

*Effective Coverage Expansions for Uninsured Kids and Their Working Parents:
Links to Job-Based Coverage*

May 18, 2001 Conference Transcript: "Parents & Employers' Attitudes"

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Uninsured Working Parents and Small Employers: Attitudes and Experience

Speakers:

- Michael Perry, President, Social Policy Research Institute
- Kathlyn Mead, CEO, Sharp Health Plan, San Diego

Moderator: Liane Wong, Institute for Health Policy Solutions

(Additional information about the speakers appears at the end of this section.)

Transcript:

MS. WONG: Good morning. I am Liane Wong with the Institute for Health Policy Solutions. As we learn throughout the day about states' plans for and implementation of coverage expansions for uninsured working families, we wanted to highlight three perspectives that are really integral to why these approaches have been created and how they've been created—namely, families—the low-wage working families—employers, and a health plan that serves them.

Our panel this morning will provide insights as to some of the preferences of these families in terms of how to obtain affordable coverage, and Kathlyn Mead is going to talk about a locally-based program that has really innovated to reach families and their dependents through small employers.

I'm very pleased to present, first, Mike Perry. Mike is the president of the Social Policy Research Institute at Lake Snell Perry and Associates here in Washington, D.C. And Mike has done a lot of work interviewing both low-wage families as well as employers across the country as the lead for several large studies funded by the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and the National Partnership for Women and Families.

Next to him is Kathlyn Mead. She is the president and CEO of Sharp Health Plan in San Diego, and she's going to talk about the FOCUS program, which is an innovative program to reach low-wage workers and their dependents through small employers.

Mike.

MR. PERRY: Thank you, Liane. I want to just note that my presentation is not in your binder. It's sort of like the empty tube at graduation. There is no diploma in there. I did bring them though. They are outside so don't worry about notetaking at all. You'll get it later.

Let me just say some things. As Liane mentioned, I am—she didn't say it in so many words—but I am really a public opinion researcher, so I'm going to be coming from a different perspective than many of your speakers, who are really health policy specialists.

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I've been spending the last three years really going around the country doing focus groups mostly with low-income families, uninsured families, asking them about the SCHIP program, asking them about Medicaid, asking them why they're not enrolled in those programs, talking to enrollees in those programs, and asking them how they're faring in them and also, along the way, talking to some low-wage employers, in particular, and talking about how they feel about insurance coverage and the barriers they face.

So I'm going to talk generally across all these studies and tell you some of the things that I've been hearing. This is not going to be news for a lot of you, but I think it's an important perspective to keep in mind as we go through the day.

First thing we need to stress is the question of, is health care a priority for these families? And it is. When I have an uninsured family sitting around the table, it is right up there. It's the number two or three thing they mention. They volunteer it as one of their big concerns in their lives right now. They say, I want insurance coverage for my children. I'm struggling to pay medical bills. And many are actively looking for insurance. They don't think that being uninsured is a permanent state at all. They think it's a temporary kind of thing. Even if it has gone on for many years, it's a temporary kind of thing, and they're always moving towards getting coverage in their minds. So it's important to keep in mind it's a top priority.

At the same time, particularly for some of the low-income families I've been talking with, there are struggles. I'll sit around the table and have a family tell me about a broken-down car that month and how that really—you know, you hear a series of events that are putting them behind the eight ball, so they're not able to afford insurance. Maybe they're not making their SCHIP premium payment that month. It is a struggle for a lot of these families.

Rent, food, utilities, paying the bills, paying for the repairs on the car that gets them to work, these are priorities. They are often shifting. And paying for health care gets in that mix, and so it's important to keep that in mind. Most of the structures and plans we have in place require steady payments to stay enrolled, and a lot of these families struggle to do that.

One important thing: parents always stand out in these groups from adults who do not have children. They are extra-concerned about being uninsured. They feel very vulnerable. I'll talk about it more in a few minutes, but clearly having uninsured children raises this issue. They talk about it all the time. It's not acceptable to them that their children don't have coverage. They will say time and time again that I [the parent] will do without. That's not a big deal. I'm grown up. I can take care of myself, but my children need care. And they don't feel very good about not having—at times, they say, I feel like a failure for not having coverage for my child. So children also can be a hook for the adult into insurance as well because it is their number one priority.

Let's talk about myths about the uninsured. When I do focus groups with other—not just low-income families but other—types of families, and we talk about the uninsured, there are some myths out there. One is that they're poor. Another is that they're not working, that they're often in families where no one has insurance. It's [uninsurance is] a status the whole family

shares. And there is a feeling that if you're working, you have access to insurance and you don't really need to worry about working people, and, of course, we know this is not true.

Myths about the uninsured

- They are poor
- They are unemployed
- They are in families where no one has insurance
- All working people get coverage for themselves and families through their employers

Here are just some statistics put out by the Kaiser Family Foundation. I think we know them all. Forty-four (44) million Americans lack health insurance. Seventy-four (74) percent come from families with at least one full time worker, so these are working families. Forty-four (44) percent come from families with incomes above 200 percent of the poverty line. It's important to keep in mind that it's not just the low-income families and the near poor who are struggling with this.

Seventy-three (73) percent are adults. Sixty-four (64) percent live in families in which at least one other person has insurance, so there is often a mixed insurance status within the family. Fifty-two (52) percent are white, although minorities are, particularly Hispanics, are increasingly at risk for being uninsured. So here are some things that are not well known in the general public, and it does shape some of the feelings out there about the uninsured.

Reasons for being uninsured that you hear time and time again from these families: The employer doesn't offer it. But if the employer does offer it, it costs too much—the premiums, the copayments cost too much. A lot of families will tell me that the employer doesn't offer dependent coverage. They have coverage; their children do not; their spouse does not.

There's a waiting period—three, six, nine, 12 months—I hear time and time again. And when I hear about the lives of a lot of these families, they're changing jobs, they're in the middle of career changes. So they're often in this waiting period, this limbo.

And they must pay other bills first. Again, insurance premiums seem less important at times than other sorts of pressures, financial pressures. They don't qualify for public programs, or they don't think they qualify for public programs. They'll talk about this as particularly a challenge for SCHIP, trying to get the higher income group that qualifies for SCHIP. They really don't believe they qualify for the program.

Reasons for being uninsured

- Employer doesn't offer it.
- If employer does offer it, it may cost too much.
- Employer doesn't offer dependent coverage.
- There is a waiting period at the job—they do not qualify.
- Must pay other bills first. Insurance premiums seem less important than food and rent.
- Don't qualify for public programs, or don't think they qualify.
- Changing life situations (new job, personal life)
- I'm healthy; my children are healthy.
- Other sources of health care—clinics, ER, sympathetic doctors.
- Immigration worries—I'll be turned in.

Changing life situations. Again, a lot of these focus groups are spent talking about their lives. There are often many balls in the air. Personal situations, a divorce, just different things going on do impact. So you can't sort of see these families as just in one light. There are many things going on.

I'm healthy. My children are healthy. Although that's not a prevailing feeling, it is part of the mix that we're doing okay right now. I'm not as worried as I would be if we were in the middle of—if there was a chronic illness in the family. And it lulls them into a false sense of security.

Other sources of health care. They are getting health services. They can tell you where to go, the clinics to go to, the doctors who are sympathetic and take what the family can pay, emergency rooms. There is a lot of sharing medications. These sorts of things are going on. It's very active, this health care safety net we have. The uninsured are using it. They're not using it for preventive care. They're not using it for kinds of care that we would hope they would.

Immigration worries. I'm not going to spend a lot of time on that, but I have done a lot of work with Hispanic families, and there is a fear, even going to their employer to talk about enrolling in a health plan, that somehow, even if they are documented, family members who are not will somehow be exposed. So there is a fear that they may get turned in whenever they try and interact formally with the health system.

Some other issues: How it feels to be an uninsured parent. This is important. This is what parents tell me. They worry all the time. They feel vulnerable. They postpone care. They rely on over-the-counter medications and home remedies. They skip preventive health care. The biggest fear is an accident will happen, their child will become very ill, and they can't afford it. That is their biggest fear.

How it feels to be an uninsured parent

- Parents say they worry all the time and feel vulnerable.
- They postpone care, rely on over-the-counter medications and home remedies, and skip preventive care.
- Biggest fear is an accident will happen or their child will become very ill, and they cannot afford care.
- Parents say they will go into bankruptcy before they will deprive their child of needed medical care.
- Many are currently paying off large medical bills.
- They say they need coverage too—hard to care for a child or hold a job when ill.

Parents say they will go into bankruptcy, though, before they will deprive their child of needed medical care. So if it is serious, they are going to get that child care. In fact, often there are people paying large ER bills around the table when I do these focus groups of the uninsured. So they are getting care but paying an awful lot when they are getting it, and they are getting it at very acute kinds of situations.

They say they need coverage, too, though. Although we're always talking about their child, they remind us that it's hard to take care of a child if you're ill, if you have a chronic illness going undetected, or it's hard to hold down a job if the parent is not being covered.

What uninsured parents want

- More affordable coverage options—they are willing to pay what they can.
- Whole-family coverage is important. They don't like it when some members are covered and others aren't—particularly when a younger child is covered, but older ones are not.
- Coverage through their employer is preferred.
- Also interested in enrolling children in SCHIP or Medicaid, but many perceive they do not qualify because they work.

What they want—the sort of things they say they want. They, of course, want more affordable coverage options. They're willing to pay what they can. Paying is not the problem. It's how much I'm paying, and can it be flexible when all the bills come together in one month and I can't make that payment.

Whole family coverage is a very important concept. They do not like it when there is mixed coverage status in their family. They don't like it when their child who is three-years old can qualify for Medicaid, but their eight-year-old or their teenager can't. It really gets them mad. They don't even know a lot of times that there are different eligibility criteria around age of child. So, really, there is a lot of passion and frustration around our system. When dependent coverage is not covered or when one, a younger child, is covered, it really breaks them out of how they want to think about coverage.

Coverage through their employer is preferred. If they are working for an employer that does offer coverage and they can afford it, they want to be like other employees and get their coverage through their employer. But they're also interested in SCHIP and Medicaid, but they don't perceive they can qualify because they're working.

Here are some specific thoughts about Medicaid and SCHIP—and I know you're going to talk about those programs a lot more over the day. But many parents of uninsured children know a lot about Medicaid, or think they know a lot about Medicaid, and that can be challenging

since there have been changes in Medicaid—simpler applications, new ways to apply—that they're not up on. So they have older images of Medicaid, and it seems like a "Medicaid 101" update is needed for a lot of these families.

Feelings about Medicaid and SCHIP

- Many parents of uninsured children know about Medicaid, but lack details. And many are unclear about the eligibility criteria for their children.
- Fewer parents know details about SCHIP. Current ads lack specifics, and many assume they earn too much to qualify.
- Ultimately, when they learn more, uninsured parents are interested in enrolling their children in either program.

They lack details about the program. Many are unclear about the eligibility criteria for children. Fewer parents know details about SCHIP. They are seeing ads. A lot of the ads are missing details. They don't know that, if I earn \$30,000, I may qualify for this program. Often the first wave of ads, at least for SCHIP, did not include income criteria, and so they also didn't know what would be covered by the plan. So a lot of details were initially missing in the outreach, and a lot of these families don't know they qualify. Ultimately, when they learn more about the programs, they are really interested in applying and getting their children covered.

Feelings about their employers. Uninsured working parents believe it is their employer's responsibility to cover them. They're pretty clear on that. They look to their employers to cover them. They think that's part of the deal. I work for you; I get coverage. But surprisingly, they're very sympathetic of employers who don't cover them. They know it costs a lot of money and—especially for the smaller employers—they don't really hold a grudge against their employers who don't offer coverage.

Many would accept help from employers to obtain other coverage. So whether it's enrolling in Medicaid or SCHIP or another idea, they would take help from their employer in that. But some do not feel comfortable sharing personal information about their lives with their employers. So that is a barrier as we talk about employer-based coverage that some employees bring up.

Feelings about their employers

- Uninsured parents believe it is their employer's responsibility to provide coverage.
- However, many do not blame their employer—they know it costs too much.
- Many would accept help from employers to obtain other coverage.
- Some do not feel comfortable sharing personal information about their lives with employers.

What employers say. Just some quick things. Again, they say cost is a major reason why they're not providing coverage. Smaller employers, particularly, feel this way. They do feel an obligation. They want to help employees. That's not at issue. They support the employer-based system of providing care. They think that it is the best way for the employees and for most Americans to get care.

Many are dubious about a larger government role in health care. A lot of their feelings about government and the rules and regulations and paperwork they're already filling out make them feel somewhat negative about government in some of these conversations.

What employers say

- Many feel an obligation to their employees and want to provide coverage.
- They support the employer-based system of providing care.
- Many are dubious about a larger government role in health coverage.

They are willing to help uninsured employees find affordable coverage. So when you brainstorm about different ways that small employers, in particular, could offer affordable coverage, they are really gung-ho. They want to know more. They are interested. They are

willing to pass out information about a lot of things. But then you find over time that they don't want something that is overly burdensome, that is going to be something new or requires some new big investment of their time. They're already fighting a lot of bottom-line kinds of concerns. So they don't want it to be something extra or new or burdensome, and they also are worried about getting too into the lives of their employees.

Employers and their uninsured employees

- They are willing to help uninsured employees find affordable coverage...
 - ✓ As long as it is not overly burdensome or time consuming
 - ✓ And if they do not have to "get into their employee's personal lives"
- They may not know much about Medicaid, and even less about SCHIP.
- *Many say that, if their employee does not accept the company's insurance, they lose track of them—they do not know if they are insured or not.*

So these are some barriers that need to be addressed. They don't really know a lot of details about Medicaid. They don't know about SCHIP. They don't know how these programs relate to them or their employees at all. There is a big disconnect between those programs and employers—that we've been picking up at least—and many say that, if the employee does not accept the company's insurance, they lose track of them. So there is a big disconnect when you're talking about an employer. They may say ten percent of my employees don't take my company's insurance. I have no idea whether they're insured or not. They don't come to me to ask me about or to get involved in this issue. So there is this disconnect to keep in mind.

And let me just wrap up with some of the implications that have been bubbling up, and I'll leave it to you and others who know a lot more than me to figure out ideas for providing coverage. Again, this disconnect, I think, between employers and their uninsured employees needs to be bridged. I think they do need to reconnect. If employees are saying they want and welcome employers' help, and if employers are saying they want to help their employees, it does seem like there is some opportunity there.

Ways need to be found to help employers, particularly small businesses, offer affordable coverage to their employees. They want to be doing that. Refine outreach and marketing of Medicaid and SCHIP. Although there's a lot of great effort going on, the question of I-don't-think-I-qualify has still not been addressed, and I think is still the major barrier for a lot of families. Allow whole families to enroll in plans. We have got to think of ways where we're not dividing up families and giving them separate status here.

Implications

- Must address the disconnect between employers and their uninsured workers.
- Find ways to help employers—particularly small businesses—to offer affordable coverage to their employees.
- Employers can play more of a role in helping employees find affordable coverage.
- Refine outreach and the marketing of Medicaid and SCHIP so that working families can see they qualify.
- Allow whole families to enroll in plans and programs—not just the employee, and not just children.
- Clarify the impact on immigration for Hispanic workers.

So we need to think more in whole-family terms and then clarify the impact on immigration for Hispanic workers. There is a lot of effort going into that right now, but being seen—like materials and health plan information that says right up front that your coming in to talk about health care is not going to affect your immigration status—that may really bridge that gap for a lot of Hispanic workers.

So I will stop there and turn it over to the next speaker. Thank you.

MS. MEAD: Good morning. I'm going to just take a few minutes to give you some background about the FOCUS program. Most of the information is in your packets.

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This program is now two, almost three, years old. We developed this program, frankly, in reaction to the SCHIP program, where Sharp Health Plan participates as a contracted provider with MRMIB¹ (whose director, Sandra Shewry, you will meet this afternoon). We also participate as a health plan with Department of Health Services for the Medi-Cal program in California.

We identified that, once the SCHIP program came into being, it was likely that the parents of those children were not going to have coverage. We developed the FOCUS program so that we could go to those employer groups and offer coverage for the parents of these children that did not have coverage, as well as the adults who were childless, who wouldn't qualify for other government programs. So we were looking for that gap population, if you will, that existing government programs would not cover.

We decided to go the route of the employer group because, much like you heard this morning from the Oregon program, San Diego is largely small-employer-group based. Eighty (80) percent of our employers have fewer than 20 employees. So we also knew that it was small-employer-group based, and as you heard earlier, there is low tolerance for large administrative hassle associated with insurance coverage.

If you look at the first slide, businesses, we have 226 businesses in this program. It took us about six months to get these businesses enrolled. Now, the interesting thing is that the vast majority of businesses came to us. We were very fortunate in San Diego in that the local television station, Channel 10, partnered with the Alliance Health Care Foundation, and aired a prime-time documentary on the problem of the uninsured in San Diego. About 27 percent of our population is uninsured.

So this program ran. We had a phone bank where people could call and ask us questions about their insurance status. And from those telephone calls, we developed a hot list or a lead list, if you will, and contacted these businesses.

Now, the interesting thing about this is that within—as I said it took six months to enroll 226 businesses, but we worked from that same hot lead list and as well took some other reference calls from businesses that we had enrolled, and we could have enrolled these folks in about three months time. As a small health plan, we just couldn't keep up with the demand, however, and couldn't enroll them as quickly as they were ready to be enrolled.

The interesting thing about these 226 businesses was that they were very highly ethnic. Fifty-five (55) percent of the businesses that came through were either Hispanic, Vietnamese or Middle Eastern. Another interesting thing we found out about these businesses is that many of them employed family members.

¹ *California's Managed Risk Medical Insurance Board, which administers California's SCHIP program, Healthy Families. – Ed.*

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So when we talked to them about their interest in enrolling in the FOCUS program, many of them said that they had wanted to do it for some time. They felt a responsibility to their employees, namely because they were family members, or they were good friends from their country of origin, et cetera, but they just couldn't find a way to do it. The FOCUS program allowed them the ability to do that. They are geographically dispersed throughout San Diego although, as you might expect, in many ethnic communities, they tend to be densely identified in certain parts of the county, but again we were county wide.

BUSINESS PROFILE SHARP HEALTH PLAN

- 226 companies enrolled
 - Wide range of business types
 - (restaurants, convenience/liquor stores, medical/legal offices, auto repair, construction, housecleaning, misc. retail, landscaping, etc.)
 - Geographic distribution throughout San Diego
 - Average # employees: 6 (80% employ 6 or fewer)
 - Average # enrolled employees: 3
 - Average # enrollees (including dependents): 7

The other interesting thing is that the size of the employer groups was about six. Only about three enrollees—or what we term as subscribers in the industry—only about three qualified, because you had to be living at or below 300 percent of federal poverty guidelines to qualify for these programs.

Now, quite typically, the business owner did not qualify for the program. The other qualification was that you had to have no other health insurance coverage for one year prior to joining the FOCUS program. Many of the business owners and a partner or a vice president, sales manager, et cetera, typically had purchased their coverage through private insurance and again could afford it.

So only three subscribers actually were involved in the program and about seven total enrollees came into the program. That included dependents. So the average family size, which is very typical, was about two.

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If you look at the next slide, the enrollee profile. About three-quarters of the enrollees fell below 200 percent of the poverty level. Single coverage. The thing that we identified that was very interesting to us was that half of our enrollees had employee-only coverage. Now, one of the requirements of the program was that these enrollees, if they elected to get into the program, would cover their uncovered dependents, spouses and children. Well, 50 percent of these people had no spouse, no children, but they could not get coverage anywhere else. So that showed us that creating this program to identify coverage for those gap enrollees, enrollees where there was no other option, actually worked.

The slide features a dark blue header with the text "ENROLLEE PROFILE" in yellow. To the right is the SHARP HEALTH PLAN logo. Below the header is a bulleted list of statistics:

- Low income
 - 3/4 of enrollees are below 200% FPL
- Single coverage
 - 1/2 of enrollees have employee-only coverage
- Children
 - 1/3 of enrollees are children
 - 90% of children are below 250% FPL (income ceiling for Medi-Cal and Healthy Families)
- Age/Gender
 - 50% of enrollees are under age 30
 - Gender is split almost exactly half female, half male

Children. Interestingly enough, a third of our enrollees were children. Now, if you look at the coverage guidelines in California, you have to qualify at about 250 percent of federal income guidelines to qualify for the SCHIP program. About 35 percent of the children in our program fell under those guidelines. So they would qualify for the SCHIP program. We identified through interviewing these families that there were two reasons [why they had not enrolled their children in SCHIP], as you might expect.

The first had to do with their immigration status, and the second had to do with mixed family status. The parents of these children did not want to enroll them in a program that they couldn't enroll themselves in or that a second or third child couldn't be enrolled in. So they elected to actually come into the FOCUS program, even though it was going to cost them more, so that they could have consistency among the family members.

That was critical for us because we knew that we only had funding for about a two-year period of time, and we knew that we wanted to continue the coverage for these children once the

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funding expired or was exhausted. So we really wanted to begin working with these families that had children that qualified for government programs early.

Just an interesting question about gender. We thought that the majority of the single enrollees would likely be young males. Well, as it turned out, we had a 50/50 gender mix. So we had the same issue with females who were childless who couldn't come into government programs, and have coverage offered through their employer groups.

The next slide is probably my favorite, which identifies where the enrollees came from. We developed this program and the subsidies based on income guidelines. So if you follow this across, you'll see that it's 150 percent to 300 percent of federal income guidelines.

(By the way, if you look back at those charts in your packets that I first brought to your attention, for those of you who know what the federal income guidelines are—we know they are wrong. Those were the charts that we developed when we first developed the program two or three years ago, and we just simply have not undated them because of cost.)

	Less than 150%	175%	200%	225%	250%	275%	300%
Ee Only	24%	6%	5%	4%	4%	2%	2%
Ee + Spouse	5%	1%	1%	1%	1%	1%	1%
Ee + Children	8%	1%	1%	1%	1%	1%	0
Ee + Family	16%	3%	2%	3%	2%	2%	1%

But if you follow the income guidelines across, you will find that the vast majority of the enrollees fell below 200 percent of the federal income guidelines, whether they had children or not. So this was a population that was earning at very low income levels working for small employer groups, and their options were very limited.

And [we heard] the same kinds of comments that Mike made earlier. Their comments were: I could not qualify for government programs and I couldn't afford to buy insurance on my own in the private insurance market. This gave them an option.

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Now, the way we established the premium for each of these areas, these categories, if you will, was that we borrowed from our community health center model, where they paid on a sliding fee scale. If you came to the community health center, they asked what your income was. You paid a certain amount based on your income. Some people paid \$5. Some people paid \$10.

So we borrowed from that model, and we identified that, across each of these categories, we would charge premium on a sliding fee scale. If you were at or below 150 percent of federal income guidelines, you would pay about what was equivalent to one percent of your annual income or, on a monthly basis, one percent of your monthly income. If you were living at 300 percent of the federal income guidelines, you would pay at about four percent of your income. That would be your premium contribution.

Your employer group would pay somewhere between 20 to 30 percent of the premium contribution. We came up with that rate for the employer group because, as you know, quite typically employer groups pay 50 to 70 percent of the premium on a monthly basis for the employee. What we identified, though, for the employer groups in this program was that the employer group was not able to only offer premium subsidy or a contribution for the employee only, but they had to be willing to offer a contribution for the employee and their dependents.

Again, one of our major concerns with private health insurance was that the take-up rate for dependents was quite low. So we wanted to be sure that the employer group was making a contribution at the dependent level so that their employee would identify the value that the employer saw in providing benefit coverage for dependents as well.

Now, a couple of things that I want to talk with you about before we get into this transition discussion about the employer groups. First, in the first year, we interviewed the employer groups and found that many of them said they would be willing to make a larger contribution than 20 to 30 percent. Right off the bat they said, I'm willing to participate at a higher level. Already I have found this program to be beneficial to me and my employees from an employee morale perspective. Interestingly enough, [it has] not [benefited these employers] from an employee retention perspective.

When we first started the program, we wanted to identify that there were three things that we were going to study: recruitment, retention, morale and productivity. Well, employers told us already that morale and productivity, they could identify.

We could not, the first year, identify whether there was an impact on recruitment and retention because, as you might expect, these were small employer groups, and many of them employed friends and family, they didn't recruit a lot. The businesses didn't grow a lot over the year, and they didn't have to retain these employees, because most of them weren't out looking for other jobs. They liked the jobs where they were working.

So one of the questions that came up from our evaluator, Dr. Rick Kronick at UCSD, was: were we, one, selecting employer groups that were predisposed to buying insurance in the first place? Remember, if I take you back to how we recruited these employer groups, 226 of

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them, most of them came in response to a television program about the uninsured. And it highlighted that there was this program available to them. Rick Kronick, again our evaluator, questioned from the very beginning whether or not those people were predisposed and at some point would have purchased health insurance for their employees. Now, we pushed back a little with Rick and looked at the length of time these employers had been in business. The average amount of time they had been in business was seven years. So we pushed back and said, okay, Rick, they hadn't bought insurance in seven years; do you think they were going to buy it just this year? They had been looking. Every one of them responded to our survey saying, of course, they had been looking, but they had never found the blend of cost and administrative fees that they were looking for. But again still very good question to raise.

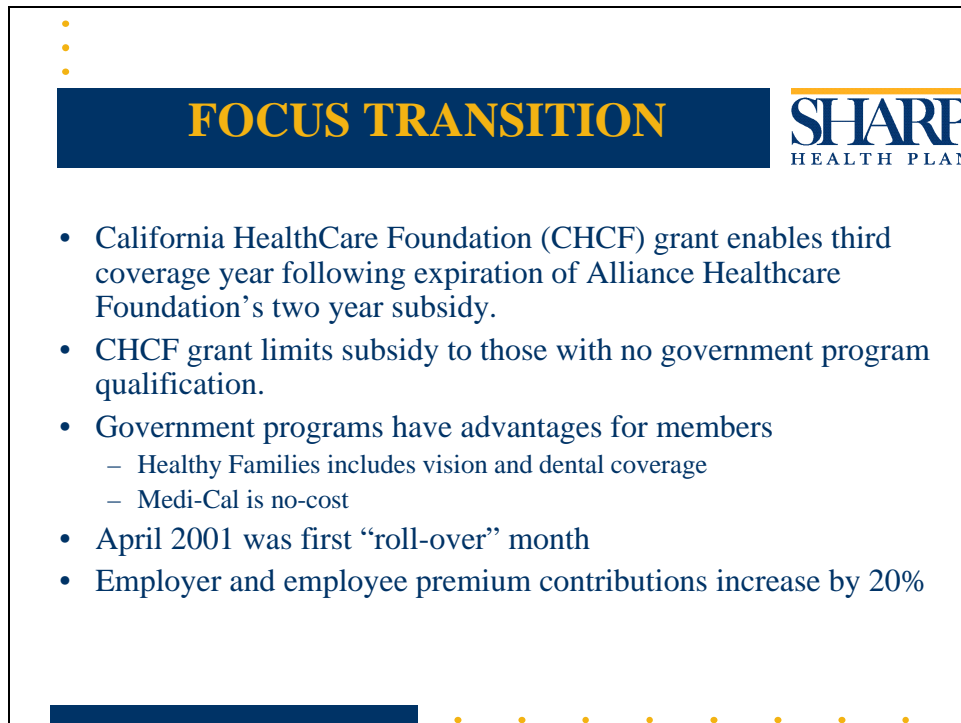
The second question about the retention and the recruitment issue was important to Rick, because what we wanted to do was introduce employer-based coverage to employers in San Diego, and we knew that one of the motivating factors would be that they would have to see a benefit in recruitment and retention. So that brought about our second grant request.

In January, I am pleased to announce that we received another million-dollar grant from the California Health Care Foundation to look at recruiting new employer groups into this study, and these employer groups would come in through cold calling. There would be no television program that was designed to get their attention and cause them to call us. Instead, we purchased a Dun & Bradstreet employer group list and we identified—well, actually we eliminated about 50 percent of the employer groups from the Dun & Bradstreet list because, as you would expect, some of them were too large. This was supposed to be small-employer-group based. Some of them employed too many employees at high levels of reimbursement—biotech firms in San Diego, those sorts of things.

But we came up with about 50 percent of the employer groups that we could cold call, and that cold calling is beginning as we speak. We're going to these employer groups, taking that first sheet that I showed you and saying, here's a program, it's for small businesses, the employer group has to pay this much, the employee has to pay this much, and if this program existed today, would you be interested in purchasing?

That will eliminate the issue, we believe, that is related to these people who are predisposed. We don't necessarily think it will eliminate the issue as it relates to if that employer group employs many of their friends and families.

The other part of the California Health Care Foundation grant enabled us to continue coverage for the first wave of FOCUS enrollees for an additional year. Now, remember, earlier I talked with you about the fact that 35 percent of the children that were enrolled would actually qualify for government programs, we believed. Well, what we wanted to do was to say, okay, now many of these people have had two years of coverage. If their coverage was threatened, would they still shy away from government programs? So we wrote our California Health Care Foundation grant so that the subsidy dollars used would only be available for people who did not qualify for other existing government programs.



FOCUS TRANSITION **SHARP**
HEALTH PLAN

- California HealthCare Foundation (CHCF) grant enables third coverage year following expiration of Alliance Healthcare Foundation's two year subsidy.
- CHCF grant limits subsidy to those with no government program qualification.
- Government programs have advantages for members
 - Healthy Families includes vision and dental coverage
 - Medi-Cal is no-cost
- April 2001 was first "roll-over" month
- Employer and employee premium contributions increase by 20%

We began working with the employer groups and saying okay, now, we have transition dollars. We can carry you on a subsidy for another year, but anybody who qualifies for other government programs must apply and be denied before we can use these dollars for them. And the interesting thing was everybody said, well, how are you going to be able to sell this to these employees because they've had this coverage for a couple of years?

Well, one, we knew that as the health plan, Sharp Health Plan, we were going to be able to bridge, to create an umbrella across these very fragmented programs, because we were the same health plan. So if these families qualified, if there was a child who was two years old and qualified for Medi-Cal, they could come into the Sharp Health Plan Medi-Cal program—a different program administered through Department of Health Services, but still Sharp would be the umbrella plan. If they had a child who was eight years old and qualified for Healthy Families, we could put that child in a Healthy Families program, again under the Sharp umbrella, and if the parents didn't qualify, they could come in through the FOCUS program, and still be under the Sharp umbrella.

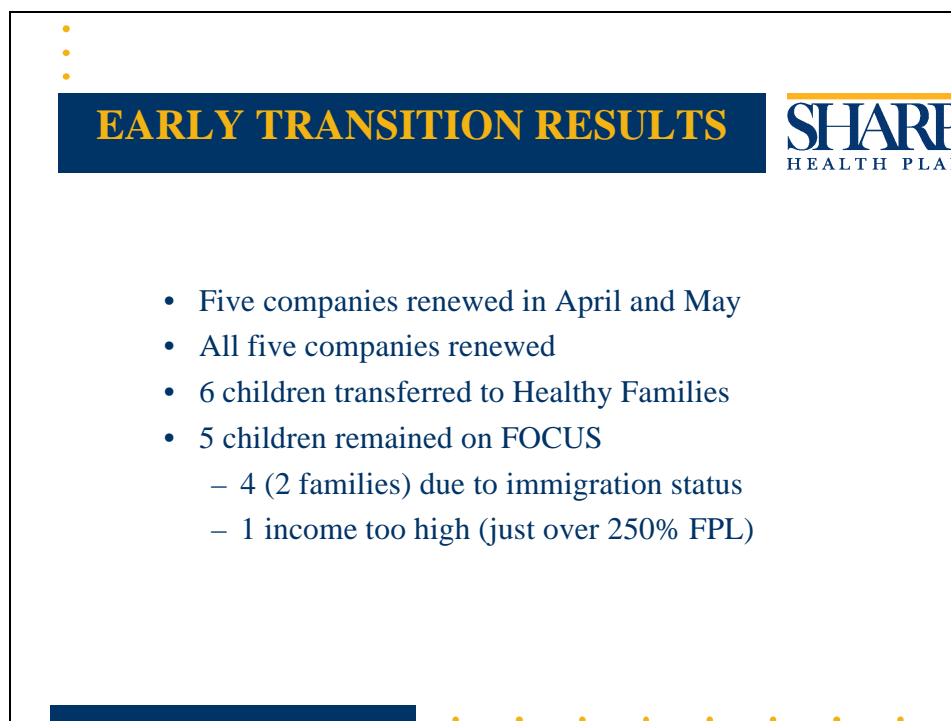
So what we believe Sharp did was, it created an umbrella, pulling together all of this very fragmented coverage. So we went into the employer groups and met with each of the employees and shared the process with them, letting them know that even, if they qualified for these other programs, they'd still have the same provider panel to select from, same physicians, same hospitals. They wouldn't be disputed, their care wouldn't be disputed, that they would still have the same rules and regulations to live by, the types of things you had to require preauthorization referrals for, the things you could go direct to specialists for, et cetera.

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And we found that many of these employees who had previously said I am not willing to enroll in these government programs said, I'm willing to participate. And we brought an assister with us to the open enrollments. They filled out the applications, and we had to wait about 30 to 60 days for word back from the state or the county to let us know whether these people qualified, and if we look at the next slide you'll find that—and unfortunately these were only April and May groups, so I can tell you this is hot off the press—that in this program, there were only five employer groups that started in those months or that were renewing in those months, but all five renewed.



EARLY TRANSITION RESULTS SHARP HEALTH PLAN

- Five companies renewed in April and May
- All five companies renewed
- 6 children transferred to Healthy Families
- 5 children remained on FOCUS
 - 4 (2 families) due to immigration status
 - 1 income too high (just over 250% FPL)

And six children or a total of 11 were actually referred to government programs. These were children who were in the FOCUS program that did not select government programs. Six were transferred to Healthy Families. None were transferred to Medi-Cal so that meant that their incomes were too high for Medi-Cal but low enough for Healthy Families. But another five stayed in the FOCUS program, and that was because, of, one, immigration status, as we had assumed there would be some immigration status issues; or, two, there was only one child whose income was too high. It came in just above the 250 percent federal income guidelines.

So we looked at April and May, if you will, as a success story in terms of transferring or rolling over these businesses, because we got about half of those children enrolled in programs they should have been enrolled in. Their benefits are much better because they now have vision and dental coverage through the state program.

We identified to the families that, or met the need of the families that, an overall umbrella program that would keep all of the families in similar programs would work, and we addressed

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the issue that Mike spoke about, which was that these families didn't have to be singled out in their employer groups, that they didn't have to say, okay, well, some of my peers have commercial insurance and some of us have government program insurance. Everybody's ID card in that employer group looks the same, whether the children are covered through the SCHIP program, whether the parents are covered through the FOCUS program, and a peer in the organization is covered through the FOCUS program.

So we are very happy with the results of our first couple of months of transition enrollment. Dr. Rick Kronik has received another grant from the California Health Care Foundation to study this second wave or the second phase of grant dollars, and I'd like to give you the Alliance Health Care Foundation's web site which is www.alliancehf.org, because the results of the first wave of our study are going to be posed on the web site this summer. By the fall, the second wave of the study will be posted. In the summer, you will receive demographic information that identifies some of the things I talked about today as well as our first round of utilization information.

When I go out on the road and talk about the focus program, the biggest question that comes up frequently is, so did these people utilize more than your commercially insured population? That was the concern. People said, okay, well, these folks knew they had coverage for only a two-year period of time. Did everybody come in and get lots more care? Well, the answer to that question we've looked at three areas right now: office visits, emergency room utilization, and we've looked at OB, because one of the things you might expect—somebody can't plan on getting the total knee or a total hip replacement, right?—but they can say, I'm only going to have this coverage for two years, and maybe this is the time for us to begin our families.

Well, I want you to know that the office visits are running at about the same. So from an office-visit perspective, we are pleased because, as you might expect, we're an HMO, we're interested in prevention, and we encourage people to get into their primary care offices for preventive care, diagnostics, et cetera. This program, and we're comparing it with our Medi-Cal population, our Healthy Families [SCHIP] population, and our commercially insureds, they are utilizing at about the same level.

As it relates to emergency room utilization, our numbers for the FOCUS program are actually lower than any of our other programs. Our assumption—this is what we'll be testing over the next period—our assumption is that this is based on the fact that these people have had to utilize—had to carefully access care in the past because they were private pay, so they don't run to the emergency room very quickly. Plus, we've also done a better job of educating them away from the emergency room, we think, because they're a smaller population.

Third, and finally, I'm pleased to tell you that our OB rates are not any higher than any of our other programs as well. We are delivering the same amount of babies in this program on a per thousand basis as we are in our other programs. What I will share with you, however, is that we have more teen pregnancies in the FOCUS program than we do even in our Medi-Cal or Healthy Families programs. So the total number of OB is the same, but there are more teen pregnancies than in our other programs.

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That's it. I'm more than happy to answer questions. Thank you.

MS. WONG: Thank you, Kathlyn. So, right before our break, we'll take a few questions for either Mike or Kathlyn.

AUDIENCE PARTICIPANT: Hi. I had a question about the FOCUS. As you said, not all of the people who are employed are eligible.

MS. MEAD: Yes.

AUDIENCE PARTICIPANT: And you said the employers had not previously provided health insurance. Did they, once they enrolled the ones that were eligible, did they go ahead and purchase from you health insurance for the other employees? How did they handle that?

MS. MEAD: That's a great question and, I have to tell you, one that our competitors in San Diego were most interested in, because they really saw this as—potentially—were we doing this as a loss leader to bring in the coverage for the businesses? We have only enrolled about ten percent of those businesses in our commercial insurance program. Those businesses where there was coverage that they were purchasing elsewhere, they preferred to stay with the other coverage, which, frankly, really surprised us because, as you know, buying individual coverage in the insurance market is much more expensive than buying it through employer group coverage, especially in our state where small group rates are filed with the state and are competitive in nature. Shadow pricing goes on all the time. So the answer is no, most of them didn't buy our commercial insurance. Most of them stayed on their private coverage.

AUDIENCE PARTICIPANT: This is a question related to your last remark about your teen pregnancy rate. I found that sort of interesting that you would find it higher than in Medi-Cal. Do you have any thoughts about that of what's causing that?

MS. MEAD: You know, at present we don't. We are concerned about the ethnic mix in our population, but as you would expect, we have a very high ethnic mix within our Medi-Cal and Healthy Families program. But we certainly are looking at that. We are concerned, frankly, about whether or not we have done enough teen education through this program. We tried to model the same adolescent education as we did through the Medi-Cal program, but we're thinking that we may have to step up those efforts. The other thing is, though, we're also looking at—I'm certainly not a data guru, but our data folks are looking at just the size of the population. We have a smaller "n" and one or two cases can certainly increase the overall statistics.

AUDIENCE PARTICIPANT: Hi. I really enjoyed your talk. I had a question about the difference between the kids who are covered by Medicaid and the kids that are covered under your product. The cards look the same, but I was just wondering if you've thought about ways to address the difference in the actual rich-versus-less-rich benefit package? You know, I can imagine if my brother or my sister that I'm working with or my best friend is getting—you know, their kid gets better eyeglasses or whatever the benefit is—that could cause a rift

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especially in these small community employee groups. Can you talk a little bit about how that might be addressed?

MS. MEAD: That's a great question and thank you. I usually give this talk in an hour and I tried to do it in 15 minutes even though I got the "T" sign three times. I know it felt very fragmented. I wanted to share that that has been one of the major issues for us, especially as you might expect, because many of these family members are saying, well, I would rather have lesser coverage and have it be the same than have richer coverage, even though we've really been pushing that if you can get your children in these richer programs, put them in those programs so they can get that level of coverage. But they don't want one child to get dental benefits or vision benefits when the other child does not.

The only way we've really identified to do this at this point is to build that into our basic benefit package. The problem is price, because we don't have the ability to do that through our grant dollars to completely cover it. It would increase the price to the families and increase the price to the employer groups. And at present, they have not been willing to do that. We're hoping that within the next year what we can do is now go back to the employer groups and show the value of having additional benefits. But initially they were saying, I just want health insurance coverage.

The good news is that, in the state of California, we already have mental health parity so at least the mental health benefits are the same. Right now it falls out as dental and vision.

MR. NEUSCHLER: I think we're going to need to cut this off here just, because we're running over. There is one question over here which is, how much does this cost?

MS. MEAD: Oh. Darn good question. Thank you. We developed the program about three years ago. At that time, what we did was we got our physician groups and hospitals to take reimbursement levels that were not quite as low as Medi-Cal or as high as commercial rates of reimbursement. So, typically, this product would cost about \$100 for a single person in San Diego—premiums are very low in San Diego, but coming up—this program would cost about \$100 [per month]. We were able to offer this program for about \$85. So the employer group pays about 30 percent of that \$85 premium, the employee pays one to five percent, so the subsidy picks up the remaining 60 to 65 percent of the \$85 premium.

Here's an interesting thing that I failed to mention. With this new wave—we've increased the premium by 20 percent with this new wave of people that we're reenrolling. And as I pointed out, five of five employer groups have renewed and all of their employees have renewed, even though we've increased the premium by 20 percent.

It seems like a lot, but as you might expect, if you're paying \$10 right now, to pay \$12 in your third year, most people aren't balking at that. And it does speak to somebody's comment earlier about the fact that this is also being deducted from their paychecks, et cetera. It makes it a lot easier than if you have to write a check for \$12 versus \$10.

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About the Speakers:

Michael J. Perry is Vice President of Lake Snell Perry and Associates (LSPA), where he heads up the Social Policy Research Institute, which is the public policy research division of the firm. Michael leads the firm's healthcare research and works primarily with foundations and non-profit organizations.

In recent years, Michael's research has focused on the healthcare challenges facing low income families. He is currently working with the Kaiser Family Foundation and the National Partnership for Women and Families to study the attitudes of low wage employers toward Medicaid and SCHIP. He has also conducted large employer studies for the Robert Wood Johnson Foundation around health coverage issues.

B. Kathlyn Mead has served in the capacity of President and Chief Executive Officer, Sharp Health Plan, since June 1996. Under her leadership, Sharp Health Plan has attained membership of more than 85,000, enrolled in commercial products sold through San Diego based employer groups, as well as government managed care programs such as AIM, Healthy Families, and Medi-Cal. Sharp Health Plan has grown significantly and steadily through product line expansion and market niche penetration, especially meeting the needs of small employers and low wage earners.

Kathlyn is actively involved in the San Diego Community. She chairs the Community Health Improvement Partners (CHIP) collaborative. In addition, Kathlyn sits on the Board of Directors for the California Association of Health Plans, the Board of Directors for the San Diego urban League, and the Board of Trustees for the Alliance HealthCare Foundation. She sits on the advisory boards for the San Diego Consumer Center for Health, Education and Advocacy as well as the Insure the Uninsured Project. Kathlyn is actively involved in San Diego LEAD (Leadership Awareness and Development).

Sharp Health Plan has received numerous grants and recognition awards for its community collaborations as well as its innovative programs.

Prior to joining Sharp Health Plan, Kathlyn was Vice President for Managed Care and Marketing, Children's Hospital San Diego. Her previous managed care experience includes managing Colorado and Utah operations for MetLife Health Care Network and provider relations and contracting for Blue Cross of California.