

**West Virginia HRSA
State Planning Grant**

Pilot Planning Project

Grant Number: 1P09OA04040-01-00

Year End Report

September 30, 2005

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A. Executive Summary

Background on HRSA SPG Activities

West Virginia's HRSA State Planning Grant (SPG) Pilot Planning Project resulted from two initial years worth of activity that was focused on the health agenda of Governor Wise to improve both the delivery of health care and the health care coverage status of West Virginians. The work he laid out for his "health cabinet" (known as the HUG) was to collaborate to improve the health care delivery system and to make that system available through affordable insurance or other coverage to all West Virginians. It is the latter goal upon which the SPG has focused its initiatives.

Prior to the grant, the initial undertaking of the HUG was a major survey of the State's citizens related to their demographic circumstances, employment and health insurance characteristics, health status, and use of the health care system. The *West Virginia Healthcare Survey 2001* was managed and the data analyzed and reported by West Virginia University's Institute for Health Policy Research (Institute). The HUG believed it was essential to have data reliable to the county level in order to identify and understand local geographic and community variations; and so 16,500 households were surveyed. The information available from that State-funded initiative (with assistance from a Robert Wood Johnson Foundation State Coverage Initiatives Planning Grant) became the basis for the State's successful application for an SPG in the spring of 2002. The lead agency for the application was the West Virginia Health Care Authority (HCA), the State's health planning and certificate of need agency, in partnership with the Institute.

Work undertaken during Year 1 of the SPG process included:

Establishment of a decision-making structure to provide input from the stakeholders and a deliberative process for recommendations on the Governor's goal of covering uninsured West Virginians. This Health Advisory Council (HAC) adopted its own version of the goal: first, to do no harm to the current levels of coverage in the State; and second, to develop a plan to make affordable coverage available to all West Virginians, reducing the 20 percent uninsurance rate for non-elderly adults to 10 percent within a five year time frame;

Additional data collection included 1) a survey of 500 State employers related to their health benefits; a series of 12 focus groups with uninsured citizens, small business employers and insurance brokers and agents; 2) literature reviews that examined "State Activities Related to Employer-Sponsored Health Insurance," and "State Activities Related to Individual Health Insurance," and (3) a technical paper and presentation: "An Analyses of Medicaid HIFA Waivers."

Additional analyses and three reports drawing from the results of the *West Virginia Healthcare Survey 2001* were prepared by Institute Staff.

The SPG contracted with the Lewin Group to begin analyses of diverse options that might be feasible for the State and an initial presentation on the framework for those options was made at the mid-winter HAC meeting.

A communications plan was developed using the American Institutes of Research (AIR) which focused on a series of town halls and business roundtables hosted by the Governor to keep the issue of uninsured West Virginians before the general public.

The communication highlight in Year 1 was a Business Summit that drew 200 plus to Charleston to hear nationally recognized experts discuss the economic impact of the uninsured on their states and the nation. The Summit's name, "Closing the Gap," became the "brand name" for the SPG project.

Finally, analysis of a buy-in option using the State employees' health coverage plan, which had been prepared under a separate (though HUG related) initiative, was presented to the HAC and would be endorsed and utilized by the project.

Year 2 activities made possible by an SPG 2003 Supplemental Grant:

The work of the HAC began to intensify and its original five subcommittees became primarily three as Benefits and Finance combined and became the focus of much of the year's work, and as it became apparent that the subcommittee on the delivery system had been charged with a reform task that not feasible to accomplish within the framework of the SPG process. The remaining subcommittees (Benefits and Finance, Accountability, and Communications) continued their work throughout the year.

A second smaller household survey of 1,600 plus households was funded in the 2003 SPG, using the same instrument as 2001 survey. It was conducted in the winter of 2003, and reliable to four designated regions of the State. Not surprising, considering the diminished economic conditions of the State, the rate of uninsurance had increased by 9 percent for non-elderly adults. This follow-on initiative made it possible to analyze and report trends in the circumstances of both individual and employer-based insurance, identifying worsening circumstances for both constituencies.

HAC recommendations made in October 2003 became the Governor's health insurance agenda for the 2004 Legislative Session. Three bills were passed to create a high risk pool; to request that the CHIP Board assess its capacity and expand children's coverage to 250% FPL if feasible; and to develop a small business insurance product, using an innovative public/private strategy to provide lower cost insurance for small groups.

Six focus groups were conducted for small business employers and for uninsured employees to identify the feasibility and marketability of low cost, limited benefit plans for both the small group and the individual markets.

The communications plan was implemented and included a series of town hall meetings in prime media areas around the State. A planned video was put on hold for implementation in favor of taking advantage of the opportunity to engage the Governor in

Cover The Uninsured Week activities in the spring of 2003. These events caught the attention of a senior reporter in the State's largest newspaper with the widest circulation. That fortunate circumstance resulted in a weekly series during the summer, each focused on "putting a face" on uninsured West Virginians, coping with the difficulties of health care access in their diverse circumstances.

Background reports on the Role of Safety Net Providers in caring for the uninsured and on Savings Related to Administrative Simplification in the State's public programs were prepared. In addition, a series of reports, using a wide diversity of population-based results of the SPG data collection activities, were developed for presentation to the HAC and for public use on the State's SPG web site.

Following the 2004 Legislative Session, SPG leadership and staff were requested by the HUG to provide and help interpret available reports and relevant information, analyses, and materials to the State agencies which were charged with undertaking the development of the two health insurance expansions passed into law in order to expedite their implementation. Additional discussion related to the successful implementation will be covered briefly in Section B.

Finally, in its initial analysis of changes in individual health insurance status between the 2001 and 2003 surveys, project staff recognized (as noted above) that the levels of individual uninsurance were increasing. For children, the increase was minor – 6.6 percent to 7.6 percent. For non-elderly or working age adults (19 through 64 years of age), there was an 8 percent increase in the numbers of adults uninsured. One group stood out as being specifically disadvantaged by their age, their health status, and their economic circumstances – those uninsured between the ages of 50 and 64. While the majority of West Virginians in this age bracket are both employed and insured, a growing proportion are early retirees, people with disabilities, widows and/or homemakers. For them, the cost of insurance in the individual market, where premiums are increased by their age and health status, is exceedingly high. The HUG and the Governor supported and encouraged an application for an SPG Pilot Planning Project to examine the targeted population's circumstances and develop an option for a pilot demonstration of a health insurance model to better meet the needs of this growing number of our citizens.

Goals of the Pilot Project Planning Grant

It should be noted that the SPG Pilot Planning Grant application was submitted in the spring of 2004. Shortly after that, Governor Wise announced that he would not run for re-election. By the time the grant was awarded, in September, 2004, the general election campaigning was in full swing, and it seemed apparent that efforts on the grant, tied as they had been to the Wise administration, should focus on administrative activities in preparation for working with the new governor's transition team.

The successful candidate, Governor Joe Manchin, had been very supportive of expanding health insurance coverage to small business employers and individuals during his campaign. However, there was no doubt that the transition between the two administrations, and an aggressive agenda for legislative resolution of the State's pressing financial and economic development

problems were essential priorities for the new Governor during the winter and spring of 2004/2005.

While it was slow going in the beginning, by the end of the second 2004 grant quarter, things were getting back on track and beginning to move with alacrity.

The Pilot Project planning goals are:

Undertake the necessary data analyses that document healthcare coverage needs and costs of uninsured West Virginians, aged 50 through 64.

Develop a communications strategy that calls attention to the needs of the target population and the benefits of providing them with opportunities for coverage to the individuals, their communities, and the State.

Develop options and plans for a pilot demonstration of health coverage expansion for the target population that meets their needs for affordability, spreads the risk equitably across the delivery system stakeholders, and demonstrates the financial feasibility and sustainability of the model in rural and urban communities.

Create a process to evaluate and measure the impact of the pilot demonstration on the target population's health outcomes and use of health services, on the healthcare delivery system, and on the reduction of the State's uninsured in order to enable the demonstration to serve as a model for other States.

Provide a Secretary's report that includes all of West Virginia's SPG activities.

Meeting these goals will enable the State to provide affordable health care coverage to a group of individuals who have contributed significantly to the history and economic and social fabric of West Virginia. It will describe a model in both urban and rural delivery settings that can serve as a model for other States.

Summary of Activities Undertaken by the Pilot Planning Grant

Decision-Making Process

In terms of decision-making, the structure and, indeed, the process changed, although many of the same individuals remain involved. Initially, the HAC Steering Committee and its Benefits and Finance Subcommittee were involved in meetings to hear about the new Pilot Planning Grant and the work it entailed for the coming year. In addition, grant leadership met with the Governor's health transition team, which gave its full support to the SPG process and its continuation. It became apparent, however, that this Governor's administrative style was more focused on actions that could be achieved and made public within relatively short timeframes. HAC leadership recommended a smaller organization, made up of dedicated HAC members willing to meet frequently to achieve this administration's goals, with additional members of the individual provider community to assure adequate stakeholder representation.

The new group, styled the Affordable Insurance Workgroup (AIW), began meeting in April, and met weekly for the next four months to meet the Governor's request for an affordable individual product for low wage workers as well as a second affordable small group product that could serve both individuals and/or small employers. It also began to explore the parameters of a low cost clinic based model that could link uninsured individuals with community health centers and/or private physician's offices. In June it slowed its pace to bi-weekly meetings, and is continuing its work through the end of the year. At that time, the group will reassess its role for the completion of the project period.

Data Collection and Analysis

Institute staff was responsible for the conduct of a series of focus groups with uninsured West Virginians, aged 50 to 64, about their circumstances and the impact of being uninsured on their use of the health care system as well as their health status. Work began in December 2004 reviewing examples of screening questionnaires, discussion guides, and brief demographics questionnaires to be completed by the individual group members. Those most appropriate were chosen and modified to reflect the special nature of this population. Once the recruiting and group methods were determined, an IRB application was submitted and approval received. Six focus groups were scheduled during September and held in a variety of urban and rural locations around the State. The report from these focus groups is being prepared and will be presented to the AIW in November.

The grant also provided for key informant interviews with community leaders from those cities and towns represented in the focus groups. The interview document and the recruitment methodology are being prepared for IRB submission in November with the interviews to take place and a report completed in the second grant quarter of 2005.

Staff has worked with the WV Bureau of Employment Security to obtain information related to the loss of employment within the State, particularly those layoffs or closings that were precipitated by a transfer of jobs to foreign countries. A report on job loss (and gains) along with a comparison of changes in type of industry and average wage is being prepared for the AIW.

The grant included a contract with the State Health Access Data Assistance Center (SHADAC) to work with Institute staff to prepare a comprehensive report on the demographics, health insurance status, system use and health status of the target group of West Virginians. A presentation on this report was presented to the AIW by SHADAC staff in October, and the full report will be delivered by the end of the month.

Communications Strategy/Public Information Campaign

In February, the Governor agreed to take a lead role in the SPG's support of Cover The Uninsured Week (CTUW). Staff contacted American Institute for Research and arranged

for AIR to provide assistance with both the Pilot Planning project and SPG's Cover The Uninsured activities. Those involved in this two-day consultation included leadership of the original HAC communications subcommittee, Institute and HCA staff, the marketing consultant for the small business plan and on the second day, members of the Governor's Office staff.

The resulting immediate strategy was for the Governor to be on the road during CTUW, working with his regional staff to set up meetings with small business leaders, talking about the small business plan's implementation (with a major marketing campaign funded by a RWJ SCI Demonstration grant) as the first piece of the health insurance solution puzzle, with the up and coming work of the AIW filling in the next piece by the fall of the year as a sign of the Governor's commitment to continuing the SPG effort.

Meeting this timeframe provided the impetus for creating the AIW, which had its first meeting on April 20 and met weekly thereafter, building on earlier HAC work and analyses.

However, the work of a special legislative session called to implement a major State bond financing interfered with the Governor's ability to participate in CTUW activities. By the time this became apparent, it was past time for being able to put together an alternate strategy.

The SPG video of the Business Summit and other expert presentations has been undertaken and copies of it are scheduled to be received this month. They will be used for programs, as originally intended, to heighten the awareness of local community service organizations throughout the State on the problems of West Virginia's uninsured.

Given the substantially modified pace of the Pilot Planning Grant project activities and the current administration's need for timely progress, necessary revisions and readjustments in the SPG communications plans will be developed this fall.

Implementation Status

The AIW is proposing the demonstration of its proposed clinic model at eight sites around the State. Since the model and any additional new recommended insurance options would violate current insurance laws and regulations, legislation will need to be prepared and will be submitted by the Governor the 2006 Legislative Session.

Recommendations to the Federal Government

Since West Virginia has received an extension of its Pilot Planning Grant through August of 2006, this subject will be covered at that time.

B. Background and Previous HRSA SPG Activities

West Virginia has been fortunate to have successive administrations (since 2001) led by Governors who established access to affordable health care as a major priority. In 2001, newly

elected Governor Wise began by convening his appointees who share responsibility for the State's healthcare policy, regulation and service programs into a "Health Cabinet" (HUG) and charged it with developing strategies that would achieve his goal of providing health coverage for every citizen, beginning with those most in need: the State's children, low-income working families, and prescription drugs and preventive care for low income seniors. He also established expectations that they would work together to improve the system of healthcare delivery in all parts of the State. He met with them monthly to discuss their shared and individual projects and mark their progress.

As a first step, the HUG contracted with West Virginia University's Institute for Health Policy Research (Institute) to provide research and planning assistance. An early HUG undertaking was a telephone survey of 16,500 households to provide information about health insurance, use of the healthcare services system, and the circumstances of the lives of the uninsured population. The survey was sufficiently large to allow data reliable to the county level. The West Virginia Healthcare Survey 2001 was conducted in the winter of 2001/2002 and was funded by a Robert Wood Johnson Foundation State Coverage Initiatives (SCI) Planning Grant and the West Virginia Health Care Authority (HCA), the State's health planning and regulatory agency.

Based on information developed through this survey, the State successfully applied for a HRSA State Planning Grant in 2002. Prior to receiving a decision on the SPG grant, the State also applied for and was successful in obtaining a Robert Wood Johnson Foundation SCI Demonstration Grant. This second grant was for the purpose of modifying, reenacting, and implementing a law that had been passed in the early 1990's that would allow the State's Public Employees Insurance Agency (PEIA) to expand its local agency pool to include small businesses.

The decision-making structure established for the purposes of the HRSA SPG process was the Health Advisory Council (HAC), a group representing the stakeholders of the health care delivery system and the geographic diversity of the State, and including senior staff of the relevant administrative agencies and the West Virginia Legislature. At its initial meeting in the fall of 2002, the Governor charged the members to find workable options that could meet his health insurance goals. However, by 2003, when the State's economy began to mirror the national recession, the HAC adopted an incremental strategy with interim goals. Those goals were: to maintain the State's public insurance programs' enrollments at their current level (e.g. West Virginian CHIP and Medicaid), and to reduce the number of uninsured non-elderly adults by fifty percent within five years.

During 2003, the group met quarterly and worked in subcommittees between meetings of the whole. It was supported through a contract with the Lewin Group for both option research and modeling and by the Institute staff for ad hoc research and data. Its work was also informed by a "Closing the Gap" Business Summit, held in June 2003, with presentations by national recognized speakers who then interacted with representative panels of the State's business constituencies. This Summit was videotaped for future development into a public presentation format that could be marketed to local community groups and service clubs.

In its first year, SPG provided the funds for a survey of 500 state employers, which was completed in mid 2003. It showed that on the one hand, 66 percent of employers have less than ten employees, but on the other, the ten percent of employers that have 50 or more workers account for 60 percent of the State's workforce. The firms least likely to offer health insurance are those that fall into the low wage category, employ ten or fewer workers, and/or have workforces with less than 25 percent full time employees. Most companies offering health insurance pay 50 percent or more of employee only premiums and more than half of them pay 50 percent of dependent coverage as well.

In the winter of 2003/2004, with funding from HRSA's SPG Supplemental Grant, the State was able to do a smaller, follow up West Virginia Healthcare Survey 2003 of 1,600 households, sufficiently reliable to four geographic regions of the State. These surveys have been able to identify not only changes in the profile of the State's uninsured, but also the changes and trends in their health status and use of the healthcare system over the two year interval. This information has helped the State's leadership understand both the nature of the problem of uninsurance in our State as well as its impact on our people and our communities.

To better appreciate the changing circumstances that provided background to the HAC's work throughout this period, it is informative to reflect on the differences that became apparent when the *West Virginia Healthcare Survey 2001* findings were compared with those in the *West Virginia Healthcare Survey 2003*.

One substantial difference is that West Virginia was one of a handful of states that had lost population in the 2000 Census and continued to lose in the timeframe between the two surveys – a decrease of 3 percent (50,248). The largest percentage was among children (5 percent), and another major loss was the 4.8 percent decline in employment during the period. By the end of 2003, the State's growing proportion of those over 65 ranked it as third highest in the nation.

During this time, the State's health insurance situation had worsened. The numbers of adults without health insurance on any given day increased from 19.9% to 21.9%, an 8.3 percent increase in uninsured working age adults. The number of adults that had been uninsured for some or all of the year went from 295,757 to 313,353 – a 6.3 percent increase. Only among children, where the State had made diligent efforts to enroll them in the State's CHIP program, had the rate of uninsurance increased minimally -- from 6.6 to 7.7 percent

The employed represented 49 percent of uninsured adults in 2003 – nearly 120,000 workers, and an increase of 20 percent in workers unable to obtain health insurance through employment. Other significant changes in type of insurance were increases in the numbers of people covered by PEIA (8 %), by Medicare disability insurance (4.4%) and a substantial 23.7% decline in the numbers of people who purchased health insurance individually. The largest numbers of uninsured workers (55 percent) were in small firms of less than 10 workers or midsize firms from 10 to 49.

Not unexpectedly, in 2003 uninsured adults reported their health status to be somewhat less favorable than those reporting in 2001. Reports of excellent or very good health declined from 44 to 33 percent. And the percentages of uninsured adults who did not have a usual source for

care increased in the 2 years between surveys. For uninsured adults, 51 percent reported they were unable to get needed medical care in 2003, an increase from 41 percent in 2001.

A special circumstance that occurred within these two years was the loss of insurance primarily in the state's northwestern region, which includes a major steel producing area in its northern panhandle. Three of the largest steel producers either were closed or went bankrupt. With these closures, both laid off and retired workers lost their health insurance (and some, their pensions as well). The level of uninsurance for that section of the state went from being the lowest in the State (14.6%) to being the highest (25.1%).

The HAC completed its first set of recommendations at its October 2003, meeting and submitted its report to the HUG and the Governor. The Governor's 2004 legislative agenda included three of the HAC recommendations for insurance expansion, all of which were passed by the Legislature. The HAC Recommendations to the HUG and the Governor were provided to the AIW as it began its work and are included in Attachment 4.

The HAC recommendations included: (1) a bill allowing the PEIA to offer lower cost health insurance to small business employers by expanding its local agency pool or by sharing its lower cost provider network in a public/private partnership with private insurers doing business in the State;¹ (2) a bill establishing a high risk pool based on the National Association of Insurance Commissions standards; and (3) a bill requesting the CHIP board to consider an expansion of health insurance coverage for children to 250% FPL. The PEIA program, known as the West Virginia Small Business Health Plan, was implemented in January 2005 and has enrolled over 123 small businesses (and some 550 individuals and their families). The full marketing program did not begin until July 2005, and more inquiries are being stimulated each month. The high risk pool, run by the WV Insurance Commission and known as Access WV, began in July and has a currently enrollment of approximately 25 high risk individuals. The CHIP board recommended the requested CHIP expansion to the 2005 Legislature, but – due to the impact of State's financial circumstances – no action was taken.

The HAC's Benefits and Finance Subcommittee was particularly diligent in its process, meeting every other week throughout the fall of 2003 to complete its recommendations. The commitment that it and other members of the HAC made to reach consensus among stakeholders who often sat on opposite sides of the table was truly impressive, and it was part of the reason for the recommendations' legislative success. For example, by the end of the day, the State's largest insurer, Mountain State Blue Cross and Blue Shield, had agreed to take a reduced administrative ratio to become a partner in the public/private partnership that created the West Virginia Small Business Health Plan, and the State's hospitals had agreed to pay an increased provider tax assessment to provide the Access WV high risk pool reserves for its first two years, understanding that they would benefit most from that program's contribution to reducing the number of uninsured.

¹ The PEIA bill had been developed by the PEIA Agency with funding from the RWJ SCI Demonstration Grant program, mentioned earlier in this report. It had also been a concept included in the Lewin Group's option modeling. Its lower costs, with no required State subsidies, made it an obvious choice for the HAC to support.

To ensure SPG progress in spite of State budget restrictions, the Governor and the HUG encouraged the HCA to submit a proposal for a HRSA Pilot Planning grant to both continue the State's uninsured planning process and to focus in the short term on near elderly, working age adults, ages 50 to 64, who have lost their connection to employer-based health insurance for reasons beyond their control. This group was identified in the comparison of the 2001 and 2003 survey results as one of the hardest hit in terms of loss of coverage. In 2003, these individuals made up 19% of West Virginia's uninsured population.

In addition to the HAC's health insurance expansion work, another SPG activity was working with HRSA's communications consultant and a HAC communications subcommittee to develop a focused plan to bring attention to the issues of uninsured West Virginians. The plan included a Business Summit in summer 2003 which was attended by over 200 individuals and co-sponsored by Mountain State Blue Cross/Blue Shield, West Virginia AFL-CIO, the West Virginia Business Roundtable, the State Chamber of Commerce, and the West Virginia Hospital Association. It also included a series of six local meetings carrying the results of research through presentations oriented to the general public and local businesses and workers. Three of these were led by the Governor (and had by far the best attendance).

The plan also included SPG participation in Cover the Uninsured Week. As a result, the largest daily newspaper in the state initiated a series of articles, beginning with the SPG grant and its activities and continuing with seven additional stories on various impacts of the high rate of uninsurance on individuals, providers, communities, employers – putting a face on real people who were willing to share their stories about the problems of uninsurance.

Hoping to re-create its success from Cover the Uninsured Week 2003 (CTUW), the staff began working in early February 2004 with a broad based advocacy committee to develop a schedule of events. It quickly became apparent that, despite the Governor's early commitment to participate, for West Virginia, CTUW had a major obstacle to achieving its purpose. The nationally determined dates were scheduled for the week in which the State's primary election was to be held. After conversations with the HUG and the Governor's Office, there was agreement that the election would be the overwhelming topic of the days leading up to and immediately after the Tuesday election day, eclipsing any coverage from CTUW activities. The Governor's Office suggested that the State have its own CTUW week, and that it be moved to June 2004. The planning meetings were postponed and, although the intent was to reschedule, the initial involvement of the advocacy groups and the Governor's Office appeared to be lost for a state-only event.

Additionally during the 2004 year, the Institute's staff was called on to provide research, data and logistical support to the implementation of the high risk health insurance expansion that was passed by the 2004 Legislature. This was an unanticipated activity, but one that seemed both necessary and within the "spirit" of the SPG process, particularly since the Insurance Commission, although charged with the program, was given the responsibility with no additional funds to support the activity. Staff conducted a literature review of other states' high risk pools and interviewed leadership in each of them to identify how they had handled a variety of issues from staffing, to benefits, long range financing, and eligibility concerns, and they participated in board meetings to present their findings and to respond to additional data requests and concerns.

Finally, in terms of data collection not previously described, staff focused on a variety of quantitative and qualitative methods to develop information related to stakeholders in the complex interaction of uninsurance on the health insurance marketplace, on providers, and on employers, individuals and communities. In addition, Institute and other agency staffs provided response to a wide variety of questions and information requested, ranging from insurance market data to other states' individual program expansion analyses.

When the notice of grant award for the 2004/2005 Pilot Planning Grant was received, the Institute and the Health Care Authority began immediately to put in place the contractual relationships necessary for the grant's operation. The contract between HCA and the Institute was renewed in October, and the contract between HCA and the University of Minnesota's State Health Access Data Assistance Center (SHADAC) too somewhat longer, but was in place by mid-January. In the interim, Institute staff, as the partner responsible for the qualitative research work, began initial work required for the submission of the research strategy to WVU's Institutional Review Board.

C. Pilot Grant Activities

To recapitulate (and paraphrase) the goals of the Pilot Planning Project, they are:

To accomplish the necessary data analyses that document the healthcare coverage needs and costs of the uninsured, ages 50 through 64;

To develop a communications strategy that calls attention to the needs of these uninsured and the benefits of providing them with coverage;

To develop options and/or models for health coverage expansions that can meet these individuals' needs for affordability, can spread their care equitably across the stakeholders, and can be financially sustainable in urban and rural communities;

To create evaluate and measure the success of the demonstration so that it may serve as a model for other states; and

To complete the State's health expansion coverage plan.

Data Collection and Analyses

The data collection activities proposed for the Pilot Planning Grant included:

Comparison of the changes that have occurred in the circumstances of this population between the 2001 and 2003 surveys;

Analysis of Bureau of Employment data to examine the characteristics of industry closings and job loss;

Review of Insurance Commission customer complaints to identify circumstances of health care insurance losses;

Report on the use of health care services by the target population and the related health care costs;

Report on the financial resources expended in the State on the care of the uninsured;

Literature review of state and national activities related to insuring the target population;

Focus groups with the target group's uninsured population in a range of urban and rural communities; and

Key informant interviews with leadership individuals in the communities where focus group participants reside.

Changes for Target Population Between WV Household Surveys

During the first quarter, a preliminary analysis of the target population was done to create a basic profile of near elderly adults, ages 50 to 64, including changes in their insurance, their employment circumstances, their health status and their related health use patterns.

In October, the Institute was asked to provide assistance in the design of a survey for the Baby Boomer Commission being sponsored by the State's Department of Health and Human Resources. These data provided additional information on the SPG target population.

Report on Bureau of Employment Data Related to Job Loss

This report has been completed after a series of negotiations that were complicated by changes in the data authority and authorization processes. The report documents the job losses from 2001 through 2005 mid year, by county and by type of industry, includes the average wage of the workers and whether the losses were occasioned by lay offs or closures. The AIW chair has reviewed the report and asked that the report also identify job creation during the same period to identify changes in numbers, location, industry, and average wage. This report addition should be completed by November.

Report on Insurance Commission's Customer Service Data Base

This information was included because staff believed it might identify personal stories of individuals in the target population who had lost health coverage, thus helping the staff "put a face or faces" these uninsured. The report became moot when staff learned that age was not a piece of information that was collected by the Commission in this database.

SHADAC Report on WV's Near Elderly Uninsured Population, its Use of the Health System, and Resulting System Costs

The contract process specified for the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota was completed in January, and SHADAC

submitted its proposed content outline for review. Because of the delay occasioned by contract processing, the timeline for the contract completion was extended.

By June, this contract had made good progress. A data sharing contract had been signed between SHADAC and the WV Hospital Association (WVHA) for the use of its hospital discharge database, and a draft report on state program and policy approaches to near elderly health insurance was under review by the Institute. In addition, an outline of the final report and its contents and the data analyses shells had been approved by all.

SHADAC had, at the SPG's request, also prepared a PowerPoint presentation intended for the Governor to use during Cover The Uninsured Week (CTUW). The presentation is equally effective for use by SPG staff for local community organization presentations. (It will be noted later in the report that the Governor was unable to participate in CTUW.)

Working collaboratively the SHADAC staff and the Institute's data analyst completed a first draft of the report by the beginning of August. It was decided at that time that the SHADAC staff would present its work to the SPG's AIW at its first October meeting. The final draft was available for approval by mid September, and the AIW PowerPoint presentation was delivered at the end of that month. The final report is expected no later than the end of October.

Report on WV Costs for Care of the Uninsured

The Institute is working with HCA staff and WVHA to develop the most appropriate avenues to complete this report, and the extent to which it will be a true reflection of costs, given the data limitations related to individual providers. In addition, SHADAC will be providing advice from its expertise and knowledge of national initiatives on calculating uninsured costs.

Literature Review of State and National Activities Related to Insuring the Near Elderly

SHADAC and the Institute staff combined forces to complete the literature review on uninsurance and the near elderly population. It has been incorporated into the SHADAC Report.

Focus Groups With WV's Uninsured Near Elderly

When the notice of grant award was received and the process for extending the partnership contract between the HCA and the Institute was completed, Institute staff began reviewing the resources available through SHADAC, other states, and research institutions to provide the necessary instruments envisioned for the SPG near elderly uninsured focus groups. In preparation for an Institutional Review Board (IRB) proposal, the methods for recruiting participants, screening applicants, guidelines for the group discussion, and a participant questionnaire were discussed, developed and documented for an initial IRB submission in December. Because staff anticipated recommendations from the decision-makers related to focus group locations, as well as any particular information issues they might feel necessary, its original intention was to provide decision-makers with an outline of the focus group plans and ask for decision-maker input.

It became apparent before the end of the year, that decision-maker input was not likely until after the end of the Legislative Session. It was also soon apparent that the decision-making process was likely to be changed in the new administration. It was decided to postpone the focus groups until these circumstances had been resolved.

Since (as will be noted further along in this report) the new decision-making Affordable Insurance Workgroup (AIW), created in April, had been charged by Governor Manchin with the specific task of providing recommendations of a small business and an individual product, along with reviewing the advisability of a clinic product, the Steering Group (the two PI's and the AIW Chair) believed the administration's requests should be the focus of the weekly meeting agendas until that work was completed. Finally, in mid July, the focus groups strategy was presented and approved by the AIW. Institute staff moved immediately to set the dates, schedule the locations, implement the recruitment plans, and take care of all necessary logistics for six groups to take place in September. These groups have been completed and findings will be presented to the AIW in October.

Key Informant Interviews

Preparation for these interviews began and was essentially completed in the same time frame as those for the focus groups. An initial IRB is in process based on an interview guideline developed by Institute staff. Discussion with the AIW about the types and diversity of the interviews will follow the presentation of the focus group findings. The interviews themselves should take place during October and November.

While the data collection proposed for the Pilot Planning Project was initially slow to get underway as the leadership and staff focused on other needs and developments, the majority of lost time has been made up during the third and fourth quarters of the project period and will be completed in a timely fashion before the end of the year. Since HCA has received a continuation of this grant through August 2006, with the changes noted (and those added under the continuation), data collection should proceed more smoothly for the remainder of the SPG Pilot Planning Project.

Communications Strategy/Public Information Campaign

As has been discussed earlier, the award of State's Pilot Planning Grant coincided with a change in the leadership of West Virginia's government. An election was in progress, and a new Governor, Joe Manchin, was elected in early November. SPG leadership was encouraged by the fact that Governor Manchin had made expansions in health care insurance for working West Virginians a substantive part of his campaign presentations throughout the State. He was clearly on the record in support of those issues.

While the new State administration was being put in place, leadership of the SPG met with the administration's health transition team to ensure they were fully informed about the SPG process, its status, the provisions of the newly received Pilot Planning Grant, and SPG's interest in having the new Governor provide leadership to the process going forward. The transition

team was very supportive of what SPG had accomplished and equally forthcoming about its intentions to recommend that the Governor become involved in its activities.

The State was, indeed, very fortunate to have two successive governors who would include expansion of health insurance among their priorities. Nevertheless, because of the processes of administration changes, beginning with transition arrangements, an Inauguration, and the new Governor's first Legislative Session, it was apparent that plans for convening the HAC might best be put on hold. In the meantime, the HAC chair was keeping members of the Legislature and its staff up to date on SPG activities through routine monthly reports.

As was mentioned earlier, Institute staff contacted the American Institute for Research (AIR) to request a consulting visit to both review and update the SPG communications plan in light of the work that had already been accomplished along with the new Pilot Planning Project. That meeting was set and took place in late March. Having been assured in February of the Governor's interest in playing a leadership role going forward, one of the initial items for review was his participation in Cover The Uninsured Week (CTUW).

The two-day consultation was planned for the leadership of the Institute, the HCA, and the communications subcommittee of the HAC, along with the marketing consultant for the West Virginia Small Business Health Plan (WVSBHP) and, on the second day, members of the Governor's office staff. The result of that planning was an immediate strategy for CTUW with the Governor on the road, using his regional staff to develop meetings with small business and community leaders in targeted media markets. The focus of the message would be the importance of affordable health insurance to all West Virginians, the introduction of the WVSBHP -- one of the HAC's recommendations which was on the market then and an important first step in a comprehensive plan -- and the commitment to have an individual insurance product available by a special legislative session being planned for the fall to demonstrate the Governor's commitment.

While the Governor's commitment to the SPG process has remained, his ability to participate in CTUW was superseded by a second Special Session of the Legislature. He did begin to make a visible commitment to the first portion of the "communications message" that was agreed upon, becoming the spokesperson for a widespread media campaign, featuring the WVSBHP. It should be noted that the media campaign was financed by the RWJ State Coverage Initiatives Demonstration Grant which was now in its third year. While there has always been cooperation between these two projects, the activities of each have been kept separate.

Given the substantially modified pace of the Pilot Planning Grant project activities and the current administration's need for timely progress, necessary revisions and readjustments in the SPG communications plans will be developed this fall.

Decision-Making Process

With the notice of the Pilot Planning Grant award, the chair of the HAC was notified and asked to continue her participation for an additional year. A Steering Committee meeting was scheduled for early December and copies of the grant application shared with the members. The Committee suggested that the SPG leadership have a conversation with the Governor's health

transition team, that the benefits and finance subcommittee meet in mid December and that the communications committee meeting in early January. It was anticipated that the first full HAC meeting would be scheduled in early February.

It quickly became apparent that the SPG needed to rethink its near term strategy because the Governor's transition team was clearly focused on a special January Legislative Session to deal with economic development, revenue shortfalls and other financial issues. Without the initial transition team conversation, plans for meetings of the HAC were put on hold. Nevertheless, as was discussed under the Communications section, the SPG leadership did have a very positive meeting with the Governor's health transition team in early January.

There had been inquiries from members of the HAC Benefits and Finance Subcommittee about the status of the SPG work, and so a meeting of that subcommittee was held in early January to discuss some final items from the previous year's work, the status of the HAC recommendations that were passed and being implemented in 2005, and the work that was contemplated under the new Pilot Planning project. Members were also provided with the results of the target population analysis and a copy of the focus group report outlining opinions on the individual health access benefit plan and the adult basic small business benefit plan – two of the HAC's October 2003 recommendations.

When the Governor met with the HCA chair in February, he confirmed the transition team's recommendation and his commitment to support the SPG process going forward. The staff began to plan for a second Steering Committee meeting and a full HAC meeting following the completion of the Legislative Session.

At the March communications committee meeting, the Governor's office charge to the SPG was to come up with an individual product that could be proposed as part of a fall Special Legislative Session agenda. Following this, SPG leadership met and agreed that the HAC and its 100 plus member structure was too cumbersome to develop a second insurance product by the CTUW deadline set. It was agreed that the HAC would be disbanded and a new group created which would include HAC members that had demonstrated the greatest interest and expertise, filled in with new members that would assure continued stakeholder representation. Styled the Affordable Insurance Workgroup (AIW), the group began its work in April with a goal of providing a private/public, non-subsidized individual product that would have a premium within the range of \$100 a month, a goal set by the Governor's staff.

The work began with two models created for the HAC in 2003, brought up to date and modified by the SPG contracted actuaries. These models were for a bare bones benefit plan with limits on services, and a more standardized benefit package with a cap on total medical services costs and on pharmaceutical costs. The group met weekly, but it soon realized that it would not be able to complete its work in time for CTUW. Since the Governor was not going to be able to participate, all involved agreed that the SPG work should continue until the second product could reasonably be completed. Additionally, a focus group was held in August to solicit opinions from insurance agents/brokers on the bare bones and standardized benefit plans in order to 'test market' these options. A report was provided to the AIW in late August.

Given a little more leeway, the AIW broadened its coverage concept to include a proposal for a preventive and primary care clinic model that had been a 2005 legislative proposal that was not acted upon. A private physician who had proposed the legislation, a community health center physician, and a rural primary care physician took the lead in developing this concept more fully, and eventually a model was proposed, fleshed out and put fully before the group for consideration. The AIW meet weekly throughout the spring and early summer (with two brief respites of a week each) and completed its recommendations on the individual products and a proposed clinic model pilot demonstration at the end of August.

It has reduced its meetings to a bi-weekly calendar, and has on its agenda for the coming months a primary focus on the Pilot Planning Project, on cost containment strategies to make insurance more affordable, as well as strategies to look at the long range reductions of health care costs, as well as completing the SPG final report to the Secretary.

D. Implementation Status

As mentioned earlier in the narrative, three of the original HAC recommendations became part of the Governor's legislative agenda for the Session in 2004. All three of them passed, and two have been successfully implemented. To briefly review:

The first recommendation was passed as Senate Bill 143, and established a small business health insurance plan, provided by a private insurance carrier offering the product in the regular small business group market (businesses with 2 to 50 employees) with a few notable exceptions. The carrier would have access to the WV Public Employees Insurance Agency (PEIA) provider reimbursement rate and PEIA providers would have the opportunity to opt out of the program annually, but those who participate would not balance bill. The carrier would reduce its administrative ratio and agents would accept reduced commissions for an estimated 22% savings on the overall costs. The small business purchaser could not have had health insurance for the past 12 months, would pay at least 50 percent of the individual employee premium, and have participation by 75% of eligible employees. The product would be overseen by a policy council chaired by the Insurance Commissioner.

The genesis of this product was a three year RWJ State Coverage Initiatives Demonstration Grant received by PEIA in January 2003. It had a Policy Advisory Committee of stakeholders that helped work through the conceptual issues and that included several members of the HAC. When initial work on the product was completed in mid 2003, it was one of the concepts the HAC was requested to consider in its recommendations. The actuarial estimates were that it would provide small business coverage at costs 20 to 25 percent below the current small business market for the same product. When Mountain State Blue Cross Blue Shield (BC/BS) announced it would market the product based on its standard small business plan model, the HAC decided to include it in its recommendations to the Governor. It appeared to provide the best option for small business coverage that had been reviewed by the HAC.

The product was ready to be marketed at the beginning of January 2005. Money from the SCI grant helped support a series of six training sessions held in November 2004 for BC/BS insurance brokers and agents with a national presenter providing CEU credit training on the small business market, its trends and its issues. The plan was called the West Virginia Small Business Health Plan (WVSBHP) and the brokers and agents were provided support with professionally designed materials and a statewide marketing campaign. Implementation built slowly and rested primarily on the agents who saw this program as another “tool” in their product kit for people who had been unable to provide their employees health insurance. When the visible marketing campaign kicked in mid-summer, inquiries immediately took a jump and are still increasing. Over 100 employers have purchased the product and have provided insurance for over 400 individuals and their families. According to BC/BS, the risk pool for this product mirrors that of their other small business plans both in age, gender, and health status.

The second recommendation was passed as Senate Bill 161. The WV high risk pool was modeled after the legislation that had been recommended by the National Association of Insurance Commissioners (NAIC). Its implementation was assisted by a federal grant from the Centers for Medicare and Medicaid Services (CMS) which provided an initial \$500,000 to cover the development costs and a second three-year grant of \$500,000 to assist with the reserves required for the pool’s start up. The legislature also provided for a public policy board, appointed by the Governor, to represent insurers, hospital providers, and the general public and to be chaired by the Insurance Commissioner. The board’s responsibility is to oversee the operation and regulation of the plan which is now known as Access WV. This product was scheduled to and did become available on the market in July 2005.

According to the law, Access WV is available to citizens who have any one of a series of high cost (and risk) diseases or conditions, whose application for insurance has been turned down for medical reasons by another insurance company, whose insurance quotation from another company is in excess of Access WV rates, who have lost group coverage and are without access to COBRA, who have been made eligible by having lost their insurance because of foreign competition – according to the provisions of the Trade Act of 2002, or are HIPAA eligible and within 63 days of credible coverage. The premiums for the program are set at 150% of the current market average for comparable coverage.

Because of the complexity of the various provisions in the NAIC model and the provisions that designated PEIA as being initially responsible for the administrative services of the program, the Policy Board decided to hire a consulting firm with experience in developing and managing high risk pools to help guide and assure its timely implementation. The consulting firm led the effort, assisted by the PEIA staff, Institute research support staff, and others. One aspect of this implementation was the need to hire the plan’s director. The recruitment of applicants was done through a nationwide search. The director came on board a brief time before implementation was due to begin. Since its beginning in July, the pool has approved and enrolled 69 high risk individuals as of October 1, 2005. It is expected that this pool will grow slowly because

of its cost and the age and risk rating of its participants. Nevertheless it serves a very real need in West Virginia where disability rates are among the highest in the nation.

The one recommendation submitted to and adopted by Governor Wise was the increase in WV CHIP coverage for children to 250% of the federal poverty level. The 2004 Legislation passed a resolution requesting the CHIP Board to consider the increase in light of available funds. The CHIP Board recommended the increase back for legislative action in 2005, but by that time funding available to the program was nearly maxed out and with Congressional renewal slated for 2006, the Legislature decided not to act on the recommendation this year.

E. Recommendations to the Federal Government and HRSA

More than a recommendation, by way of thank you, West Virginia's SPG leadership greatly appreciates the flexibility of the HRSA State Planning Grant process that well understands that plans that are conceived in one year under one set of circumstances may very well require minor (and sometimes major) adjustment when "on the ground" circumstances change abruptly or even over time. HRSA staff understanding and support when the course of planning fails to run smooth has contributed enormously to West Virginia's ability to be able to continue its planning process and to make real progress.

After 3 years of experience, one of the most essential characteristics to the SPG planning process is its "inclusivity" and never failing to give an ear to stakeholders or interested parties that want to be heard. Whether it is through surveys and focus groups, through town meetings, public hearings or the State's strict adherence to open meetings laws, or just listening to callers who want to give you an earful, people want to have their say about this aspect of their lives so integral to their well-being. The work we have done, and the products that are the result of that work are much better because they have been informed by active listening.

HRSA's SPG grant process has enabled West Virginia to have real data and information about the uninsured, about employer-based insurance, about the health care delivery system, among other things. And it informs decisions that are made far beyond the work of the grant itself. The State actually made its first SPG application in 2001, and it was not chosen. In reviewing the application after Governor Wise was elected, it didn't fail because it didn't have worthwhile goals, it failed because it couldn't show that the State had any credible data about uninsurance in the state and no definitive plans to correct that deficiency. When the State, considered applying again, it recognized that first it had to invest resources into being able to define the problem, and suggest some possible solutions. The *West Virginia Healthcare Survey 2001* was the result. And throughout these five years, HRSA has worked with other federal agencies that collection data on a statewide and national basis to make those federal efforts serve states that may not have the resources or know how to collect their own. This is one of the most important activities of the SPG process and hopefully will be continued.

An on-going concern at the state level is the increasing rise in the nation's health costs in general, and in its public programs in particular. This is more specifically a concern with

Medicaid and a looming federal budget cut of 10 billion dollars when many states are facing only the beginning of a turn around in their financial circumstances. Although the West Virginia SPG program recognizes that its recommendations are for the realm of the HRSA SPG program, it would strongly recommend that the program be continued to allow the States to continuing their efforts in finding ways to insure the uninsured, even incrementally. We believe that every step we make in that direction, is a step towards helping to maintain stability (and thus costs) in the healthcare delivery systems within each of our states.

F. Appendix 1: Summary of Policy Options

Appendix 1 attached is the final work of the Lewin Group giving its summary of policy options with pros and cons to the HAC. While it does not follow the exact format of the suggested Appendix format, it provides the essential information when viewed in context with the report.

An additional Appendix 1 document will be forwarded by the end of the month.

G. Appendix 2: Updated Project Management Matrix

Appendix 2 is attached.

H. Appendix 3: Reports and/or Products from HRSA Pilot Project Planning Grant

As noted in the narrative above, several of the reports from Pilot Planning activities are in currently in process of completion and/or final editing. At this time there are no reports or products that have been supported by HRSA Pilot funds to include.

I. Appendix 4:

Copy of HAC recommendations PowerPoint presentation that was presented to the Affordable Insurance Workgroup (AIW) in April 2005.