DELAWARE HEALTH CARE COMMISSION

March 30th Addendum to the Final Report to:

Department of Health & Human Services
Health Resources and Services Administration
CFDA # 93.000
State Planning Grant Program

March 30, 2002

Executive Summary

Through the continued discharge of it's ***Uninsured Action Plan (UAP)***, the Delaware Health Care Commission (DHCC) remains focused on completing planning and service activities that demonstrate commitment to expanding access to health coverage and healthcare to uninsured Delawareans. The UAP has received funding support for the completion of these activities through the federal Health Resources and Services Administration (HRSA) and through designated proceeds generated by the Master Settlement Agreement reached by the nation's attorneys general and the tobacco industry. The HRSA State Planning Grant program has provided the financial means by which to complete thorough and comprehensive research needed for planning and policy direction. The HRSA Community Access Program has financially enabled the design and implementation of a statewide enrollment based program that provides qualified enrollees with linkage to public insurance and/or linkage to an income based primary health home and a network of medical subspecialty services.

Nearly three quarters of Delaware's uninsured work and have incomes over the federal poverty line, but are uninsured either because insurance isn't offered as a benefit of employment or it is too expensive to be affordable. A healthy and robust economy needs a properly trained and healthy workforce. Lack of access to appropriate care prevents the uninsured from maintaining good health. Good health is an essential ingredient to economic growth in Delaware. Towards that end, the Commission has since October been persistent in keeping attention on this fact despite a less than desirable economic environment both within the State and nationally. Supporting safety net providers who will provide care to the uninsured irrespective of an individual's insurance status, and identifying pathways and partnerships for making affordable health insurance coverage more widely available to employers and individuals who must make difficult financial tradeoffs to maintain coverage, remain central to health policy deliberations.

This report serves as addendum to the Final Report submitted under the State Planning Grant Program on October 29, 2001. It provides explanation of supplemental planning activities completed subsequent to the submission of the Final Report, their intent, and applicable outcomes. To the degree that the environment has changed, this report provides that update.

Section 1. Uninsured Individuals and Families

The most recent survey research completed in Delaware states that approximately 86,500 Delawareans are uninsured. Uninsured individuals represent approximately 12.7% of the total Delaware population- a percentage that has gone down from 14% in the 2000 CPS. This research has drawn on a series of survey research data sets collected in Delaware to produce the findings that are included in Appendix A. There are three principal sources; 1) the Census Bureau's March Current Population survey with a sample of between 600 and 700 households in Delaware analyzed between 1982 and 2000 when health insurance questions were asked, 2) the Behavioral Risk Factor Surveillance System has been conducted monthly since 1989 in Delaware with sample sizes increasing from approximately 1800 adults to 3500 adults today, and 3) the Consumer Assessment of Health Plans Survey or CAHPS, which in Delaware is a sample of 1800 adults.

Since October 2001, the annual Current Population Survey was re-administered with the addition of validation data. New nationwide CPS weights were issued in December, 2001 and have subsequently been utilized to re-analyze uninsured statistics. Also, since the October, 2001 report, the Behavioral Risk Factor Surveillance System (BRFSS) has been re- administered to a larger sample size and with more confirmation questions about being uninsured. (A revised "Delawareans without Health Insurance" report using this new data will be issued by the University of Delaware in April 2002 and will be appended to the final end of grant period report to HRSA.) The updated demographic analysis has facilitated a more concise breakdown of the uninsured by age and poverty level. This quantitative breakdown is being used as a baseline for determining the impact of programs and a strategy for implementing incremental reforms and methodologies.

There are many demographic variables detailed in Appendix A. The Commission's continued planning and policy analysis activities, discussed in Section Four of this report, focus on segmenting the uninsured and designing programs that respond uniquely to such characteristics. To date community input demonstrates support for initiating an incremental strategy that builds from the bottom up- ensuring that those who are at the lowest levels of poverty have access to coverage and services. This does not suggest that there is no need for a more comprehensive strategy targeting those who are above poverty levels and employed. In fact among the 86,500 uninsured, 80% are above the poverty line, 69% are employed, and some 30% live in households with incomes exceeding $50,000. Roughly 75% of uninsured children (0-18) are living in households with incomes less than 200% of the poverty level and thus should qualify for Medicaid or SCHIP. These data suggest several things:

a) There is an opportunity to cover more people with Medicaid and/or SCHIP,

b) We do not fully understand the reasons that impede this population from accessing a program for which they are likely eligible,

c) There is a significant group that seemingly has not seen the need to access the health care system while they are without health insurance,

d) There is evidence to suggest that the self-employed are almost twice as likely to be without insurance compared to those working for employers,

e) It is not uncommon for dual wage-earning families to not have access to employer sponsored health coverage for either spouse and/or a combined inability to take coverage due to its high cost. Among the 30% of the uninsured with family incomes greater than $50,000, this scenario suggests that they, too, face significant affordability issues.

f) Other data analysis tasks/research that was competed post October 2001 is an updated "Total Cost of Health Care in Delaware" report. This annual report provides consistent information utilizing the same methodology on the level and manner of Delaware health spending and a means to measure financial change and variability. This information can be used to determine the value of health care received for the dollars spent, which is useful in recommending and setting state policy. This is particularly true when combined with information on the demographics of the uninsured and overall satisfaction with the health care delivery system. The report provides detailed information on the percent of gross state product spent on health care, allowing policymakers to know how much of the state economic capacity is spent on health care versus other sectors. It provides a critical review of the implications of cost on health care access. Policymakers need to understand the structure and size of health care costs to more fully comprehend the problems of access that can be related to costs.

New to the report this period is an update of Cost Shift work that was originally completed for the Commission in 1999. That work has been utilized as the basis of demonstrating the impact the uninsured have on particular segments of the health system and any causal relationships that can be identified. Understanding the insidious nature of cost-shift and being able to quantifiably communicate its existence in the health care system is imperative to gaining the political will of many constituencies who with such understanding can better embrace varying expansion options and their financing mechanisms. The 1999 report highlighted the three opportunities to cost shift; physicians, payers, and hospitals. The study found insufficient evidence and limited opportunity for physician cost shift; and not evidence of cost shift in the payer category – either from large, ERISA exempt groups into small groups, or from HMOs to traditional insurance. The study did find evidence of hospital cost shift: In 1997, Delaware private insurance customers paid approximately 128% of their corresponding costs. The study found that the need for hospitals to cost shift in Delaware due to uncompensated care losses is roughly equivalent to surrounding states. This suggests that Delaware hospitals have higher costs than surrounding states and the national average, which contributes to an overall higher Delaware rate of cost shift. Information in the Total Cost of Health Care In Delaware 2001 on cost shift indicate that although cost shift in Delaware, the region and nation, have fallen in recent years, Delaware still reports higher levels than those at the regional and national level. However, it is important to note that Delaware has held its hospital costs per adjusted admission constant for several years, while surrounding states and the US average tended to increase.

The Total Cost Report with the Updated Cost Shift Analysis has been completed and presented to the Commission in draft format. (The final version will be issued by the University of Delaware in April 2002 and will be appended to the final end of grant period report to HRSA.)

Section 2. Employer-Based Coverage

Prior to the submission of the October 2001 State Planning Grant Report, both quantitative and qualitative research was conducted on statewide small businesses (less than 50 employees). This research consisted of vendor conducted focus groups (see Appendix B for focus group results) and the administration of a mailed survey by the University of Delaware. A large proportion of the uninsured in the state of Delaware are employed in companies with less than 50 employees. These companies represent the largest growing segment of Delaware's economy. Efforts were concentrated on getting information from employees of these small and medium size businesses. The 2000 Small Employer benefits survey by the Blue Cross Blue Shield Association, Employee Benefit Research Institute and the Consumer Health Education Council was used as a basis for the design of a survey instrument administered to employers of these individuals. The survey was developed to find out the reasons why small employers in Delaware with less than 50 employees do not offer health insurance.

The survey instrument consisted of two separate questionnaires. One to be filled out by businesses that offer health insurance to their employees and the other by businesses that do not offer any health plans to their employees. The questions in the questionnaire were divided into three distinctive groups:

- Attitudes towards offering health plans to employees
- Information about the business (such as number of employees, full time/part time status, annual earnings,)
- General knowledge of the health insurance market

The sample size of the Small Employer Health Insurance survey was 1598, providing appropriate representation by county. The surveys were sent in 4 separate mailings over a period of 2 months. The response rate for the survey was nearly 50 percent. The data gathered was weighted to appropriately represent the population of small businesses in the state of Delaware. A full report of the Employer Survey process is provided in Appendix C.

This research clearly indicated that cost, or the perception of cost, is the single largest determinant of a business's decision to offer or not offer health insurance benefits. This is despite the fact that the majority of employers responding stated that they do feel a significant obligation to provide coverage and recognize that lack of this benefit dramatically impacts ability to recruit and retain employees.

The most striking lesson learned through the research and consensus building process is the high level of misunderstanding and confusion that exists among small businesses about the topic of health insurance. Employers who do not offer coverage, over sixty percent of the time, believed actual costs of insuring an employee to be nearly double that of actual costs. (This was a true statement at the time the survey was administered. However, anecdotal information about the dramatic increases in health insurance premiums raise questions about its validity now. This is an issue worth investigating during the final months of the project period.) Many employers indicated confusion and difficulty in gathering information, making informed purchasing decisions, or tax

treatment of the cost of providing health insurance benefits. Given the state of the marketplace discussed in the next section of this report, the Commission continues to regard this educational opportunity as a strategy/option in and of itself. Ongoing dialogue about the design and delivery of an employer education program is discussed under Section 4 of this report. In the meantime, the University is completing additional research work on the results from the above referenced survey work. Many employers had written comments on the survey form that are currently under compilation, the assessment of which will be included in the final end of grant period report.

Section 3. Summary of Findings: Health Care Marketplace

Delaware's economy changed drastically during the course of the planning process and continues to have a decided impact on consensus building activities and general strategy development. Prior to this change in fiscal climate, there was a general level of interest in the issue of the problems of the uninsured and possible solutions. Now the focus has shifted to efforts to maintain what coverage already exists, both in the private and public sectors. The cost and general availability of insurance products is more central to dialogue at this time than are such subjects as social equity. This creates an even more pressing need to develop and communicate a multi-pronged and incremental strategy that speaks to the needs of many constituencies. Immediate planning focus remains on the lower-income uninsured and is a strategy that is generally supported. Fear that the small group marketplace is in such disarray that a new segment of the uninsured will present itself has reaffirmed that the cornerstones of policy deliberation are an employer education/engagement strategy and a strong safety net.

Delaware has a limited amount of significantly sized small group insurers, and recently two such companies announced plans to leave the market effective April, 2002. The Commission has recently been a part of discussions with community advocacy group that is very interested in this emerging situation, and is evaluating whether to advocate that limited access to small group insurance products impedes access to health care. According to a representative from the State Department of Insurance the following key issues affect the small group market:

Small group coverage in Delaware is defined as no more than 50 lives.

- A series of recently-enacted insurance mandates tend to contribute to increased costs of carriers doing business; thus increasing rates consumers have to pay. This is exacerbated in Delaware, since most of the insured population receives coverage through large ERISA employers, and are, therefore, exempt from state insurance mandates. Other state and federal government regulatory measures such as "Patient's Bill of Rights" and the administrative simplification provisions of the Health Insurance Portability and Availability Act are adding to the overall costs insurance carriers already experience.
- Brokers' commissions are being cut, creating disincentives to actively market products – brokers feel they cannot make a living selling health insurance products and are focusing on other product lines.
- Increasing national health care costs; particularly in advanced medical technology and the aging population, compound the issue.
- An average of 6 carriers have withdrawn from the small employer market annually since 1998 – typically managed care products.
- The Office of the Insurance Commissioner provides basic information about small group carriers, and frequently asked questions, to employers who may be adversely affected by health plans' departure.
- The only recourse for some individuals will be to purchase policy(s) through the individual market. However, this market is also volatile, and products can be very expensive.

- In 1992 Delaware enacted small group insurance reforms that were based on model legislation developed by the National Association of Insurance Commissioners. Among the provisions if this 1992 law are the following:
- Any carrier who files in Delaware must submit two (2) plans and rates (basic and standard). The Office of the Insurance Commission reviews these filings for adequacy.
- Carriers must meet specific criteria in terms of experience rating vs. community rating. Carriers "experience" rate, staying within specified certain bands and specific guidelines within a given class of business. The highest rates cannot exceed the lowest rate offered by more than a specific percentage that is outlined in the law.
- Small group insurers must provide some products on a guaranteed issue basis – A policy must be available to any small employers wishing to purchase it.

Compounding the delicate state of the small group market is the potential merger and conversion of the local Blue Cross Blue Shield organization. A regional carrier, CareFirst, recently acquired Delaware Blue Cross Blue Shield. The Delaware Blues have been servicing Delaware's public programs. Now CareFirst plans to merge with Wellpoint Health Networks based in California and has filed to convert from a not for profit to a for profit company. These activities have implications on the proportion of market share that Delaware insured individuals will have on company business practices and medical management.

The continuing ascent of workmen's compensation premiums creates hardship on employers operating budgets. Worker's compensation is required of all Delaware employers. These increased expenses in combination with the declining economy and lessened consumer spending are not helping employer bottom lines nor creating an environment conducive to dialogue about incurring additional expense; e.g. health insurance coverage for employees.

Delaware physicians are experiencing rate hikes in medical malpractice premiums, as event that threatens to further complicate the insurance market in Delaware. One major firm has decided to withdraw from Delaware.

Delaware has however made significant strides in recent years to expand public programs. The Diamond State Health Plan (the State's Medicaid managed care program) provides coverage for adults up to 100%FPL and pregnant women and infants to one year up to 200%FPL. The Delaware Healthy Children Program (the State's S-CHIP) provides coverage to children in families up to 200%FPL. Though not an insurance product, Delaware's Community Healthcare Access Program provides income-based primary care and medical specialty services to adults between 100-200%FPL and undocumented citizens up to 200%FPL.

The current economic downturn and corresponding state budget problems have forced state officials to turn from serious examination of program expansion to efforts to preserve the gains already made. In the spirit of preventing erosion to these public programs, the Delaware Division of Social Services (DSS) submitted a HIFA waiver

application in mid-March 2002. The Commission's Uninsured Action Plan workgroup received an overview of the State's intended use of HIFA waiver flexibility to capitalize on opportunity to continue serving a population(s) that might otherwise be subjected to restrictions/loss of coverage. Using the HIFA waiver opportunity, it is the proposal of DSS to transition some of the present expanded enrollment Medicaid population from their existing status as Medicaid enrollees to the SCHIP. This diversion tactic made possible by the HIFA effectively could negate what would otherwise be a limitation/reduction of Medicaid benefits to expanded benefit enrollees during an austere budget period. Following are the expanded populations that have been targeted for redistribution using HIFA flexibility:

- Pregnant women 133 – 200% are "optional" enrollees. Will exercise the unborn children option and transfer to SCHIP.
- Drop eligibility level for adult Medicaid to 65% FPL. Adults at 66% - 100% FPL moved to SCHIP.
- Welfare to Work – health benefits are now provided for 24 months. The second 12-month benefit period will be moved under the SCHIP and will shortly be terminated irrespectively.
- 1931 waiver group – 66% - 100% FPL – moved to SCHIP.

Feedback from the HIFA submission and implications on levels of public insurance coverage will be discussed in the final end of grant period report.

Section 4. Options for Expanding Coverage

The Delaware path forward consists of several types of strategies; education, strengthening the safety net, forging public/private partnerships, and building on existing resources. Inherent to each of these activities is continued outreach to individuals who may currently be eligible for participation in public programs. Discussed below are a summarized set of options that continue to be at the center of policy discussion and planning in order that any one or some combination of strategies might be ready for final consideration and possible implementation when the state's fiscal situation makes that practical. We recognize that there is some overlap among the options in terms of the people who would be helped to get coverage. Adoption of one or more of the options might make adoption of some of the others ultimately unnecessary. It is unlikely, however, that all of these options would be implemented simultaneously, so there would be time to evaluate the effectiveness of options in place before initiating others. A visual tool that depicts segments of the overall uninsured population by age, level of income, and how they may be impacted by the various options discussed below is under development by the Commission.

For each of the options discussed below, information is provided in the way of general update on the Commission's continued activities subsequent to the October 2001 report. Cost and population impact statements based upon detailed actuarial work are found in tabular format within Appendix D. More detailed analyses for the options, along with the underlying assumptions, are available in Appendix E. It is important to recognize that the cost and impact estimates are made with the assumption that no other option has been put in place. Since there is some overlap in the target populations, the estimates would need to be recalculated if more than one option were implemented. The cost estimates are in year 2000 dollars.

Strengthening the Safety Net- The Delaware Community Healthcare Access Program (CHAP) links safety net providers in an enrollment based system in which eligible patients are assigned to a volunteer or low cost medical home. CHAP also provides access to a statewide network of volunteer or discounted medical subspecialty services via community health centers or a network of private volunteer physicians orchestrated by the Medical Society of Delaware. Dialogue is underway with hospitals and private companies for the statewide availability of discounted diagnostic (laboratory and radiology) services. CHAP eligibility requires completion of a universal financial and health status screening process, income between 100-200FPL, and ineligibility for a public insurance program. There are approximately 15,000 uninsured individuals in this bracket of eligibility.

Since the CHAP "went live" in June 2001 over 1300 patients have been assisted, over 200 enrolled in Medicaid, and nearly 900 enrolled in CHAP and linked to a primary health home. As part of the planning process, the need for a comprehensive assessment of safety net capacity and financial viability was identified. A Request for Proposal process was used and a vendor (John Snow Inc.) contracted in February 2002 to initiate analysis. Deliverables include a detailed assessment of the capacity and financial viability of Delaware's four community health center programs which are integral to

CHAP and a broader environmental scan of resources that may not currently be aligned in what we have traditionally considered the "safety net".

The information gleaned from this work will dovetail that of continued health policy consulting services focused on how the CHAP may be used as a foundation for building a reimbursement strategy/subsidy system for providers who continue to absorb these "working poor" individuals who do not have access to employer sponsored coverage, or for whom the concept of insurance has little to no value. Ideas that have been broadly explored but are subject to continued in-depth analysis include development of a limited benefit coverage program for individuals enrolled in the CHAP, providing a direct, service-linked, subsidy to the CHAP network of safety net providers, or exploring community based systems development initiatives such as expansion of the federally qualified health center model. {One of Delaware's four community health centers received United States Public Health Service (USPS) classification as a federally qualified health center in March 2002. A second of the four is currently developing an application to the USPHS for federally qualified health center "look-alike" status as a prelude to full application in the coming two years.}

Target the Working Uninsured through Public Private Partnerships- Devising a targeted plan that leverages state and federal dollars, and/or blends those dollars with private sector dollars to produce low cost products tailored to small employers who typically employ low wage workers remains central to Commission planning activity. These are not mutually exclusive strategies but rather possibilities that must be closely coordinated for incremental and evolutionary implementation.

- Expand the Delaware Healthy Children Program (DE SCHIP) to cover parents of enrolled children and eligible, but un-enrolled, children. The proposed use of HIFA waiver flexibility to expand SCHIP and simultaneously protect some targeted currently eligible populations (discussed in Section 3 of this report) we believe will establish a solid foundation for the General Assembly's investment in the SCHIP. It is our hope that this exercise will serve as an important illustration of the SCHIP's expansion potential (expanded populations as well as employer buy-in) for when the economy shifts- particularly given the higher match and the fact that SCHIP is not an entitlement program.

- Further explore employer buy-in possibilities and how HIFA waiver flexibility may allow some blending of this strategy with SCHIP expansion. Representatives from the Commission and the Medicaid office will be attending a State Coverage Initiatives Program small group consultation session to further explore these possibilities.

- Continue exploration of a "one third share" plan in which a less comprehensive benefit package is made available to employees through their employers. Premium costs are shared between employer, employee, and "one-third" state subsidy. A typical one-third share is $50- a cost which employers indicated is within their range of willingness to pay. Dialogue has been initiated with representatives from Access Health, a 1/3 share plan in Muskegon County,

Michigan. Program representatives have visited with key stakeholders in Delaware and continue to offer various insights and experiences.

Cooperative Purchasing Strategies

Though national experience demonstrates that purchasing pools have not been very successful in lowering cost, they have delivered primary benefits of greater choice and administrative simplicities. Delaware individuals and businesses continue to have much interest in purchasing pools and hold a conceptual belief that they offer savings. Pooling strategies warrant further study in order to address the actual impact on cost, either as a means of dispelling these beliefs or identifying strategies for further action. The small group market issues discussed in Section 3 have resulted in increased attention and discussion on the subject of pooling, with such notions of crossing state lines for gaining group volume being broached.

A subsidized purchasing pool approach evolved from a preliminary discussion of an option that would permit certain target populations to buy into the state employees' plan. For a variety of compelling reasons, that buy-in option was rejected, but it was recognized that there is a group of uninsured people who have trouble finding affordable coverage but who are unlikely to be eligible for other subsidized programs—in general, employees of small employers and people whose incomes fall between 200 percent and 300 percent of the poverty level. This approach targets this population. It combines some of the elements that were considered when the state employee plan buy-in was still on the table with elements of a purchasing cooperative.

The basic idea is to establish an entity, under state auspices, that would act as a purchaser of health coverage, negotiating with carriers and health plans on behalf of the target populations and then offering a choice of all the selected health plans to eligible employers and individuals. The expectation is that the total purchasing power of the state (resulting from its contracts with health plans for Medicaid and the state employees' plan) could provide effective leverage to negotiate contracts that would include favorable terms, thus ensuring that people who enroll would get more affordable, high-quality coverage. In some permutations of this plan, a state subsidy is required in order to bring costs down.

While this option deserves further consideration, it has many implications and many unresolved issues that would need to be addressed before a plan for implementation could be developed. Continued community interest around pooling, combined with an exceedingly limited ability to gain a critical mass for spreading risk, suggests that perhaps the only pooling strategy that would have a sufficient volume of enrollees is to in some manner leverage the State employees plan. Given the fiscal condition of the State and a mixed perception of the State's ability to effectively yield negotiating leverage, this strategy remains one that is premature to either advance or abandon.

However, the State of Delaware is experimenting with a consolidated bidding approach this year, requiring companies to bid on both the state employees health benefit plan and

the Medicaid population. It is hoped that this experience will be useful for any future discussions on this option.

Employer Education- A strategy that culminated as a result of quantitative and qualitative employer research was the piloted development of a method for providing easily understandable information about how to purchase health insurance, particularly for small businesses.

The executive director of the Washington, D.C. based Consumer Health Education Council (CHEC), an affiliate of the Employee Benefit Research Institute (EBRI) has met with the Commission to discuss the opportunity to develop resources and a tool kit for small employers. Additionally, the Delaware State Chamber of Commerce, the Delaware Economic Development Office, the Welfare to Work Program, and the Medical Society of Delaware (as the potential lead agency on the Robert Wood Johnson Foundation's Covering Kids and Families grant program) have been identified as potential local collaborators that may have vested interest in participating in the development of educational materials for small employers. Dialogue with CHEC has been predicated upon these summary observations resulting from aforementioned survey and focus group work:

- Most employers would like to offer insurance, but do not because of cost.
- For some employers of low-wage workers, particularly those with high turn over rates, the costs of providing health insurance are a greater proportion of overall employee costs than those incurred by employers of higher-wage workers.
- Many employers who do not offer insurance believe the cost to be higher than it actually is.
- Many employers who do not offer insurance do not realize that the cost of purchasing insurance can be deducted from taxes.
- Employers who offer insurance experience frustration because the cost of insurance is going up and the process of making good purchasing decisions is complex and difficult.

Therefore, Commission discussion to address issues of employer education has centered on:

1. Messages to inform employers about the true cost of insurance and the tax advantages of purchasing insurance
2. Methods to help small employers understand how to purchase health insurance.

Next steps including continuing dialogue with CHEC and local collaborators to put employer sponsored insurance in a larger social and policy context. Survey and research activities and anecdotal evidence to date suggest that employers do not view offering health insurance in terms of a larger social benefit that improves the health of the workforce, but, rather, as another cost of doing business. Employer education could have a different dimension of exploring the benefits of having insurance, the consequences of not having insurance, and determining if employers fundamentally believe it is a problem that some people – particularly workers – do not have insurance. Some do not understand

that the type of care that the uninsured do receive is expensive, wasteful and inappropriate. Others do not understand that range of implications that caring for the uninsured has on other segments of the populations through cost shift, and a less healthy workforce.

Given this scenario, employer education efforts <u>could</u> unfold as follows:

1. Conduct an environmental analysis to determine if there is general agreement that
    a) More people should be covered by the most financially efficient means,
    b) Employers are important to successful expansion whether they increase their offerings and take up or improve the market for uninsured employers or support public coverage and safety nets.
2. Explore with employers the fundamental solutions whether they be perceived as responsibility of the government or the private sector – employer sponsored insurance or individual insurance.
3. Determine if there is a market for solving the problem and if so what determine its fundamental structure and nature.

There are underlying questions belying this approach, which include but are not limited to:

- What is the real motivation for employer sponsored insurance? Cost of doing business? Improved employee recruiting?
- If costs are going up, why is it that employers are not dropping coverage?
- How real is the perceived tension between affordability and reluctance to alienate employees by in some way modifying what the evidence says is the most important benefit.
- Is there any reason why employers would sponsor their own plans if a low cost public plan were available?
- Is there opportunity to engage in a discussion of the great social good?
- Is there opportunity for employers who offer coverage to "weigh in" on the discussion on the value of offering insurance?

CHEC has begun the concept development of an employer tool kit to aid small employers purchase of health insurance but needs additional resources to more fully develop and desires the benefit of field-testing such ideas at local levels. Through the remaining grant period, the Commission will fully explore the costs and benefits of a tool kit strategy and if warranted, will move forward with a pilot testing.

Section 5. Consensus Building Strategies

The Delaware Health Care Commission (DHCC) served as a steering committee to state planning activities and has invited technical assistance from the Delaware Division of Social Services and the University of Delaware, the two principal data owners of the required information for this process. These key partners are leading authorities on the characteristics, demographics, and trends of Delaware's uninsured population. Over the course of the planning period, other key public and private stakeholders, including the Governor's Office have been identified and their input sought on an ongoing basis. The DHCC is an independent public body that reports directly to the Governor and the General Assembly. Commission membership is comprised of five (5) government officials and six (6) private citizens. The Commission chair is the Lieutenant Governor. The enabling legislation used by the General Assembly in 1990 to create the Commission specifically charged the entity with creating a pathway to basic affordable health care for all Delawareans. The Commission has undertaken this charge through the systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms.

There is no agency or organization in the state better suited than the Delaware Health Care Commission (DHCC) to have lead a planning process requiring critical input from government, public and private sectors. Systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms have been required to render any possible comprehensive and effective solution(s) to the problem of the uninsured. The DHCC has for nearly a decade tracked and investigated the issue of the uninsured through the compilation of research and the administration of pilot initiatives.

Interest in the State Planning Grant program was most strongly linked to the harmony between SPG purpose and legislated purpose of the DHCC. In addition, the DHCC is in a unique position to provide input to potential long term financing strategies, such as the use of tobacco settlement monies flowing the state. The Delaware Health Fund was created to receive these funds. The Delaware Health Fund Advisory Committee makes recommendations on their use, within legislative guidelines. The Commission is charged with providing research, guidance, and advice to the Committee. Success indicators for the expenditure of these proceeds have been established based on public input and include *"Strengthening the infrastructure, and expanding access to health insurance and services for all Delawareans."*

It is important to note that the Commission attends to the broader responsibility of overseeing the "Uninsured Action Plan" (UAP). The UAP has two components: planning and policy direction, and implementation of direct service delivery initiatives. As a recipient of proceeds of the state's tobacco settlement, the Commission made a commitment to pursue the thoughtful development of strategies to address the problem of the uninsured in Delaware. These tobacco settlement funds provided significant leverage to the Commission on two federal Health Services and Resources Administration grant awards: the State Planning Grant (SPG) and the Community Access Program (CAP). Receipt of federal funding under each of these programs (SPG and CAP) has enabled

more thorough completion of activities, and perhaps more importantly the opportunity to safeguard the tobacco settlement funding for use in implementing strategies on which consensus has been reached as a result of the planning process.

Since the time of initiating state planning activities, Delaware has experienced a change in administration. New cabinet secretaries resulted in three new commission members. Parallel to these changes in administration, Delaware's economy turned downward. The State is operating within an environment of extreme fiscal constraint at present. The consensus building process has provided repeated indication of the need for economic feasibility of implementing any strategy. The fiscal environment does not at this time provide such feasibility for implementing any option, but does provide the stimulus to continue research into such tangential items as provider capacity, safety net capacity, and alternative financing mechanisms in order that our ultimate implementation strategy stands poised to address political, fiscal, and philosophical viability tests.

Key stakeholders, including all members of the General Assembly, and members of the public have been involved throughout the planning process through the use of a consensus-building model adapted from a model termed the "Assembly Method". Use of this method requires that key stakeholders be pulled together at the onset of the process in order for issues to be framed. A core group then oversees the completion of research and information gathering activities, and reconvenes the larger group of stakeholders at such time that findings can be shared and input received. As the final leg in the process, the core group formulates a strategy based on input received from stakeholders to review and applicably modify. Delaware utilized this series of three policy conferences, beginning in February 2001, meeting again in June 2001, and was scheduled to meet during mid-September 2001 for a final meeting. That third policy conference, due to national events, was postponed until December 2001. The second and third conferences utilized technology to tabulate audience responses in the way of priority and general support. Results of those processes have led to the prioritized strategy and consideration of methodologies described in the previous section of this report. Aside from conducting policy forums (summaries of which are located in Appendix F), the Commission has launched an informational website with ongoing opportunity for public input, conducted regular discussion on the topic at Commission's monthly public meeting, and has completed presentation of the process and its continued path forward at a variety of community meetings on an ad hoc basis.

Commission staff has met with numerous key stakeholder groups and has made presentations and engaged in discussion about the planning project.

The coalition of stakeholders involved in the Community Health Care Access Program, funded through the HRSA Community Access Program grant offers continuing and on-going opportunities to keep constituencies updated on planning activities and receive input and information from those who might be most impacted by implementation of any option in the future.

Section 6. Lessons Learned and Recommendations to States

A significant allocation of time and the commitment of key individuals to the planning process are required at the onset. One year sounds like a lot of time but in actuality was not enough. Approaching the end of the first year, the Commission had comfortably identified an array of community-supported strategies but would have been unable, without more time, to prioritize them or continue planning targeted solutions. Commissioners overseeing our state planning process are leaders from the health industry, state government, and universities. They met biweekly for the first year, and continue to meet monthly. Meetings averaged three hours in length and represent an extraordinary commitment on the part of all. Increasingly, as meeting time must be spent in engaging meaningful conversation that links options, to impacts, to financing mechanisms, to overall societal benefit, work activities are completed offline by smaller workgroups, Commission staff, or contracted professional services. This activity requires a philosophical commitment in spirit and purpose and due to the chronic, unrelenting political and financial considerations associated with the topic of the uninsured can not be viewed as a standalone activity but conversely a systemic restructuring of values, financing systems, and roles of public and private sectors.

In terms of the effectiveness of varying types of research conducted, we encourage other states to think carefully as to the target participants, locations, times of day, and recruitment strategy for focus groups. We found the recruitment process to be inordinately difficult and the hardship experienced during that process in some ways diminished our enthusiasm for the results rendered. Upon reflection we concluded that the use of the focus group contractor to recruit participants may have been a mistake. We suspect that the people contacted did not recognize the name of the firm, and we may have lost the opportunity to communicate the importance and role of the focus groups in developing state policy. We would encourage states to lend the name of state government to the project.

States wishing to enter into a comprehensive planning process should be mindful of rapid change that occurs. Despite the earlier observation that one year is insufficient time to completely analyze your insurance market, the nature of the uninsured population, develop options and build consensus around which options make sense for your state, it is equally true that many aspects of your political, economic and insurance environment will change during the course of the year. It is advisable to keep abreast with these changes and be flexible and agile enough to alter your course accordingly.

State based data is critical. National data is very good and useful for benchmarking how your state compares, but it is essential to be in touch with your own insurance market, the challenges your small employers are facing, as well as to have a firm grasp on who your uninsured are. Investment in state-specific data is worth the time and money.

We strongly recommend careful consideration of the role played by the safety net as insurance expansion strategies are postulated. The safety net's capacity, financial viability, and ideological willingness to be a part of systemic state level change must be assessed and incorporated to the planning process. In addition to being significantly

impacted by new patients and new health plans, the safety net will always treat patients for whom the term “insurance” has little to no meaning. This too is a critical concept to be regarded in planning activities.

Lastly we caution states to recognize that the planning process is hard work, and there are no easy solutions. There are multiple points of view about the severity of the problem and the potential solutions. There are no easy answers. This should not be viewed as a deterrent as much as an encouragement. States should not be discouraged from entering into this process, but should recognize that, to date, no easy comprehensive solutions have been identified.

Section 7. Recommendations to the Federal Government

Multi-faceted, targeted strategies that build on a strong safety net as well as employer sponsored insurance coverage are required as the general solution towards expanding access to coverage to more uninsured Delawareans. However, in order for Delaware to move toward more universal health insurance coverage for the uninsured, financial resources from the federal government are prerequisite.

We are greatly appreciative of the flexibilities and technical assistance that has been federally provided through the State Planning Grant process, and look to the Health Insurance Flexibility and Accountability Initiative as an excellent example of the additional federal flexibility required of states to make innovative public and private partnerships actually work.

The federal government should view states as partners, and work collaboratively to find solutions to some of the more fundamental problems plaguing the health care system today.

One such problem is the "disconnect" between the purchase and consumption of health care. Health care is one of the few commodities in which the purchaser is not the consumer. This creates a fundamental tension about what types of services should be delivered versus how those services are paid for. In short we live in a culture in which everyone wants the best health care, but no one wants to pay for it. Unraveling this deep-rooted notion is difficult, but an effort that should be explored.

The federal government must also be mindful of the interplay of multiple aspects of health care on the entire system. Rising costs are driven by several factors, some of which cannot be changed, such as the aging population. Shortages in several health professions impact access to health care, even for those who have health insurance. Federal financing strategies that may save dollars, but also impact the ability to deliver care all impact the entire health care eco-system. Expanding coverage, as essential as it is in order to maintain a healthy population, must be done with an eye to the other financing and capacity issues within the health care system.

APPENDIX A:

DELAWAREANS WITHOUT HEALTH INSURANCE 2000 REPORT

Delawareans Without Health Insurance
2000

prepared for
the Delaware Health Care Commission

by

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Introduction

The Delaware Health Care Commission has, since its inception, been concerned about access to health care for all Delawareans. While that is not its only focus, since the Commission's mandate is broad, improving access to health care is a primary goal. Access to health care has several dimensions. One of those dimensions is covered in this report, and that is health insurance coverage. Those with health insurance typically enjoy greater access to health care providers than do those who are without it.

Persons who do not have health insurance are still likely to require medical care at some point in time. When they do require such services, their condition may be significantly worse than had it been detected and addressed at an earlier stage. In addition, the uninsured will tend to use one of the most expensive providers, the emergency room. Ultimately, providers must cover all of their costs. Services delivered to the insured and the uninsured alike, figure into that cost. As a result, some of the cost of services provided to the uninsured is shifted to the insured population. This raises the overall cost of fringe benefits to employers.

To better understand the nature of the uninsured population, the Delaware Health Care Commission has been monitoring its size and structure for a number of years. This report is a significant update and offers both new information and analysis. It adds information for the years 1998 and 2000 to the database. In addition, much of the information is now reported as three-year averages in order to add stability to the estimates. Finally, adjustments have been made to some of the tables to reflect recently reported 2000 Census data. This will make figures that report counts rather than percentages inconsistent with prior reports.

The report has three major sections. In the first section, the current status of the uninsured in Delaware and the region is discussed. A time series, beginning in 1982 and ending in 2000 is used to show any trends. The second section focuses on the labor market in Delaware and existing and future trends that might affect employer provided health coverage. The third section contains information on health insurance coverage for a variety of demographic variables. The implications of current demographic trends are also considered in this section.

The Uninsured

Background

Two primary sources of data are available for measuring access to health insurance in Delaware. The first source is the March Current Population Survey (CPS), conducted annually by the U.S. Bureau of Census. The second source is the Behavioral Risk Factor Surveillance System, conducted monthly for the U.S. Centers for Disease Control and Prevention by the Center for Applied Demography and Survey Research at the University of Delaware, through the Delaware Division of Public Health. Both sources are valuable in their own right, but each has associated advantages and disadvantages.

The CPS is conducted monthly throughout the nation and is designed to measure the unemployment rate and other employment related statistics for the 50 states and the nation. More than 64,000 households are included in the sample and data is gathered on approximately 131,800 persons in those households. Each month, the basic employment information is gathered along with optional information that changes from month to month. The March CPS is usually referred to as the annual demographic file, since it captures a broad array of demographic information along with basic employment data. Part of that demographic information concerns health insurance coverage.

In Delaware, the CPS involves about 700 households monthly, usually containing more than 1,400 persons. This sample size is sufficient for producing statewide estimates on a wide variety of demographic indicators. When measuring the percentage of the population without health insurance, for example, the accuracy is approximately +/- 1.7%. This year for the first time, three-year averages can be reported at the county level.

The health insurance questions were added to the CPS in 1982. There were modifications to the questions in 1989 and again in 1995. However, a consistent data series can be constructed in spite of the changes. One aspect of the health insurance questions, time frame, is important to understand, since it differs between the two primary sources of data. The questions on the CPS are asked with reference to the previous year. Thus, in March 2000, respondents were asked about health insurance coverage in 1999. However, there is considerable evidence to suggest that the responses

given are highly correlated with their current health insurance status or at least to the current quarter. The U.S. Bureau of Census conducted significant parallel testing between the Survey of Income and Program Participation (SIPP) and the Current Population Survey. The SIPP sample of households is part of a panel that is re-interviewed quarterly for more than two years. Thus, the survey is able to more accurately follow the respondent's health insurance status over time. The comparisons of estimates of health insurance coverage obtained from the CPS show a strong relationship between the SIPP responses and the CPS responses at the time the questions were asked. Thus, for purposes of this report, the year referenced in the tables and text always refers to the year in which the question was asked.

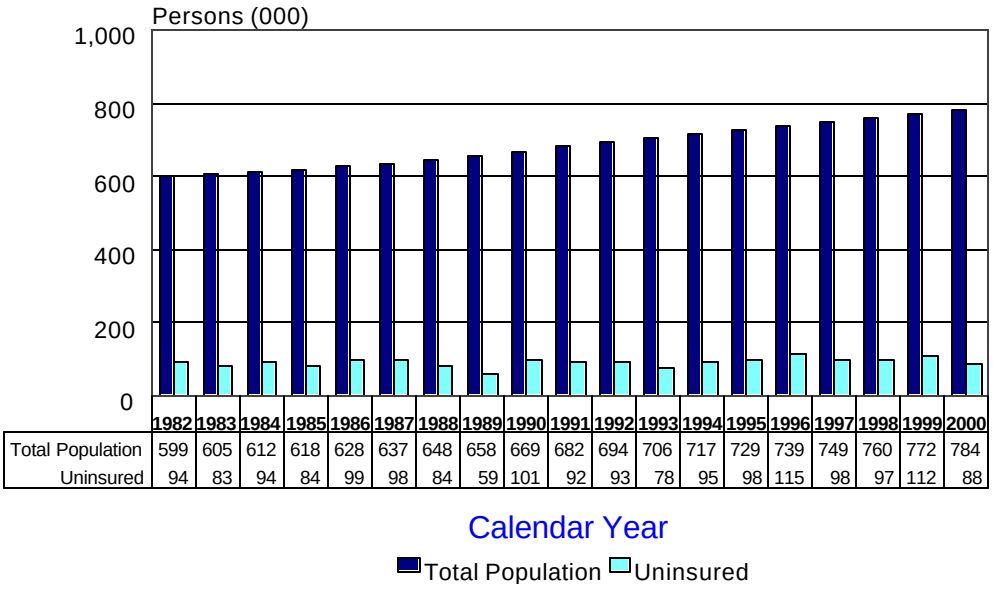
The second source of health insurance information is the Behavioral Risk Factor Surveillance System (BRFSS). The survey has been carried out by the Center for Applied Demography and Survey Research since 1990. The sample consists of residents of the state who are 18 years old or older. Each month approximately 300 households are contacted statewide and then an adult respondent is randomly chosen from within each household to be interviewed. The survey is wide-ranging. Among the questions asked are whether the person being interviewed currently has health coverage. If they are not covered, they are asked how much time has elapsed since they were covered. The limitation of BRFSS is that it only represents adults. However, the sample size is sufficient to obtain county level estimates that are more accurate than those that can now be obtained from the CPS. Together the BRFSS and the CPS provide a powerful set of data for understanding the health insurance problems in Delaware today.

In the balance of this section, the current estimates of the uninsured will be presented. In addition, time series information will be used to show trends contained within those estimates. Finally, county level estimates will be provided along with a comparison of Delaware with the larger region.

The Uninsured 1982-2000

The point estimates for the number of persons without health insurance from 1982 to 2000 are shown in Figure 1-1 below. The term “point estimate” is used here to describe the results obtained from the CPS for a single year. There are several general observations that can be made about the information contained in this figure. First, the number of persons without

Figure 1-1
Estimated Persons without Health Insurance
in the State of Delaware

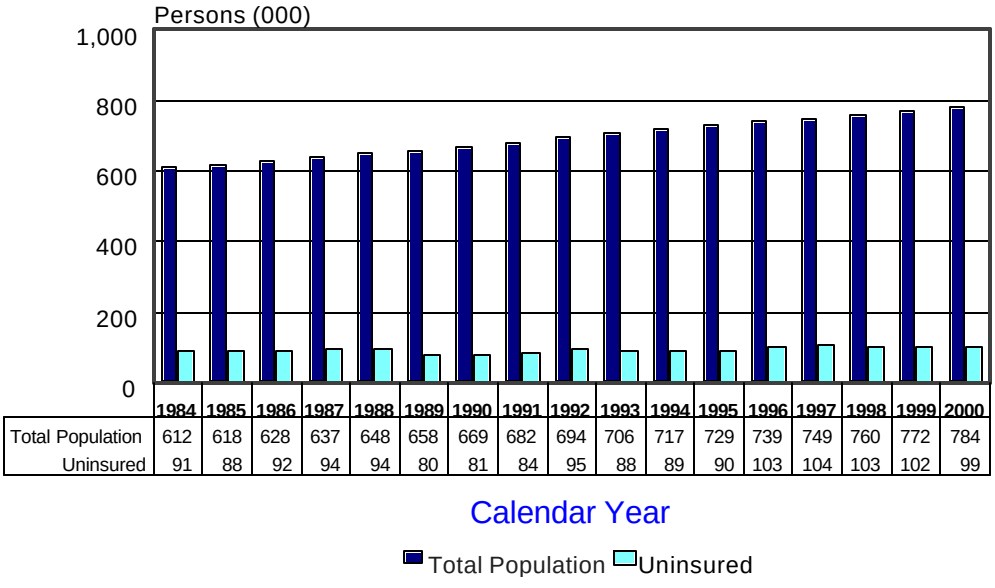


	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Population	599	605	612	618	628	637	648	658	669	682	694	706	717	729	739	749	760	772	784
Uninsured	94	83	94	84	99	98	84	59	101	92	93	78	95	98	115	98	97	112	88

VII. Source: Center for Applied Demography and Survey Research, University of Delaware

US Bureau of Census, Current Population Survey, March 1982-2000

Figure 1-2
Estimated Persons without Health Insurance
in the State of Delaware (3 year average)



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Population	612	618	628	637	648	658	669	682	694	706	717	729	739	749	760	772	784
Uninsured	91	88	92	94	94	80	81	84	95	88	89	90	103	104	103	102	99

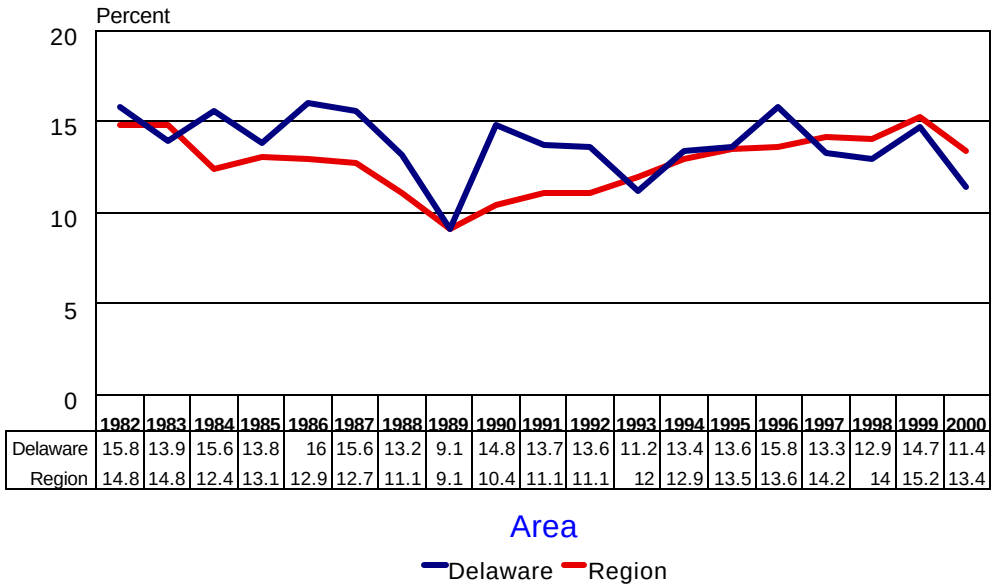
VIII. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1982-2000

health insurance in 2000 (88,000) dropped substantially during the past year. Last year's estimate could have been the result of random variation. However, this year's estimate includes the full impact of the CHIP program for the first time. Both sources may have contributed to this result. This also includes the 2000 population count and that is 23,000 larger than previously estimated.

Second, while the number of uninsured has remained reasonably stable, the population of Delaware has increased by more than 185,000 since 1982. Had the number of uninsured kept pace with population growth, there would have been more than 35,000 additional persons without health insurance in 2000 based on the one-year estimate. Clearly, there are other factors operating that impact the number of uninsured apart from population growth.

Figure 1-2 shows the same information as a three-year moving average. This tends to remove some of the year-to-year fluctuations that are due to random variation associated with sample surveys. The number of uninsured varies between 80,000 and 104,000 over the entire period, which is a relatively small range given that the standard error is about 13,000. The sudden increase in the 1996 estimate appears to have been a statistical artifact that was not confirmed in either 1997 or 1998. A similar pattern occurred in 1999-2000. The 3-year average tends to moderate those movements.

Figure 1-3
Percent of Persons without Health Insurance
for Delaware and the Region



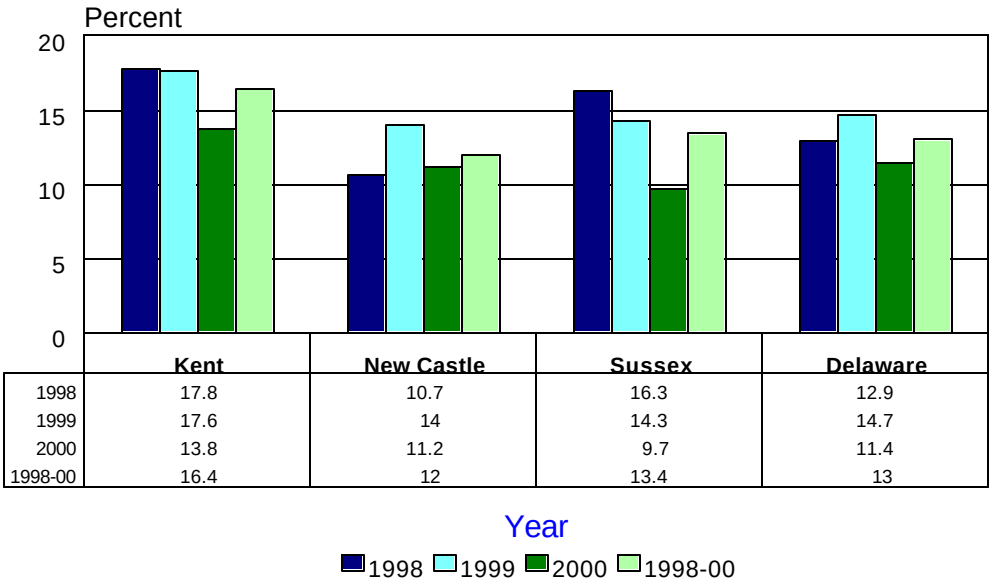
	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	15.8	13.9	15.6	13.8	16	15.6	13.2	9.1	14.8	13.7	13.6	11.2	13.4	13.6	15.8	13.3	12.9	14.7	11.4
Region	14.8	14.8	12.4	13.1	12.9	12.7	11.1	9.1	10.4	11.1	11.1	12	12.9	13.5	13.6	14.2	14	15.2	13.4

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1982-2000

The proportion of the population without health insurance, shown in Figure 1-3 above, has also shown distinct improvement since the recent peak in 1996. The rate has fallen over the years from about 15% in the 1982-1987 period to approximately 13.0% in the late-1990s. Some of this is undoubtedly due to legislative and policy initiatives, but at least some of the shift may be attributed to favorable demographics. In either case, Delaware is better off.

Also found in Figure 1-3 are comparative rates for the region which includes Maryland, Pennsylvania, New Jersey, and New York. From 1982 through 1992 Delaware's percentage of uninsured tended to be about 2% higher than that calculated for the entire region. However, as the graph shows, the percentage in the region began to rise after 1989 and has been flat or higher in most years. Delaware's rates, although more variable, tended to fall during the same period. At least part of this has to do with Delaware's economy, a job creation machine that was even able to absorb the impact of major job cuts by some of the state's larger employers.

Figure 1-4
Percent of Persons without Health Insurance in Delaware
By County

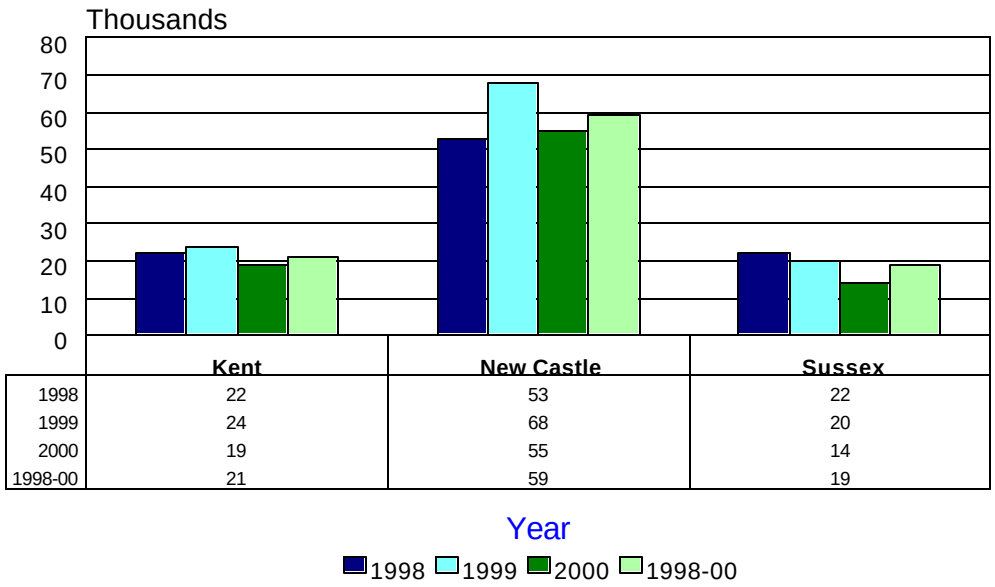


IX. Source: Center for Applied Demography and Survey Research, University of Delaware

US Bureau of Census, Current Population Survey, March 1998-2000

Since 1996, the Census Bureau has provided county level identifiers on the CPS data. The sample sizes are sufficient to produce some rudimentary estimates at the county level. Since the sample sizes are small in Kent and Sussex counties, more random variation can be expected. The percentage of uninsured in each county is found in Figure 1-4, above. Both the single year estimates and the three-year averages show significant differences between the county rates. Residents of New Castle County enjoy the lowest rate consistently during the three-year period. Kent County is highest, with the percentage of uninsured reaching more than almost 16% for the 1998-2000 period. Kent County residents are almost 37% more likely to be without insurance than those in New Castle County.

Figure 1-5
Persons without Health Insurance in Delaware
by County



X. Source: Center for Applied Demography and Survey Research, University of Delaware

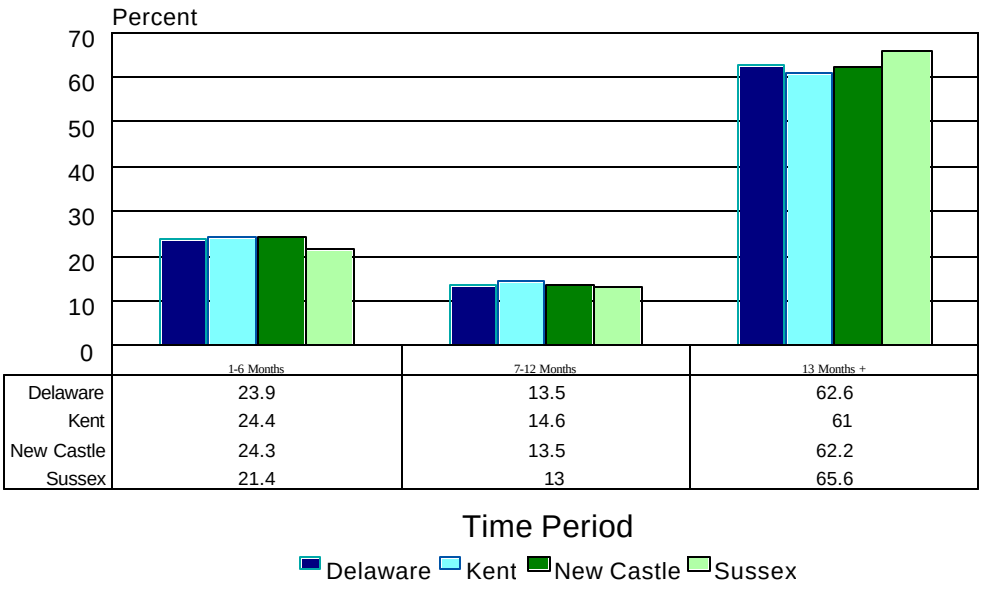
US Bureau of Census, Current Population Survey, March 1998-2000

The estimates of uninsured persons by county are provided in Figure 1-5, above. New Castle County residents are the most numerous even though the rate is significantly lower. Almost 60% of the uninsured reside in New Castle County. The distribution is also reasonably stable over the three-year period with occasional exceptions.

There are several interesting questions that can be addressed by the Behavioral Risk Factor Surveillance System, information particularly about those who are without health insurance. Those respondents were asked, "About how long has it been since you had health coverage?" Their answers are displayed in Figure 1-6, below. The data is reported as a three year average since there is a great deal of variability in the responses given the sample size is constrained to the number of persons currently without health insurance. Even with that constraint, the results are quite consistent. About 24% of Delawareans who are uninsured are without insurance for from one to six months. A little more than 13% of the uninsured respondents report being without insurance for up to a year. These data suggest that the majority (almost 63%) of Delaware's uninsured adults have remained uninsured for a significant amount of time. The longer the period an individual is without coverage, the higher the likelihood that they will develop a need for medical services.

Figure 1-6

Length of Time without Health Insurance in Delaware by County



	1-6 Months	7-12 Months	13 Months +
Delaware	23.9	13.5	62.6
Kent	24.4	14.6	61
New Castle	24.3	13.5	62.2
Sussex	21.4	13	65.6

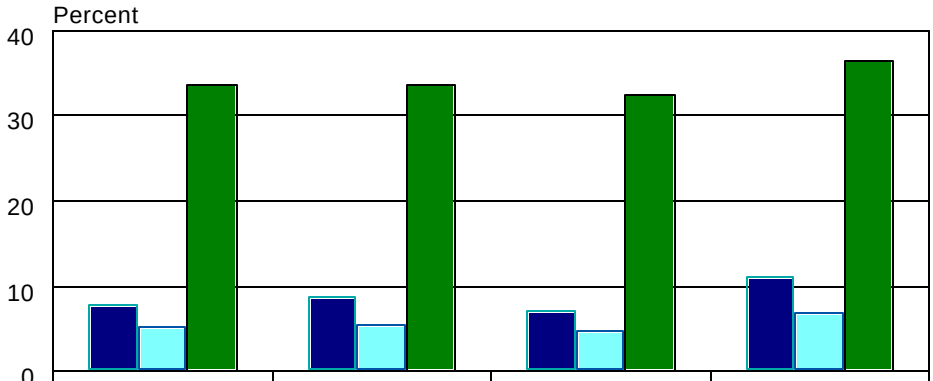
Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

If 63% of adult Delawareans remain uninsured for one year or more, there is a high likelihood that they may need medical services of some kind. In addition, it is also likely that routine preventative measures may be overlooked. The BRFSS gives some insight to this issue in a question addressed to all respondents. They were asked if they had needed to see a doctor in the past 12 months but could not because of the cost. Their answers are tabulated in Figure 1-7, below.

About 5% of the people who currently had health insurance answered affirmatively to that question. In contrast, those currently uninsured were seven times more likely to say that they had to forego a visit with a doctor. Those same results apply equally well across the three counties.

Figure 1-7
Needed a Doctor but too Costly

by Insurance Status and County



	Delaware	Kent	New Castle	Sussex
All	7.8	8.8	7.1	11.1
Insured	5.2	5.4	4.7	6.8
Uninsured	33.5	33.5	32.5	36.5

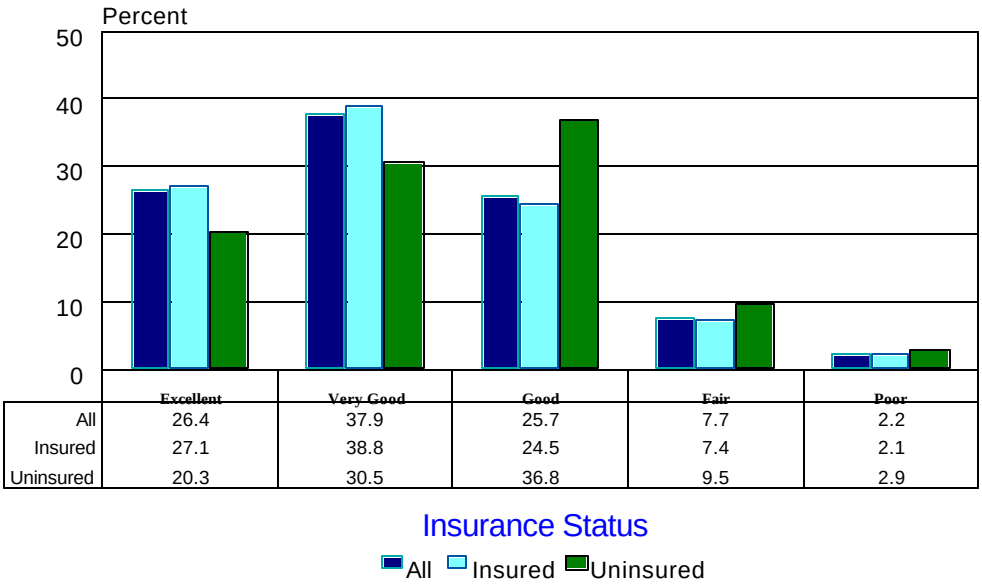
Insurance Status

All Insured Uninsured

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

Figure 1-8
Health Status
by Insurance Status

Delawareans without Health Insurance – 2000
The Uninsured

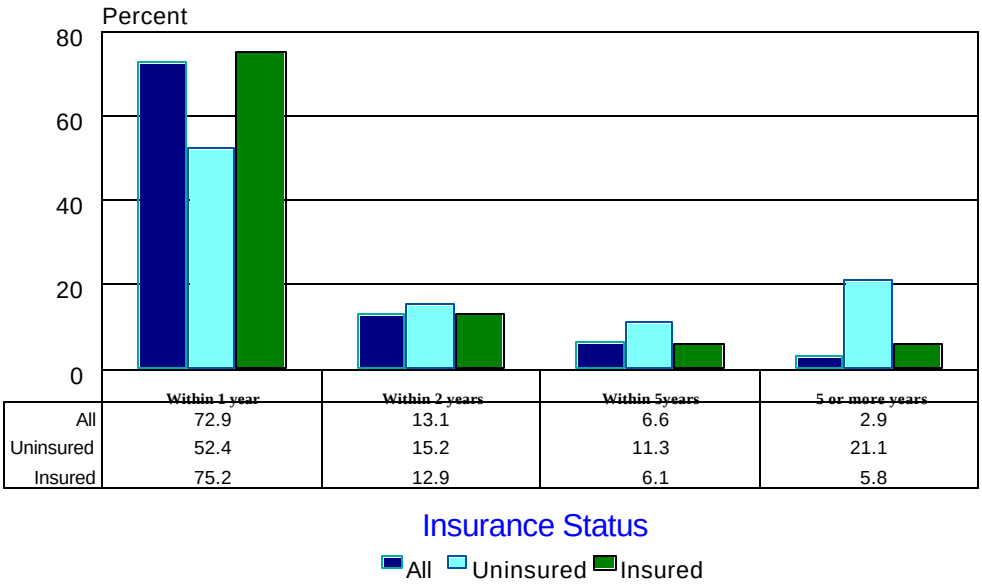


	Excellent	Very Good	Good	Fair	Poor
All	26.4	37.9	25.7	7.7	2.2
Insured	27.1	38.8	24.5	7.4	2.1
Uninsured	20.3	30.5	36.8	9.5	2.9

Source: Center for Applied Demography and SurveyResearch, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

There is also reason to be concerned about the uninsured and their need for medical coverage. They may need a doctor more often if their health status is less positive than those who are insured. Evidence to this possibility is found in Figure 1-8 above, where the uninsured tend to be less optimistic about their health status.

Figure 1-9
Time Since Last Routine Checkup
by Insurance Status



XI. Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

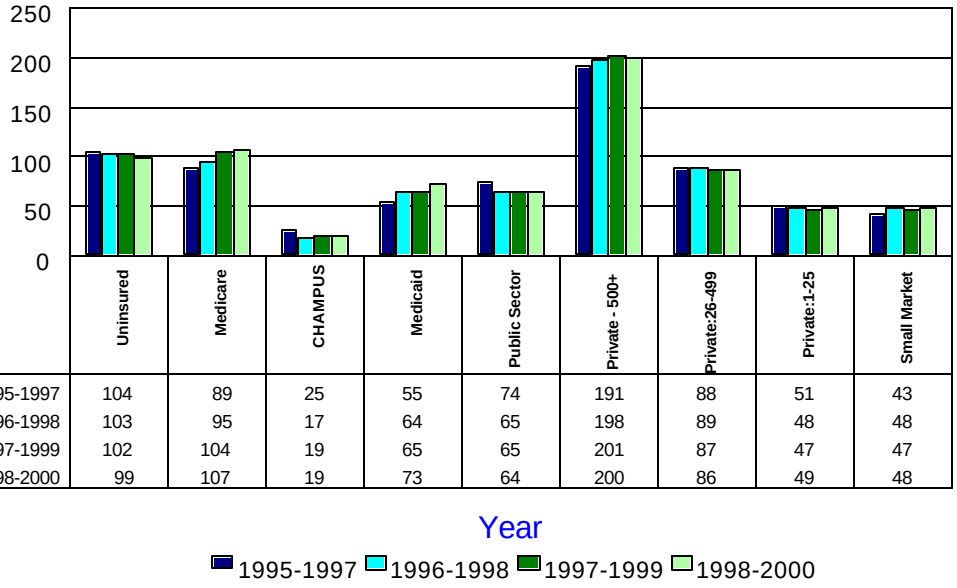
One other often mentioned feature of the uninsured is that problems are detected late and then treatment is more difficult. This position is supported by the data displayed in Figure 1-9 above. A person who reports being without insurance during the last year is more likely not to have had a routine checkup.

Finally, it is useful to understand something about how people obtain their health coverage. This can be particularly important in determining the amount of influence government policy can have on Delaware's population. Figure 1-10 below shows that Delawareans get their health insurance in many different ways. Excluding the 99,000 uninsured, about 199,000 people receive their health insurance through one of three government programs, Medicare, Medicaid, or

one of several military sources (CHAMPUS). The public sector at all levels insures some 64,000 residents. Within the private sector there are two distinct groups. The large employers (more than 500 employees) are largely self-insured and don't utilize the insurance market in a conventional way. These account for the largest single group of residents numbering more than 200,000. The balance, some 183,000 obtain their insurance through smaller employers who purchase various group plans in the insurance market or obtain insurance as individuals.

Figure 1-10

Number of Persons in Delaware by Source of Insurance



	Uninsured	Medicare	CHAMPUS	Medicaid	Public Sector	Private - 500+	Private:26-499	Private:1-25	Small Market
1995-1997	104	89	25	55	74	191	88	51	43
1996-1998	103	95	17	64	65	198	89	48	48
1997-1999	102	104	19	65	65	201	87	47	47
1998-2000	99	107	19	73	64	200	86	49	48

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 1995-2000

One interesting feature of this information, not found in Figure 1-10, is that many people report having multiple sources of health insurance over the year. For example in 2000, 13.2% of the population reported receiving Medicare, but only 4.6% say that Medicare was the only source of insurance that they had during the year. Similarly, 13% reported Medicaid as their source of coverage, but only 4.2% said that it was their only means of coverage. These two situations probably represent two different dynamics. Medicare recipients are quite often carrying additional insurance to cover any medical services not handled by that program. Medicaid recipients, on the other hand, seem to be more likely to move from some type of group coverage to Medicaid and back again as their life situation changes.

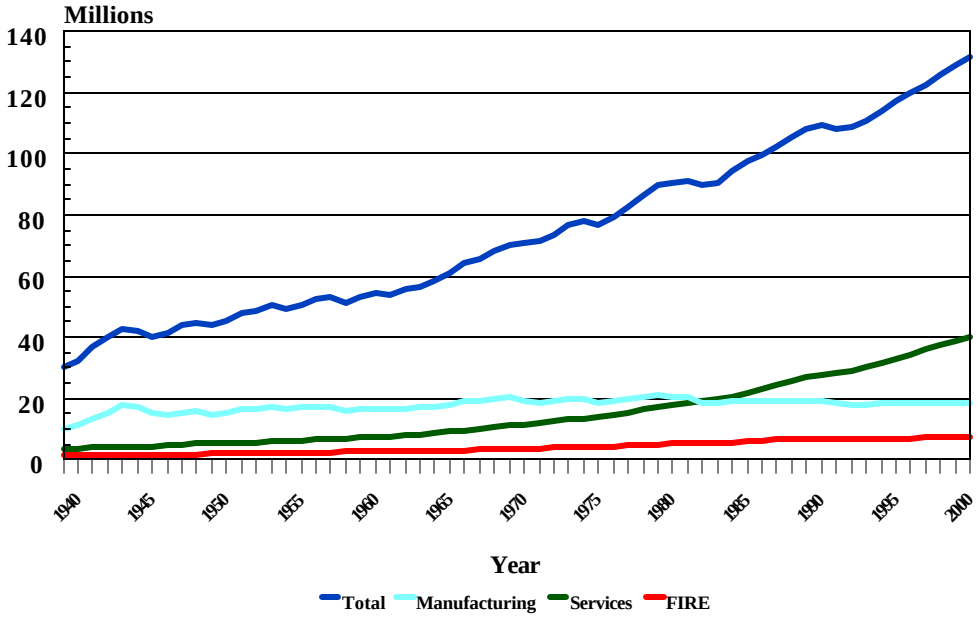
In conclusion, it should be noted that, while at any point there are approximately 11.4% of Delawareans uninsured, the proportion that are uninsured at some point during the year is closer to 18% based on national statistics. The same statistic derived from the Survey of Income and Program Participation, points to a median time without coverage of 7.1 months. This rate is lower than the one shown in Figure 1-6 above because children, who are less likely to experience periods without coverage, are included in the estimate. Overall, it appears that health insurance coverage in Delaware is headed in the right direction and, with the addition of Medicaid managed care and the Childrens Health Insurance Program, the proportion of uninsured Delawareans should fall or at least be stable absent changes in other demographic and economic variables.

Labor Market Issues

Background

Health care coverage is inexorably linked to an individual's employment status along with the type and size of firm for which they work. Many Delawareans have recently experienced more instability in their labor market activity and this has, inevitably, affected aspects of their coverage. The factors producing this increased instability are varied and are both national and international in scope. There are, however, some basic trends that are important to understand since they are affecting and will continue to affect health care coverage in the years to come.

Figure 2-1
US Non-Agricultural Employment:
Selected Sectors 1939-2000

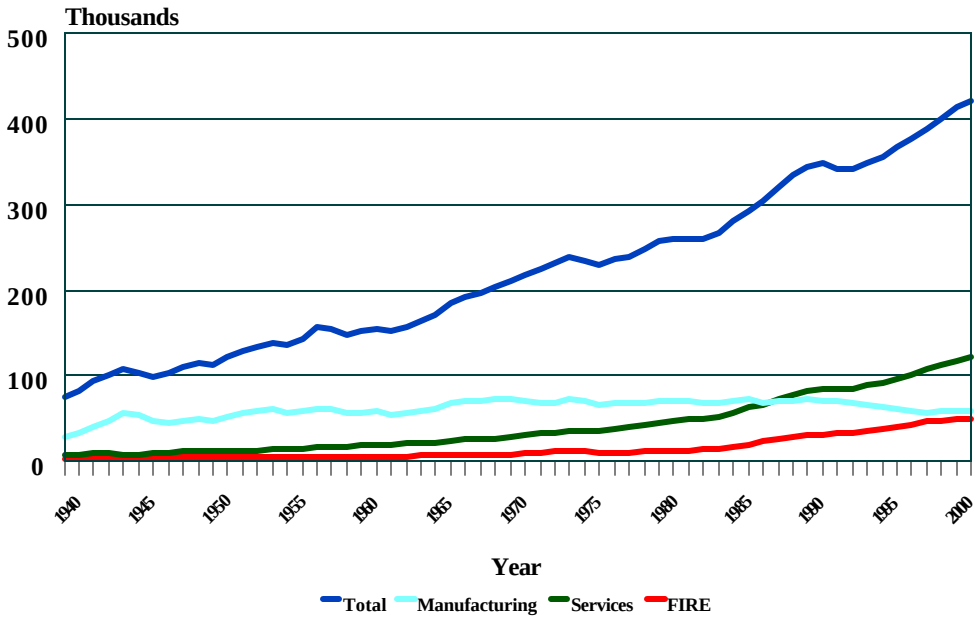


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics

In Figure 2-1 above, the total employment for the United States from 1939 through 2000 is shown along with three of the ten employment sectors namely: manufacturing, services, and FIRE (finance, insurance, and real estate). The graph clearly shows the impact that the business cycle has had on total employment in the mid-1970s, the early 1980s, and the early 1990s. All of these economic events are associated with rapid increases in the percentage of persons without health coverage. The more subtle

influence is related to the change in the structure of employment. Manufacturing employment reached its peak in the late 1970s and has been in a steady but very shallow decline for the most part. Service industry employment increased steadily over the entire period and began accelerating its growth when manufacturing employment was at its peak. In 1981, service sector employment surpassed manufacturing employment and today it accounts for nearly twice as much employment as manufacturing. This trend will probably continue unabated for the foreseeable future.

Figure 2-2
Delaware Non-Agricultural Employment:
Selected Sectors 1939-2000

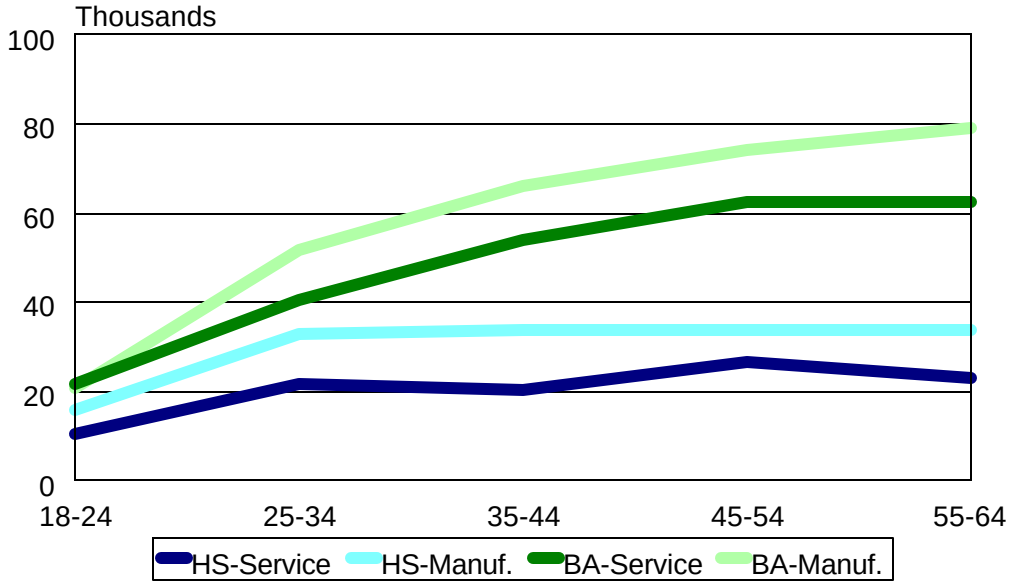


XII. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics, Delaware Department of Labor

The pattern was similar in Delaware, although the recession of the mid-1970s was more severe and the later ones were perhaps less damaging than they had been nationwide. For instance, statewide manufacturing employment peaked during 1989. This marked the end of the expansion of the 1980s. Since then, the number of manufacturing jobs available to Delawareans

has dropped significantly and continues to fall even today. In 1986, four years after it happened nationally, statewide service industry employment surpassed manufacturing employment. The rate of growth in service sector employment in recent years has slowed somewhat compared with the rate for the U.S. but this has been offset by the incredible growth in the FIRE sector. Employment in the FIRE sector clearly exploded after the passage of the Financial Center Development Act in the early 1980s. It continued to grow dramatically until the 1990-1991 recession. To most observers' surprise, the growth re-ignited in 1992 and continues today. A comparison of the trends in Figure 2-1 and Figure 2-2 show this to be a Delaware phenomenon.

Figure 2-3
Average Annual Earnings by
Sector, Age, and Education in 1998-2000



XIII.
XIV.
XV. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 2000

The importance of these inter-sector employment shifts is shown in Figure 2-3 above. Figure 2-3 shows the average annual earnings by age, education, and industrial sector. The top two lines represent annual earnings for college graduates in the manufacturing and service sector respectively. The bottom two lines depict the same information for high school graduates in the same two sectors.

The graph shows a difference of about $40,000 in annual earnings between the two sectors for both levels of education. If the same health care benefits were offered in both sectors, the cost to employers would be a much larger proportion of the annual salary in the service sector than in manufacturing. This suggests that employees in the service sector will likely be offered fewer benefits.

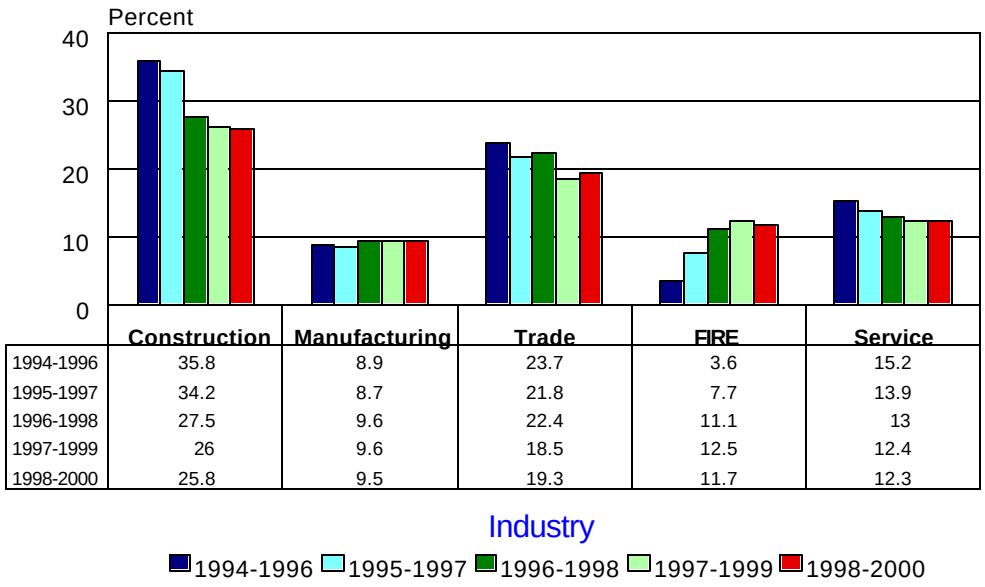
In addition, those employed in manufacturing are much more likely to be represented in a collective bargaining unit, a union. They are also more likely to work full-time with significant overtime, which further reduces the impact of the cost of benefits on total compensation. In contrast, service sector workers are more likely to be employed by non-union companies and are much more likely to work part-time. These factors, coupled with the increasing number of service sector workers relative to the number of manufacturing workers will tend to increase the number of uninsured or under-insured people.

Firm Sector and Size

There are significant differences in both the level and pattern of the uninsured, depending upon the type of industry in which an individual is employed. For instance, according to Figure 2-4 below, construction workers frequently report being uninsured. Although it may be noted that some construction workers are unionized, and are usually provided health coverage, many more are either employed by a non-union company or are self-employed. Overall, it is estimated that more than 25% of all construction workers are uninsured.

Figure 2-4

Percent of Persons without Health Insurance in Delaware by Industrial Sector



XVI. Source: Center for Applied Demography and Survey Research, University of Delaware

XVII. US Bureau of Census, Current Population Survey, March 1994-2000

Many persons employed in the trade industry (retail and wholesale) also find themselves without health coverage. Because this sector is not heavily unionized and is reliant on a large number of part-time workers (most of whom do not qualify for a typical health insurance package), it is not unexpected that an estimated 19% of those employed in the trade industry currently lack health coverage. The most recent data suggests that the upward trend operating since 1994 has moderated.

Of the other industries represented in Figure 2-4, approximately 12% of all those employed in the service industry are not offered access to health insurance as part of a benefits package. This number appears to be declining somewhat over the period. This probably reflects the changing nature of the service industry.

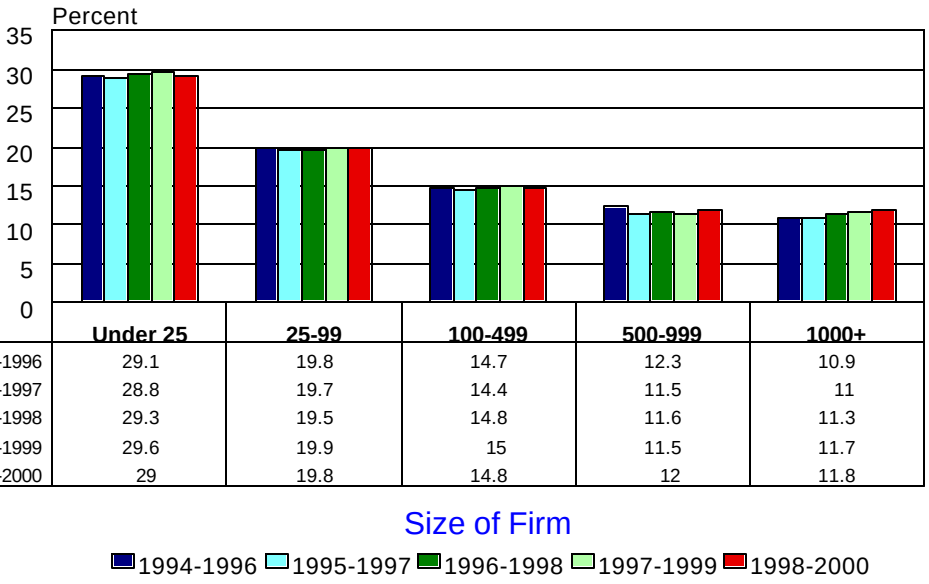
Roughly 10% of those employed in manufacturing and FIRE do not have health coverage. However, the proportion uninsured in the FIRE sector appears to be increasing. This could, for example, reflect an increase in full-time temporary employees in this sector

Finally, it also should be pointed out that the differences in coverage between industries are among the largest observed for any variable in this report. The importance of this information relates to the changing structure of the economy. As employment shifts from manufacturing to the service sector, the percentage of uninsured workers increases by about 3%. The importance of the FIRE sector in Delaware cannot be over estimated at least with respect to health coverage, although the 2000 estimates make this

conclusion less clear. While the percentage of uninsured in the region has been rising, Delaware's rate has either been falling or remaining steady. This appears, in large part, to be related to the accelerating FIRE sector and to a less rapidly growing service sector.

The other important inter-sector shift, which is more subtle, is associated with the nature of downsizing in Delaware's manufacturing sector. A significant portion of those employees who were "downsized" belonged to headquarters support operations as opposed to the factory floor. In many cases, those same employees started or joined firms that supplied services to their previous employer who simply wanted to "out-source" those functions. Many of these new jobs are classified as business services, part of the service sector, and are far from the typical "hamburger flipper" often discussed in the media. This has produced increases in annual earnings in the service sector that bodes well for benefit programs in the future.

Figure 2-5
Percent of Persons without Health Insurance in the US by Size of Firm



	Under 25	25-99	100-499	500-999	1000+
1994-1996	29.1	19.8	14.7	12.3	10.9
1995-1997	28.8	19.7	14.4	11.5	11
1996-1998	29.3	19.5	14.8	11.6	11.3
1997-1999	29.6	19.9	15	11.5	11.7
1998-2000	29	19.8	14.8	12	11.8

Size of Firm

1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Employees who work for small firms (under 100 employees) are less likely to have health insurance than those that work for large firms (more than 500 employees). Figure 2-5 above shows this relationship.

The graph shows that there are two distinct groupings: (1) firms with less than 100 employees where the percentage without health insurance is 24% and (2) firms with more than 500 employees where the percentage of those without health insurance is 12%. The larger firms are perhaps more likely to be unionized at least to the extent that larger firms have a higher probability of being in sectors such as manufacturing. They are also more likely to pay higher wages, which makes the relative cost of health insurance more tolerable. From a tax perspective, the provision of health insurance also provides a convenient way to increase total compensation.

A somewhat disturbing trend is also evident in Figure 2-5. It appears, at least from the national perspective, that those working for smallest firms are not improving their insurance coverage in comparison with five years ago. What makes this trend so disconcerting is the fact

that the economy has been expanding for almost ten years. The same can be said for larger firms, however. One explanation for this lack of improvement is the lack of increases in wages nationally and the restructuring and cost cutting practiced by most firms, which has produced significant increases in earnings.

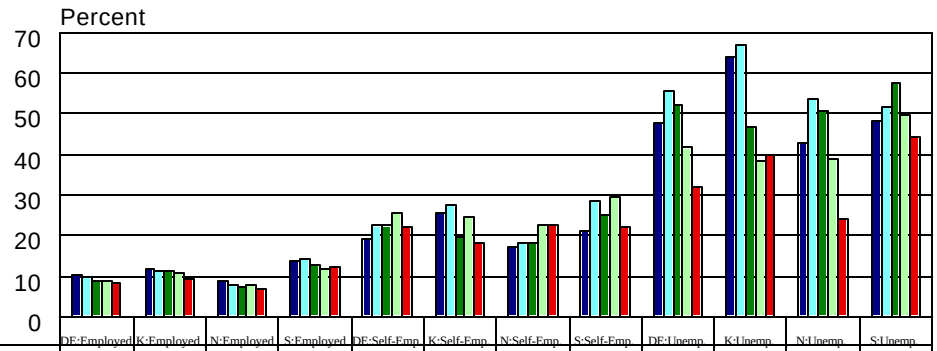
In conclusion, these data suggest that any effort to increase coverage must focus on smaller firms. Those firms will tend to provide lower levels of compensation, will probably use more part-time employees, and may offer less stable employment. However, they are growing faster and becoming a bigger part of the economy. This fact may tend to mitigate some of the negative factors over time. On the other hand, the large firms with better coverage are becoming smaller and that does not help the long-term outlook. There is no doubt, however, that all of these factors will tend to make the goal of better access to health care a challenge for the foreseeable future.

Employment Status and Class

Approximately 75% of all Delawareans are covered by some form of group health insurance. The vast majority is covered through their employer and therefore any disruption in employment will undoubtedly increase the likelihood that coverage will lapse. The reason that coverage may not automatically lapse is because that individual may be covered by another worker in the family, or the coverage may be extended through payments by the employee, or the individual may qualify for some government sponsored plan like Medicaid or Medicare. Still, the disruption is significant as is shown in Figure 2-6, below.

The information reported in Figure 2-6 shows that the probability of being without heath insurance increases by nearly a factor of four when the individual is unemployed. The percentage on the average rises from about 8% to in the vicinity of 32% as the individual's employment status changes. There is considerably more volatility in the estimates in Kent and Sussex counties because of small sample sizes, but the relationship mirrors that in New Castle County where sample size is not a problem. While those that are self-employed are also found in relatively small numbers in the BRFSS survey, the lack of health insurance is at least twice as prevalent as that of those with traditional employment. This year there is little observable difference between the counties with respect to the self-employed.

Figure 2-6
Percent of Adults without Health Insurance in Delaware by County and Employment Status



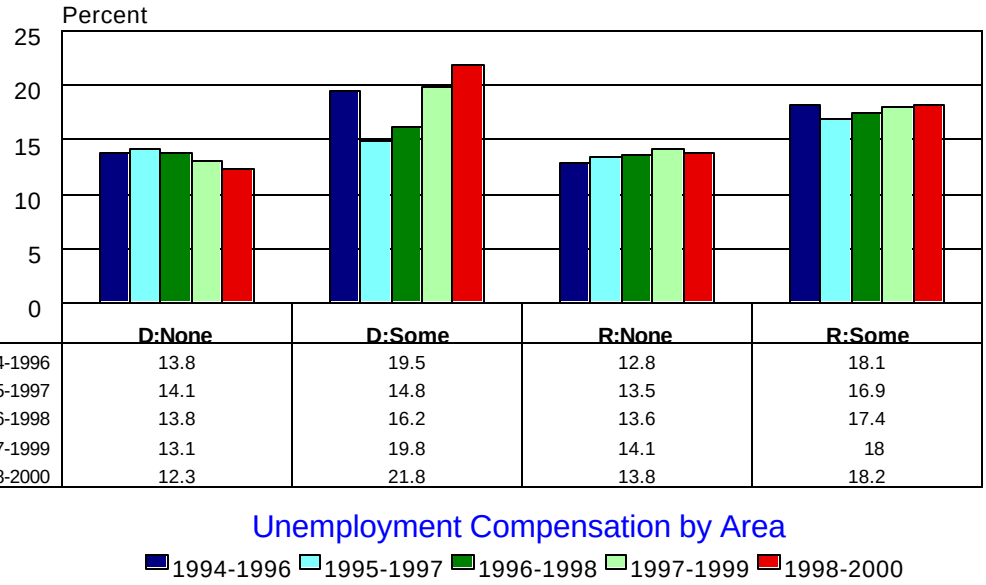
	DE:Employed	K:Employed	N:Employed	S:Employed	DE:Self-Emp	K:Self-Emp	N:Self-Emp	S:Self-Emp	DE:Unemp	K:Unemp	N:Unemp	S:Unemp
1994-1996	10.3	11.7	8.9	13.9	18.9	25.4	17.2	21.1	47.7	63.9	42.9	48.2
1995-1997	9.6	11.4	7.9	14.3	22.3	27.4	18	28.6	55.6	66.7	53.6	51.7
1996-1998	8.7	11.3	7.2	12.6	22.3	19.5	18.1	25	52	46.7	50.6	57.6
1997-1999	8.8	10.6	7.6	11.8	25.5	24.6	22.5	29.6	41.5	38.4	38.7	49.5
1998-2000	8.2	9.4	7	12.1	22	18.1	22.5	22.1	31.7	39.9	24.1	44

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1994-2000 Behavioral Risk Factor Survey

The other piece of information that deserves comment is the relative differences between the lack of coverage for employed workers in the three counties. The rate in New Castle County is significantly lower than those observed in Kent and Sussex counties. Following the earlier argument, this probably arises from differences in the economic base, since larger firms with higher wages and more stable employment are located primarily in the northern part of the state.

In Figure 2-7 below, further evidence is found about the relationship between insurance coverage and employment status. In this analysis, the receipt of unemployment compensation is used as an indicator of an interruption of employment at some point during the year. In both Delaware and the region, there is a significant rise in the lack of health coverage associated with receiving benefits. While the effect is more muted than in Figure 2-6, where a more direct measure was available, the percentage is always higher in the region where the sample size permits a better estimate.

Figure 2-7
Percent of Persons without Health Insurance
by Receipt of Unemployment Compensation and Area



	D:None	D:Some	R:None	R:Some
1994-1996	13.8	19.5	12.8	18.1
1995-1997	14.1	14.8	13.5	16.9
1996-1998	13.8	16.2	13.6	17.4
1997-1999	13.1	19.8	14.1	18
1998-2000	12.3	21.8	13.8	18.2

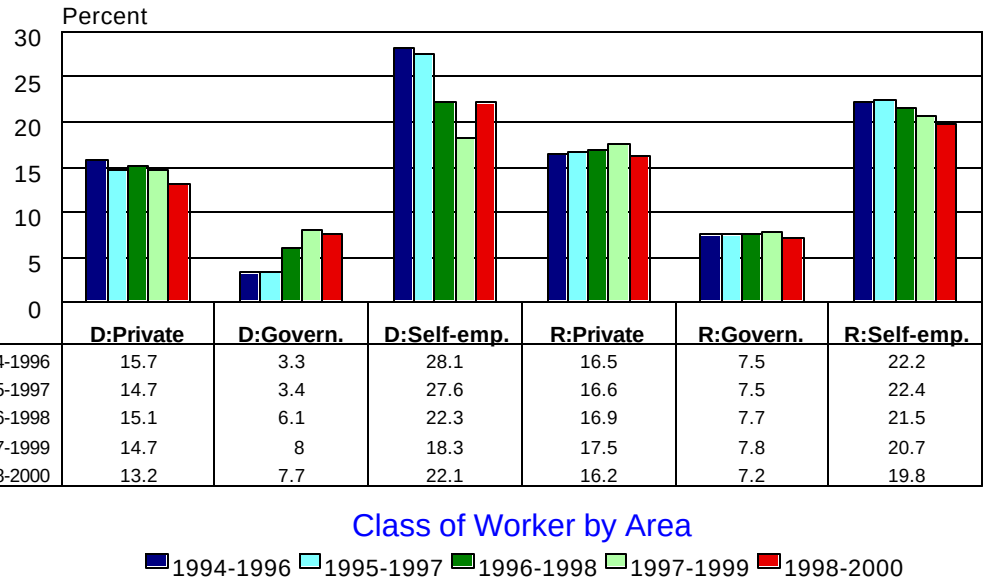
XVIII. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final graph in this section of the report represents the percentage of workers without health insurance in Delaware and the region as indicated by three broad classes namely: private sector workers, government workers, and the self-employed. In Figure 2-8 below, Delaware workers in the private sector average 3% fewer uninsured than those in the region. Within the private sector, Delaware seems to be improving slightly over the time period, which is consistent with the increase in workers in the FIRE sector. The rates in the region, for the private sector, are increasing, which probably reflects increases in the service sector and in part-time employees. Both trends should be watched carefully.

It is no surprise that government employees both in Delaware and the region are far more likely to have health insurance than the private sector in general. Government rates are comparable with very large private sector firms operating in a unionized work place. The only government workers who are likely to lack coverage are temporary/part-time workers or private contractors.

Figure 2-8

Percent of Persons without Health Insurance by Class of Worker and Area



	D:Private	D:Govern.	D:Self-emp.	R:Private	R:Govern.	R:Self-emp.
1994-1996	15.7	3.3	28.1	16.5	7.5	22.2
1995-1997	14.7	3.4	27.6	16.6	7.5	22.4
1996-1998	15.1	6.1	22.3	16.9	7.7	21.5
1997-1999	14.7	8	18.3	17.5	7.8	20.7
1998-2000	13.2	7.7	22.1	16.2	7.2	19.8

XIX. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

A more interesting structural shift, which has been underway for some time, is that government workers are representing a smaller proportion of the labor force, since that sector is growing less rapidly than employment overall. This implies that the percentage of uninsured workers will tend to rise, even if all the rates within these classes remain constant.

The information about the self-employed corroborates the information from the BRFSS discussed earlier. The data for the region, however, shows that the significant upward trend previously identified has moderated. There are a variety of potential explanations. One reason, which is consistent with other data, is that tight labor markets have allowed many of those previously classified as "self-employed" to find work and to gain benefits. Those that remain self-employed are likely to be financially stronger and better able to obtain health insurance.

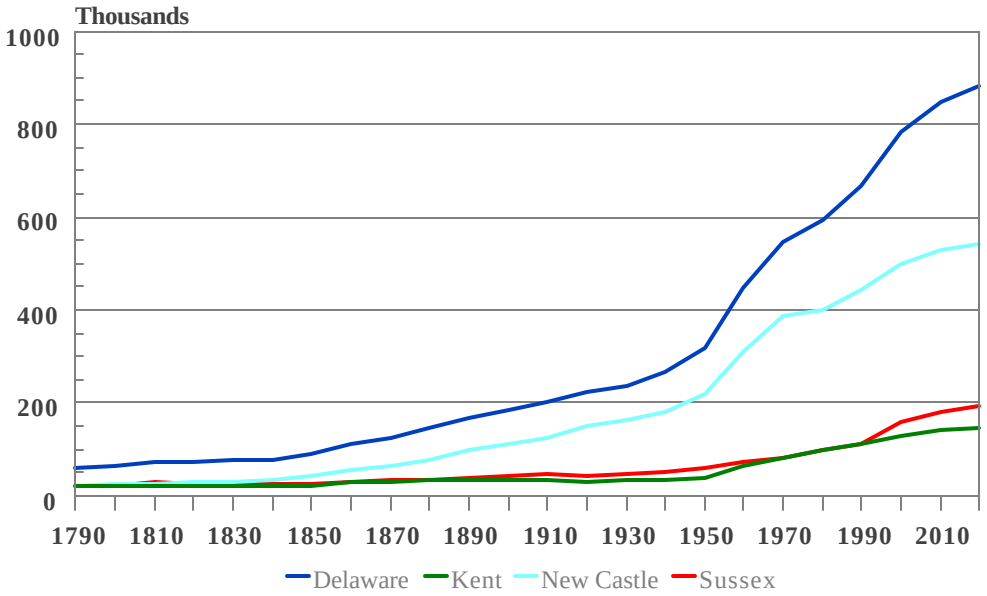
Demographic Characteristics

Background

Labor market characteristics are only some of the variables that play a role in influencing the proportion of people without health insurance. Demographic variables also may help explain a population's lack of health insurance. Others simply provide a convenient method for describing this condition among subsets of the population. Both will be addressed in this section.

Before returning to the health insurance issue, a few important factors driving population growth need to be addressed. In the first section of the report, it was reported that the number of uninsured had remained reasonably stable while the population increased substantially. There are, however, some recent indications, also discussed in the previous section, that future population increases could be accompanied by increasing numbers of uninsured. For that reason, it is important to understand how Delaware is growing.

Figure 3-1
Population of Delaware and Counties



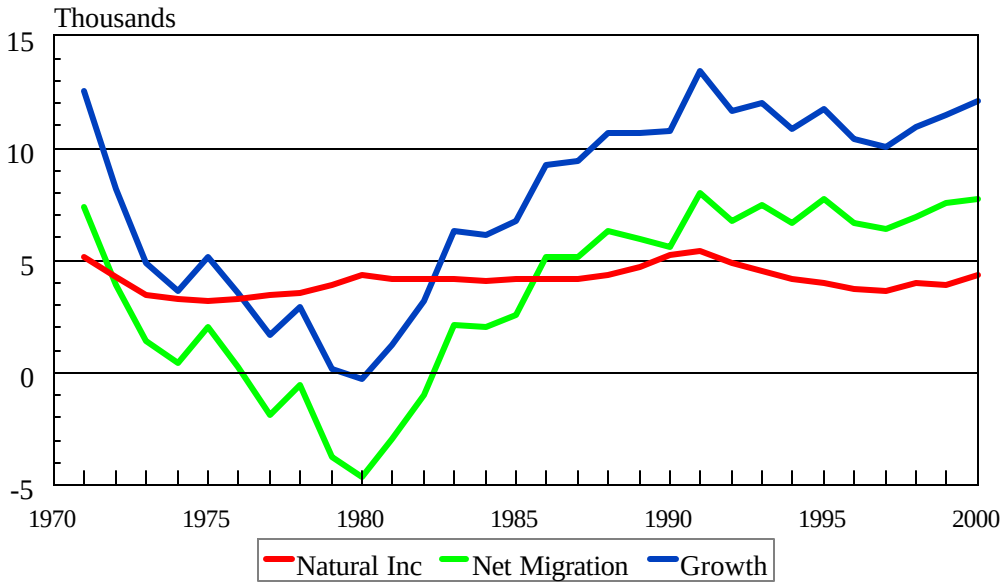
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Decennial Census 1790-2000
Delaware Population Consortium, June 2000

In Figure 3-1 above, the pattern of population growth for the state and for each county is shown from the first U.S. census in 1790 through the current 30-year projection in 2020. The state grew at a fairly steady rate from 1840 to 1950, when population

growth began to explode. This pattern continued unabated for 20 years until the oil-crisis induced recession and the migration to the sun-belt began. Population growth resumed in 1980, although at a much slower rate, and is predicted to continue to grow at rates around 1% annually. Kent County continues to grow slowly at rates that are consistent with those of the state in the last century. However, Sussex County has been growing at a rate of 3% per year, which approaches those observed in New Castle County during 1950-1970.

If current conditions continue, this population growth would likely generate another 15,000-20,000 uninsured persons over the next 20 years. But, current conditions, especially those in the labor market, are unlikely to continue. In fact, global competition and pressure on production costs may cause employers to rethink the total compensation package. The structural changes in the labor market alone will probably lead to an increase in the uninsured. Legislative changes and innovative government programs may also act to mitigate any increase in those numbers. However, it is difficult to speculate as to how these different factors will average out.

Figure 3-2
Sources of Population Growth in Delaware



XX.

XXI. Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-2 above illustrates the components of Delaware's population growth since 1980. The darkest line in the graph represents annual population growth. It has been as little as 2,000 persons in 1982, at the end of the recession, and as much as 13,000 persons when the economy peaked in 1989.

Overall growth is dependent upon two components: natural increase and net migration. Natural increase is the number of births to Delaware residents less the number of Delaware residents that die. That quantity is represented by the lightest curve in Figure 3-2 and has been around 4,000 per year until the "baby boomlet" started in 1985 and ended in 1991.

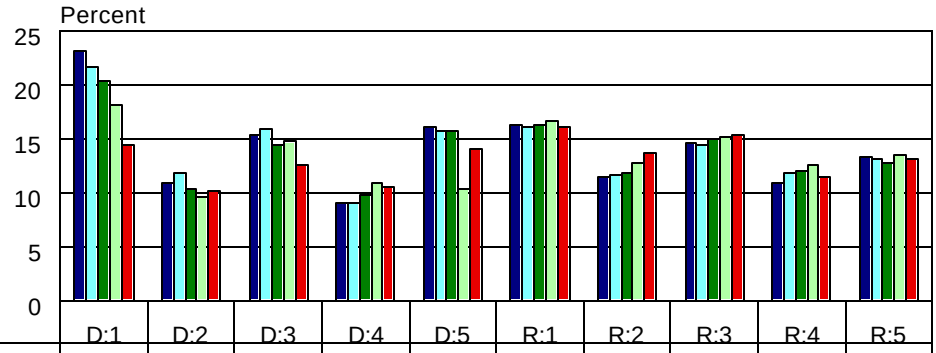
Net migration, which is the result of persons moving into Delaware less persons moving out of Delaware, is clearly the volatile component of the growth picture. It has moved from net out-migration in 1982 of -2000 to a high of +8000 net in-migration at the peak of the economic cycle. It then fell during the recession years of the early 1990s and today accounts for about half of all population growth. From these data, it is easy to see that Delaware's population growth is heavily influenced by local labor market conditions. Delaware's economy has consistently produced unemployment rates below those for the nation and region and has continued to generate new jobs sufficient to attract net in-migration. The characteristics of those jobs, in particular their health benefits, can and probably have affected coverage rates in Delaware.

Household Composition

The size and structure of the households, within which individuals live, has much to do with the probability of having health care coverage. Each of the variables addressed in this section, to include household size, marital status, and relationship to head of household, give a slightly different slant on the problem. Figure 3-3 below, contains information about the percentage of uninsured in relation to household size within Delaware and the region. The most disadvantaged group is the single person household. The percentage of uninsured is 7% above the proportions for most of the other categories. Single person households also fare somewhat worse in Delaware than in the region. Those individuals are somewhat disadvantaged since there is no second worker in the household to share the risk of losing coverage. They are also more likely to be a younger person at the low-end of the life cycle of earnings and are more likely to work in a job that does not provide health insurance coverage. Of course, the rate is reduced somewhat by older persons living alone who are covered by Medicare.

Figure 3-3

Percent of Persons without Health Insurance by Household Size and Area



	D:1	D:2	D:3	D:4	D:5	R:1	R:2	R:3	R:4	R:5
1994-1996	23.1	10.9	15.3	9	16	16.2	11.4	14.6	10.9	13.3
1995-1997	21.6	11.9	15.9	9	15.7	16.1	11.7	14.5	11.8	13.1
1996-1998	20.4	10.4	14.5	9.8	15.8	16.2	11.9	15	12.1	12.7
1997-1999	18.1	9.7	14.7	11	10.4	16.7	12.8	15.1	12.6	13.5
1998-2000	14.5	10.2	12.5	10.5	14	16	13.6	15.4	11.5	13.2

XXII. Source: Center for Applied Demography and Survey Research, University of Delaware

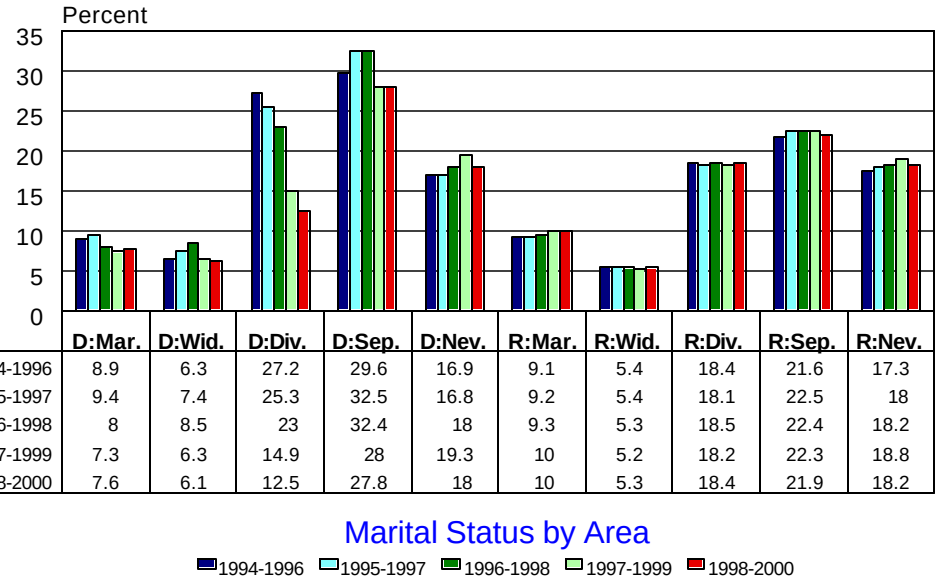
US Bureau of Census, Current Population Survey, March 1994-2000

Two and four person households were least likely to report lacking health coverage. The two-person household has a high probability of being a married couple with two incomes. The four-person household is also likely to have two working adults within it. The three-person household is a mixed picture since it also includes a single parent with two minor children, thus the risk of being without coverage rises. Overall the relationship between household size and the lack of health insurance coverage in Delaware tracks well with that of the region.

Marital status is closely linked to household size and composition. This relationship can be easily seen in Figure 3-4 below. For instance, the lowest rates observed over the period, usually under 6%, are reported by the widowed. This is expected since the largest majority of this group is qualified for Medicare. Thus, age may have more to do with their higher insurance rate than marital status. Married people have the next lowest rate with less than 8%. Married couples, with or without children, usually have two chances to obtain coverage. That may not be true if one spouse is not in the labor force or only works part-time. Still, the probabilities of having

health insurance increases and household members are more likely to be protected against the loss of coverage during times when one or the other is unemployed.

Figure 3-4
Percent of Persons without Health Insurance
by Marital Status and Area



	D:Mar.	D:Wid.	D:Div.	D:Sep.	D:Nev.	R:Mar.	R:Wid.	R:Div.	R:Sep.	R:Nev.
1994-1996	8.9	6.3	27.2	29.6	16.9	9.1	5.4	18.4	21.6	17.3
1995-1997	9.4	7.4	25.3	32.5	16.8	9.2	5.4	18.1	22.5	18
1996-1998	8	8.5	23	32.4	18	9.3	5.3	18.5	22.4	18.2
1997-1999	7.3	6.3	14.9	28	19.3	10	5.2	18.2	22.3	18.8
1998-2000	7.6	6.1	12.5	27.8	18	10	5.3	18.4	21.9	18.2

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

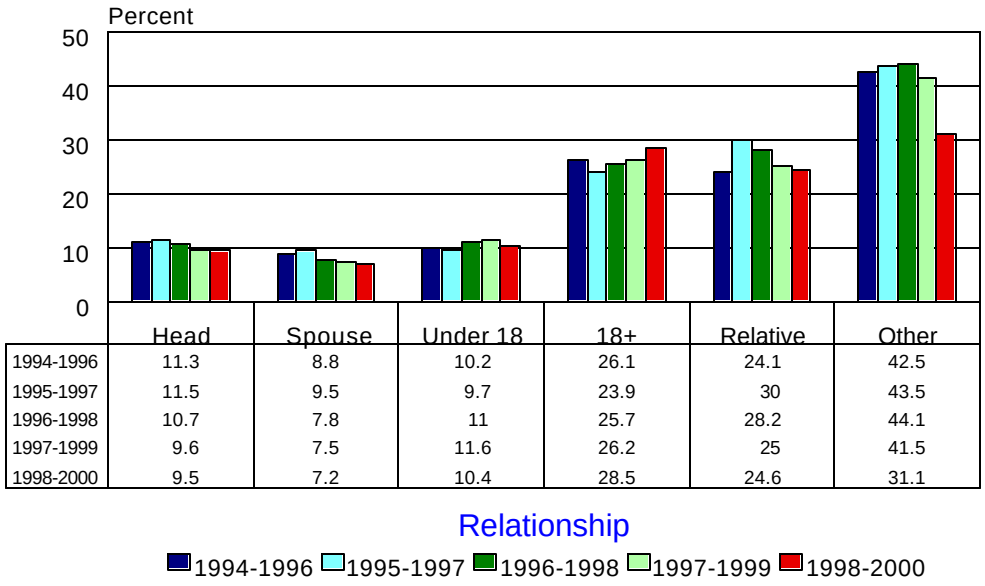
Younger adults heavily populate the "never married" category and, as will be explained later, are less likely to have coverage. For this reason, their risk of being uninsured is more than twice that of a married person.

The last two groups, which are usually one-adult households, are interesting for different reasons. First, the "separated" group in Delaware is quite volatile, however on the average the risk is higher than that observed for the younger, "never married" category. This group is typically a transitional one and the person will probably move on to the divorced category. The separated person's lack of coverage is less than that of the divorced person because some may be able to legally retain coverage until a final disposition of the marriage is reached. Once the person is divorced, the probability of having coverage will depend in large part on the person's labor force status. It should be kept in mind that a significant number of people in this category are making major transitions and may suffer significant income losses. Interestingly, Delawareans in this

category are significantly worse off than their regional counterparts. Given the similarity in all of the other categories, this difference does stand out, although it is not at all clear why there should be such a difference.

Figure 3-5

Percent of Persons without Health Insurance in Delaware by Relationship to Head



	Head	Spouse	Under 18	18+	Relative	Other
1994-1996	11.3	8.8	10.2	26.1	24.1	42.5
1995-1997	11.5	9.5	9.7	23.9	30	43.5
1996-1998	10.7	7.8	11	25.7	28.2	44.1
1997-1999	9.6	7.5	11.6	26.2	25	41.5
1998-2000	9.5	7.2	10.4	28.5	24.6	31.1

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final demographic variable in this series is relationship to the head of household. Figure 3-5 above depicts its association with the risk of being without health insurance. There are, once again, two distinct groupings. First, there are the typical adults and minor children whose risk levels are around 10%. (This group of children excludes many who are not the children of the head of household but are living in the house.) The head group also includes all of those single person households whose risks were also elevated. This is the reason why the spouse group has about a 2% less risk of being without health insurance. Minor children are dependent on the adult(s) health insurance coverage and there may be either one or two adults in the household. Thus, the risk will always be higher than that for the spouse group where there must be two married adults in the household.

The second major grouping includes adult offspring who are living at their parent's home, relatives or non-related persons. The risk level for all three groups is more than twice that of the first group. With the exception of full-time students who still might be covered by their parent's insurance, all will require health insurance through some other means. The fact that they are adults living in a household where they are neither the head or spouse in the household

suggests that they are less likely to be active labor force participants. In addition, there are many children in these groups as well.

Taken together these demographic variables point in the same direction. Does the person have multiple opportunities to obtain health insurance coverage? For instance, households that contain two married adults have a lower risk not only for themselves, but also for any minor children. Unfortunately, demographic trends do not favor this model. First, from 1980 to 1990 the number of single person households rose from 21% of all households to 23% and is continuing to grow. Second, those living in non-family households rose from 11% in 1980 to 13% in 1990. The number of married couple households with or without children has fallen from 61% in 1980 to 57% in 1990. Finally, the number of children under the age of 18 living with only one parent has risen from 19% to 21% over the decade. None of these trends favors reducing the risk of being without health insurance coverage and it is unlikely that those trends will be easily reversed.

Age Structure

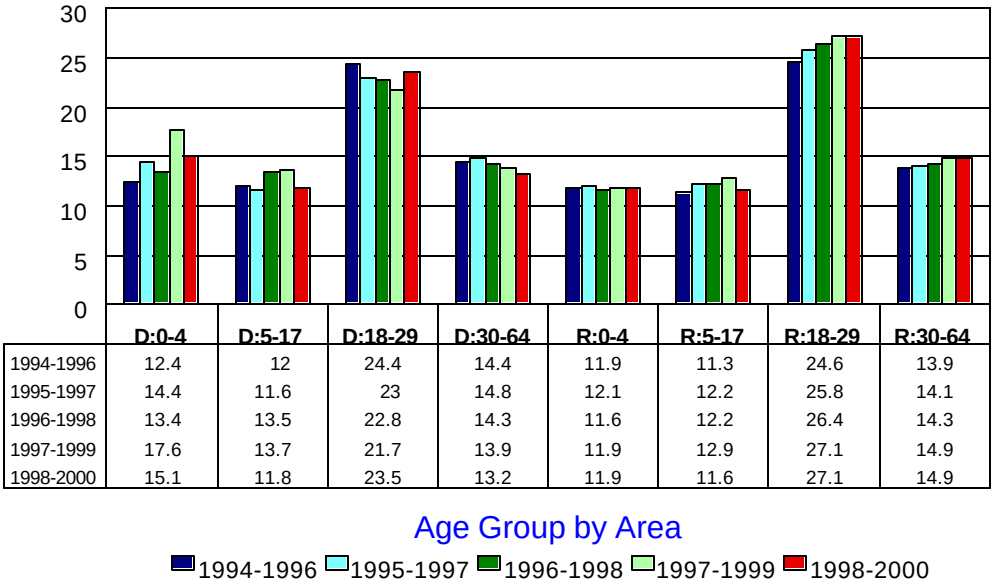
By and large, age appears to be a factor that influences the probability a person has health coverage. The most obvious example is the relationship between age and one's eligibility to qualify for Medicare, i.e. the person is 65 years old or older. Thus, the question for that age group must focus on the extent of coverage and not on its existence.

Because the majority of persons 65 years and older have access to health coverage, only the percentage of persons without health insurance coverage for the other age groups is found in Figure 3-6 below. In both Delaware and the region, dependent children, those under the age of 18, have the lowest risk of being uninsured. Only about 13% of them are estimated to lack health coverage. Their uninsured rate is somewhat higher than it was in Figure 3-5, which imposed the additional requirement that they also live in and were related to the head of household. Thus, it should be remembered that the following graph contains information for all children, regardless of their living arrangement. Only recently have these measurements been influenced by the CHIP program.

For a variety of reasons, persons aged 18-29 were most likely to report being uninsured. In both the state and the region, the risk of not having health coverage for this group exceeds 23% and there is no sign of improvement in the time series and it may be worsening. This group suffers from a multitude of disadvantages. First, they are more likely to be unmarried. Second,

they are more likely to hold lower paying jobs which provide no health benefits. Third, because their income levels are generally lower, it is often difficult for them to purchase private insurance. Fourth, since they are generally healthy, it may seem reasonable not to expend the additional resources needed to purchase health coverage. As this group ages into the next group, aged 30-64, the risk begins to fall as those disadvantages recede.

Figure 3-6
Percent of Persons without Health Insurance
by Age Group and Area



	D:0-4	D:5-17	D:18-29	D:30-64	R:0-4	R:5-17	R:18-29	R:30-64
1994-1996	12.4	12	24.4	14.4	11.9	11.3	24.6	13.9
1995-1997	14.4	11.6	23	14.8	12.1	12.2	25.8	14.1
1996-1998	13.4	13.5	22.8	14.3	11.6	12.2	26.4	14.3
1997-1999	17.6	13.7	21.7	13.9	11.9	12.9	27.1	14.9
1998-2000	15.1	11.8	23.5	13.2	11.9	11.6	27.1	14.9

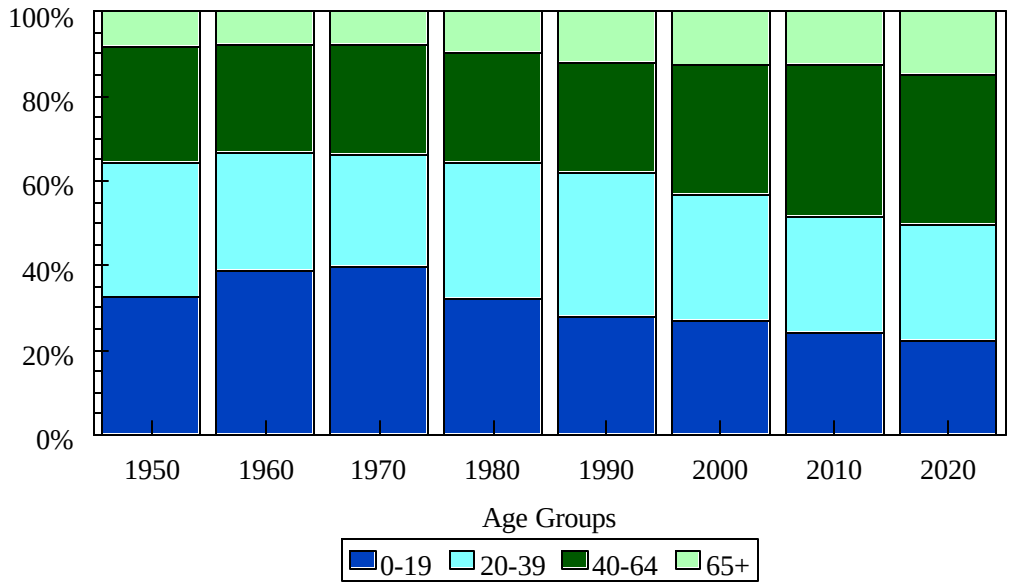
XXIII. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Given these very predictable differences, the way the age distribution changes over time will have a definite impact on the overall level of health insurance coverage in Delaware. This progression is found in Figure 3-7 below. In 1990, the largest age group is 20-39 and contains about 30% of the population. By the year 2010, however, the largest group is 40-64. Their ranks are being swollen by net in-migration, which disproportionately affects those under the age of 50 and the movement of the baby boomers through time.

There are several observations to be made about Figure 3-7 below. First, the proportion of the population ages 0-19 and 20-39 decreases steadily over the coming decades. The falling numbers in this group are part of the reason Delaware's health coverage rates have been stable. As the proportion of population in the two oldest groups increases, overall risk of being uninsured will fall. As the "baby boomers" age (and they represent a significant part of the age distribution), their overall risk level should decrease. The real issue, therefore, will be economic conditions in the state and in the nation as this huge group reaches what would normally be their peak earning years.

Figure 3-7

Age Structure in Delaware
1950-2020



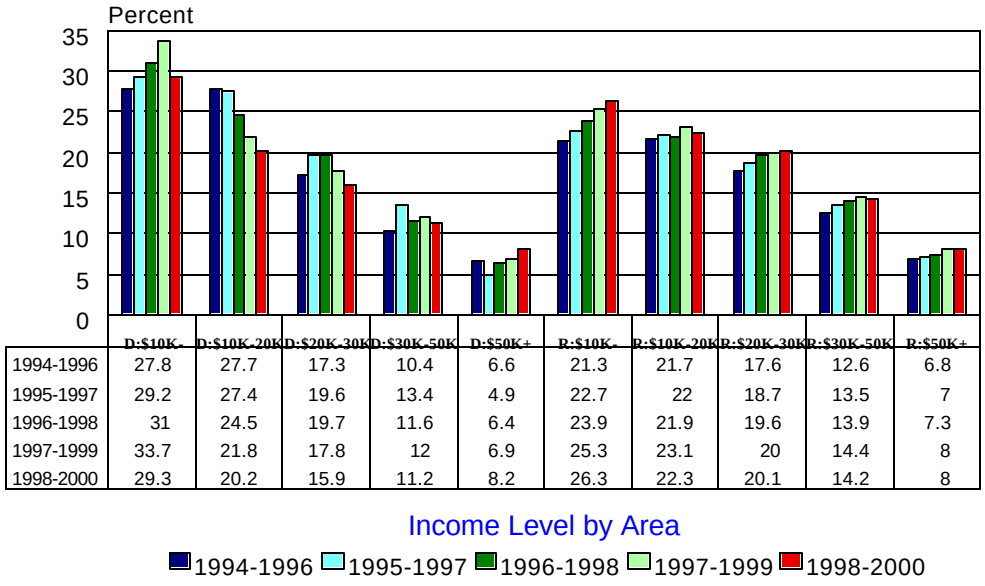
Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Population Consortium, June 2000

Will they be the victims of another round of downsizing? Will they become frustrated with the lack of advancement since there are so many competing for the same jobs? Will they turn to self-employment as a means of increasing their standard of living? All of these are unknown at this point but are likely to have an effect either positive or negative on health insurance coverage. This aging population will also put pressure on health care costs and will probably alter the behavior of employers.

Income and Education

Economic well-being has two different effects on the probability of having health insurance coverage. At the low end of the income spectrum, there are programs such as Medicaid available as part of the social safety net. Individuals at the high end of the income spectrum have the assets and income that allow them to be unconcerned about insuring their health. They can afford to take the risk. The biggest problem arises among those that do not qualify for a government program, cannot afford insurance, and certainly cannot pay the medical bills if their luck runs out. Figure 3-8 below provides data with respect to annual income and lack of health insurance.

Figure 3-8
Percent of Persons without Health Insurance
by Household Income and Area



	D:$10K-	D:$10K-20K	D:$20K-30K	D:$30K-50K	D:$50K+	R:$10K-	R:$10K-20K	R:$20K-30K	R:$30K-50K	R:$50K+
1994-1996	27.8	27.7	17.3	10.4	6.6	21.3	21.7	17.6	12.6	6.8
1995-1997	29.2	27.4	19.6	13.4	4.9	22.7	22	18.7	13.5	7
1996-1998	31	24.5	19.7	11.6	6.4	23.9	21.9	19.6	13.9	7.3
1997-1999	33.7	21.8	17.8	12	6.9	25.3	23.1	20	14.4	8
1998-2000	29.3	20.2	15.9	11.2	8.2	26.3	22.3	20.1	14.2	8

XXIV. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

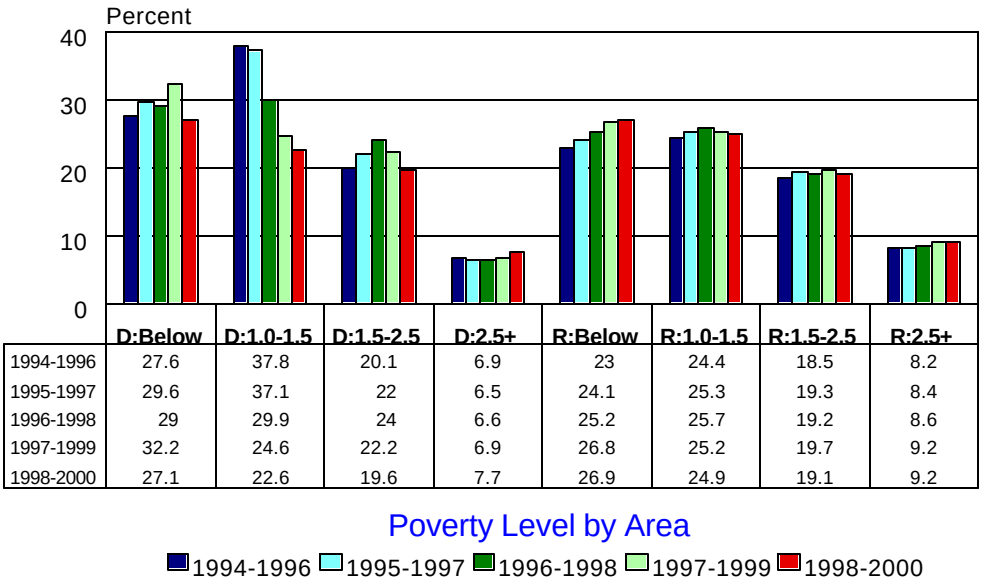
Persons whose annual income is under $20,000 per year have a risk more than 1 in 4 of being without health insurance coverage. In the lowest income category, Delaware seems to average about 6% higher than the region as a whole. As income increases, the percentage of persons without coverage falls. At the $50,000 and over level, about 8% or 1 in 12 are without health insurance and some of those may have sufficient assets to warrant self-insurance. This

strong relationship undoubtedly represents the fact that health insurance as a percentage of total compensation falls as income rises and thus holders of those jobs are likely to be given those benefits.

Poverty is a function of two variables, household income and household size. It is poverty status that tends to be used to define who is eligible for government health insurance programs. In Figure 3-9 below data are found relating poverty to the lack of health insurance coverage. There seems to be very little difference between those below poverty and the near poverty group, which is between 1.0 and 1.5 of the poverty level. The effect of Medicaid serves to keep the rate somewhat lower for those below poverty than it would be in the absence of the program. Some people in the second group also qualify for Medicaid, but the proportion is smaller than in the below poverty group. The trend for the lowest group is in the wrong direction.

Figure 3-9

Percent of Persons without Health Insurance by Poverty Level and Area



	D:Below	D:1.0-1.5	D:1.5-2.5	D:2.5+	R:Below	R:1.0-1.5	R:1.5-2.5	R:2.5+
1994-1996	27.6	37.8	20.1	6.9	23	24.4	18.5	8.2
1995-1997	29.6	37.1	22	6.5	24.1	25.3	19.3	8.4
1996-1998	29	29.9	24	6.6	25.2	25.7	19.2	8.6
1997-1999	32.2	24.6	22.2	6.9	26.8	25.2	19.7	9.2
1998-2000	27.1	22.6	19.6	7.7	26.9	24.9	19.1	9.2

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Overall, the percentage of persons without health insurance falls as the distance from the below poverty group increases. The lowest level of risk appears to be experienced by households with incomes above $45,000, the median household income in Delaware. Finally, the rates in Delaware are roughly comparable to those in the region. However, there does seem to be a steady

increase in the proportion of persons in the poverty group in Delaware, while the regional proportion has remained consistently lower but increasing.

Table 3-1
Cumulative Persons by Poverty Status, Age Group, and Health Insurance Coverage
(3-year average 1998-2000)

Poverty	0-18 All	0-18 No HI	19+	19+ No HI
under 0.50	14,785	4,209	16,540	6,466
0.50 to 0.74	26,240	6,397	28,274	9,499
0.75 to 0.99	36,497	8,016	43,287	13,695
1.00 to 1.24	48,031	11,147	60,463	17,402
1.25 to 1.49	54,419	12,427	76,385	21,704
1.50 to 1.74	70,740	18,449	100,036	28,170
1.75 to 1.99	80,294	20,241	121,903	31,924
2.00 to 2.49	102,377	22,279	165,229	39,030
2.50 to 2.99	126,510	25,141	219,391	48,787
3.00 to 3.49	143,331	25,745	261,453	51,206
3.50 to 3.99	161,629	26,611	309,511	56,238
4.00 to 4.49	174,559	27,046	342,752	58,661
4.50 to 4.99	182,125	27,248	371,244	61,531
5.00 & over	218,698	28,930	549,571	71,494

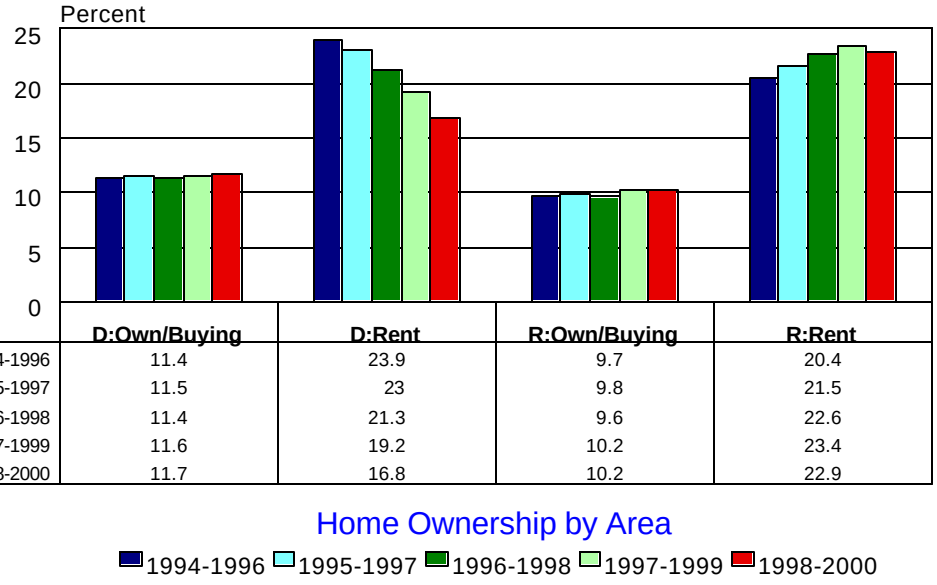
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

In Table 3-1 above, the cumulative distribution of persons by poverty, age, and health insurance status is shown. A three-year moving average is used to reduce the sampling variability.

These data have particular meaning for those charged with providing healthcare to those 18 years and younger in Delaware. The table shows that an estimated 28,930 are without health insurance. Of those, only 8,016 are officially classified as being under the poverty line, and just over 30% are above 2.00 times the poverty line.

Another measure of economic wellbeing is the accumulation of assets. One such measure of that accumulation is home ownership. Those results are found in Figure 3-10 below. The graph shows that for renters, the percentage of those without coverage is twice the rate for those who own or are buying their principal place of residence. That pattern is confirmed by the results for the region, which are quite comparable to those reported for Delaware. Certainly, this finding is not unexpected given that renters tend to be younger and have lower incomes, both

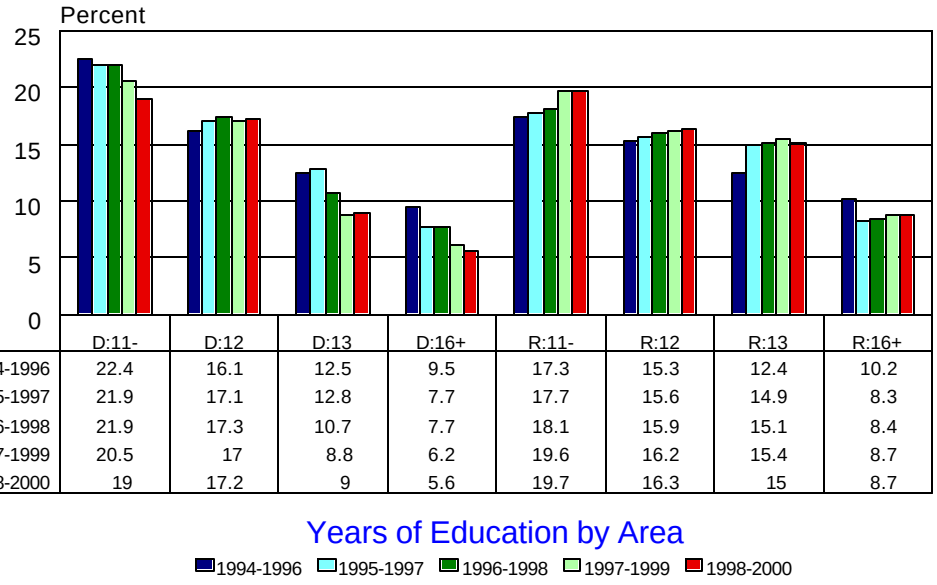
Figure 3-10
Percent of Persons without Health Insurance
by Home Ownership and Area



	D:Own/Buying	D:Rent	R:Own/Buying	R:Rent
1994-1996	11.4	23.9	9.7	20.4
1995-1997	11.5	23	9.8	21.5
1996-1998	11.4	21.3	9.6	22.6
1997-1999	11.6	19.2	10.2	23.4
1998-2000	11.7	16.8	10.2	22.9

Source: Center for Applied Demography and Survey Research, University of Delaware
XXV. US Bureau of Census, Current Population Survey, March 1994-2000

Figure 3-11
Percent of Persons without Health Insurance
by Years of Education and Area



	D:11-	D:12	D:13	D:16+	R:11-	R:12	R:13	R:16+
1994-1996	22.4	16.1	12.5	9.5	17.3	15.3	12.4	10.2
1995-1997	21.9	17.1	12.8	7.7	17.7	15.6	14.9	8.3
1996-1998	21.9	17.3	10.7	7.7	18.1	15.9	15.1	8.4
1997-1999	20.5	17	8.8	6.2	19.6	16.2	15.4	8.7
1998-2000	19	17.2	9	5.6	19.7	16.3	15	8.7

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1993-2000

factors that are correlated with higher risk. They are also less likely to have the assets to continue their insurance privately if there is an interruption in coverage.

The final figure in this section, Figure 3-11 above, relates the educational level of the respondent and their health insurance status. Education could have two significant effects on health insurance coverage. First, it is possible that more educated people are better able to understand the advantages and disadvantages of health coverage and therefore, make better decisions. More likely, however, education is having an indirect effect with higher education being correlated with higher incomes and better jobs/benefits.

Coverage rates increase significantly as educational level increases. Predictably, those without a high school diploma are the most at risk of being without health insurance. It appears that the most disadvantaged group fares about the same in Delaware as in the region. The uninsured rate falls by 2% for a high school diploma, another 8% for post high school education and finally 3% for those completing college.

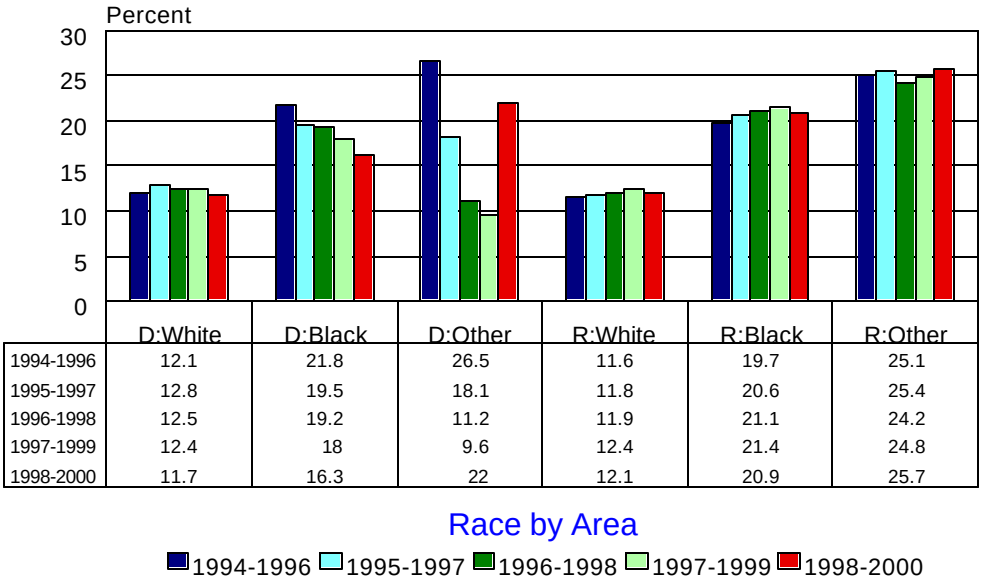
Race and Hispanic Origin

Health insurance coverage or lack thereof within sub-groups of the general population is shown in Figure 3-12 below to illustrate the impact of all the underlying contributing variables which determine who has health insurance coverage and who does not. Most of the research in this area suggests that there are significant differences, but do not report any divergence in cultural or risk-taking characteristics that would explain those differences. Thus, the differences are the result of other variables, which themselves differ within segments of the population.

There are significant differences between the three racial groups. Those respondents who classify themselves as black have nearly a 40% higher risk of being without health insurance coverage as those that report being white. However, the historical trend has been decreasing for African-Americans. The "other" category includes primarily Native Americans, Asians, those of mixed race, and those who do not find any of the categories listed to be appropriate. Overall, these rates throughout are consistent between Delaware and the larger region.

Figure 3-12
Percent of Persons without Health Insurance

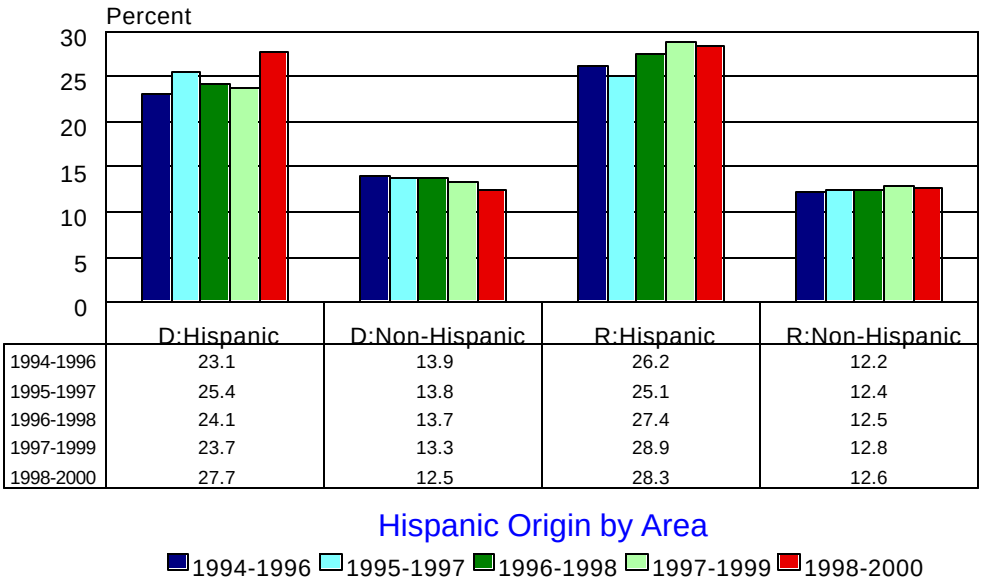
by Race and Area



	D:White	D:Black	D:Other	R:White	R:Black	R:Other
1994-1996	12.1	21.8	26.5	11.6	19.7	25.1
1995-1997	12.8	19.5	18.1	11.8	20.6	25.4
1996-1998	12.5	19.2	11.2	11.9	21.1	24.2
1997-1999	12.4	18	9.6	12.4	21.4	24.8
1998-2000	11.7	16.3	22	12.1	20.9	25.7

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1993-2000

Figure 3-13
Percent of Persons without Health Insurance
by Hispanic Origin and Area



	D:Hispanic	D:Non-Hispanic	R:Hispanic	R:Non-Hispanic
1994-1996	23.1	13.9	26.2	12.2
1995-1997	25.4	13.8	25.1	12.4
1996-1998	24.1	13.7	27.4	12.5
1997-1999	23.7	13.3	28.9	12.8
1998-2000	27.7	12.5	28.3	12.6

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The results for Hispanic respondents are shown in Figure 3-13, above. The percentages within Delaware are quite volatile because of the small sample size, but on average during the period, slightly less than 28% of those respondents who classify themselves as being of Hispanic origin are without health insurance coverage. This rate is more than double that for non-Hispanics. In 2000, just more than 10% of all the uninsured are estimated to be Hispanic. The regional results are similar to those found in Delaware.

Observations

Those lacking health care coverage in Delaware are a diverse group. This is summarized by the list below:

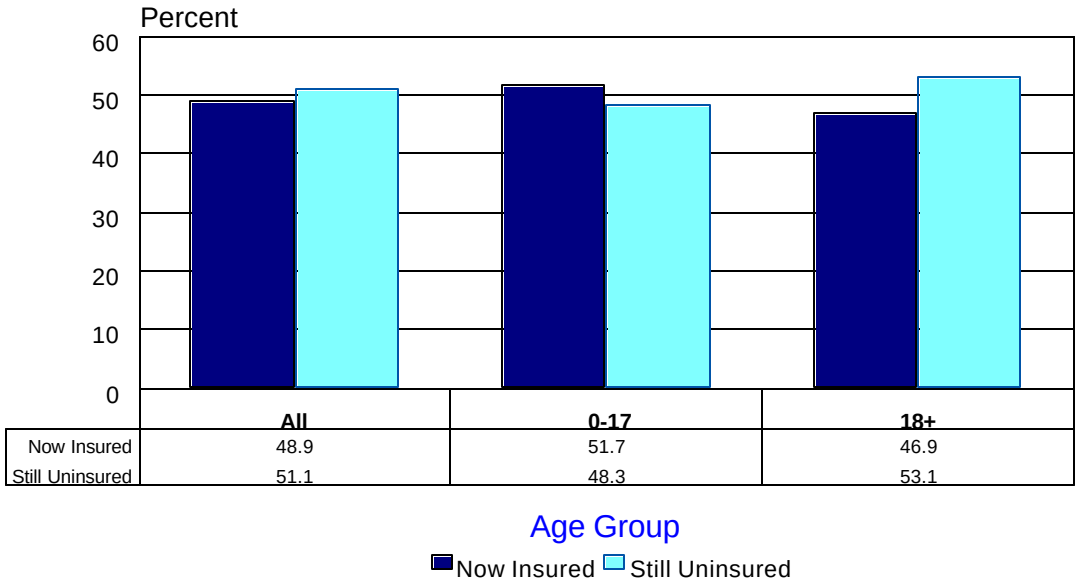
Figure 4-1
Who are the 99,000 Uninsured?

- **74% are over the age of 17**
- **53% are male**
- **68% are white**
- **10% are Hispanic**
- **66% own or are buying their home**
- **15% live alone**
- **80% are above the poverty line**
- **30% have household incomes over $50,000**
- **69% of the adults are single**
- **69% of the adults are working**
- **6% are self-employed**

This list illustrates both the complexity of the task and the need to use targeted strategies. Since 26% of the uninsured are children (which is down significantly since last years report), efforts to increase the coverage of Medicaid, the CHIP program, and the clinics offered by the A. I. DuPont Institute are likely to be effective. There are, however, still likely to be children who may never qualify under Medicaid because their parents are above the income limits and yet may still experience periodic unemployment. It is this population that the CHIP program is designed to help. The effectiveness of the program in covering children will depend significantly on the actions taken by the parent(s) of those children.

Since 69% of the uninsured adults are working at least part-time, legislative initiatives that encourage employer offered health coverage will have some effect. It's not clear at this point in time if any plan can help the low wage earner or part-time employee, since the cost of the insurance might represent a huge increase in labor costs. The working poor, in particular those in the 1.0-1.5 category of poverty, are of particular concern.

Figure 4-2
Percent of Persons who Moved from Uninsured to Insured Status by Age Group

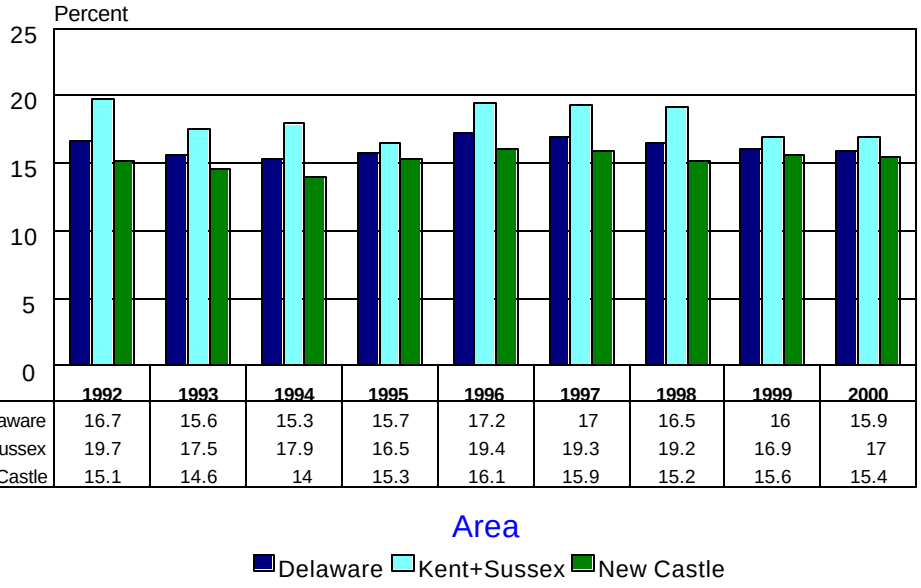


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Dealing with the uninsured is not an easy task because people are continually joining and leaving the ranks of the uninsured (see Figure 4-2, above). Nearly half of those that are uninsured this year (48.9%) will have insurance next year. That proportion is higher for adults than for children.

The problem is not only a question of different rates of movement in and out of the uninsured status. It is also spatially different within the state (see Figures 4-3 and 4-4, below). This may require the execution of very different strategies.

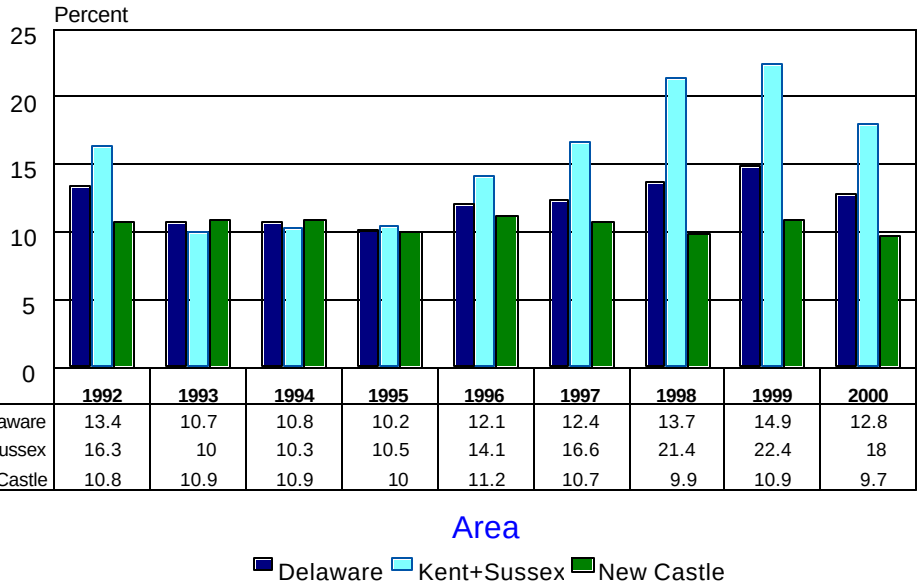
Figure 4-3
Percent of Persons 18-64 Without Health Insurance
by Area



	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	16.7	15.6	15.3	15.7	17.2	17	16.5	16	15.9
Kent+Sussex	19.7	17.5	17.9	16.5	19.4	19.3	19.2	16.9	17
New Castle	15.1	14.6	14	15.3	16.1	15.9	15.2	15.6	15.4

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1990-2000

Figure 4-4
Percent of Persons 0-17 Without Health Insurance
by Area



	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	13.4	10.7	10.8	10.2	12.1	12.4	13.7	14.9	12.8
Kent+Sussex	16.3	10	10.3	10.5	14.1	16.6	21.4	22.4	18
New Castle	10.8	10.9	10.9	10	11.2	10.7	9.9	10.9	9.7

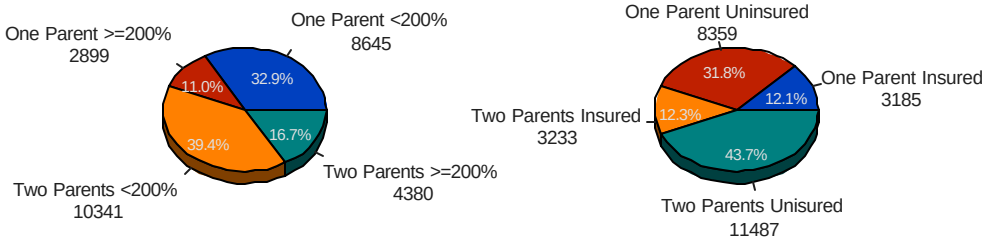
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1990-2000

First of all, the information provided for the 18-64 year old age group excludes dependents and Medicare recipients. This core group of adults is reasonably stable over the past eight years. Even the differences between the counties are reasonably consistent.

In contrast, the pattern with dependents age 0-17 shown in Figure 4-4 above is strikingly different. While the rates in New Castle County appear stable, those in the combined Kent/Sussex region increased dramatically from 1995 to 1999 and then fell sharply. This is consistent with the implementation of the CHIP program and outreach efforts in lower Delaware. Age and/or geography specific programs are clearly warranted

Overall, Delaware seems to be doing better than the region in keeping the percentage of uninsured down. However, the longer-term demographics of the population and the labor market suggest that this will probably be a continuing challenge. In addition the focus on the CHIP program coupled with identification of Medicaid eligible children is likely to reap significant benefits. It is also clear that there will need to be continued focus on the problems in Kent and Sussex counties if this problem is to be controlled.

Figure 4-5
Persons 0-17 Without Health Insurance
by Family Type, Poverty Status and Parental Insurance

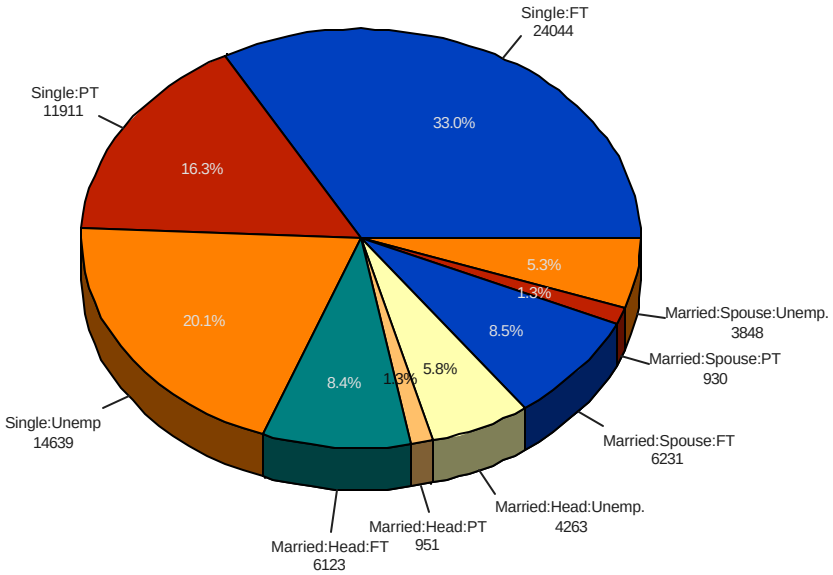


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

Finally, one other useful way of looking at this problem is to divide the uninsured into independent groups, i.e. they do not overlap. There are approximately 26,000 persons under the age of 18 who are uninsured (see Figure 4-5, above). Of the 26,000, some 11,500 can be found in single parent families with 14,500 being in two parent

households. Of the 11,500, about 2,900 are above 200% of the poverty level and thus are not currently eligible for CHIP. Of those same 11,500, approximately 8,400 live with parents who also do not have insurance.

Figure 4-6
Persons 18-64 Without Health Insurance
by Marital Status, Household Relationship, and Employment



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

In Figure 4-6, above the 73,000 uninsured adults are displayed by marital status, employment status and household relationship. Almost 70% of the uninsured population is single and they are almost equally split between full-time employment where they might possibility get access to health insurance and an employment status where access to health insurance through an employer is realistically remote. In fact, one could reasonably conclude that only half of the lack of health insurance problem with adults can be approached through employers and that is an outside limit.

APPENDIX B:

FOCUS GROUP SUMMARY REPORT

Summary of Focus Groups for the Delaware Health Care Commission

Recruitment

Although the Delaware Chamber of Commerce, and several local Chambers of Commerce had been contacted to assist with, and had agreed to, recruit small business owners and employees for the focus groups, recruiting was inordinately difficult.

The focus groups were originally scheduled for May 8th and 9th. Upon contacting the Chambers, all reported a lack of ability to recruit members for the focus groups. The New Castle Chamber of Commerce and the Central Delaware Chamber of Commerce reported that business owners did not want to take the time away from their businesses to participate in the two hour sessions. The decision was made to offer stipends to participants to compensate them (in some small way) for their time: $100 to Business Owners; $50 to Employees of Small Businesses.

The Delaware State Chamber of Commerce forwarded their list of members (650 names), and between April 26th and May 1st , 177 businesses were contacted by HMA staff. Fifty-four reported having health insurance for their employees; 6 business owners agreed to attend; 1 said "possibly" they would attend.

On May 3rd the decision was made to postpone the focus groups and pursue other avenues for recruitment. The dates were changed to May 30th and May 31st. The six participants were contacted and four were able to be re-scheduled to the new dates.

Additionally, contacts were made with the Delaware Association of Non-Profit Agencies (DANA) and the Delaware Chapter of the National Federation of Independent Businesses (NFIB), and recruiting letters were sent to each to be forwarded to their members. DANA reported forwarding the information to approximately 150 of 300 members. NFIB reported forwarding the information to a 17 member "leadership council".

Participation

On May 30th, two focus groups were conducted in Dover, Delaware.

The Employer/Business Owner group was held from 11am to 1pm, with 8 participants – one of which was contacted by NFIB and one of which was contacted by the Association of Non-Profit Agencies.

The Employee group was held from 3pm to 5pm, with two participants – one of which was contacted by NFIB and one of which was contacted by the Association of Non-Profit Agencies.

On May 31st, two interviews were conducted in Newcastle, Delaware.

The Employer/Business Owner group was held from 8:30am to 10:30am with one participant, who was contacted by the Association of Non-Profit Agencies.

The Employee group was held from 11:30am to 1:30pm with one participant, who was contacted by the Association of Non-Profit Agencies.

Findings

The focus group discussions were divided into four main sections: Issues and Problems of Small Businesses; Benefits; Health Insurance; and Reaction to the Options for Coverage Expansion.

Issues and Problems of Small Businesses

The Employers/Business Owners reported that cash flow, employee dedication, employee retention/turnover, and recruitment of employees are their most pressing issues. They also stated that it is "more expensive" for small businesses to offer the same benefits that larger corporations offer, and that the percentage of revenues devoted to benefits for employees is much higher for small businesses. They also reported that is harder to attract and retain employees now than it was a year ago. All emphasized that they offer greater "flexibility" as an incentive to attract and keep good employees (An example of the needs of a working parent was given.)

Employees also understood the tight financial constraints of their employers.

Benefits

Most Employers/Business Owners reported that health insurance is the most important benefit that can be offered to an employee, but one offered that they are very generous with "free" benefits, such as flex time, vacation time, sick leave, holidays, etc., even for part-time employees.

One business offers employees $860 annually to be used toward health insurance or medical expenses, and this benefit was highly valued by one of the employees who attended the Employee group because it could be used for expenses such as eyeglasses, counseling sessions (as needed), and other miscellaneous medical expenses.

Employees faced with the question of changing jobs to receive health insurance, stated that would be a difficult decision.

Health Insurance

Three of the participating employers reported that they have insurance themselves, but did not offer it to their employees.

Great concern was expressed over two issues:

- The medical underwriting of small groups, and the dramatic premium increases when a member gets sick – one participant reported that her husband had a

pacemaker, and their premiums increased from $847 per month to $1400 per month, but she could not change plans because of the pre-existing condition.

? The high, and increasing, costs of prescription drugs.

The sources of information regarding health insurance included insurance agents, chambers of commerce (who offered plans in the past, but do not currently), mail solicitation, and telephone calls.

The single most important barrier to offering health insurance is cost. This is influenced by the medical underwriting, and rates set according to health condition of employees. Two of the employers reported that all of their employees are covered by another source.

Most participants believe that there is an obligation on the part of the employer to provide health insurance coverage. Only one participant stated that she does not think employers should pay for health insurance, "because we pay for workers' compensation anyway."

Most participants also believe that employees have an obligation to pay for part of their health insurance coverage, but some stated that employees cannot afford to do this. One participant suggested that possibly the state or federal government could pay the portion of the premium that an employee cannot afford to pay.

The perception among business owners is that state and federal funding is available for programs for the uninsured – the federal surplus and the tobacco money were specifically stated.

Lastly, there was great frustration among all participants over the insurance companies' and pharmaceutical companies' high profits. It was suggested more than once that government should "take a look" at the practices of these industries and "set controls." (A $3.7 million salary for a health plan CEO, and $18 for a 15 cent pill were stated as examples.)

Reaction to the Options of Coverage Expansion

Ten concepts were presented. The most popular concept was the opportunity to buy-in to the state employees health plan, but with the important change that it be available to all employees (including owners) of small businesses, on a sliding scale (with no subsidy above a certain income).
The state employee plan is perceived to be a rich benefit package, with affordable rates, due to the fact that the state is able to "negotiate" with providers.

The options to buy into the Delaware Healthy Children Program was perceived by some participants as "discriminatory" because it was only available to people with children.

The Subsidized Employer-based program, such as the Wayne County model, was deemed too complicated by some participants, but was of interest to others.

The Limited Benefits plan (IHP) was not supported, because it is believed that if a hospital stay or surgery is required, hospitals will "come after you" and doctors will avoid surgery because they will not be paid for it. "What happens if you go to the doctor for a check-up and they find something wrong?"

Purchasing pools were also considered too complicated and the participants did not like the idea of "setting up another level of bureaucracy".

Reactions to the single payor model were mixed, although it was suggested that as a small state, Delaware might be a good place to try this.

Tax credits for individuals were considered more paperwork, and of little benefit in solving the problem.

The first group of employers insisted on adding Option #11 which is "better regulating and imposing price caps on insurance companies and pharmaceutical companies".

Finally, it was stated that the issue not be framed solely as expanding coverage for the uninsured, but that concern and consideration also be given to keeping insurance affordable to those who have it.

APPENDIX C:

DELAWARES SMALL EMPLOYERS: THE HEALTH INSURANCE DILEMMA 2001 REPORT

Delaware's Small Employers: the Health Insurance Dilemma 2001

prepared for
the Delaware Health Care Commission

by

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Highlights of the 2001 Delaware Small Business Survey

- 1601 firms sampled; 725 responses; 550 with insurance and 175 without
- Top three reasons for **Not** offering health insurance: 1) business can't afford it; 2) employees can't afford it; 3) Revenue too uncertain.
- One-third of the firms suggest that the employees have insurance elsewhere or that they are seasonal or part-time workers. The owner has insurance elsewhere 24% of the time.
- Employee recruitment, retention, performance issues related to health insurance are seen as important by less than one fifth of the firms. Businesses that offer health insurance are twice as likely to believe that these issues are important.
- About one-fifth of businesses have previously offered health insurance in the past 5 years and nearly 60% have contacted some provider about insurance in the last year.
- The median firm expects that the total cost of providing health insurance for an employee is about $4800. The actual cost is about $2800.
- Of those that could offer an estimate, the median contribution they would be willing to make was $900 per year and that is less than 20% of the anticipated cost. It is roughly one-third of the cost that small employers tend to pay.
- Government provided assistance would influence about half of these businesses. They would be looking for a 60% contribution. This would require the employee to provide 20% coupled with the 20% the employer is willing to contribute. Remember the employers are overestimating the actual cost of the typical small business.
- On the series of true/false questions about health insurance, business that do not offer health insurance tend to get the right answer 58% of the time. The result for those businesses that offer health insurance was 64%.
- Seventy six percent of the firms without health plans are family owned compared with 57% for those with health plans. Seventy six percent of the owners of businesses that don't have health plans are covered compared with 90% of the owners for firms with insurance having coverage.
- Those businesses without insurance are 3 years younger (12 years in business compared with 15).

- Turnover rates are 24% for those firms without health plans compared with 13% for those with insurance.

- Median full-time employees are 3 for those without insurance and 13 for those with insurance. Median salary for salaried employee is $25,000 compared with $30,000 for those offering insurance. Hourly workers receive $9.00 compared with $10.00 for those who offer health insurance. The median business without insurance has 20% of employees under 30 compared with 17% for those with insurance.

- Forty one percent of businesses that do not offer health insurance think they have either a small obligation or no obligation to do so.

- Half of those that offer insurance also pay something for dependent coverage.

- Roughly a third of the businesses say less than 50% of their employees take the insurance. Roughly a third report participation by 100% of their employees. The median firm suggests that 25% of their employees have some dependent

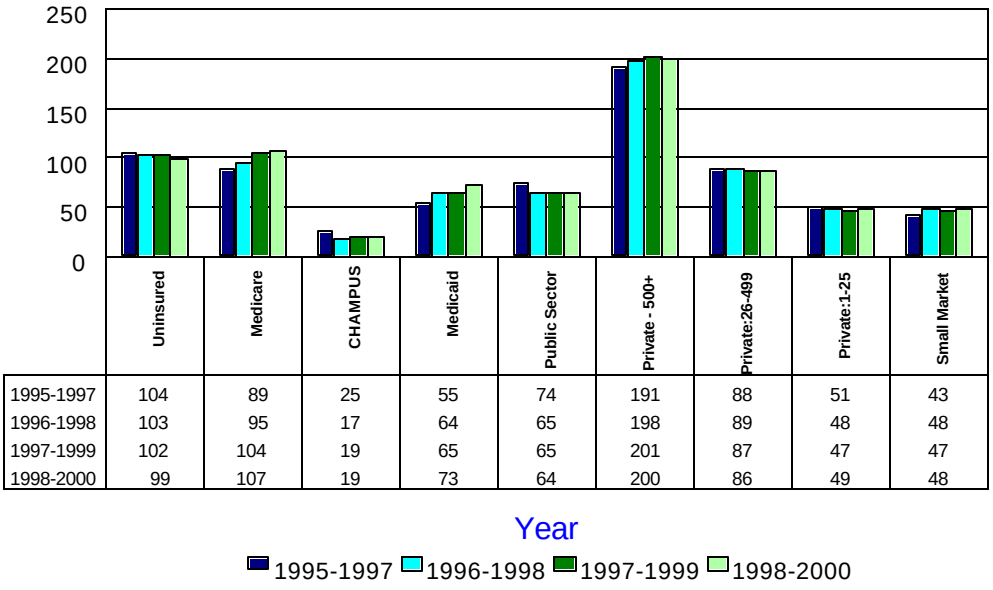
Introduction

The Delaware Health Care Commission has, since its inception, been concerned about access to health care for all Delawareans. While that is not its only focus, since the Commission's mandate is broad, improving access to health care is a primary goal. Access to health care has several dimensions. One of those dimensions is covered in this report, and that is health insurance coverage. Those with health insurance typically enjoy greater access to health care providers than do those who are without it.

Persons who do not have health insurance are still likely to require medical care at some point in time. When they do require such services, their condition may be significantly worse than had it been detected and addressed at an earlier stage. In addition, the uninsured will tend to use one of the most expensive providers, the emergency room. Ultimately, providers must cover all of their costs. Services delivered to the insured and the uninsured alike, figure into that cost. As a result, some of the cost of services provided to the uninsured is shifted to the insured population. This raises the overall cost of fringe benefits to employers.

Figure 1-1

Number of Persons in Delaware
by Source of Insurance



	Uninsured	Medicare	CHAMPUS	Medicaid	Public Sector	Private - 500+	Private:26-499	Private:1-25	Small Market
1995-1997	104	89	25	55	74	191	88	51	43
1996-1998	103	95	17	64	65	198	89	48	48
1997-1999	102	104	19	65	65	201	87	47	47
1998-2000	99	107	19	73	64	200	86	49	48

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 1995-2000

To better understand the nature of the uninsured population, the Delaware Health Care Commission has been monitoring its size and structure for a number of years. This report adds to the depth of this information and analysis by focusing on the small employers of the state. Most Delawareans, who are not covered by one of the government programs, are dependent on their employers for health insurance (see Figure 1-1, above). Unfortunately, the capacity for employers to provide this coverage and for employees to pay their share is uneven. This is particularly true for employers with fewer than 50 employees and for employers who have low wage and/or part-time employees.

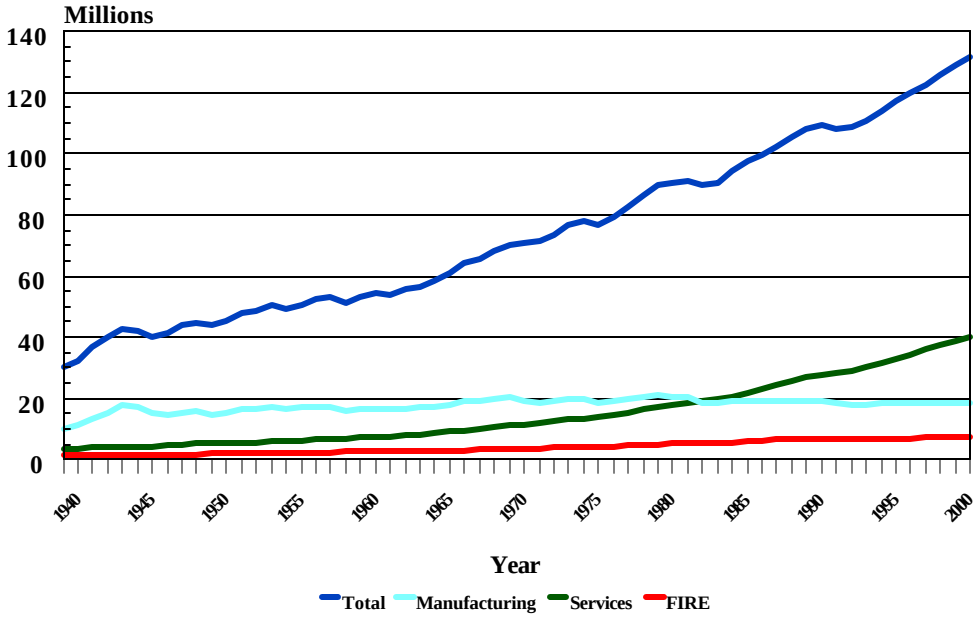
The report has four major sections. In the first section, the focus is on the labor market in Delaware and on existing and future trends that might affect employer provided health coverage. The second section contains results from the employer survey conducted this year that focuses on the variables that are correlated with not having a health plan. This survey draws heavily on the instrumentation used in the "2000 Small Employer Health Benefits Survey", which was co-sponsored by the Blue Cross and Blue Shield Association, the Employee Benefit Research Institute, and the Consumer Health Education Council. The third section focuses on firms that do not have health plans. Observations about these trends and responses are provided in the last section.

The Labor Market

Background

Health care coverage is inexorably linked to an individual's employment status along with the type and size of firm for which they work. Many Delawareans have recently experienced more instability in their labor market activity and this has, inevitably, affected aspects of their coverage. The factors producing this increased instability are varied and are both national and international in scope. There are, however, some basic trends that are important to understand since they are affecting and will continue to affect health care coverage in the years to come.

Figure 2-1
US Non-Agricultural Employment:
Selected Sectors 1939-2000

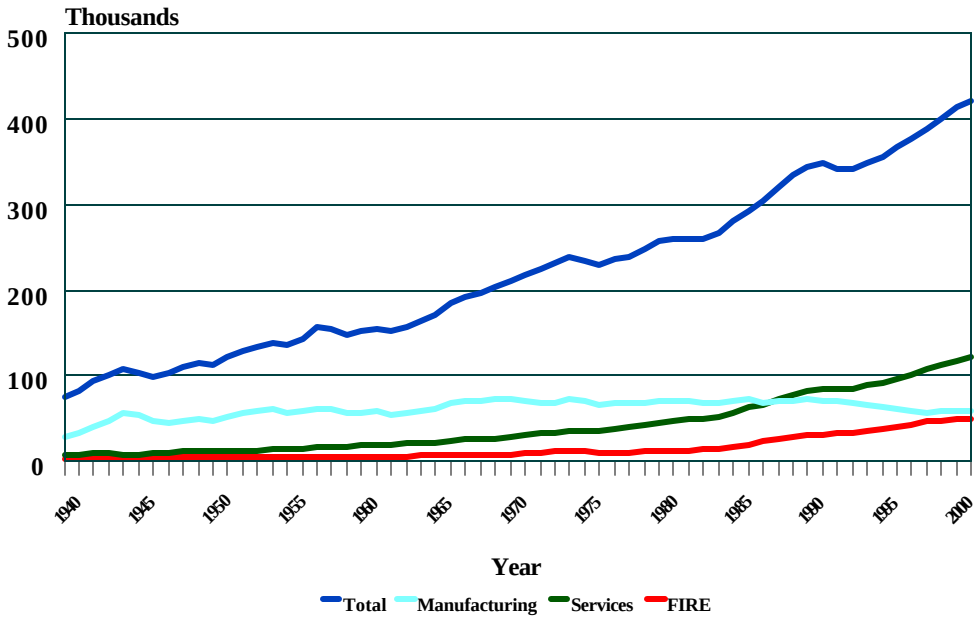


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics

In Figure 2-1 above, the total employment for the United States from 1939 through 2000 is shown along with three of the ten employment sectors namely: manufacturing, services, and FIRE (finance, insurance, and real estate). The graph clearly shows the impact that the business cycle has had on total employment in the mid-1970s, the early 1980s, and the early 1990s. All of these economic events are associated with rapid increases in the percentage of persons without health coverage. The more subtle

influence is related to the change in the structure of employment. Manufacturing employment reached its peak in the late 1970s and has been in a steady but very shallow decline for the most part. Service industry employment increased steadily over the entire period and began accelerating its growth when manufacturing employment was at its peak. In 1981, service sector employment surpassed manufacturing employment and today it accounts for nearly twice as much employment as manufacturing. This trend will probably continue unabated for the foreseeable future.

Figure 2-2
Delaware Non-Agricultural Employment:
Selected Sectors 1939-2000

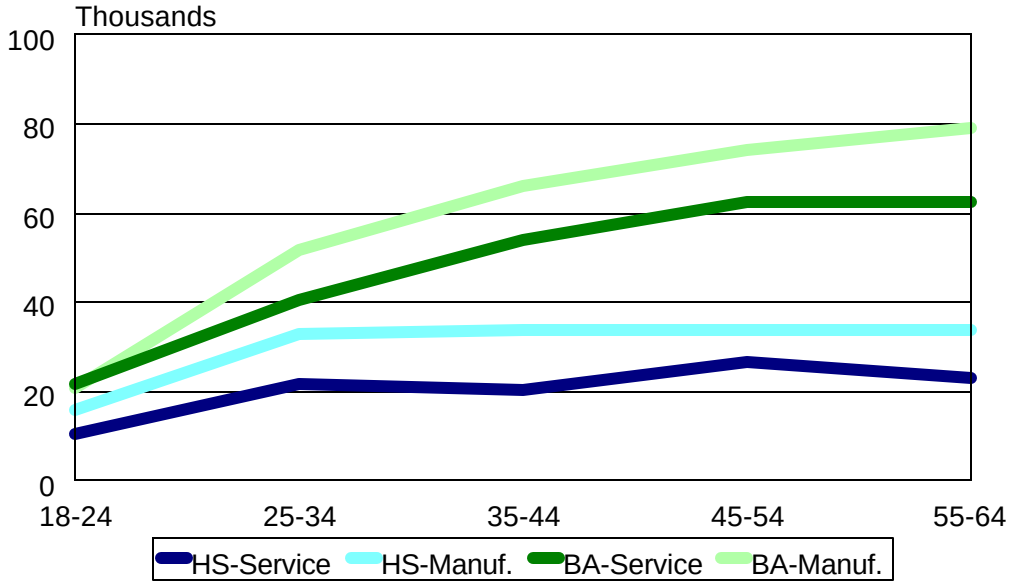


XXVIII. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics, Delaware Department of Labor

The pattern was similar in Delaware, although the recession of the mid-1970s was more severe and the later ones were perhaps less damaging than they had been nationwide. For instance, statewide manufacturing employment peaked during 1989. This marked the end of the expansion of the 1980s. Since then, the number of manufacturing jobs available to Delawareans

has dropped significantly and continues to fall even today. In 1986, four years after it happened nationally, statewide service industry employment surpassed manufacturing employment. The rate of growth in service sector employment in recent years has slowed somewhat compared with the rate for the U.S. but this has been offset by the incredible growth in the FIRE sector. Employment in the FIRE sector clearly exploded after the passage of the Financial Center Development Act in the early 1980s. It continued to grow dramatically until the 1990-1991 recession. To most observers' surprise, the growth re-ignited in 1992 and continues today. A comparison of the trends in Figure 2-1 and Figure 2-2 show this to be a Delaware phenomenon.

Figure 2-3
Average Annual Earnings by
Sector, Age, and Education in 1998-2000



XXIX.
XXX.
XXXI. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 2000

The importance of these inter-sector employment shifts is shown in Figure 2-3 above. Figure 2-3 shows the average annual earnings by age, education, and industrial sector. The top two lines represent annual earnings for college graduates in the manufacturing and service sector respectively. The bottom two lines depict the same information for high school graduates in the same two sectors.

The graph shows a difference of about $40,000 in annual earnings between the two sectors for both levels of education. If the same health care benefits were offered in both sectors, the cost to employers would be a much larger proportion of the annual salary in the service sector than in manufacturing. This suggests that employees in the service sector will likely be offered fewer benefits.

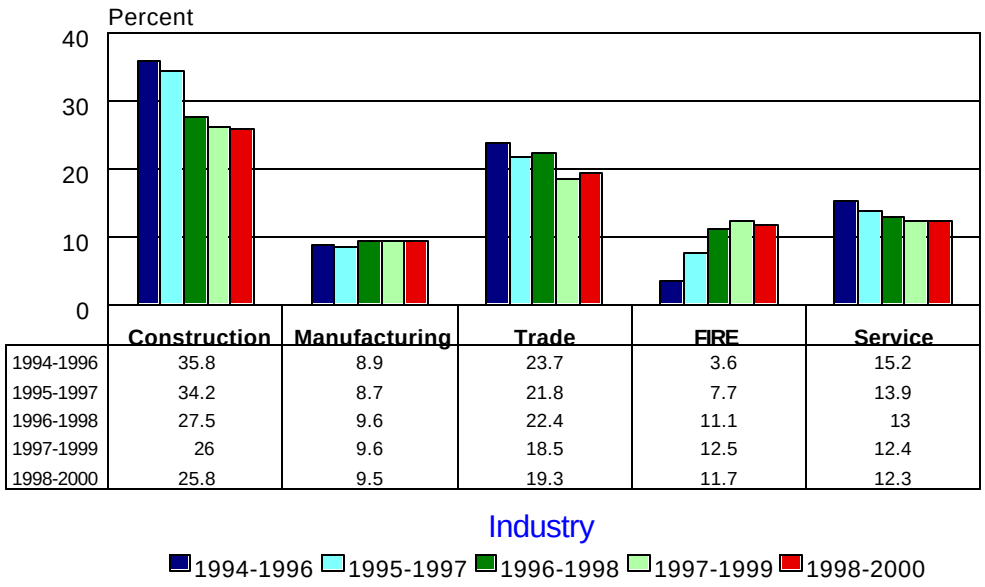
In addition, those employed in manufacturing are much more likely to be represented in a collective bargaining unit, a union. They are also more likely to work full-time with significant overtime, which further reduces the impact of the cost of benefits on total compensation. In contrast, service sector workers are more likely to be employed by non-union companies and are much more likely to work part-time. These factors, coupled with the increasing number of service sector workers relative to the number of manufacturing workers will tend to increase the number of uninsured or under-insured people.

Firm Sector and Size

There are significant differences in both the level and pattern of the uninsured, depending upon the type of industry in which an individual is employed. For instance, according to Figure 2-4 below, construction workers frequently report being uninsured. Although it may be noted that some construction workers are unionized, and are usually provided health coverage, many more are either employed by a non-union company or are self-employed. Overall, it is estimated that more than 25% of all construction workers are uninsured.

Figure 2-4

Percent of Persons without Health Insurance in Delaware by Industrial Sector



	Construction	Manufacturing	Trade	FIRE	Service
1994-1996	35.8	8.9	23.7	3.6	15.2
1995-1997	34.2	8.7	21.8	7.7	13.9
1996-1998	27.5	9.6	22.4	11.1	13
1997-1999	26	9.6	18.5	12.5	12.4
1998-2000	25.8	9.5	19.3	11.7	12.3

XXXII. Source: Center for Applied Demography and Survey Research, University of Delaware

XXXIII. US Bureau of Census, Current Population Survey, March 1994-2000

Many persons employed in the trade industry (retail and wholesale) also find themselves without health coverage. Because this sector is not heavily unionized and is reliant on a large number of part-time workers (most of whom do not qualify for a typical health insurance package), it is not unexpected that an estimated 19% of those employed in the trade industry currently lack health coverage. The most recent data suggests that the upward trend operating since 1994 has moderated.

Of the other industries represented in Figure 2-4, approximately 12% of all those employed in the service industry are not offered access to health insurance as part of a benefits package. This number appears to be declining somewhat over the period. This probably reflects the changing nature of the service industry.

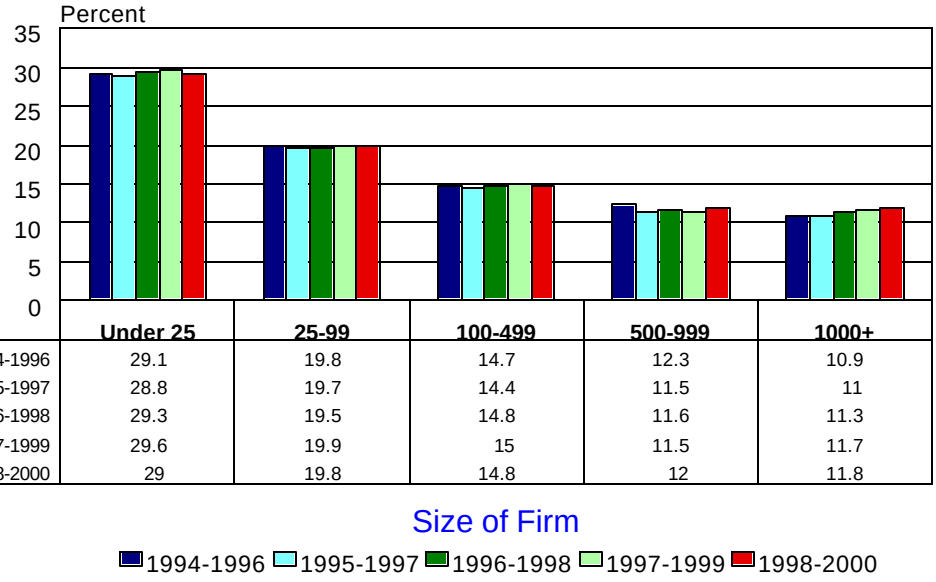
Roughly 10% of those employed in manufacturing and FIRE do not have health coverage. However, the proportion uninsured in the FIRE sector appears to be increasing. This could, for example, reflect an increase in full-time temporary employees in this sector

Finally, it also should be pointed out that the differences in coverage between industries are among the largest observed for any variable in this report. The importance of this information relates to the changing structure of the economy. As employment shifts from manufacturing to the service sector, the percentage of uninsured workers increases by about 3%. The importance of the FIRE sector in Delaware cannot be over

estimated at least with respect to health coverage, although the 2000 estimates make this conclusion less clear. While the percentage of uninsured in the region has been rising, Delaware's rate has either been falling or remaining steady. This appears, in large part, to be related to the accelerating FIRE sector and to a less rapidly growing service sector.

The other important inter-sector shift, which is more subtle, is associated with the nature of downsizing in Delaware's manufacturing sector. A significant portion of those employees who were "downsized" belonged to headquarters support operations as opposed to the factory floor. In many cases, those same employees started or joined firms that supplied services to their previous employer who simply wanted to "out-source" those functions. Many of these new jobs are classified as business services, part of the service sector, and are far from the typical "hamburger flipper" often discussed in the media. This has produced increases in annual earnings in the service sector that bodes well for benefit programs in the future.

Figure 2-5
Percent of Persons without Health Insurance in the US
by Size of Firm



	Under 25	25-99	100-499	500-999	1000+
1994-1996	29.1	19.8	14.7	12.3	10.9
1995-1997	28.8	19.7	14.4	11.5	11
1996-1998	29.3	19.5	14.8	11.6	11.3
1997-1999	29.6	19.9	15	11.5	11.7
1998-2000	29	19.8	14.8	12	11.8

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Employees who work for small firms (under 100 employees) are less likely to have health insurance than those that work for large firms (more than 500 employees). Figure 2-5 above shows this relationship.

The graph shows that there are two distinct groupings: (1) firms with less than 100 employees where the percentage without health insurance is 24% and (2) firms with more than 500 employees where the percentage of those without health insurance is 12%. The larger firms are perhaps more likely to be unionized at least to the extent that larger firms have a higher probability of being in sectors such as manufacturing. They are also more likely to pay higher wages, which makes the relative cost of health insurance more tolerable. From a tax perspective, the provision of health insurance also provides a convenient way to increase total compensation.

A somewhat disturbing trend is also evident in Figure 2-5. It appears, at least from the national perspective, that those working for smallest firms are not improving their insurance coverage in comparison with five years ago. What makes this trend so disconcerting is the fact

that the economy has been expanding for almost ten years. The same can be said for larger firms, however. One explanation for this lack of improvement is the lack of increases in wages nationally and the restructuring and cost cutting practiced by most firms, which has produced significant increases in earnings.

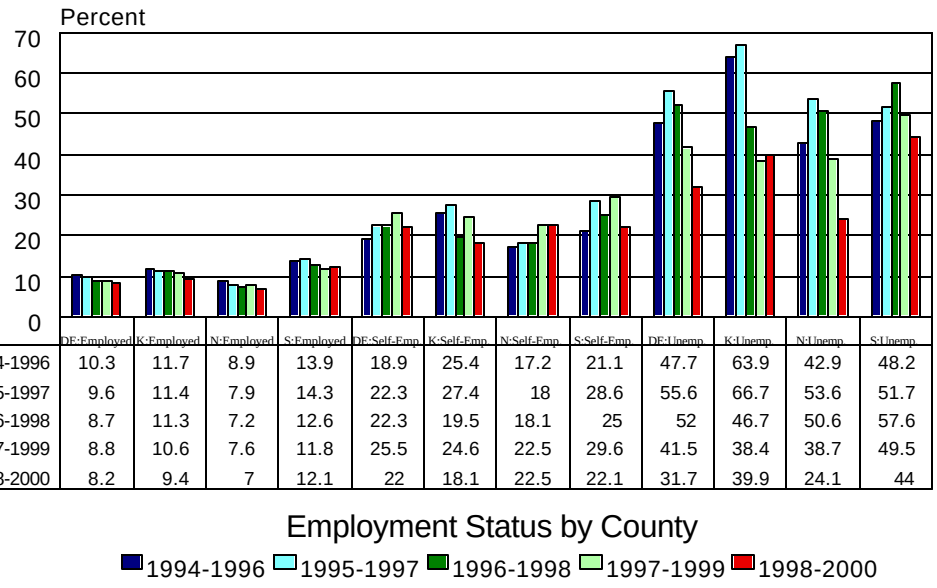
In conclusion, these data suggest that any effort to increase coverage must focus on smaller firms. Those firms will tend to provide lower levels of compensation, will probably use more part-time employees, and may offer less stable employment. However, they are growing faster and becoming a bigger part of the economy. This fact may tend to mitigate some of the negative factors over time. On the other hand, the large firms with better coverage are becoming smaller and that does not help the long-term outlook. There is no doubt, however, that all of these factors will tend to make the goal of better access to health care a challenge for the foreseeable future.

Employment Status and Class

Approximately 75% of all Delawareans are covered by some form of group health insurance. The vast majority is covered through their employer and therefore any disruption in employment will undoubtedly increase the likelihood that coverage will lapse. The reason that coverage may not automatically lapse is because that individual may be covered by another worker in the family, or the coverage may be extended through payments by the employee, or the individual may qualify for some government sponsored plan like Medicaid or Medicare. Still, the disruption is significant as is shown in Figure 2-6, below.

The information reported in Figure 2-6 shows that the probability of being without heath insurance increases by nearly a factor of four when the individual is unemployed. The percentage on the average rises from about 8% to in the vicinity of 32% as the individual's employment status changes. There is considerably more volatility in the estimates in Kent and Sussex counties because of small sample sizes, but the relationship mirrors that in New Castle County where sample size is not a problem. While those that are self-employed are also found in relatively small numbers in the BRFSS survey, the lack of health insurance is at least twice as prevalent as that of those with traditional employment. This year there is little observable difference between the counties with respect to the self-employed.

Figure 2-6
Percent of Adults without Health Insurance in Delaware
by County and Employment Status



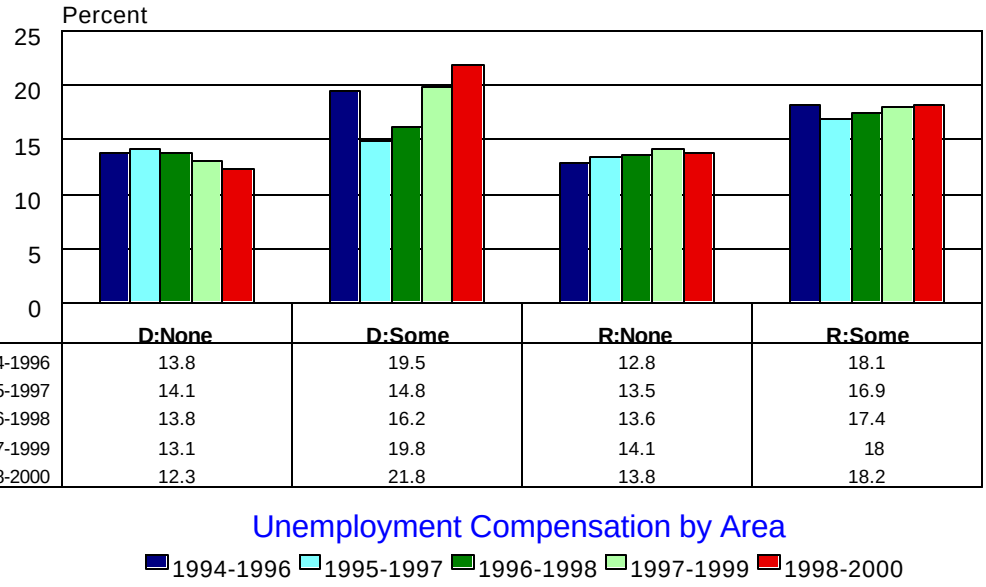
	DE:Employed	K:Employed	N:Employed	S:Employed	DE:Self-Emp	K:Self-Emp	N:Self-Emp	S:Self-Emp	DE:Unemp	K:Unemp	N:Unemp	S:Unemp
1994-1996	10.3	11.7	8.9	13.9	18.9	25.4	17.2	21.1	47.7	63.9	42.9	48.2
1995-1997	9.6	11.4	7.9	14.3	22.3	27.4	18	28.6	55.6	66.7	53.6	51.7
1996-1998	8.7	11.3	7.2	12.6	22.3	19.5	18.1	25	52	46.7	50.6	57.6
1997-1999	8.8	10.6	7.6	11.8	25.5	24.6	22.5	29.6	41.5	38.4	38.7	49.5
1998-2000	8.2	9.4	7	12.1	22	18.1	22.5	22.1	31.7	39.9	24.1	44

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1994-2000 Behavioral Risk Factor Survey

The other piece of information that deserves comment is the relative differences between the lack of coverage for employed workers in the three counties. The rate in New Castle County is significantly lower than those observed in Kent and Sussex counties. Following the earlier argument, this probably arises from differences in the economic base, since larger firms with higher wages and more stable employment are located primarily in the northern part of the state.

In Figure 2-7 below, further evidence is found about the relationship between insurance coverage and employment status. In this analysis, the receipt of unemployment compensation is used as an indicator of an interruption of employment at some point during the year. In both Delaware and the region, there is a significant rise in the lack of health coverage associated with receiving benefits. While the effect is more muted than in Figure 2-6, where a more direct measure was available, the percentage is always higher in the region where the sample size permits a better estimate.

Figure 2-7
Percent of Persons without Health Insurance
by Receipt of Unemployment Compensation and Area



	D:None	D:Some	R:None	R:Some
1994-1996	13.8	19.5	12.8	18.1
1995-1997	14.1	14.8	13.5	16.9
1996-1998	13.8	16.2	13.6	17.4
1997-1999	13.1	19.8	14.1	18
1998-2000	12.3	21.8	13.8	18.2

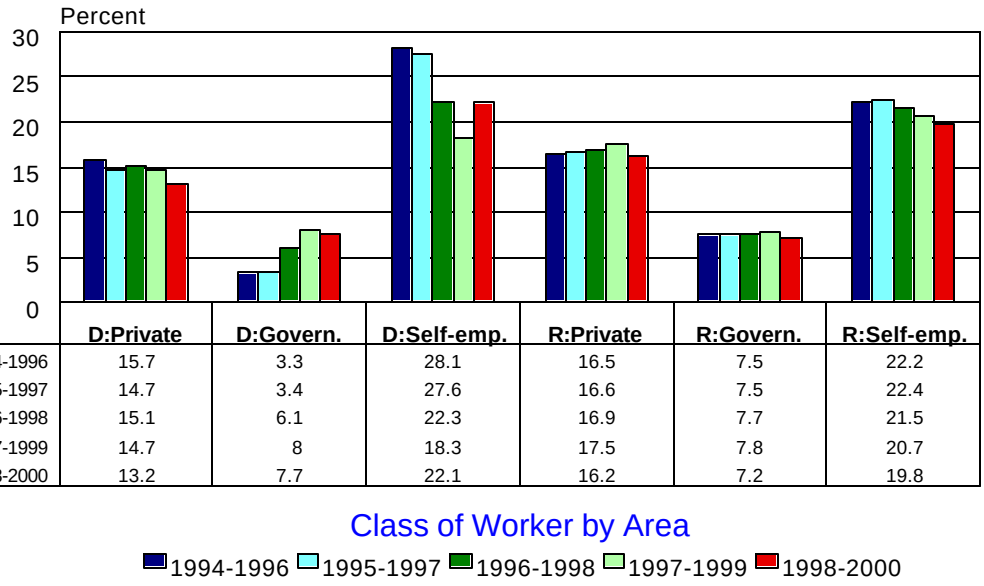
XXXIV. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final graph in this section of the report represents the percentage of workers without health insurance in Delaware and the region as indicated by three broad classes namely: private sector workers, government workers, and the self-employed. In Figure 2-8 below, Delaware workers in the private sector average 3% fewer uninsured than those in the region. Within the private sector, Delaware seems to be improving slightly over the time period, which is consistent with the increase in workers in the FIRE sector. The rates in the region, for the private sector, are increasing, which probably reflects increases in the service sector and in part-time employees. Both trends should be watched carefully.

It is no surprise that government employees both in Delaware and the region are far more likely to have health insurance than the private sector in general. Government rates are comparable with very large private sector firms operating in a unionized work place. The only government workers who are likely to lack coverage are temporary/part-time workers or private contractors.

Figure 2-8

Percent of Persons without Health Insurance by Class of Worker and Area



	D:Private	D:Govern.	D:Self-emp.	R:Private	R:Govern.	R:Self-emp.
1994-1996	15.7	3.3	28.1	16.5	7.5	22.2
1995-1997	14.7	3.4	27.6	16.6	7.5	22.4
1996-1998	15.1	6.1	22.3	16.9	7.7	21.5
1997-1999	14.7	8	18.3	17.5	7.8	20.7
1998-2000	13.2	7.7	22.1	16.2	7.2	19.8

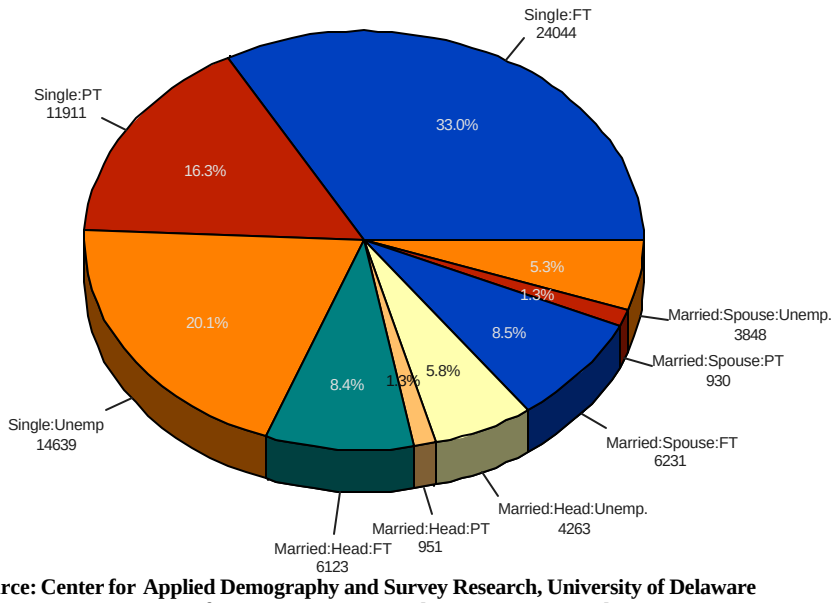
XXXV. Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

A more interesting structural shift, which has been underway for some time, is that government workers are representing a smaller proportion of the labor force, since that sector is growing less rapidly than employment overall. This implies that the percentage of uninsured workers will tend to rise, even if all the rates within these classes remain constant.

The information about the self-employed corroborates the information from the BRFSS discussed earlier. The data for the region, however, shows that the significant upward trend previously identified has moderated. There are a variety of potential explanations. One reason, which is consistent with other data, is that tight labor markets have allowed many of those previously classified as "self-employed" to find work and to gain benefits. Those that remain self-employed are likely to be financially stronger and better able to obtain health insurance.

Finally, one other useful way of looking at this problem is to divide the uninsured into independent groups, i.e. they do not overlap. There are approximately 26,000 persons under the age of 18 who are uninsured. In Figure 2-9, below the 73,000 uninsured adults are displayed by marital status, employment status and household relationship. Almost 70% of the uninsured population is single and they are almost equally split between full-time employment where they might possibility get access to health insurance and an employment status where access to health insurance through an employer is realistically remote. In fact, one could reasonably conclude that only half of the lack of health insurance problem with adults can be approached through employers and that is an outside limit.

Figure 2-9
Persons 18-64 Without Health Insurance
by Marital Status, Household Relationship, and Employment



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

Health Plan Status

Background

In the previous section, clear evidence was presented that suggested that small employers required special study if the number of uninsured was to be reduced. The proportion of those uninsured who were working for employers with 25 or fewer employees was 2.5 times the rate found in Delaware's largest employers (29% compared with 11.8%). In addition, about half of those who are currently uninsured are working full-time, and many of those work for small employers. This information led to the conclusion that any potential solution to the problems of the uninsured must address the situation faced by small employers. The result of that observation was the design, execution, and analysis of a survey of this group of employers.

Using a database supplied by the Delaware Department of Labor, some 12,875 firms with between 2 and 50 employees were identified. Together they comprised 92% of the firms with more than a single employee. Single employee firms were judged to be special cases since they included only the firm owner in most cases and were excluded from the study.

The study used a disproportionate stratified sample design with four strata, namely 1) less than 6 employees, 2) 6 to 15 employees, 3) 16 to 25 employees, and 4) 26 to 50 employees. The sample was drawn to produce equal numbers of firms in each strata. While this makes the analysis more complex, it satisfied the need to do analysis between the groups as well as for the overall sample.

Each employer received an initial letter from the Delaware Healthcare Commission explaining the purpose of the study set to arrive several days before the actual survey instrument. Two survey instruments were mailed out asking employers to fill out the green survey if they offered insurance and a different survey colored red if they did not. If a response was not received within a week a reminder post card was sent,

followed by a second copy of the questionnaire. This too was followed by another reminder card and a third survey.

Of the 1601 surveys that were mailed, 725 were returned at the completion of the protocol yielding an overall response rate of 45.3%. The response rates for the four strata were similar namely, 1) 45.4%, 2) 39.2%, 3) 48.9%, and 4) 45.7%. While these levels are not sufficient to suggest that the potential for non-response bias is minimal, they are significantly higher levels than typically are found in business surveys. This is at least consistent with the hypothesis that the problem of health insurance is a matter of concern to this particular group of employers.

Health Plan Status

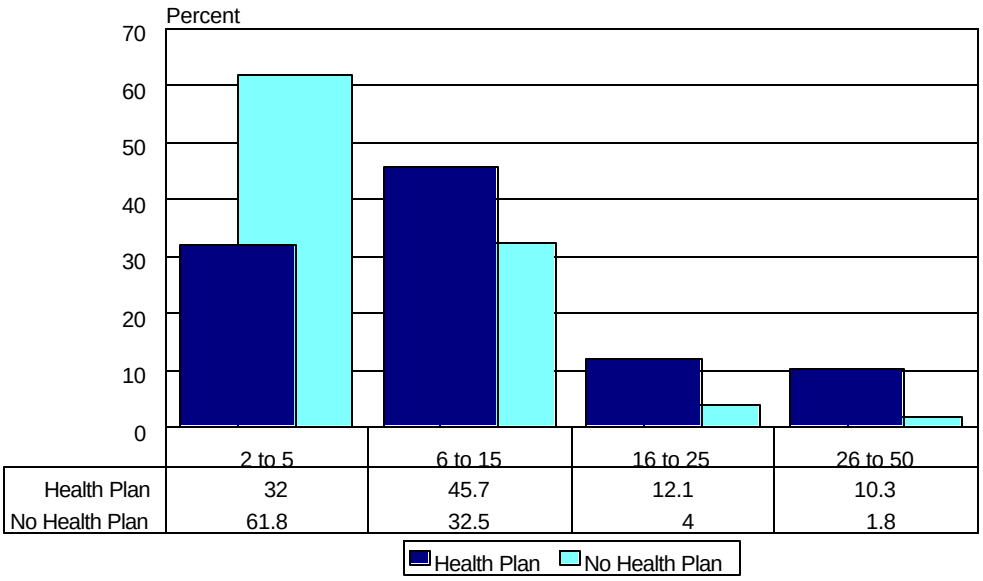
A number of factors affect the decision to offer health insurance coverage to employees and many of those factors are directly related to the nature and structure of the business the employer is conducting. In this section, a series of those factors will be addressed with respect to two different relationships between the variable and the business's health coverage status.

Size of firm in terms of the number of employees is important, as was noted in the first part of this report where significant differences were noted in health coverage for employees working for firms of different sizes. In Figure 3-1 below, the distribution of employers within each health coverage status is displayed.

Figure 3-1

Number of Employees

by Firm Health Plan Status



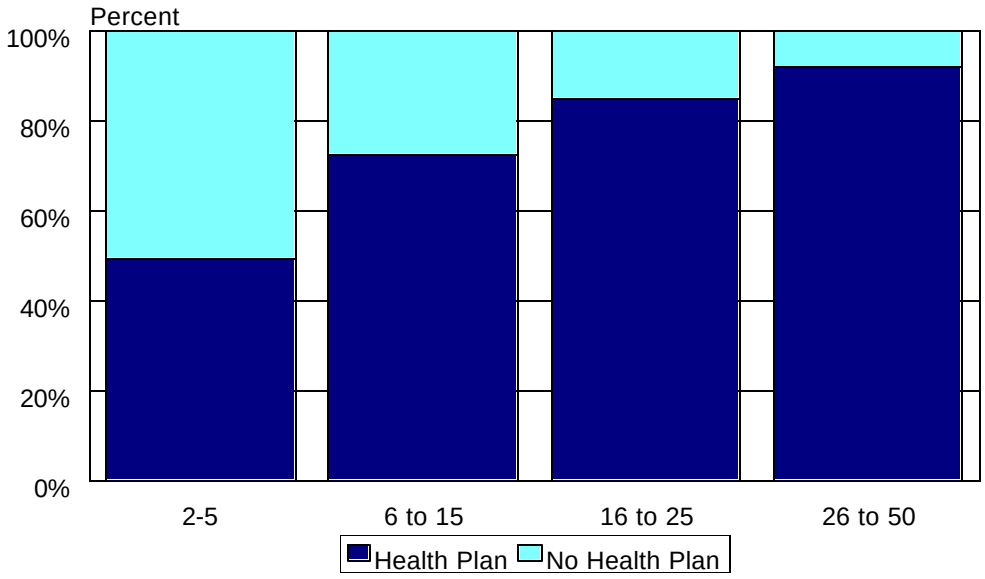
Source: Center for Applied Demography and Survey Research, University of Delaware

It is hardly unexpected that firms that do not offer health insurance are disproportionately concentrated in the smallest employee category with a proportion that is nearly twice that of those who offer coverage. The overall relationship is even clearer showing the probability of providing coverage within each size classification (see Figure 3-2, below).

Figure 3-2

Firm Health Plan Status

by Number of Employees



Source: Center for Applied Demography and Survey Research, University of Delaware

The chart shows that the proportion of firms offering health insurance increases as the number of employees increases. It is instructive to see that nearly 50% of the firms even in the smallest size category offer coverage. Obviously there is significant variation in the profitability and stability independent of size in order to afford this benefit. There are substantial differences between a small accounting firm with full-time professionals and a small retail firm with part-time low wage employees.

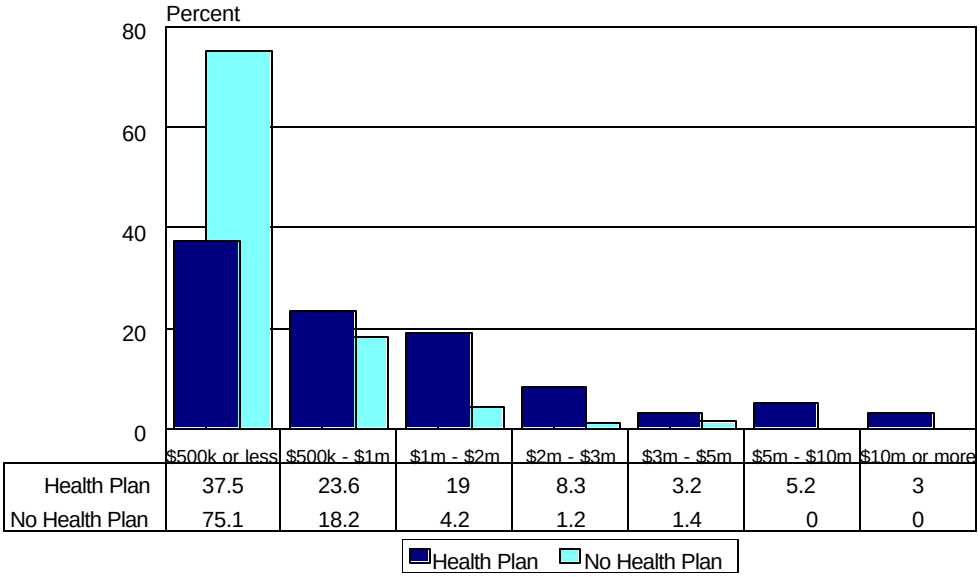
There is more than one measure of economic size. Gross revenue is quite often used as a measure to complement the number of employees. The results with health plan status are much more pronounced than the earlier chart by number of employees (see Figure 3-3, below). Firms that do not offer plans are even more concentrated in the smallest revenue category and are totally absent in the two largest categories.

The distribution within revenue class is shown in Figure 3-4, below. A smaller proportion of firms within the smallest revenue class offer health insurance compared with the smallest employee class. Clearly, health insurance coverage increases as revenue increases.

Figure 3-3

Revenue Class

by Firm Health Plan Status



	$500k or less	$500k - $1m	$1m - $2m	$2m - $3m	$3m - $5m	$5m - $10m	$10m or more
Health Plan	37.5	23.6	19	8.3	3.2	5.2	3
No Health Plan	75.1	18.2	4.2	1.2	1.4	0	0

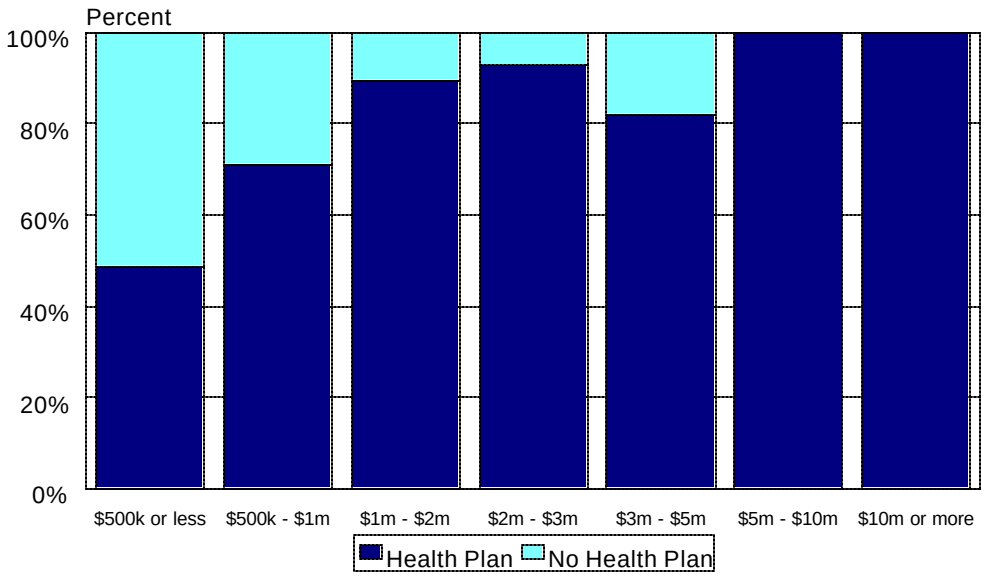
Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-4

Firm Health Plan Status

by Revenue Class

Delaware's Small Employers: the Health Insurance Dilemma 2001
Health Plan Status



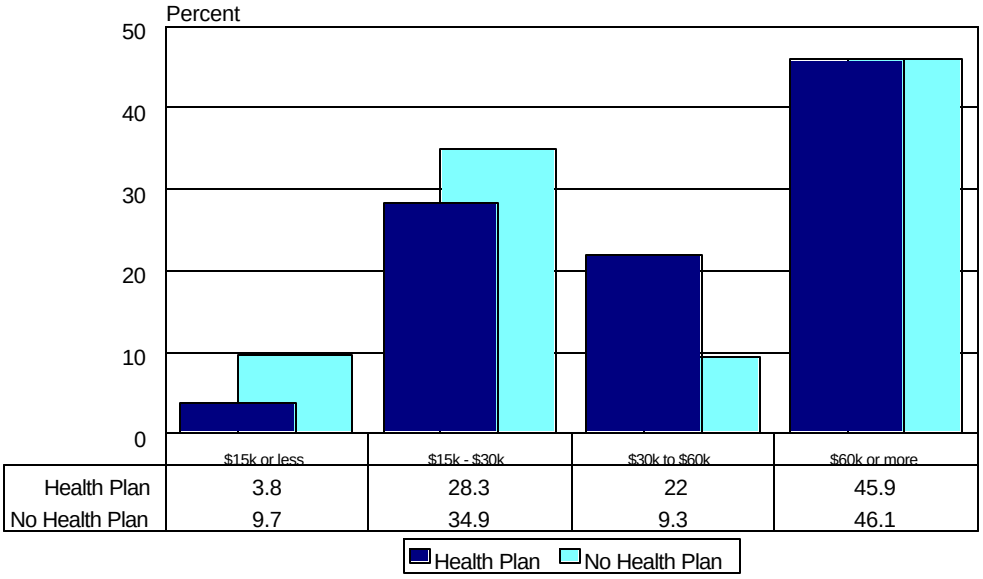
Source: Center for Applied Demography and Survey Research, University of Delaware

The ability of the employee to share in the cost of health insurance coverage and the willingness of the employer to contribute depends at least to some degree on the amount the typical employee is being paid. The larger the wage, the easier it is for the employee to contribute. As the wage increases, health insurance costs become a smaller share of total employment costs.

Figure 3-5

Full-time Employee Salary Class

by Firm Health Plan Status



	$15k or less	$15k - $30k	$30k to $60k	$60k or more
Health Plan	3.8	28.3	22	45.9
No Health Plan	9.7	34.9	9.3	46.1

Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-5, above, shows the distribution of firms within health plan status across categories depicting the typical salary of a full-time worker in the firm. In contrast to many of the other charts, there is no clear pattern. In fact, both categories of firms have almost identical representation in the highest salary category.

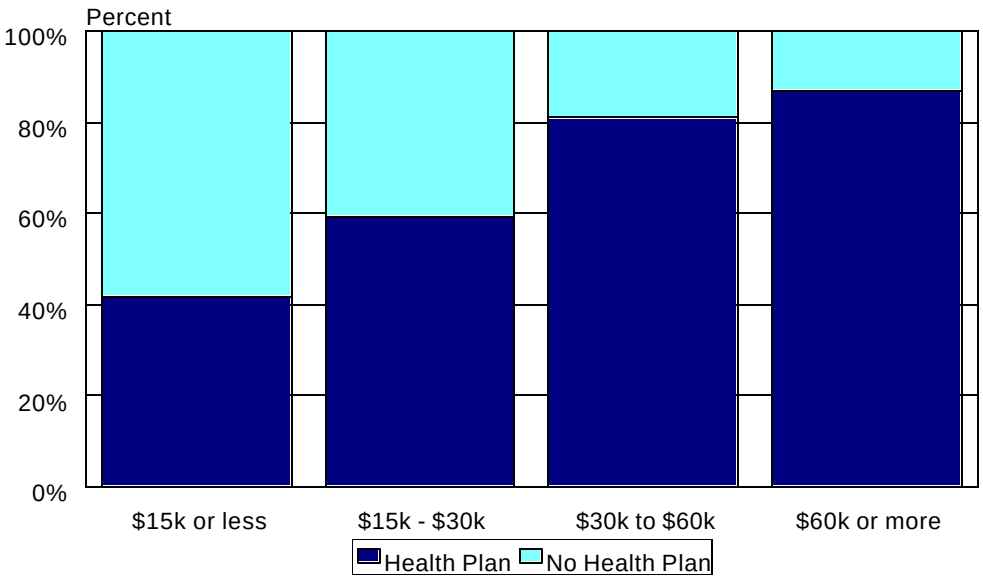
A much clearer view emerges when one looks within each salary category. That result is found in Figure 3-6, below. In this chart the positive relationship between salary levels and the availability of a health plan is readily apparent. Over that range the ratio of

total health insurance cost to the typical individual's salary falls from 19% to under 5%. In addition, the tax benefit even further expands the difference.

Figure 3-6

Firm Health Plan Status

by Full-time Employee Salary Class



Source: Center for Applied Demography and Survey Research, University of Delaware

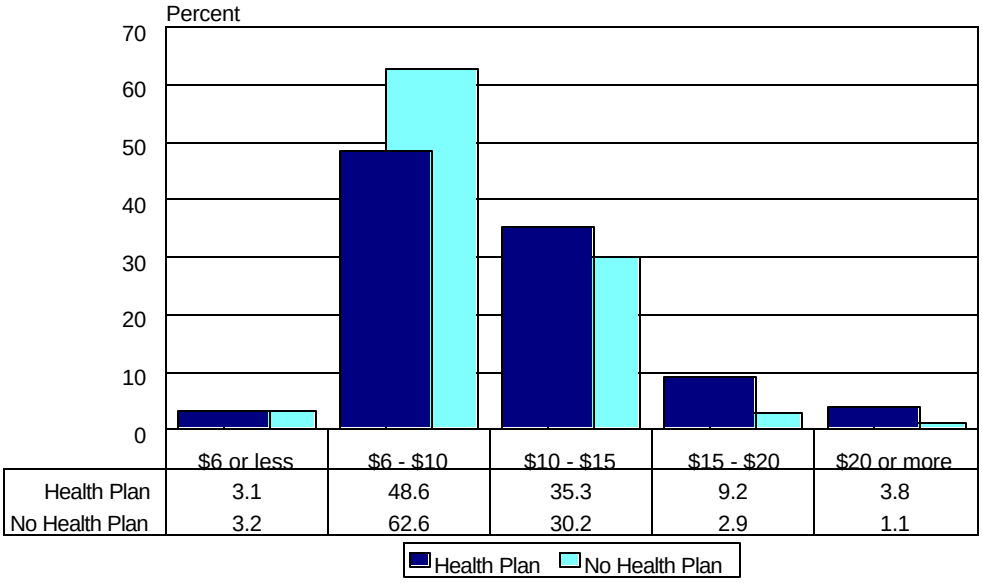
Since a significant proportion of the labor force receives an hourly pay rate as opposed to an annual salary, respondents were asked about the typical hourly wage rate as well. The pattern is quite similar to that observed for the annual salary data. Both sets of firms are distributed similarly across the wage spectrum. If anything, firms that do not offer health insurance tend to more frequently report paying wages under $10 per hour and there are very few of those firms that pay more than $15 per hour. This can be seen in Figure 3-7 below.

In Figure 3-8, below, the relationship between offering a health plan and typical hourly wage is even clearer. Instead of the rather nice rising relationship between annual salary and health coverage, there appears to be a threshold effect operating at $15 per hour. Below that wage, the probability of the firm offering health insurance is reasonably stable. After that point, which is the equivalent of $30,000 per year at full-employment, there is a substantial increase in the probability of offering insurance. That level is similar to what was observed for salaried workers in the $30,000 to $60,000 salary class.

Figure 3-7

Typical Hourly Wage

by Firm Health Plan Status



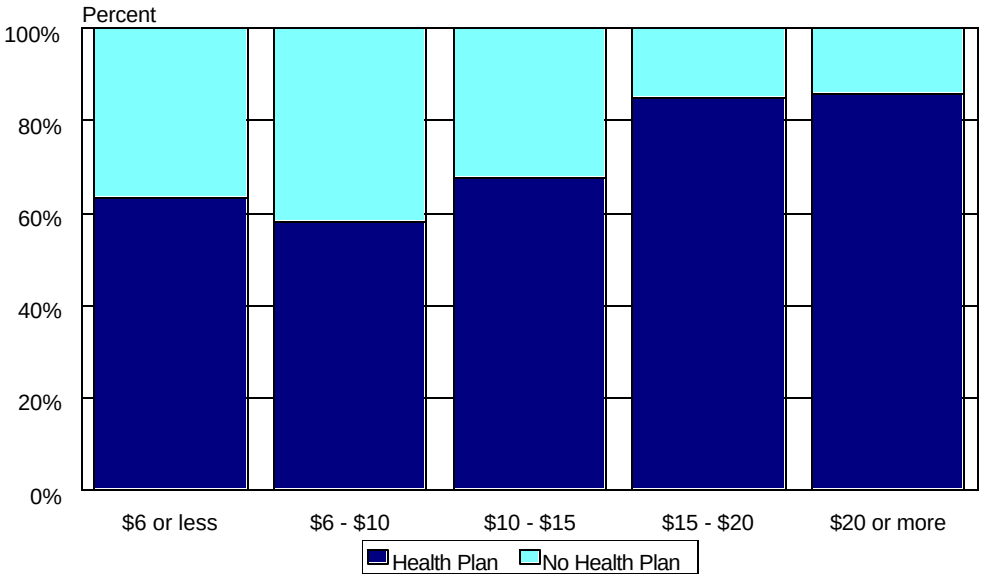
	$6 or less	$6 - $10	$10 - $15	$15 - $20	$20 or more
Health Plan	3.1	48.6	35.3	9.2	3.8
No Health Plan	3.2	62.6	30.2	2.9	1.1

Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-8

Firm Health Plan Status

by Typical Hourly Wage



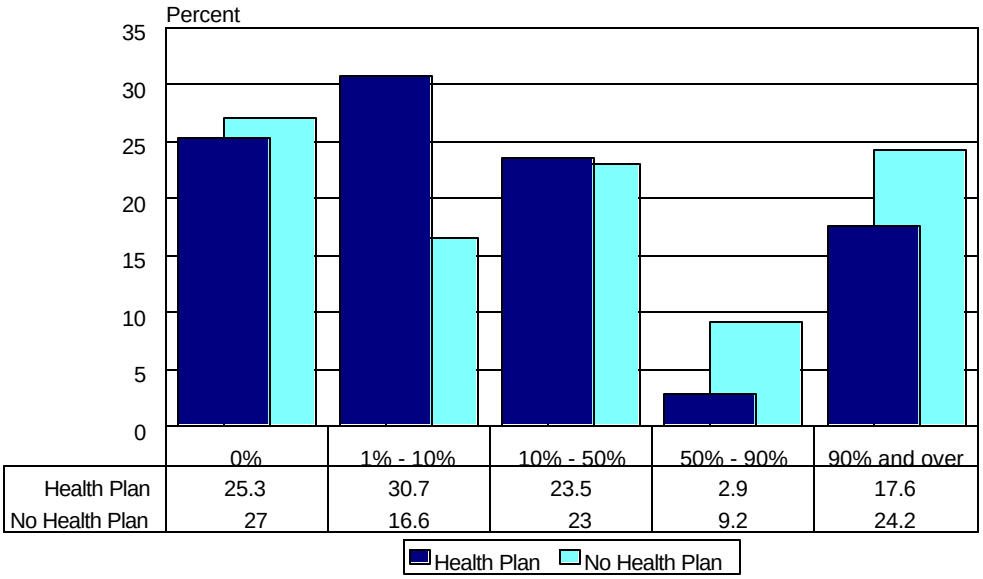
Source: Center for Applied Demography and Survey Research, University of Delaware

The relationship between turnover rates and the willingness of an employer to offer health coverage is complex. Turnover is in part defined by the tightness of the labor markets where employees continually try to improve their income level, benefit offering or working conditions. An employer will be very sensitive if there are significant training costs associated with new employees. If these costs are low relative to the wages paid, then turnover becomes the norm. Offering health insurance coverage will probably add to employment costs without corresponding productivity. The turnover rates for the two sets of firms are shown in Figure 3-9, below.

Figure 3-9

Turnover Rates

by Firm Health Plan Status



Source: Center for Applied Demography and Survey Research, University of Delaware

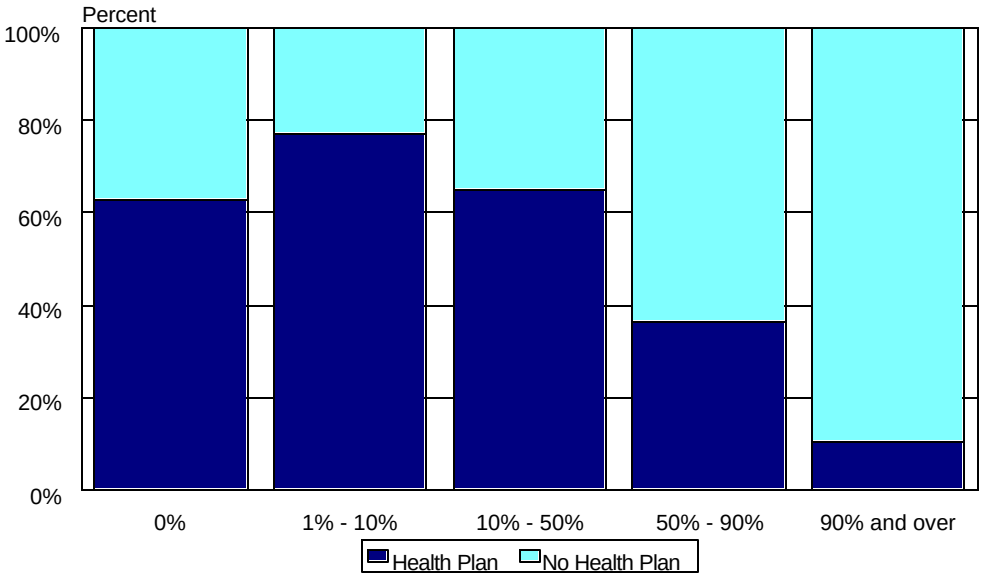
There is a great deal of similarity between the two sets of firms with respect to health plan status. In fact about a quarter of firms in both categories are in the "no turnover" category. Firms with a health plan are more prevalent in the low turnover category (1%-10%) and firms without health insurance coverage are much more prevalent in the 50% and higher categories.

The relationship between health plan status and the turnover categories is also interesting (see Figure 3-10, below). The no turnover category is a special case and not having health insurance coverage obviously is not a problem for those employees. For the other categories, there is a clear decrease in the availability of coverage as the turnover rate increases. While there certainly appears to be a relationship, the information is not sufficient to draw the conclusion that health insurance plans reduce turnover. Their existence is certainly correlated with turnover.

Figure 3-10

Firm Health Plan Status

by Turnover Rate



Source: Center for Applied Demography and Survey Research, University of Delaware

Turnover is probably more of an issue for firms that have a significant number of part-time employees. This is particularly true if the part-time employee is really not part-time by choice. In general, part-time employees rarely have access to a health plan especially if they are hourly workers. Thus, as the proportion of the employees in the firm who are part-time grows, one would expect the likelihood of having a health plan would fall.

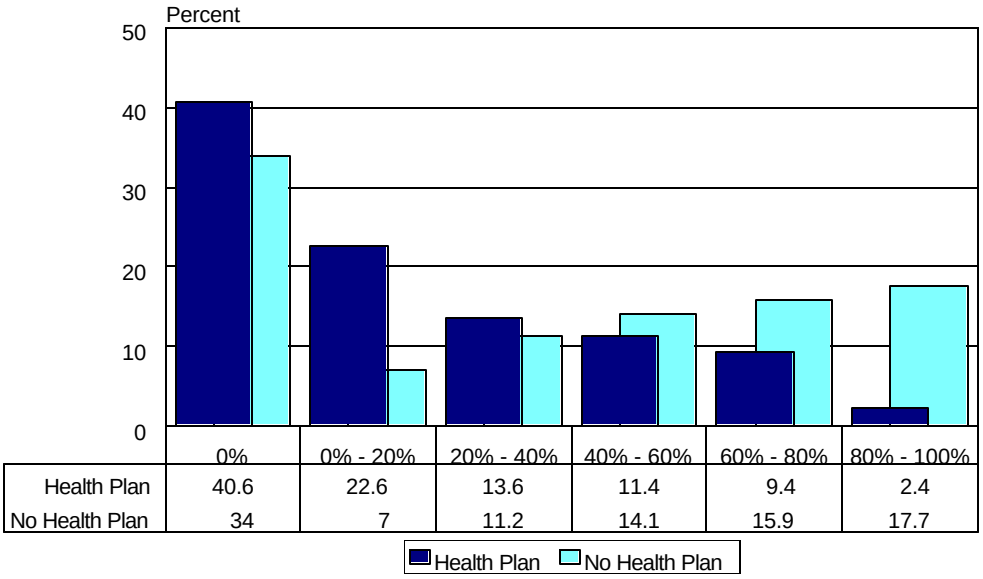
In Figure 3-11, below, there are substantial differences in the way the two groups of firms are distributed across the percent part-time employment categories. Putting aside the special case of no part-time employees where there are similar proportions of both groups, the proportion of firms with no health plan increases consistently. At the same time the proportion of firms who have health plans falls in a systematic fashion.

This same relationship is even clearer in Figure 3-12, below. It offers the single strongest relationship in predicting whether a firm will have a health plan. For firms with less than 20% part-time employees, over 80% have health plans. For those with nearly all part-time employees, 80% do not have health plans.

Figure 3-11

Percent Part-time Employees

by Firm Health Plan Status



	0%	0% - 20%	20% - 40%	40% - 60%	60% - 80%	80% - 100%
Health Plan	40.6	22.6	13.6	11.4	9.4	2.4
No Health Plan	34	7	11.2	14.1	15.9	17.7

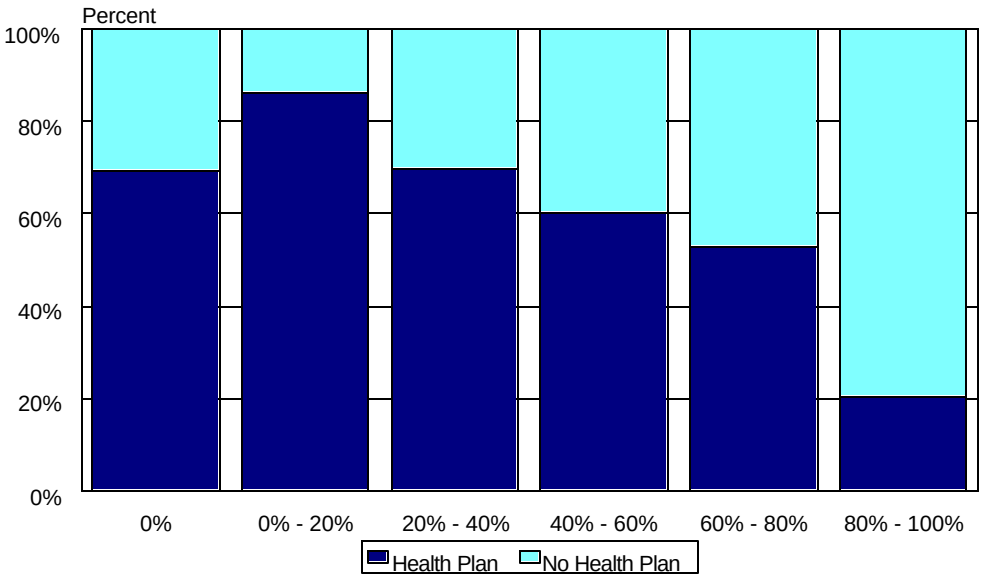
Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-12

Health Plan Status

by Percent Part-time Employees

Delaware's Small Employers: the Health Insurance Dilemma 2001
Health Plan Status



Source: Center for Applied Demography and Survey Research, University of Delaware

Other variables were explored, but none offered significant insight into this issue:

- Age of business should be related to size, revenue, and other key variables but this only made a small difference in the proportion having health plans for firms in business for 20 years or more.

- The firms in this study were more than 90% non-union and the differences in health status were insignificant largely because of sample size.

- The gender distributions between the two groups of firms were similar although firms with health plans had a higher proportion of males (60%). The higher proportion of females (50%) in firms without health plans is related to the differences in part-time workers.

Overall, the variables that explain the differences in having or not having a health plan seem directly related to the economic circumstances of the firm. In the next section, the data gathered from firms who do not have health plans will be explored in more depth.

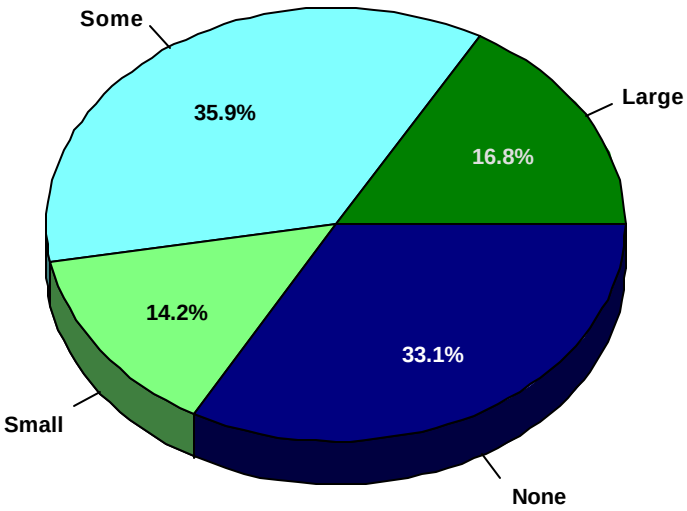
Businesses Without Health Plans

Technically, no business is required to offer health insurance. It has been considered mutually beneficial to provide the benefit for a number of reasons. In addition, since the benefit is generally not taxable, the value to the employee is greater than the equivalent amount of salary. In spite of these factors, many firms do not offer benefits for a lot of different reasons. One of the overarching reasons for offering health insurance is that there is an obligation since this is how most people obtain insurance. The survey results for this question among those that do not currently offer insurance are displayed.

Figure 4-1

Obligation of an Employer

to Provide Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

More than half of these firms feel that there is no obligation or only a small obligation to offer this benefit. It is interesting to note that among those businesses that do offer insurance, 66% stated that "It was the right thing to do" was a major factor in

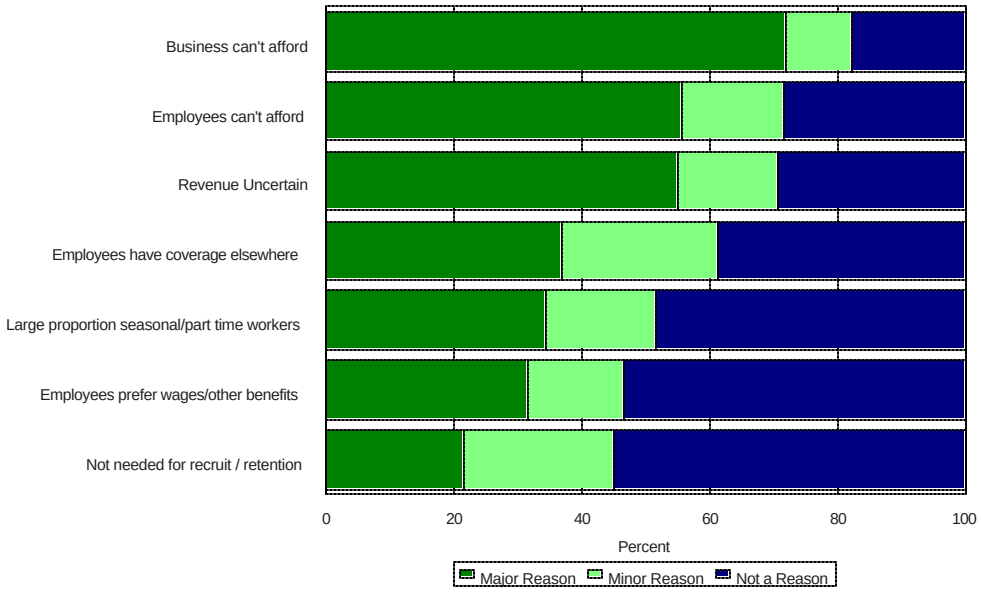
their decision. That also corresponds to 71% on a national survey of employers conducted in 2000 who felt the same. Clearly, there is a difference of opinion in this area.

One of the most important reasons for doing the employer survey was to gain some understanding as to why employers didn't offer health insurance. Figure 4-2 below sheds some light on the issue. Employers were asked to classify seven areas as to whether each was a major reason, a minor reason, or no reason at all for not offering health insurance.

Figure 4-2

Reasons for Not Offering Health Insurance

by Level of Importance



Source: Center for Applied Demography and Survey Research, University of Delaware

The top three reasons are related to simple economics for either the employer or the employee. The employer can't commit either because there are insufficient profit margins or because those profit margins are volatile. The employees on the other hand can't afford to pay their share since it would mean a substantial reduction in their

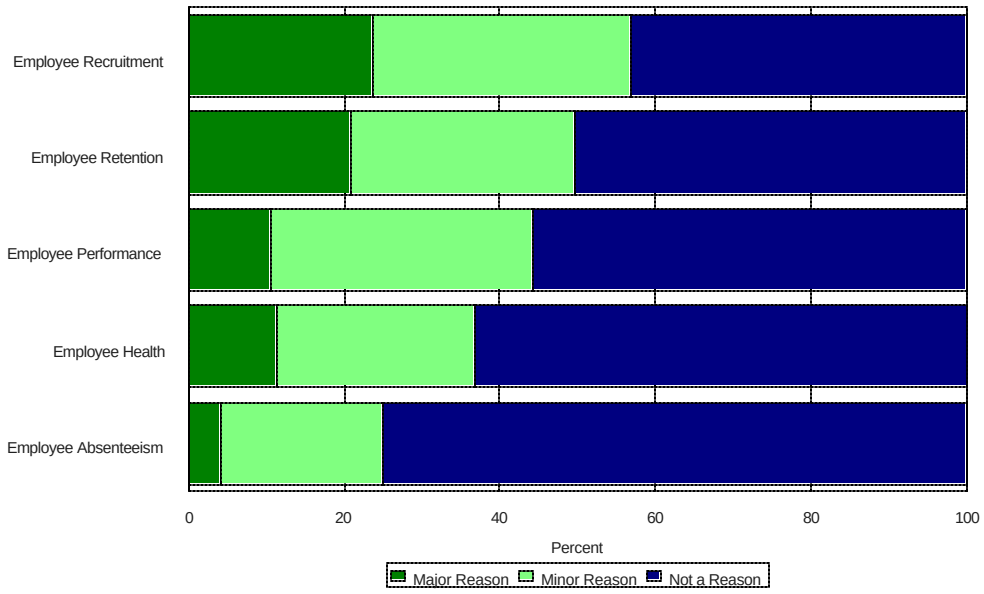
disposable income. All three issues are related to the general problems faced by small businesses and their employees every day.

Once again the results from this survey were similar to those in the national poll. If any thing, the Delaware businesses were more certain that they couldn't afford to provide the health insurance (82% to 69%). They were also more certain that their employees could not afford their share (72% to 54%).

Figure 4-3

Impact of Not Offering Health Insurance

by Level of Importance



Source: Center for Applied Demography and Survey Research, University of Delaware

Ultimately, business owners will be unlikely to provide a benefit like health insurance if they feel it will make little or no difference to the business. Altruism was effectively ruled out in the earlier discussion. In Figure 4-3 above, only one of the potential positive reasons for offering this benefit is considered a reason for doing so by more than 50% of the businesses that currently do not offer health insurance coverage. However, only one in four consider offering health insurance coverage as having a major impact on employee recruitment.

In the national survey 70% or more of the small businesses responded that offering health insurance had no impact any of the five factors listed above. Generally, Delaware's small business owners were far less likely to agree with that assessment. That may reflect the tightness in Delaware's labor market over the past ten years. This chart coupled with Figure 4-2 could lead one to conclude that these businesses do see the

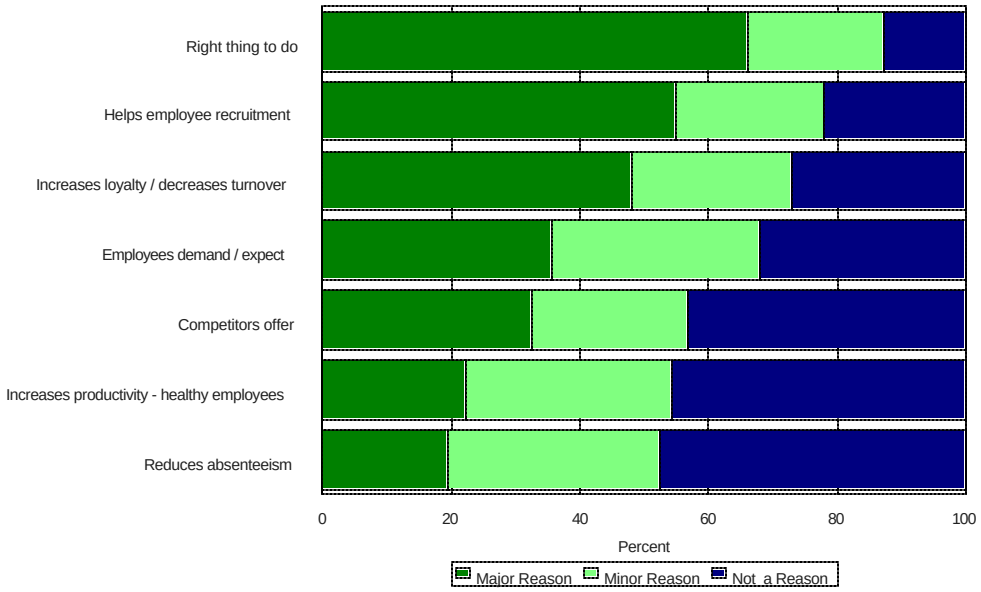
positive aspects of offering health coverage although with modest levels of intensity, but economic factors make this impossible for many of them.

Just as small businesses have reasons for not offering health insurance, others have reasons for doing so. In the figure below, the importance of seven different reasons for offering health insurance are evaluated.

Figure 4-4

Reasons for Offering Health Insurance

by Level of Importance



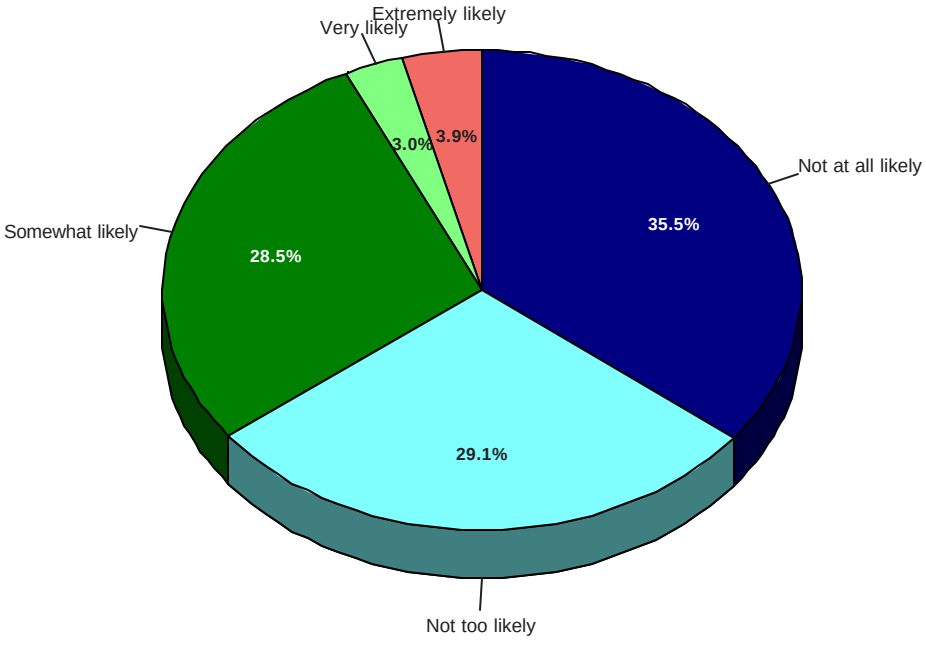
Source: Center for Applied Demography and Survey Research, University of Delaware

One of the interesting aspects of the information found in Figure 4-4, above, is the different level of intensity expressed by firms that have health plans in contrast to evaluations of the same or similar factors by firms that currently do not have health plans.

First, the fact that "it's the right thing to do" is the most important factor is in direct conflict with the level of obligation felt by business owners who currently do not offer coverage. Second, these firms rate recruitment and retention consistently higher in terms of the positive impact than the other firms rate the negative impact on the same items. Finally, while the ratings are lower for the remaining items, those without health plans consistently evaluated the items as even less important.

Figure 4-5

Likelihood that the Business Will Offer Health Insurance within Two Years



Source: Center for Applied Demography and Survey Research, University of Delaware

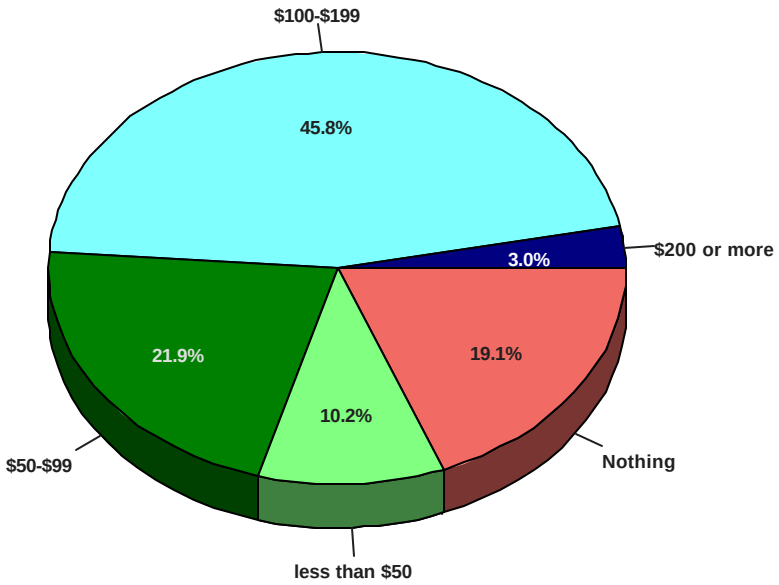
Among those businesses that do not currently offer health insurance coverage, 21% have offered coverage of some type in the last five years. That compares with 12% nationally. However, as can be seen in Figure 4-5 above, 65% effectively rule out starting a health plan for employees within the next two years. Approximately 13% of those that had previously offered coverage indicated that they are extremely likely or very likely to do so again. This compares with 5% of businesses that have never offered a health plan.

Perhaps one bright side of this data is that almost 44% of the businesses indicated that they have contacted someone about obtaining coverage. Presumably this means that the information received was not compelling enough to take the next step or that the cost was prohibitive. Once again, Delaware's businesses were more likely to have taken this step since only 31% of the national sample did so.

Figure 4-6

Amount the Business Would Be Willing to Pay

Per Month for Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

There is ample evidence provided in the survey that cost is one of the primary drivers in deciding whether or not to offer health insurance. In Figure 4-6 above, the amounts that employers would be willing to pay to cover their employees are shown. First of all, its important to note that two-thirds of the respondents could not or would not make an estimate as to the amount that they would be willing to pay. Thus, the chart refers only to those who would hazard an estimate. Overall, these data are similar to that derived from the national survey.

If a typical plan costs $2800, including both the employer and the employee shares, then about half of those responding would be willing to cover half of the annual cost for their employees. For the typical employee making $8 per hour in these businesses, the employee share amounts to a 10% reduction in pretax wages. In contrast, employees in firms that offer insurance typically earn 50% more or $12 per hour with a correspondingly lower proportional outlay in pretax wages.

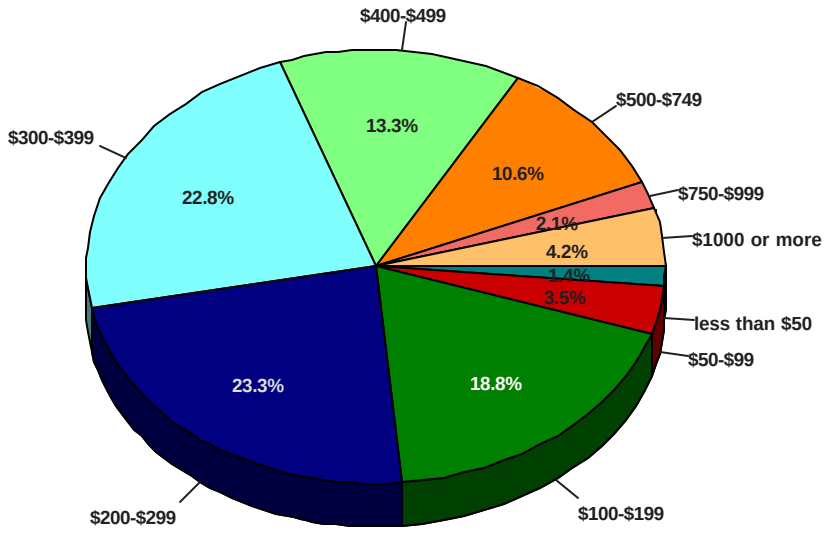
Just under half of these businesses that do not offer health insurance coverage have inquired about coverage in the past year. This would imply that they have some understanding of the costs of such a benefit. Respondents were asked about the cost of

typical health insurance coverage. In this case almost 70% could provide an estimate and those responses are found in Figure 4-7, below.

Figure 4-7

Amount that Health Insurance Would Cost

Monthly Per Employee



Source: Center for Applied Demography and Survey Research, University of Delaware

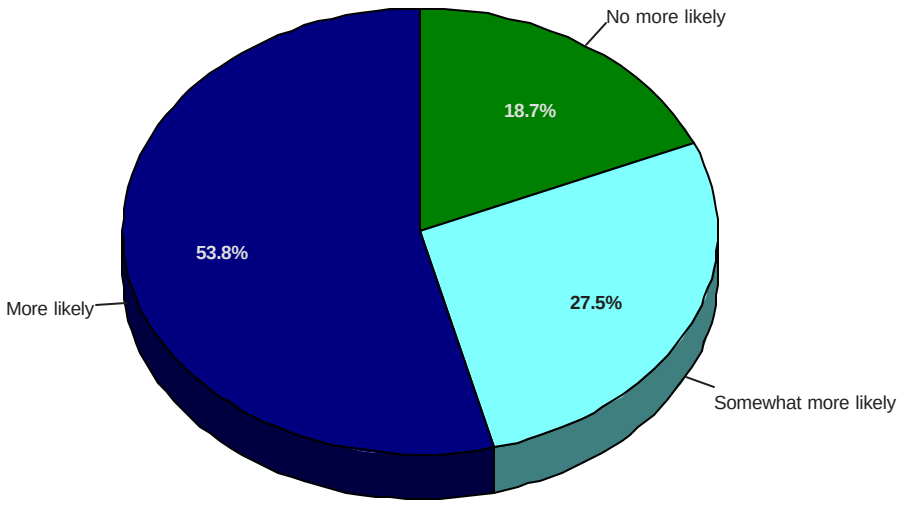
The first important aspect of this chart is that 53% of the businesses estimate costs $300 or above when the typical cost for employee and employer together is closer to $220 per month. In the national survey, only 33% of businesses provided estimates above the typical cost. It was also interesting to find that the accuracy of the estimate varied little between those that had recently asked about coverage and those that had not. It also might mean that businesses tend to get estimates on a high benefit plan as opposed to bare bones plan.

One conclusion that could be drawn as to why some businesses do not offer health insurance coverage is that they have not carefully reviewed the range of options that are

available. However, it also may be that the time cost of this search process is excessive so that many never even start the search until some motivating factor is in place e.g. a key employee or recruit is adamant.

Figure 4-8

Government Assistance Would Make the Business More Likely to Offer Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

One potential way to increase the probability that a business will offer health coverage is to offer incentives that reduce the economic cost of doing so. It also may make it possible to increase the employer share from 50% to 80% and thus increase the probability that a low wage employee will take the coverage.

In Figure 4-8 above, more than 80% of the businesses surveyed said that the likelihood of offering health insurance coverage would increase if there was an incentive.

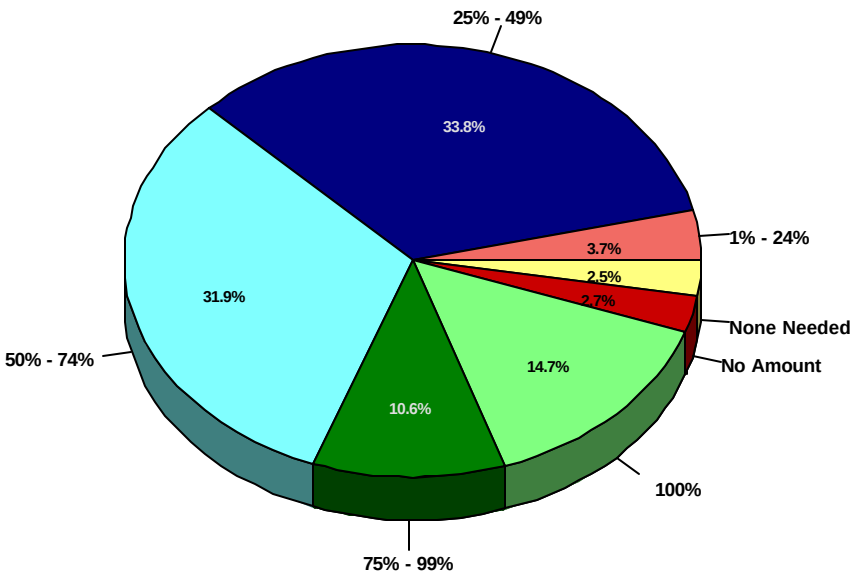
In the national survey only 64% fell into those two categories. However, the question remains as to how much an incentive (subsidy) would be required to make a measurable difference in the number of businesses offering coverage.

To add some reality to the question of what proportion the government should pay of the employers cost, respondents were asked for an estimate. Any time a survey question of this type is asked, one can safely assume the respondent will lean in the direction that favors their situation. This type of result is evident in Figure 4-9, below.

Figure 4-9

Percentage Government Would Have to Pay

for the Business to Offer Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

It is probably safe to say that government is highly unlikely to pay more than 50% of the cost of health insurance for small businesses like these given crowd-out issues and

the total cost. There are however programs where government has paid up to one-third of the total cost for selected employers in order to gain some participation and to bring the cost to employees within a reasonable range.

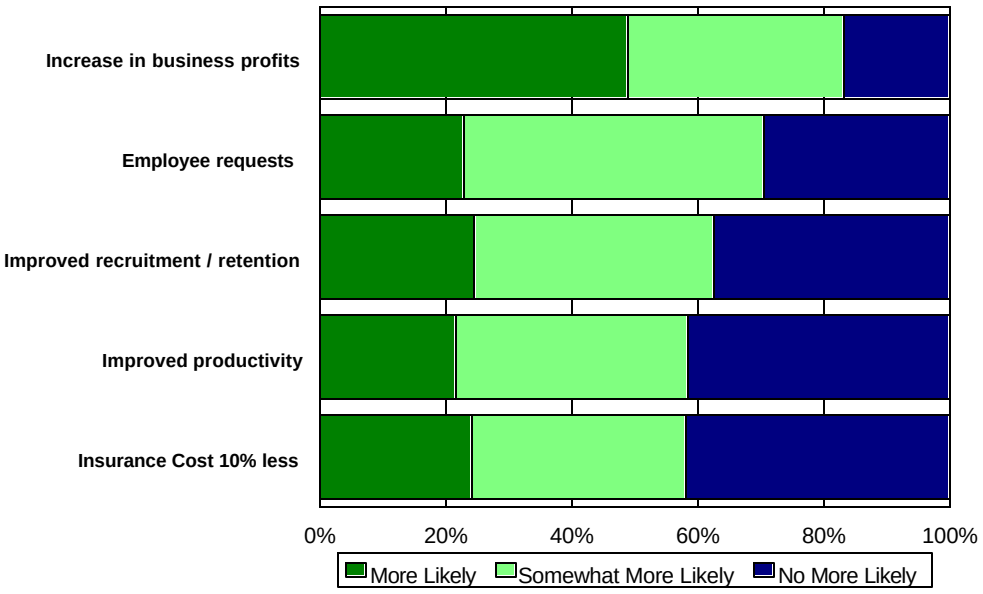
From the chart, one would say that about 40% of small businesses that do not currently offer health insurance might be influenced if the government would subsidize up to 50% of the premium. That suggests that only half of the original 80% (see Figure 4-7) who originally said they might offer health insurance with a subsidy, would actually receive a subsidy sufficient to commit to offering coverage. These estimates also correspond very closely to the national survey where 40% of the businesses providing an estimate expected a subsidy of less than 50%.

Most of the data examined thus far suggests that most of the small businesses that currently do not offer health insurance coverage may be difficult to convince to change their ways. The economic issues predominate and this is reflected in Figure 4-10 below.

Figure 4-10

Factors that Might Influence the

Likelihood of the Business Offering Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

These businesses were also asked what factors might be influential in changing their decision on offering health coverage. The responses were somewhat predictable. Any factor that touched the business bottom line in a positive way was seen in a favorable light.

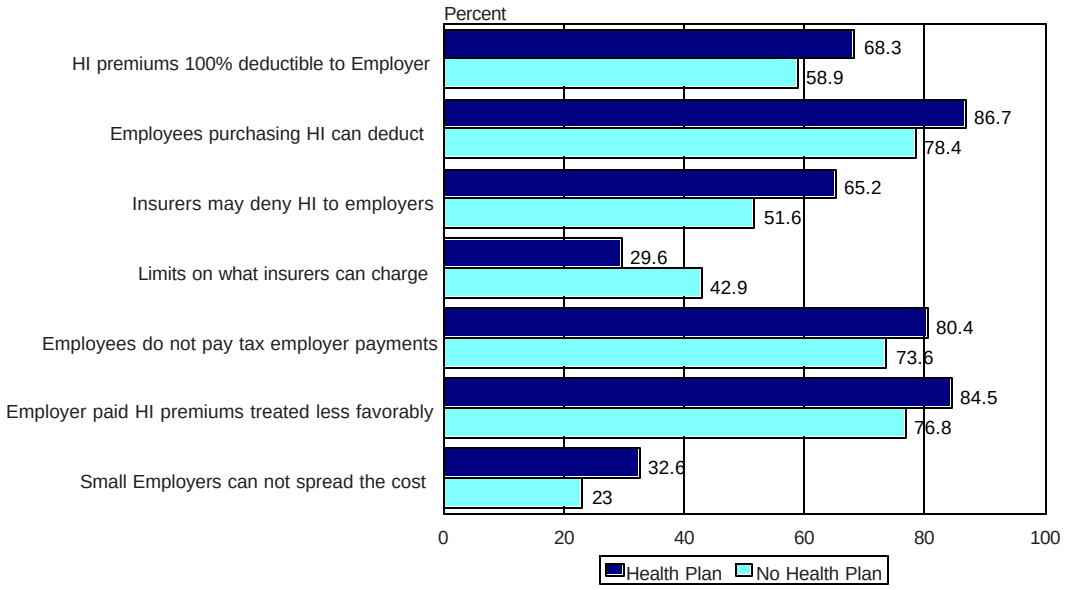
This discussion has only dealt with health insurance for the employee and does not address family coverage. Since family coverage averages three times the cost of covering an individual, it is unlikely that these businesses will take that path unless pressed by a key employee or forced by competition for workers. In addition, typical employee shares of the total cost of health insurance are closer to 15% than 50% for those businesses that currently offer the benefit. In short, it may be difficult to induce this group of employers and employees to

Finally, the question arises as to whether the firms that do not have health plans hold some misconceptions about the product and the process. There was some evidence presented earlier that is consistent with that view. To test this hypothesis a set of seven true-false questions dealing with health insurance were asked of both groups of firms. The results are displayed in Figure 4-11, below.

Figure 4-11

Percent Answering the Question Correctly

by Firm Health Plan Status



The full text of the questions asked were as follows:

1) Health Insurance premiums are 100% tax deductible to the employer (true);
2) Employees who purchase health insurance on their own generally can deduct 100% of their health insurance premiums for federal income tax (false).
3) Insurers may deny health insurance coverage to employers with 2 to 50 employees due to health status (false).
4) There are limits on what insurers can charge employers with sick workers (true).
5) Employees do not pay tax on the share of their premiums that are paid by their employer (true).
6) Employer paid health insurance premiums are treated less favorably than general business expense with regard to taxes (false).
7) Small employers cannot spread the cost of sick employees across a large pool of workers (false).

On six of the seven questions, those firms with health plans answered correctly more often although the differences were not large. Probably the single most startling result is the fact that neither group did very well on the first question dealing with the deductibility of employer paid health insurance premiums.

OBSERVATIONS

This investigation of health insurance coverage among Delaware's employers with particular emphasis on the small employer has been revealing. During the survey, it was very clear that this topic was on the minds of small employers whether they currently had a health plan or not. They responded at rates much higher than experienced previously in this state and at substantially higher rates than in the national study. In addition, a significant number of employers provided written comments detailing their concerns about the health insurance problems with which they are faced. The information presented here coupled with other data not detailed suggests that solving the lack of employer paid health insurance among smaller firms will not be easy.

- If the sample of small employers that do not currently have health plans had looked like a random sample drawn from all small employers it might have been concluded that the problem was manageable. However those that do not have health plans are not like those that do.

- Small employers that do not have health plans are generally smaller than those that currently have them.

- Small employers that do not have health plans have significantly more part-time workers who rarely qualify for health benefits even when working for employers that have health plans.

- Both salaries and hourly wages are lower in those firms that do not currently offer health plans. This suggests that those businesses would be paying disproportionate amounts for of the total cost of employment if they offered health care benefits. In addition, workers faced with perhaps paying 50% of the cost would find that an unacceptable reduction in take-home pay.

- Small employers that do not have health plans tend to have higher turnover rates than in those firms that have them. This is not unusual given the concentration of part-time jobs. It is also likely that firms with higher turnover rates would have tried to reduce them by paying higher rates of pay and benefits if it was to their economic advantage. In other words if the costs of turnover were less than the cure, they will not take the cure.

- Small employers that do not have health plans seem to understand the basics of health plans as well as those that currently have them. They also seem to periodically check in with insurers to see if there might be a plan for them. Thus, the provision of additional information is likely to have a positive but small effect on these employers.

- Small employers without health plans see less positive benefit coming from providing health coverage. Issues such as recruitment, retention, productivity, and absenteeism do not register anywhere as near as high on the scale as they do for those that already have plans.

- While small employers overestimate the true cost of a health plan, the amount that they are willing to contribute is probably insufficient to make a standard plan viable. In addition the amount they would expect the government to subsidize is also probably unrealistic.

- If a significant proportion of these small employers without health plans are to change their position, it will take a multi-pronged approach of improved information, government subsidies, limited benefit plans, and other innovative approaches to make it happen.

APPENDIX D:

COST AND TAKE-UP RATE ESTIMATES PER OPTION

LIMITED BENEFIT PLAN ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS)

Number Eligible	12,700
Number Taking Up	5,000 – 7,000
Percent Taking Up	40% - 60%
Annual Total Cost (millions)	$2.0 - $4.2
Annual State Cost (millions)	$2.0 - $4.2
Per Capita Cost	$400 - $570
State Cost per Newly Covered Person	$400 - $570
Funding by Source (%)	
Contribution by Insured Individual	0%
Contribution by Employer	0%
Federal Share	0%
State Share	100%

ONE-THIRD SHARE PLAN ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS)

Number Eligible	7,400
Number Taking Up	800 – 1,200
Percent Taking Up	11% - 15%
Annual Total Cost (millions)	$1.5 - $2.2
Annual State Cost (millions)	$0.5 - $0.7
Per Capita Cost	$1,800
State Cost per Newly Covered Person	$600
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

S-CHIP EXPANSION ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), ASSUMING NO CROWD-OUT EFFECTS

Number Eligible	16,500
Number Taking Up	2,900 – 7,700
Percent Taking Up	18% - 46%
Annual Total Cost (millions)	$1.5 - $2.2
Annual State Cost (millions)	$1.2 - $4.7
Per Capita Cost	$1,200 - $1,700
State Cost per Newly Covered Person	$430 - $610
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

S-CHIP EXPANSION ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH CROWD-OUT EFFECTS INCLUDED

Number Eligible	42,400
Number Taking Up	4,800 – 12,000
Percent Taking Up	11% - 29%
Annual Total Cost (millions)	$6 – $21.7
Annual State Cost (millions)	$2 - $7.5
Per Capita Cost	$1,250 - $1,800
State Cost per Newly Covered Person	$440 - $625
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

SUBSIDIZED PURCHASING POOL ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH STATE ABSORBING ALL ADVERSE SELECTION COSTS AND EMPLOYER AND EMPLOYEES SHARING EQUALLY IN THE PREMIUM

Number Eligible	46,700
Number Taking Up	13,300 – 18,800
Percent Taking Up	29% - 40%
Annual Total Cost (millions)	$28.7 - $57.8
Annual State Cost (millions)	Less than $1- $16.6
Per Capita Cost	$2,150-$3,100
State Cost per Newly Covered Person	$100 - $880
Funding by Source (%)	
Contribution by Insured Individuals	81% - 58%*
Contribution by Employer	13% - 19%
Federal Share	0%
State Share	1% - 29%

*Although the employee share is 50 percent when those signing up are part of an employer-sponsored plan, individuals enrolling on their own would pay 100 percent of the cost. Since the estimates assume large numbers of such individuals opt for this plan, the insured individuals' share averages well above 50 percent.

SUBSIDIZED PURCHASING POOL ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH STATE ABSORBING 50 PERCENT OF ADVERSE SELECTION COSTS AND WITH REMAINDER OF PREMIUM BEING SHARED EQUALLY BY STATE, EMPLOYER, AND EMPLOYEE (ONE-THIRD EACH)

Number Eligible	46,700
Number Taking Up	14,500 – 20,500
Percent Taking Up	31% - 44%
Annual Total Cost (millions)	$31.4 - $63.3
Annual State Cost (millions)	$10.4- $24.3
Per Capita Cost	$2,150-$3,100
State Cost per Newly Covered Person	$700 - $1,200
Funding by Source (%)	
Contribution by Insured Individuals	56% - 61%*
Contribution by Employer	6%
Federal Share	0%
State Share	33% - 38%

*Although the employee share is one-third when those signing up are part of an employer-sponsored plan, individuals enrolling on their own would pay two-thirds of the cost. Since the estimates assume large numbers of such individuals opt for this plan, the insured individuals' share averages well above one-third.

APPENDIX E:

ACTUARIAL ANALYSIS OF OPTIONS

XXXVI. Actuarial Model Methodology

The discussion that follows explains the methodology used to develop actuarial estimates of the number of people covered and the cost for each of the options analyzed for the State of Delaware.

Developing the Sample Population

The first step in setting up the model was the development of a sample population of all the individuals residing in the State of Delaware. Delaware has about 552,402 adults and 225,886 kids. We utilized data supplied by the University of Delaware's Center for Applied Demography & Survey Research for this sample population.

The sample population was representative of the socio-economic characteristics of the Delaware population. Each record representing the population contains very detailed information. Our sample file has about 7,742 adult records and 2,725 child records. Each of these adult records represents approximately 71 adults and each child record represents approximately 83 children in the State with almost identical profiles.

Setting Take-up Rates

The next step in setting up the model was to set up our take-up rate tables. Each of our take–up rate tables is a range of numbers between 0 and 1.0 that represent the probability that an individual with certain characteristics will apply for and accept coverage under a specific program option. The take-up rate tables vary by age, sex, income-level, family size and plan type (Medicaid extension, SCHIP extension, employer subsidized plan, subsidized purchasing pool). Initially, we developed these tables based upon Delaware's take-up experience with other state programs, take-up rates for employer provided coverage, take-up experience for the State employee benefit plan and our experience with programs in other states.

Setting Baseline Cost Rates

We also determined a table of baseline cost rates per adult and child for each program. Similar to the baseline take-up rates, the baseline cost rates vary by age, sex, and plan type. We developed the cost rates using the program expenditures for other state-run health programs in Delaware, claims experience from the State of Delaware employee benefit program, cost surveys for employer-provided health benefit programs, information available for the private non-group markets and our knowledge of other state health programs. All costs are based on 2000 experience. They can be adjusted to 2002 with trend rates that reflect the change in costs. We also developed a set of plan design adjustment factors to adjust for the difference between the plan designs underlying the available claims experience and the plan designs outlined in the program options.

Besides considering the specific characteristics of the sample record, the program eligibility provisions are also considered when assigning the baseline take-up rate. For example, if the program targets individuals with income below 300% of the federal

poverty level (FPL), the model will assign a take-up rate of zero to any individual on the sample file with income above 300% of FPL.

Adjusting for Specific Parameters

The next step of the model is a series of parameter adjustments that modify the baseline take-up rates and the cost rates for a specific record. These adjustment factors are for specific parameters that are not recognized in the development of the baseline take-up rates or baseline costs. For example, the take-up rates are adjusted for the level of individual cost sharing required under the program option—higher cost sharing would reduce take-up rates. Other adjustments for the baseline take-up rates include: employment status, insured or uninsured status, outreach/communication programs, and employer size. Adjustments for the baseline costs include: adverse selection/pent-up demand, county where the individual resides, health status, trend and minimum participation requirements.

Consolidating the Model

Finally, all of the pieces described above are consolidated in our model. Our model selects one sample person record, determines the baseline take-up and cost rates for that record, adjusts for the program eligibility provisions and specific parameters and then multiplies the components to produce an expected cost. The formula below summarizes this process:

(Baseline take-up rate varying by age, sex, income level, family size and plan type)
x
(Baseline cost rate per person varying by age, sex, and plan type)
x
(Adjustment factors to baseline take-up and cost rates including eligibility provisions and specific parameters)

= (Expected cost of the program for a sample record)

The model repeats this calculation for each record. Results are saved and accumulated for all of the records. Individuals' contributions to the cost of the program, if any, are also accumulated. The accumulated results from the sample records are then projected to those for the entire population by using the corresponding adult and child population weights. These results are then summarized in exhibits produced by the model.

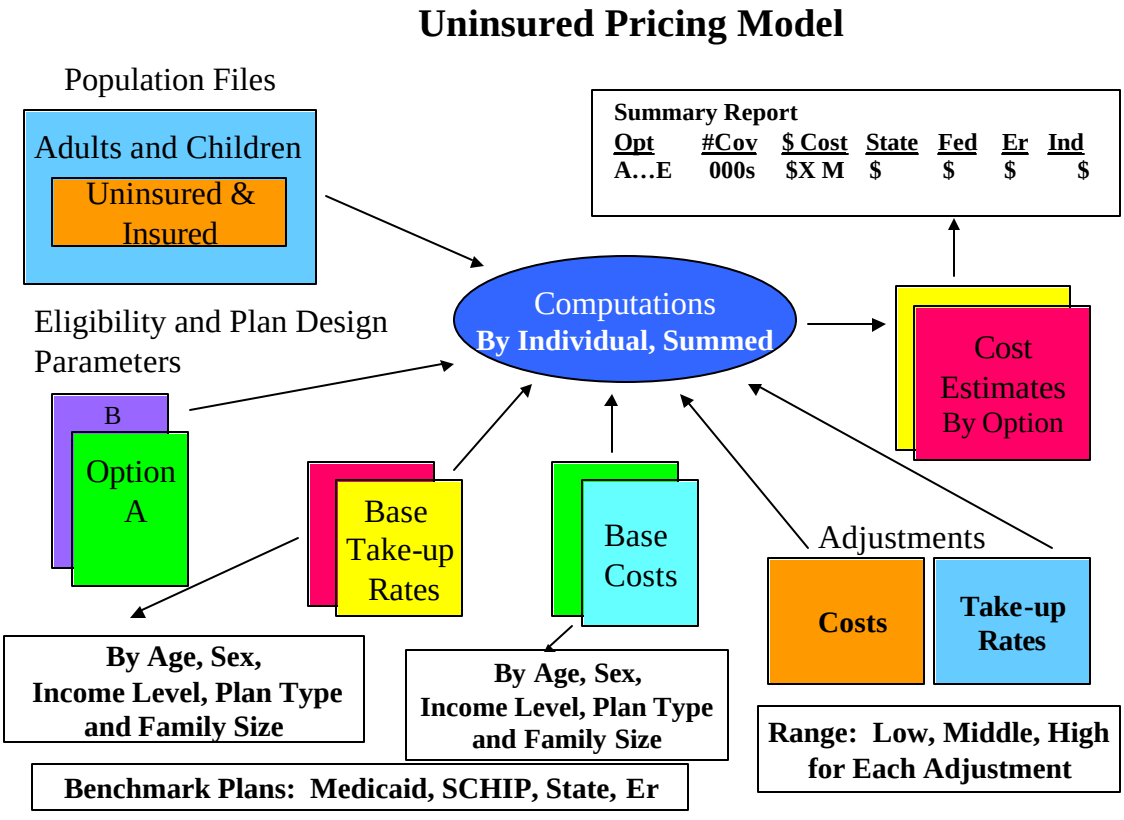
Some of the participants in the model may be assigned a take-up probability for a program option even though they are already covered by another health plan. We defined these individuals as "crowd-out" participants. The model separately accumulates results for crowd-out participants, which allows us to properly measure the *net* reduction in the number of uninsured individuals.

Assigning Range Variations

Rather than arriving at a single estimate of the effect of an option in terms of the number of people covered and the cost of the option, we provide an estimate range. The model does this by assigning a range of variation to each specific parameter adjustment we employ in the calculation process. These ranges are based upon our judgments concerning the consistency and credibility of the underlying source data used to develop the baseline take-up rate, baseline costs and parameter adjustment factor. Using the cumulative effects of these ranges, high and low range estimates for each midpoint results are produced in the final exhibits.

This model provides a consistent and reliable methodology for measuring the cost implications of the various program options. It meets the challenge of managing a complicated array of participant characteristics, program eligibility provisions, actuarial benefit plan values and claim cost expectations.

The following graphic displays the model in its current configuration:



APPENDIX F:

POLICY FORUMS

POLICY FORUMS

February 2001

- An explanation of the Commission's Uninsured Action Plan; state planning and service delivery initiatives (CAP).
- Remarks from the Governor and Lt. Governor
- A profile of the state's uninsured population
- A description of the information gathering process to include research, focus group, survey, travel, and future stakeholder session methodologies.
- Presentation by the State Coverage Initiatives Program on state/federal experience.
- Public Dialogue

Approximately three hundred invitations were issued and approximately 80 individuals attended. (Delaware's first major snowstorm of the season unfortunately struck on this day closing schools early throughout the state and impacting our attendance.)

Issues Raised by stakeholders at the event included:

- Part of the planning dialogue should contain discussion of a "single payer system"
- What is underinsurance?
- Pre-existing conditions such as mental health illness should be regarded in planning.
- How will undocumented citizens be regarded in the planning process?
- View the problem from the financial perspective of individuals.
- Recognition that change is incremental and that cultivating public/private partnerships is imperative.
- Create a "suggestion box" web-based tool".
- Any indication of financial support for community screening and disease prevention programs?
- Need to draw conclusions about the adequacy of marketplace competition.

These considerations have been addressed to the extent possible as opportunities have allowed through not only the State Planning activity but also the Community Access Program implementation. Based on feedback obtained at the health policy conference, eligibility for CAP participation includes undocumented citizens who fall within established income guidelines, the issue of underinsurance is being addressed at least for adults between 100 and 200% of the federal poverty level, health status is being collected on all enrollees as a means of introducing applicable disease management protocols.

June 2001

- Report updated numbers from the University of Delaware
- Employer Survey response highlights
- Define guiding principles
- Pros/Cons and preliminary costs of a wide range of options
- Discard options that are clearly not feasible
- Method for gaining input

The June health policy conference was critical for gaining input from key stakeholders. A technological vendor who utilized an "audience response system" of polling was secured and conference participants "voted" on a number of issues throughout the day, including guiding principles, target populations, and options. Voting results indicated concurrence on guiding principles, priority towards addressing the low income population first and other populations incrementally thereafter, and, interestingly, nearly level interest in all options. The single option that scored slightly higher than the others was SCHIP expansion to parents.

September 2001

- Provide research findings
- Discuss the importance of the safety net
- What other states are doing presentation by the Academy
- Recommendations for path forward

The September conference invitation was extended to over 400 individuals and was intended to serve as an unveiling of our findings and recommended path forward. Plans were not to use electronic polling devices but have an extended question and answer period utilizing both microphones and index cards. A panel of state and national experts would respond to questions. An important aspect of the September event was drawing further attention to the critical role played by the safety net, and highlighting the critical role it has played in successfully implementing the Delaware Community Healthcare Access Program.

National events occurring in September precluded our ability to gather a final round of input and continue this collaborative process.