HRSA State Planning Grants Program: Final Report

January 2008

Produced by: AcademyHealth
Contract: 250-01-0057

TABLE OF CONTENTS

Introduction

The Health Resources and Services Administration (HRSA) State Planning Grants (SPG) program provided grants to states to develop plans for access to health insurance for all citizens. By 2005, the concluding year of the program, SPG had awarded grants to 47 states, the District of Columbia, and four territories (American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands). Ultimately, every applicant received funding and only Ohio, Nevada, and New York did not apply for SPG funds. The SPG program provided significant resources over a five year period to allow states to examine their uninsured populations and the dynamics of their health care marketplaces, to support community and stakeholder involvement in the planning process, and to generate consensus around viable coverage expansion options.

This is the final report on the activities of the SPG program and it consolidates and synthesizes information on the experiences and findings of the state grantees. With the last of the HRSA SPG funding awarded in 2005, this report offers a valuable look back at the activities and experiences of the SPG states. Over the last several years, state fiscal conditions have stabilized and strengthened, offering a helpful prism through which to view the experiences of the SPG states. With this stability has come a renewed focus on health coverage issues at the state level. Recently, 42 states reported efforts to expand health insurance coverage, according to a survey released by the Kaiser Commission on Medicaid and the Uninsured.[1] These efforts ran the gamut from expansions aimed at particular groups such as uninsured children to comprehensive proposals that would not only ensure near-universal coverage for all state residents but also aim for system-wide reforms.

For many of these states, the HRSA SPG program made possible the data analysis and consensus building groundwork that helped inform these strategies. As a result, the SPG helped revitalize the discussion of health care coverage across the nation and made possible the most comprehensive set of data on the topic ever made available to state policy makers.

Organization of Report

This report is based on the individual reports of the SPG grantees, as well as site visit reports prepared by AcademyHealth. The template used by states to prepare their individual reports is included in Appendix E. This report includes the following chapters:

- Chapter I is an overview of the program and participating states.
- Chapter II reviews the diagnostic work undertaken by states.
- Chapter III discusses the capacity and consensus building efforts of states as well as stakeholder engagement and diffusion of knowledge.
- Chapter IV reviews the policy options considered and implemented by states.
- Chapter V covers the lessons learned by grantee states.
- Chapter VI discusses the recommendations made by grantee states to the federal government.

Chapter I: Overview of Program and Participating States

SPG Program Background and Goals

In March 2000, HRSA announced the SPG program. Through this program, HRSA awarded annual grants to states and territories to develop strategies for providing access to affordable health insurance for all residents. The program provided substantial 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.

From 2000 to 2005, SPG awarded grants to 47 states, the District of Columbia, and four territories, with Alaska receiving the last planning grant under the program in 2005. Starting in 2004, HRSA expanded SPG funding under its Pilot Planning Grant Program, awarding pilot grants to 19 states and 1 territory. These pilot grants provided funding to SPG states that had developed policy options and needed further resources to proceed with planning for implementation. The federal FY 2006 budget eliminated funding for the SPG program.

Initially funded by Congress at $15 million, the SPG program dispersed almost $76 million in funds over its five year lifecycle (Table 1-1). With these funds, the SPG program sought to help states address high rates of uninsurance across the United States and to harness the direct interest of states in reducing the number of residents who lacked health insurance coverage. 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.

Table 1-1: 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

State	Initial Year Funded for Planning Grant	Planning Grants, 2001-2005	Pilot Grants 2004-2005	Total
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**

With relatively modest funding of $76 million, 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 report provides a response to these questions by profiling the activities of SPG states across several important activities: data collection, option development, and consensus building.

There are four components 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, states improved their analytic capabilities and increased their abilities to support policy discussions. The SPG program provided a "roadmap" to the state health policy process.

It is also important to note that SPG funding is 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 their 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 important, 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.

SPG Program Highlights

It is difficult to summarize the multitude of efforts undertaken with SPG planning grant funds. The next few chapters provide detail on and examples of the data collection and consensus building strategies undertaken by states with SPG resources. Below, we offer a few examples of policy options implemented, some of the programs that were designed, refined, and launched with assistance from HRSA's SPG program, as well as notable major reforms implemented. Appendix A provides an overview of the activities of all the SPG states and the reports that they published with SPG resources.

Policy Options Implemented by SPG States:

- Medicaid/SCHIP Expansions: **29** states
- Group Purchasing arrangements: **9** states
- Limited Benefit/bare bones: **12** states

- Premium Assistance: **10** states
- High Risk Pools: **10** states
- Outreach to eligible but not enrolled: **4** states
- Safety Net Strategies: **4** states
- Tax Credits for individuals/employers: **3** state
- Employer mandates/"Fair Share": **4** states
- Individual mandates: **1** state

- **Arizona** expanded accessible and affordable coverage to the uninsured by enhancing one component of the State's continuum of health coverage options, Healthcare Group 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 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 will 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 fifty workers.

- Three new community health centers have been funded since the inception of **Montana's** State Planning Grant.

- In September 2005, CMS approved the **Oklahoma** Employer/Employee Partnership for Insurance Coverage (O-EPIC) under the HIFA 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, the Oregon received approval for two more demonstration amendments. The state was allowed to extend the eligibility period for SCHIP from six 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 10 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 laid 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.

SPG grants served as one of the catalysts for innovative state health coverage reform including:

- **Maine Dirigo Health Reform**
- **Vermont Catamount Health**
- **Utah Primary Care Network**

Pilot Planning States

In 2004, HRSA introduced its Pilot Planning Grant Program, an expansion of the SPG program. HRSA awarded pilot grants of nearly $8 million to 19 states and one territory. These grants provided funds to states that had already developed policy options through SPG funds and needed assistance in conducting further work and implementing the proposals they had developed under their SPG grant. Table 1-2 presents an overview of activities that states undertook as part of their pilot planning program grant.

Table 1-2: State Pilot Grants, 2004 - 2005

State	Pilot Grants Award Amount	Year of Award	Summary of Pilot Grant Activities
American Samoa	$400,000	2005	Pursued a unique community-based pilot planning process utilizing traditional leaders to develop community-specific plans for coverage and integrate the regional plans to a territory-wide plan of its Coverage for All in American Samoa program.
Connecticut	$391,740	2004	Developed strategies to provide premium assistance targeted to low-income workers in firms that already offer coverage, and to design a small employer health insurance premium assistance pilot targeted to small firms that do not offer coverage.
Delaware	$355,910	2004	Updated their data on the uninsured, convened a small business advisory committee, and updated the cost estimates for prior models and developed assessments of new strategies. Established goals to strengthen the safety net via its Community Health Access Program, and incorporate disease management and strategies to address health disparities in policy options. Improve health information technology in new policy options.
Georgia	$400,000	2004	Developed a "three-share" program in which employers, workers, and the local government share in the cost of health care. Another community is considering partnering with commercial insurers to reduce costs.
Idaho	$400,000	2005	Evaluated and expanded coverage via its *Access to Health Insurance* program, a premium assistance program. Strengthened participation of county providers in planning and designing the County Medical Care pilot, a primary care program for uninsured adults. Developed a plan for expanding coverage to low-income, uninsured women based on

State	Pilot Grants Award Amount	Year of Award	Summary of Pilot Grant Activities
			Healthy Mothers, Healthy Babies, a family planning expansion.
Illinois	$400,000	2004	Designed two additional three-share programs. Researched and designed alternative financing mechanisms.
Indiana	$273,800	2004	Further developed options to expand coverage to low-income working individuals.
Kansas	$400,000	2004	Modeled impact of a reinsurance mechanism on insurance claims data. Planned a pilot to modify tax credits to employers for maximum impact.
Maine	$399,998	2005	Further refined and improved the Dirigo Health Reform.
Missouri	$399,998	2005	Using the data collection activities and consensus building strategies from the SPG, the team will developed models for several employer-based coverage options.
New Mexico	$414,058	2005	Allowed the New Mexico Human Services Department to work together with the Governor's Insure New Mexico to develop new coverage options based on the employer system blending public and private programs.
Oklahoma	$400,000	2004	Worked towards creating a premium assistance program with their grant funds.
Oregon	$397,467	2005	Prepared for further expansions as the state faced renewal of its 1115 and HIFA Waivers. Assessed a sustainable approach to covering more children and non-categorical adults in existing public programs. Reviewed and improved Oregon's Population Survey (OPS) to ensure its reliability and validity as a tool for monitoring health insurance status in the state.
Rhode Island	$398,485	2005	Designed a new private, lower cost insurance product for small employers, employees, and the self-employed, to coordinate with the existing private market, RIte Care, and RIte Share.
Tennessee	$414,202	2005	Developed a comprehensive plan for the implementation of a pilot project for the uninsured called "Cover Tennessee." The project sought to make insurance affordable for small employers, their employees, and individuals through the development of creative reinsurance arrangements with health insurers.
Texas	$398,500	2005	Focused on how to provide a lower cost

State	Pilot Grants Award Amount	Year of Award	Summary of Pilot Grant Activities
			insurance product for small business, in conjunction with the Greater Houston Partnership Public Health Care Task Force.
Virgin Islands	$351,687	2004	Sought to develop a purchasing collaborative, increase Medicaid enrollment, and continue to analyze the costs of uncompensated care.
Washington	$400,000	2005	Provided expert technical assistance to design a small business assistance program.
West Virginia	$399,991	2004	Developed options to offer affordable health insurance to the pre-Medicare population (aged 50 to 64), specifically those who have lost and are at risk of losing their retiree benefits.
Wisconsin	$400,000	2005	Researched and developed a plan to expand BadgerCare to children (under the age of 21) to 300 percent FPL, and to develop a BadgerCare health insurance premium payment (HIPP) model for children above 300 percent FPL.
Total	**$7,795,836**	**N/A**	**N/A**

Role of Program Partners

At the outset, HRSA sought to maximize the resources available to states by making national experts available to grantees and by supporting collaborative working relationships. This strategy complemented HRSA's expertise and provided to state grantees an important link to technical resources. The SPG program established relationships with private non-profit organizations that shared the program's objective of helping states in their efforts to expand coverage to the uninsured. One such relationship was with AcademyHealth, which serves as the national program office for the Robert Wood Johnson Foundation's (RWJF) State Coverage Initiatives (SCI) program. The SCI program has wide experience in working with states to plan, execute, and maintain health insurance expansions, as well as in improving the availability and affordability of health care coverage.

> "AcademyHealth was critical to our efforts. Time and time again we have sought their expertise and have always met a very helpful staff. They gave us constructive feedback and also put us in touch with other key experts. Their meetings (in) particular were always on the pulse of the latest policy debate and were very timely."
>
> *Indiana, September 2006*

HRSA contracted with AcademyHealth's staff to help states fine tune their research and develop effective coverage strategies. Staff offered technical assistance, supporting HRSA SPG awardees in various capacities, including:

- Developing stakeholder and consensus-building strategies;
- Disseminating research findings from other SPG states; and
- Providing guidance on coverage expansion strategies.

AcademyHealth staff also made themselves available to work with states' teams on-site and over the phone to: 1) provide answers to coverage questions; 2) help track down coverage information; and 3) assist with stakeholder and consensus-building activities. One of the requirements of the SPG grant was for states to participate in a site visit with AcademyHealth, offering grantees an opportunity to use AcademyHealth staff as members of their team and to seek guidance as they prepared their reports to the Secretary of Health and Human Services (HHS). AcademyHealth also assisted in planning and facilitating quarterly meetings for grantees. SPG grantees commented that AcademyHealth provided valuable technical assistance and served as an important 'go to' resource to learn about the efforts of other states.

A few examples of the technical assistance that AcademyHealth provided include:

- In **Connecticut**, AcademyHealth's site visits enabled state staff to assess progress and communicate the challenges they were facing "in moving projects forward in an environment of fiscal constraint and political change," according to the state's 2006 final report. AcademyHealth helped identify colleagues in other states who were facing similar challenges and also arranged for technical assistance related to the state's premium assistance activities. Finally, the state described the statecoverage.net Web site as "an invaluable tool that we use often to gather information about other state's activities and coverage proposals."

- **Indiana** noted the important role that SCI played in linking the state with experts. "The presence of AcademyHealth and the State Coverage Initiatives has also been extremely helpful. The ability to contact a single source that has its pulse on state efforts as well as key experts has been critical and will be moving forward," the state said in its 2006 final interim report.

- In its final 2006 report, **Minnesota** commented that "participation in AcademyHealth's State Coverage Initiatives meetings provided excellent opportunities to learn about other states' policy initiatives related to health care coverage, and to hear from experts about emerging trends and their implications for health care coverage and cost containment."

- **Oregon** also credited AcademyHealth program with invaluable networking opportunities with other state policy makers.

- Similarily, **Washington** noted the important networking opportunities that AcademyHealth facilitated. "Partnering with the SCI program enabled valuable networking with nationally recognized experts of a caliber generally not found within state governments," the state said in its final 2007 report.

A critical resource for states' data collection and analysis efforts was the expertise and resources offered by the State Health Access Data Assistance Center (SHADAC). Funded by a grant from the Robert Wood Johnson Foundation, SHADAC is a research and policy center at the University of Minnesota that provides advice and technical support to state analysts and policy makers in the areas of survey design, data collection, and policy development. In addition to having provided more direct hands-on services to SPG recipients through individual contracts, SHADAC offered general technical assistance and advice to the SPG awardees on their surveys and facilitated information sharing among states for both household and employer surveys, as well as focus group protocols.

The important role of SHADAC in the data collection activities of SPG states is described in greater detail in Chapter II. Examples of the technical assistance that SHADAC provided include:

- **Arizona's** AHCCCS program developed a survey tool with SHADAC's assistance to improve available data on the working uninsured and used results from the survey to help inform the legislature as to policy options. SHADAC also conducted an analysis on the phenomenon of pent up demand for the state. In its 2006 final report, the state commented that "SHADAC's assistance has been excellent."

- In 2005, SHADAC provided technical assistance to **Louisiana** State University in their undertaking of a research supplement on Medicaid undercount issues. This research included a survey of Medicaid enrollees to estimate the Medicaid undercount and to adjust subsequent estimates of uninsured populations. It is common for Medicaid enrollees to report uninsured or privately insured, thereby misreporting their insurance status, and resulting in an undercount of state Medicaid enrollees.

- SHADAC provided advice and guidance on measuring crowd-out using state employer survey data and state household survey data to **Massachusetts**.

- In their final 2006 report, **Minnesota** commented that it "benefited significantly from the technical assistance provided by SHADAC."

- **Vermont** sought assistance from SHADAC on how to understand and manage differences between Current Population Survey (CPS) and state survey results. Since several states have had to manage this issue, SHADAC organized a conference call with representatives from eleven states to provide input on this topic.

- In their final 2007 report, **Washington** commented that "SHADAC provided neutral guidance on many difficult technical issues that was enormously beneficial and raised the credibility of our work."

SHADAC offered timely and critical expertise on a variety of data-related topics, including the strengths and weaknesses of various national sources of state-level data. For example, many states relied on SHADAC to explain the pros and cons of using the federal CPS as a source of state-level data on insurance coverage. SHADAC conducted

frequent conference call to help states understand their own household survey results in relation to CPS data, and to connect states with one another so that they could share their experiences in managing CPS data issues.

One of the most important contributions of SHADAC to the success of states in collecting state-level data is the Coordinated State Coverage Survey (CSCS). CSCS is a household telephone survey developed by SHADAC staff for estimation of health insurance coverage at the state level. This survey was fielded by numerous SPG recipients. CSCS targets primary residences using county identifiers and establishes contact with the person in the household who is most knowledgeable about health insurance. CSCS allowed states to work with an existing, tested instrument, which they could tailor to meet their state-specific needs, thus saving time and staff resources by not having to develop their own health insurance coverage instrument.

SHADAC also prepared numerous documents summarizing the state data collection activities of SPG grantees, which can be found in Appendix B and which will be discussed in greater detail in Chapter II.

Grant Application Process

HRSA expected applicants to demonstrate commitment to the goal of providing coverage for all residents through a comprehensive proposal and a clear operational plan for accomplishing that goal. HRSA also required applicants to demonstrate working relationships with all state government health-related agencies, to have established partnerships and collaboration with the private sector and the state's legislative leadership, and to have demonstrated the ability to complete the technical analysis and prepare the report to the Secretary of HHS. The SPG grant specified one application per state and asked the Governor to designate the individual or agency responsible for the state's application.

Thirty-five states and territories submitted applications to HRSA in July of 2000. The large number of states that expressed interest, even with the lure of federal funding, was a surprise to many. It provided ample evidence that states were deeply concerned about the uninsured and interested in additional research and planning to better understand and respond to the issues.

Reviewers found that 20 states had submitted applications that met the grant criteria for an award. HRSA awarded FY 2000 State Planning Grants to the top-ranked 11 states. In FY 2001, the SPG program was funded at $15 million to support the remaining nine state applications that reviewers had judged met the criteria. In FY 2002, Congress appropriated another $15 million to fund up to 10 new grants, bringing the total to 30 state planning grants.

The Planning Grant States

The original 20 grantee states reflected the diversity that HRSA had envisioned for the program. The addition of 27 states, the District of Columbia, and four territories over the five years of the program significantly increased the range of experiences and the ability of the SPG program to contribute to national insight on solving the problem of the uninsured. States' analyses found that their economic, political, geographic, demographic, and cultural differences played an enormous role in their approach to the problem of the uninsured and the options they explored. A solution pursued by one state did not necessarily work as well in another. These differences lend credence to the value of developing and supporting state-based solutions for the uninsured.

Table 1-2 compares the SPG states across three important dimensions that show the diverse demographic and economic situations of the states: median family income, minority populations, and population under 200 percent of the federal poverty level (FPL). The percentage of the population under 200 percent FPL ranges from lows of 23 percent in New Hampshire and 24 percent in Minnesota to 12 states (plus the District of Columbia) at 40 percent or over (Alabama, Arizona, Arkansas, California, District of Columbia, Kentucky, Louisiana, Mississippi, Montana, New Mexico, Oklahoma, Tennessee, and West Virginia). The percent of minorities within each state ranges from a low of 4 percent in West Virginia to 69 percent in the District of Columbia and 81 percent in Hawaii.[3]

What is perhaps most notable about Table 1-3 is that differences in demographic and economic situations had little bearing on the effectiveness of SPG funds. In fact, as we discuss later, states' ability to move forward with analysis of coverage options and reach consensus on recommendations was more closely linked to their political and economic conditions.

Table 1-3: SPG Program Grantee Demographic and Economic Characteristics

State	2004-2005 Percentage of the Population Under 200 percent FPL (%)	2003-2005 Median Annual Household Income	2003-2005 Rank Median Family Income	2004-2005 Percent Minority (%)
Alabama	41	$38,180	44	31
Alaska	30	$55,935	7	31
Am. Samoa	N/A	N/A	N/A	N/A
Arizona	40	$44,748	28	41
Arkansas	43	$35,591	48	23
California	40	$51,647	12	55
Colorado	30	$52,011	11	28
Connecticut	27	$57,369	5	23
Delaware	31	$50,970	13	31
DC	42	N/A	51	69
Florida	37	$42,079	35	38
Georgia	38	$44,439	29	41

State	2004-2005 Percentage of the Population Under 200 percent FPL (%)	2003-2005 Median Annual Household Income	2003-2005 Rank Median Family Income	2004-2005 Percent Minority (%)
Guam	N/A	N/A	N/A	N/A
Hawaii	33	$57,572	4	81
Idaho	36	$44,994	26	14
Illinois	33	$47,978	18	33
Indiana	34	$43,735	32	15
Iowa	31	$45,086	25	10
Kansas	34	$43,802	31	16
Kentucky	41	$37,566	45	10
Louisiana	45	$36,814	46	37
Maine	35	$42,006	36	5
Maryland	29	$58,347	2	41
Massachusetts	29	$54,617	8	19
Michigan	34	$45,793	23	22
Minnesota	24	$56,084	6	14
Mississippi	48	$34,508	50	42
Missouri	35	$44,324	30	17
Montana	41	$36,200	47	9
Nebraska	31	$46,613	20	17
New Hampshire	23	$58,223	3	5
New Mexico	44	$39,029	42	57
New Jersey	27	$59,989	1	36
North Carolina	38	$41,067	39	33
North Dakota	32	$41,869	38	12
Oklahoma	40	$38,895	43	27
Oregon	37	$43,570	33	19
Pennsylvania	34	$45,814	22	17
Puerto Rico	N/A	N/A	N/A	N/A
Rhode Island	33	$48,823	15	20
South Carolina	40	$40,350	40	34
South Dakota	34	$42,525	34	14
Tennessee	40	$39,524	41	23
Texas	43	$41,959	37	52
Utah	34	$53,226	10	16
Vermont	28	$48,508	16	5
Virgin Islands	N/A	N/A	N/A	N/A
Virginia	30	$54,301	9	32
Washington	31	$50,885	14	21
West Virginia	42	$35,234	49	4
Wisconsin	32	$47,004	19	15
Wyoming	31	$45,598	24	11
National Avg.	**35**	**$46,037**		

Source: Kaiser Family Foundation State Health Facts Online at www.statehealthfacts.kff.org.
N/A= not available.

State Policy Environments

In order to develop their plans for coverage of the uninsured, states first devoted considerable energy and resources to gaining an in-depth understanding of their health care marketplaces, including analysis of 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.

- **High rates of uninsured and poor health status of uninsured.** Some states, such as New Mexico, reported that already high uninsured rates are exacerbated by border issues, cultural gaps, stigma, health education deficits, and health status concerns. States reported that their uninsured populations rely on safety net services, and many receive care in emergency rooms. The uninsured experience problems in accessing primary care, pharmacy, dental, and vision. In Missouri, 58 percent of the state's uninsured residents do not have a regular source of care. 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. Indiana reported that some immigrant populations are distrustful of public programs.

- **Strained health care infrastructures.** Population growth and a large undocumented immigrant population have strained the health care infrastructure in several states, even resulting in treatment delays in area hospitals. A number of states described workforce shortages that are affecting resources available for the uninsured to receive health care services other than in the emergency room. In Arizona, rapid population growth is making it difficult for the state to accommodate the needs of its growing population.

- **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—have resulted in significant cost shifting (both in terms of premium contributions and out-of-pocket costs) to employees and ultimately less affordable coverage options. Combined with already high unemployment rates, these factors have contributed to a growing number of uninsured in many states. For example, in Oregon, these trends combined with the state's shrinking Medicaid Oregon Health Plan and resulted in a marked increase in that state's uninsured population from 14 percent in 2002 to 17 percent in 2004.

- **Contraction in group health insurance coverage.** Many states reported declines in group health coverage, particularly among small employers generally with less than 50 employees in low-wage jobs. Connecticut, for example, experienced a jump in the number of uninsured who are working, from 58 percent to 62 percent between 2004 and 2006. This increase in uninsured workers took place despite an increase in the number of residents with employment-based coverage among the state's general population during this same time period.

Many uninsured workers are 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) work 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. And New Mexico's economy is based largely on retail, construction, tourism, and small service businesses—industries that often lack health care coverage. As a result, New Mexico has a high uninsured rate of 21.0 percent compared to a nationally average of 15.3 percent (Table 2-2).

- **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."[4]

- **Growth in self-insured employers.** Across the board, states reported an increase in the number of employers who are choosing to self insure rather than purchase fully-insured coverage options from health plans. These employers gain an exemption from requirements related to ERISA, the Employment Retirement Income Security Act of 1974, allowing them more flexibility in plan design.[5] In general, this continues to be a challenging issue for states as they work towards designing coverage and financing options aimed at small employers.

- **Changing political climate.** The election cycle has always been a pervasive influence on the policymaking process in states. Not surprisingly, several states experienced significant changes on the political front in the form of new leadership in the Governor's mansion and new faces in the state legislature. These changes played a significant role in shaping the policy options that these states could pursue with the assistance of the SPG program.

Grantees carefully examined other states' experiences (and even other countries' experiences) with coverage expansion and this information played an important role in states' deliberations regarding health care coverage.

Arizona, for example, commissioned a paper by Milliman USA, Inc. to examine other states' experiences in establishing purchasing pools for small-employee groups, and for individuals and families.[6] The paper explored the challenges faced by these pools and their effectiveness in improving access and affordability to health insurance. From this study, Arizona learned that historically purchasing pools have faced a number of

challenges, including low employer enrollment, lack of health plan participation, and adverse selection. In a separate brief, Milliman investigated other states' efforts to implement risk pools designed to cover individuals whose high health care costs have made it difficult for them to secure coverage in the commercial market.[7] From this paper, Arizona learned that risk pools play a key role in coverage reforms by reducing the number of uninsured and injecting stability to health care marketplace. The paper also highlighted a critical issue in establishing high-risk pools, which is to ensure that they are well funded with revenue sources beyond premiums and assessments.

SPG States Caught in a Changing Environment

For many states, participation in the SPG program began during 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. The states' economic climate in 1999 and 2000, when the SPG program was conceived, was far more positive with many states experiencing budget surpluses. 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. One lesson from this period of fiscal challenge is that state budgets ultimately dictate what a state can and cannot accomplish regarding reforms. During times of economic distress, states generally do not have the resources to implement coverage reforms, reforms that typically entail affordable and reasonable benefit packages.

> "Even though concern about the plight of Idaho's uninsured and understanding about the economic and social costs borne by all Idahoans have increased, state revenues have declined dramatically. Medicaid budget overruns are causing great consternation among legislators, who are demanding cost controls."
>
> *Idaho, Final Report, 2002*

In 2001, just as the SPG program was getting underway, states faced budget shortfalls of $38 billion. The harsh economic conditions forced states to reduce their previously enacted fiscal 2001 budgets by about $1.9 billion. To resolve budget gaps, 19 states were forced to make budget cuts after their fiscal 2001 budget had passed. Ten states used across-the-board cuts, four used rainy day funds, one state laid off employees, another offered early retirement, and others implemented a variety of cost cutting measures. At the same time states were taking these drastic measures, rapid growth in state Medicaid programs and health care costs continued to exert enormous pressure on state budgets.[8]

The National Conference of State Legislatures estimated that between fiscal 2002 and fiscal 2004, states had to contend with budget gaps that amounted to a staggering $200 billion. By 2005, the last year of the SPG program financial conditions appeared to be improving for many, but not all, states. By fiscal 2005, states' combined budget shortfall of nearly $40 billion was half the shortfall they had faced the previous year.

In the following years, many states have experienced additional environmental and financial challenges, and competing budget priorities that shaped their goal of expanding

coverage under the SPG program. As a result, 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.

Chapter II: The Diagnostic Work of the Planning States

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. The states collected quantitative and qualitative information on the uninsured and used it to develop strategies to meet the coverage needs of their populations. Many states chose to spend a majority of their grants on state-level data collection and all states made the development of a base of information about the dimensions of the problem a foundation of their work. 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 policy makers 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

A variety of national resources are available to states, some of which are federally-sponsored surveys, and others of which are privately-sponsored surveys. The strengths and weaknesses of these sources are described in greater detail in SHADAC's publication *A State Perspective on National Survey Data on the Uninsured.*[9] In summary, states have a several national data sources at their disposal, but each comes with its own 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. As a result, some grantees decided to purchase additional sample size to enhance the accuracy of the MEPS-IC data. Throughout the SPG years, the program provided AHRQ with funds to purchase additional samples of varying amounts, primarily focused on small firms. The additional MEPS-IC samples enabled states to improve the precision of their estimates and to undertake some additional state-specific analyses. The following states purchased additional samples: Arkansas in 2001, Delaware in 2000, Kansas in 2000, Maryland in 2002, Michigan in 2005, New Hampshire in 2000, Vermont in 2002, Virginia in 2005, Virgin Islands in 2003, Washington in 2004, and Wisconsin in 2001.

- **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.

Other national data sources include the National Health Interview Survey (NHIS), the State and Local Area Integrated Telephone Survey (SLAITS), the Survey of Income and Program Participation (SIPP), the Community Tracking Study Household Survey, and the National Survey of America's Families (NASF).

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.

Arkansas shared the resulting solutions with HRSA and other SPG states, concluding that other states shared the same challenges and expressed interest in the data extraction tool that Arkansas had developed. HRSA then asked Arkansas to submit a proposal to develop tools that would enable other states to achieve similar access to data.

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: 1) 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.

To implement the MSID, both desktop and web-based solutions are provided to each state. The web version requires no installation or setup at the state site because it is installed, configured, and maintained at the host site - Arkansas. Users simply navigate the MSID host Web site, www.HealthDataNow.info, enter their username and password and are immediately able to begin viewing data. In addition, each participating state receives three licenses for the desktop software. This software connects to the data sets in Arkansas via the Internet and data can either be viewed or downloaded to a computer for use at a later time.

The Arkansas team provides training and user support to all participating states via a user's conference and web-based training sessions. The Arkansas team also provides user support to all participants through a telephone Help Desk and e-mail helpline. With the lack of funding moving forward, the MSID will no longer be a web-based tool and will be made available via local servers and/or CPUs. The MSID team continues to seek new

sources of funding for updating the nationally available datasets that are incorporated in the MSID.

As of 2007, 25 SPG states had received access to the database and several incorporated their state-specific survey data into the database. These MSID users have incorporated MSID data in the development of legislative briefs and policy discussions, state fact books and information tools for stakeholders, as well as there SPG reports to HHS. Ease of use has enabled states to incorporate the MSID in policy conversations. Access to MSID has been particularly valuable to states such as Mississippi and Alabama, which historically have lacked data resources. The MSID has also been invaluable to the Arkansas SPG project by providing data to inform policy discussions at both the state legislature and the Arkansas Health Insurance Roundtable.

Value of State Data Collection

Most states used at least a portion of the SPG funds to undertake their own state-specific surveys. These surveys both enhanced their understanding of the problem and helped inform policy options related to expanding coverage and access.[10] The data collection activities proved critical to states, enabling them to develop: (1) a clearer picture of the uninsured, including their demographics, health care seeking patterns, and barriers to care; and (2) develop a general framework within which to explore specific policy options.

Grantees used SPG program funds for state-level data collection and analysis that provided critical inputs to state policy debates and decisions regarding coverage strategies. These funds enabled states to undertake in-depth analyses of state-specific characteristics and circumstances. State-specific surveys conducted by grantees generally had larger sample sizes than most national surveys, enabling states to develop estimates of important subpopulations among their uninsured residents. This information enabled grantees to undertake an informed decision-making process for both new policy options and expansions to existing coverage.

State surveys also enabled grantees to prepare estimates for specific subpopulations. SHADAC reports that typical state sampling frames included over-sampling for rural and other geographic areas, racial and ethnic groups, low-income populations, and children.[11] These estimates enabled states to better understand disparities in health insurance coverage not only by race, but also by income and geographic area. This data proved very useful to local communities in their own planning efforts. National surveys are not able to provide this level of sampling and sub-analyses.

Grantees reported again and again that the state level data provided a unique and valuable political purpose.[12] 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.

It should be noted, however, that state-level survey collection did face challenges.[13] SHADAC points out that most of the state-level surveys were telephone surveys, which may underestimate low-income households that lack a telephone. In addition, many states conducted these surveys for the first time and lacked history and documentation of potential problems, problems that national surveys have more experience in addressing. In some cases, the cost of conducting the survey also limited states, and resulted in some surveys that lacked one or more key variables of interest or information on all individuals in a household.

Overview of State Data Collection Activities

The SPG grants allowed states a unique and invaluable opportunity to collect in-depth state and local-level data on the uninsured and on the extent of employer-based coverage—information that had not been or is not currently available from national surveys. States conducted both quantitative and qualitative research to provide a more comprehensive picture for policy makers. Most states used several data collection approaches, combining core household and employer surveys with focus groups, key informant interviews, informal meetings with stakeholder groups, and other information-generating mechanisms. Qualitative data collection allowed states to test options as well as understand the beliefs and attitudes that shape behavior of the uninsured, employers, and key stakeholders within their health care system.

The data collection activities funded throughout the five-year SPG program included:[14]

- Analyzing data on uninsured individuals, employers, and marketplace trends;
- Conducting focus groups and key stakeholder interviews with individuals, employers and other organizations to develop a better understanding of the health insurance marketplace and to test options for reform;
- Using state-level data to model small area estimates of health insurance coverage at the county or other regional level;
- Using state-level data generated by the SPG program to study and develop a research agenda on racial and ethnic disparities in the use of preventive and other services, as well as barriers to accessing these services; and
- Modeling coverage options and the costs and benefits associated with a range of coverage policy approaches.

For states who received funding under the pilot project planning grants, data collection focused on pre-implementation activities, including:

- Continuing analysis of uninsured populations to fine tune policy options;
- Modeling options and determining which strategy/recommendation best achieves coverage expansion for the targeted population; and
- Development of implementation strategies

Table 2-1 provides an overview of the data-collection activities undertaken by state grantees and the year in which major surveys and focus groups were undertaken.

Table 2-1: Overview of SPG-funded Data-Collection Activities

State	Household Survey	Uninsured or Consumer Focus Groups	Employer Survey	Employer Focus Groups
	Year Conducted			
Alabama	2003	2002, 2003		2003
Alaska	2006	2006	2006	2006
American Samoa	2005			
Arizona				
Arkansas	2001, 2004	2001, 2005	2001	2000, 2005
California	2001, 2003			
Colorado	2001			2001
Connecticut	2001, 2004		2001, 2003	
Delaware			2001	2000
District of Columbia		2004	2005	2005
Florida	2004	2004		2004
Georgia	2002	2002	2002	2002
Guam	2005		2005	
Hawaii	2002	2002	2002	2002
Idaho	2005	2001	2001	2001
Illinois	2001	2000		2000
Indiana	2003	2002		2002
Iowa	2001, 2005	2000	2001, 2004	2000
Kansas	2001		2000, 2004	2004
Kentucky	2005		2005	
Louisiana*	2005	2004		2002
Maine	2002			2002
Maryland	2001	2002	2002	2002
Massachusetts	2000, 2004	2000, 2004	2001, 2005	
Michigan	2005	2005	2005	2005
Minnesota	2001, 2004	2001	2002, 2006	2001
Mississippi	2004	2004		2003
Missouri	2004	2004		2004
Montana	2003	2002	2003	2002
Nebraska	2004	2004	2004	2004
New Hampshire	2001	2000	2001	2000
New Mexico	2004		2004	
New Jersey	2001			2003
North Carolina	2005	2005		2005
North Dakota	2004	2004	2005	2004
Oklahoma	2004	2003	2003, 2004	2003
Oregon	2001, 2004	2000		2000
Pennsylvania	2004	2005		2005
Puerto Rico	2005	2005	2005	
Rhode Island			2005	2005

State	Household Survey	Uninsured or Consumer Focus Groups	Employer Survey	Employer Focus Groups
	Year Conducted			
South Carolina	2003	2002	2002	2002
South Dakota	2001	2001	2001	2001
Tennessee	2005	2005	2005	2005
Texas	2001	2001, 2005	2001, 2004	2001, 2005, 2006
Utah	2001	2001	2002	
Vermont	2000	2000	2000	2000
Virgin Islands	2003	2003		2003
Virginia	2004		2005	
Washington	2000, 2002, 2004, 2006		2004, 2005	
West Virginia	2000, 2001	2004	2003	2002, 2004
Wisconsin	2001	2000	2001	2000
Wyoming	2002	2002	2003	2002
Total	**48**	**37**	**35**	**40**

Source: SHADAC, updated November 2007.
*Louisiana's ability to complete a planned employer surveys was stymied by destruction following Hurricanes Katrina and Rita.

- **Household surveys and consumer focus groups.** Prior to the HRSA SPG program only a handful of states (for example, Hawaii, Kentucky, Maine, Minnesota, Oregon, Utah, Vermont, and Wisconsin) funded household surveys that monitored state-level health insurance coverage.[15] The SPG program provided substantial funding for state-level surveys; in fact, more than three-quarters of SPG grantees conducted household surveys.

  Without state-specific surveys, states must rely on national data sources. As discussed earlier, a number of federal and private surveys offer estimates of uninsured populations. The most commonly used national survey for state estimates of health coverage is the Census Bureau's annual March Demographic Supplement to the CPS. Although the CPS has served as a source of health insurance information for over two decades, providing state estimates of insurance coverage rates, it "was not designed as a health insurance survey"[16] and does not provide the level of detail needed to make informed state health policy decisions. CPS provides valuable insurance trend information, but "comparisons with other surveys have indicated that its estimates for the uninsured tend to be somewhat higher than other major surveys, indicating that underreporting [of insurance coverage or public program enrollment] may be a larger problem for the CPS than for some of the other major national surveys" that include questions about health insurance status.[17]

  Rhode Island, for example, concluded in its 2005 final report that CPS underreporting for that state may be "considerable." Rhode Island noted that in March 2001 new questions were added to the CPS specifically addressing SCHIP coverage. CPS data for Rhode Island[18] showed SCHIP coverage estimates to be 83 percent less, however, than the actual SCHIP coverage in the state as reported by the state to CMS.

The decision by the majority of state grantees to conduct household surveys reflected their need to improve and expand upon the data provided by CPS, as well as seek state-specific health insurance coverage data that would better guide policy making. The SPG-funded state surveys also enabled states to examine county and regional trends related to the uninsured. The subpopulation analyses undertaken by states are described in greater detail later in this section.

Many states chose to complement their household surveys with focus groups of state residents. The focus groups afforded states the opportunity to supplement quantitative data with qualitative information on the views of uninsured toward health insurance coverage, their health care-seeking patterns, and barriers they experience in accessing care.

- **Employer surveys and focus groups.** States conducted employer surveys and focus groups to learn more about how employers make decisions about offering coverage and what their opinions were of different state programs and policy options for expanding coverage. The employer surveys and focus groups combined to enable states to examine their own employer behavior and preferences in developing coverage options. These findings will also serve as a valuable baseline for future assessment of employer-based coverage.

- **Health care environments.** States also collected information on their health care environments to determine the number of employers offering health coverage, the characteristics of their health care market offerings, and the safety net mechanisms available to those without coverage.

Every grantee state engaged in an extensive period of information gathering. These activities yielded nearly 300 reports as states prepared written analyses on their uninsured populations and potential solutions. These reports deepened states' understanding of the uninsured and their health care needs; they also served to assist an important consensus building process. These reports also provided to the federal government the first in-depth view of the effects of uninsurance on health care access at the state and local level. To give a sense of the breadth of topics, here are some examples of excellent reports produced as a result of the SPG process (a list of state reports can be found in Appendix D):

Spitz, B. "The Insurers' Perspective on the Health Care System, Insurance, and the Uninsured," Spitz Consulting Group, June 2002.

The Lewin Group, Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California, April 2002.

Ratledge, E.C. and T. Toth. "Delaware's Small Employers: The Health Insurance Dilemma," University of Delaware, April 2001.

Ketsche, P. "Employment Based Health Insurance: Analysis of Rural Urban Differences in One State," Georgia State University, August 2005.

Stroebel, H. "Medical Indigency in Idaho: An Analysis of County Indigency and State Catastrophic Health Care Services," Center for Health Policy, Boise State University, February 2003.

Smith, B.L. and E. Sylvia. "Voices of the Uninsured: Kansans Tell Their Stories and Offer Solutions," University of Kansas Medical Center, January 2002.

The Costs of Not Having Health Insurance in the State of Maryland, December 2003

Ehret, D.A. "Accessing Health Insurance in Minnesota: Report of Focus Group Discussion with American Indian, Hmong and Somali Community Members," Center for Cross-Cultural health, December 2001.

Moreland-Young, C. and R.P. Walker. "Understanding Current and Future Insurance And Utilization Issues Affecting Healthcare Providers And the Marketplace in Mississippi," PathFinders and Associates, 2005.

Spitz, B. "The Insurers' Perspective on the Health Care System, Insurance, and the Uninsured," Spitz Consulting Group, June 2002.

Sheils, J. et al. "Covering VHAP and SCHIP Enrollees Under a Voucher Model: Program Design and Actuarial Analysis," The Lewin Group, September 2002.

Description of State Household Surveys

Forty-eight SPG grantees conducted household surveys. Appendix B provides a summary of the variety of approaches used by state grantees to conduct their household surveys from 2000-2002. The majority of states used telephone surveys to collect the data. One state also used in-person surveys to reach certain sub-populations. The sample size of the surveys ranged from approximately 598 households in Texas to more than 55,000 adults in California. A majority of grantees hired researchers from state universities to conduct the surveys, while a few hired national survey research or policy research firms.

Several examples of how state-level household survey results improved state analyses of the uninsured, guided policy decisions, and informed legislative deliberations are described below. SHADAC describes these examples in its February 2007 *Technical Report: HRSA SPG Data Collection Activities Summary*.[19]

- Through its state-level household survey results, **Georgia** found that although rural residents throughout the state were more likely to be uninsured than their urban counterparts, the patterns of coverage in northern versus southern rural areas of the state were remarkably different. This finding helped guide policy interventions considered by the state.

- **Hawaii's** state-level survey entailed over-sampling less populated counties and was crucial in producing both county-level estimates and estimates of the state's unique ethnic mix. These findings helped inform stakeholders and policy makers.
- **Illinois'** state-level survey produced data that focused coverage expansion efforts on development of an affordable health coverage product for small employers with 25 or fewer workers who do not currently offer health coverage. Following a series of statewide meetings, Illinois launched a pilot project in St. Clair County, one of the most economically disadvantaged areas of the state.
- Armed with state-level survey results that examined smaller geographic areas, local communities in **Massachusetts** pinpointed local needs and tailored grant applications.
- In **Minnesota**, the state-level survey has allowed the state to add questions on topics of specific policy-interest from year to year. Examples of topics addressed by the state-level survey have included dental insurance, supplemental insurance, and prescription drug coverage.
- **Montana** used detailed survey data to apply and receive funding for community health centers.

Several states commented that both the quantitative and qualitative data collection helped move the policy discussion from anecdotal conversations to substantive discussions of policy options. States found that quantifying the dimensions of the problem gave policy makers ownership of the issue. In a 2006-2007 SPG grantee survey conducted by SHADAC three-fourths (75 percent) of respondents considered the household survey data "extremely valuable" and no respondents considered it "not at all valuable." When presented with a list of topics commonly addressed by the household surveys undertaken by SPG states, information on the working uninsured, income differences, regional and local estimates, and age differences topped states' list of the most important health insurance coverage issues addressed by household surveys. States said that the most important issues addressed in their household surveys that related to access include utilization of health care services, financial and non-financial barriers to care, and emergency room access.[20]

State-specific, and in many cases, county-level and sub-population data highlighted the saliency of the problem and helped states challenge myths that had previously hindered productive policy debate. In this sense, the data collection activities were successful in moving states toward action in considering coverage reforms that would either enhance current programs to address the uninsured or develop new ones.

Examples where data gathered from state household surveys helped build consensus and momentum for health coverage strategies include the following.[21]

- County-level estimates produced by **Hawaii** were important in building consensus among key policy makers, community groups, and other stakeholders.
- **Oregon** conducted a children's access survey, which was a critical element in the eventual development of the state's Healthy Kids proposal. Policy analysts found that local data on uninsured children helped involve legislators in developing and

supporting this proposal. The state commented that data from the survey helped counteract anecdotes that had proven unhelpful to the process.

- Policy analysts in **Washington** found political value in local data collection efforts and results. State-specific data, and detailed county-level information, had greater credibility with policy makers and stakeholders than national data that rarely matched local administrative record.
- **West Virginia** was able to present its legislature with reports documenting the demographic characteristics, perceived health status, health care usage and costs of its citizens, comparing the uninsured with their insured counterparts. As a result, information from the report contributed to a 15 week series in the state's leading newspaper regarding the uninsured and their impact on stakeholder groups including employers and providers. The state feels that the public reporting of this information contributed to passage of three pieces of legislation in 2004 that created opportunities for expansion of private and public health insurance coverage.

Description of Consumer Focus Groups

Thirty-seven states chose to supplement household surveys with focus groups of state residents. The focus groups enabled states both to put a human dimension on coverage issues and to compile a list of options and preferences from the consumers' point of view. Furthermore, states were able to use the focus groups to explore the values and attitudes of different subpopulations and to better understand the factors these groups considered in making complex decisions on insurance. States used the qualitative information generated by these focus groups to provide a context for the quantitative findings generated from household surveys. Some states also conducted key informant interviews either in lieu of or in addition to focus groups. Alaska, for example conducted key informant interviews with business roundtable members, native tribal health care providers, military and Veterans Administration representatives, minority advocates, non-profit organizations, and small employers.

> In order to put a human face on the uninsurance issue, a total of 13 focus group interviews were conducted... The results of the focus group interviews revealed that many of the uninsured and the underinsured worry about the cost of health care and often delay care because of the cost. Also, without adequate health insurance, individuals feel "depressed," "frustrated," "hopeless," and "suicidal."
>
> *Nebraska, Final Report, 2005*

Appendix B includes a summary of states' consumer focus group activities. Some states conducted only a few focus groups (e.g., Idaho, Vermont), while others conducted more than 20 (e.g., Arkansas, Georgia, Indiana, Minnesota, Texas). Focus group participants typically included uninsured, low-income individuals. States used the focus groups to learn more about barriers to health insurance faced by these individuals, how they made decisions to seek or forego coverage, and to solicit their opinions on different coverage options and strategies. Many states contracted with local universities to conduct the focus groups while others contracted with consulting firms.

Some examples of the value of consumer focus groups and qualitative interviews are provided below.[22] Later in this section, we discuss in greater detail findings from qualitative research, including focus groups, undertaken by states.

- **Hawaii** conducted qualitative interviews of over 250 uninsured persons and their medical providers. The state learned of the difficulties experienced by the uninsured in accessing health care in a timely manner and the concerns of providers who felt that their patients' health had been seriously compromised by lack of adequate and timely health care. The state also learned that its safety ent had been stretched beyond capacity with specific subpopulations falling "between the holes," including immigrants, part-time and self employed workers, the recently imprisoned, the disabled, the elderly with multiple chronic conditions, and legal migrant residents from Micronesia.

- **Mississippi** conducted focus groups with college students, SCHIP non-renewals, and social workers, child support workers and Chancery judges to deepen their understanding of issues affecting access these groups and agencies that work on behalf of families and children. Focus groups discussed the importance of health insurance to themselves and to the families and children they serve. While they regarded the state's Medicaid and SCHIP programs favorably, they expressed concern over systemic barriers to enrollment.

Description of State Employer Surveys

Thirty-five states conducted employer surveys. A description of these surveys is found in Appendix B. Typically, states conducted these surveys by either telephone or mail. Some states conducted a pre-screening interview, followed by a mail survey and then telephone follow-up for non-responders (e.g. Arkansas, Kansas, Maryland). Many states used state estimates of employer coverage from the MEPS-IC, a survey conducted by the Census Bureau and sponsored by AHRQ. The sample size of the survey varied from 314 (Kansas) to nearly 11,000 completed surveys (Texas). A number of states targeted small business with fewer than 50 employees (Delaware, Texas), while others targeted a broader set of employers by canvassing small, moderate, and large businesses. Many states contracted with universities to complete the surveys and others worked with consulting firms.

- SPG funding allowed **Massachusetts** to conduct its first employer survey, producing information that was "very useful to state policy makers." The state undertook a second employer survey in 2003, the results of which were used to inform the state's health reform activities and as input to presentations made by the governor and his staff. [23]

- **Rhode Island** found that the most critical lesson from its data gathering effort was an understanding of the size of the problem when it came to lack of insurance offerings among very small businesses. The state concluded that the problem was more significant than it had initially believed; less than half of businesses with fewer than

10 employees offered health insurance and the state found a significant decline in the share of small business employees being offered insurance.

Descriptions of State Employer Focus Groups

Forty states conducted employer focus groups. Of these states, 26 undertook both employer surveys *and* employer focus groups. The number of employer focus groups conducted by states ranged from 2 (Delaware) to more than 20 (Idaho, Indiana, New Je`rsey, Texas). While some states targeted small employers (Delaware, Oregon, Wisconsin), others sought a geographic representation of employers (Iowa), and others segmented focus groups by firms that do and do not offer health coverage (Maryland, Vermont, Wisconsin).

In general, states undertook the employer focus groups to identify factors that influence employers' decisions to offer (or not offer) health insurance. In addition, states sought to understand the perspectives of employers, the barriers they face, and which options are most appealing for increasing affordable coverage in their states. Many states found that the focus groups offered nuance and a perspective that complemented their quantitative findings. A number of states hired professional consultants to conduct the employer focus groups. Examples of states' experiences with these focus groups include the following. Additional information regarding findings from states' focus groups are described later in this section.

- **Illinois** conducted a series of focus groups and key informants interviews that asked a series of predetermined questions intended to generate answers that would offer "texture and nuance" to the quantitative data collected by the state. The state noted in its 2001 interim report that while these findings could not be generalized to the broader population, they did "enrich and enhance the quantitative data by telling some of the 'insider's story' of many of the stakeholders involved.

- **North Carolina** conducted focus group research aimed at better understanding both individual and employer decisions regarding health insurance. Topics covered by the focus groups included affordability, participation, and options for expanding coverage to the uninsured. In general, the state found that employers believed health insurance is an important benefit for recruiting and retaining employees. Faced with rising premiums, employers however reported that they were taking steps to reduce dependent coverage and limit insurance options offered to their workers.

Appendix B provides an overview of states' employer focus group activities.

Quantitative Research Findings: Uninsured Individuals and Families

Grantees used different methodologies to collect data on the uninsured in their states, so their estimates of health insurance coverage rates cannot be compared. State estimates of uninsurance from the Current Population Survey offer a point of comparison for rates of coverage across states (Table 2-2).

Table 2-2 CPS Estimates of the Percentage of People Without Health Insurance Coverage by State

State	CPS Estimate 2-year average: 2004-2005	90 percent confidence interval, 2004-2005	CPS Estimate 2-year average: 2005-2006	90 percent confidence interval, 2005-2006
Alabama	13.5%	1.1	14.9%	1.2
Alaska	16.9%	1.3	16.9%	1.3
American Samoa	N/A	N/A	N/A	N/A
Arizona	18.1%	1.2	20.2%	1.2
Arkansas	16.8%	1.3	18.2%	1.3
California	18.4%	0.5	18.8%	0.5
Colorado	16.3%	1.3	16.9%	1.3
Connecticut	10.9%	1.1	10.2%	1.0
Delaware	12.7%	1.2	12.2%	1.1
District of Columbia	12.8%	1.3	12.4%	1.3
Florida	19.8%	0.7	20.7%	0.7
Georgia	17.6%	0.9	18.0%	0.9
Guam	N/A	N/A	N/A	N/A
Hawaii	8.5%	0.9	8.7%	0.9
Idaho	14.7%	1.2	15.1%	1.2
Illinois	13.4%	0.7	13.9%	0.7
Indiana	13.7%	1.0	12.7%	0.9
Iowa	8.7%	1.0	9.4%	1.0
Kansas	10.5%	1.1	11.3%	1.1
Kentucky	13.0%	1.2	13.9%	1.2
Louisiana	16.9%	1.3	19.8%	1.4
Maine	9.6%	1.1	9.8%	1.1
Maryland	13.4%	1.0	13.6%	1.1
Massachusetts	10.3%	0.8	9.8%	0.8
Michigan	10.7%	0.7	10.4%	0.7
Minnesota	8.2%	0.9	8.6%	0.9
Mississippi	16.8%	1.3	18.8%	1.3
Missouri	11.8%	1.0	12.5%	1.0
Montana	16.9%	1.3	16.4%	1.3
Nebraska	10.5%	1.1	11.4%	1.1
New Hampshire	9.9%	1.0	10.6%	1.1
New Mexico	20.1%	1.5	21.6%	1.5
New Jersey	14.2%	0.9	15.0%	0.9
North Carolina	15.1%	0.9	16.6%	0.9

State	CPS Estimate 2-year average: 2004-2005	90 percent confidence interval, 2004-2005	CPS Estimate 2-year average: 2005-2006	90 percent confidence interval, 2005-2006
North Dakota	10.5%	1.1	11.6%	1.1
Oklahoma	18.5%	1.4	18.4%	1.3
Oregon	15.9%	1.3	16.7%	1.3
Pennsylvania	10.3%	0.6	9.9%	0.6
Puerto Rico	N/A	N/A	N/A	N/A
Rhode Island	10.9%	1.1	10.1%	1.1
South Carolina	16.0%	1.3	16.6%	1.3
South Dakota	11.4%	1.0	11.7%	1.0
Tennessee	13.3%	1.0	13.6%	1.0
Texas	23.9%	0.7	24.1%	0.7
Utah	14.9%	1.1	16.9%	1.2
Vermont	11.0%	1.2	10.9%	1.1
Virgin Islands	N/A	N/A	N/A	N/A
Virginia	13.1%	0.9	13.1%	0.9
Washington	12.8%	1.0	12.5%	1.0
West Virginia	16.5%	1.2	15.2%	1.1
Wisconsin	9.7%	0.9	9.1%	0.9
Wyoming	13.7%	1.3	14.6%	1.3
Total	**15.1%**	**0.1**	**15.5%**	**0.1**

Source: U.S. Census Bureau, Current Population Survey, 2005 to 2007 Annual Social and Economic Supplements, August 2007.

CPS data shows that average uninsurance rates among the SPG states, based on a two-year average from 2004 to 2005, ranged from 8.2 percent (Minnesota) to 24.1 percent (Texas). The national percentage of people without health insurance coverage during this same time period was 15.3 percent. The two year average percentage of people without health insurance coverage for the period 2002-2003 was 15.4 percent; and the two year average for 2001-2002 was 14.9 percent.

In addition to determining overall health coverage rates, states were asked to identify the population groupings that were particularly important when developing targeted coverage expansion options for the uninsured. To respond to this query, states used state-specific surveys conducted with the support of HRSA SPG funding. Some states, such as California, were also able to use recently completed household surveys to analyze their uninsured populations.

California contracted with the UCLA Center for Health Policy Research to conduct an analysis of the 2001 California Health Interview Survey, a survey of over 55,000 randomly selected California households. The survey addressed insurance status, public program eligibility and enrollment, and access and utilization of health care services. The analysis found that 85 percent of non-elderly Californians had health insurance coverage in 2001 and almost two-thirds were covered by employer-sponsored insurance. California determined that, of the non-elderly, individuals with low incomes—especially Latinos—were vulnerable to high rates of uninsurance. Among poor non-elderly Latinos, more than

one-third with incomes below poverty were uninsured. And Latino children comprised a significant portion of those eligible but not enrolled in public programs. The analysis also found that non-citizens experienced high rates of uninsurance.

Overall, states found that the subpopulations of greatest concern were those determined by several key factors including age, employment (status and firm size), income level relative to the FPL, ethnicity, education, citizenship, and geography. Typically, these groups included low-income uninsured children and their parents, low-income uninsured adults, working uninsured in small size firms, and the rural uninsured. Several states expressed concern regarding seasonal workers. Alaska, for example, has many workers who come for oil field work, tourism related jobs, fishing and fish processing. These workers face significant challenges in obtaining health care coverage. Maryland expressed concern regarding individuals who are experiencing a job or life transition that results in a break in coverage.

As discussed above, a number of states specifically oversampled subpopulations that have historically included the greatest percentages of uninsured individuals, a benefit that state-sponsored surveys afford. States typically included over-sampling for rural and other areas, racial and ethnic groups, low-income groups, and children. As a result, states obtained a wealth of information on these important sub-groups, groups that are typically not included in national surveys. The following is an overview of some of the state-specific findings pertaining to these populations.

- Poor and near poor more likely to be uninsured. Not surprisingly, states found that their low income residents were more vulnerable to periods of uninsurance than their moderate to high income residents. In addition, the chance of a state resident having coverage appears to increase with income. California, where the poor and near poor were most likely to be uninsured in 2001, offers a text book example of this vulnerability. For adults, approximately 52 percent with incomes under 100 percent of poverty were insured for the entire 12 months preceding the 2001 California Health Interview Survey. This figure rises to about 60 percent of adults with incomes between one and two times poverty. The comparable percentage of insured adults with incomes between two and three times poverty was about 88 percent. The state found a similar pattern for children with about 75 percent of children with incomes below poverty insured for the 12 month period preceding the survey, while the comparable percentage for children in families with incomes above 300 percent of poverty rose to 96 percent.

- More adults than children lack health care coverage; young adults comprise largest proportion of uninsured for many states. Many states found that more adults than children lack health care coverage. This finding may reflect the success of states in insuring children through programs such as the State Children's Health Insurance Program (SCHIP). In Connecticut, the majority of the uninsured are working adults (69 percent). In Maryland, the largest proportion of uninsured individuals is young adults between ages 18 and 34, comprising 40 percent of the state's uninsured. Pennsylvania had similar findings with nearly half the uninsured falling between 18

and 34 years of age, and one of every five young adults lacking health care coverage. In Maine between 12 and 13 percent of the population is uninsured and 23 percent of young adults below age 30 were uninsured at least part of the year.

- Many uninsured are employed. Maine determined that 38 percent of very small business employees (10 or fewer workers) were uninsured at least part of the year during which the state undertook its survey. Like Maine, many states found that a significant proportion of their uninsured citizens work for small businesses that may not offer health care coverage. These small employers tend to operate on narrow margins and health insurance is not the only benefit these businesses perceive as unaffordable. States also reported that numerous uninsured are in fact workers who are eligible for coverage but decline, primarily due to the burdensome cost of coverage. In Maryland, focus group research with uninsured families found that affordability was the primary reason why they failed to sign up for employer-based coverage. These families understood the value of insurance coverage but simply could not afford it after paying their mortgage, rent, car payment, food, child care, and other expenses.

- Residents in rural areas are more vulnerable to gaps in health care coverage than their urban counterparts. States discovered that, for their rural residents, access to health coverage is more challenging due to health care workforce shortages, combined with hospital closures over the last two decades, and lack of public transportation. Furthermore, rural residents are less likely to have health insurance because they are less likely to have employers that offer such coverage.[24] Combined, these factors tend to lead to poorer health outcomes for residents in rural areas. In Maine, the more rural parts of the state have older populations, lower average income levels, a lower rate of insurance coverage, and greater chronic illness burden than the more densely populated areas in the economically stronger southern part of the state.

Quantitative Research Findings: Employers and Employer-Based Coverage

States used a variety of approaches to collect information on employer health coverage offerings. Because states used different methods to estimate the number of firms offering health insurance, results of state grantee surveys cannot be compared. Estimates from the Medical Expenditure Survey Panel – Insurance Component (MEPS-IC) offer a point of comparison across SPG states for the proportion of private sector employers offering health insurance coverage benefits (Table 2-3). Between 2000 and 2005, the national average dropped from 59.3 percent to 56.3 percent.

Table 2-3 MEPS-IC Estimates of Employer Offerings

	Percent of Private-Sector Establishments Offering Coverage			
State	**2000**	**2000 Standard Error**	**2005**	**2005 Standard Error**
Alabama	62.1	2.95	59.8	2.28
Alaska	N/A	N/A	42.4	2.96
American Samoa	N/A	N/A	N/A	N/A
Arizona	62.9	2.68	55.0	1.48
Arkansas	46.4	2.41	40.8	2.44
California	56.8	1.37	59.8	1.61
Colorado	64.6	2.74	54.1	1.65
Connecticut	69.4	2.89	63.8	2.97
Delaware	N/A	N/A	57.6	2.26
District of Columbia	N/A	N/A	74.3	1.57
Florida	57.7	2.01	51.2	2.27
Georgia	54.7	3.41	52.3	2.72
Guam	N/A	N/A	N/A	N/A
Hawaii	N/A	N/A	89.6	1.63
Idaho	N/A	N/A	43.8	1.76
Illinois	59.6	1.74	53.3	2.15
Indiana	58.4	2.27	55.9	1.84
Iowa	53.3	2.06	47.9	1.49
Kansas	58.1	2.01	50.8	1.90
Kentucky	61.5	3.35	57.1	2.60
Louisiana	50.4	2.50	52.6	1.56
Maine	N/A	N/A	55.6	2.96
Maryland	57.7	2.36	64.1	2.88
Massachusetts	68.2	2.79	63.3	2.16
Michigan	63.0	2.63	59.9	2.25
Minnesota	55.4	3.14	54.3	2.61
Mississippi	52.4	2.16	45.3	1.75
Missouri	58.3	1.40	50.6	2.12
Montana	N/A	N/A	39.2	2.85
Nebraska	46.3	2.05	45.2	2.22
New Hampshire	65.1	2.47	62.0	2.87
New Mexico	52.6	3.10	51.2	1.52
New Jersey	65.1	2.53	69.3	3.05
North Carolina	61.4	1.91	56.7	1.61
North Dakota	46.1	3.33	49.1	1.32
Oklahoma	51.9	2.88	48.3	2.84
Oregon	55.3	1.89	56.7	1.80
Pennsylvania	68.5	1.37	61.5	2.52
Puerto Rico	N/A	N/A	N/A	N/A
Rhode Island	N/A	N/A	59.5	3.95
South Carolina	56.7	1.76	63.2	2.14
South Dakota	42.4	2.89	48.1	3.20

State	Percent of Private-Sector Establishments Offering Coverage			
	2000	2000 Standard Error	2005	2005 Standard Error
Tennessee	58.3	1.56	54.7	2.57
Texas	52.8	1.74	50.1	1.42
Utah	54.7	3.16	44.1	2.18
Vermont	N/A	N/A	56.8	1.66
Virgin Islands	N/A	N/A	N/A	N/A
Virginia	60.0	1.45	56.7	2.08
Washington	59.3	2.48	53.8	1.78
West Virginia	55.0	1.97	48.8	2.80
Wisconsin	58.3	1.69	59.3	2.50
Wyoming	N/A	N/A	38.6	1.94
States not shown separately	60.2	3.19	N/A	N/A
Total	**59.3**	**0.43**	**56.3**	**0.50**

Source: 2000 and 2005 MEPS-IC, Table II.A.2.

States were asked to provide overall rates of employer-based coverage in their states. In response, some used MEPS-IC (Arizona), while many others used state-specific surveys of employers (Alaska, Connecticut, Delaware, Michigan, Minnesota), state household surveys (Vermont,) and the Current Population Survey (North Carolina). Some states relied on previously conducted surveys. California did not conduct new data gathering, instead relying on the 2001 California Health Benefits survey conducted by the Henry J. Kaiser Family Foundation and the Health Research Educational Trust.

Several themes emerged from states' collection of data related to employer-based coverage.

- **Steady decline in employer-sponsored health insurance.** Mirroring national trends, many states found that employer-sponsored coverage as the primary source of health insurance slipped during recent years. North Carolina found that the decline in that state's employer sponsored insurance dropped 9 percent between 2000 and 2003.

- **Small firms least likely to offer coverage.** Vermont's Family Health Insurance Survey found that only 26.6 percent of workers in firms with fewer than 5 employees are offered coverage at work. In comparison, more than 90 percent of employees in firms with over 50 workers were offered health insurance. Similarly, California found that while only 61 percent of firms with 3 to 9 employees offered coverage, 95 percent of firms with 200-999 workers offered coverage at work.

- **Premium cost poses significant deterrent to employers.** Delaware commented that its 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."

Similarly, Maryland found that the primary reason small employers gave for not electing to provide coverage was cost and affordability.

- **Lack of knowledge also poses barrier.** Several states commented that employers – especially small employers- found the process of offering health insurance "complicated" and "overwhelming" (Maryland). Many of these employers have little knowledge of health insurance and feared that offering coverage would entail significant additional work. Delaware commented that there is a "high level of misunderstanding and confusion…among small businesses about the topic of health insurance."

Qualitative Research Findings

The majority of states complemented quantitative data from household surveys with qualitative information gathered through focus groups and key informant interviews. These qualitative methods enabled states to explore and understand more fully the decisions that the uninsured make about coverage and the factors that influence employers to offer coverage, or not. Issues studied included why people do not take public or employer insurance for which they are eligible, what constitutes affordable coverage for a low-income individual, how the uninsured meet their medical needs, barriers to meeting those needs, and employers decision-making when it comes to health care coverage.

- **Failure to enroll when eligible for Medicaid.** States sought to improve their understanding about the barriers to access faced by Medicaid-eligible adults who fail to enroll and are uninsured as a result. For good reason—recent research shows that 25 percent of the uninsured are eligible but not enrolled in public health programs. And an astounding 74 percent of uninsured children are eligible for public programs.[25]

  Research suggests that these individuals face substantial barriers to health care, and use fewer services than their counterparts with Medicaid coverage.[26] Other states noted that many uninsured individuals have access to non-Medicaid health care coverage but choose not to take it.

  - **Texas** found that more than two million of that state's uninsured (40 percent) are young adults ages 18-34, who are generally healthy, and may opt to go without insurance even if they can afford it. This finding suggests that education is important in encouraging young people to purchase health insurance coverage.
  - In **Pennsylvania**, where half the uninsured are young adults between the ages of 18 and 34, the state similarly found that members of this age cohort expressed confidence in their health and preferred to use funds for other expenses.
  - In **Illinois**, individuals who were eligible but not enrolled described affordability barriers to public programs, noting that some programs charge premiums, copays, and deductibles. But many uninsured individuals were not aware of the accurate costs of the program, or even their existence. Participants in Illinois' focus groups described another common barrier for those who are eligible but not enrolled—

the stigma of public programs, saying they "'do not want to be lumped together with those who are freeloading.'"[27]

- Interestingly, **Maryland**'s focus group participants felt that premiums alone were far more affordable than premiums combined with copays and other cost sharing mechanisms.

- **Insurance costs and other barriers faced by individuals.** In a 1999 survey sponsored by the Commonwealth Fund, about one-half of lower wage workers who declined coverage cited high costs and/or inadequate benefits as the main reasons they declined coverage. Among higher wage workers, however, the availability of health insurance through a family member was more commonly cited as the reason for declining coverage.[28] For low wage workers, cost was the major reason given by uninsured individuals and families for not participating in employer-sponsored coverage for which they are eligible. These findings are supported by the employer and employee focus groups undertaken by SPG grantees. States found that consumer focus groups provided a community "voice" to their planning efforts. The lack of affordable options was frequently cited as a significant barrier.

  - **Florida** conducted ten focus groups across the state, including two in Spanish and/or Haitian Creole. Consumers in these focus groups consistently identified premiums that are not affordable and exclusionary provisions for pre-existing health conditions as barriers to obtaining health care coverage.
  - In **North Carolina**, focus group participants indicated that they desired coverage but did not think they could afford it.
  - **Vermont** conducted two focus groups to better understand the reasons why some individuals and families go without insurance. While participants agreed that health insurance was important, affordability appeared to be the main barrier for them. Most had health insurance at one point, but lost it when they changed employers. And many reported they would purchase coverage if they received a significant pay raise or went to work for a business that offered health insurance.

  For many states, these focus groups helped not only to articulate specific barriers experienced by individuals in obtaining coverage, but also to test specific benefit package options.

  - In **New Hampshire**, both focus group and survey results found that consumers had significant concerns about affordability, and had limited willingness and ability to pay for a benefits package. New Hampshire found that only 23 percent of working uninsured would participate in a benefits plan that cost as little as $90 a month.
  - **West Virginia** conducted six focus groups to solicit input on two "affordable" benefit package designs: an adult basic product for the small group market and a streamlined individual product.

- **Where the uninsured receive care.** The question of where the uninsured receive care resulted in little new insight into the ways in which uninsured individuals meet

their medical needs. States found that the uninsured receive care through many different sources, including hospital emergency rooms, safety net providers such as federally qualified health centers, pay out of pocket for private providers when possible and at the risk of incurring substantial debt, or go without care.

- **Maryland** noted that its uninsured residents receive care through many different mechanisms and paid for by many different sources, including state funded programs, grant funded programs, and philanthropic efforts.
- **West Virginia's** focus groups also revealed that the uninsured met their needs in a variety of ways. Some uninsured individuals treat themselves with over-the-counter medications, seeking care only when their condition deteriorates. Others seek care knowing that they will either get a reduced rate or work out a payment arrangement with the provider.

- **Employer decision-making and incentives.** Through focus groups and other qualitative approaches, such as key stakeholder interviews, states made a concerted effort to gather information on employer decision-making on health care coverage. In addition to cost serving as the primary deterrent in an employer's decision not to provide coverage, states uncovered a great deal of confusion amongst employers—especially small businesses. Delaware found a "strikingly high level of misunderstanding and confusion" among small businesses on the topic of health insurance coverage. These findings led the state to beef up its plans to disseminate educational materials to the employer community.

  - **Delaware** undertook both an employer survey and employer focus groups; the state reported that "cost, or perception of cost, is the single determinant of a business's decision to offer or not offer health insurance benefits."[29]
  - Similarly, **Florida** found that "price" was the number one reason that employers either did not offer health insurance or discontinued coverage.
  - **Maryland**'s focus groups revealed that many small employers are particularly prone to not offering coverage if they have a high employee turnover or employ greater numbers of workers from the retail industries; "trade" businesses such as beauty salons, travel agencies, florists, and auto shops were also found to be less likely to offer coverage.
  - In **New Hampshire**, employer focus group participants described cost as a major barrier that affected their decision whether to offer health insurance. These employers believed that competition, and the hope for a resultant reduction in premiums, would be the only way to encourage more employers to offer coverage.
  - In **North Carolina**, focus groups revealed that employers viewed health insurance as an important benefit to recruit and retain staff. At the same time, employers reported that they were cutting back on dependent coverage in response to rising premiums.

Modeling and Actuarial Studies

Many SPG states undertook modeling and actuarial studies that were designed to predict the costs and benefits associated with different health coverage options, and ultimately to assist states in selecting the strategy that best addressed coverage expansion for the targeted uninsured population. Examples of these studies include the following.

- **California** selected the Lewin Group to conduct microsimulation modeling of the economic impacts of reform options developed by health policy experts. The Lewin Group's final report provides detailed estimates of the cost and coverage impacts of each proposal considered by the state, including an estimated ten year budget for each coverage option. The model also examined the impact of changes individual out of pocket costs, costs to employers, and impacts on safety net programs.

- In 2002, **Massachusetts** contracted with Jonathan Gruber, Ph.D. of MIT, to develop a microsimulation model that would show the impact of potential changes to the state's public programs to increase health care coverage. The model examined the impact of different tax policies, including tax credits for non-group insurance purchases and for employers and employees. The model also evaluated the impact of different scenarios on the state's public safety net. One of the key findings from these simulations that without what the state describes as an "individual responsibility mechanism," tax incentives had little effect.

- Using FY 2004 and 2005 SPG funds, **Minnesota** also hired Jonathan Gruber to develop a microsimulation model using the 2004 Minnesota Health Access Survey data. The purpose of the model was to estimate enrollment and cost impacts of various coverage options, and to assist policymakers in considering strategies for maintaining or increasing coverage. The modeling results showed that a wide range of impacts in terms of the number of insured persons covered and the estimated cost per individual. The most cost-effective option was a tax credit or voucher to purchase private health insurance.

- **Wisconsin** hired consultants to prepare an impact analysis of potential changes in public program enrollment on hospital's provision of uncompensated care. The study quantified the impact of expanding BadgerCare and found that expansion of the program from its inception in 1999 through 2004 had resulted in a savings of $283.08 million in hospital's uncompensated care spending.

Chapter III: Governance and Consensus Building

SPG states established governance structures to coordinate their grant activities and to oversee outreach to groups with a stake in selecting coverage options for the uninsured. These governance structures typically included an executive branch lead agency designated by the governor and complemented by various committees to oversee data collection and consideration of policy options. States used these structures to guide the process by which they collected state-specific data on the characteristics of the uninsured and developed policy options to expand health care coverage within the state. These structures were also the nexus of activities for obtaining input and support from key stakeholders.

Selection of SPG Lead Agency

Governors had to request the grant to show his or her support and to indicate SPG activities were part of a state-wide effort to develop plans to cover all of the state's uninsured populations. Each state Governor designated a single agency with authority for coordinating SPG tasks and funding. Many Governors selected their departments of health insurance or commerce or their own governor's office to serve as the lead agency. In some cases, the decision by states to designate a lead agency reflected the state's current policy environment and political realities.

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.

- **Washington**, for example, faced a potential biennium deficit of $1 billion at the time of SPG grant award. Not surprisingly, the Governor's budget office served as the lead agency for managing that state's SPG grant activities. Moreover, Washington found that the initial housing of the SPG program research and planning activities under the Governor's Policy Office separated staff with SPG program responsibilities from the day-to-day operations of the Medicaid and other public programs. As a result, the SPG program came to be viewed as a neutral and critical clearinghouse for data on the uninsured and for analysis of coverage options.

- In **Maine**, Governor John E. Baldacci's first act as Governor was an Executive Order creating the Governor's Office of Health Policy and Finance (GOHPF), with oversight responsibility for health reform initiatives and health policy. Locating SPG activities in the GOHPF ensured the involvement of key state agencies from the outset and also kept state leadership informed of policy strategies as they developed.

Table 3-1 lists the lead agency identified by each state.

Table 3-1: SPG Grant Lead Agencies

State	Lead Agency
Alabama	Department of Public Health
Alaska	Department of Health and Social Services
American Samoa	Office of the Governor
Arizona	Arizona Health Care Cost Containment System (Medicaid Agency)
Arkansas	Arkansas Department of Health, which contracted the project to the Arkansas Center for Health Improvement Health Policy and Research Center)
California	Health and Human Services Agency
Colorado	Office of the Governor
Connecticut	Office of Health Care Access (Executive branch research and policy center)
Delaware	Delaware Health Care Commission
DC	Department of Health
Florida	Agency for Health Care Administration
Georgia	Office of the Governor, which contracted the project to the Georgia Health Policy Center at Georgia State University's Andrew Young School of Policy Studies
Guam	Department of Public Health and Social Services
Hawaii	Department of Health
Idaho	Department of Commerce
Illinois	Department of Insurance
Indiana	Indiana Family and Social Services Administration
Iowa	Department of Public Health
Kansas	Department of Insurance
Kentucky	Kentucky Office of Rural Health
Louisiana	Department of Health and Hospitals
Maine	The Governor's Office of Health Policy and Finance, which contracted with the Health Policy Institute at the University of Southern Maine
Maryland	Department of Health and Mental Hygiene, Maryland Health Care Commission, Johns Hopkins University Bloomberg School of Public Health (partnership)
Massachusetts	Division of Medical Assistance and the Division of Health Care Finance and Policy
Michigan	Department of Community Health
Minnesota	Department of Health (Health Economic Program)
Mississippi	Office of the Governor, Division of Medicaid
Missouri	Department of Health and Senior Services
Montana	Department of Public Health and Human Services
Nebraska	Health and Human Services System
New Hampshire	Department of Health and Human Services (Office of Planning and Research)
New Mexico	Human Services Department
New Jersey	Department of Human Services

State	Lead Agency
North Carolina	Department of Health and Human Services
North Dakota	Department of Health
Oklahoma	Health Care Authority
Oregon	Office for Oregon Health Plan Policy and Research
Pennsylvania	Governor's Office of Health Care Reform
Puerto Rico	University of Puerto Rico, School of Medicine
Rhode Island	Department of Human Services
South Carolina	Department of Insurance
South Dakota	Department of Health
Tennessee	Department of Commerce and Insurance
Texas	Department of Insurance
Utah	Department of Health (Division of Health Care Financing)
Vermont	Agency of Human Services (Office of Vermont Health Access)
Virgin Islands	Office of the Governor
Virginia	Department of Health
Washington	Office of Financial Management (Governor's Budget Office)
West Virginia	Health Care Authority
Wisconsin	Department of Health and Family Services (Division of Health Care Financing)
Wyoming	Department of Health

Governance Structures

Most states and some Governors specifically established a core steering committee complemented by advisory panels with diverse membership to review and recommend coverage options. Examples of these structures include the following:

- **Arizona** established a legislatively-sponsored committee, The Statewide Health Care Insurance Plan Task Force, charged with designing an accessible and affordable health care coverage plan. The Task Force included six legislators from both rural and urban districts, and three representatives appointed by the Governor, one each from the health care provider, consumer advocacy, and business communities. During the first phase of SPG planning, a Technical Advisory Committee composed of representatives from the physician community, insurance companies, hospitals, and relevant state agencies provided guidance and feedback on proposed approaches.

- **California** established the Health Care Options Project (HCOP) designed to meet legislative requirements calling for the examination of options for providing health care coverage to Californians. Decision-making authority was lodged with the Secretary of Health and Human Services, with input and advice from a wide range of experts, state officials, and stakeholders. The Secretary first convened several groups of advisors to provide guidance on the best ways to develop options and the design of the public input process. A cross-section of stakeholders were invited to join a public advisory group, including providers, associations, insurers, health planners,

consumers, businesses, local government, and labor interests, as well as legislative staff. The advisory group was charged with providing input to HCOP on selecting health care coverage options to be explored, and organization of a series of five statewide symposia to gain public input, among other tasks. The advisory group also assisted a modeling contractor in discussions of the design and assumptions used for an economic analysis of coverage options.

- In **Colorado,** the Governor's Office served as the lead agency for the SPG project. The HRSA grant was administered through its Project Management Team, a public/private partnership with private sector representation by the Colorado Coalition for the Medically Underserved. The Coalition was composed of over 150 individuals and organizations representing health care providers, consumers, businesses, government agencies, philanthropic organizations, and others. The governance structure of Colorado's Project Management Team as well as its Strategic Planning Group represented a bipartisan approach to addressing the issue of the uninsured.

- In **Maryland**, staff from key state agencies and branches involved in issues surrounding the uninsured served on the Health Care Coverage Workgroup, which held facilitated meetings on a regular basis to provide input and feedback. The project was staffed by individuals from the Maryland Department of Health and Mental Hygiene's Medicaid and Public Health Divisions as well as a large contingent from the Maryland Health Care Commission. The 28-member Workgroup included representatives from the State's medical provider, insurance, health plan, business, health care advocacy, and health care research communities. To ensure public feedback from as diverse a constituency as possible, the Workgroup held meetings in different areas of the state.

- **Pennsylvania** formed four Advisory Work Panels comprised of approximately 20 members each, with representation from unions, businesses, health care providers, consumers, consumer advocacy organizations, and academia. The panels provided advice on the policy options considered by the states and focused on the following four topic areas: 1) affordable health coverage for small businesses; 2) publicly funded health care coverage; 3) quality; and 4) cost.

- In **Rhode Island**, a Directors' Health Care Group represented leadership from key state agencies including the Department of Health, the Department of Labor, and the Health Insurance Commissioner who chaired the group. The Directors' Health Care Coverage Group was supported by five issue groups that handled topics from wellness to health information to state health care purchasing. The state found that the "silos" of state government were a barrier to progress at the beginning of the project but that the creation of the Directors' Health Care Group greatly facilitated collaboration and integration of efforts across state agencies. Rhode Island also formed a Small Employer Advisory Group, an informal group of employers who provided feedback on insurance affordability and other topics.

Analysis and Selection of Policy Recommendations: Public Input

Once states designated a lead agency and developed a governance structure for moving forward, they involved key stakeholder groups in a deliberative process to consider policy options. States sought input and support from key public and private sector leaders, including representatives from state departments of health and insurance, hospitals, advocacy groups, unions, and academic institutions. This public input process varied from state to state both in terms of from whom the state sought input to developing policy recommendations, and how and when their input was solicited. In some states this process was informal and involved myriad ad hoc meetings and educational presentations. In other states, the public input process was quite formal and entailed statewide conferences with a carefully orchestrated approach to seeking public input.

By involving a broad array of public and private stakeholders, and communicating their progress on a regular basis, states effectively used their SPG funds to build a community of stakeholders with a vested interest in increasing health coverage. States included many of these stakeholders directly in the SPG project planning through their advisory group memberships. Other stakeholders were engaged in project planning via focus groups, key informant interviews, special briefings, and community forums.

Many states took steps to ensure the transparency of the deliberative process by which they developed policy recommendations. States communicated their activities and deliberations to the public by holding public advisory group meetings and, in some cases, by conducting meetings in different regions of the states. Many states also posted project updates on a designated Web site.

Examples of the different ways that states sought public input include the following.

- **California** hosted a series of four symposia across the state in early 2002. The state used these forums as their primary method for obtaining input on reform options under consideration by the HCOP. The California Research Bureau, a division of the California State Library, organized the symposia including a mailing of brochures to 900 potential participants. Attendance ranged from about 75 individuals at the Fresno symposia to 250 at the Oakland site. In all, 600 people attended these events, which included presentations by the authors of nine reform options. The symposia afforded opportunities for comments from local stakeholders, and extensive question and answer sessions which generated nearly 1,000 written question and comment forms.

- In contrast to California's highly structured approach, **Tennessee** offers an example of a fairly informal public input process that was typical of many SPG grantees. Tennessee's outreach activities centered on educational meetings with groups that had expressed an interest in learning more about the project. In addition to these meetings, project staff had frequent and ongoing informal contacts with a wide array of providers, insurers, and legislators. The state also established a Web site for the project that offered information related to the uninsured.

- **The Vermont Ethics Network (VEN)** received a foundation grant from the Study Circles Fund (Topsfield Foundation) to develop and conduct a series of weekly study circles. This effort consisted of 40 regional study groups of 8 to 12 participants each to discuss access to health care in Vermont. VEN then partnered with the Commission on the Public's Health Care Values and Priorities for the purpose of distributing questionnaires to study circle participants for the purpose of comparing health choices made by individuals selected to participate in study circles and randomly chosen individuals (via telephone survey). The state trained facilitators for the study circles. Study circle participants also completed questionnaires in order to compare their health choices to those randomly chosen for a telephone survey.

Table 3-2: Types of Stakeholder Groups Involved in SPG Grant Activities

Public Sector	Private Sector
Governor's office	Hospital association/local hospitals
Department of Health	Medical society/private physicians
Department of Human Services	Nurses association/individual nurses
Medicaid agency	Health plans
Other coverage program agencies (e.g., SCHIP, high-risk pool)	Insurance brokers/agents
Department of Commerce	Chamber of Commerce/employer groups
Department of Labor	Employer purchasing pools
State employees	Employees/labor unions
Local/county government	Farmers/farming groups
State university-based health policy center	Consumer advocacy groups/consumers
Independent health care commission	Community health centers/FQHCs
State legislators/committee staff	Religious groups/leaders
Health insurance task force	Philanthropic foundations
	Universities, researchers

Consensus Building Strategies and Lessons Learned

As they developed policy options for expanding health care coverage to the uninsured, states employed several strategies to achieve stakeholder and community consensus. Some of these strategies offer lessons learned in gaining consensus during the difficult process of narrowing the list of viable coverage options.

- **Establish a diverse governance structure with representation by multiple stakeholders; remain flexible.** In designing and implementing their governance structures, a common theme emerges across states. Whether they established a single, central task force operating alone or a task force supported by multiple advisory groups, including a range of stakeholders in their governance structures proved to be a critical step for most states.

  - While **Alaska** chose a strong internal leadership team, the state was confident that it would involve a statewide stakeholder group through forums, key informant interviews and other statewide meetings. The Governor identified the Department

of Health and Social Services as the lead agency for SPG grant activity and appointed a leadership team composed of high-level representatives from three key cabinet departments: Health and Social Services, Labor and Workforce Development, and Commerce. The Governor chose an internal leadership team in order to foster a strong working relationship across the key affected agencies, and to streamline oversight with frequent, short meetings that would have been difficult to achieve with an oversight group comprised of stakeholders from across the state.

- **California** used a centralized decision-making governance structure with Cabinet Secretary leadership enhanced by multiple advisory groups. California described this model as "highly effective" and "sufficiently flexible to allow improvements (to) the design and timing of the HCOP, but was structured enough to ensure that all goals and objectives of the HCOP were met."
- **North Carolina** summed up this lesson learned by commenting that "pulling together key governmental, provider and advocacy organization representatives into a Task Force setting allows for a thoughtful and deliberative evaluation of the problem of lack of health insurance coverage to North Carolinians. This gave rise to practical options with the greatest potential for resulting in a substantive set of policy recommendations" that could be supported by the Task Force members and moved through the legislative process.

- **Find balance between political decision-making and topical expertise.** Many states involved both legislative staff, in addition to stakeholders and a range of outside experts.

  - **Arizona** found that using both a legislative-based task force and a technical advisory committee offered an important balance between political decision-making and the input of experts. Involving the legislature from the outset was critical ultimately to passage of legislation based on the task force recommendations. "Only through the active involvement of the Governor and key policy makers in the Legislature, continued support of Health Care Group (HCG) members and providers, and a series of meetings with concerned stakeholder groups was the Arizona Health Care Cost Containment System Administration (AHCCCSA) able to achieve resolution and final passage of the legislation."

Chapter IV: Policy Options

The SPG program enabled states to research and develop plans for covering their uninsured populations and—when the political and economic environment was right—move forward with programs that offered coverage to those populations. Developing specific policy options required significant effort by states to build support and consensus among stakeholders that would then ensure successful implementation of their efforts.

One of the challenges to states was that no *single* approach was likely both to gain widespread support and to be effective in significantly reducing the uninsured. At the outset, states needed to identify a range of options that could achieve broad support and that offered realistic alternatives to stakeholders, including policy makers, legislators, providers, and purchasers.

This chapter provides an overview of how grantees developed policy options for addressing the needs of the uninsured in their states, what options they chose to pursue, and also, what options they rejected and why. The chapter is divided into the following sections:

- **Guiding principles and assumptions** that states developed at the outset.
- An overview of the **policy options considered** by state, and those that they chose to implement.
- **Options** that states classified as **"off the table"** and a discussion of their reasoning.

Guiding Principles and Assumptions

A number of states established guiding principles to assist policy makers and stakeholders in the consensus building and option development process. These principles helped grantees both to focus on desired outcomes and to uncover the breadth of options available to them. Arizona, for example, developed a set of specific questions or criteria that were revisited throughout the course of the state's deliberations surrounding development of a plan to address accessible, affordable health care in Arizona.

Table 4-1 presents a compilation of these principles, grouped by theme. Each state did not adopt every principle, but sought to move forward with their research and coverage expansion strategies with these beliefs in mind.

Table 4-1: States' Guiding Principles

Theme	States moved forward with their research and exploration of coverage expansion strategies with the belief that options should:
State capacity	• Reflect that health care coverage should be accessible, affordable, and provided for in cooperation with all stakeholders involved. • Reflect that health care should be provided seamlessly and with the goal of offering the highest quality care possible. • Reflect that state governments cannot fully solve the problem of the uninsured; states will require increased federal funding and

Theme	States moved forward with their research and exploration of coverage expansion strategies with the belief that options should:
	flexibility to address the needs of the uninsured. • Reflect that reaching 100 percent coverage under the current system may not be achievable. Vermont, for example, decided on a goal of 95 percent coverage for adults, 97.5 percent for children. • Be politically and economically acceptable. • Reflect that health care coverage should be accessible and affordable to individuals, taxpayers, employers, and government. • Emphasize shared responsibility among individuals, providers, government, and businesses.
Program tenets	• Embrace strategies that are multi-pronged, or part of a broader set of solutions. • Be incremental and maintain gains of the past. • Improve access to care, and provide that care at a cost that is reasonable and affordable to individuals, taxpayers, employers, and government. • Incorporate a comprehensive wellness focused benefits package and promote individual responsibility toward wellness. • Offer basic benefits that are available and accessible. • Be pursued in collaboration and in cooperation with both public and private stakeholders and foster competition.
Building on existing infrastructure	• Maintain the employer-based system as the foundation upon which reforms are built and encourage public-private partnerships where possible. • Target the working uninsured and small employers, where the majority of uninsured are employed. • Avoid replacing private coverage with public coverage. • Improve capacity and demand in local communities' delivery systems. • Increase enrollment of those already eligible.
Financing	• Maximize available state and federal dollars. • Develop affordable and properly financed strategies. • Utilize subsidies. • Maintain financial flexibility in the face of changing economies.
Target groups	• Reflect the needs and characteristics of different uninsured subgroups (e.g. Hispanic, black, rural, near elderly, eligible but not enrolled). • Educate consumers, employers, and other stakeholders about the health care system and their options within it. • Target the financially needy, particularly those below 200 percent FPL.

With these guiding principles in mind, states used their quantitative and qualitative research to identify feasible approaches to address access, affordability, and coverage.

Policy Options: Emerging Themes

As states developed their guiding principles and began studying a range of options for expanding coverage to the uninsured, a number of themes emerged. Examples of how states addressed these issues are described later in this chapter.

- **Uninsured below 200 percent FPL are key target group.** Many states developed options aimed at individuals living below 200 percent FPL. Those states that already covered individuals up to or above 200 percent FPL turned their attention to improving outreach and enrollment to those who are already eligible. A common theme among SPG states was the need to educate young working adults who are eligible but not enrolled in public programs or private coverage either because they feel healthy and do not need coverage or because they want to avoid the stigma of enrollment.

- **Working uninsured and small employers are critical target groups.** Many states found that a significant proportion of their uninsured citizens work for small businesses that do not offer health care coverage.

> "Probably the most critical lesson was around the depth of the problem for very small businesses. With less than half of employers under 10 offering health insurance, and a significant decline in the share of small business employees offered insurance, the problem is bigger than we might have initially believed."
>
> *Rhode Island, Final Report, September 2005*

- **History of coverage expansions and dynamics of private insurance market play important roles.** In the years prior to the SPG program, many states had made progress in increasing access to health coverage by expanding eligibility to public programs beyond federally mandated levels for children, pregnant women and adults. Some states—Connecticut, Delaware, Massachusetts, Minnesota, Oregon, Vermont, and Wisconsin—lead the nation in terms of high eligibility levels for public programs. Thus, these states tended to investigate options for expanding coverage through private markets. Other states—including Arkansas, Idaho, and Texas—that have high uninsurance rates combined with lower eligibility for public programs and contracting employer-based coverage faced a more daunting challenge in identifying feasible options.

- **Supporting the existing safety net viewed as key component.** Many SPG states expressed concern with the impact that coverage expansion plans might have on safety net providers and sought measures that ensured the continued vitality of these providers.

> "Simultaneous with receipt of the initial grant in 2001, Washington's economy and state budget were hit hard by recession. In fact, within days of receipt of the grant we got an inkling of things to come—an inquiry from legislative staff wondering if we'd lost our marbles talking about coverage expansion when the state couldn't afford to cover people already on its programs!"
>
> *Washington, September 2004 Report*

- **Fiscal realities forced focus on maintenance of coverage, not expansions.** Expanding coverage is difficult in the best of times. While the fiscal outlook for states has strengthened in the last year or two, from 2001 until 2005 the SPG program coincided with a time when the majority of states faced significant budget deficits and poor economic conditions. As a result, many states found that incremental changes were more realistic than wholesale transformation. These states focused on maintaining and enhancing existing health care coverage structures. In addition, many states were hesitant to pursue program expansions without new federal flexibility and funding.

Options for Expanding Coverage

Grantees considered an array of policy options during the course of the SPG program, ranging from increased outreach efforts to those individuals who are eligible but not enrolled in public programs, to approaches that would transform the delivery and financing of health care within their state. Table 4-2 lists some of those options. A full list of policy options that states considered and those that they implemented with assistance from the SPG program is presented in Appendix C.

Table 4-2: Policy Options Considered & Implemented by States

Policy Option	Number of States Considered	Number of States Implemented
Building on Existing Public Programs		
Medicaid/SCHIP expansions	**41**	**29**
Safety net strategies	**16**	**4**
Outreach to eligible but not enrolled	**11**	**4**
Building on Employer-Based Coverage		
Group purchasing arrangements	**24**	**9**
Employer mandates/ "fair share"	**9**	**4**
Tax credits for employers or individuals	**10**	**3**
Improve Access to Private Insurance Markets		
Limited benefit/ "bare bones" coverage	**21**	**12**
High risk pools	**15**	**10**
Premium assistance programs	**19**	**10**
Individual coverage mandates	**7**	**1**

In general, states acknowledged the importance of building on the existing private insurance and employer-based systems, and also the need to maximize federal and state funding for public programs. States analyzed possible solutions with an eye toward several practical considerations. Montana, for example, screened proposals on several criteria, including whether the proposals would: 1) have a significant fiscal impact on the state; 2) require new state legislation; and 3) require a new state funding mechanism.

For purposes of the following overview, we have divided the strategies pursued by states into several broad categories:

- those that **built on existing public programs**,
- those that sought to **enhance the existing employer-based coverage structure**, and
- those that aimed to **improve access to private insurance markets**.

Within each of these categories, we offer examples of approaches that states are considering or have implemented. Note that some states are using more than one strategy

Building on Existing Public Programs

Building on Medicaid Eligibility

Expanding eligibility in public programs enabled states to utilize existing coverage structures and maximize state and federal funding. This option proved the most popular of all strategies with 41 states considering a Medicaid or SCHIP expansion and 29 states actually pursuing implementation of this approach.

- **Idaho** planned to use its grant funds to develop a plan for expanding coverage to low-income, uninsured women based on Healthy Mothers, Healthy Babies—a family planning expansion.

- **Wisconsin** researched and developed a plan to expand BadgerCare to children (under the age of 21) to 300 percent FPL, and to develop a BadgerCare health insurance premium payment model for children above 300 percent FPL. CMS approved the state's waiver to allow its BadgerCare expansion, BadgerCare Plus, to move forward and enrollment will start on February 1, 2008. Under BadgerCare Plus, families with incomes that exceed eligibility for current public programs will be able to purchase basic health coverage for their children for $10 to $68.53 a month, depending on their income. Wisconsin plans to subsidize premium costs for those families with incomes up to 300 percent FPL. Families with incomes above 300 percent FPL will be required to contribute the full cost of coverage.

- **Mississippi** examined the feasibility of a Medicaid buy-in that would enable low-income people and low-wage small employers to purchase coverage through Medicaid at full cost to the purchaser. Premiums would be lower than comparable private coverage due to the heavily discounted provider payment rates (about 25 percent) under Medicaid. The state also examined the feasibility of a "third-share" program whereby low-income people would be permitted to buy-in to Medicaid with the state, employers, and individuals each paying one-third of the buy-in premium (but has not moved forward with this initiative).

Improving Outreach and Education

A number of states proposed improved outreach to eligible populations within the state's existing public programs. States' quantitative and qualitative research helped pinpoint those subpopulations eligible but not enrolled in public programs. This research also suggested some of the areas in which states' needed to redouble their efforts to educate and reach out to these groups. Examples of states' activities to simplify program administration, improve educational efforts, and strengthen outreach efforts include the following.

- **Massachusetts** debated options for expanding health care coverage to the over half million residents who lack health insurance. Ultimately, this debate resulted in passage of the Massachusetts Health Care Reform Plan in April 2006. One unique feature of this reform plan is the Commonwealth Health Insurance Connector, or the Connector, which helps individuals and small businesses find affordable insurance products more easily. In May 2007, the Connector approved seven Commonwealth Choice plan designs offered by six health insurers, including two low cost products designed for young adults. All seven of these products are available to all residents, but are specifically geared to those above 300 percent FPL.

- **Vermont** implemented a number of initiatives to increase enrollment of children in existing public programs, including media campaigns and outreach through schools and providers.

Expanding Community-Based Programs

A number of states sought to enhance existing community involvement—whether through local providers, purchasers, or other stakeholders—in expanding coverage to uninsured populations.

- **American Samoa** implemented a unique community-based pilot planning process utilizing traditional leaders to develop community-specific plans for coverage and to integrate the regional plans to a territory-wide plan.

- The **District of Columbia** established the Healthcare Alliance, which provides free health care to uninsured District residents with family incomes below 200 percent FPL. The Alliance provides HMO-like coverage through a network of primary care "medical homes," with specialty and hospital services from participating providers. This program is funded solely by the District.

- **Georgia** developed a multi-share model in three communities. The model is based on the "three-share" program pioneered by Muskegon, Michigan where the cost of the premium is shared between the employee, the employer, and the community, providing for low cost health insurance to small employers and their workers. In March 2006, the Healthcare Georgia Foundation awarded two year grants to the three Georgia communities designing the three-share programs so that they could continue their work beyond the term of the SPG grant. Accomplishments to date include

establishment of working committees, community meetings, and employer/employee focus groups. The state has conducted surveys of small business and uninsured small firm workers, and has developed a benefit design and undertaken actuarial modeling. Issues that the state is still working to resolve include source of funding for the "third" share, the administrative structure needed to support the program, and regulatory issues.

- **Idaho** strengthened participation of county providers in planning and designing the County Medical Care pilot, a primary care program for uninsured adults.

- Like Georgia, **Illinois** designed a community-based three-share coverage program with premium costs shared by employer, employee, and the community. The state established a permanent trust fund account for Illinois counties that wish to implement a three-share program. The state selected St. Clair County, one of the most economically disadvantaged areas in the state, as a pilot site for the three-share program.

- **Oregon** assessed a sustainable approach to covering more children and non-categorical adults in existing public programs. The state examined options for maximizing enrollment of children eligible in both public and private coverage, and later expanded these efforts to adults. The state also provided planning and technical assistance to two committed communities that are working on community-level expansions by reforming their delivery systems and maximizing finances.

Preserving the Safety Net

States sought both to address the reliance among low-income and poor individuals on safety-net services and the affordability of available coverage options for employers and workers.

- **Arizona** is participating in the development of HealthCare Connect, a public-private partnership in Maricopa County that connects low-income uninsured persons with health care at affordable rates.

- **Arkansas** developed a new insurance program, ARHealthNet, designed to help qualified small businesses, with low income workers, provide an affordable package of health care benefits to their employees. ARHealthNet is a HIFA initiative, available to businesses with 2 to 500 employees who have not offered a group health plan in the past 12 months or longer. ARHealthNet is a unique partnership between state and federal government, employers and families, designed to provide needed health coverage for low income employees at an affordable price. The program will provide a 'safety net' benefit package to approximately 50,000 uninsured working individuals over 5 years. Eligible are parents and spouses of Medicaid and SCHIP children and childless adults aged 19-64 who do not have other insurance coverage, are ineligible for Medicaid or Medicare and have family incomes at or below 200 percent FPL.

- **Delaware** implemented a Community Health Access Program (CHAP) that helps provide access to primary care doctors, medical specialists, prescription programs, laboratory and radiology services through community based healthcare centers, and private doctors who accept CHAP patients and agree to serve as a medical home.

- **New Hampshire** undertook a statewide health care planning process that carefully considered the role of the state's safety net, comprised of 24 community-based hospitals and eight federally qualified health care centers (FQHCs). As part of this process, the state conducted a survey of community clinics and hospitals to assess the extent to which uninsured individuals had access to subsidized care. In addition, the state prepared a report, Strengthening the Safety Net: The Financial Status of NH's Community Health Centers, which informed the state's planning process. The report included recommendations in the areas of financing, technical assistance, workforce development, and research.

1115 waivers: Taking Advantage of HIFA Flexibility and Medicaid/SCHIP Innovation

A number of states took advantage of federal flexibility through the Health Insurance Flexibility and Accountability (HIFA) 1115 waiver guidance, which enables states to adjust scope of benefits and amount of beneficiary cost sharing for optional or expansion populations in public programs.

- In March 2006, **Arkansas** received approval for their HIFA initiative, the Arkansas Safety Net Benefit Program, recently renamed ARHealthNet and described in the previous section. The program is designed to increase health insurance coverage through a public/private partnership that will provide a 'safety net' benefit package to approximately 50,000 uninsured working individuals. The demonstration will occur in two phases, with Phase I (years one and two) being capped at 15,000 parents and childless adults. Phase II will begin in year three and will target approximately 35,000 parents and childless adults. Arkansas used its SPG grant resources to develop and submitted the HIFA waiver application for this program.

- The **District of Columbia** received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a Medicaid Section 1115 demonstration to provide primary and preventive health care services to non-disabled adults, between the ages of 50 to 64, with incomes at or below 50 percent FPL, who are not custodial parents or resident care takers of children under the age of 19 (i.e., childless adults). The waiver was approved for a five-year period, with an annual enrollment cap of 2,400.

- **Florida** received approval in 2005 for its Medicaid reform waiver. In 2006, the state began implementing a plan that enables Medicaid participants in two counties to choose among a variety of private sector managed care plans offering benefit packages tailored to their needs. In addition to comprehensive and catastrophic benefit packages, the plans are offering an enhanced benefits package with an incentive for those Medicaid participants who engage in healthy behaviors.

- In 2002, **Illinois** received approval from CMS for a HIFA waiver. The waiver allowed the State to provide FamilyCare coverage to parents and caregiver relatives of children eligible for SCHIP up to 185 percent of FPL. FamilyCare was fully phased-in over the course of several years, with the final expansion to 185 percent FPL took effect January 1, 2006.

- In mid-December 2007, CMS announced the approval of the Healthy **Indiana** Plan (HIP), an 1115 waiver demonstration project. HIP will be available to uninsured adults between 22 and 200 percent FPL who are not eligible for Medicaid. A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive $500 of pre-deductible, free preventive care and have a $1,100 deductible.

- **Maine** received approval from CMS for a HIFA waiver in 2002 to expand health insurance coverage to childless adults with incomes at or below 125 percent FPL by redirecting a portion of its disproportionate share hospital allocation to cover this population. Coverage was expanded in two phases, covering childless adults to 100 percent FPL in the first phase and expanding to 125 percent FPL after the DirigoChoice program began in January 2004. This latter expansion was since repealed by the Maine legislature when expenditure projections for the program indicated the waiver limit would be otherwise exceeded.

- **Mississippi** received a Section 1115 waiver in 2004 to provide Medicaid benefits to a select group of the formerly covered Poverty Level Aged and Disabled (PLAD) population after services had been discontinued. The demonstration currently serves an expansion population of 4,400 from the neediest of the former PLAD population of individuals who do not have Medicare coverage.

- In 2002, **New Mexico** received a HIFA waiver to expand coverage to low-income uninsured working adults. In July 2005, the state implemented the New Mexico State Coverage Insurance (SCI). This is a public-private partnership resulting in the creation of a new employer-sponsored insurance program. The state contracts with managed care organizations to provide the product. The program is available to low-income, uninsured, working adults with family income below 200 percent of FPL. An individual may enroll through their employer, as a self-employed individual, or as an individual without employer-sponsored insurance. The premium is paid through contributions from the employer and employee in combination with state and federal funds. Individuals and the self-employed must pay the employer as well as the employee portion of the premium. The benefit package is a comprehensive health care benefit with a claims benefit maximum. The SCI plan features cost-sharing designed to ensure that low-income participants would have access to care. Enrollment in the program began July 2005 and, as of fall 2007, the program covered over 10,200 lives.

- In September 2005, CMS approved the **Oklahoma** Employer/Employee Partnership for Insurance Coverage (O-EPIC) under the HIFA initiative. Oklahoma used its SPG

resources to research other states that obtained similar HIFA waivers, specifically studying these states' approaches to conducting eligibility, cost effectiveness, and subsidy levels. In 2007, the legislature increased the eligibility level for the program from 185 percent FPL to 200 percent FPL and renamed the program Insure Oklahoma. Enrollment reached 4,349 in late 2007.

Enhancing the Employer-Based Structure

Employer-based projects studied by grantees using resources from the SPG program cover a range of approaches and activities. A number of states sought approaches that would support low-income individuals who have access to employer-based coverage. Here are just a few examples of activities supported by SPG grants. These approaches ranged from consensus-driven expansion of existing employer-based coverage options to mandates that require employers to finance a portion of their employees' health insurance costs.

- **Connecticut** directed its efforts toward reducing the uninsured population by supporting enrollment and retention of employer-sponsored health coverage. The state explored the feasibility of expanding the Medicaid program to make employer coverage accessible to low-income workers through a pilot premium subsidy program.

- **Maine** undertook further refinements and improvements to its Dirigo Health Reform program. Maine's 2004 State Planning Grant provided research support for the state's ongoing reform effort, which built on the Dirigo Health Reform Act of 2003. Maine received an initial grant in 2002 and a supplemental grant in 2003. SPG funding afforded the state the opportunity to increase employer participation in DirigoChoice by testing changes in the benefit package, subsidy, and a new marketing program. In addition, Maine will study new cost-containment strategies.

- **Maryland** became the first state to require an employer to spend a specific minimum percentage of payroll on health care for its employees in 2006. The Maryland General Assembly passed legislation requiring private-sector for-profit employers with 10,000 or more employees to spend at least 8 percent of their payroll (or 6 percent in the case of a nonprofit employer) on health care. While there are other employers in the state with more than 10,000 employees, only Wal-Mart does not meet the percentage threshold; therefore the Act has become known as the "Wal-Mart" Bill. Those employers that provided less than the required amount had to pay the difference between their health insurance expenses and the percentage threshold into a new Fair Share Health Care Fund, which then directed the funds into the state's Medicaid program. In July 2006, the U.S. District Court struck down the "Wall-Mart" Bill, declaring the measure was pre-empted and was therefore invalid.

- **Missouri** used the data collection activities and consensus building strategies supported by its SPG grant to model several employer-based coverage options specifically using the purchasing power of state employees.

- **New Mexico** worked through the Governor's Insure New Mexico Council to develop new coverage options based on the employer system and blending public and private programs; to evaluate a new State Coverage Insurance program; and to implement a new Small Employers Insurance Program.

Meeting the Needs of Small Employers

Many states sought health coverage options that would expand access to affordable, accessible health insurance coverage for small employers. For these states, workers at small businesses represented a sizeable number of their uninsured.

- **Idaho's** Access Card program offers premium assistance to adults whose gross annual income is below 185 percent FPL and who are employed by an Idaho small business, or who are the spouse of an employee. The program began enrollment in 2005 and is capped at 1,000 adults. As of fall 2006, the program had approximately 300 adults enrolled.

- **Illinois'** "three-share" programs for St. Clair County and a program for Jackson, Franklin and Williamson Counties are aimed at low-wage, small businesses (2-50 employees) that currently do not offer insurance.

- **Oklahoma's** Employer/Employee Partnership for Insurance Coverage (O-EPIC) 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 ; unemployed individuals currently seeking work ; and individuals whose employers don't offer health coverage with household incomes at or below 185 percent FPL. The program had 4,349 enrollees as of Fall 2007.

- **Massachusetts'** Connector facilitates the process of small employers offering Section 125 plans and offers newly developed Commonwealth Choice plans which are unsubsidized. Part-time and seasonal workers can combine employer contributions within the Connector. It also allows individuals to keep their policy even if they switch employees.

- 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.

Improving Access to Private Insurance Markets

Several states have pursued options that enhance public and/or private coverage by reforming the insurance market.

- **Arizona** expanded accessible and affordable coverage to the uninsured by enhancing one component of the State's continuum of health coverage options, Healthcare Group of Arizona, a state-sponsored insurance program for small businesses. Arizona

surveyed the working uninsured to determine their specific needs, perceptions, and price sensitivity related to health insurance.

- **Arkansas** developed the first Health Insurance Purchasing Group (HIPG) in the nation, allowing small businesses with fewer than 100 employees to pool purchasing power and negotiate coverage.

- **Georgia** developed the Consumer Choice Benefits Health Insurance Plan, which offers a choice between a fully mandated health insurance plan and a less costly plan with fewer mandates. It also allows more small businesses the opportunity to choose which type of health care coverage best suits their individual needs and affordability.

- **Maryland** developed a high risk insurance pool for residents who are considered uninsurable either because they are high risk or have a history of medical problems that makes it difficult for them to find affordable insurance coverage in the individual market. The Maryland Health Insurance Plan (MHIP) now has more than 9,200 enrollees and offers a successful model of a high risk insurance pool that serves as a critical safety net to individuals who cannot find affordable health coverage. MHIP is funded by assessments on Maryland hospitals' net patient revenues, a subsidy mechanism that distributes the cost of the risk pool broadly.

- **Rhode Island** designed and implemented a new private, lower cost insurance product that will be attractive to small employers, employees, and the self-employed. This new product will coordinate with the existing market, RIte Care, and RIte Share.

- **Tennessee** developed a comprehensive plan for implementing a pilot project for the uninsured called "Cover Tennessee." The project will seek to make insurance affordable for small employers, their employees, and individuals through the development of creative reinsurance arrangements with health insurers.

- **Texas** focused on how to provide a lower cost insurance product for small business, in conjunction with the Greater Houston Partnership Public Health Care Task Force.

- **Washington** designed a Small Business Assistance program. The focus of the program is a small employer purchasing pool; a component of the program is premium assistance to help low-income families buy into employer coverage.

Options "Off the Table"

Some states eliminated options early in the process, while others adjusted expectations as their deliberations progressed, particularly in response to declining state resources and input from stakeholder groups. States cited political and fiscal constraints as the most common reasons for deciding against implementing specific coverage or policy options.

> "Colorado is reluctant to establish programs that may not require State dollars now but could well do so in (the) future, if their initial funding base is not reliable over the long term."
> *Colorado, Progress Report, October 2004*

Some examples of options rejected by states and their reasoning follow.

- **Mississippi** examined the feasibility of a small employer pool and concluded that such a pool is unlikely to reduce costs in Mississippi, based upon a review of the data available on the cost performance of existing small employer pools in other states. The provider market in the state is not sufficiently competitive for a pool to be successful in negotiating significant volume discounts. Mississippi referred to research that shows purchasing pools do not reduce administrative costs overall. Mississippi also considered expanding Medicaid to cover new populations but decided against this option due to fiscal constraints.

- **Missouri** considered a variety of Medicaid expansions, including expanding eligibility for dependents up to age 21. The state decided against this strategy because of the difficulty of an expansion given the state's budget environment. Given the rate of uninsured for children in Missouri, policy makers were not sure the state needed to do much more on strengthening Medicaid and SCHIP for children.

- **Oregon** considered and ultimately decided against several options, including: 1) tax credits for employees or employers, 2) an individual mandates, and 3) a standard Medicaid expansion. The deciding factor against the use of tax credits was political resistance and the complexity of administering such a credit. The state decided against pursuing private market individual coverage for fear that commercial insurers would not participate, and, if they did, the premiums would be too high. In the case of individual mandates, Oregon determined that political resistance to this approach would be steep.

Chapter V: Lessons Learned

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. In many instances, grantees reported that their data collection efforts helped overturn myths and misconceptions regarding the uninsured in their states. This section highlights states' perspectives on the usefulness of their data collection activities, insights as to the value of specific data collection methods, and the role of those activities in their planning process.

> "In order to develop health plans and insurance options that are attractive and affordable for the working uninsured, it is necessary to understand who this population is, what they need, and what they can afford."
> *Arizona, Annual Report, 2005*

- **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 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.

> "The qualitative research (focus groups with uninsured Oregonians, small

- **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 mistakes 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.

Other state-specific lessons related to data collection include:

  - *Use national databases.* It can be difficult for states to collect sufficiently large samples from which to draw strong conclusions. National databases can complement state-specific data collection, helping to clarify or solidify conclusions drawn from state databases. (Utah)

  - *Use microsimulation modeling.* Simulations or modeling the impact of different reform options can be a valuable tool. Furthermore, applying consistent assumptions to different approaches improves the ability of policy makers and others to compare potential impacts across a range of different and important policy parameters. (California)

  - *Collect individual stories.* Information collected should include compelling individual stories that can help policy makers understand the human dimensions of the complex problems of the uninsured. "They are a diverse group … helping to share their stories is a worthwhile effort." (Oregon)

  - *Small incentives can increase the response rates*. A cash incentive or small gift (pen, calling card) can improve the response rate for surveys and focus groups. (Utah)

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 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 meaning 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 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.

- **Include the public in a meaningful way.** The general 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.

> "A very positive result of involving the business community in this effort has been increased awareness among Idaho's large and medium-sized businesses who do offer insurance that they have an economic and social interest in reducing Idaho's rate of uninsured."
>
> *Idaho, Final Report, 2002*

- **Identify champions and rely on 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.

> "We caution states to recognize that the planning process is hard work, and there are no easy solutions."
>
> *Delaware, Addendum to Final Report, 2002*

- **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.

Other state-specific lessons related to planning include:

- **One year may not be sufficient time for a consensus building process**. Significant time and commitment are needed for the planning process. Several states commented that while one year sounds like a lot of time, it turned out to be insufficient to seek input and build consensus from stakeholder groups.

- **Keep expectations realistic**. States found that it was very important to remind stakeholders that their expectations vis a vis "success" need to be moderate.

- **Contract with local university experts**. Using local experts and analysts to both conduct survey work and analyze options was helpful to many grantees. Local experts offer familiarity with the marketplace and stakeholders unique to a given state. University researchers can also serve as an effective neutral partner.

- **Hire a national consultant.** On the other hand, a national expert or firm can provide context in terms of what has worked in other states and why. (Utah)

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. Arizona recommended that other states 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.'

> "Tying access expansions to cost containment measures and quality enhancements was critical to the political acceptability of the reform proposal and is critical to its sustainability."
>
> *Final Report, Maine, 2006*

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

State-specific lessons include:

- *Give careful consideration to capacity of safety net.* States need to evaluate safety net providers' capacity, financial viability, and willingness to participate in reforms. (Delaware)

- *The last mile is difficult.* Covering the last 5 to 10 percent of the population will be complex and difficult. It will also be complicated by the conflicting priorities of various stakeholders in the system. (Vermont)

Chapter VI: Recommendations to the Federal Government

States made recommendations to the federal government on a range of topics, including support for continued state research on the uninsured, support for encouraging and understanding consumer-driven health care, and federal flexibility in design of Medicaid and SCHIP programs. States also identified a number of research gaps that federal agencies could play an active role in filling.

Continued Support for State Research on the Uninsured and State Planning

- **State-specific data useful but needs to be expanded and made available more quickly.** States found CPS data invaluable in tracking changes in health coverage and the uninsured. The National Medical Expenditure Panel Survey provided states with useful longitudinal data for tracking changes in coverage status among individuals and families. MEPS also enabled states to track insurance costs by employer size at the state level. However, these data sources would be more helpful if state-specific components could be made available more quickly after the surveys are conducted.

- **More information on other states' experiences needed.** States would benefit from in-depth case studies and evaluations of different state approaches. The experiences of other states in terms of program design, implementation hurdles, stakeholder response, and costs associated with different models of access expansion would help states evaluate their options and determine their strategies.

- **States need to conduct surveys of uninsured on an ongoing basis.** While one-time surveys are helpful, most surveys need to be repeated to provide long-term value. The federal government should consider providing funds for states to develop surveys on the uninsured on an on-going basis, with data requirements that would enable baseline comparisons across states.

- **Facilitate communication among states.** The federal government can help states who are considering similar HIFA waiver strategies to communicate and to learn from one another. In addition the federal government could consider an organizing role in helping states with high-risk pools to share information regarding the interaction of individual tax credits and high risk pools.

- **Build on momentum started by SPG program.** The federal government should continue to fund state research on the uninsured including the development of strategies to prevent erosion of current coverage programs. HRSA should consider funding a mechanism to enable SPG states to continue sharing lessons learned with one another.

- **Continue support for SHADAC and the Arkansas Multi-State Integrated Database.** Efforts such as these have great potential to help states understand the state-specific information they are collecting.

Federal Flexibility/Federal Demonstration Waivers

- **Allow states more flexibility.** States need more flexibility in the design and operation of Medicaid and SCHIP. This is the case in particular with options such as premium assistance programs whose potential effectiveness is limited by federal regulations.

- **Provide matching funds for state efforts to broaden coverage.** The federal government could support state efforts to allocate resources across a broader population by showing federal flexibility in matching state and other funds for individuals who would otherwise be uninsured.

Consumer Education

- **Support consumer-driven health care.** While the private sector is moving toward transparency of cost and quality information, the Federal government needs to do more to support such efforts. Rhode Island commented that the Federal government should support initiatives to make 'sticker-priced' health care a reality for consumers, otherwise 'consumer-driven' is just a euphemism for 'consumer pays out of pocket.'

- **Consider grant program so that states can educate consumers on importance of health insurance.** Consumers who can afford health care coverage but choose not to purchase it may not understand the value of insurance coverage. A federally-funded education campaign would be an effective tool in promoting personal responsibility for health coverage and health care.

States Identify Additional Research Needs

- **Information on insurance markets needed.** States need a better understanding of how insurance markets perform (particularly non-group and small group markets) and the regulatory and other tradeoffs involved with different reform options. Every state has a different insurance market and the specific dynamics of these markets affect whether states are successful in their reform efforts. While some markets have many competitors, others like Maine and Rhode Island have one or two dominant insurers. These different markets need different approaches.

- **Support research on the impact of cost-sharing.** States need to better understand the impact of premiums and cost-sharing on people with little or no income.

- **Research on underinsured elderly needed.** The federal government should consider funding a program on the problems presented by the growth in the number of underinsured elderly who are in need of long-term care services.

- **Research on cost containment strategies.** As states develop coverage expansion options, it would be helpful to have additional research on cost containment strategies. What works? What doesn't? What are the savings?

- **Research on public input process.** The federal government needs to support research efforts that explore strategies for soliciting public input regarding values and preferences related to health care coverage.

- **Additional research topics.** Research related to the concept of "underinsurance," affordability of premiums to individuals (i.e., what would convince working uninsured individuals with available employer-sponsored coverage to take the health insurance?), and crowd-out are always relevant.

Other Recommendations

- **Support health care safety net.** The federal government needs to continue its efforts to support and strengthen the health care safety net, including federally qualified health care centers and rural health clinics.

- **Stabilize premiums for small employers.** Consider developing funding mechanisms that will help states defray the cost of implementing programs that reduce and stabilize premiums paid by small employers.

Chapter VII: Where are SPG States Today?

During the five year lifespan of HRSA's SPG program—from 2000 to 2005—the situation for America's uninsured worsened. The number of uninsured Americans increased by 1.3 million in 2005 alone, bringing the total uninsured to 46.1 million and continuing an upward trend that began in 2000.[30] The economic downturn that began in 2001, combined with rising health care costs and premiums, triggered a protracted decline in employer-sponsored health care coverage.[31]

While the majority of Americans continue to receive health insurance through their employer, the period 2000 through 2005 brought unprecedented erosion in employer-sponsored coverage. Not surprisingly, the steady decline in employer-sponsored health coverage is mirrored by an increase in the number of uninsured individuals for the same period. Between 2001 and 2005, the portion of workers covered by employer-sponsored insurance decreased by almost four percentage points, from 81.2 percent to 77.4 percent.[32]

Access to employer-sponsored insurance is an even greater concern for workers of small employers. While most businesses with 200 or more workers offer health insurance, smaller firms are much less likely to offer such coverage. In fact, the smaller the firm, the less likely it is to offer health insurance. More than three-quarters of U.S. businesses are considered small, and they employ almost one-third of the private-sector workforce. These workers are particularly vulnerable to being uninsured. In 2003, half of the uninsured worked for businesses with fewer than 26 employees or were self-employed.[33]

Against this sobering backdrop, the SPG program laid an essential foundation for states to better understand and address the needs of their uninsured residents. Since the conclusion of the SPG program, the problem of the uninsured has both increased in magnitude and gained greater public recognition on the eve of the 2008 Presidential campaign. These factors alone warrant a look back at the contributions of the SPG program to each state's struggle to address the issue of the uninsured.

The SPG program contributed three critical components to state's ability to extend coverage to the uninsured.

- **State-specific data collection.** Using SPG resources to conduct data collection and state-specific surveys, grantees developed a clearer picture of the uninsured, a picture that helped them move forward with the work of developing specific policy options to address the complex needs of their residents who lacked health coverage.

- **Outreach and consensus-building strategies.** States pursued a range of outreach approaches in

> "…the SPG grant will leave a legacy of initiating the discussion around the uninsured, providing solid evidence and data to keep policy issues. If our State passes legislation expanding Medicaid and for a new reinsurance pool, the grant will be ultimately responsible for supporting this effort."
>
> *Indiana, September 2006*

an effort to successfully engage stakeholders in building consensus around policy options for expanding health care coverage to the uninsured. These strategies offer important lessons to both states and federal agencies.

- **Shared learning.** The SPG program offered the opportunity for states to share research findings and lessons both among themselves and with federal agencies.

A closer look at the efforts of several states since the conclusion of the SPG program offers additional insights and lessons. This snapshot also reinforces the legacy of the program across the three dimensions described above.

Arizona: Meeting the Needs of Small Business Owners

In 2001, Arizona received HRSA SPG funds to research and develop strategies for providing uninsured Arizonans with affordable, accessible health insurance. Phase I consisted of research on Arizona's health insurance market and reviewing best practices from other states. Phase II developed Arizona-specific coverage options that focused on closing the gap between public and private insurance. During this phase, a Statewide Health Care Insurance Plan Task Force developed a general plan to address coverage of the uninsured.

Arizona's SPG funded activities focused, in part, on strategies for expanding one component of the State's continuum of health coverage options—the Healthcare Group of Arizona (HCG)—as a means for providing affordable coverage to the uninsured. HCG is a state-sponsored health care plan for small employers with 50 or fewer employees, political subdivisions, and the self-employed. No income limits apply, but HCG does have employee participation requirements and firms must not have offered group insurance for six months. These guaranteed-issue products are delivered by managed care organizations and employees can select between several benefit options. In 2006, HCG expanded benefit package choices, creating a statewide Preferred Point of Service product and adding dental and vision benefits.

> "HRSA SPG meetings have been invaluable to providing perspective and additional information that have assisted Arizona in its efforts from the initial grant through the continuation grants."
>
> *Annual Report, September 2006*

Under its SPG grant activities, the state sought to learn more about the needs of small employers and their employees in Southern Arizona. In addition, the state used SPG resources to develop linkages via an electronic Health-e-Arizona (HeA) application process that would provide information to small employers and their workers on HCG and other available coverage options. "SPG made a significant contribution to development of the Health-e-Arizona application," says Anita Murcko, M.D., Medical Director, Clinical Informatics & Provider Adoption, AHCCCS.

One challenge facing the state in pursuing enhancements to its HCG program was to understand the disparate demographics and needs of the urban, rural, and frontier areas of

the state. To this end, AHCCCS conducted focus groups in Phoenix and Tucson, two of the largest metropolitan centers served by HCG. The focus groups showed that employer groups were satisfied overall with HCG and were interested in a number of potential additional coverage options. In addition, AHCCCS developed a survey tool to improve available data on the working uninsured. Results from this survey helped inform public policy discussions in the legislature. SHADAC also conducted a literature review on the phenomenon of pent-up demand. "SHADAC did a remarkable job, allowing us to fine tune our benefits and prepare better estimates of true premiums," says HCG's Marc Wynne, Research & Development Administrator.

Focus group results also showed that low-cost, guaranteed-issue, and the ability to insure small groups and part-time employees were some of the key factors that initially attracted employers to HCG. As a result, HCG enjoyed strong growth for several years, growing, for example, by between 2.5 and 4.5 percent each month from September 2004 through September 2006. Enrollment peaked in July 2007 at 26,000.

HCG's popularity and affordable products, however, created problems as the program began to attract high risk patients whose medical conditions made it difficult for them to obtain private coverage. This shift resulted in the need to increase premiums for HCG's products. As a result, the program faced a $23 million deficit, resulting also from changes that reduced program subsidies and legislative regulations that made it harder for the program to uninsured businesses. More recently, HCG has faced difficult times with enrollment dropping as employers realize they can no longer afford the premiums for HCG's products. Many of these employers are coming to terms with the state's declining real estate market and other economic forces that are placing pressure on their cash flows.

As HCG struggled with a growing share of chronically ill subscribers, it requested $8 million in state funds to continue providing coverage to its enrollees. In September 2007, the Legislature suspended new enrollment into HCG resulting in enrollment declines that endanger its viability. As Arizona's lawmakers gear up for their next session, they will be debating whether HCG needs to be overhauled, privatized, or modified to continue meeting the needs of the state's small businesses. One option being considered is the creation of a state-sponsored high risk pool and rolling HCG members into the revised program. However, due to projected shortages in the state's budget, any changes to the HCG model that implies an increase in state support will face stiff scrutiny.

Michigan: A Legacy of Collaboration

In 2004, Michigan received SPG funds to develop a plan to put forth a set of realistic strategies and viable options that would lead to health insurance coverage for all Michigan residents and promote a better understanding of uninsurance issues among key stakeholders and policymakers. The SPG project undertook a range of data collection activities including: household and employer surveys, focus groups of small and mid-size employers and insurance brokers, key informant interviews with policymakers, and town hall meetings.

Michigan is developing an initiative that would extend health care coverage to individuals up to 200 percent FPL. The state is in the midst of negotiating its waiver with CMS. Over the years, stakeholders have failed to reach accord on reforms aimed at the uninsured. With SPG program resources, the state pulled together a broad group of stakeholders, broader than with past initiatives. This time around, the climate was different. "Stakeholders around the table had really reached a tipping point," says Lonnie David Barnett of the state's Department of Community Health. "Some members of the advisory group said they had been waiting 25 years for a diverse group like this to come together." Barnett explains that the group reached agreement up front that it needed to stay at the table until the group had developed feasible options for moving forward and that doing nothing was no longer an option.

Recently, representatives from business, labor, health care, religious institutions, consumers, and insurers formed the non-profit Michigan Health Insurance Access Advisory Council with the mission of identifying and further developing strategies to ensure all Michigan residents have access to affordable health insurance. MHIAC is the successor council to the Michigan State Planning Project for the Uninsured Advisory Council, which was a Michigan Department of Community Health initiative funded under the HRSA SPG grant. Barnett views the launching of MHIAC as a direct result of the state's SPG grant, and attributes the successful consensus-building that took place under the grant to effective facilitation. "Strong facilitation was key to our success, and allowed for new leadership to emerge," says Barnett.

For Michigan, the data collection activities that took place under the SPG grant also proved pivotal to the state's ability to move forward. Like many states, Michigan found that the SPG program provided heretofore unavailable resources for data collection. The state would like to continue the surveys it undertook with SPG funding but lacks resources at this time.

Oregon: Inspiring the Next Generation

In 2000, Oregon received HRSA SPG funds to perform a collaborative and comprehensive study of universal health care options in Oregon. The goals of the project included:

- Increase expansion of public and private programs;
- Increase enrollment of those already eligible; and
- Improve capacity and demand in Oregon communities' delivery systems.

Activities conducted for the grant included a household survey, focus groups among uninsured individuals, small business owners, and health care providers/administrators across Oregon, and an assessment of the small group market in Oregon.

In 2005, HRSA awarded Oregon a pilot planning project grant to prepare for expansions as the state faced renewal of its 1115 and HIFA Waivers. Oregon undertook an evaluation of potential approaches for covering more children and non-categorical adults

in existing public programs. In April 2006, CMS granted approval to Oregon for two more demonstration amendments that went into effect in June 2006. The first extended the state's eligibility period for SCHIP from six months to 12 months. In addition, the state was allowed to amend the premium policy for individuals enrolled in OHP Standard by exempting from the premium requirement those with incomes at or below 10 percent FPL and by eliminating the six-month lock-out for nonpayment of premiums for those with incomes above 10 percent FPL. Individuals above 10 percent of the FPL must pay all past due premiums before they can qualify for a new eligibility period.

The state also provided planning and technical assistance to two committed communities working on community-level expansions by reforming their delivery systems and maximizing finances. Lastly, Oregon reviewed and improved Oregon's Population Survey (OPS) to ensure its reliability and validity as a tool for monitoring health insurance status in the state.

In 2006, Oregon Governor Ted Kulongoski (D) proposed a plan to cover uninsured children through an expansion of the Oregon Health Plan, combined with a private purchasing arrangement for higher income children. Under the Healthy Kids initiative, Oregon would cover all children with family incomes under 200 percent FPL under the Oregon Health Plan. A premium subsidy program would offer financial assistance to those children with family incomes up to 300 percent FPL. With strong public support, the proposal, known as Measure 50 will appear on the state's November 6th ballot. In addition to providing universal health care for children and youths under age 19, Measure 50 would expand health coverage for low-income adults and bolster tobacco-use prevention.

Using SPG funding, the state conducted a children's access survey, which proved invaluable to the formulation of the Healthy Kids proposal. "I cannot stress enough how important local data on uninsured children was to legislators involved in this process," said Tina Edlund of the Office for Oregon Health Policy and Research. The SPG grant made possible "good solid data that is neutral and unbiased to counteract anecdotes."

"I cannot stress enough how important local data on uninsured children was to legislators involved in this process."
Tina Edlund, Office for Oregon Health Policy and Research

For Oregon, another key legacy of the SPG program was the resources that helped attract the next generation of policymakers. "The grant allowed us to bring folks in who we couldn't attract previously; the next generation needs to be inspired," said Jeanene Smith of the Office for Oregon Health Policy and Research. Both Smith and Edlund also credit the SPG program with invaluable networking opportunities with other state policy makers.

The Oregon legislative and executive branches are now working to craft new health care reform legislation. The Oregon Health Policy Commission recently submitted a report, *Road Map for HealthCare Reform: Creating a High-Value, Affordable Health Care System* to Governor Kulongoski outlining major recommendations for reform in the state. Following the experience of recent state reforms, many of the policies outlined by the

Commission reflect the same elements in the reforms that have recently been announced or implemented. These recommendations include:

- The creation of a Health Insurance Exchange;
- An individual mandate to purchase affordable coverage;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians;
- Sustainable system financing, including a broad-based employer contribution;
- Public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent; and
- Supporting community-based innovations that align resources for more cost-effective, higher quality care.

Currently, a bill is being drafted that incorporates many of the recommendations in the Commission report.

Pennsylvania: Covering Children

In 2004, Pennsylvania received HRSA SPG funds to increase the level of understanding concerning Pennsylvania's uninsured population and the actions needed to contain costs, improve the quality of health care, and improve health outcomes for the long term. The state collected and analyzed quantitative and qualitative data necessary to develop options for the expansion of health care access, to control costs, and to ensure quality of care. Also, the team also assessed the individual and small group insurance market in Pennsylvania and market reform efforts that have proven successful for other states.

In 2006, Pennsylvania's legislature approved funding for Cover All Kids, a program allowing families with incomes above SCHIP eligibility levels to purchase health coverage for their children on a sliding scale based relative to income. The state legislature approved $4.4 million for Cover All Kids for its first year of operation. Earlier this year, CMS approved an expansion of the program to provide health coverage to children of parents with annual incomes up to 300 percent of the federal poverty level. Enrollment in this program was scheduled to begin in March. About 133,000 Pennsylvania children are uninsured and of those, 111,000 will qualify for coverage under the expanded program.

> "The SPG program was instrumental in providing much of the data that was used to develop the Governor's health care plan."
> *Gregory Howe, Office of the Governor*

In early 2007, Pennsylvania Governor Ed Rendell (D) announced a Cover All Pennsylvanians (CAP) proposal that would assist uninsured adults and small businesses to obtain basic coverage through private insurers. Premiums would be set on a sliding scale based on income, with the state subsidizing a portion of the premium up to 300 percent FPL. Uninsured individuals earning more than 300 percent FPL would be able to participate in the program by paying the full premium. The Governor's proposed coverage expansion program has been introduced as part of HB 700, which is the omnibus bill that includes the Governor's health care reform proposals. The House has

not acted on the entire proposal, but several legislators have indicated their intention to introduce the CAP proposal as a separate bill.

The state continues to use the data and reports that resulted from its SPG grant. "We are fortunate to have a Governor who recognizes the importance of health care and covering the uninsured and has been very active in working on these issues and promoting this agenda throughout the state," says Gregory Howe of the state's Office of the Governor. While health care reform and coverage expansion are top priorities for the Governor, the legislature is confronting a number of large and competing issues and has not made health care a top priority at this time. "Our challenge is engaging the Legislature and convincing legislators to take action on these issues," he explains.

Vermont: A Bi-partisan Compromise

In 2000, Vermont received HRSA State Planning Grant funds to research, evaluate, and develop consensus about how to provide insurance to the state's uninsured. Under the grant, Vermont fielded the 2000 Vermont Family Health Insurance Survey, conducted focus groups, and developed policy options. Vermont further developed several policy options, including a buy-in to the Vermont Health Access Plan, premium assistance, and medical savings accounts.

Vermont's reform efforts demonstrate that bi-partisan compromise and comprehensive reforms are possible, given sufficient time and effort. In 2006, the Vermont Legislature and Governor Jim Douglas (R) reached agreement on a new program for Vermont's uninsured called Catamount Health program with the goal of reaching universal coverage by 2010. The program offers a new insurance product with subsidies for individuals below 300 percent FPL, as well as several chronic disease management initiatives. The state's Premium Assistance Program substantially reduces the cost of coverage by offering assistance to individuals whose family income is below 300 percent of FPL. The Catamount Health program is financed through a combination of individual premiums, an assessment on employers who do not offer health insurance, new tobacco taxes, and possible federal matching funds. The program is being coupled with a major outreach effort aimed at educating those residents who are already eligible for coverage.

The health care debate in Vermont acknowledged the fact that the majority of health care dollars are consumed by individuals with chronic diseases such as asthma and diabetes. The Vermont Blueprint for Health's Chronic Care Initiative uses a collaborative approach to improve the health of Vermonters living with chronic diseases and uses the Chronic Care Model as the framework for system changes aimed at preventing the spread of chronic diseases.

"These reports helped inform the

To achieve the reforms that lead to implementation of the Catamount Health program, Vermont weathered a number of bumps in the road as the governor's office shifted from democratic to republic, and the state experienced several years of tight fiscal constraints. The state used its SPG funds during this time period to conduct a household survey in 2005 that found an increase in uninsured residents from 2000, and an erosion of employer-sponsored insurance coverage.

Frank Russell of the Office of Vermont Health Access points to the household survey as a major legacy of the SPG program. Noting that these surveys are expensive undertakings, Russell said that the survey results "really gave us some data on our insurance markets that both articulated concerns and helped us think about solutions." In addition, the HRSA grant allowed the state to fund several reports on the feasibility of a premium assistance program. "These reports helped inform the legislature as to what was and wasn't feasible," says Russell.

Washington: Substantial Reforms Enacted

In 2001, Washington received HRSA SPG funds to profile the uninsured in the state and to research innovations in providing access to affordable health insurance coverage and adequate benefits, especially through expanded public-private partnerships. Three continuation grants (in 2002, 2003, and 2005) created a spotlight in the Governor's Office on the uninsured and laid the groundwork for obtaining a Pilot Planning grant in 2005.

Under the initial SPG activities, in-depth profiles of uninsured individuals and families plus the mapping of current pathways for coverage and for access to safety-net-provided care allowed Washington to set the stage for detailed analysis of gaps, overlaps, and barriers to coverage and care. A special emphasis was placed on understanding individual affordability. Major data sources consisted of existing surveys (population-based and employer-based), a project-specific survey to gather information on benefit designs and costs, administrative data, and focus groups.

In 2005, Washington's pilot project planning grant enabled the provision of expert technical assistance for the state to design a small business assistance program. The focus of that program was a small employer purchasing pool; a component of the program was premium assistance to help low-income families buy-into employer coverage.

Washington enacted significant health reform legislation in 2007. Much of the groundwork for the coverage reforms was laid during the state's SPG grant period and with technical assistance and resources provided by the program. Washington's 2004-2005 report notes that "although it is difficult to directly tie SPG efforts to coverage maintenance and expansion outcomes, we believe SPG-supported activities have had a strong and positive influence."

- **Covering all kids by 2010.** In May 2007, Governor Chris Gregoire (D) signed legislation whose express purpose is to provide access to coverage for all children in

the state by 2010. The law authorizes funding for intensive education, outreach, and administrative simplification in order to ensure the enrollment of all currently eligible children, who now account for over one-half of Washington's uninsured children. "About sixty-three percent of our uninsured kids are potentially eligible for public programs. Targeted outreach programs will help these kids get into our programs and stay in as long as they are eligible by reducing some of the administrative burdens," says Jenny Hamilton in the Governor's Office of Financial Management.

- **Premium subsidies for low-income families.** As of January 2009, the legislation expands the state's SCHIP program to children in families with income up to 300 percent of FPL; the current eligibility level is 250 percent of FPL. In addition, children in families with income above 300 percent of FPL will have access to SCHIP at full cost. Premiums will apply to children above 200 percent of FPL. The law also includes, if cost-effective, a premium assistance program for families with access to employer-sponsored insurance.

- **Massachusetts-style Connector.** Additional legislation, also signed in May 2007, creates the Washington Health Insurance Partnership (HIP) replacing the premium assistance program known as the Small Employer Health Insurance Partnership (SEHIP), which was enacted in 2006 to assist employees of small business in purchasing health insurance. A Massachusetts-style Connector, the HIP increases the opportunity for small employers to offer affordable health insurance to their low-income workers. The law establishes sliding-scale premium subsidies for individuals earning less than 200 percent of FPL based on gross family income. Under the guidance of a 7-member Board appointed by the Governor, implementation design of the HIP is underway. Critical statutory changes needed to support implementation, including the timeline, are currently being considered by the 2008 Legislature. The state is also studying the feasibility of expanding the HIP to additional markets--such as the individual market and select public programs.

Furthermore, SPG funds helped institutionalize the state's State Population Survey as the most robust and reliable source of local data on the insurance status of Washington residents. Likewise, the Employer Health Insurance Database, which was developed and revised with SPG support has become "the place to go" for information on employer-sponsored insurance. Finally, Hamilton remarked on the importance of the networking opportunities afforded by the SPG program. SHADAC has proven an invaluable ongoing source of technical expertise and the state has taken advantage of many opportunities for support and expert assistance not typically accessible to states.

Looking Ahead

The state reform efforts undertaken by Michigan, Oregon, Pennsylvania, and Vermont represent only a small handful of actions taken by states on the uninsured. These reforms are part of a growing trend for more state-based reforms aimed at the uninsured—a trend that seems likely to continue. In the absence of federal action, states have taken the lead in developing innovative solutions aimed at extending coverage. It remains to be seen

whether federal action on the uninsured will move to the forefront of competing national priorities. In the meantime, many policy makers are looking to states to pioneer innovative solutions for the uninsured. By offering critical resources to explore policy options, the SPG program made an important contribution to many states in their ability to develop those innovative solutions.

---

[1] Smith, V. et al., *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008*, Kaiser Commission on Medicaid and the Uninsured, October 2007.
[2] Lieb, D. "Missouri Plan Seeks to Expand Health Insurance to Small Businesses," Jefferson City News Tribune, December 30, 2006.
[3] For consistency, the data are drawn from the Kaiser Family Foundation's *State Health Facts*.
[4] Arizona Health Care Cost Containment System Administration, Arizona State Planning Grant, Final Report to the Secretary U.S. Department of Health and Human Services, September 2004, p. 26.
[5] ERISA contains a broad preemption provision stating that federal law supercedes any state law that relates to ERISA plans, except those that regulate insurance, banking, and securities. States cannot deem employee plans to be insurers with which the employee plans contract, creating the distinction between insured plans (which states can regulate) and self-insured plans (which they cannot).
[6] Brandell SJ and LJ Pfannerstill, Arizona Health Care Cost Containment System, "Issue Paper on High Risk Pools," August 27, 2001.
[7] Scott BT and DF Ogden, Arizona Health Care Cost Containment System, "Issue Paper on High Risk Pools," August 27, 2001.
[8] National Association of State Budget Officers and National Governors' Association, *The Fiscal Survey of States: December 2001.*
[9] SHADAC, *A State Perspective on National Survey Data on the Uninsured.*
[10] Helms, W.D. L Nichols, and S Patel, "Commentary-How to Improve Federal Health data for Coverage, Access, and State-Specific Needs," *Health Services Research*, 41:3, Part 1 (June 2006).
[11] SHADAC, *HRSA SPG Data Collection Activities Summary*, Technical Report, February 2007.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Nelson, CT and R.J. Mills. *The March CPS Health Insurance Verification Question and its Effect on Estimates of the Uninsured,* U.S. Bureau of the Census, August 2002.
[17] Nelson, C.T. and R. J. Mills. *The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey,* U.S. Bureau of the Census, August 2002.
[18] Nelson, CT, and RJ Mills, The Characteristics of Persons Reporting State Children's Health Insurance Program Coverage in the March 2001 Current Population Survey, U.S. Bureau of the Census, August 2002.
[19] SHADAC, *HRSA SPG Data Collection Activities Summary*, Technical Report, February 2007.
[20] SHADAC, 2006-2007 SPG Grantee Survey, Preliminary Results, May 2007. The questionnaire was sent to representatives from 46 states, Washington D.C., and four territories. The survey yielded 32 responses out of 51 mailed surveys, a response rate of 62.7 percent.
[21] SHADAC, *HRSA SPG Data Collection Activities Summary*, Technical Report, February 2007.
[22] Blewett L., *Value of State-Level Data to State Policy Analysts and Officials,* Working Paper Series, SHADAC, April 2004.
[23] Ibid.
[24] *The Uninsured in Rural America*, Kaiser Commission on Medicaid and the Uninsured, April 2003.
[25] Dubay, L., J. Holahan, and A. Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, 26, no. 1, 2007.

[26] Davidoff, A.J., B. Garrett, and A. Yemane, *Medicaid Eligible Adults Who Are Not Enrolled*, Urban Institute, October 2001.
[27] Illinois State Planning Grant, Final Report to Secretary, September 2005.
[28] Duchon, L., et al. Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, The Commonwealth Fund, January 2000.
[29] Delaware Health Care Commission, State Planning Grant Program, Interim Report, September 30, 2004, p. 5.
[30] Holahan J. and A. Cook, *Why Did the Number of Uninsured Continue to Increase in 2005?* Kaiser Commission on Medicaid and the Uninsured, October 2006.
[31] *The Uninsured and Their Access to Health Care*, Kaiser Commission on Medicaid and the Uninsured, October 2006.
[32] Clemans-Cope L., B. Garrett, and C. Hoffman, *Changes in Employees' Health Insurance Coverage, 2001-2005*, Kaiser Commission on Medicaid and the Uninsured, October 2006.
[33] Gencarelli, D. *Health Insurance Coverage for Small Employers*, NHPF Background Paper, National Health Policy Forum, April 19, 2005.

APPENDICES

APPENDIX A: State Profiles

While it is difficult to summarize the multitude of efforts undertaken with SPG planning grant funds, the table below provides an overview of the expanded coverage initiatives that were implemented by the SPG states, as well as legislative proposals, Federal waivers, and reports that states published with SPG resources. The activities highlighted below are in addition to the enormous data collection activities undertaken by SPG states, and a full range of dedicated consensus building efforts; these activities are described in the body of the report.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
Alabama	None	None	None	N/A	July 2003 - 2003 Alabama Health Care Insurance and Access Survey: Select Results.
Arizona		Legislation enacted in 2002: Transferring administrative functions (marketing, enrollment and premium pricing) back to HCG (the State); Implementing a single uniform benefit package; Gathering household income information making it possible for the State to provide subsidies to only those in need; Establishing risk-adjusted premiums adequate to cover medical and administrative; Legislation enacted in 2004: Allows HCG to contract directly with providers in the event no contracted health plan is willing to provide an adequate provider network; Allows HCG to contract with commercial insurers; Allows HIFA parents of	HIFA Waiver (2001): expand coverage to Medicaid and SCHIP parents (implemented 10/2002)		Arizona Health Care Cost Containment System, Arizona Basic Health Benefit Plan: A Comprehensive Review, July 2001. Arizona Health Care Cost Containment System, Elasticity of the Demand for Health Care Services, October 2001. Arizona Health Care Cost Containment System, Faces of the Uninsured and State Strategies to Meet Their Needs: A Briefing Paper, July 2001. Arizona Health Care Cost Containment System, Financial Impact of Recently Enacted Health Insurance Mandates, October 2001. Arizona Health Care Cost Containment System, HealthCare Group: Moving Towards Accountability, August 2001. Arizona Health Care Cost Containment System, Health Insurance Administration Costs, October 2001. Arizona Health Care Cost Containment System, Initiatives to Improve Access to Rural Health Care Services, July 2001. Arizona Health Care Cost Containment System,

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
		Medicaid/ SCHIP children who participate in the Premium Assistance Program (see next section) to enroll in HCG; Allows uninsured persons who lost their jobs due to foreign trade and qualify for federal tax credit for health insurance to enroll in HCG (coverage option permitted under Trade Act of 2002); Allows HCG to pay insurance brokers/producers a one-time enrollment commission; Requires small business to go bare for 180 days to be eligible to enroll in HCG; Prohibits HCG and its plans from using the AHCCCS fee-for service rates for hospitals as a default rate. In 2007, HCG requested $8 million in state funds to continue providing coverage to its enrollees. In September 2007, the Legislature suspended new enrollment into HCG resulting in enrollment declines that endanger its viability. Options for HCG moving forward are being reviewed by the state legislature.			Inventory of Arizona Strategies to Address Rural Health Care Infrastructure, October 2001. Arizona Health Care Cost Containment System, Key Stakeholder Interviews of Rural Employers and Employee Benefit Specialists, October 2002. Arizona Health Care Cost Containment System, Review of Self-Insuring of Health Benefits, October 2001. Arizona Health Care Cost Containment System, Rural Healthcare Provider Interviews: Developing a Strong Rural Health Care Infrastructure - Challenges and Successes, October 2002. Arizona Health Care Cost Containment System, State Employee Health Plan Self-Funding Survey, January 2002. Bentley, T.S. and D.F. Ogden. "High-Risk Pools," Arizona Health Care Cost Containment System, August 2001. Brandel, S.S. and L.J. Pfannerstill. "Purchasing Pools," Arizona Health Care Cost Containment System, August 2001. Reed, J.A. et al. "International Approaches to a Socialized Insurance System," Arizona Health Care Cost Containment System, August 2001. Snook, T.D. "Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage," Millman USA, Inc., August 2001. The Southwest Border Rural Health Research Center, University of Arizona, Health Care Coverage in Arizona, January 2002.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
Arkansas	ARKidsA (84,441 people served as of 11/04); ARKidsB (8,659 people served as of 11/04) Arkansas developed a new insurance program, ARHealthNet, designed to help qualified small businesses, with low income workers, provide an affordable package of health care benefits to their employees. ARHealthNet is a HIFA initiative, available to businesses with 2 to 500 employees who have not offered a group health plan in the past 12 months or longer.	H.B. 1660 (2001): Small Employer Health Insurance Purchasing Group Act (passed)	HIFA Waiver to cover low-income workers (submitted Jan. 2003, failed)	93,100 people served ARHealthNet: 2000	2005 Arkansas Fact Book: A Profile of the Uninsured, September 2005. Improving Health with Master Settlement Agreement Tobacco Dollars: The Arkansas Experience. Health Affairs, Nov/Dec 2003. Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members. Medical Care 40(3):190-200, March 2002. Performance indicators in women's health: incorporating women's health in the health plan employer data and information set (HEDIS). Women's Health Issues 12(1):46-58, Jan-Feb. 2002 .
California	None	SB 2 (2004) Pay or Play proposal (passed, later repealed by voters); SB 840 (2005): Universal Health Insurance (pending)	None	N/A	"Cross Cutting Analysis of Coverage Reforms: Qualitative Analysis," January 2002. "Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance in Coverage in California," April 2002.
Colorado	A campaign to help small business	Legislation was introduced to expand the definition of	HIFA waiver (approved 9/02)		None

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	employees be smart purchasers of health coverage for their employees.	"dependent" to include 18-24 who are not full time students. FAILED (2002). Two bills were enacted that allowed for greater rating flexibility by small-group carriers. Also, the Basic Health Benefit Plan was modified to reflect a lower level of benefits, including the removal of certain mandates (2003). Legislation was enacted to modify the Basic Plan so it could qualify as a high deductible plan to be utilized with Health Savings Accounts. Legislation passed to make it easier for small businesses to band together through a bona fide association to purchase health insurance.	expands coverage to pregnant women with income b/w 133% FPL and 185% FPL		
Connecticut	None	HB 5023 authorizes Dept. of Social Services to seek a federal waiver for premium assistance, contract with vendors, develop and analyze options, and examine cost effectiveness; CT General Assembly authorized funds for premium assistance (2003), currently $3.6M in 2005 bi-annual budget	None		Why Premium Assistance Strategies Can Succeed in Connecticut, March 2005. Connecticut Office of Health Care Access 2004 Small Employer Health Insurance Survey. SNAPSHOT: Connecticut's Health Insurance Coverage, January 2005. Who are the Uninsured? January 2003.
Delaware	CHAP (Community Health Access Program) went live in	SB 146: Purchasing Pool plus reinsurance (in session, June 2005)	March 2002, HIFA waiver submitted to CMS called Delaware	15,500 people served	Analysis of the Delaware Safety Net, 2002. Chronic Illness and Disease Management: Findings of House Joint Resolution 10 Task

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	2001 (12,000 people served, 6/15/05); Public outreach and enrollment via Covering Kids and Families in 2003 (3,500 people served, 6/15/05); Website for small business (2004) http://www.healthinsurancechecklist.com/		Healthy Adult Program (CMS denied the wavier March 2003)		Force, June 2004. Condliffe, S. and E.C. Ratledge. "The Total Cost of Health Care in Delaware, 2003," University of Delaware, 2003. Condliffe, S. and E.C. Ratledge. "The Total Cost of Health Care in Delaware, 2002," University of Delaware, 2002. Condliffe, S. and E.C. Ratledge. "The Total Cost of Health Care in Delaware, 2000," University of Delaware, 2000. Delaware Health Care Commission, Small Business Health Insurance Task Force: Final Report, June 2003. Jacobson, E. et al. "Health Disparities in Delaware 2004," University of Delaware, 2004. Ratledge, E.C. "Delawareans Without Health Insurance 2002," University of Delaware, January 2003. Ratledge, E.C. and T. Toth. "Delaware's Small Employers: The Health Insurance Dilemma," University of Delaware, April 2001. Ratledge, E.C. and T. Toth. "Delawareans without Health Insurance 2000 Report," University of Delaware, 2000.
District of Columbia	The District of Columbia established the Healthcare Alliance, which provides free health care to uninsured District residents with family incomes below 200 percent FPL.	None	None	N/A	King, J. et al. "Insurance and Uninsurance in DC: Starting with the Numbers," D.C. Department of Health, 2005. Improving Health Coverage in the District of Columbia, April 2006

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
Florida	None	HB 1629 passed – Small Employers Access Program; HB 1629 also included provisions making changes to the existing Health Flex program; HB 1629 also creates the Florida Health Insurance Plan for people with no other option for coverage	In 2005, Florida received approval for its Medicaid Reform waiver. The waiver does not expand eligibility; however, it makes significant changes to the program. The Florida Medicaid Reform Model comprises comprehensive and catastrophic financing mechanisms, an individual enhanced benefit account, or an option to opt-out of Medicaid and direct their Medicaid premium to employer-sponsored insurance. The program was initially implemented in two counties and then expanded to three additional counties.		Duncan, P. et al. "Comparative Findings from the 1999 and 2004 Florida Health Insurance Studies," Department of Health Services Research, Management and Policy, University of Florida, August 2005. Duncan, P. et al. "County Estimates of People Without Health Insurance from the 2004 Florida Health Insurance Study," Department of Health Services Research, Management and Policy, University of Florida, August 2005. Duncan, P. et al. "Focus Groups Findings: The 2004 Insurance Study," Department of Health Services Research, Management and Policy, University of Florida, March 2005. Duncan, P. et al. "Profile of Uninsured Floridians: Findings From the 2004 Florida Health Insurance Study," Department of Health Services Research, Management and Policy, University of Florida, February 2005. Duncan, P. et al. "The Florida Health Insurance Study: Telephone Survey Findings," Department of Health Services Research, Management and Policy, University of Florida, July 2005. Duncan, P. et al. "Zip Code Estimates of People Without Health Insurance from the 2004 Florida Health Insurance Study," Department of Health Services Research, Management and Policy, University of Florida, August 2005. Florida Health Insurance Study, Sample Design and Methodology, February 2004. Gaps in Coverage: Uninsured Part of the Year, Fact Sheet #3, September 2005. Health Insurance Among Children in Florida,

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					Fact Sheet #2, August 2005. Highlights from The 2004 Florida Health Insurance Study, November 2004. Kelley, M. and N. Moulton. "Key Information Interview Findings: The 2004 Insurance Study," Health Management Associates, March 2005. Racial and Ethnic Disparities in Rates of Health Insurance Coverage, Fact Sheet #1, April 2005. The 2004 Florida Health Insurance Study Telephone Survey Instrument, March 2004.
Georgia	None	SB 102 (2005): Group Accident/Sickness Insurance Act (Senate read second time); SB 174 (2005): Georgia Consumer Choice Benefits Health Insurance Plan Act (Signed by Gov. Perdue 5/10/05); HB 320 (2005): Georgia Health Insurance Risk Pool (signed by Gov. 5/10/05, effective 7/1/05); HB 166 (2005): "Health Share" Volunteers in Medicine Act (signed by Gov. 5/10/05, effective 7/1/05); HB 198 (2005): Health Care Bond Authority Act (House second read)	2005 – The state is considering premium support to the parents of PeachCare eligible children to enable parents to purchase group coverage through employers (under analysis and review)	N/A	2004 Georgia Employer Health Benefits Survey, September 2005 Assessment of Georgia's Primary Care Safety Net, March 2003 Georgia Employer Health Benefits Survey, April 2003 Georgians' Attitudes on Providing Coverage for the Uninsured, April 2003 Grant Overview - What Is the Georgia Healthcare Coverage Project? Insuring the Uninsured: Three Models for Financing Healthcare Coverage, May 2004 Ketsche, P. "Employment Based Health Insurance: Analysis of Rural Urban Differences in One State," Georgia State University, August 2005. The View of Small Business Owners, April 2004 Towards More Accessible and Affordable Health Coverage, January 2004 Understanding and Reducing the Number of Uninsured Georgians

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
Hawaii	None	None	None		A Plan for Action: Post Conference Summation 2001, January 2002 Coverage for All Policy Brief, January 2005 Lee, S.H. "The Effect of Mandatory Employer-Sponsored Insurance on Health Insurance Coverage and Employment in Hawaii: Evidence from the CPS 1994-2003," University of Hawaii, Manoa, September 2004. On Common Ground: 2003 Coverage Report Policy Brief: A Historical Overview of Hawaii's Prepaid Health Care Act, July 2004 Policy Brief: Impacts of the Compact of Free Association on Hawaii's Health Care System, July 2004
Idaho	CHIP B expansion; Access Card (implemented for kids July 2004 and adults July 2005); State Board of Education mandated college student coverage the first year of the grant. Idaho's Access Card program offers premium assistance to adults whose gross annual income is below 185 percent FPL and who are employed by an Idaho small business, or who	2003 Access Card legislation (enacted 4/22/03)	Amendment to State Plan – SCHIP B all children 185% federal poverty (approved 6/04); 1115 Waiver – Access Card – CHIP "A" and "B" children can receive either direct coverage or premium assistance (approved 11/04); Amendment to 1115 Waiver – "Small Business Health Insurance Program" (pending)	As of fall 2006, Idaho's Access Card program had approximately 300 adults enrolled.	Idaho State Planning Grant, Idahoans Without Health Insurance: A Data Report, October 2001. Strategic Report Submitted to the Governor by the Steering Committee of the Idaho State Planning Grant, February 2002 Stroebel, H. and G. Gray. "Policy Considerations in Privatization of CHIP: Report to the Idaho CHIP Task Force," Center for Health Policy, Boise State University, September 2002. Stroebel, H. et al. "Health Insurance Affordability: Consumer Preferences in Cost Sharing," Center for Health Policy, Boise State University, September 2002. Stroebel, H. "Medical Indigency in Idaho: An Analysis of County Indigency and State Catastrophic Health Care Services," Center for Health Policy, Boise State University, February 2003.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	are the spouse of an employee. The program began enrollment in 2005 and is capped at 1,000 adults.				Economic Analysis of the Effects of Extending Insurance Benefits to Idaho's Uninsured Population Idaho State Planning Grant on the Uninsured: Data and Policy work Group Findings, September 2001
Illinois	2003: Eligibility for KidCare expanded from 185% FPL to 200% FPL (3,226 served as of 6/20/05); 2002: implemented FamilyCare (98,544 served as of 6/20/05); 2002: Established Ombudsman for the uninsured (2,843 served as of 6/20/05); St. Claire County Pilot (2005); Implemented presumptive eligibility for KidCare (2004)	92-331 – law established the Uninsured Ombudsman – passed 1/02 in place Spring 2002; HB 23 (2003) – Family Care – cover parents to 185%, failed, but accomplished through waiver; Fall 2003 – As part of larger Tax Bill, legislative language creates Trust Fund – dedicated revenue source for 3-share program (revenue is federal funds generated through community match)	HIFA Waiver (approved 2002) – FamilyCare- expanded coverage of parents from 38% FPL to 185% (phased in)	104,613 people served	Report of Illinois Assembly, October 2001 Rucinski, D. "Report to the Illinois Assembly on the Uninsured: Illinois Population Survey of Uninsured and Newly Insured," University of Illinois-Chicago, 2001. McNamara, P.E. "Health Insurance Coverage of Illinoisans: Analysis of Current Situation, Trends and Correlated Health Behaviors Using BRFSS Data," Illinois Department of Public Health, October 2001. Cox, C. et al. "Opinions Concerning Access to Health Insurance in Illinois: A Report of Focus Groups and Key Informant Interviews," Illinois Department of Insurance State Planning Grant, September 2001.
Indiana	None: Medicaid expansion to parents, expected implementation 2007 (will serve an estimated 240,000)	None (one expected in 2006 legislative session)	In mid-December 2007, CMS announced the approval of the Healthy Indiana Plan (HIP), an 1115 waiver demonstration project. HIP will be available to uninsured adults between 22 and 200 percent FPL who are	N/A	Health Insurance for Indiana Families Committee, 10,000 Person Household Survey, November 2004. Health Insurance for Indiana Families Committee, Actuarial Analysis of Policy Options, November 2004. Health Insurance for Indiana Families Committee, Assessment of Indiana Health Funding, November 2004. Health Insurance for Indiana Families

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
			not eligible for Medicaid. A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive $500 of pre-deductible, free preventive care and have a $1,100 deductible.		Committee, Assessment of National & State Efforts to Address the Uninsured, November 2004. Health Insurance for Indiana Families Committee, Focus Groups of Businesses, Uninsured Brokers and Providers, November 2004. Health Insurance for Indiana Families Committee, Indiana Market Assessment and Drivers of Health Care Cost, November 2004. Health Insurance for Indiana Families Committee, Safety Net Assessment, November 2004.
Iowa	Rethinking Health Insurance Project – promotional campaign on the issue of uninsurance	None	Family Planning waiver (pending)		Kinzel, A. "What a Drag It Is...The Economic Impacts of Rising Health Insurance Premiums," Iowa Department of Public Health, July 2004. Iowa Department of Public Health, Striving to Expand Health Insurance to All Iowans: Focus Group Proceedings, Summer 2001. Iowa Department of Public Health, Striving to Expand Health Insurance to All Iowans, Spring 2001.
Kansas	Kansas Business Health Partnership (pooling mechanism) – 1,030 people served as of 2/05; Kansas Health Authority (Administrative Simplification)	Governor's agenda, *HealthyKansas* (2004), consists of: Administrative simplification; Cost Containment Commission; Small Business Risk Pools; Obesity and chronic condition awareness campaign; Public/Private collaboration to cover additional 40,000 children and 30,000 working parents;	None	1,030 people served	Allison, R.A. and C.C. Huang. "Uninsured Children in Kansas: Who Are They and How Could They Be Reached," Kansas Health Institute, October 2003. Duncan, P.R. "Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans," Kansas Insurance Department, August 2001. Small Business Health Insurance Survey Findings, 2004

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
		2005: House Substitute for Senate Bill 272: Includes $500,000 allocation for Business Health Partnership (Passed); HB 2531 (2005): Establishes Kansas Health Policy Authority (passed); Substitution for Senate Bill 257 (2005): Amends current employer tax credit law (passed)			Smith, B.L. and E. Sylvia. "Voices of the Uninsured: Kansans Tell Their Stories and Offer Solutions," University of Kansas Medical Center, January 2002.
Kentucky					Data Briefing 1: Uninsured Kentuckians Older, Poorer, and More Likely to Be Underemployed than the U.S. Average Data Briefing 2: Cost a Major Barrier for Kentucky's Uninsured Data Briefing 3: Substantial Portion of Uninsured, Working-Age Kentuckians Discouraged from Seeking Needed Health Care by Costs
Louisiana					The Cypress Papers: A Series on Uninsurance in Louisiana. Low-Income Uninsured, March 2005. The Cypress Papers: A Series on Uninsurance in Louisiana. Uninsured Parents of Medicaid and SCHIP Kids, March 2005. Low Income Uninsured Focus Groups: Final Report, April 2004.
Maine	DirigoChoice, 2005; SCHIP parents expansion, 2005	LD 1611 (2003): Dirigo Health Reform Act (passed)	None	Enrollment has reached a combined total of 28,000 for the DirigoChoice program and	2007 State Health Plan. The State of Maine's Health: A Regional Comparison, August 2005. Health Insurance Coverage Among Maine Residents: The Results of a Household Survey, May 2003.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
				Dirigo Health's MaineCare companion plan for eligible parents.	Commission to Study Maine's Hospitals: Report to the Legislature, February 2005. Tough Choices in Health Care, May 2005.
Maryland	Maryland developed a high risk insurance pool, the Maryland Health Insurance Plan (MHIP,) for residents who are considered uninsurable either because they are high risk or have a history of medical problems that makes it difficult for them to find affordable insurance coverage in the individual market.	Tax penalty for high-income individuals with no health insurance (failed, 2004); Tax penalty for high-income individuals with not health insurance (failed, 2005);	1115 Waiver amendment to create the Maryland Primary Care Program	MHIP now has more than 9,200 enrollees.	Assessment of the Impact of Premiums: Final Report, April 2004 Health Insurance Coverage in Maryland through 2002 Maryland Current Population Survey: Medicaid Undercount Study, July 2005 Morlock, L. et al. "Policy Options for the Uninsured Young Adults in the State of Maryland," Johns Hopkins Bloomberg School of Public Health, June 2004. Options for Covering the Uninsured: A Report to the Maryland General Assembly, January 2004 Results of the 2002 Maryland Children's Health Program (MCHP) Premium Focus Group Project, May 2003 Results of the 2003 Small Employer Focus Group Project, May 2003 The Costs of Not Having Health Insurance in the State of Maryland, December 2003 Water, H. et al. "Final Report - Goal 4: Develop and Assess the Impact of Options to Expand Insurance Coverage," Johns Hopkins Bloomberg School of Public Health, January 2005.
Massachusetts	Massachusetts Health Care Reform Plan in April 2006	None	None	As of December 2007, the program covered close to	Employers Who Have 50 or More Employees Using Public Health Assistance, February 2005 Health Insurance Status of Massachusetts

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
				160,000 previously uninsured individuals.	Residents, Fourth Edition, November 2004 Health Insurance Survey of Massachusetts Employers: Core Results, 2005 Massachusetts Employer Health Insurance Survey, Spring/Summer Massachusetts Health Care Task Force: Final Report, 2002
Michigan	Michigan is developing an initiative that would extend health care coverage to individuals up to 200 percent FPL.		The state is in the midst of negotiating its waiver with CMS.		None.
Minnesota	2001 Cover All Kids Legislation: Expanded MA eligibility for kids ages 2 to 18 to 170% fpl and allowed for enhanced SCHIP match for parents up to 200% fpl. (served 12,000 uninsured kids and 27,000 uninsured parents as of June 2001); 2001 Small Employer Purchasing Alliance Stop-Loss Fund Legislation: Allowed small employers in certain rural areas of the state to form purchasing	2001 SF 4: Cover All Kids (Passed during 2001 special session. The poverty level limit for kids was reduced to 150% during the 2003 special session); 2001 SF 4: Eliminating Health Disparities (Passed during 2001 special session.); 2001 SF 4: Small Employer Purchasing Alliance Stop-Loss Fund (Passed during 2001 special session.); 2002 HF 2988: Small Employer Reform (Passed during 2002 session); 2005 HF 1809: No-Mandate Health Plans (Passed during 2005 session.); 2005 HF 1481: State Health Care Purchasing Authority (Passed during 2005 session); 2005 SF	(2001): 1115 MinnesotaCare Waiver gives Minnesota authority to obtain enhanced SCHIP matching funds for parents up to 200% FPL (approved 6/2001, in 2003, 41,317 parents were enrolled)	39,000 people served	Ehret, D.A. "Accessing Health Insurance in Minnesota: Report of Focus Group Discussion with American Indian, Hmong and Somali Community Members," Center for Cross-Cultural health, December 2001. Health Economics Program, Minnesota Department of Health, 2001 Health Insurance Coverage for Minnesota Counties, December 2002. Health Economics Program, Minnesota Department of Health, A Brief Overview of Medicare Supplemental Coverage in Minnesota and the United States, December 2002. Health Economics Program, Minnesota Department of Health, Accessing Health Insurance in Minnesota: Barriers for the Farming Community, May 2002. Health Economics Program, Minnesota Department of Health, Employer-Based Health

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	pools to buy insurance and allocated funds to reinsure high cost claims as a way to reduce premiums (unknown # served); 2002 Small Employer Reform Legislation: These reforms were intended to increase the number of insurers in the small employer market, make it easier for employers to jointly self-insure, and reduce volatility in small employer premium rates by limiting annual increases in rates (unknown # served); 2005 No-Mandate Health Plans Legislation: This legislation was designed to increase the number of employers and small employers in particular who offer health insurance coverage (unknown # served); 2005 State Health Care	65: MinnesotaCare Small Employer Option (Bill was included in the Senate omnibus health and human services budget bill, but not in the House version. House and Senate bills are currently in conference committee.); 2005 SF 1933: Health Insurance Reform (Bill was introduced in the Senate and House (HF 2175), but it has not had a hearing.); 2005 HF 132: Children's Health Security Program (Bill was introduced in 2004 and 2005 in the House and Senate (SF 20), but it has never had a hearing)			Insurance: Family Decisions to Enroll, September 2002 Health Economics Program, Minnesota Department of Health, Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey, March 2005. Health Economics Program, Minnesota Department of Health, Health Insurance Coverage in Minnesota, 2001 vs. 2004, February 2005. Health Economics Program, Minnesota Department of Health, Medicare Supplemental Coverage in Minnesota, December 2002. Health Economics Program, Minnesota Department of Health, Prescription Drug Coverage and Spending in Minnesota, February 2003 Health Economics Program, Minnesota Department of Health, The Structure of Cost-Sharing and Benefit Levels in Minnesota's Small Group and Individual Insurance Markets, October 2003. Health Economics Program, Minnesota Department of Health, Trends in Employer Sponsored Health Insurance: Preliminary Results from the 2002 Minnesota Employer Health Insurance Survey, March 2003. Health Economics Program, Minnesota Department of Health, Trends in Minnesota's Individual Health Insurance Market, October 2003. Health Economics Program, Minnesota Department of Health, Uninsured in Minnesota:

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	Purchasing Authority Legislation: This legislation was designed to reduce costs for health care paid for by the state of Minnesota by purchasing health care more effectively (unknown # served)				Perspectives of Key Informants, December 2002. Health Economics Program, Minnesota Department of Health, Variations in the Use of Health Services in Minnesota: Results from the 2001 Minnesota Health Access Survey, February 2004. Krueger and Associates, Listening to Small Business Owners: Summary of Focus Groups on Health Insurance, June 2002. Krueger and Associates, Understanding Uninsured Young People: Summary of Focus Groups on Health Insurance, June 2002. Minnesota Department of Health, Health Economics Program Publications MinnesotaCare Disenrollee Survey Report, July 2002 Minnesota's Uninsured: Findings from 2001 Health Access Survey, April 2002. Smalda, S.A. et al. "Disparities in Health Access: Voices from Minnesota's Latino Community," Hispanic Advocacy and Community Empowerment through Research, January 2002.
Mississippi	None	None	Mississippi received a Section 1115 waiver in 2004 to provide Medicaid benefits to a select group of the formerly covered Poverty Level Aged and Disabled population after	4,400	Moreland-Young, C. and R.P. Walker. "Understanding Current and Future Insurance And Utilization Issues Affecting Healthcare Providers And the Marketplace in Mississippi," PathFinders and Associates, 2005. Walker, R.P. and C. Moreland-Young. "Identifying Coverage Levels and Specific Options, and Exploring Mechanisms Supported by Private and Public Insurers to Address

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
			services had been discontinued. Mississippi also received CMS approval for an SCHIP employer buy-in program, but implementation has been put on hold indefinitely.		Access and Affordability and Coverage," PathFinders and Associates, 2005.
Missouri	None	SB 0881 (2004): Legislation requiring health insurers to treat mental health in same manner as other medical services (passed); HB 437 (2003): changes the Missouri High Risk Pool from 175% to 150% FPL (failed); HB 596 (2005): Allows employers to provide or contract for health insurance at reduced rates for employees who do not use tobacco products (passed)	None	N/A	Missouri Department of Health and Senior Services, Issue Brief: Health Insurance Coverage, November 2003. Missouri Department of Health and Senior Services, Public Deliberations Discussion Guide, August 2005. State Health Access Data Assistance Center, 2004 Missouri Health Care Insurance and Access Survey: Select Results, February 2005.
Montana	2003: $609,000 added to CHIP program to prevent program reduction (Initiative added 1,300 children to the program as of Fall 2003); October 2004: $1.9M additional funds from BCBS reserves (Estimated number	None	Medicaid Section 1115 waiver (Approved 1/04)	12,200 people served	"Montana Safety Net Report" Historical Efforts to Reduce Montana's Uninsured, May 2 003 Seninger, S. et al. "Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana," Bureau of Business and Economic Research, University of Montana, February 2004.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	served: 10,900 as of October 2004); October 2004 State of MT contract with BCBS calls provides 75 % of any CHIP reserves at the end of 2004 and 50% of any future reserves to revert back to CHIP (maintain # served)				
Nebraska	None	None	None		Carlson, E. et al. "Reactions to Proposed Strategies to Increase Health Insurance Coverage in Nebraska: Results from the Nebraska State Planning Grant Year-Two Focus Groups," Nebraska Center for Rural Health Research, August 2005. Carlson, E.K. et al. "Making the Good Life Meaningful for All Nebraskans: The Importance of Health Insurance," Nebraska Health Information Project, May 2005. Chen, L.W. et al. "The Cost of Uncompensated Health Care and Expenditures of Self Pay Hospital Inpatient Care In Nebraska," Nebraska Center for Rural Health Research, July 2005. Mueller, K. et al. "Health Insurance Coverage In Nebraska: Results from the Nebraska State Planning Grant," Nebraska Center for Rural Health Research, December 2004. Nebraska Health Insurance Policy Coalition, State Options for Expanding Health Insurance Coverage and Strengthening the Health Care Safety Net, August 2005. Nebraska Workforce Development, Department

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					of Labor, 2004 Nebraska Employee Benefits Report, December 2004. Xu, L. et al. "Health Insurance Status of Nebraskans," Nebraska Health Information Project, May 2005
New Jersey	None	A3359: Health Insurance Affordability and Accessibility Reform Act (2004, failed?)	None	In 2003, New Jersey received approval from CMS to modify its SCHIP 1115 waiver to standardize coverage to uninsured parents and relative caretakers of children in the Medicaid and SCHIP programs whose incomes are at or below 133 percent FPL to that of the parents between 134 percent and 200 percent FPL, which was a standard commercial benefit package.	Belloff, E. and K. Fox. "Maximizing Enrollment in the Premium Support Program: Results from the Employer Interviews," New Jersey Department of Human Services, September 2004. DeLia, D. et al. "The Low Income Uninsured: Chartbook 2," New Jersey Department of Human Services, August 2005. DeLia, D. et al. "The Medically Uninsured in New Jersey: A Chartbook," New Jersey Department of Human Services, August 2004. Gaboda, D. et al. "New Jersey FamilyCare Express Enrollment: Report on the Pilot Program," Rutgers Center for State Health Policy, April 2005.
New Hampshire	None	SB 118 Established a subcommittee of the NH Healthy Kids Corporation (2001)	None	N/A	Health Insurance Coverage and the Uninsured in New Hampshire: Issue Brief, November 1999 Health Insurance in New Hampshire: Issue

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
		In 2005, New Hampshire passed legislation (SC 125) establishing the New Hampshire Reinsurance Pool by January 1, 2006. The legislation requires all health insurance carriers become members of the reinsurance pool. The reinsurance pool board has developed a standard benefit package for small employers that on which reinsurance premiums are based. Any insurer may purchase reinsurance from the pool, with a $5,000 deductible per covered life. The choice to reinsure is determined by individual carriers, but if pool expenses exceed premiums, all member carriers will be assessed proportionally on the number of lives they cover.			Brief, October 2002 The Health of New Hampshire's Community Health System: A Compilation of Reports Analyzing New Hampshire's Community Hospitals, Health Care Market, and Health Care Trusts, December 2000 New Hampshire' s Community Hospital System and the Health Care Market Analysis of Health Care Charitable Trusts in New Hampshire: The Hospital Sector Assessing Competitiveness: A Focus on Hospitals The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis, December 2000 The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis (Full Report), October 2000 New Hampshire Department of Health and Human Services, Strengthening the Safety Net (Full Report), October 2000. New Hampshire Department of Health and Human Services, Strengthening the Safety Net (Issue Brief), October 2000. New Hampshire Employer Based Health Insurance Coverage: Issue Brief, October 2002 New Hampshire Department of Health and Human Services, Health Insurance Coverage and the Uninsured in New Hampshire: Results from the 2001 Family and Employer Health Insurance Survey: Full Report, October 2002. Spitz, B. "The Insurers' Perspective on the Health Care System, Insurance, and the Uninsured," Spitz Consulting Group, June 2002.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					New Jersey Belloff, E. and K. Fox. "Maximizing Enrollment in the Premium Support Program: Results from the Employer Interviews," New Jersey Department of Human Services, September 2004. DeLia, D. et al. "The Low Income Uninsured: Chartbook 2," New Jersey Department of Human Services, August 2005. DeLia, D. et al. "The Medically Uninsured in New Jersey: A Chartbook," New Jersey Department of Human Services, August 2004. Gaboda, D. et al. "New Jersey FamilyCare Express Enrollment: Report on the Pilot Program," Rutgers Center for State Health Policy, April 2005.
New Mexico	SCI July 2005	HB 523 & SB 271 Small Employer Health Coverage Access (2005, passed/signed and being implemented); HB 394 Health Insurance Rates and Alliance Membership (2005, passed/signed and being implemented); HB 335 & SB 271 Coverage for Unmarried Dependents (2005, passed/signed and being implemented); HB 289 Part-Time Employee Insurance Coverage (2005, passed/signed and being implemented)	HIFA Waiver for SCI (accepted, 2002)	6,000 people served	2004 Household Health Insurance Survey: Final Report, 2004 A Report to Governor Bill Richardson Addressing Health Care Coverage and Access in New Mexico, October 2003 Insure New Mexico Council: Report to Governor Bill Richardson, January 2005 New Mexico Project Summary, 2005 White Paper on Uninsurance in New Mexico and Options to Provide Coverage: A Synopsis, April 2004
North Dakota	None	None	None		Cogan, M. et al. "Health Insurance Access in North Dakota: Dakota Conference on Rural and

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					Public Health," Presentation, March 8, 2005. Cogan, M. et al. "Which Factors Increase the Likelihood of Being Uninsured in a Rural State: Identify Opportunities to Reduce Disparities," Presentation, June 27, 2005. Knudson, A. et al. "Health Insurance Coverage Among North Dakotans", Presentation, March 2005. Knudson, A. et al. "Health Insurance Coverage Among North Dakotans," Presentation, May 2004. Knudson, A. et al. "Who Are North Dakota's Uninsured?", Presentation, May 2005.
Oklahoma	Premium Assistance Plan	SB 1546 OK Health Care Authority to develop premium assistance program (passed, 2004); HB 2660 "Special Health Care Revolving Fund" (passed, 2004); Oklahoma Health Care Recovery Act (passed, 5/04); Cigarette tax approved by OK voters in referendum (11/04)	In September 2005, CMS approved the Oklahoma Premium Assistance Plan under the HIFA initiative.	4,349 as of Fall 2007	"It's Health Care, Not Welfare" report of four studies, March 2004. Crawford, S.A. and G.L. Splinter. "Appropriate Rate Structure for Services Rendered and Estimates Percent of Co-Pays Collected under the Medicaid Program," University of Oklahoma Health Sciences Center, January 2004. Crawford, S.A. and G.L. Splinter. "Beneficiary Attitudes Towards Paying Enrollment Fees, Co-Payments, and Premiums to Obtain Health Insurance Coverage Under Expanded Medicaid Program," University of Oklahoma Health Sciences Center, January 2004. Crawford, S.A. and G.L. Splinter. "Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care Program," University of Oklahoma Health Sciences Center, December 2003. Crawford, S.A. and G.L. Splinter. "Attitudes

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					and Opinions of Small Business Owners in Oklahoma Toward Reforms to the Medicaid Health Care Program," University of Oklahoma Health Sciences Center, October 2003.
Oregon		HB 2537 directed Insurance Pool Governing Board to provide affordable health benefit plan for small employers (2-50 employees)	HIFA Waiver approved for development of OPH2 (2003) In 2006, CMS approved two demonstration amendments: 1) to extend the eligibility period for SCHIP from six to 12 months; and 2) amend the premium policy for individuals enrolled in OHP.		Chart: Community-based Delivery Systems, April 2001 Cost Sharing Strategies for OHP Medical Services: Draft, July 2001 "Crosswalk" Between OHP and Commercial Insurance, April 2001 Dual Eligibles: Integrating Medicare and Medicaid, February 2001 Edlund, T. "FHIAP Leavers Survey: Summary Report," Oregon Health Policy Institute, September 2001. Garland, M. and Oliver, J. "Health Values Survey Report 2004," Office for Oregon Health Policy and Research, November 2004. HRSA Household Survey Instrument, March 2001 Issues Involved in Designing a Basic Benefit Package and Determining Actuarial Equivalence, February 2001 Neal, M.B. and T. Hammond. "Statewide Household Survey on Health Care: Summary Report," Survey Research Laboratory, Portland State University, August 2001. Oregon Business Tax Deductions/Exclusions for Employee Health Insurance, May 2001 Oregon Health Policy and Research, Small Market Report: Challenges and Opportunities in Serving OHP Enrollees and the Uninsured, August 2002.

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					Oregon Health Policy Institute, Summary Report of Survey of FHIAP Enrollees and Individuals on Reservation Lis t, June 2001. Role of the Health Care Safety Net, April 2001 Santa, J. "Lessons Learned from The Family Health Insurance Assistance Program (FHIAP)," Office of Oregon Health Plan Policy and Research, July 2001. SCHIP Funding for Employer-Sponsored Insurance: Federal Issues and Barriers Encountered, February 2001 Securing Children Health Insurance Program Funding for Oregon's Safety Net, February 2001 Transitional Medicaid Assistance: Health Insurance Coverage for Families Leaving or Diverted from Welfare, February 2001 Washington State Health Care Authority, A Study of Washington State Basic Health Plan, June 2002.
Rhode Island	None	None	None		Bogen, K. "Who Are the Uninsured in Rhode Island? Demographic Trends, Access to Care, and Health Status for the Under 65 Population," Medicaid Research and Evaluation Project, January 2005. Hayward, J.A. and R.A. Lebel. "The Rhode Island Health Care for Families Act 2004 Report to the General Assembly," Rhode Island Office of Health and Human Services, January 2005. Private Sector Sponsored Health Insurance in Rhode Island: Results of the Insurance Component of the MEPS-IC, April 2005
South	None	None	None	N/A	Expanding Health Coverage to South

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
Carolina					Carolinians South Carolina Health Care Insurance and Access Survey, 2003 South Carolina Health Insurance Survey Small Employer Health Insurance Survey Summary of Key Informant Interviews, January 2003
South Dakota	Risk Pool, 2003 (590 people served as of 6/1/05)	SDCL 58-17, 113-142 (2003): Legislation to establish a risk pool (passed)	None	590 people served	"South Dakota's Uninsured Population: A Follow-Up Study on South Dakotans Without Health Insurance"
Texas	Limited benefit plans; Health insurance fairs and rate guides	Legislation to expand options for creation of both small/large employer health insurance purchasing cooperatives (enacted, 2003); Legislature created new Consumer Choice Benefit Plans	None		Lessem, A. et al. "Uninsured Texans: Attitudes Towards Coverage," Public Policy Research Institute, Texas A&M University, January 2002. Lessem, A. et al. "Uninsured Texans: Attitudes Toward Coverage," Presentation, January 2002. Longley, D. "State Planning Grant Overview Summary," Presentation, January 2002. Texas Department of Insurance, Final Report Executive Summary, March 2003. Texas Department of Insurance, Small Employers and Health Insurance: Final Results of the Texas Small Employer Survey, 2001, January 2002
Utah	PCN as five year demonstration (implemented 7/02) 43,037 people served (6/05)	HB 122 allows PCN like product to be sold in private market (passed)	1115 Waiver for PCN (approved 2/01)	43,037 people served	"Background on Utah's New Medicaid Waiver" (5/02) "Utah's Primary Care Network: The Link to Inpatient Hospital Care" (2/03)
Vermont	None	H.373 (2001): Vermont Health	None	700 in Catamount	Views on Health Insurance and the Uninsured in

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
		Access Plan, catastrophic health insurance (not referred out of committee); H. 252 (2001): Vermont Health Access Plan, buy-in plans (not referred out of committee); H.416 (2003) Vermont Health Access Plan, buy-in for farmers (not referred out of committee); S.180 (2003) Health Insurance – Universal Access (not referred out of committee); H.615 (2004) Vermont Health Access Plan, premium based plan for service providers, home care providers, small business, those providing services to individuals eligible for public benefits (not referred out of committee); H.759 (2004) Small Market Access Reinvestment Trust Plan (passed the House); H.516 (2005) studies to support universal access, expand FQHC type centers in every county, development of employer sponsored insurance program (passed house and senate, signed by Gov.); H.524 (2005) Universal Access to Health Care, by 2009 access to affordable, high quality health care (passed house and senate); S.108 (2005) Healthy Vermont (not referred out of committee);		Health during first month of enrollment, fall 2007	Vermont, June 18, 2001 Insurer Workgroup Report, May 21, 2001 Provider Workgroup Meeting Summary, May 21, 2001 Analysis of the Costs and Impact of a Single Payer Model for the State of Vermont, 2001 "Health Insurance and the Uninsured in Vermont: Policy Option Test Marketing" September 6, 2001 "Covering VHAP and SCHIP Enrollees under a Voucher Model: Program Analysis and Actuarial Design" September 28, 2002 "Report on the Vermont Health Access Plan Study – Small Business Buy-in" 2004 "A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers: Cost and Coverage Impacts" 2004

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
		H.467 (2005) Vermont Health Access Plan, employers (not referred out of committee); H.485 Hospital coverage of all Vermonters (not referred out of committee) In 2006, the Vermont Legislature and Governor Jim Douglas (R) reached agreement on a new program for Vermont's uninsured called Catamount Health program with the goal of reaching universal coverage by 2010.			
Virginia	None	None	None		2003 AHRQ, MEPS-IC Survey Report: Issue Brief, Data Tables and Additional Analyses, 2005 Center for Health Policy Research & Ethics, George Mason University, Lessons Learned From Other States and Virginia: Challenges and Opportunities in Expanding Health Insurance Coverage, April 2005. Employment And Insurance Coverage In Virginia 2004 Facts At A Glance Household Income And Insurance Coverage In Virginia 2004 Facts At A Glance Overview of Proposed Model Option to Expand Health Insurance Coverage Among Employed Virginians, July 2005 State Health Data Assistance Center, 2004 Virginia Health Care Insurance and Access Survey, March 2005. State Health Data Assistance Center, Virginia

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					HRSA State Planning Grant Additional Analyses: 2004 Virginia Health Care Insurance and Access Survey, April 2005. State Health Data Assistance Center, Virginia Health Insurance and Access Survey: Virginia Health Insurance and Access Survey: Technical Report, Survey Methodology, May 2005. Snapshot of Health Coverage Provided By Virginia Small Businesses, September 2001 The Cost and Consequences of Uninsurance: A Virginia State Planning Grant Technical Briefing Paper Virginia Department of Business Assistance, 2005 Virginia Business Health Insurance Survey, August 2005. Virginia Uninsurance Facts at a Glance
Virgin Islands	None	None	None	N/A	None
Washington	Coverage for the working disabled (2002, 552 people served); Basic Health opened to people eligible for health coverage tax credit through the Federal Trade Act (2004, 27 people served); Small group rating reform (2004, 354,000 people served)	(SB 6422) Small Employers and Basic Health. Failed; (HB 2015) Health Insurance for small employers and their employees. Failed; (HB 2087) Definition of small employer. Failed; SSB 5521) Health insurance for employers and employees. Failed; (HB 2785) Increasing access to health insurance coverage. Failed; (SHB 3047) Health care services. Failed; (SB 5944) Employers and Basic	None	354,597 people served	Financial Incentives to Employers to Offer Insurance, April 2002 Financial Incentives to Individuals and Families to Increase Insurance, April 2002 Income Adequacy an the Affordability of Health Insurance in Washington State, June 2002 Options for Distilling the Current Array of Medical Benefit Packages. June 2002 State Planning Grant, Administrative Simplification: An Overview of Selected Administrative Simplification Initiatives and Potential State Actions for Support, April 2002 Targeting the Uninsured in Washington State,

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	In May 2007, Governor Chris Gregoire (D) signed legislation whose express purpose is to provide access to coverage for all children in the state by 2010. The law authorizes funding for intensive education, outreach, and administrative simplification in order to ensure the enrollment of all currently eligible children, who now account for over one-half of Washington's uninsured children. As of January 2009, the legislation expands the state's SCHIP program to children in families with income up to 300 percent of FPL; the current eligibility level is 250 percent of FPL. Additional legislation, also signed in May 2007, creates the	Health. Failed; (HB 1830) Public program coverage of employed individuals. Failed; SB 5704) Employer participation in Basic Health. Failed; (SHB 2985) Individual health insurance for retired and disabled public employees. Passed; (ESSB 6112) Multiple employer welfare arrangements. Passed; (HB 2798) Stabilizing the health insurance market and providing coverage for the uninsured. Failed; (HB 2018) High risk pool eligibility. Failed; (ESHB 2797) Health insurance for people eligible for the Federal Health Coverage Tax Credit. Passed; (SB 6057) Basic health funding. Passed; (HB 2285) Cost-sharing in public programs. Passed; (EHB 1777) Homecare worker coverage. Passed; 2003 Biennial and 2004 Supplemental Budgets. Passed; (SB 5944) Employers and Basic Health. Failed; (SB 5704) Employer participation in Basic Health. Failed; (HB 1375) Basic Health eligibility. Failed; (SHB 2019) Basic Health eligibility. Failed; (ESSB 5807) Basic Health eligibility. Failed; SB 5998) Community-based demonstrations. Failed; (HCR			April 2002 Washington State Planning Grant, Public Financing and Uncompensated Care Provided by Washington State Community Hospitals and Community Health Centers. October 2004

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
	Washington Health Insurance Partnership (HIP), a Massachusetts-style Connector that increases the opportunity for small employers to offer affordable health insurance to their low-income workers.	4403) Health Care Access Options Working Group. Failed; (SB 5313) Washington Health Care Recovery. Failed			
West Virginia	Small Business Plan, January 2005 (319 people served as of May 1, 2005)	Authorization for high risk pool for HIPAA eligibles and persons deemed medically uninsurable; Public/private partnership involving small employer buy-in for Public Employees Insurance Agency (passed 3/04); plan for CHIP expansion	None	319 people served	Dempkowski, A. "Literature Review on State Activities Related to Employer-Sponsored Insurance," West Virginia State Planning Grant, February 2003. Dempkowski, A. "Literature Review on State Activities Related to Individual Health Insurance," West Virginia State Planning Grant, April 2003. Health Insurance and West Virginia's Children: Fact Shee t, February 2005 Health Insurance and West Virginia's Non Elderly Adults: Fact Sheet, February 2005 Health Insurance and West Virginia's Older Adults: Fact Sheet, February 2005 Institute for Health Policy Research, West Virginia University, The Uninsured in West Virginia: Putting a Human Face on the Problem of Uninsurance, March 2003. Richardson, S.A. "An Evaluation of Health Insurance and Health Insurance Options in West Virginia: Qualitative Study of Employers,

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					Uninsured Consumers and Insurance Agents," Institute for Health Policy Research, West Virginia University, October 2003. Richardson, S.K. "Health Insurance in West Virginia: The Children's Report," Institute for Health Policy Research, West Virginia University, April 2002. Richardson, S.K. "Health Insurance in West Virginia: The Non Elderly Adult Report," Institute for Health Policy Research, West Virginia University, July 2002. Richardson, S.K. "Health Insurance in West Virginia: The Older Adult Report," Institute for Health Policy Research, West Virginia University, January 2003. Richardson, S.K. "West Virginia Employer Survey Report," Institute for Health Policy Research, West Virginia University, October 2003 Richardson, S.K. "Working Adults and Health Insurance in West Virginia," Institute for Health Policy Research, West Virginia University, June 2003. Options to Expand Insurance Coverage in West Virginia, June 2003 (revised August 2003) West Virginia State Planning Grant, Impact of the Safety Net Providers on the Uninsured in West Virginia, August 2004. West Virginia State Planning Grant, October 15 th Health Advisory Council Subcommittee Recommendations, October 2003. West Virginia State Planning Grant, The WV Health Insurance Focus Group Report: An Evaluation of the Individual Health Access Plan

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
					and Adult Basic Benefit Plan by Individuals, the Self-Employed, Small Business Owners and Insurance Industry Representatives, March 2004.
Wisconsin	SeniorCare 2002 (158,274 served, 9/02-5/05); Well Woman Program 2002 (454 served, 1/02-5/05)	WI Act 16 established SeniorCare (2001, enacted Sept. 2002); Breast and Cervical Cancer Treatment Act of 2000 – Well Woman Program (2000, enacted Jan. 2002)	SeniorCare (enacted Sept. 2002) CMS approved the state's waiver to allow its BadgerCare expansion, BadgerCare Plus, to move forward and enrollment will start on February 1, 2008. Under BadgerCare Plus, families with incomes that exceed eligibility for current public programs will be able to purchase basic health coverage for their children for $10 to $68.53 a month, depending on their income. Wisconsin plans to subsidize premium costs for those families with incomes up to 300 percent FPL. Families with incomes above 300 percent	158,728 people served	Employer-Based Health Insurance Coverage in Wisconsin, September 2001 Employer-Sponsored Health Insurance Coverage, Wisconsin Family Health Survey, 2002 and 2003, February 2005 Findings from Focus Groups: Select Populations in Dade County, September 2001 Health Insurance and Health Care Utilization in Wisconsin, September 2001 Health Insurance and the Young Adult Population in Wisconsin, September 2001 Health Insurance Coverage for Non-Elderly Adults Living in Households Without Children, September 2001 Health Insurance Needs of Farm Families, September 2001 HIPP Enrollment Process Review, December 2004 HIPP Program-wide Cost-Effectiveness Evaluation, January 2005 Milwaukee County General Assistance Medical Program, September 2001 SPG Report on Wisconsin's Old Order Amish Population, 2002 Wisconsin State Planning Grant - Employer-Based Health Coverage in Wisconsin and Nationally, 1998-2002, April 2005

State	Cumulative number of new Coverage initiatives implemented	Cumulative number of State legislative proposals	Cumulative number of Federal waivers	# People Served	Written Products
			FPL will be required to contribute the full cost of coverage.		
Wyoming	2003 WY expanded income eligibility for KidCare CHIP from 133% FPL to 185% FPL (One third of the 4,500 additional children estimated eligible for the program enrolled As of May 2005) ; *2005 WY will increase Kid Care CHIP from 185% FPL to 200% FPL (an estimated 1,500 additional children will be eligible as of 6/05)	HB 0046: Health Care Commission created in 2003; SF 0034: Un-reimbursed catastrophic trauma care study, 2004 (study completed); SF 0077: Un-reimbursed trauma care, 2005 ($2,500,000 appropriated from the general fund)	None		Covering Wyoming's Uninsured: A Strategic Plan to Improve Health Insurance Access, December 2003 Waiver Expansion Study, January 2005 Gallagher, T. et al. "Private Sector Employee Access to Health Insurance and the Potential WYO-CARE Market," Wyoming Department of Employment, February 2005 State Planning Grant (SPG): Planning for Wyoming's Uninsured, October 2003

APPENDIX B – State Surveys and Focus Group Work

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006

State	Year	Purpose of Focus Groups	Target Populations	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Focus Groups	Budget and Funding Source(s)
Alabama	2002	To gain an understanding of how the uninsured population is changing over time	Consumers, Hispanic consumers, health care providers	Telephone calls to individuals in certain geographic locations and known income levels	6	14-16	Southeast Research, Inc.	Alabama Department of Public Health	$35,000; HRSA State Planning Grant
Alabama	2003	To obtain qualitative data on the uninsured and unstably insured and employers.	Uninsured, unstably insured, employers	Partnership with CHIP and County Health Department	6	5-15	Auburn University Montgomery	Alabama Department of Public Health	$40,000; HRSA State Planning Grant
Alaska	2006	Focus group work with populations of concern. An important topic for focus groups is the concept of "health insurance coverage" since the perceptions and values associated with insurance vs. access are expected to be diverse	Minority populations, seasonal occupations, part time workers, low income working families, etc.	Not reported	12 to 21	Not reported	University of Alaska Institute for Social and Economic Research	Alaska Department of Health and Social Services	HRSA State Planning Grant
Arkansas	2001	To understand circumstances influencing adults' rationale when making decisions regarding health insurance	Geographically diverse participants, including the uninsured and insured with incomes above and below 200% FPL, rural farmers, African Americans, and Hispanics	Participants recruited by community based organizations across the state via posted notices and phone using screener form to identify eligible participants	26	8-10	Arkansas Advocates for Children and Families (AACF) & University of Arkansas at Pine Bluff (UAPB)	Arkansas Center for Health Improvement (ACHI)	$60,000 to AACF and $20,000 to UAPB; HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Arkansas	2005	To investigate the circumstances influencing adults' rationale when making decisions regarding health insurance.	All households		5	7-10	Arkansas Advocates for Children and Families	Arkansas SPG team	HRSA State Planning Grant
District of Columbia	2004	Gauge opinions of public health programs in the District of Columbia	Uninsured, publicly insured, Latinas	SPG Advisory Panel Members, Department of Health moderator recruitment	5	9	Rivera Qualitative Research, Buffalo Qualitative Research	District of Columbia Department of Health	$2,000 to $4,000 per group; HRSA State Planning Grant
Florida	2004	To understand the social and economic climate in Florida regarding health insurance coverage. Also conducted 10 key informant interviews with consumer advocates, insurers, health care providers, local government and safety net providers.	Groups representative of geographic and demographic groups across Florida, including: Miami area (Hispanic and Haitian), Glades area (African American and Aglo), Tampa Bay, Panhandle, and Jacksonville.	UF team contacted local organizations in the specified locality, including Health Councils, free clinics, County Health Departments, and ethnic coalitions.	7	Target of 12 (attendance ranged from 3-21)	Health Management Associates and Survey Research Center at UF's Bureau of Economic and Business Research.	Agency for Health Care Administration	$5,280 for key informant interviews, $414,275 for focus groups (includes costs of household survey); HRSA State Planning Grant
Georgia	2002	Measure attitudes and opinions regarding the development of plans to provide access to affordable coverage or health care to all Georgians	Residents meeting criteria for 12 identified social group (done through the PRIZM methodology)	ZIP code-based cold calls from telephone list purchased from Experian	21	11	Georgia Health Decisions	Governor's Office of Planning and Budget/Georgia Health Policy Center	$126,500 (includes employer focus groups); HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Hawaii	2002	To document basic lifestyle demographics, employment, medical history and service utilization of individuals with and without health insurance coverage	Uninsured, and care providers of uninsured persons	Offered a gift certificate of $20 to local pharmacy	5	8-10 (note: also conducted 180 key informant interviews)	Hawaii Health Information Corporation	University of Hawaii Manoa	$25,000; HRSA State Planning Grant
Idaho	2001	Identify the primary reasons that the uninsured do not have health coverage	Uninsured small business employees	Small business who did not provide insurance were found through local Chambers of Commerce and contacted for names of their employees	3	6-7 (also conducted 156 interviews with uninsured individuals)	Boise State University Center for Health Policy	Idaho Department of Commerce	$6,475; HRSA State Planning Grant
Illinois	2000	To provide texture and nuance to the quantitative findings and literature reviews	Health care providers, insurance representatives, health and social service agents, local government representatives, and the uninsured	Experts from Southern Illinois University recruited participants from seven targeted constituencies in five distinct geographic regions.	19	4-6	Southern Illinois University at Carbondale (SIUC) in conjunction with Program Evaluation for Education and Communities (PEEC)	Illinois Department of Financial and Professional Regulation: Division of Insurance	$215,000 (Grand total for 27 focus groups)
Indiana	2002	Gain understanding of why uninsured were either not eligible for insurance or why they chose not to purchase insurance	Uninsured, with a focus on Latino populations, and physician provider groups	Letters were sent to directors requesting assistance with setting up focus groups with their members	22	8-15	Health Evolutions	Indiana Family and Social Services Admin.	$65,000; HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Iowa	2000	To understand the reasons why individuals are uninsured and what alternatives for health coverage may be appealing to them	Uninsured individuals (including 3 groups targeting Hispanics)	Personal Marketing Research, Inc. and American Public Opinion recruited participants from target groups in geographically diverse areas. Reminder calls were made, a stipend was offered, and transportation was arranged in certain areas	12	8-10	State Public Policy Group, Personal Marketing Research Inc. and American Public Opinion Survey and Market Research Corporation	Iowa Department of Health	$50,000 total for all Focus Groups; HRSA State Planning Grant
Louisiana	2004	To gather qualitative information on such things as attitude about health insurance patterns of care, relative values of various potential benefits, and changes in behavior that would occur if uninsured individuals obtained health insurance	Low-income uninsured adults 19-64 years old	Local organizations were asked to recruit members from the target population who had experience with health care services. Specifically, individuals age 19-64 who are uninsured and whose family income is < 200% FPL; a mix with and without dependent children, a mix representing the geographic areas intended to be captured.	8	New Orleans Groups 8 and 9; Abbeville group 9, Woodworth group 7, Baton Rouge group 5, Iowa Group 5, Shreveport group 8, Delhi group 10	E, P, & P Consulting Firm	Louisiana Department of Health and Hospitals	HRSA State Planning Grant and other sources

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Maryland	2002	To identify key socio-demographic and workplace characteristics of the state's uninsured	Parents of children who had contacted SCHIP for an application but had never enrolled; parents who had disenrolled their children from SCHIP for unknown reasons	Vendor recruited SCHIP applicants and disenrollees by telephone	8 focus groups; 10 in-depth telephone interview with parents of disenrolled children	3-10	Shugoll Research, Bethesda, MD	Maryland Department of Health and Mental Hygiene	$24,000; HRSA State Planning Grant
Massachusetts	2004	To learn more about decision-making regarding health insurance among lower paid health/human services employees. Also conducted 30 key informant interviews with individuals who reported having ESI in the household survey.	Health/human services employees working in nursing homes, home health agencies, community health centers, etc.	Posters in facilities, outreach to HR departments, payroll stuffers	3 focus groups, 10 key informant interviews	12	Strategic Opinion Research	Massachusetts Division of Health Care Finance and Policy	Individual focus groups: Robert Wood Johnson Foundation; Key Informant Interviews: Commonwealth Fund ($25,000)

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Massachusetts	2000	To assess barriers to coverage; to explore why people eligible for public programs are uninsured and why Latinos eligible for employer sponsored coverage opt not to enroll	Uninsured individuals, Latinos, and people eligible but not enrolled in employer coverage	Focus groups were targeted to areas with high Latino populations. Recruitment done by community partners with strong ties in the area and understanding of the community	6	6-9	The Access Project, in conjunction with the Massachusetts Immigrant and Refugee Advocacy Coalition (MIRA) and the Latin American Health Institute (LHI)	Massachusetts Division of Health Care Finance and Policy	$75,000 for qualitative data collection included planning and conducting focus groups, literature review and report writing
Michigan	2005	To assess the importance of health care and health insurance, financing structures participants consider to be fair and viable, their concerns with uninsurance, and recommendations for providing health insurance to additional Michigan residents.	Uninsured individuals, insurance agents, and employers	Free clinics and community health centers helped with recruiting uninsured individuals. Professional associations and insurance companies assisted with recruitment of insurance agents	3 with uninsured individuals and 2 with insurance agents	24 uninsured individuals and 12 insurance agents. Additionally, two telephone interviews were held with insurance agents	Center for Collaborative Research in Health Outcomes and Policy, Michigan Public Health Institute	Michigan Department of Community Health	HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Minnesota	2001 2001	To identify barriers to medical care and health insurance coverage in the private and public sectors	American Indians, Hispanics/Latinos, Hmong, and Somali individuals, young adults	Community leaders were used to recruit participants; participants were paid a stipend; childcare and transportation were also provided	22	6-8	University of Minnesota Crookston, Center for Cross-Cultural Health; University of Minnesota Twin Cities, HACER (Hispanic Advocacy and Community Empowerment through Research)	Minnesota Department of Health, Health Economics Program	$148,533; HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Mississippi	2004	To assist in the development of a comprehensive understanding of Mississippi's uninsured as part of an effort "to develop specific plan options." Results will be combined with findings from other Mississippi research entities to provide a more complete view of the status of uninsured Mississippians.	Underrepresented populations, including African Americans, Hispanic Americans, Asian Americans, and Native Americans.	Potential participants were identified with assistance of local community entities and personnel identified as knowledgeable about and trusted by each underrepresented population group. Targeted announcements were made to members of each of the four populations for this study. Participants volunteered their time and information and received a $30 Walmart gift card.	8 (2 per underrepresented population)	up to 20	Mississippi State University's Social Science Research Center	Mississippi Division of Medicaid	HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Missouri	2004	To conduct focus groups with individuals as it pertains to the study of health insurance coverage; Also to interview key informants who are knowledgeable about health insurance.	Individual consumers of health insurance or those not insured. Also interviewed representatives from insurance companies, hospitals, group purchasers of health insurance, Local Public Health Agencies, physicians, Federally Qualified Health Centers.	Recruitment sites consist of local public health departments, community health centers, chambers of commerce, through phone contacts, email and mailings of local providers and coalitions. A database of participants was developed to assure ongoing contact with participants though the project.	15	2-21 (mean 9)	University of Missouri, Columbia Sinclair School of Nursing	Missouri Department of Health and Senior Services	Firm, fixed price of $70,894; $310 per key informant interview
Montana	2002	Identify problems and obstacles to obtaining health insurance	Uninsured and intermittently insured	Telephone	4	10	Bureau of Business and Economic Research, University of Montana	Montana Department of Public Health and Human Services	$15,000; HRSA State Planning Grant
Nebraska	2004	Supplement household survey; put a human face on uninsured population. Also talked to state legislators to obtain reaction to proposed strategies to reduce the number of uninsured.	Low-income, new refugees, minority, students; State legislators	Had a key contact(s) in every community and for every group	9	3-10 (mean 7.5)	Nebraska Center for Rural Health Research, UNMC	Office of Public Health, Nebraska Health and Human Services System	$28,700; HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
New Hampshire	2000	To provide context for the quantitative analyses and address specific models and implementation	Uninsured individuals, parents of children eligible but not enrolled in SCHIP, and uninsured individuals who use safety net providers	Screened for desirable demographics; some identified by CHCs; all under 65 with household income <250% FPL, and were uninsured	9	8	Strategic Opinion Research	New Hampshire Department of Health and Human Services	$65,000; HRSA State Planning Grant
North Carolina	2005	Explore reasons why uninsured lack coverage; focus group participants will be asked to consider different insurance options to identify willingness to purchase at different insurance prices.	Uninsured individuals from rural and urban areas with incomes above and below 200% FPL	Random digit dialing, participants will be contacted and screened for eligibility for focus groups	5	8-12	FGI Research	Sheps Center for Health Services Research, UNC-CH	$122,150 to support all focus groups; HRSA State Planning Grant
North Dakota	2004	Examine the reasons why uninsured lack coverage, determine the importance of health insurance to the uninsured, assess access to health care of uninsured; and determine what it would take for uninsured to get health insurance	Uninsured identified in telephone survey	91 Uninsured North Dakotans invited to attend, paid $20	1	5	University of North Dakota Center for Rural Health	North Dakota Department of Health	$14,500 HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
North Dakota	2004	To learn what ND residents think about the cost of health insurance	All ND residents within 50 miles of participating cities	Invitations to attend were mailed to 1,100 North Dakota residents	4	5-13	University of North Dakota Center for Rural Health	North Dakota Department of Health	$15,000 HRSA State Planning Grant
Oklahoma	2003	Present and discuss health care issues, particularly their opinion of the current Medicaid program and what key changes should be instituted to make Medicaid a quality health care delivery program.	Working uninsured	Most were recruited from businesses that participated in our previous study of small business owners in OK. Additional subjects were recruited from the Dept of Family and Preventive Medicine staff, free clinics, and from staff contacts or word-of-mouth, and from Project Access.		150 total participants	Department of Family & Preventive Medicine at the University of Oklahoma Health Sciences Center.	Oklahoma Health Care Authority	HRSA State Planning Grant
Oregon	2000	To discuss current options, what are adequate benefits, and affordability	Low-income, uninsured individuals	Purposeful – informal social networks, professional contacts	10	9	Department of Anthropology, Oregon State University, Corvallis, OR	HRSA State Planning Team	$40,345 (for all focus groups including 8 uninsured, 6 employer groups, 4 provider groups); HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Pennsylvania	2005	Examine attitudes about insurance and the uninsured.	Will be conducted with groups likely to face different barriers to appropriate care (e.g., near elderly, rural self-employed, persons with disabilities, etc.)					Governor's Office of Health Care Reform	HRSA State Planning Grant
Puerto Rico	2005	To identify providers' perceptions of the number of uninsured, reasons for uninsurance, and their perspectives on the effectiveness of Reforma policies	Safety net program directors and primary care physicians	Department of Health staff will call the directors of safety net programs; will also identify licensed physicians participating in the Reforma program		8-10 for safety net providers; 7-12 for primary care physicians	Dr. Rosa Soto from the Puerto Rican Department of Health	Puerto Rico Department of Health	HRSA State Planning Grant
South Carolina	2002	Better understand the impact of being uninsured and the concerns of those without insurance; generate ideas for potential solutions	People who are uninsured and working	Networks of small business organizations, health care providers, outreach groups working with the uninsured	5	11	Clemson University	South Carolina Department of Insurance	~$25,000 (budgeted $5,000 per group); HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
South Dakota	2001	To help understand the reasons why individuals not covered, their attitudes about insurance, and the kinds of initiatives effective in enabling these individuals to obtain coverage	Low-income individuals; Native Americans (living on and off-reservation); older and elderly persons; and farmers and ranchers	Snowball sampling techniques; participants were offered a financial incentive	6	8-15	The Lewin Group; American Public Opinion Survey & Market Research Corporation recruited participants and obtained sites for the groups	South Dakota Department of Health	$50,000 total for Individual and Employer Focus Groups; HRSA State Planning Grant
Tennessee	2005	To gather information from providers to better understand the impacts of the uninsured on the health care system and to identify what primary care services the uninsured are accessing	Health care providers	Word of mouth and ads in newspapers	4	10	UT Memphis	Tennessee Department of Commerce and Insurance	HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Texas	2001	To better understand why people do not have coverage, what kinds of assistance or support might help the uninsured obtain coverage, how to best share information with the public about insurance coverage option, and to learn more about people's experience with health insurance agents and providers	Uninsured unemployed individuals and uninsured employed individuals	Ads in local newspapers, local workforce center offices, radio announcements, information posted at Texas Cooperative Extension Service offices, community organizations, temporary employment agencies, health provider sites, word of mouth	30	5-8	Texas A&M University Public Policy Research Institute (PPRI)	Texas Department of Insurance	$135,000; HRSA State Planning Grant
Texas	2005	1. Factors contributing to Texas's high uninsured rate; 2. Ideas for improving accessibility and affordability of health care. 3. Local factors that impact purchasing patterns and perceptions of health insurance	Uninsured individuals	Ads in local newspapers, local workforce center offices, radio announcements, information posted at Texas Cooperative Extension Service offices, community organizations, temporary employment agencies, health provider sites, word of mouth.	7	5-8	Texas A&M University Public Policy Research Institute (PPRI)	Texas Department of Insurance	$32,500 HRSA State Planning Grant; TDI contracted with PPRI for one set price for the individual and small employer focus groups combined.

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Utah	2001	To gather information about concerns and barriers toward health care coverage and access	Uninsured individuals, individuals on public programs (CHIP, Medicaid), individuals at or below 200% FPL	Participants in the survey were asked if they were willing to further participate; recruited participants via the telephone according to a stratified sample of those willing to be contacted again	17	10	Utah Department of Health	Utah Department of Health	$40,000; HRSA State Planning Grant
Vermont	2000	To understand the various reasons that the uninsured are without health insurance, and to obtain their views on opportunities to expand health insurance in the state	Low-income, uninsured individuals	The Vermont Coalition of Clinics for the Uninsured recruited participants; participants were offered a stipend	2	8	Action Research, and The Lewin Group, Inc.	Office of Vermont Health Access (OVHA)	$225,000 for focus groups of individuals, employers, insurance providers, medical care providers, workgroups and in-depth interviews.; HRSA State Planning Grant
Virgin Islands	2003	Develop understanding of health insurance and health care issues from lay perspective	General community of adults active in their church drawn from Interfaith Coalition	Calls to ministers active in Interfaith Coalition to invite participants	3 (on each on St. Thomas, St. Croix, and St. John)	10-20	Consultant from the University of Virgin Islands	Bureau of Economic Research	$9,600 (includes employer focus groups); HRSA State Planning Grant

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
West Virginia	2004	Feedback on benefits and program design	Low-income, uninsured workers and self-employed individuals	Some recruited by local survey contractor; others recruited by local community leaders.	2	14 (average)	William Lindsay, Benefits Management Association	West Virginia University Institute for Health Policy Research	HRSA State Planning Grant
Wisconsin	2000	To explore workers' perceptions about obtaining health insurance through their workplace; To study health insurance coverage where access to health insurance may be restricted due to language or other cultural barriers; to explore young adults decision making about health coverage	Uninsured low-wage workers in small firms; minority racial and ethnic groups; and uninsured 18-24 year olds	Used the QPL program (developed by GAO and modified by IHPS) as a screening tool to recruit low-wage workers; Latino, Hmong and African American focus group participants often knew recruiter; many community groups assisted 18-24 year olds recruited by phone and mail; Madison hospitals recruited patients	11	8-10	Institute for Health Policy Solutions, subcontracting with Consumer Pulse in Milwaukee and Delve in Appleton; Latino Hmong, African-American and 18-24 year old focus groups were carried out under a memorandum of agreement between WI DHFS and Dane Co. DHS	Wisconsin Department of Health and Family Services	$109,490 for both the low-wage worker groups and employer groups (see Table 2-5); HRSA State Planning Grant; $21,000 for the minority and 18-24 year old groups; HRSA State Planning Grant and United Way of Dane County

Table B1. Summary of SPG Consumer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Target Populations**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Focus Groups**	**Budget and Funding Source(s)**
Wyoming	2002	To better understand the reasons why individuals lack coverage, the barriers and benefits of having health insurance, and the impact of being uninsured; to identify and evaluate alternatives for improving access to care	Uninsured persons, small employers, and health care providers	With coordinators throughout the state, participant selection was managed by the UW Cooperative Extension Service's Initiative for Enhancing Wyoming Communities and Households; participants offered a stipend and childcare was provided	7	6-8	University of Wyoming School of Nursing	Wyoming Department of Health	$10,000; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Alabama	2003	To obtain qualitative data on employer's insurance benefits		Telephone calls to businesses in certain geographic locations	2	5-15	Auburn University Montgomery	Alabama Department of Public Health	$6,000; HRSA State Planning Grant
Alaska	2006	Discussion of how employers make decisions about the health insurance they will offer to their Employees. What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?	Large and small (not defined)	Not reported yet	Not reported	Not reported	University of Alaska Institute of Social and Economic Research	Alaska Department of Health and Social Services	HRSA State Planning Grant
Arkansas	2000	To understand circumstances influencing employers' rationale when making decisions regarding employer sponsored health insurance	Small- to moderate-sized employers (included one health insurance broker group)	Participants were recruited by the Arkansas Center for Health Improvement, the Arkansas Farm Bureau and the Arkansas Chapter of the National Federation of Independent Business (NFIB)	7	7-10	State Planning Grant staff conducted all employer focus groups	Arkansas Center for Health Improvement, Arkansas State Planning Grant Roundtable, Arkansas Department of Health	$30,000; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Arkansas	2005	To investigate the decision making process of small to moderate size employers with regard to employer-sponsored health insurance.	Small to moderate sized employers		5	NA, total of 35 employers participating	Arkansas Advocates for Children and Families	Arkansas Center for Health Improvement	HRSA State Planning Grant
Colorado	2001	To identify the factors that influence employers' decisions to offer or not to offer insurance to employees	Small Employers	Participants from 13 regions; small employers from various industries, types of employees and health care insurance status	13	8-10	Colorado Strategic Planning Group on Health Care Coverage	Office of the Governor	$39,000; HRSA State Planning Grant
Delaware	2000	To understand the hardships of employers, what would motivate them to offer coverage, and to obtain employers' reactions to different strategies to increase coverage	Firms with less than 50 employees who do not offer coverage, or did not within the past two years	State and local Chambers provided members who fit eligibility criteria based on firm size; vendor completed recruitment calls	2	4-6	Health Management Associates	Delaware Health Care Commission	Focus groups factored as expense within an overall $395,000 health policy consulting agreement; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
District of Columbia	2005	To get opinions of small business owners on how they are able to offer health insurance or why they are unable	Small business owners located in the District of Columbia	Moderator contracted with a market research firm	5	8 (on average)	LaScola Qualitative Research	District of Columbia Department of Health	Approximately $6,000 per group; HRSA State Planning Grant
Florida	2004	To identify barriers to offering health insurance coverage or reasons that employers do or would offer coverage, to learn the features and compromises that employers find acceptable and/or desirable in health insurance plans, to gather opinions and input on proposed policy options.	Two groups targeted, employers who currently offer coverage and those who do not.	Contacted by telephone from a list provided by local health planners, which was from local business groups.	2	3-10	Health Management Associates, and the Survey Research Center at UF's Bureau of Economic and Business Research	Agency for Health Care Administration	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Georgia	2002	To assess small business owners' opinions and attitudes regarding health care access and coverage expansions; to understand barriers that small employers face in providing coverage for their employees	Business owners with between 2-50 employees from service, retail and manufacturing establishments	Local Chambers of Commerce	5 (all types), 4 (do not offer)	10	Georgia Health Decisions	Governor's Office of Planning and Budget/Georgia Health Policy Center	$126,500 (includes individuals focus groups) HRSA State Planning Grant
Hawaii	2002	To gain in-depth understanding of attitudes toward coverage issues among employed persons	Human resource decision makers from small, medium, and large businesses	Recruitment through Ward Research, a research and marketing firm; Individuals received $100 in cash for their participation	3	6-8	Hawaii Health Information Corporation	University of Hawaii Manoa and community partners	$9,800; HRSA State Planning Grant
Idaho	2001	To identify factors that influence small employers' decisions not to offer health insurance to employees	Small businesses that do not offer health insurance	Contacts were made with small employers belonging to local Chamber of Commerce organizations	27 individual Inter-views	1	Boise State University's Center for Health Policy	Idaho Department of Commerce	$4,200; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Illinois	2000	To provide texture and nuance to the quantitative findings and literature reviews	Businesses who do and do not offer health coverage	Experts from Southern Illinois University recruited participants from seven targeted constituencies in five distinct geographic regions	8	5-6	Southern Illinois University at Carbondale (SIUC) in conjunction with Program Evaluation for Education and Communities (PEEC)	Illinois Department of Financial and Professional Regulation: Division of Insurance	$215,000 Grand total for all 27 focus groups
Indiana	2002	To gain an understanding of why employers do or do not offer insurance	Small businesses	Letters were sent to CEO's and directors asking them to participate in focus group	22	10-20	Health Evolutions	Indiana Family and Social Services Admin.	$65,000; HRSA State Planning Grant
Iowa	2000	To identify the factors that influence employers' decisions to offer or not to offer health insurance to employees and to understand options for increasing affordable coverage	Mid-size employers that offer insurance, small employers not offering insurance and self-employed workers	Personal Marketing Research, Inc. and American Public Opinion recruited participants from targeted employer groups; a stipend was provided	12	8-10	State Public Policy Group	Iowa Department of Public Health	$50,000 total for all Focus Groups; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Kansas	2004	To determine what would motivate small employers to offer coverage, what barriers they face, and what actions by the state would be of assistance	Small employers (less than 50 employees)	Used state and local business associations and Steering Committee member contacts	8	5-6	Michael Bailitt, Wellesley, MA	Kansas Insurance Department	$60,900; HRSA State Planning Grant
Louisiana	2005	To better understand the impact of uninsurance on employers (e.g., costs of lower productivity) and to explore employer support for various options to address the accessibility of affordable health coverage	A diversity of the State's employer population representing different firm sizes, industries and geography	Use employer trade associations such as the National Federation of Independent Business, Louisiana Business Group on Health, Louisiana Association of Business and Industry, and the Louisiana Association of Independent Businesses to recruit participants	16		An in-state contractor to be announced	Louisiana Department of Health and Hospitals	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Maine	2002	Information on current market trends and response to various reform option scenarios	Businesses of 50 or fewer employees. Also conducted 9 interviews with large businesses (500+ employees)	Inquiries with local Chamber of Commerce, business leaders, legislative reps., then snowball name collection and queries	4: 2 with employers that provided coverage and 2 that did not	10	The Muskie School of Public Service	Maine Department of Human Services	Embedded in subcontract to the Muskie School; HRSA State Planning Grant
Maryland	2002	To learn about employers' knowledge and impressions of insurance and CHSBP; reasons for not offering coverage; reasons for beginning to offer coverage; and reactions to various marketing materials	Employers participating in CHSBP, <11 and 11-50 employees. Employers not participating in the CHSBP, <11 and 11-25, and 26-50 employees	Participants recruited from the Maryland Chamber of Commerce and the Maryland Chapter of the National Federation of Independent Business	10	8-12	Shugoll Research, Bethesda, MD	Maryland Department of Health and Mental Hygiene	NA; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Michigan	2005	To enhance information on perceived barriers to providing employer-sponsored health insurance, and provide more detail on the state-level policy changes that would most likely influence business towards providing health insurance to their employees	Small- to mid-size business owners and insurance agents. Groups will contain employers who do not offer insurance and those that do. Two focus groups will be held with brokers and agents.	A question at the end of the employer survey will ask if respondents are interested in participating in a focus group. Financial stipend and mileage reimbursement will be provided. The Small Business Association of Michigan will assist in recruitment.	10 (5 with employers who offer insurance and 5 with employers who do not offer insurance)	20 employers offering insurance and 13 employers not offering insurance (varying numbers in each group). Also, 46 telephone interviews were held with employers offering insurance and 42 with employers not offering insurance.	Survey Research Unit (SUR), Center for Collaborative Research in Health Outcomes and Policy (CRHOP), Michigan Public Health Institute (MPHI)	Michigan Department of Community Health	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Minnesota	2001	To better understand how small employers view the value of health insurance, what coverage options they provide, and their opinions of different government assistance options	Small employers that do and those that do not offer coverage	Small employers called or personally invited based on geographic location	6	6	Krueger & Associates	Minnesota Department of Health, Health Economics Program	$20,000 Supplemental HRSA State Planning Grant
Mississippi	2003	To better understand how small (< 50 employees) view offering health insurance coverage to employees. Findings were used to develop a quantitative employer survey instrument.	2-9 employees; 10-19 employees; 20-49	Not reported	3	Not reported	University of Southern Mississippi Center for Applied Research and Evaluation	Mississippi Division of Medicaid	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Missouri	2004	To better understand the issue of health insurance as it pertains to small business specifically pertaining to those that offer health insurance and those that do not, coverage by employee type, co-pay requirements, employee cost sharing	Small business	To recruit participants associated with local chambers, state business associations, community partnerships, and the Department of Economic Development	10	Average participation was 6-7	Southwest Missouri State University, Ozarks Public Health Institute	Missouri Department of Health and Senior Services	Firm, fixed price of $2,093 per completed focus group of employer-based participants or 60-100 people total.
Montana	2002	To identify problems and obstacles to offering health insurance	Small to medium-sized employers	Telephone	2	10	Bureau of Business and Economic Research	University of Montana	$11,000; HRSA State Planning Grant
Nebraska	2004	Supplement to employer and household surveys	Small employers in rural and urban areas	Had a key contact in every community for every group	4	4-11 (mean 6.5)	Nebraska Center for Rural Health Research, UNMC	Office of Public Health, Nebraska Health and Human Services System	$7,340; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
New Hampshire	2000	To provide context to information collected in the employer survey and to ask about specific program and policy models	large employers, large seasonal employers, small employers (<50 employees) and a large number of "micro" employers (<10 employees)	Chambers of Commerce	8	10	Institute for Health, Law & Ethics, Franklin Pierce Law Center; Facilitator: Capitol Health Strategies	New Hampshire Department of Health and Human Services	$37,000; HRSA State Planning Grant
New Jersey	2003	Conducted short, qualitative telephone interviews; Also interviewed officials in other states running premium support programs or full cost buy-in programs	Private employers based in NJ. Both businesses that offer and those that do no offer. All sizes of employers.	Called from a list of 200 employers that FamilyCare enrollees listed as their place of employment	26 employers were inter-viewed	1	Rutgers Center for State Health Policy	NJ Department of Human Services	$158,000 (combined with other costs);

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
North Carolina	2005	Explore reasons that employers offer or don't offer insurance, or limitations in coverage. Explore reasons why uninsured employees lack coverage. Focus group participants will be asked to consider different insurance options to identify willingness to purchase at different insurance prices	Employer representatives who are responsible for or involved in the decision to offer health insurance (2 with large employers, 2 with medium employers, and 4 with small employers)	FGI Research will use employer databank to randomly select eligible employers. A screening tool will be used to determine eligibility for participation	8	8-12	FGI Research	Sheps Center for Health Services Research, UNC-HC	$122,150 in funding to support all focus group work; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
North Dakota	2004	What factors do employers consider when deciding what health insurance to offer employees	Participants included health care (7), services (3), financial/banking (3), education (2), construction/ manufacturing (2), wholesale (2), retail (2), government (2), and agriculture (1)	Invitations to attend were mailed to 1,200 North Dakota employers	4	7-10	University of North Dakota Center for Rural Health	North Dakota Department of Health	$15,500 HRSA State Planning Grant
Oklahoma	2003	Discuss health care issues, including government-sponsored health insurance and Medicaid reforms among small business employers in order to redesign the current Medicaid program in Oklahoma.	Individuals and small business employers (size not defined).	Not reported	Not reported	175 respondents in total	Department of Family & Preventive Medicine at the University of Oklahoma Health Sciences Center,	Oklahoma Heath Care Authority	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Oregon	2000	To investigate why employers do or do not offer coverage, employer trends, and interest in state expansion program	Small employers (<25 employees)	Purposeful	6	5-6	Department of Anthropology, Oregon State University	HRSA State Planning Team	$40,345; HRSA State Planning Grant
Pennsylvania	2005	Groups not conducted at time of last report	Not reported	Not reported	Not reported	Not reported	Not reported	Governor's Office of Health Care Reform, Commonwealth of Pennsylvania	HRSA State Planning Grant
Rhode Island	2005	Gather information about employer decision-making criteria, and what their likely response would be to a variety of possible state initiatives for reform	Small employers (Less than 50 employees) and Self-employed individuals	NA (Conducted summer of 2005, report will be released in October 2005)	Not reported	Not reported	Not reported	Rhode Island Department of Human Services	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
South Carolina	2002	To determine why businesses do not offer insurance; to identify options for assisting small businesses in offering health care coverage	Service, professional, construction, light manufacturing, distribution, nonprofit, communications, health care, and wholesale	Networks of small business organizations, service providers for small businesses, and insurance providers	5	10	Clemson University	South Carolina Department of Insurance	HRSA State Planning Grant
South Dakota	2001	To identify the factors that influence small employers' decision to offer or not offer health insurance to workers	Small employers	Snowball sampling techniques; participants were offered a financial incentive	2	9-12	The Lewin Group; American Public Opinion Survey & Market Research Corporation recruited participants and obtained sites for the groups	South Dakota Department of Health	$50,000 total between the Employer and Individual Focus Groups; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Tennessee	2005	To collect information from employers about health insurance decisions	Small employers	Word of mouth and ads in newspapers	4	10	UT Knoxville	Department of Commerce and Insurance	$250,000 (includes all data collections costs); HRSA State Planning Grant
Texas	2001	To identify factors that influence small employers' decisions to offer or not to offer health insurance to employees	Small employers who do and do not offer health insurance	Information about the focus groups was included in a survey of small employers. Also newspaper ads and recruitment through local business organizations.	15	7-9	Texas A&M University Public Policy Research Institute (PPRI)	Texas Department of Insurance	$45,000; HRSA State Planning Grant
Texas	2006	To present pilot small employer health insurance plans and receive input on their costs and benefits from uninsured Houston area small employers and employees	Houston area small employers who do not offer health insurance	Purchased a list of Houston area small employers from the Texas workforce commission	25	2-5	Texas Department of Insurance	Texas Department of insurance	$4,500 HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Texas	2005	1. Factors contributing to Texas' high uninsurance rates; 2. Ideas for improving accessibility and affordability; 3. local factors that might impact purchasing patterns and perceptions	small employers who do not offer health insurance	Recruitment though local business organizations and chambers of commerce	7	7-9	Texas A&M University and Public Policy Research Institute (PPRI)	Texas Department of Insurance	$32,000 HRSA State Planning Grant
Vermont	2000	To identify the factors that influence employers' decisions about whether to offer health insurance, and to obtain employers' ideas regarding possible ways to expand health insurance coverage	Employers who do not offer insurance (all sizes); Employers who do offer insurance including small firms (1-9 employees), medium firms (10-50 employees), and large firms (51+ employees)	High-level employees responsible for the administration of employee benefits (frequently the owner, president, vice-president or human resources director) were recruited to participate; all participants were offered a stipend	16	8-12	Action Research and The Lewin Group	Office of Vermont Health Access (OVHA)	$225,000 (includes focus groups of employers, insurance providers, medical care providers, workgroups and in-depth interviews); HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Virgin Islands	2003	Develop understanding of health insurance and health care issues from employer perspective	Employers in all industries grouped by size of workforce. 50 participants: 8 self-employed, 16 with 2-9 employees, and 26 with 10+ employees.	Recommendations and cold calling by the Focus Group Facilitator in coordination with Grant Management Team	6 (3 on St. Thomas, 2 on St. Croix, and 1 on St. John)	8-9	Consultant from the University of Virgin Islands	Bureau of Economic Research, Office of the Governor	$9,600 (includes cost of individual focus groups) HRSA State Planning Grant
West Virginia	2004	To understand how offer decisions are made, role of states, general concerns, benefits and financing, small businesses	Small businesses	Some recruited by local survey contractor; others recruited by local business and community leaders.			William Lindsay, Benefits Management Association	West Virginia Institute for Health Policy Research	HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
West Virginia	2002	To examine employer values; impact of offering insurance on retention; changes anticipated to cope with rising costs. Also, specific plan design, willingness to pay at various price points.	Small businesses (2-50 employees) who offer (6) and don't offer (3) groups); agents/brokers (3 groups).	Some recruited by local survey contractor; others recruited by local business and community leaders.	12	8-9	Lake, Snell, Perry & Associates (via Lewin); and William Lindsay, Benefits Management Association	West Virginia Institute for Health Policy Research	$104,000 for all focus groups; HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Wisconsin	2000	To assess small employer attitudes toward health care coverage, and to explore the likelihood of employers who do not offer coverage being influenced by the development of purchasing alliances, individual or employer subsidies/tax incentives or an economic downturn	Employers with 2-50 employees that did and did not offer health insurance, that have at least 2 full-time employees, and that have at least one full-time employee earning less than $10 per hour	The Wisconsin Chapter of the National Federation of Independent Business and the Wisconsin Department of Workforce Development also provided recruiting assistance	9	7	Institute for Health Policy Solutions; Professional consultants assisted with recruiting: Mazur-Zachow of Brookfield, WI, Lien-Spiegelhoff also of Brookfield, and Delve of Appleton, WI	Wisconsin Department of Health and Family Services	$109,490 for both the employer groups and the low-wage worker groups (see Table 2-3); HRSA State Planning Grant

Table B2. Summary of SPG Employer Focus Group Activity, 2000-2006									
State	**Year**	**Purpose of Focus Groups**	**Types of Employers Participating**	**Participant Recruitment Process**	**Number of Groups**	**Number of Participants per Group**	**Vendor(s)**	**Agency Overseeing Data Collection**	**Budget and Funding Source**
Wyoming	2002	To understand decision-making, barriers, and opportunities for small employers with respect to health insurance coverage for employees; to evaluate feasible alternatives for enhancing access to care	Employers with less than 20 employees, including employers that do and do not provide health insurance	Chamber of Commerce offices located in Rock Springs and Casper managed local coordination and participant selection for the focus groups.	2	16	University of Wyoming School of Nursing	Wyoming Department of Health	Combined with other costs; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Alabama	2003	Alabama Health Care Insurance and Access Survey; Insurance Direction for Every Alabamian (IDEA)	Telephone	7,200 households	RDD, oversampling for 12 geographic regions, children, and Hispanics	47%	University of Minnesota	Alabama Department of Public Health	$493,112; HRSA State Planning Grant
Alaska	2006	Alaska Modified Behavioral Risk Factor Survey	Telephone	2,500 per year (500 per region)	Disproportionate Stratified Sample Design (DSS), by 5 regions, using Genesys.	63% (CASRO)	University of Alaska Institute of Social and Economic Research	Alaska Department of Health and Social Services	Supported by State Planning Grant funds.
American Samoa	2005	Coverage for All in America Samoa Project	In-person				American Samoa Community College; University of Hawaii	Governor's Office, American Samoa	HRSA State Planning Grant
Arkansas	2001	Arkansas Household Survey of Health Insurance Status	Telephone	2,572 households representing 6,596 individuals	Stratified statewide RDD sampling design; 75 counties were stratified into three regions (Delta, Mountain, and Other); oversampled in Delta and Mountain regions	62%	Center for Survey Research (CSR), University of Massachusetts	Arkansas Center for Health Improvement (ACHI)	$270,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Arkansas	2004	Arkansas Household Survey of Health Insurance Status	Telephone	2,625 households representing 6,000 individuals	Stratified statewide RDD sampling design; 75 counties were stratified into three regions (Delta, Mountain, and Other); oversampled in Delta and Mountain regions		Center for Survey Research (CSR), University of Massachusetts	Arkansas Center for Health Improvement (ACHI)	HRSA State Planning Grant
California	2001	California Health Interview Survey (CHIS)	Telephone	55,428 adults, 5,801 adolescents, 12,592 children	RDD with 58 counties arranged into 41 strata; oversampled three cities with health departments, Asian American subgroups and American Indians	Adult rate 64%	Center for Health Policy Research, University of California Los Angeles	Collaboration between California Department of Health, UCLA Center for Health Policy Research, and the Public Health Institute	$11.6 million; CA Dept. of Health Services; CA Endowment; CA Children & Families Commission; Nat'l Cancer Institute; CDC; Indian Health Service

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
California	2003	California Health Interview Survey (CHIS)	Telephone	42,044 adults, 4,010 adolescents, 8,526 children	RDD with 58 counties arranged into 41 strata; oversampled three cities with health departments, Asian American subgroups and American Indians	Adult rate: 60.0%	Center for Health Policy Research, University of California Los Angeles	Collaboration between California Department of Health, UCLA Center for Health Policy Research, and the Public Health Institute	
Colorado	2001	Colorado Household Survey (CHS)	Telephone	10,217 households	Disproportionate stratified sample; oversampled low-income and 13 sub-regions, people of color, and rural populations; undersampled people over 65	30%	The Tarrance Group	Governor's Office of Policy and Initiatives	$400,000 (including analysis costs); HRSA State Planning Grant
Connecticut	2004	Office of Health Care Access State Planning Grant Survey	Telephone	3,519 households	Multi-stage random sample with oversample of four urban areas.	36%	University of Connecticut, Center for Survey Research & Analysis (CSRA)	Office of Health Care Access	$150,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Connecticut	2001	Office of Health Care Access State Planning Grant Survey	Telephone	14,333 households sampled; 3,985 households completed interviews	Statewide RDD	44%	University of Connecticut, Center for Survey Research & Analysis (CSRA)	Office of Health Care Access	$237,000; HRSA State Planning Grant
Florida	2004	Florida Health Insurance Study	Telephone with mail follow-up for non-contacts	17,436 households, with data collected about 46,920 individuals	Stratified RDD sample in each of the 17 districts as in the 1999 Fieldwork Household Survey (FHIS)	25%	University of Florida Department of Health Services Research, Management and Policy; and the Survey Research Center at UF's Bureau of Economic and Business Research	Florida Agency for Health Care Administration, Division of Medicaid	$414,275 for fieldwork; $58,000 for data analysis; HRSA State Planning Grant
Georgia	2002	Georgia Household Health Insurance Survey	Telephone	10,088 households	RDD, oversampling by geographic region and income	44%	University of Minnesota Survey Research Center	Governor's Office of Planning and Budget, Georgia Health Policy Center	$400,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Guam	2005	Household Income and Expenditure Survey	Telephone and in-person	1,027 to date			University of Guam-Cooperative Extension Service	Guam Department of Public Health and Social Services	HRSA State Planning Grant
Hawaii	2002	General Public Survey	Telephone	6,000 households	RDD, oversample of smaller islands		University of Hawaii	Hawaii Uninsured Project	$80,000; State funds.
Idaho	2005		Mail	2,224 households (sampled from one county only)	Oversample of low-income (sampled from one county only)	16%	Boise State University	Ada County Healthy Communities Access Program	$9,300 HRSA-SP; Idaho Department of Health and Welfare; Boise State University
Illinois	2001	Illinois Population Survey of Uninsured and Newly Uninsured	Telephone	25,735 individuals	Disproportionate stratified random sample with five strata: Northwestern Illinois, Central Illinois, Southern Illinois, Cook County; and the Collar Counties of Cook County	52%	University of Illinois-Chicago, Health Research and Policy Centers (HRPC) and the Survey Research Laboratory (SRL)	Illinois Department of Financial and Professional Regulation: Division of Insurance	$512,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Indiana	2003	Health Insurance for Indiana's Families Survey	Telephone	9,965 households	RDD, oversample of Hispanics, African Americans and low income	40%	Indiana University Public Opinion Laboratory (IUPOL)	Indiana Family and Social Services Administration	$500,000; HSRA State Planning Grant.
Iowa	2001	Survey of the Uninsured	Telephone	1,500 uninsured individuals	RDD with oversampling in lower income areas	Achieved target of 1500 completes	The Lewin Group and Baselice and Associates	Iowa Department of Public Health	$200,000; HRSA State Planning Grant
Iowa	2005	Survey of the Uninsured	Telephone	1,202 Individuals	RDD	17%	Selzer and Company	Iowa Department of Public Health	
Kansas	2001	Kansas Health Insurance Survey	Telephone	8,004 households representing 22,691 individuals	Stratified random sample with over-sampling of Hispanics, African Americans, and low income	44%	University of Florida Department of Health Services Administration	Kansas Insurance Department	$335,000; HRSA State Planning Grant
Kentucky	2005	Kentucky Health Insurance Research Project 2005 Household Survey	Telephone	2,400 households	Random sampling of 1,600 households plus an oversample of the uninsured (400) and the non-white population (400)	51%	University of Kentucky Survey Research Center (UK-SRC)	Kentucky State Office of Rural Health	HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Louisiana	2005	Louisiana Health Insurance Survey	Telephone	10,000 households	Randomly selected stratified households, stratified by parish, region & income	23%	Louisiana State University Public Policy Research Lab	Louisiana Department of Health and Hospitals	$409,683 for survey and forecasting; State General Funds and Title XXI (SCHIP) matching funds
Maine	2002	Household Survey: Maine State Planning Grant	Telephone	8,756 phone numbers released, 3,536 completed interviews	Probability sample stratified by urban/rural region	61%	Mathematica Policy Research, Inc.	Muskie School of Public Service University of Southern Maine	$330,000; HRSA State Planning Grant.
Maryland	2001		Telephone	5,000 individuals	RDD, oversampled rural residents below 300% FPL; and families with children	NA	Johns Hopkins Bloomberg School of Public Health	Maryland Department of Health and Mental Hygiene; OPDF and MHCC	Funded through Maryland Health Care Commission and HCFA match.
Massachusetts	2004	Household Survey of Health Insurance Status	Telephone	4,725 households	Stratified statewide RDD sample. The state of Massachusetts was divided into 5 geographic regions.	60%	Center for Survey Research (CSR), University of Massachusetts	Massachusetts Division of Health Care Finance and Policy (DHCFP)	$450,000; State Legislature over two years

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Massachusetts	2000	Household Survey of Health Insurance Status	Telephone	2,632 households representing 7,069 individuals completed interviews; Urban over-sample of another 2,132 households representing 5,535 individuals completed interviews	RDD stratified by regions; RDD for select urban areas	62% statewide; 63% over-sample	Center for Survey Research (CSR), University of Massachusetts	Massachusetts Division of Health Care Finance and Policy (DHCFP)	$450,000; HRSA State Planning Grant and Division of Health Care Finance and Policy
Michigan	2005	Michigan Household Health Insurance Survey	Telephone	13,091 households, 34,113 individuals	RDD disproportionate stratified sample of seven regions; oversample of low-income populations	40%	Center for Collaborative Research in Health Outcomes and Policy, Michigan Public Health Institute (MPHI)	Michigan Department of Community Health	HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Minnesota	2001	Minnesota Health Access Survey	Telephone and in-person (but separate projects - telephone and in-person data have never been combined)	27,310 individuals (telephone);	Stratified random sample, stratified by geography for telephone; Clustered random sample, clustered by geography for in person; oversampled African Americans, Asian Americans, Hispanics, rural and low income	65%	University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Survey Research Center	Minnesota Department of Health, Health Economics Program	$785,379 for telephone; $263,437 for in-person; HRSA State Planning Grant ($1,00,841).
Minnesota	2004	Minnesota Health Access Survey	Telephone	13,802 households	RDD, stratified with an oversample of minority populations and rural regions	59%	University of Minnesota	Minnesota Department of Health, Health Economics Program	$515,000; BCBS of Minnesota, HRSA State Planning Grant ($115,000), and the Minnesota Department of Human Services

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Mississippi	2004	Mississippi Household Insurance Survey	Telephone	7,620	RDD, non-elderly households. 75% of sample drawn from households with <$35,000 income; 25% drawn from income of $35,000 - $75,000. Stratified into MS's five Medicaid regions	29% to 42%, based on region	Center for Applied Research and Evaluation, University of Southern Mississippi	Mississippi Division of Medicaid	HRSA State Planning Grant
Missouri	2004	Missouri Health Insurance Coverage and Access Survey	Telephone	7000 households	RDD, stratified by region	41%	University of Missouri, Columbia Department of Health and Management and Informatics	Missouri Department of Health and Senior Services	$38.75 per completed survey, not to exceed $310,000; HRSA State Planning Grant
Montana	2003	2003 Household Survey	Telephone	4,000 individuals	Stratified RDD	70+%	Bureau of Business and Econ Research University of Montana, Missoula	Department of Public Health and Human Services	$175,000; HRSA State Planning Grant.

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Nebraska	2004	Nebraska Uninsurance Survey	Telephone	2,625 interviews completed	Adequate sample in six geographic regions; Hispanics and African Americans over-sampled	70%	Nebraska Center for Rural Health Research, UNMC and University of Minnesota	Office for Public Health, Nebraska Health and Human Services System	$57,000; HRSA State Planning Grant
New Hampshire	2001	New Hampshire Family Insurance Survey	Telephone	5,177 households	Proportional sample: 1,000 uninsured and 4,700 insured	73%	Health Economics Research, RKM Research and Communications, University of New Hampshire	NH Department of Health and Human Services	$350,000; HRSA State Planning Grant
New Jersey		New Jersey Family Care Family Health Survey	Telephone	679 families	Children enrolled in NJ FamilyCare as of May 2002	52%	Center for State Health Policy (CSHP); CSHP subcontracted with Shulman, Ronca, and Bucuvalas (SRBI) to field the survey	New Jersey Department of Human Services	$261,000; HRSA State Planning Grant.

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
New Mexico	2004	Human Services Department/NMSU Uninsured Household Survey	Telephone	7,566 households	Stratified cluster	NA	New Mexico State University & Research & Polling, Inc.	New Mexico Human Services Department	$300,000; HRSA State Planning Grant
North Carolina	2005		Telephone	15,000 households	2005 NC BRFSS, added 12 questions; oversample 22 counties and 13 regions with smaller counties	NA	North Carolina State Center for Health Statistics	North Carolina State Center for Health Statistics	HRSA State Planning Grant
North Dakota	2004	North Dakota Household Survey	Telephone	3,199 households	RDD, stratified by three regions (urban, large rural, and small rural)	61%	University of North Dakota Center for Rural Health, University of North Dakota Social Science Research Institute, and Mathematica Policy Research, Inc.	North Dakota Department of Health, University of North Dakota Center for Rural Health	$182,800; HRSA State Planning Grant
Oklahoma	2004	Oklahoma Health Care Insurance and Access Survey	Telephone	5,847	RDD stratified into three regions	45% (AAPOR RR4)	SHADAC; Survey Research Center at the University of Minnesota	Oklahoma Health Care Authority	HRSA State Planning Grant (total grant = 874,360)

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Oregon	2004	Health Values Survey	Telephone	4508	Simple random sample; oversampled Native Americans, African Americans, Asian Americans and Hispanics	24%	Northwest Research Group	Oregon Progress Board	$244,710: Each of the participating state agencies
Oregon	2001	Household Survey	Telephone	709 households completed interviews	Simple random sample	39%	Survey Research Laboratory, Portland State University	HRSA State Planning Grant Team	$25,000; HRSA State Planning Grant
Pennsylvania	2004		Telephone	6,700 households	Random sample designed to produce state and county-level estimates		Market Decisions, Inc.	Governor's Office of Health Care Reform	State funds and HRSA State Planning Grant
Puerto Rico	2005		Telephone	20,000 households	Plans to add items to the Puerto Rico Health Survey which is conducted twice a year		School of Medicine, University of Puerto Rico	School of Medicine, University of Puerto Rico	HRSA State Planning Grant
South Carolina	2003	South Carolina Health Care Insurance and Access Survey	Telephone	1,600 households; with additional 400 uninsured individuals	RDD, oversampled uninsured	70%	University of South Carolina	South Carolina Department of Insurance	$275,000; HRSA State Planning Grant.

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
South Dakota	2001	South Dakota Survey of the Uninsured	Telephone	1,502 households with at least one uninsured person	RDD sample based proportionately on county population estimates grouped into eight geographic regions; Oversampled rural areas, Native Americans	Achieved target of 1500 completes.	The Lewin Group and Baselice and Associates (Conducted telephone interviews.)	South Dakota Department of Health	$400,000; HRSA State Planning Grant
Tennessee	2005	Health Insurance Survey of Tennessee Residents	Telephone	26,000 - 4,886 responses	Stratified random sample		University of Tennessee, Memphis	Tennessee Department of Commerce and Insurance	$900,000; HRSA State Planning Grant
Texas	2001	Survey of Households Above 200% of the Federal Poverty Level	Telephone	598 Households	RDD, stratified by county. Random numbers were distributed across all eligible blocks in proportion to their density of listed telephone households; oversampled Hispanics	44%	Survey Research Laboratory, Texas A&M; Public Policy Research Institute	Texas Department of Insurance	$110,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Utah	2001	2001 Health Status Survey	Telephone	7,250 households representing 24,088 individuals	Single-stage, non-clustered RDD selection from residential listings; CATI	41%	PEGUS Research Inc.	Office of Public Health Assessment, Utah Department of Health	$305,000; HRSA State Planning Grant and state funds
Vermont	2000	Family Health Insurance Survey	Telephone	8,623 households representing 22,258 individuals	Disproportionate random sampling aimed at meeting precision targets at the state, county and subpopulation levels; oversampled low income and senior citizens	68%	Market Decisions, Inc as survey contractor; Mathematica Policy Research, Inc. for technical assistance	Banking, Insurance, Securities and Health Care Administration (BISHCA)	$200,000; HRSA State Planning Grant; $50,000; Office of Vermont Health Access; $50,000; BISHCA
Virgin Islands	2003	2003 Virgin Islands Health Insurance and Access Survey	Telephone	2,073 individuals	RDD stratified by island	66%	Eastern Caribbean Center; University of the Virgin Islands	VI Bureau of Economic Research	$411,738; HRSA State Planning Grant
Virginia	2004	2004 Virginia Health Insurance and Access Survey: Household Survey	Telephone	4000	RDD, stratified sample with strata for five regions and low-income families	35%	Clearwater Research Inc.	Virginia Department of Health	$120,000; HRSA State Planning Grant

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Washington	2002	Washington State Population Survey	Telephone	6,842 households	RDD stratified sample by region (eight regions ot draw general population sample); oversampling of African Americans, Asians, Hispanics, and Native Americans	42.2%%	Gilmore Research Group	Office of Financial Management	$265,000; General Fund State
Washington	2000	Washington State Population Survey	Telephone	6,726 households completed interviews	RDD stratified into eight geographic regions to draw general population sample; oversampling of African Americans, Asians, Hispanics, Native Americans	43% General population; 29% expanded sample	Contract with Washington State University for data collection	Office of Financial Management	$265,000; state funds
Washington	2006	Washington State Population Survey	Telephone	7,082 households	RDD statified sample by region (eight regions) King County oversampled to get better representation form minorites who are primarily located there	27.5% (many more unworkable phone numbers than in the past)	Gilmore Research Group	Office of Financial Management	$321,445 State Funds

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Washington	2004	Washington State Population Survey	Telephone	7,097	RDD stratified sample by region (eight regions). King County oversampled to get better representation from minorities who are primarily located there	38%	Gilmore Research Group	Office of Financial Management	$300,000; General Fund State
West Virginia	2000	2003 West Virginia Healthcare Survey	Telephone	1,600 individuals	Stratified 3-stage cluster	51%	TNSI, the Lewin Group	West Virginia Health Care Authority	HRSA State Planning Grant
West Virginia	2001	2001 West Virginia Healthcare Survey	Telephone	16,493 individuals	RDD, oversampled rural, African Americans	51%	Institute for Health Policy Research at West Virginia University	West Virginia Health Care Authority	$500,000;state funds (85%) RWJF (15%)

Table B3. Summary of SPG Household Survey Activity, 2000-2006									
State	**Year**	**Survey Name**	**Methodology**	**Sample Size**	**Sample Design**	**Response Rate**	**Vendor(s)**	**Agency Overseeing Survey**	**Budget and Funding Source(s)**
Wisconsin	2001	Wisconsin Family Health Survey	Telephone	2,436 households representing 6,368 individuals	Disproportionate random sample, stratified by five health regions. Over sampled telephone prefixes in City of Milwaukee known to have higher-than-average concentrations of African American households; also conducted separate surveys of farmers and young	66%	University of Wisconsin Survey Center	Wisconsin Department of Health and Family Services	$133,470; HRSA State Planning Grant and state funds (Jan-June 2001)
Wyoming	2002	Wyoming Household Insurance Survey	Mail, Telephone	4,315 mail;1,196 phone; 50 in person (in group quarters)	Oversampled counties, residents in group quarters	85%	Survey Research Center & Statistical Consulting Service	Wyoming Department of Health, Office of Medicaid	$121,000; HRSA State Planning Grant

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Alaska	2006	Mail	Expected to be about 3,200	Sampling was structured using five employee size categories: 1-3, 4-9, 10-49, 50-249, and 250+.	Only firms that reported employment in all four quarters were used as the universe of employers eligible to be surveyed.	67% in 2001 survey		HRSA State Planning Grant	Alaska Department of Labor and Workforce and Alaska Department of Health and Social Services
Arkansas	2001	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	Used the 2001 MEPS-IC; increased sample size from 800 to 1,800	Stratified nationally representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate and large business establishments and governments	70%	Agency for Healthcare Research and Quality	HRSA State Planning Grant	Arkansas Center for Health Improvement (ACHI)
Connecticut	2003	Telephone	810	Disproportionately stratified by private business sector – oversampled construction and retail firms and excluded those in mining	Private sector firms between 2 and 300 employees	Not reported	University of Connecticut, Center for Survey Research & Analysis (CRSA)	HRSA State Planning Grant	Office of Health Care Access

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Connecticut	2001	Telephone	805 completes	Disproportionate sample stratified by industry clusters; drawn from databases maintained by Dunn and Bradstreet	Included all business located in the state with two or more employees; excluded government agencies and public facilities	41.5%	University of Connecticut, Center for Survey Research & Analysis (CRSA)	HRSA State Planning Grant	Office of Health Care Access
Delaware	2001	Mail	1,601 employers sampled; 725 completes	Stratified by number of employees	Small businesses (less than 50 employees) that do and do not currently offer health coverage	45%	University of Delaware, Center for Applied Demography and Survey Research, and the Institute for Public Administration	HRSA State Planning Grant	Delaware Health Care Commission
District of Columbia	2005	Telephone	410	Stratified by firm size, industry, years in business	Small Firms (1 to 50 employees)	Not yet available (preliminary results "relatively high")	Data Source	HRSA State Planning Grant	Urban Institute

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Georgia	2002	Mail (2004 data currently being analyzed)	1,399 completes	Stratified based on 3 regions and 5 firm size categories. In 2004: stratified for 3 regions, oversampled 4 communities, 3 firm size categories.	All except agriculture and state employees	21%	Georgia Health Policy Center	$54,700, HRSA State Planning Grant	Governor's Office of Planning and Budget/Georgia Health Policy Center
Guam	2005				Large and small businesses			700 HRSA State Planning Grant	HRSA State Planning Grant
Hawaii	2002	Telephone	450	Sample obtained from Hawaii business directory and sent to individuals who make health insurance decisions at businesses. Small, medium, and large businesses surveyed according to their proportionate presence in the Hawaii market	Human resource personnel from small, medium, and large businesses	100%	University of Hawaii Manoa and Ward Research	HRSA State Planning Grant	Hawaii Uninsured Project

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Idaho	2001	Mail	3,647 completes	Stratified random sample	Idaho's businesses, excluding government agencies and most schools	18%	State of Idaho via Idaho's Employer Health Care Benefits Survey	State appropriations and HRSA State Planning Grant	Idaho Department of Commerce
Iowa	2001	Telephone	550 completes	The American Business Directory and other databases were used for the sampling frame; stratified into four geographic regions	All private businesses (non-government) with at least one employee	Achieved target of 550 completes	The Lewin Group, Baselice and Associates, and the State Public Policy Group and the Selzer Company		Iowa Department of Health
Iowa	2004	Phone	1003	The sample frame was intended to be broadly representative of Iowa businesses. The sample of employers was provided by Survey Sampling, Inc. of Fairfield, CT, drawn from business directories and yellow page listings.	All	Not reported.	Selzer & Co., University of Iowa College of Public Health	HRSA State Planning Grant	Iowa Department of Public Health

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Kansas	2004	Mail	314 completes	Stratified random sample	Small employers	33%	University of Florida Department of Health Services Administration	HRSA State Planning Grant	Kansas Insurance Department
Kansas	2000	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	MEPS-IC buy-in	National representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate, and large business establishments and governments		Agency for Healthcare Research and Quality (AHRQ); survey conducted by the US Census Bureau	HRSA State Planning Grant	Kansas Department of Insurance
Kentucky	2005	Telephone	500	Random sample of business with 1-49 employees. Removed firms which were clearly subsidiaries and domestic employers (N=59) were replaced with next 59 records.	Small businesses (less than 50 employees)	45%	University of Kentucky Survey Research Center (UK-SRC)		Kentucky State Office of Rural Health

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Maryland	2002	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	MEPS-IC buy-in; additional sample of 800	National representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate, and large business establishments and governments		Agency for Healthcare Research and Quality (AHRQ); survey conducted by the US Census Bureau	HRSA State Planning Grant	Maryland Department of Health and Mental Hygiene
Massachusetts	2005	Mail (After identifying correct recipient by phone and sending an alert postcard. Each survey sent with $10 bill. Numerous phone follow-ups were done.)	1500	Randomly selected from D & B, stratified by size; all small employers who responded in 2003 still in business to be resurveyed.	Nonpublic, larger than 1 employee	Not yet known (60% in previous year)	Center for Survey Research at the University of Massachusetts, Boston	HRSA State Planning Grant	Massachusetts Division of Health Care Finance and Policy

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Massachusetts	2001	Telephone with mail follow-up to non-responders; premium tables could be filled out separately by fax	1,014 completes	Sample stratified by size of employer (2-49, 50-149, 150-249, 250+)	All non-government employers (this includes schools and libraries) with at least two employees	55%	Center for Survey Research at the University of Massachusetts, Boston	HRSA State Planning Grant	Massachusetts Division of Health Care Finance and Policy
Michigan	2005	Mail survey with telephone follow-up for non-responders; modified version of MEPS-IC	Mailed to 9,000 (minimum of 3,150 completions anticipated)	Random sample drawn from the American Business Directory, the Small Business Association of Michigan, the Michigan Chamber of Commerce and other trade associations	Large and small	13%	Survey Research Unit (SUR), Center for Collaborative Research in Health Outcomes and Policy (CRHOP), Michigan Public Health Institute (MPHI)	HRSA State Planning Grant	Michigan Department of Community Health

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Minnesota	2006	2006 Minnesota Employer Health Insurance Survey	~3,000	Mail survey				$200,000	Minnesota Department of Health
Minnesota	2002	Telephone	2,400 employers sampled	Stratified random sample, stratified by employer size, geographic region, and single or multi-establishment firm	All non-government employers with at least one employee (self-employed with no employees were out of scope)	65%	University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Survey Research Center	$400,000 HRSA State Planning Grant	Minnesota Department of Health, Health Economics Program
Montana	2003	Telephone	520	Stratified by firm size	All types	85%+	Montana Bureau of Business and Economic Research	$25,000 HRSA State Planning Grant	Montana Department of Public Health and Human Services

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Nebraska	2004	Mail	9,005 surveys analyzed	Adequate sample in six geographic regions	Large and small	65%	Nebraska Department of Labor	HRSA State Planning Grant	Office of Public Health, Nebraska Health and Human Services System
New Hampshire	2001	Telephone	4,800 employers sampled; 642 completes	Random sample	Self-employed; Single site, HQ; franchise, branch;	66%	Health Economics Research and RKM Research and Communications	HRSA State Planning Grant	New Hampshire Department of Health and Human Services
New Mexico	2004	Telephone	Universe based on Department of Labor lists; 1,336	Stratified random sample	At least 2 employees, all non-public bodies	68.5%	New Mexico State University & Research & Polling, Inc.	HRSA State Planning Grant	New Mexico Health Policy Commission
North Dakota	2005	Mail	5304	Random Sample	Random sample of all employers in eight regions of the state of North Dakota	50.2%	University of North Dakota Center for Rural Health and Job Service North Dakota	HRSA State Planning Grant, $20,000	North Dakota Department of Health

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Oklahoma	2003	Mail, handout	150	Sample was drawn from the yellow pages, chambers of commerce, trade organizations (such as Pharmacy Providers of Oklahoma), community business groups (such as the Rotary Club), and individual recommendations and contacts.	Under 50 FTE employees, representative mix of industry types	33% (50 surveys returned; 49 were usable)	Primary Care Health Policy Division, Department of Family & Preventive Medicine, University of Oklahoma Health Sciences Center		Oklahoma Health Care Authority
Oklahoma	2004	Mixed mode: mail, fax, e-mail, handout	More than 4,000	Distributed statewide by regular mail, e-mail, fax, by hand, and through professional associations and organizations, such as the Oklahoma Chambers of Commerce.	Various	298 surveys returned; response rate unknown	Primary Care Health Policy Division, Department of Family & Preventive Medicine, University of Oklahoma Health Sciences Center		Oklahoma Health Care Authority

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Puerto Rico	2005	Mail		Stratified random sample of employers that do not offer health insurance using data bases from the Puerto Rico Department of Labor, the Puerto Rico Association of Retailers and the Puerto Rico Chamber of Commerce					Puerto Rico Department of Health
Rhode Island	2005	Mail, supplemented by telephone reminders and interviews.	1,436 (completes)	The sample included for-profit companies, nonprofit organizations and government agencies.	3 to 10,600 employees	51%	JSI Research & Training Institute	HRSA State Planning Grant	Rhode Island Department of Human Services
South Carolina	2002	Mail	2,499 (mailed)	"Take-all" population with appropriate employers identified and provided by the South Carolina Employment Security Commission	All small employers of 100 or less with home offices located in South Carolina	39%	South Carolina Office of Research and Statistics	HRSA State Planning Grant	South Carolina Department of Insurance

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
South Dakota	2001	Telephone	6,197 employers sampled; 401 completes	Random selection of one-tenth of entire South Dakota Business Directory File, segmented into zip code regions	All private business (non-government) with two or more employees	Achieved target of 400 completes.	The Lewin Group and Baselice & Associates, Inc.	HRSA State Planning Grant	South Dakota Department of Health
Tennessee	2005	Mail	9,600 surveys mailed; 2,681 completed	Random sample of all TN firms (from TN Dept of Labor and Workforce Development) with 2+ employees; stratified by 2-19, 20-99, 100+. The two larger groups were oversampled. Follow-up mailings to nonrespondents oversampled Western TN.	All Types	27.9%	UT Knoxville	HRSA State Planning Grant	Department of Commerce and Insurance
Texas	2001	Mail	50,000 employers sampled; 10,968 completed	Random selection from TX Workforce Commission database, stratified by number of employees	Small Employers (2-50 employees)	22% usable response rate	Texas Department of Insurance	Budget: $80,000; HRSA State Planning Grant	Texas Department of Insurance

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Texas	2004	Mail	20,000 employers samples; 4,303 completed	Geographically representative selection from TX Workforce Commission, stratified by number of employees	Small Employers (2-50 employees)	22%	Texas Department of Insurance	Budget: $36,000, Funding: HRSA State Planning Gran	Texas Department of Insurance
Utah	2002	Telephone survey modeled on national employer survey with specific modifications	420 responses from 1,300 sample	Cross-sectional sample selection A random sample of 1,300 businesses from the Dept of Workforce Services and Economic Development (pop = approx. 65,000 businesses). 350 sampled in each of four groups: 1-9, 10-49, 50-99 or 100+ employees	Business with 1-9, 10-49, 50-99 or 100+ employees; divided equally between urban and rural locations	32%	Dan Jones and Associates	HRSA State Planning Grant	Utah Department of Health

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Vermont	2000	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	MEPS-IC buy-in	National representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate, and large business establishments and governments		Agency for Healthcare Research and Quality (AHRQ); survey conducted by the US Census Bureau		Vermont Agency of Human Services
Virginia	2005	MEPS-IC Over Sample	800	Sub-state analysis for the 5 SPG regions in VA	Virginia Private Businesses		Federally contracted	AHRQ State Planning Grant, subcontractors	

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Washington	2004	Mail – with telephone follow-up. Survey limited in scope – Washington Employee Benefits Survey (WEBS) results used to provide current, local perspective on information gathered from the Medical Expenditure Panel Survey (MEPS)	17,800 establishments (of total of 102,300)	Stratified sample by industry with oversampling of selected industries (e.g., manufacturing, health care)	Industry-wide; firms with 2 or more employees surveyed in 2004 (previous surveys included firms of 4 or more employees); Multiple-establishment firms (e.g., Starbucks) included as 1 firm in 2004 survey. Previous surveys included each establishment as a unique firm	58%	Employment Security Department	$75,000 State Funds	Employment Security Department

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Washington	2005	Washington State Employer Benefit Survey	17,702 establishments (of total of 101,250)	Stratified sample by industry with oversampling of selected industries (e.g., manufacturing, health care)	Industry-wide; firms with 2 or more employees surveyed in 2005 (prior to 2004surveys included firms of 4 or more employees); Multiple-establishment firms (e.g., Starbucks) included as 1 firm in 2005 survey. Previous surveys included each establishment as a unique firm	57%	Employment Security Department	$75,000	Employment Security Department

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
West Virginia	2003	Random sample of firms with more than three employees operating in West Virginia using a Computer Assisted Telephone Interviewing system	515	Stratified sample based on firm size (4-9, 10-49, 50-99, 100+), region of state, and industry type. D&B sampling.	Firms operating in West Virginia with more than 3 employees	32.2%	Taylor, Nelson, Sofres Intersearch, via The Lewin Group	HRSA State Planning Grant	West Virginia University Institute for Health Policy Research
Wisconsin	2001	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	Used data from 2001 MEPS-IC; 1,600 employers sampled	Stratified nationally representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate and large business establishments and governments	70%	Agency for Healthcare Research and Quality (AHRQ), conducted by the US Census Bureau	HRSA State Planning Grant	Wisconsin Department of Health and Family Services

Table B4. Summary of SPG Employer Survey Activity, 2000-2006									
State	**Year**	**Methodology**	**Sample Size**	**Sample Design**	**Types of Employers Surveyed**	**Response Rate**	**Vendor(s)**	**Budget and Funding Source**	**Agency Overseeing Survey**
Wyoming	2003	Mail with telephone follow-up	Stratified random sample of 500 employers from unemploy-ment data base	Random selection by employment size, class, industry, and Region	Employers from all ten major SIC divisions and six employer size classes	64.4%	Wyoming Department of Employment	HRSA State Planning Grant and Wyoming DOE	Wyoming Department of Health

Appendix C: HRSA SPG List of Policy Options

(Includes options considered, developed or implemented during the course of the SPG program. However, some developments may not necessarily be attributed to SPG funding.)

- **Expanding Medicaid/SCHIP to new population/s or Medicaid reform:**

Considered

- Alabama
- District of Columbia
- Kansas
- Louisiana
- Maryland
- Nebraska
- New Hampshire
- North Carolina
- South Carolina
- South Dakota
- Texas
- Wisconsin

Implemented

- Arkansas
- Arizona
- California
- Colorado
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois (AllKids)

- Indiana-implement in 2007
- Iowa
- Kentucky
- Maine
- Massachusetts (MassHealth)
- Michigan
- Minnesota
- Montana
- New Mexico
- New Jersey
- Oklahoma
- Oregon
- Pennsylvania
- Tennessee
- Utah
- Vermont
- Washington
- West Virginia
- Wyoming

Premium Assistance Programs

Considered

- Minnesota
- Arizona-future implementation
- California
- Connecticut
- Florida
- Louisiana
- Nebraska
- North Dakota

- Vermont

Implemented

- Georgia (PeachCare family assistance)
- Idaho
- Illinois
- Missouri
- New Jersey
- New Mexico
- Oklahoma
- Oregon
- Rhode Island
- Wisconsin

- **Outreach/Marketing for Unenrolled but Eligible**

Considered

- Hawaii
- Colorado
- Florida
- Massachusetts
- Montana
- North Dakota
- Texas

Implemented

- Delaware
- Kansas
- Maine
- New Mexico

Individual Coverage Mandate

Considered

- Louisiana
- Maryland
- Montana (considered for college students)
- Tennessee
- Utah

Implemented

- Idaho (implemented for college students)
- Massachusetts (future implementation)

Employer Mandate/Fair Share

Considered

- Georgia
- Louisiana
- Tennessee
- Utah
- Virginia

Implemented

- California-implemented (but repealed)
- Maryland-passed (but struck down by courts)
- Massachusetts
- Vermont

- **Employer Mandated Benefits**

Implemented

- Georgia

- **Safety Net Strategy**

Considered

- Alaska
- Arkansas
- Hawaii
- Kentucky
- Montana
- Nebraska
- New Hampshire
- Oregon
- South Carolina
- Utah
- Washington
- Wyoming

Implemented

- Arizona
- Delaware
- Florida
- Idaho

- **Three Share Model**

Considered

- North Dakota
- South Carolina
- Utah
- Georgia

Implemented

- Illinois (implemented in several counties)
- Michigan (Muskegon County)

High Risk Pool

Considered

- Arizona
- Florida
- Oregon
- North Carolina
- Tennessee

Implemented

- Georgia
- Maryland
- Idaho
- Iowa
- Kansas
- Missouri
- New Hampshire
- New Mexico
- South Dakota
- West Virginia

- **Purchasing Pool for Individuals**

Considered

- Montana
- Oregon
- Washington

Implemented

- Minnesota

- **Reinsurance**

Considered

- Arkansas
- District of Columbia
- Illinois
- Kansas
- Louisiana
- Minnesota
- Missouri
- Nebraska
- North Carolina
- Tennessee
- Virginia
- West Virginia

Implemented

- New Hampshire

- **Tax Credits for Employers or Individuals**

Considered

- Colorado
- Idaho
- Massachusetts
- Minnesota
- New Mexico
- Virginia
- Washington

Implemented

- Kansas
- Maine
- Montana

- **State Universal Health Plan**

Considered

- California
- Idaho
- Maryland
- Tennessee
- Utah

Implemented

- Maine (Dirigo Health Reform Act)
- Massachusetts (future implementation)
- Vermont(Catamount Health)

- **Limited benefit/bare bones coverage**

Considered

- Idaho
- Indiana

- Louisiana
- Massachusetts
- Minnesota
- Oregon
- North Carolina
- Tennessee
- Wyoming

Implemented

- Arkansas
- Colorado
- Florida
- Georgia
- Kentucky
- Maryland
- Montana
- New Jersey
- North Dakota
- Texas
- Utah
- Washington

Primary/Community Care Plans

Considered

- Georgia
- Rhode Island

Implemented

- Maryland (PAC)
- Utah (PCN)

- **Buy-in to employees health plan or existing pool**

Considered

- District of Columbia
- Maryland
- Massachusetts
- Minnesota
- Missouri
- Kansas
- Kentucky
- South Dakota
- Rhode Island
- Tennessee
- Utah
- Virginia
- West Virginia
- Wyoming

Implemented

- New Mexico

- **Expand definition of "dependent" in health coverage**

Considered

- Kansas
- Louisiana
- Maryland

Implemented

- Colorado
- New Jersey

- New Mexico
- Utah

- **Consumer driven care with high deductibles**

Considered

- Idaho
- Massachusetts
- North Dakota
- Virginia

Implemented

- Colorado

- **Small group rating reforms**

Considered

- North Carolina
- Wisconsin
- Tennessee
- Texas
- Virginia
- Maryland

Implemented

- Colorado
- New Hampshire

- **Individual/small market reform**

Considered

- Louisiana
- Maryland
- Virginia

Implemented

- Minnesota
- New Hampshire
- Washington

- **Group Purchasing Arrangement**

Considered

- California
- District of Columbia
- Indiana
- Arkansas
- Illinois
- Iowa
- Louisiana
- Massachusetts
- Missouri
- Nebraska
- North Dakota
- South Carolina
- Tennessee
- Virgin Islands
- Wyoming

Implemented

- Arkansas
- Colorado
- Florida
- Minnesota
- Kansas
- Montana
- New Mexico
- Texas
- Virginia (future implementation)

- **Health savings accounts**

Considered

- Florida
- North Dakota
- Tennessee

Implemented

- Arkansas
- Colorado

- **Education and prevention**

Considered

- Arkansas
- Florida
- Nebraska
- South Carolina
- Texas

Implemented

- Delaware-implemented (small business website and CHAP marketing)

Other

- Iowa-provide short term coverage to unemployed
- Wisconsin-created SeniorCare program
- Wisconsin-Well Woman Program (cancer screening program for low income women)
- Missouri-cost savings with disease management. Improve rural infrastructure.

Appendix D: HRSA SPG State Reports

Alabama
State Health Access Data Assistance Center, ***Alabama Health Care Insurance and Access Survey: Select Results***, July 2003.

Arizona
Arizona Health Care Cost Containment System, ***Arizona Basic Health Benefit Plan: A Comprehensive Review***, July 2001.

Arizona Health Care Cost Containment System, ***Elasticity of the Demand for Health Care Services***, October 2001.

Arizona Health Care Cost Containment System, ***Faces of the Uninsured and State Strategies to Meet Their Needs: A Briefing Paper***, July 2001.

Arizona Health Care Cost Containment System, ***Financial Impact of Recently Enacted Health Insurance Mandates***, October 2001.

Arizona Health Care Cost Containment System, ***HealthCare Group: Moving Towards Accountability***, August 2001.

Arizona Health Care Cost Containment System, ***Health Insurance Administration Costs***, October 2001.

Arizona Health Care Cost Containment System, ***Initiatives to Improve Access to Rural Health Care Services***, July 2001.

Arizona Health Care Cost Containment System, ***Inventory of Arizona Strategies to Address Rural Health Care Infrastructure***, October 2001.

Arizona Health Care Cost Containment System, ***Key Stakeholder Interviews of Rural Employers and Employee Benefit Specialists***, October 2002.

Arizona Health Care Cost Containment System, ***Review of Self-Insuring of Health Benefits***, October 2001.

Arizona Health Care Cost Containment System, ***Rural Healthcare Provider Interviews: Developing a Strong Rural Health Care Infrastructure - Challenges and Successes***, October 2002.

Arizona Health Care Cost Containment System, ***State Employee Health Plan Self-Funding Survey***, January 2002.

Bentley, T.S. and D.F. Ogden. "**High-Risk Pools**," Arizona Health Care Cost Containment System, August 2001.

Brandel, S.S. and L.J. Pfannerstill. "**Purchasing Pools**," Arizona Health Care Cost Containment System, August 2001.

Reed, J.A. et al. "**International Approaches to a Socialized Insurance System**," Arizona Health Care Cost Containment System, August 2001.

Snook, T.D. "**Implementation of Incentives and Regulatory Mandates to Increase Health Insurance Coverage**," Millman USA, Inc., August 2001.

The Southwest Border Rural Health Research Center, University of Arizona, ***Health Care Coverage in Arizona***, January 2002.

Arkansas
2005 Arkansas Fact Book: A Profile of the Uninsured, September 2005

"Improving Health with Master Settlement Agreement Tobacco Dollars: The Arkansas Experience,"*Health Affairs,* Nov/Dec 2003.

"Using Telephone Interviews to Reduce Non-response Bias to Mail Surveys of Health Plan Members,"*Medical Care,* March 2002.

"Performance Indicators in Women's Health: Incorporating Women's Health in the Health Plan Employer Data and Information Set (HEDIS),"*Women's Health Issues,* Jan/Feb 2002.

California
Williams, C. "**Cross-Cutting Analysis of Coverage Reforms: Qualitative Analysis**," AZA Consulting, January 2002.

The Lewin Group, ***Cost and Coverage Analysis of Nine Proposals to Expand Health Insurance Coverage in California***, April 2002.

Colorado
none

Connecticut
Why Premium Assistance Strategies Can Succeed in Connecticut, March 2005

Connecticut Office of Health Care Access 2004 Small Employer Health Insurance Survey

SNAPSHOT: Connecticut's Health Insurance Coverage, January 2005

Who are the Uninsured?, January 2003

For additional publications, please visit the **Connecticut Office of Health Care Access Publications Archive.**

Delaware

Analysis of the Delaware Safety Net, 2002

Chronic Illness and Disease Management: Findings of House Joint Resolution 10 Task Force, June 2004.

Condliffe, S. and E.C. Ratledge. "**The Total Cost of Health Care in Delaware, 2003**," University of Delaware, 2003.

Condliffe, S. and E.C. Ratledge. "**The Total Cost of Health Care in Delaware, 2002**," University of Delaware, 2002.

Condliffe, S. and E.C. Ratledge. "**The Total Cost of Health Care in Delaware, 2000**," University of Delaware, 2000.

Delaware Health Care Commission, ***Small Business Health Insurance Task Force: Final Report***, June 2003.

Jacobson, E. et al. "**Health Disparities in Delaware 2004**," University of Delaware, 2004.

Ratledge, E.C. "**Delawareans Without Health Insurance 2002**," University of Delaware, January 2003.

Ratledge, E.C. and T. Toth. "**Delaware's Small Employers: The Health Insurance Dilemma**," University of Delaware, April 2001.

Ratledge, E.C. and T. Toth. "**Delawareans without Health Insurance 2000 Report**," University of Delaware, 2000.

Florida

Duncan, P. et al. "**Comparative Findings from the 1999 and 2004 Florida Health Insurance Studies**," Department of Health Services Research, Management and Policy, University of Florida, August 2005.

Duncan, P. et al. "**County Estimates of People Without Health Insurance from the 2004 Florida Health Insurance Study**," Department of Health Services Research, Management and Policy, University of Florida, August 2005.

Duncan, P. et al. "**Focus Groups Findings: The 2004 Insurance Study**," Department of Health Services Research, Management and Policy, University of Florida, March 2005.

Duncan, P. et al. "**Profile of Uninsured Floridians: Findings From the 2004 Florida Health Insurance Study**," Department of Health Services Research, Management and Policy, University of Florida, February 2005.

Duncan, P. et al. "**The Florida Health Insurance Study: Telephone Survey Findings**," Department of Health Services Research, Management and Policy, University of Florida, July 2005.

Duncan, P. et al. "**Zip Code Estimates of People Without Health Insurance from the 2004 Florida Health Insurance Study**," Department of Health Services Research, Management and Policy, University of Florida, August 2005.

Florida Health Insurance Study, Sample Design and Methodology, February 2004.

Gaps in Coverage: Uninsured Part of the Year, Fact Sheet #3, September 2005.

Health Insurance Among Children in Florida, Fact Sheet #2, August 2005.

Highlights from The 2004 Florida Health Insurance Study, November 2004.

HRSA State Planning Grant Abstract

Kelley, M. and N. Moulton. "**Key Information Interview Findings: The 2004 Insurance Study**," Health Management Associates, March 2005.

Project Objectives, January 2004

Racial and Ethnic Disparities in Rates of Health Insurance Coverage, Fact Sheet #1, April 2005.

The 2004 Florida Health Insurance Study Telephone Survey Instrument, March 2004.

Georgia

2004 Georgia Employer Health Benefits Survey, September 2005

Assessment of Georgia's Primary Care Safety Net, March 2003

Georgia Employer Health Benefits Survey, April 2003

Georgians' Attitudes on Providing Coverage for the Uninsured, April 2003

Grant Overview - What Is the Georgia Healthcare Coverage Project?

Insuring the Uninsured: Three Models for Financing Healthcare Coverage, May 2004

*Ketsche, P. "**Employment Based Health Insurance: Analysis of Rural Urban Differences in One State**," Georgia State University, August 2005.*

The View of Small Business Owners, April 2004

Towards More Accessible and Affordable Health Coverage, January 2004

Understanding and Reducing the Number of Uninsured Georgians

Hawaii
A **Plan for Action: Post Conference Summation 2001**, January 2002

Coverage for All Policy Brief, January 2005

Lee, S.H. "**The Effect of Mandatory Employer-Sponsored Insurance on Health Insurance Coverage and Employment in Hawaii: Evidence from the CPS 1994-2003**," University of Hawaii, Manoa, September 2004.

On Common Ground: 2003 Coverage Report

Policy Brief: A Historical Overview of Hawaii's Prepaid Health Care Act, July 2004

Policy Brief: Impacts of the Compact of Free Association on Hawaii's Health Care System, July 2004

Idaho
Idaho State Planning Grant, ***Idahoans Without Health Insurance: A Data Report***, October 2001.

Strategic Report Submitted to the Governor by the Steering Committee of the Idaho State Planning Grant, February 2002

Stroebel, H. and G. Gray. "**Policy Considerations in Privatization of CHIP: Report to the Idaho CHIP Task Force**," Center for Health Policy, Boise State University, September 2002.

Stroebel, H. et al. "**Health Insurance Affordability: Consumer Preferences in Cost Sharing**," Center for Health Policy, Boise State University, September 2002.

Stroebel, H. "**Medical Indigency in Idaho: An Analysis of County Indigency and State Catastrophic Health Care Services**," Center for Health Policy, Boise State University, February 2003.

Economic Analysis of the Effects of Extending Insurance Benefits to Idaho's Uninsured Population

Idaho State Planning Grant on the Uninsured: Data and Policy work Group Findings, September 2001

Illinois
Report of Illinois Assembly, October 2001

Rucinski, D. "**Report to the Illinois Assembly on the Uninsured: Illinois Population Survey of Uninsured and Newly Insured**," University of Illinois-Chicago, 2001.

McNamara, P.E. "**Health Insurance Coverage of Illinoisans: Analysis of Current Situation, Trends and Correlated Health Behaviors Using BRFSS Data**," Illinois Department of Public Health, October 2001.

Cox, C. et al. "**Opinions Concerning Access to Health Insurance in Illinois: A Report of Focus Groups and Key Informant Interviews**," Illinois Department of Insurance State Planning Grant, September 2001.

Indiana
Health Insurance for Indiana Families Committee, ***10,000 Person Household Survey***, November 2004.

Health Insurance for Indiana Families Committee, ***Actuarial Analysis of Policy Options***, November 2004.

Health Insurance for Indiana Families Committee, ***Assessment of Indiana Health Funding***, November 2004.

Health Insurance for Indiana Families Committee, ***Assessment of National & State Efforts to Address the Uninsured***, November 2004.

Health Insurance for Indiana Families Committee, ***Focus Groups of Businesses, Uninsured Brokers and Providers***, November 2004.

Health Insurance for Indiana Families Committee, ***Indiana Market Assessment and Drivers of Health Care Cost***, November 2004.

Health Insurance for Indiana Families Committee, ***Safety Net Assessment***, November 2004.

Iowa
Kinzel, A. "**What a Drag It Is...The Economic Impacts of Rising Health Insurance Premiums**," Iowa Department of Public Health, July 2004.

Iowa Department of Public Health, ***Striving to Expand Health Insurance to All Iowans: Focus Group Proceedings, Summer 2001.***

Iowa Department of Public Health, ***Striving to Expand Health Insurance to All Iowans, Spring 2001.***

Kansas
Allison, R.A. and C.C. Huang. "**Uninsured Children in Kansas: Who Are They and How Could They Be Reached**," Kansas Health Institute, October 2003.

Duncan, P.R. "**Finding and Filling the Gaps: Developing a Strategic Plan to Cover All Kansans**," Kansas Insurance Department, August 2001.

Small Business Health Insurance Survey Findings, 2004

Smith, B.L. and E. Sylvia. "**Voices of the Uninsured: Kansans Tell Their Stories and Offer Solutions**," University of Kansas Medical Center, January 2002.

Kentucky
Data Briefing 1: Uninsured Kentuckians Older, Poorer, and More Likely to Be Underemployed than the U.S. Average

Data Briefing 2: Cost a Major Barrier for Kentucky's Uninsured

Data Briefing 3: Substantial Portion of Uninsured, Working-Age Kentuckians Discouraged from Seeking Needed Health Care by Costs

Louisiana
The Cypress Papers: A Series on Uninsurance in Louisiana. Low-Income Uninsured, March 2005.

The Cypress Papers: A Series on Uninsurance in Louisiana. Uninsured Parents of Medicaid and SCHIP Kids, March 2005.

Low Income Uninsured Focus Groups: Final Report, April 2004.

Maine
2007 State Health Plan

The State of Maine's Health: A Regional Comparison, August 2005

Health Insurance Coverage Among Maine Residents: The Results of a Household Survey, May 2003

Commission to Study Maine's Hospitals: Report to the Legislature, February 2005

Tough Choices in Health Care, May 2005

Maryland
Assessment of the Impact of Premiums: Final Report, April 2004

Health Insurance Coverage in Maryland through 2002

Maryland Current Population Survey: Medicaid Undercount Study, July 2005

Morlock, L. et al. "**Policy Options for the Uninsured Young Adults in the State of Maryland**," Johns Hopkins Bloomberg School of Public Health, June 2004.

Options for Covering the Uninsured: A Report to the Maryland General Assembly, January 2004

Results of the 2002 Maryland Children's Health Program (MCHP) Premium Focus Group Project, May 2003

Results of the 2003 Small Employer Focus Group Project, May 2003

The Costs of Not Having Health Insurance in the State of Maryland, December 2003

Water, H. et al. "**Final Report - Goal 4: Develop and Assess the Impact of Options to Expand Insurance Coverage**," Johns Hopkins Bloomberg School of Public Health, January 2005.

Massachusetts
Employers Who Have 50 or More Employees Using Public Health Assistance, February 2005

Health Insurance Status of Massachusetts Residents, Fourth Edition, November 2004

Health Insurance Survey of Massachusetts Employers: Core Results, 2005

Massachusetts Employer Health Insurance Survey, Spring/Summer

Massachusetts Health Care Task Force: Final Report, 2002

Michigan
none

Minnesota
Ehret, D.A. "**Accessing Health Insurance in Minnesota: Report of Focus Group Discussion with American Indian, Hmong and Somali Community Members**," Center for Cross-Cultural health, December 2001.

Health Economics Program, Minnesota Department of Health, **2001 Health Insurance Coverage for Minnesota Counties**, December 2002.

Health Economics Program, Minnesota Department of Health, **A Brief Overview of Medicare Supplemental Coverage in Minnesota and the United States**, December 2002.

Health Economics Program, Minnesota Department of Health, *Accessing Health Insurance in Minnesota: Barriers for the Farming Community,* May 2002.

Health Economics Program, Minnesota Department of Health, **Employer-Based Health Insurance: Family Decisions to Enroll**, September 2002

Health Economics Program, Minnesota Department of Health, **Employer-Based Health Insurance in Minnesota: Results from the 2002 Employer Health Insurance Survey**, March 2005.

Health Economics Program, Minnesota Department of Health, **Health Insurance Coverage in Minnesota, 2001 vs. 2004**, February 2005.

Health Economics Program, Minnesota Department of Health, **Medicare Supplemental Coverage in Minnesota**, December 2002.

Health Economics Program, Minnesota Department of Health, **Prescription Drug Coverage and Spending in Minnesota**, February 2003

Health Economics Program, Minnesota Department of Health, **The Structure of Cost-Sharing and Benefit Levels in Minnesota's Small Group and Individual Insurance Markets**, October 2003.

Health Economics Program, Minnesota Department of Health, **Trends in Employer Sponsored Health Insurance: Preliminary Results from the 2002 Minnesota Employer Health Insurance Survey**, March 2003.

Health Economics Program, Minnesota Department of Health, **Trends in Minnesota's Individual Health Insurance Market**, October 2003.

Health Economics Program, Minnesota Department of Health, **Uninsured in Minnesota: Perspectives of Key Informants**, December 2002.

Health Economics Program, Minnesota Department of Health, **Variations in the Use of Health Services in Minnesota: Results from the 2001 Minnesota Health Access Survey**, February 2004.

Krueger and Associates, **Listening to Small Business Owners: Summary of Focus Groups on Health Insurance**, June 2002.

Krueger and Associates, **Understanding Uninsured Young People: Summary of Focus Groups on Health Insurance**, June 2002.

Minnesota Department of Health, Health Economics Program Publications

MinnesotaCare Disenrollee Survey Report, July 2002

Minnesota's Uninsured: Findings from 2001 Health Access Survey, April 2002.

Smalda, S.A. et al. "**Disparities in Health Access: Voices from Minnesota's Latino Community**," Hispanic Advocacy and Community Empowerment through Research, January 2002.

Mississippi

Focus Group Results from Mississippi's Uninsured College Students, December 2004

Focus Group Results from Mississippi's Uninsured Underrepresented Populations, December 2004

Focus Groups with Mississippi Department of Human Services Social Workers, April 2005

Health Coverage for Low Income and Part-Time Workers, March 2004

Interviews with Chancery Court Judges, April 2005

Interviews with Health Policy Makers, January 2005

Mississippi Department of Human Services (MDHS) Child Support Workers: Focus Groups, June 2005

Mississippi Household Insurance Survey Findings, 2003-2004

Mississippi Employer Focus Groups and Survey Findings 2003-2004

Moreland-Young, C. and R.P. Walker. "**Understanding Current and Future Insurance And Utilization Issues Affecting Healthcare Providers And the Marketplace in Mississippi**," PathFinders and Associates, 2005.

SCHIP/ Medicaid Non Re-enrollee Focus Groups, June 2005

Walker, R.P. and C. Moreland-Young. "**Identifying Coverage Levels and Specific Options, and Exploring Mechanisms Supported by Private and Public Insurers to Address Access and Affordability and Coverage**," PathFinders and Associates, 2005.

Missouri
Missouri Department of Health and Senior Services, ***Issue Brief: Health Insurance Coverage***, November 2003.

Missouri Department of Health and Senior Services, ***Public Deliberations Discussion Guide***, August 2005.

State Health Access Data Assistance Center, ***2004 Missouri Health Care Insurance and Access Survey: Select Results***, February 2005.

Montana
Executive Summary for Focus Groups, June 2003

Focus Group Report: Part One, August 2003

Focus Group Report: Part Two, August 2003

Grant Overview and Organizational Structure, September 2002

Historical Efforts to Reduce Montana's Uninsured, May 2 003

Seninger, S. et al. "**Household Survey and Employer Survey Findings about Health Insurance Coverage in Montana**," Bureau of Business and Economic Research, University of Montana, February 2004.

SPG Grant Update, April 2003

SPG Grant Update, September 2003

Nebraska
Carlson, E. et al. "**Reactions to Proposed Strategies to Increase Health Insurance Coverage in Nebraska: Results from the Nebraska State Planning Grant Year-Two Focus Groups**," Nebraska Center for Rural Health Research, August 2005.

Carlson, E.K. et al. "**Making the Good Life Meaningful for All Nebraskans: The Importance of Health Insurance**," Nebraska Health Information Project, May 2005.

Chen, L.W. et al. "**The Cost of Uncompensated Health Care and Expenditures of Self Pay Hospital Inpatient Care In Nebraska**," Nebraska Center for Rural Health Research, July 2005.

Mueller, K. et al. "**Health Insurance Coverage In Nebraska: Results from the Nebraska State Planning Grant**," Nebraska Center for Rural Health Research, December 2004.

Nebraska Health Insurance Policy Coalition, ***State Options for Expanding Health Insurance Coverage and Strengthening the Health Care Safety Net***, August 2005.

Nebraska Workforce Development, Department of Labor, **2004 Nebraska Employee Benefits Report**, December 2004.

Xu, L. et al. "**Health Insurance Status of Nebraskans**," Nebraska Health Information Project, May 2005

Nevada
none

New Hampshire
Health Insurance Coverage and the Uninsured in New Hampshire: Issue Brief, November 1999

Health Insurance in New Hampshire: Issue Brief, October 2002

The Health of New Hampshire's Community Health System: A Compilation of Reports Analyzing New Hampshire's Community Hospitals, Health Care Market, and Health Care Trusts, December 2000

- *New Hampshire' s Community Hospital System and the Health Care Market*
- *Analysis of Health Care Charitable Trusts in New Hampshire: The Hospital Sector*
- *Assessing Competitiveness: A Focus on Hospitals*

The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis, December 2000

The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis (Full Report), October 2000

New Hampshire Department of Health and Human Services, *Strengthening the Safety Net (Full Report),* October 2000.

New Hampshire Department of Health and Human Services, *Strengthening the Safety Net (Issue Brief)*, October 2000.

New Hampshire Employer Based Health Insurance Coverage: Issue Brief, October 2002

New Hampshire Department of Health and Human Services, Health Insurance Coverage and the Uninsured in New Hampshire: Results from the 2001 Family and Employer Health Insurance Survey: Full Report, October 2002.

Spitz, B. "The Insurers' Perspective on the Health Care System, Insurance, and the Uninsured," Spitz Consulting Group, June 2002.

New Jersey

Belloff, E. and K. Fox. "**Maximizing Enrollment in the Premium Support Program: Results from the Employer Interviews**," New Jersey Department of Human Services, September 2004.

DeLia, D. et al. "**The Low Income Uninsured: Chartbook 2**," New Jersey Department of Human Services, August 2005.

DeLia, D. et al. "**The Medically Uninsured in New Jersey: A Chartbook**," New Jersey Department of Human Services, August 2004.

Gaboda, D. et al. "**New Jersey FamilyCare Express Enrollment: Report on the Pilot Program**," Rutgers Center for State Health Policy, April 2005.

New Mexico

2004 Household Health Insurance Survey: Final Report, 2004

A Report to Governor Bill Richardson Addressing Health Care Coverage and Access in New Mexico, October 2003

Insure New Mexico Council: Report to Governor Bill Richardson, January 2005

New Mexico Project Summary, 2005

White Paper on Uninsurance in New Mexico and Options to Provide Coverage: A Synopsis, April 2004

North Carolina
Holmes, M. "**Employer Sponsored Insurance in North Carolina**," Task Force on Covering the Uninsured, June 24, 2005.

Holmes, M. "**The Low Income Uninsured in North Carolina**," Task Force on Covering the Uninsured, April 22, 2005 .

Holladay, K. "**Covering the Uninsured in North Carolina: Focus Group Results**," FGI Research, July 15, 2005.

Sparer, M. et al. "**Making Health Care Work in North Carolina: The IEI Reform Agenda**," April 22, 2005.

Silberman, P. "**Covering the Uninsured: North Carolina State Planning Grant**," North Carolina Institute of Medicine, February 24, 2005.

North Dakota
Cogan, M. et al. "**Health Insurance Access in North Dakota: Dakota Conference on Rural and Public Health**," Presentation, March 8, 2005.

Cogan, M. et al. "**Which Factors Increase the Likelihood of Being Uninsured in a Rural State: Identify Opportunities to Reduce Disparities**," Presentation, June 27, 2005.

Knudson, A. et al. "**Health Insurance Coverage Among North Dakotans**", Presentation, March 2005.

Knudson, A. et al. "**Health Insurance Coverage Among North Dakotans**," Presentation, May 2004.

Knudson, A. et al. "**Who Are North Dakota's Uninsured?**", Presentation, May 2005.

Ohio
none

Oklahoma
It's Health Care, Not Welfare: Final Report, March 2004

Crawford, S.A. and G.L. Splinter. "**Appropriate Rate Structure for Services Rendered and Estimates Percent of Co-Pays Collected under the Medicaid Program**," University of Oklahoma Health Sciences Center, January 31, 2004.

Crawford, S.A. and G.L. Splinter. "**Beneficiary Attitudes Towards Paying Enrollment Fees, Co-Payments, and Premiums to Obtain Health Insurance Coverage Under Expanded Medicaid Program**," University of Oklahoma Health Sciences Center, January 31, 2004.

Crawford, S.A. and G.L. Splinter. "**Key Programmatic Elements Needed to Ensure Provider Participation in the Medicaid Health Care Program**," University of Oklahoma Health Sciences Center, December 31, 2003.

Crawford, S.A. and G.L. Splinter. "**Attitudes and Opinions of Small Business Owners in Oklahoma Toward Reforms to the Medicaid Health Care Program**," University of Oklahoma Health Sciences Center, October 31, 2003.

Oregon
Chart: Community-based Delivery Systems, April 2001

Cost Sharing Strategies for OHP Medical Services: Draft, July 2001

"Crosswalk" Between OHP and Commercial Insurance, April 2001

Dual Eligibles: Integrating Medicare and Medicaid, February 2001

Edlund, T. "**FHIAP Leavers Survey: Summary Report**," Oregon Health Policy Institute, September 2001.

Garland, M. and Oliver, J. "**Health Values Survey Report 2004**," Office for Oregon Health Policy and Research, November 2004.

HRSA Household Survey Instrument, March 2001

Issues Involved in Designing a Basic Benefit Package and Determining Actuarial Equivalence, February 2001

Neal, M.B. and T. Hammond. "**Statewide Household Survey on Health Care: Summary Report**," Survey Research Laboratory, Portland State University, August 2001.

Oregon Business Tax Deductions/Exclusions for Employee Health Insurance, May 2001

Oregon Health Policy and Research, ***Small Market Report: Challenges and Opportunities in Serving OHP Enrollees and the Uninsured***, August 2002.

Oregon Health Policy Institute, *Summary Report of Survey of FHIAP Enrollees and Individuals on Reservation Lis* **t**, June 2001.

Role of the Health Care Safety Net, April 2001

Santa, J. "**Lessons Learned from The Family Health Insurance Assistance Program (FHIAP)**," Office of Oregon Health Plan Policy and Research, July 2001.

SCHIP Funding for Employer-Sponsored Insurance: Federal Issues and Barriers Encountered, February 2001

Securing Children Health Insurance Program Funding for Oregon's Safety Net, February 2001

Transitional Medicaid Assistance: Health Insurance Coverage for Families Leaving or Diverted from Welfare, February 2001

Washington State Health Care Authority, ***A Study of Washington State Basic Health Plan***, June 2002.

Pennsylvania
none

Rhode Island
Bogen, K. "**Who Are the Uninsured in Rhode Island? Demographic Trends, Access to Care, and Health Status for the Under 65 Population**," Medicaid Research and Evaluation Project, January 2005.

Hayward, J.A. and R.A. Lebel. "**The Rhode Island Health Care for Families Act 2004 Report to the General Assembly**," Rhode Island Office of Health and Human Services, January 2005.

Private Sector Sponsored Health Insurance in Rhode Island: Results of the Insurance Component of the MEPS-IC, April 2005

South Carolina
Expanding Health Coverage to South Carolinians

South Carolina Health Care Insurance and Access Survey, 2003

South Carolina Health Insurance Survey

Small Employer Health Insurance Survey

Summary of Key Informant Interviews, January 2003

South Dakota
Feimer, S. et al. "**South Dakota's Uninsured Population: A Follow-up Study on South Dakotans Without Health Insurance**," Government Research Bureau, December 2004.

Tennessee
none

Texas
Lessem, A. et al. "**Uninsured Texans: Attitudes Towards Coverage**," Public Policy Research Institute, Texas A&M University, January 2002.

Lessem, A. et al. "**Uninsured Texans: Attitudes Toward Coverage**," Presentation, January 2002.

Longley, D. "**State Planning Grant Overview Summary**," Presentation, January 2002.

Texas Department of Insurance, **Final Report Executive Summary**, March 2003.

Texas Department of Insurance, **Small Employers and Health Insurance: Final Results of the Texas Small Employer Survey, 2001**, January 2002

Utah
Betit, R. "**Background on Utah's New Medicaid Waiver**," Utah Department of Health, May 2002.

Betit, R. "**Utah's Primary Care Network: The Link to Inpatient Hospital Care**," Utah Department of Health, February 2003.

Vermont
The Lewin Group, **A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers: Cost and Coverage Impacts**, February 9, 2004.

Sheils, J. et al. "**Covering VHAP and SCHIP Enrollees Under a Voucher Model: Program Design and Actuarial Analysis**," The Lewin Group, September 2002.

Report on the Vermont Health Access Plan Study - Small Business Buy-in, February 2004

Virginia

2003 AHRQ, MEPS-IC Survey Report: Issue Brief, Data Tables and Additional Analyses, 2005

Center for Health Policy Research & Ethics, George Mason University, ***Lessons Learned From Other States and Virginia: Challenges and Opportunities in Expanding Health Insurance Coverage,*** April 2005.

Employment And Insurance Coverage In Virginia 2004 Facts At A Glance

Household Income And Insurance Coverage In Virginia 2004 Facts At A Glance

Overview of Proposed Model Option to Expand Health Insurance Coverage Among Employed Virginians, July 2005

State Health Data Assistance Center, ***2004 Virginia Health Care Insurance and Access Survey,*** March 2005.

State Health Data Assistance Center, ***Virginia HRSA State Planning Grant Additional Analyses: 2004 Virginia Health Care Insurance and Access Survey***, April 2005.

State Health Data Assistance Center, **Virginia Health Insurance and Access Survey: Virginia Health Insurance and Access Survey: Technical Report, Survey Methodology**, May 2005.

Snapshot of Health Coverage Provided By Virginia Small Businesses, September 2001

The Cost and Consequences of Uninsurance: A Virginia State Planning Grant Technical Briefing Paper

Virginia Department of Business Assistance, *2005 Virginia Business Health Insurance Survey,* August 2005.

Virginia Uninsurance Facts at a Glance

Washington

Financial Incentives to Employers to Offer Insurance, April 2002

Financial Incentives to Individuals and Families to Increase Insurance, April 2002

Income Adequacy an the Affordability of Health Insurance in Washington State, June 2002

Options for Distilling the Current Array of Medical Benefit Packages. June 2002

State Planning Grant, Administrative Simplification: An Overview of Selected Administrative Simplification Initiatives and Potential State Actions for Support, April 2002

Targeting the Uninsured in Washington State, April 2002

Washington State Planning Grant, Public Financing and Uncompensated Care Provided by Washington State Community Hospitals and Community Health Centers. October 2004

Washington D.C.
King, J. et al. "**Insurance and Uninsurance in DC: Starting with the Numbers**," D.C. Department of Health, 2005.

Improving Health Coverage in the District of Columbia, April 2006

West Virginia
Dempkowski, A. "**Literature Review on State Activities Related to Employer-Sponsored Insurance**," West Virginia State Planning Grant, February 2003.

Dempkowski, A. "**Literature Review on State Activities Related to Individual Health Insurance**," West Virginia State Planning Grant, April 2003.

Health Insurance and West Virginia's Children: Fact Shee **t**, February 2005

Health Insurance and West Virginia's Non Elderly Adults: Fact Sheet, February 2005

Health Insurance and West Virginia's Older Adults: Fact Sheet, February 2005

Institute for Health Policy Research, West Virginia University, ***The Uninsured in West Virginia: Putting a Human Face on the Problem of Uninsurance,*** March 2003.

Richardson, S.A. "**An Evaluation of Health Insurance and Health Insurance Options in West Virginia: Qualitative Study of Employers, Uninsured Consumers and Insurance Agents**," Institute for Health Policy Research, West Virginia University, October 2003.

Richardson, S.K. "**Health Insurance in West Virginia: The Children's Report**," Institute for Health Policy Research, West Virginia University, April 2002.

Richardson, S.K. "**Health Insurance in West Virginia: The Non Elderly Adult Report**," Institute for Health Policy Research, West Virginia University, July 2002.

Richardson, S.K. "**Health Insurance in West Virginia: The Older Adult Report**," Institute for Health Policy Research, West Virginia University, January 2003.

Richardson, S.K. "**West Virginia Employer Survey Report**," Institute for Health Policy Research, West Virginia University, October 2003

Richardson, S.K. "**Working Adults and Health Insurance in West Virginia**," Institute for Health Policy Research, West Virginia University, June 2003.

Options to Expand Insurance Coverage in West Virginia, June 2003 (revised August 2003)

West Virginia State Planning Grant, *Impact of the Safety Net Providers on the Uninsured in West Virginia,* August 2004.

West Virginia State Planning Grant, *October 15 th Health Advisory Council Subcommittee Recommendations,* October 2003.

West Virginia State Planning Grant, *The WV Health Insurance Focus Group Report: An Evaluation of the Individual Health Access Plan and Adult Basic Benefit Plan by Individuals, the Self-Employed, Small Business Owners and Insurance Industry Representatives,* March 2004.

Wisconsin

Employer-Based Health Insurance Coverage in Wisconsin, September 2001

Employer-Sponsored Health Insurance Coverage, Wisconsin Family Health Survey, 2002 and 2003, February 2005

Findings from Focus Groups: Select Populations in Dade County, September 2001

Health Insurance and Health Care Utilization in Wisconsin, September 2001

Health Insurance and the Young Adult Population in Wisconsin, September 2001

Health Insurance Coverage for Non-Elderly Adults Living in Households Without Children, September 2001

Health Insurance Needs of Farm Families, September 2001

HIPP Enrollment Process Review, December 2004

HIPP Program-wide Cost-Effectiveness Evaluation, January 2005

Milwaukee County General Assistance Medical Program, September 2001

SPG Report on Wisconsin's Old Order Amish Population, 2002

Wisconsin State Planning Grant - Employer-Based Health Coverage in Wisconsin and Nationally, 1998-2002, April 2005

Wyoming

Covering Wyoming's Uninsured: A Strategic Plan to Improve Health Insurance Access, December 2003

Waiver Expansion Study, January 2005

Gallagher, T. et al. "**Private Sector Employee Access to Health Insurance and the Potential WYO-CARE Market**," Wyoming Department of Employment, February 2005

State Planning Grant (SPG): Planning for Wyoming's Uninsured, October 2003

HRSA STATE PLANNING GRANTS

FINAL REPORT TO THE SECRETARY: OVERVIEW

Each HRSA grantee State will complete a final report to the Secretary due thirty days after the grant end date. These reports will reflect the State's experience in examining the uninsured population and developing proposals to expand health insurance coverage. HRSA will use the final State reports to develop a consolidated report to the Secretary on the State Planning Grant program.

The final State reports are to include the following major components:

Executive Summary

A summary of the activities conducted under the HRSA grant -- including the State's data collection activities and the policy options selected to increase health insurance coverage in the State -- and recommendations for Federal and State actions to support State efforts to provide health insurance for the remaining uninsured.

Section 1. Uninsured Individuals and Families

This section will include baseline information about health insurance in the State, including who the uninsured are; how the State approached the issue of studying the uninsured; and how the State used these findings in developing its plan for coverage expansion.

Section 2. Employer-based Coverage

This section includes an assessment of employer-based coverage in the State, employers' views on providing health insurance to their employees, and how this information informed the State's decisions on how to expand health insurance coverage.

Section 3. Health Care Marketplace

An assessment of the State's health care marketplace, including a description of how this information was obtained and how the findings affected policy deliberations.

Section 4. Options for Expanding Coverage

In this section, the State discusses the policy options selected for expanding coverage and the decision-making process used to reach those decisions. Includes a discussion of the State-level changes that would accompany such a plan.

Section 5. Consensus Building Strategies

The State discusses the process it used to achieve consensus on the policy options selected.

Section 6. Lessons Learned and Recommendations to States

The State discusses what it learned in designing its plan that could assist other States in seeking to expand coverage to all citizens. The State should also include any recommendations to other States regarding the policy planning process itself.

Section 7. Recommendations to the Federal Government

This section will include recommendations for Federal actions that could support State efforts.

HRSA Pilot Planning Grant
Annual Report Template

The purpose of this report is to summarize the achievements under the Pilot Grant. The report should include a summary of grant activities and their status and should follow the format provided in this paper. The report length should be sufficient to address the questions outlined in this format, but should be no longer than 40 pages (not including the appendices).

A. Executive Summary (no longer than 5 pages)

A summary of the report should be provided and should include:

- Background on HRSA SPG activities prior to pilot and other state activities on uninsured
- Brief description of the goals of the Pilot Project Planning grant
- Summary of activities under the Pilot Planning grant
- Implementation Status
- Recommendations to Federal Government

B. Background and previous HRSA SPG accomplishments

This section of the report should describe the starting point for the HRSA Pilot project. It should describe previous state efforts to address the uninsured and the policy environment in the state.

Please describe the involvement of key policy makers (Governor, Legislature, Cabinet Secretaries, provider or advocacy groups) in the grant activities or development or implementation of policy options.

Please summarize accomplishments under the state's prior HRSA SPG (both initial grant and continuation funding). The narrative of this section should include a description of the options considered, the goals of the options and whether they were accepted or rejected and why. Using the chart in Appendix 1, it should summarize the options considered by providing: the target population to be served; an estimate of the number of people served; the status of approval (including waivers or legislation proposed); the status of implementation; and if implemented a current estimate of the number of people served.

C. Pilot grant activities

This section should describe the policy option(s) that is the focus of the pilot planning grant and what factors influenced the selection of policy option(s). It should describe the activities supported by the Pilot grant and their outcome or expected outcome. Please describe any evolution of the project from what was initially planned. Please describe any grant activities that were not completed and why or alternative activities that were completed. Finally, please describe the status of Pilot Planning Projects, including

whether legislation or waivers were proposed as a result of the project; whether a program was implemented and how many people are expected to be served by the initiative.

The project management matrix, which provides an update of specific grant activities, should be included in appendix 2.

D. Implementation status

Please describe the implementation status of any HRSA related activity (original planning grant, pilot and any continuation grants) and identify any challenges in developing the options or implementing options. Summarize any anticipated barriers to implementation. Based on the experience of the grant, summarize any recommendations for other states engaged in similar projects.

E. Recommendations to the Federal Government and HRSA

Please describe how the Federal Government can support additional state efforts to expand coverage to the uninsured. Does your state have any recommendations to HRSA about the Pilot Project Planning Grants (timetable, reporting format, proposal process)?

F. Appendix 1: Summary of Policy Options

Using the following chart, please list the policy options considered under the HRSA SPG, including original grant and continuation grants. Per each policy option described, please include data on a cumulative basis per fiscal year (FY), e.g. FY 2005 started October 1, 2004 and ends September 30, 2005.

Option considered	Target Population	Estimated Number of People Served	Status of approval (for example waivers submitted or legislation proposed)	Status of implementation (please include date program or initiative began)	If implemented, most recent estimate of number people served. (date and point in time estimate)
1.					
2.					
3.					

G. Appendix 2: Project Management Matrix
H. Appendix 3:

Please provide copies of completed reports and products supported by HRSA Pilot Project Planning Grant