utilized.

- While the ER is a likely destination for those seeking immediate care, the fear of bankruptcy, gaining additional debt, or receiving a bad credit rating dissuades many from accessing care when it is needed most. Most access the ER as a "last resort" due to the financial consequences that will result.

"I could get a job, lose my Medicaid benefits, and pay someone more than I would make to care for my invalid husband and disabled child. But I made an economic and personal decision that I could give better care and be better off myself."

Region 8 woman not working so that she qualifies for Medicaid

- Hoosier Healthwise is a wonderful health program for the kids who qualify – but their parents usually have to go without coverage.

- Preventative care (i.e., screenings), vision, and dental are the most sought after benefits in insurance plans. Prescription drugs are also a great need, but once inside the safety net system, many are

"I am almost at the end of my transitional Medicaid assistance benefit. I am working for a daycare center where no insurance was offered. I don't know what I will do when my Medicaid benefits run out."

Region 10 Type 1 insulin-dependant diabetic

"I have bills over $500,000 of mostly hospital debt. I know I will never be able to pay it off. "

Region 8 woman

"I left my teaching position with good health insurance to care for my children, one of whom has a physical disability. My husband works construction and does not have access to any insurance coverage. Although my children are eligible for Hoosier Healthwise, my husband and I are left without any coverage."

Region 4 mother

able to access prescription drugs through office samples or one of the Pharma programs.

- The uninsured are willing to spend money on the "right" health plan. Generally speaking, the uninsured expressed willingness to pay anywhere from $150 to $500 per month for the security and protection they would have with insurance.

- The uninsured believe that the government, the employer, and the individual all have a role in addressing the uninsured issue, but the government must lead the effort.

- Proving the need to purchase healthcare insurance is a hurdle for Hispanics. Based on cultural reasons regarding the definition of an illness, their ancestor's experience with government-run healthcare systems, and fear of governmental scrutiny, many Hispanics do not seek healthcare and are less inclined to pursue healthcare insurance coverage. Hispanics also typically work in the kinds of positions (temps, restaurants, construction) that do not offer affordable insurance. Hence, the growing numbers of Hispanics in all parts of the state contribute to the growing number of uninsured.

Additional Vignettes from the Uninsured

The following vignettes are either descriptions of actual participants or the actual feedback given by those participating in the focus groups. It is hoped that these vignettes help to clarify the very significant challenges facing the uninsured when they need to access the healthcare system and then pay for medical services.

"I cannot get medical coverage, and am afraid to apply for Medicaid for fear of losing my home. I utilize the free clinic."

A woman in her late 50s who cares for her sick mother on Social Security

"I cannot obtain affordable medical coverage, so I regularly visit the free clinic, as do many of the men living in my recovery home. Indiana public health programs help women and children, but it is difficult for men to qualify for public healthcare programs."

A middle aged male diabetic who manages a new life recovery home

"I cannot get my disabled mother physician care without providing money up front. She is in need of specialty diagnostic and treatment procedures which require 100% payment in advance before the physician will treat her. In order to get her routine care, she goes to the free clinic and utilizes prescription cards from the major companies to obtain medications."

A middle aged man who takes care of his disabled mom

"I make about $750 per month from Social Security and cannot afford my prescription drugs. As an alternative I lay down to alleviate abdominal pain. I attempted to get treated at the local hospital emergency room for diagnostic services, but was then referred to a large public teaching hospital in the city for a CT scan. After 36 hours, the hospital informed me that since he was not a resident within the tax district that supports the hospital; the hospital was unable to provide treatment. I was sent back home without receiving any treatment."

Disabled man in his mid 60s

"I lost my benefits after the premiums went up 250% in one year. I was covered under my parents' plan until I graduated from college. After that, I carried an individual plan with a $100 deductible and even some prescription coverage. Although I never filed a claim, the premiums started going up and I gradually increased my deductible to $1,000 and dropped all coverage except major medical and hospitalization. When the premiums reached $2,400 per year, I dropped the coverage and now have no insurance. I work two part-time jobs making about $8.00 per hour. I value the protection of insurance even though the only claim ever paid was to have my appendix removed when I was ten years old."

25-year old single woman without any children

"My public health coverage forces me to get my drugs at the beginning of the month. (This is because of spend-down requirements of Medicaid) If something happened to me medically towards the end of the month, I have to wait until the first of the next month to go seek treatment in order to get some assistance from my public insurance."

Woman in her late 40s to early 50s

"I work for McDonald's and I am on their insurance plan. I have to accrue $300 dollars for prescriptions before being reimbursed and only get a small percentage of medical bills paid by insurance plan."

A single mother in her early 40s with children

"I work for a temporary agency and do not receive any health insurance benefits. I will not go to the free clinic for healthcare due to the low quality of care that is provided."

Female in her mid 20s

"I have worked for many temp agencies who assigned me to small manufacturers making $6 per hour. I am not interested in health insurance unless it costs me only a few dollars per month."

Female in her mid 40s

Access to healthcare is a right.

Access to healthcare insurance is not a right.

Providers

- Coverage is not available to the unemployed, the employees of small businesses, and/or those earning minimum wage.
- Primary and preventative care will prevent the uninsured from flooding emergency rooms, but educating this population is a crucial prerequisite.
- Although it seems to be getting better, Medicaid is perceived as a slow, bureaucratic system that dissuades many physicians from participation by virtue of very low reimbursement levels, lots of paperwork, and an overall "hassle" factor. Many said this does not bode well for the success of any potential state-sponsored health plan.
- Medicaid coverage is extremely benefit-rich and its first dollar coverage incentivizes inappropriate utilization of healthcare resources.
- Insurance coverage should be mandatory for individuals to carry.
- Prescription drugs are extremely unattainable for the uninsured due to their out-of-pocket costs.
- Physicians would be willing to donate more time to serving the uninsured if the overall reimbursement levels were higher and the state would assist them with liability and malpractice insurance coverage.
- Free clinics are being used – but having limited effect on reducing ER volumes.
- The relatively low level of provider reimbursement for uninsured populations directly impacts the quality of care they receive because this population is largely a higher risk population that is often non-compliant with their prescribed treatment and is more likely to sue providers for alleged malpractice.

"I am working in a bakery and am waiting for the insurance coverage to begin in six months. I recently had family difficulties after one of my sons was shot by another son. When I called to get counseling help, I was told I would have to wait two months for an appointment. The safety net clinic was able to assist me in getting an appointment."

Region 8 woman in desperate need of mental health counseling

The safety net clinic in Region 5 sees about the same number of patients but they are in greater need of accessing prescription drugs.

Many respondents told of grandparents raising their grandchildren and not knowing how to access care.

Community Groups

- Cost is the #1 issue to acquiring coverage.
- Not all community healthcare safety nets are alike – some are much better than others in large part due to the level of federal funding they receive.
- Not all funding mechanisms for the safety nets are alike – some communities are better at accessing grants than others.
- Personal pride and social stigma of public assistance prevents many in rural areas (particularly seniors) from seeking public assistance.
- General awareness of state programs varies by county and community and their communication is dependent upon word of mouth. Many nurses and doctors do not know about safety net programs and are unable to assist patients in accessing these programs.
- Many Hispanics are often reluctant to seek care and some communities are much more proactive on outreach than others. Language is only one barrier to seeking care.
- The safety net system helps provide primary care but does not help with specialty care. For example, the person may come into the ER with chest pains but the patient will not get free care for a coronary bypass.

Healthcare insurance and coverage is a privilege – not necessarily a right.

"The owner's eyes go directly to the bottom line and they work backward to the benefits. They love the service but hate the rates."

Broker describing what happens when he delivers the renewal quotes

Benefit mandates from the state hurt the group insurance market and the lack of condition waivers hurts the individual insurance market.

"If the spouse of the owner has insurance, he or she is less likely to offer insurance to the employees."

"People choose to make material purchases before buying health insurance."

"Lifestyle choices make the need for future healthcare services inevitable."

Various Brokers

Insurance Brokers

- Cost is the primary criteria in an employer's decision to offer coverage.
- In small businesses, the decision of whether to offer coverage is very owner dependent and is often a decision on gaining personal coverage.
- While HIPAA has increased the complexity and cost of administering health insurance by 10-15%, it has helped to police fraud in employer information disclosure.
- Cost shifting as a tactic in spreading the sharply increased costs of healthcare coverage is alive and well (whether from employer to employee, from employee to spouse's employer, etc.).
- Insurance carriers often "underprice" a prospective new employer account, then raise rates in the following years to compensate for losses in the early years.
- Benefit mandates from the state add significant costs, to the cost of group insurance.
- The absence of significant condition waiver legislation from the state diminishes the market for affordable coverage options for individuals.
- Tax credits may be a good incentive for individuals to purchase insurance.
- Many people do not understand the impact one's lifestyle choices have on the costs of health insurance coverage.

Affording healthcare coverage is an impossible situation.

Small Businesses

- Addressing the skyrocketing cost of health insurance is the #1 issue to increasing coverage in this group.
- A small employer's ability to offer coverage is directly tied to the health of the overall economy.
- Yearly premium rate increases in small businesses of 25-30% are common.
- It's not unusual for some employees of a small employer to be labeled as "high risk" which can then send premiums up 75-100% the following year.
- Offering health insurance adds significant overhead expense to the cost of employment. For minimum wage employees, health insurance can increase payroll expense an additional 50-80% per person - thereby creating a significant disincentive to hire additional workers
- Employers are utilizing any and all cost-shifting strategies toward employees with many employers moving toward defined contribution.
- Even those small business employees earning well above minimum wage ($30-$40,000 per year) are not choosing to accept coverage due to its relatively high cost (approximately $800 per month or over 25% of salary for access to a large PPO based plan).
- Several employers have joined Professional Employment Organizations (PEOs) in order to purchase coverage at discounted rates - with varying success.
- Awareness of state programs which employees may qualify for is virtually non-existent.
- Very skeptical of any government sponsored initiatives to address the uninsured (i.e., state health plan).
- Employees (and employers) need to become better consumers of healthcare – but the lack of any comparative information makes this difficult.
- Employer tax credits for offering coverage are viable if the benefit is prorated based on the level of coverage offered.
- Many employees aged 40 and below do not feel they need coverage.

- Many employees 40 and older do not feel they can afford coverage because of its high cost and assume if they become ill, the local hospital will treat them and establish a plan for repayment.

SUMMARY

The skyrocketing rise in the cost of health care has decreased the level of coverage employers have been available to offer to their employees, as well as the coverage employees have been able to afford, thus increasing the ranks of the uninsured in Indiana. Small businesses appear to have been severely affected (relative to large employers) since small business premium cost trends have averaged 20-30 percent per year recently and sometimes reach 100 percent depending on specific individual risks. In fact, some of these small business employees with significant risks have been classified by their employer's insurance providers as having a "pre-existing condition" and are thus uninsurable or prohibitively expensive to cover. If these employees were not excluded from the outset, they are usually effectively excluded due to the size of the premium needed to cover them.

Unlike large employers who may be self-insured and subject to the ERISA exemption from following state benefit mandates, these small employers cite state benefit mandates as a key driver of the increase in health insurance premiums. Small employers' health insurance costs are decreasing the ability of the small employer to hiring additional workers, thus inhibiting economic growth. Even though most all small employers have tried to battle rising premiums through the usual tactics such as increased cost sharing, higher deductibles, higher co-pays, excluding spouses from coverage scaling back the benefit plan, premiums continue to rise faster than average. Some small employers even admitted to conducting "applicant profiling" in order to screen out those applicants who if hired, would increase premiums substantially such as applicants with families or those with significant health problems.

The interviews also confirmed that while coverage is unaffordable for many small businesses, it is not even made available to many small business employees namely those working in seasonal jobs like construction and those working in hotel, restaurant, and retail environments. In addition, many uninsured respondents cited the jobs most likely to become available to those who are unemployed are those with temporary agencies or with companies who want to hire part-time employees. Unfortunately, health insurance benefits are usually not available to temporary employees nor to part-time employees. Due to the expense of offering health benefits to employees, it should come as no surprise that small companies have a strong financial incentive to hire temps and to hold hourly workers to under 40 hours per week in order to control expenses.

So where do the uninsured (temps, part-time employees, those working in seasonal businesses) access health care? They most often use the local hospital emergency room or a local free clinic if available. The availability of free clinics varies widely from county to county and some of the more successful models are adept at applying and winning federal grant money for program development.

While most all the groups we spoke with would welcome any incentives the state could offer to promote employers to offer health insurance, most of the focus group attendees realized effective long-term health care cost control lies in education and the dissemination of information. Most insurance brokers and small business employers felt that if employers and employees received more information on their health care status and their treatment options (including projected costs), in addition to having access to comparative performance data on various potential health providers, competition and the free market would lower health costs tremendously. The small employers were especially adamant that they should have access to provider performance data in order to make better informed decisions on which health providers to contract with. As a result, these employers support the use of high deductible heath plans or medical savings accounts so that the employee becomes more aware of the true cost of healthcare resources.

Aside from incentives, many uninsured individuals believed that state government has a role to play in working with employers and individuals to find ways to increase health care coverage. However, some were skeptical whether public health programs administered by the state government will help to solve the issue long term. It was suggested the state could dramatically help the uninsured if it would improve the awareness of current programs through more effective external communications programs.

One area where most all respondents agreed that state government could help is facilitating the development of "basic" health insurance program that the uninsured can "buy into" based on a sliding scale of income level. While most of the physicians polled agreed that such a plan should focus on offering preventative care and primary care in order to replace the acute and emergency care the uninsured usually access in the emergency room setting, the uninsured respondents said such a plan needs to offer vision and dental benefits in addition to providing diagnostic screening procedures and catastrophic coverage. The physicians also said the state could help increase the ability of physicians to volunteer at free clinics and thus offload current emergency room volumes if it would facilitate the procurement of

CONCLUSION

In conclusion, there are different reasons people do not have access to affordable health insurance. Businesses, and in particular small businesses, will not able to continue to absorb the increases and almost all businesses, large and small, are passing on some portion of the increase to their employees. In addition, the it is unlikely that administration and legislative leaders will propose any major expansions in the current budget environment without significant leveraging opportunities.

While the state has committed significant resources to expanding the safety net system, there continue to be large gaps in coverage both geographically and in secondary and tertiary care as well as access to pharmaceuticals.

Finding solutions will require a focus on the many dimensions of the health care system, including access to care, access to affordable insurance, provider supply, and quality. It will require leadership and consensus from key stakeholder groups. There will need to be agreement on the direction, the scope and the timetable for achieving the goal of expanding coverage to all Hoosiers.

Appendix A – Summary of Responses by Stakeholder

Summary Responses – Uninsured

On coverage

- Increasingly being dropped by employers
- If offered by employer, very likely not to be taken by employee due to its high cost
- Large companies can afford, small businesses cannot
- Temporary and part-time workers are ineligible to qualify to purchase
- Preexisting conditions prevents many from qualifying

On costs

- Unaffordable by small business employers and employees
- On consequences
- High cost discourages the use of medical care
- Providers demand payment in advance; high cost specialty procedures are unaffordable, and hence not performed
- Fear of bankruptcy and/or damage to credit record discourages utilization
- Access to physicians is very difficult, appointments are difficult to obtain

On a "Basic Plan" and how much to pay?

- Rx drugs, MD visits, hospitalizations, vision, dental, preventative and diagnostic screenings
- How much? – between $10-$200 per month per individual based on income level

On where to go for care, who pays, and what are the implications?

- Free care/Free clinics - where available
- ER
- On the recent healthcare experience
- Access to physician offices is greatly enhanced with insurance
- Attitude of staff improves when one has insurance

On government programs and the Medicaid program in particular

- Awareness of programs varies by county
- Generally, program information is poorly communicated or coordinated among existing infrastructure (with exceptions)
- Hoosier Healthwise – rave reviews
- Medicaid – eligibility is difficult, complex process/system of qualification very few understand, long waiting periods, lots of paperwork, and relatively rich benefit package creates disincentives to leave program

Appendix A – Summary of Responses by Stakeholder (continued)

Summary Responses – Physicians

On the uninsured

- Who are they? unemployed, minimum wage, small businesses, immigrants
- Challenges they face: access to MDs, bankruptcies on increase, ERs are overcrowded, Rx drugs are unaffordable

On coverage

- It exists – need to motivate individuals to purchase or participate
- Too costly for employers and employees
- Not a priority purchase for many to make

On where to go for care, who pays, and what are the implications?

- ER, free clinics
- Free clinics are being utilized more, but ER load is not decreasing
- What should a state sponsor "Basic" health plan cover?
- Emergency care, Rx drugs, physician care, mental health, health screenings, and other preventative care to relieve the ER demand

On government and the Medicaid program in particular

- Less government involvement is better
- Care rationing is needed
- Need more preventative care
- Too many MDs do not accept Medicaid patients
- Medicaid is currently too expensive to operate – too many man hours required, provider reimbursements are too low, paperwork is a hassle, auditing is too costly to endure, and the first dollar coverage incentivizes inappropriate utilization
- HIPAA paperwork is excessive
- Public does not want more programs until they are in need
- Government needs to mandate insurance coverage, maintain low bureaucracy

On responsibility for coverage and recommendations for the future

- Government mandated, co-pays, premiums/co-pays based on income
- Need to educate families on importance of preventative care
- A state-sponsored minimal insurance program covering primary and preventative care on a pay-as-you-go basis
- Government programs are not acceptable by public until they are in need

Other comments

- Nurses now spend 35% of their time on non patient issues (i.e., paperwork)
- Pool of volunteer MDs for free clinics would increase if malpractice/liability insurance was provided by the state
- Tort reform, incentivize primary care, ability to cost shift to private sector is a key reason for Medicare

Appendix A – Summary of Responses by Stakeholder (continued)

Summary Responses - Community Groups

On coverage
- Employer based
- Lack of coverage exacerbated by poor economy
- People without insurance get coverage via Medicare and Medicaid
- Hospital write-offs are growing
- Pre-existing conditions are the major obstacle to qualifying for coverage
- 25% do not have insurance, 50% have insurance, 25% on Medicaid (Kokomo)
- Certain cultural beliefs are obstacles to care (Example: Hispanics and pregnancy)

On costs
- Premiums are generally affordable – co-pays and deductibles are the problem
- Premiums are outpacing wages

On consequences
- Employers moving to HMOs or dropping coverage altogether
- Poor access to specialists
- Preventative care is elusive
- Fear of financial losses and/or receiving bad credit hinders appropriate utilization
- Who are uninsured?
- Part-time and the unemployed
- Those who lack coverage are in "low end" jobs (retail, hotel, restaurants, seasonal)
- Why are they uninsured?
- Coverage relatively unimportant to most people

On a "Basic Plan" and how much to pay?
- Preventative care, immunizations, basic dental, mental health, prenatal care
- How much? – between $100-$200 month with reasonable co-pays

On where to go for care, who pays, and what are the implications?
- ER, free clinic, community health center
- Sliding scale clinic is good but overcrowded and prescriptions are difficult to obtain

On government programs and the Medicaid program in particular
- Awareness varies by location (very good to very poor), external communications program is lacking, communication is word of mouth
- Many do not know how to access government programs
- Pride and stigma of public programs hinders participation
- Medicaid – complex program, lots of paperwork, eligibility decisions take too long (six months), CHIP and Hoosier Healthwise are successful, does not cover enough people – just the very poor, provider network is too small, many do not understand the program

Appendix A – Summary of Responses by Stakeholder (continued)

Summary Responses - Community Groups (continued)

On responsibility for coverage and recommendations for the future

- Government – but it changes too much
- Employers
- State basic health program – with premiums based on sliding scale according to income, easy access to physician, expand eligibility to include those trying to work, needs extensive publication, preventative care model, need to re-define disability, exchange coverage for volunteer work, administer the program through local clinics

Summary Responses – Insurance Brokers

Why do small businesses offer coverage?

- Attract and retain employees, social expectations
- Owner wants coverage for self and spouse
- Tax deductibility

Recent rate increases (Past three years)

- 15-30% for simple plans
- 75-100% for other plans with high risks (i.e., cancer cases, etc.)
- HIPAA responsible for some of the increase
- Individual risks can raise rates 100% or more (need verify)

Key attributes of offering coverage to an employer

- Cost, cost, cost
- Scope of provider network
- Service in administering claims
- Reputation of carrier
- Policy waiting periods
- Once the above are met, then commission level and whether carrier can guarantee premium for at least one year

Size of business more likely to offer coverage

- Between 11-50 employees
- Older more established businesses
- If less than five employees – likely not to offer coverage
- Many “Mom and Pop” businesses offer (less than 10 employees), but employees do not accept due to high cost

Types of business more likely to offer coverage

- Auto parts, union shops, white collar, 12-month employees (not seasonal)

Appendix A – Summary of Responses by Stakeholder (continued)

Insurance Brokers (continued)

Types of businesses less likely to offer coverage

- Steelmakers, small manufacturers, tool and die makers, service businesses (gas stations), seasonal or those businesses with high turnover (retail, restaurants, and hotels)

Strategies used to lower premium costs

- Raise deductibles and co-pays (i.e., cost shift to the employee), spousal exclusions, fixed level of contributions from employer, health reimbursement accounts, eliminate dependent coverage, encourage to join spouse's plan, drop dental and vision coverage, disease management initiatives, eliminate short-term disability coverage, employee education

Other factors

- Level of paperwork due to HIPAA
- Willingness of employers to commit to 25% average annual premium increases
- Agent service levels to provide necessary education to employees about their benefits
- Disease exclusions only apply to employers with over 50 employees
- Stated level of employer's contribution not audited – how much are premiums subsidized?
- 30 hours per week threshold before coverage is mandated

On responsibility for coverage and recommendations for the future

- State needs to offer incentives for people to buy insurance
- Reinstitute waivers for individual insurance market
- Eliminate mandated coverage for group market
- State sponsored education to inform people of their options (i.e., affordable MSAs with high deductibles)
- Need ability to decrease level of benefits to lower the cost
- Expand defined contribution programs
- Offer MSAs with high deductible catastrophic care policy
- Offer individual tax credits for purchasing coverage
- Fix ICHIA – limit lifetime maximums in line with commercial insurers ($2-$3 million) and eliminate the three month premium paid in advance to enroll because many qualified people cannot afford
- Allow exclusions for some individuals in small groups in order to lower premiums for small businesses
- State-subsidized insurance is bad idea, as government should not be involved in the healthcare purchase
- Keep incentives aligned – so that people will want to work to expand their benefit package

Other comments

- Health insurance coverage is a privilege, but employees believe health insurance coverage is a right

Appendix A – Summary of Responses by Stakeholder (continued)

Summary Responses - Small Business

Why offer coverage

- Employee retention and attraction
- Tax deductibility of premiums
- Recent rate increases (Past three years)
- Between 20-50% with some at 75-100%

Strategies used to keep costs down

- Implement Medical Savings Accounts (MSAs) combined with catastrophic coverage with high deductible
- Scale back benefits
- Raise deductibles, co-pays
- Pay cash directly to employees ("under the table")
- Extensive education to employees on true cost of coverage
- Join Professional Employment Organizations (PEOs)
- Change carriers frequently
- Purchase insurance through a larger group association
- Applicant "profiling" – avoid hiring those who could drive up premiums

What level of premium would prompt you to withdraw coverage altogether?

- Question arises each year
- Target number is rapidly approaching as profits decline and premiums increase
- Very dependent upon local economic conditions
- Current premium

Recommendations to increase coverage for employees

- Employer tax credits prorated based on the level of employer's contribution
- Move employer-based insurance model back to where it began - catastrophic care only
- More information needed on the costs/value of different healthcare providers

What should the government's role be (if any) to increase healthcare coverage

- Keep government out of the health insurance marketplace
- Help to better inform employers and consumers of provider costs
- Educate employees that healthcare is not an entitlement
- Mandate insurance companies inform employees of state programs, if eligible
- Increase awareness of public programs
- Need to revamp ICHIA funding formula and eligibility criteria for high risk individuals – currently serves too many out of state residents
- Ensure neighborhood clinics are in place for the uninsured

Appendix B – Questionnaires for Stakeholder Groups

HEALTH EVOLUTIONS
HRSA State Planning Grant
Focus Group Discussion Guide for ***Community Groups***
Draft 2/24/03

Welcome and Introductions: Hello and welcome to our session. My name is _____, and I want to thank you for taking the time to join us in this discussion. I'd like to also introduce _____ who is here to assist me this morning/afternoon/evening. We are here because the state is interested in learning more about the uninsured in Indiana to determine what can be done to help more people receive adequate health care coverage in the future. This is just one of nearly 60 sessions that will be held throughout the state. Your opinions are very important and may be the basis from which changes in health insurance coverage are made. There are no wrong answers but you may have different opinions on what is being said. This morning/afternoon/evening we welcome all points of view, and we just need to agree that at times we'll disagree. Please feel free to share your thoughts even if it's different from what others have said. There are a couple of ground rules for this morning/afternoon/evening. First of all, please speak one at a time and secondly, don't have any side conversations.

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Please help yourselves to the refreshments, and if you need to use the restroom, it is located _____. Before we begin with our questions, I would like you to tell us the first name that you would like to be called tonight, where you live, and if you work, tell us what kind of work you do.

Health Insurance Coverage:

HIC 1. Do the folks that you work with currently have health insurance coverage, such as coverage through a job, through the government or that is purchased on their own?
HIC 2. Has this trend changed in the last two years? What happened that caused the change?
HIC 3. Are folks currently self-employed, employed by someone else, or unemployed?
HIC 4. For those who work for a company, does the employer offer any type of health insurance coverage for its employees? If they are not eligible, why?
HIC 5. Do you find that if folks are eligible for employer-sponsored health insurance, why do they not sign up for it?
HIC 6. Do you find that various members of the households have different health insurance such as through their employer, work, government, individual policy, etc. Does this create problems?
HIC 7. What services should be covered in a basic, low-cost health insurance plan?

Cost of Coverage:

CC 1. What are some reasons that your constituents might not buy health insurance on their own or sign up for coverage? (Probe: health status, expense, don't have a problem getting care without it, etc.)
CC 2. What concerns you most about the cost of health insurance?

Consequences of No Coverage

CQ 1. If people in your area get sick or needed medical care, where would they go for care? If they are uninsured, has it been difficult or easy to get medical care when they need it? (Probe: examples of how it has been difficult)
CQ 2. Who would pay the bill for that care? (Probe: borrow the money, wouldn't pay, would pay over a long period of time, etc.)
CQ 3. Have there been times when people have not sought medical care when they or a family member may have needed it because of concern about the cost? (Probe: examples)
CQ 5. What worries those you know most about not having health insurance? Have there been financial consequences because they do not have health insurance?

Health Care Experience

HCE 1. Overall, how would you describe the experiences when they have required health care? (Probe: ease of getting service, time with doctor, attitude of doctor and staff, etc.)

Willingness/Ability to Pay

WP 1. How much, if anything, do you think people would or should be willing or able to pay each month out of their own pocket for a health plan that provides basic coverage for doctor visits, hospitalizations and prescription drugs?

Government and Health Insurance

GHP 1. Are you familiar with health insurance coverage available from public entities? How do people/you get your information on this coverage?
GHP 2. How many of your constituents have you ever been enrolled in a public health insurance program? If so, what happened so that you are now not on the program?
GHP 3. Do you believe that your constituents or other members of their household are currently eligible for public health insurance programs? If so, have they signed up? If they haven't signed up, what is keeping them from signing up?
GHP 4. From what you know, do you think Medicaid is a good or bad program? What about CHIP?

Closing Questions

CQ 1. Who do you think should be responsible for providing health insurance coverage? (Probe: individuals, employers, government, others?)
CQ 2. What would your recommendation be to increase health care coverage of people throughout Indiana?
CQ 3. Let's pretend you have one minute to talk with government officials about health care coverage. What are the main points you would want to make?
CQ 4. Is there anything else related to the topic of health insurance that you would like to make before we close? Have we missed anything?

Closing Comments

I want to thank you again for taking the time to participate in our discussion. Your input has been very helpful.

HEALTH EVOLUTIONS
HRSA State Planning Grant
Focus Group Discussion Guide for Providers
Draft 3/03/03

Welcome and Introductions: Hello and welcome to our session. My name is _____, and I want to thank you for taking the time to join us in this discussion. I'd like to also introduce _____ who is here to assist me this morning/afternoon/evening. We are here because the state is interested in learning more about the uninsured in Indiana to determine what can be done to help more people receive adequate health care coverage in the future. This is just one of nearly 60 sessions that will be held throughout the state. This session will help the state understand the provider's perspectives on the uninsured and the impact that they have on providers. Your opinions are very important and may be the basis from which changes in health insurance coverage are made. There are no wrong answers but you may have different opinions on what is being said. This morning/afternoon/evening we welcome all points of view, and we just need to agree that at times we'll disagree. Please feel free to share your thoughts even if it's different from what others have said. There are a couple of ground rules for this morning/afternoon/evening. First of all, please speak one at a time and secondly, don't have any side conversations.

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Uninsured Questions:

UQ 1. Based upon your experience, why don't people in Indiana have health insurance? What factors cause them to be uninsured?
UQ 2. Are there particular populations who seem to lack coverage? If yes, who?
UQ 3. What are the greatest problems for the uninsured?

Impact of the Uninsured Questions:

IUQ 1. How are the uninsured getting their health care needs met?
IUQ 2. Have you seen the number of uninsured patients accessing your system increase? If yes, how significant is the increase and what has the impact been on you?
IUQ 3. Have you made any changes in the way you practice as a result on the increase number of uninsured? If yes, how?

General Coverage Questions:

GCQ 1. How do you think health coverage could be provided to everyone?

GCQ 2. If you do not believe that health coverage should be provided to everyone, do you believe that at a minimum all children should be covered? Should proof of coverage be a requirement for school enrollment?

GCQ 3. How do you define a minimally acceptable insurance benefit package? What services should be covered?

Public Coverage Questions:

PCQ 1. From a business perspective, what is your experience with public insurance programs?
PCQ 2. From a health care perspective, what is your experience with public insurance programs?
PCQ 3. Why do you think some people don't participate in public programs even though they are eligible?
PCQ 4. If there was a way to expand public insurance programs, how would that affect you?
PCQ 5. In your opinion, how should the government work with providers to address the uninsured problem?
PCQ 6. How can people be better informed about public programs that are available?

Closing Questions

Just a few more questions before we close our session today.

CQ 1. Do you believe that the overall health insurance system needs to be changed? If yes, why and how would you change it?
CQ 2. What should the government's role be in increasing health coverage? Should tax credits be provided to employers to assist in covering premium expenses?
CQ 3. Are there any additional relevant comments that you would like to make before we wrap-up this session?
CQ 4. Is there anything we missed?

Closing Comments

I want to thank you again for taking the time to participate in our discussion. You input has been very helpful.

HEALTH EVOLUTIONS
HRSA State Planning Grant
Focus Group Discussion Guide for Small Businesses
Draft 3/03/03

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Employee Health Insurance Coverage:

EHIC 1. Please place a dot next to each category of employee that is offered coverage by your firm.

- Full-time salaried
- Part-time (20 hours or more)
- Part-time (less than 20 hours)
- Hourly
- Seasonal/temporary
- Other

EHIC 2. To what percentage of your employees do you offer health coverage?
EHIC 3. What percentage of your employees accepts this coverage? Please describe the types of employees who accept it. i.e. age, family status (married, single, with children, etc.), salary
EHIC 4. How are the costs of coverage shared between you and your employees (ratio)?
EHIC 5. Do you offer more than one plan? If so, how many, and how do the plans vary (in cost, scope, type, etc.)? Does geographic region influence the health care that is offered? i.e. rural vs. urban

EHIC 6. What about the employees? Are they covered elsewhere (through spouse) or uninsured? Please explain.
EHIC 7. Why don't you offer insurance to everyone?

EHIC 8. For those of you who don't have health insurance, have you ever had it? What happened that caused you to no longer have health insurance?
EHIC 9. For those of you who offer health insurance, what have your rate increases been over the last three years?
EHIC 10. What are you doing differently as a result of the increase in cost? (Probe: move to a different carrier, increase employee contributions, change benefit plan design, drop health benefits, etc.)h

Factors Influencing Employers' Provision of Health Coverage:

FIC 1. How do you benefit from offering employee health coverage?
FIC 2. How do your employees benefit from having coverage?
FIC 3. What are the main drawbacks to offering coverage from the company's perspective?
FIC 4. Under what circumstances would your company have to seriously reassess the health coverage it offers? Please explain.
FIC 5. How would you consider changing the coverage your company offers? (Probe: employer/employee contribution ration, changing plans, other benefit reductions, etc.)
FIC 6. In what situations would you totally withdraw your offer of coverage? (Probe: a certain % of premium increase, a certain $ amount increase, etc.)

Employers Without Health Coverage:

EWHC 1. For those of you representing companies that do not offer health coverage, has your company ever offered health benefits? If yes, what caused you to discontinue them? How did your employees react when you discontinued coverage?
EWHC 2. What are the main advantages to not offering coverage? What are the main disadvantages?
EWHC 3. What do you see as the key benefits to a company providing health coverage to its employees?
EWHC 4. What factors pose the biggest barriers to offering health coverage in the state?
EWHC 5. What are the main reasons your company does not currently offer health insurance? How do the following influence your decision? Cost of the plan per employee, administrative time/paperwork, pre-existing conditions limitations, unnecessary to attract/retain employees
EWHC 6. In your opinion, how are your employees effected by not having health coverage?
EWHC 7. Under what conditions would your company consider offering health coverage? (Probe: competition for workers, decrease in premiums, etc.)
EWHC 8. What types of internal changes would your company need to make if it were to offer health coverage?

State Health Coverage

SHC 1. Describe the responsibility for health coverage in Indiana that each of the following parties currently carries?
- Employers
- Government
- Employees

SHC 2. How has the burden of providing health coverage to employees in the state shifted over the years?
SHC 3. Who do you think should be responsible for health coverage, now and in the future? Should the responsibility be shared, and if yes, how?

Increasing Health Coverage

IHC 1. Image you have been hired to develop ideas and practical ways to increase health coverage of employees. What are some different options and solutions that you would suggest? Consider the roles and responsibilities of the following:
- Employees
- Individuals themselves
- Individual employers
- Employers as a group
- The state

Include examples that would consider offering employers incentives to extend coverage to all employees, encourage employees to take advantage of employer-sponsored coverage.
IHC 2. What idea or recommendations do you feel would be most readily embraced by:
- Employers
- Employees

IHC 3. Are there ideas or recommendations that you feel would NOT be embraced by:
- Employers
- Employees

Why?

IHC 4. How appealing is the idea of participating in a subsidized insurance program through the government? (Probe: Premium discounts, tax credits, Medicaid expansion, etc.)
IHC 5. How do you feel about state funds being used to help make coverage more affordable to lower-wage employees in Indiana? (Probe: tax breaks for individuals or firms, premium supports, etc.)
IHC 6. What incentives do you think would be effective in encouraging employers to offer health insurance and should these incentives be offered to companies that already offer health insurance?
IHC 7. How do you think employers would respond to the idea that health insurance should be mandated by the government?

Closing Questions

Just a few more questions before we close our session today.

CQ 1. What would your final recommendation be to increase health coverage of employees in Indiana?
CQ 2. What should the government's role be in increasing health coverage?
CQ 3. Are there any additional relevant comments that you would like to make before we wrap-up this session?
CQ 4. Is there anything we missed?

Closing Comments

I want to thank you again for taking the time to participate in our discussion. You input has been very helpful.

HEALTH EVOLUTIONS
HRSA State Planning Grant
Focus Group Discussion Guide for Insurers/Brokers
Draft 5/28/03

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Broker Perceptions:

1. What do you find to be the major reasons that small employers offer Health insurance? (.eg: employee retention, employee satisfaction, morale, etc.)
2. What attributes are most important to them when deciding to offer health insurance (i.e., cost, comprehensiveness, catastrophic care?)
3. What size small business is most likely to offer health insurance? Which size is less likely to offer health insurance? (2 to 10 employees versus 11 to 50 employees)
4. Are there different types of businesses that are more likely to offer health insurance? (i.e. professional services, construction, etc.) and what types are less likely to offer health insurance (i.e., retail, cleaning, etc.)

Cost of Health Insurance

5. For those employers who offer health insurance, what have the rate increases been over the last three years?
6. What are you advising your clients to do differently as a result of the increase in cost? (Probe: cost sharing, premium sharing, move to a different carrier, increase employee contributions, change benefit plan design, drop health benefits, etc.)
7. Are employers asking for different kinds of information in recent years? If so, what kinds?

Other factors than cost – Broker Perceptions

8. Other than cost, what do you believe to be the major problems and concerns that small employers have with offering health insurance to employees?
9. Are there other major market factors (other than cost) that have impacted the small business market in recent years? (e..g "take up" rate) What do you think is driving that change?

Broker Service/ Broker Information

10. For those of you that represent multiple carriers, how do you decide what plan type and company to represent? i.e., commissions/incentives, claims service, educational materials, etc.)
11. What concerns, if any, do you received from clients about how the plan administration may be too complicated? How do you counter those concerns?

Recent Changes in Benefits:

12. What is the change most often requested by employers in the last two or three years? (e.g., dropping/adding dependent coverage, dropping/adding Rx, increasing deductibles, etc.)
13. What change(s) are you most often recommending to your clients in the last several years? (e.g., dropping/adding dependent coverage, dropping/adding Rx, increasing deductibles, etc.)

Increasing Health Coverage:

14. Imagine you have been hired by __(whom) _____? to develop ideas and practical ways to increase health coverage of employees. What are some different options and solutions that you would suggest? Consider the roles and responsibilities of the following:

- Employees
- Individuals
- Individual employers
- The state

15. What idea or recommendations do you feel would be most readily embraced by:
- Employers

- Employees

16. Are there ideas or recommendations that you feel would NOT be embraced by:
- Employers

- Employees

Why?

Potential Role of State Government

17. How appealing is the idea of participating in a subsidized insurance program through the government? (Probe: Premium discounts, tax credits, Medicaid expansion, etc.)
18. How do you feel about state funds being used to help make coverage more affordable to lower-wage employees in Indiana? (Probe: tax breaks for individuals or firms, premium supports, etc.)
19. Are there other government-led incentives do you think would be effective in encouraging employers to offer health insurance and should these incentives be offered to companies that already offer health insurance?
20. How do you think employers would respond to the idea that health insurance should be mandated by the government?

Closing Questions

21. How would you proposed to increase health coverage of employees in Indiana?
22. What should the government's role be in increasing health coverage?

Closing Comments - want to thank you again for taking the time to participate in our discussion. You input has been very helpful.

HEALTH EVOLUTIONS
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Focus Group Discussion Guide for Uninsured
Draft 5/28/03

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HIC 5. If you are eligible for employer-sponsored health insurance, why do you not sign up for it?
HIC 6. Do other members of your household have health insurance? If so, how? (Probe: through work, government, individual policy, etc.)

Cost of Coverage

CC 1. What concerns you most about the cost of health insurance?

Have there been times when you have not sought medical care when you or a family member may have needed it because you were concerned about the cost? (Probe: examples)
HIC 8. What services should be covered in a basic, low-cost health insurance plan?

Reasons (other than cost) for not getting coverage

CC 2. What are other reasons besides cost, that you, and others you may know, might not buy health insurance on your own or sign up for coverage? (Probe: health status, expense, don't have a problem getting care without it, etc.)

Consequences of No Coverage

CQ 5. What worries you and those you know most about not having health insurance?
CQ 1. If you or a family member got sick or needed medical care, where would you go for care?
Who would pay the bill for that care? (Probe: borrow the money, wouldn't pay, would pay over a long period of time, etc.)
HIC 7. What difficulties does your household experience if some members have coverage and others don't?
CQ 3. Since you've been uninsured, has it been difficult or easy for you to get medical care when you need it? (Probe: examples of how it has been difficult)
CQ 6. What kind of negative financial impact or negative financial consequences have you had because you do not have health insurance?

Health Care Experience

HCE 1.Overall, how would you describe your experiences when you have required health care? (Probe: ease of getting service, time with doctor, attitude of doctor and staff, etc.)

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