Lessons from the HRSA State Planning Grant Program

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Background

The Health Resources and Services Administration (HRSA) state planning grants (SPG) program was an important resource to states and U.S. territories looking to develop strategies to improve insurance coverage in their states. The program provided funding to enable states to collect and analyze data on the characteristics of their uninsured populations and health care markets, to support community and stakeholder involvement in the planning process, and to identify and develop comprehensive options for reducing the number of uninsured. The program also sought to address states' need for financial support as they explored the feasibility of different solutions and programs to target the complex needs of uninsured populations.

From 2000 to 2005, the SPG program awarded grants to 47 states, the District of Columbia, and four territories, with Alaska receiving the last planning grant under the program in 2005. These pilot grants provided funds to states that had already developed policy options and needed assistance in conducting further work and implementing proposals they had developed under their SPG grants.

Initially funded by Congress at $15 million, the SPG program dispersed almost $76 million in funds over its five year lifecycle. As a complement to the SPG program, starting in 2004, HRSA's Pilot Planning Grant Program awarded pilot grants of nearly $8 million to 19 states and one territory. The federal FY 2006 budget eliminated funding for the SPG program.

With relatively modest funding, the SPG program had an ambitious agenda to assist states in: a) collecting and analyzing data; b) devising options that would meet the varied needs of the uninsured; and c) working with key constituency groups and the public to reach consensus on viable insurance expansions options. Was the SPG program worth the investment? Were the milestones reached and programs developed sufficient achievement, or did the program fall short of its ambitious goal to increase health coverage within each grantee state? This brief provides a response to these questions by profiling the activities of SPG states across several important activities: data collection, option development, and consensus building.

Four elements are necessary to affect change in the health policy arena: 1) leadership; 2) political will; 3) financing; and 4) technical and organizational structures. The SPG program undoubtedly addressed and bolstered the technical and organization backbone of participating states. As a result of their grants, many states improved their analytic capabilities and increased their abilities to support policy discussions.

It is also important to note that SPG funding was just one component or building block used by states in their efforts to address the needs of the uninsured. Other factors played key roles, including for each state's own individual fiscal health, political situation, stakeholder interests, market dynamics, and previous reform efforts.

The SPG program resulted in numerous outcomes—bills passed in state legislatures, policy options that were implemented, and decreases in the number of uninsured. More importantly however, the program, in many cases, fostered consensus building and policy development efforts at the state level. These effects are difficult to measure and quantify but have had a lasting impact on many states' community building, their inter-agency interaction, their health policy environments, and ultimately, their ability to meet the needs of uninsured residents.

The SPG program provided essential resources for states to focus on the needs of the uninsured and served as a valuable catalyst for the policy process. For many states, the program's legacy was to create a self-sustaining process for educating and engaging stakeholders to work together to tackle the complex challenges of a growing uninsured population. Furthermore, the program created unparalleled opportunities for states to learn from one another, and for states to share those lessons with the federal government.

State Policy Environments

Over the five year lifespan of the SPG program, states experienced environmental and financial challenges, as well as competing budget priorities that affected their capacity to expand coverage under the SPG program. The states' economic climate in 1999 and 2000, when the SPG program was conceived, was far more positive, with many states experiencing budget surpluses. By the time the SPG program began, states had entered into a period of harsh financial conditions, in the wake of the September 2001 terrorist attacks when state economies and budgets were hit hard by recession. States faced budget shortfalls of $38 billion forcing a reduction in their previously enacted fiscal 2001 budgets by about $1.9 billion. At the same time states were being forced to take drastic cost cutting measures, rapid growth in state Medicaid programs and health care costs continued to exert enormous pressure on state budgets.

The consequences of the economic downturn that began in 2001 remained palpable over the following few years, with states facing persistent budget shortfalls, continued unemployment, a slow recovery in tax revenues, and growing financial responsibilities. As a result, budgets ultimately dictated what states could accomplish. Many states readjusted their focus and applied their SPG funds toward maintaining coverage—making the best use of their existing infrastructure and resources for coverage—and modest expansions. By 2005, the last year of the SPG program, financial conditions appeared to be improving for many, but not all, states.

In order to develop their plans for covering the uninsured, states first devoted considerable energy and resources to gaining an in-depth understanding of their health care marketplaces as well as an understanding other states' coverage expansion efforts. As states undertook this work, a number of common issues emerged—issues that would have profound effects on states' policy deliberations. At the time the data were collected, states were just starting to get a more detailed understanding of what was happening in within their own borders.

- **High rates of uninsured and poor health status of uninsured.** States reported that their uninsured populations relied on safety net services, and many receive care in emergency rooms. The uninsured experienced problems in accessing primary care, pharmacy, dental, and vision benefits. Not surprisingly, many states reported lower health status for the uninsured than for their insured counterparts. States found that this situation is compounded by the feeling of stigma associated with using public programs and lack of awareness of public programs.

- **Strained health care infrastructures.** Population growth and a large undocumented immigrant population strained the health care infrastructure in several states, resulting in treatment delays in area hospitals. A number of states described workforce shortages that affected resources available for the uninsured to receive health care services other than in the emergency room.

- **Premium cost increases and cost shifting.** Many states reported that insurance cost increases—as much as 10 to 20 percent annual premium increases in Arizona for example—resulted in either significant cost shifting (both in terms of premium contributions and out-of-pocket costs) to employees or less affordable coverage options. Combined with already high unemployment rates, these factors contributed to a growing number of uninsured in many states.

- **Contraction in group health insurance coverage.** The majority of states reported declines in group health coverage, particularly among small employers with fewer than 50 employees in low-wage jobs. Many uninsured workers were employed at small businesses that are less likely to offer health benefits. North Carolina found that more than half of its uninsured workers (52.8 percent) worked for small businesses with fewer than 25 employees. This issue is of particular concern in those states where small employers make up a sizeable proportion of the employer base. In Indiana, for example, small employers with fewer than 50 workers represent nearly half of all Indiana businesses. In Maine, 38 percent of employees in very small businesses with 10 or fewer workers were uninsured at least part of the year for which the state conducted a household survey.

- **Persistent access barriers in rural areas.** Several states reported persistent barriers in improving access to rural health care services, including lack of providers, geographic isolation, and poor hospital solvency. In Arizona, the Statewide Health Care Insurance Plan Task Force expressed concern about the impact of workforce shortages on that state's "already fragile rural health care infrastructure and the affordability and accessibility of coverage options for rural residents—a group considered to be at increased risk for higher rates of uninsurance compared to their urban counterparts."[1]

- **Growth in self-insured employers.** Across the board, states reported an increase in the number of employers choosing to self insure rather than purchase fully insured coverage options from health plans. The Employment Retirement Income Security Act of 1974 (ERISA) allows these employers to be exempted from certain state regulatory requirements.

Policy Approaches Pursued by SPG States

While it is difficult to summarize the multitude of efforts undertaken with SPG planning grant funds, the policies implemented by states fall into the following categories:

- Medicaid/SCHIP Expansions
- Group purchasing arrangements
- Limited/bare bones benefit design
- Premium Assistance
- High Risk Pools
- Outreach to eligible but not enrolled
- Safety net strategies
- Tax credits for individuals/employers
- Employer mandates—"fair share"
- Individual mandates

SPG grants served as one of the catalysts for innovative state health coverage reforms, including Maine's Dirigo Health Reform, Massachusetts's Health Care Reform Plan, Pennsylvania's Covering All Pennsylvanians proposal, Vermont's Catamount Health, and Utah's Primary Care Network. While these high profile reforms are well known in policy circles, the SPG program spurred countless other reforms and innovations, lessons from which need to reach a broader audience. Examples of these reforms include the following.

- **Arizona** expanded accessible and affordable coverage to the uninsured by enhancing one component of the state's continuum of health coverage options, Healthcare Group (HCG) of Arizona, a state-sponsored insurance program for small businesses. HCG operates a reinsured product for small business, the self employed, and political subdivisions. In 2006, HCG expanded benefit package choices, creating a statewide Preferred Point of Service product and adding dental and vision benefits.

- **Idaho** launched its Access Card program, which offers premium assistance to adults whose gross annual income is below 185 percent of the federal poverty level (FPL) and who are employed by an Idaho small business, or who are the spouse of an employee. The program is capped at 1,000 adults; it began enrollment in July 2005. As of fall 2006, approximately 300 adults were enrolled in the program.

- Funded by the state's SPG pilot grant, the **Illinois** Division of Insurance assisted with the development of two pilot community "three-share" programs for St. Clair County and a program for Jackson, Franklin and Williamson Counties. The product is designed for low-wage, small businesses (2-50 employees) that currently do not offer insurance. These programs intend to begin enrollment once a stable community subsidy is in place.

- **Missouri** modeled several employer-based coverage options that would expand affordable health insurance options for small businesses, and developed a detailed proposal for executive and legislative consideration. Almost half of Missouri's total small business employees, more than 300,000 individuals, work at firms that do not offer health insurance.[2] The state legislature is now considering a bill that would allow a buy-in option to the Missouri Consolidated Health Care Plan, the state public employee health care agency, for small employers with fewer than 50 workers.

- Three new community health centers were funded following the inception of **Montana's** State Planning Grant.

- In September 2005, the Centers for Medicaid and Medicare Services (CMS) approved the **Oklahoma** Employer/Employee Partnership for Insurance Coverage (O-EPIC) under the Health Insurance Flexibility and Accountability (HIFA) waiver initiative. The program was originally implemented to target residents with incomes at or below 185 percent FPL. The program also covers workers and their spouses, who work in firms with 50 or fewer workers and contribute up to 15 percent of premium costs;

self-employed; and unemployed individuals currently seeking work. In 2007, the legislature increased the eligibility levels to 200 percent FPL and renamed the program Insure Oklahoma. As of fall 2007, enrollment reached 4,349.

- In 2005, **Oregon** was awarded a HRSA pilot planning project grant to prepare for further expansions as the state faced renewal of its 1115 and HIFA Waivers. Oregon undertook a careful assessment of sustainable approaches for covering more children and non-categorical adults in existing public programs. In April 2006, Oregon received approval for two more demonstration amendments. The state was allowed to extend the eligibility period for SCHIP from 6 months to 12 months. In addition, the state was allowed to amend the premium policy for individuals enrolled in the Oregon Health Plan (OHP) Standard by exempting from the premium requirement those with incomes at or below 100 percent FPL and by eliminating the six month lock-out for nonpayment of premiums for those with incomes above 10 percent FPL. These demonstration amendments went into effect in June 2006.

- As part of **Rhode Island's** grant activities, the state sought methods to enable Rhode Island businesses to continue offering health insurance coverage. An increasing number of businesses with fewer than 50 workers reported volatile rate increases and difficulty in obtaining or maintaining coverage options for their employees. As a result of these trends, staff at the state's Department of Human Services prepared a legislative package to address these problems. As of October 2007, small businesses in Rhode Island have a new, lower-premium option to provide health insurance coverage to their employees—HealthPact RI plans.

- **Washington** received an SPG grant in 2001 and a pilot planning grant in 2005. In 2007, the state enacted significant health reform legislation. The technical assistance and resources provided by the SPG program provided an important foundation for the reforms enacted by this legislation, which include an initiative to cover all kids by 2010, premium subsidies for low-income families, and a Massachusetts-style Connector.

- After **West Virginia** presented comprehensive data on the state's uninsured from its SPG funded state-level household survey, the state's leading newspaper ran a 15-week series on the uninsured. The state commented that public reporting of this information contributed to passage of three pieces of legislation in 2004 that expanded public and private health care coverage options in the state.

Lessons Learned from the SPG States

Capturing the experiences and lessons learned of the grantee states was one of the major goals of the SPG program. States shared lessons in three major areas:

- Data collection and research;
- Planning process; and
- Organization and operations of health care programs.

These observations and lessons are of benefit both to other states as they seek approaches for successfully expanding coverage to underinsured populations, and to federal agencies as they search for the best means of assisting states in these efforts.

Lessons—Data Collection and Research

The majority of states used their SPG resources to undertake extensive collection of both quantitative and qualitative data. These data were critical to states' consensus building process and examination of potential strategies for expanding coverage. Appendix 2 provides an overview of national data sources, and their strengths and weaknesses. In many instances, grantees reported that their local data collection efforts helped overturn myths and misconceptions regarding the uninsured in their states.

- **Analysis of state-specific data critical**. State-specific data were critical to the decision-making process, enabling states to determine those populations or subgroups for which erosion in the availability of employer-sponsored health insurance was occurring. Many states concluded that the federal Current Population Survey (CPS) data did not provide sufficient detail to support development of tailored reform options. State-specific data collected by grantees helped move discussions from the anecdotal to more substantive issues. Indiana commented that their market analysis and study of cost drivers will likely be the "legacy" of the SPG program.

- **Qualitative information also important**. Many states found that qualitative data collection—employer focus groups, for example—was critical in augmenting findings from quantitative data collection. States often "road tested" different policy options among stakeholder groups. Collecting this qualitative information, particularly from stakeholder interviews, was useful in gauging stakeholder priorities. It also allowed states to provide a more personal, human perspective to complement the large amounts of quantitative data.

- **Learn from the experiences of other states**. Information on the experiences of other states proved invaluable, allowing political leaders to understand which approaches had proven effective in other states, and which had not. Many SPG grantees carefully examined these experiences—both the failures and the successes—in considering the feasibility of any given policy option. This step was also critical to consensus building, often providing a sense of assurance to key stakeholder groups, particularly legislators.

Lessons—Planning Process

The planning process proved complex for many grantees, particularly given the involvement of large numbers of stakeholders to achieve a difficult task. As a result, states have many lessons to share from the process by which they developed consensus and considered strategies for expanding access to health insurance. While the planning process varied from state to state, the lessons that states offered are remarkably similar and reflected several common concerns including: involving a diverse group of stakeholders in an effective process, ensuring effective inter-agency communication and cooperation, and providing a meaningful approach to gaining public input.

- **Involve diverse stakeholders**. Successful efforts need the involvement of a diverse community of stakeholders, from both the public and private sectors. Rhode Island learned the importance of including insurers in the process for their business perspective, market research capability, and experience in developing affordable products for

small businesses. Florida commented on the importance of including county health officials and community health center representatives early in the planning process. Idaho remarked on the necessity of including local chambers of commerce and industry groups throughout the states to ensure their sense of ownership in the process and outcome. Other states pointed out that the needs of large, medium, and small employers are quite different.

- **Communicate across state agencies**. State agencies need to communicate and cooperate with each other. For some states, the "silos" of state government proved a barrier at the outset. Creation of a collaborative cross-agency group to guide the planning process helped overcome these barriers. States found it important to educate and include any and all state agencies which may be "touched" by problems related to the uninsured or proposed solutions.

- **Executive branch support.** A myriad of factors affected whether the SPG projects had visibility, political support, and access to high-level policymakers through the duration of the grant. Some of these factors, of course, are intangible and very difficult to measure, particularly when they are influenced by politics. Likewise, while there is interest in showing the relationship between the "success" of the programs and where they were housed, it is a difficult correlation to prove. Nonetheless, it does appear that the closer projects were housed to the governors' offices, the more they garnered political support. It appears to be the case for the inverse, as well.

- **Include the public in a meaningful way.** The public must be included in the reform debate in a meaningful way; it can't just be an "insiders' game" where public officials and stakeholders argue about options. Outreach and education of the public can increase understanding and support for reforms, as well as ensure adequate input from citizens.

- **Identify champions and rely upon them**. Many states found it helpful to have a champion who would push for reform and spearhead the consensus-building process. Oregon urged other states to "work with your critics and respect them" noting that reform efforts will gain more credibility with taxpayers if this step is taken.

- **Examine past reform efforts for lessons learned**. States learned that it is important to carefully evaluate previous attempts at reform within their own states and from observing the experiences of other states.

- **Public-private partnerships are critical but challenging**. Connections between public and private approaches are essential; however, they can be particularly challenging, often requiring a profound amount of persistence.

Lessons—Organization and Operations of Health Care Programs

Although the primary goal of the SPG program was to aid states in their development of health coverage strategies, one of the other hallmarks of the program was the insight it gave states on what is needed to affect real change in policy. For many states, the completion of the HRSA SPG goals within the required timeframe stretched their resources and posed significant challenges in terms of defining and accomplishing the task.

- **Make incremental changes over time.** The political and fiscal realities faced by many states made broad-based reform unlikely. Oregon commented that health care coverage expansions compete with "other health issues including, including mental health reform, broad based social needs of children, the need for improved reimbursement for current providers, and access problems." As a result, many states found that changes in coverage strategy needed to be incremental in order to gain the necessary buy-in from stakeholders. Some recommended that states should consider a multi-year phase in, rather than tackling the entire problem of the uninsured all at once. A common refrain heard from states was 'be realistic about what one can accomplish in a year—everything takes longer than expected.'

- **Coverage is a shared responsibility.** Successful initiatives exhibited the belief that coverage is a shared responsibility with involvement and commitment from individuals, employers, providers, health plans, and government.

- **Tie expansions to cost containment and quality assurance.** States found that tying access expansions to both cost containment measures and quality enhancements is critical not only to the political acceptability of reform proposals but also to the sustainability of reforms. In the past, political will to subsidize affordable insurance products for low-income citizens has dissipated when cost pressures increase. Many states found that, while employers understand the burden of uncompensated care, efforts to expand coverage must be linked to initiatives designed to reign in health care cost increases.

- **Be ready with alternative policy approaches.** Given that the policy process is dynamic, it is important that coverage models are fluid and alternatives can be generated quickly.

Conclusion

Over the past few years, the momentum among states to address the uninsured has continued to build. The reason for continued efforts are two-fold: the successful enactment of reforms in several states in 2006 raised expectations for progress while, as in previous years, the growth in the number of uninsured, rising health care costs, declining employer-sponsored insurance, and lack of response at the federal level have left states with no choice but to address health care reform themselves. It remains to be seen whether federal action on the uninsured will occur with a new federal administration. In the meantime, policymakers are looking to states to pioneer new models to address the growing number uninsured. By offering critical resources to explore policy options, the SPG program made an important contribution to many states in their ability to develop these innovative solutions.

About the Project

AcademyHealth served as the contractor for the SPG program. AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health research and policy. For more information about the SPG program please visit http://www.statecoverage.org/node/975.

Endnotes

1 "Arizona State Planning Grant Final Report to the Secretary", prepared by the Arizona Health Care Cost Containment System Administration,

Appendix 1: State Planning Grants and Pilot Grants, 2001 – 2005

State	Initial Year Funded for Planning Grant	Planning Grants, 2001-2005	Pilot Grants 2004-2005	Total
Alabama	2002	$1,125,506		$1,125,506
Alaska	2005	$964,000		$964,000
American Samoa	2004	$868,841	$400,000	$1,268,841
Arizona	2001	$1,562,879		$1,562,879
Arkansas (MSID)	2000	$1,652,220		$1,652,220
Arkansas (SPG)	2000	$2,294,153		$2,294,153
California	2001	$1,197,000		$1,197,000
Colorado	2001	$1,490,000		$1,490,000
Connecticut	2001	$1,117,895	$391,740	$1,509,635
Delaware	2000	$1,144,900	$355,910	$1,500,810
District of Columbia	2003	$1,180,000		$1,180,000
Florida	2003	$1,125,000		$1,125,000
Georgia	2002	$1,345,518	$400,000	$1,745,518
Guam	2004	$373,955		$373,955
Hawaii	2002	$1,697,210		$1,697,210
Idaho	2001	$1,404,421	$400,000	$1,804,421
Illinois	2000	$1,829,000	$400,000	$2,229,000
Indiana	2002	$1,367,268	$273,800	$1,641,068
Iowa	2000	$1,618,654		$1,618,654
Kansas	2000	$1,681,457	$400,000	$2,081,457
Kentucky	2004	$890,090		$890,090
Louisiana	2004	$801,319		$801,319
Maine	2002	$1,630,423	$399,998	$2,030,421
Maryland	2002	$1,417,301		$1,417,301
Massachusetts	2000	$1,254,195		$1,254,195
Michigan	2004	$900,000		$900,000
Minnesota	2000	$2,508,938		$2,508,938
Mississippi	2003	$1,395,699		$1,395,699
Missouri	2003	$1,088,489	$399,998	$1,488,487
Montana	2002	$987,595		$987,595
Nebraska	2003	$967,765		$967,765
New Hampshire	2000	$1,223,095		$1,223,095
New Mexico	2003	$905,000	$414,058	$1,319,058
New Jersey	2002	$1,475,635		$1,475,635
North Carolina	2004	$864,598		$864,598
North Dakota	2003	$1,151,702		$1,151,702
Oklahoma	2003	$874,360	$400,000	$1,274,360
Oregon	2000	$1,796,635	$397,467	$2,194,102
Pennsylvania	2004	$900,000		$900,000
Puerto Rico	2004	$712,811		$712,811
Rhode Island	2003	$961,156	$398,485	$1,359,641
South Carolina	2002	$1,213,560		$1,213,560
South Dakota	2001	$1,140,336		$1,140,336
Tennessee	2004	$962,726	$414,202	$1,376,928
Texas	2001	$1,564,944	$398,500	$1,963,444
Utah	2001	$1,102,000		$1,102,000
Vermont	2000	$1,610,625		$1,610,625
Virgin Islands	2002	$1,034,587	$351,687	$1,386,274
Virginia	2003	$1,334,729		$1,334,729
Washington	2001	$1,788,974	$400,000	$2,188,974
West Virginia	2002	$1,557,074	$399,991	$1,957,065
Wisconsin	2000	$1,722,346	$400,000	$2,122,346
Wyoming	2002	$1,395,938		$1,395,938
Total	**N/A**	**$68,174,522**	**$7,795,836**	**$75,955,535**

Appendix 2: The Challenges of Collecting State-Level Data

The SPG program served as a critical resource for states, enabling them to build their capacity to collect, analyze, and interpret important state-level data on the uninsured. Recognizing the importance of providing technical support services to the grantees in the areas of data collection and analysis, HRSA allocated some SPG funds to the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to provide technical assistance to build state capacity and ensure quality in state-level data collection and interpretation.

With the support of HRSA SPG funding, states developed state-specific data that enabled them to frame coverage policy decisions, and to deepen their understanding of the characteristics of the uninsured. This process resulted in a greater understanding among policymakers about the importance of state-specific data and the inadequacies of current federal data sources. As a result, states were able to undertake better informed policy discussions.

Limitations of Federal Data Sources

The SPG program made available to states invaluable resources for collecting state-specific data. While a variety of national resources are available to states, some of which are federally-sponsored surveys, and others of which are privately-sponsored surveys, these resources have numerous limitations.

- **Behavioral Risk Factor Surveillance System (BRFSS).** The BRFSS was established to provide previously unavailable national data on health status and risk behaviors to states. States conduct the BRFSS using monthly telephone surveys with a common sampling methodology and core questions, including questions on health insurance, thereby allowing for comparisons across states. An advantage of the BRFSS is that states conduct it themselves, maintaining control over the questions and analysis. For coverage discussions, however, the survey's principal weaknesses are that it is focused on working-aged adults and does not sample children.

- **Current Population Survey (CPS)**. Each year, the March Supplement of the CPS labor force data on the civilian noninstitutional population 16 years and older includes questions related to health insurance coverage. While the CPS is the most frequently used source for rates of uninsurance, it was not originally designed to produce state estimates of uninsurance. As a result, for many states, the sample size is quite small and may include only a limited number of counties for a given state.

- **Medical Expenditure Panel Survey-Household Component (MEPS-HC)**. The MEPS is a national survey conducted by the Agency for Healthcare Research and Quality (AHRQ), which provides information on the financing and utilization of medical care. The Household Component (HC) is one of four MEPS components and gathers information on the health care services Americans use, the frequency of use and cost of services, and how services are paid. While the MEPS-HC is a well designed and tested household survey, the sample size is insufficient to produce state estimates of the uninsured. States can model state expenditures in select categories, but are reluctant to use data that does not mirror the unique features of their populations.

- **Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).** Many states relied on state estimates of employer coverage from the MEPS-IC, an annual survey of employers and their health insurance offerings. The sample of employers is derived from 1) a nationally representative sample of employers, and 2) a sample of employers whose workers responded to the MEPS-HC. The MEPS-IC samples a nationally representative list of businesses and governments that is maintained by the U.S. Census Bureau, and offers a snapshot of the status of employer health insurance for the year both at the state and industry level. Like the MEPS-HC, the MEPS-IC is well-designed and tested. One significant drawback of the MEPS-IC is that the data currently available dates to 1996. And while the MEPS-IC collects information on employer-provided health insurance and publishes state-specific estimates, there are some limitations to the usefulness of the MEPS-IC data for state-specific policy work. In addition, confidentiality restrictions on the availability of micro-level data mean that states must go through a cumbersome process if they want to do their own analyses. Finally, the MEPS-IC sample sizes may not be large enough for some state-specific analyses.

- **Census Bureau's County Business Patterns (CBP).** The CBP is an annual series that provides subnational economic data by industry. The series is useful for studying the economic activity of small areas; analyzing economic changes over time; and as a benchmark for statistical series, surveys, and databases between economic censuses. The series is useful for studying the economic activity of small areas; analyzing economic changes over time; and as a benchmark for statistical series, surveys, and databases between economic censuses.

Arkansas' Multi-State Integrated Database System (MSID)

Arkansas' MSID attempted to remedy some of the shortcoming associated with federal data sources. As one of the original participating states in the SPG program for grant period 2000-2001, Arkansas found it needed to have access to data in a timely manner for policy discussions. To address this need, Arkansas developed methods for incorporating existing data sources into manageable formats. The result of these efforts was the development of a data extraction tool.

With HRSA's support and funding, the Arkansas team was able to develop the MSID, providing access to data for all funded states. Currently there are three national datasets available for querying in the MSID: the 1999-2001 BRFSS, the 1999-2001 CBP, and the 1999-2001 CPS. To provide access to the national database, the Arkansas team must acquire or capture data. This step includes performing integrity checks on the raw data captured from these data sources to ensure accuracy of raw data compared to nationally published data information available through traditional routes. The Arkansas team has obtained the MSID, CBP, and CPS national datasets, completed all integrity checks of the data, and loaded data into the MSID system. In turn, the system supports state's work on health insurance expansion options and other data-driven health policy issues. The MSID provides access to existing data on health insurance coverage, employment, demographic profiles, health care access, health risk behaviors, and economic profiles for businesses by state and county.

Grantees reported again and again that the state level data provided a unique and valuable political purpose. First, the state household surveys could be tailored to address unique local policy interests and options. Second, states had control over the timing of the survey and the release of findings, especially when tied to the legislative calendar. Third, analysts were able to respond to detailed questions from legislators and policymakers because they were armed with sub-analyses. Fourth, states were able to engage local groups in the policy making process in a more meaningful way because they could share data that reflected local priorities.