Nebraska State Planning Grant to Expand Health Insurance Coverage

Final Report

Submitted to

Health Resources and Services Administration (HRSA)
U. S. Department of Health and Human Services

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Executive Summary

The purpose of the Nebraska State Planning Grant Project is to identify the characteristics of the uninsured population in Nebraska and to develop a strategic plan to expand health insurance coverage and ultimately improve access to affordable health care services. This report describes the activities and highlights the results of the first year of the project.

After receiving notification of the grant award, Governor Johanns appointed 28 members to the Nebraska Health Insurance Policy Coalition. The Coalition has a very diverse membership that includes representatives from state agencies, the state legislature, business and industry, the health insurance sector, non-profit agencies, minority populations, health professional organizations, and the two medical schools. The Coalition has held six meetings during the year.

The Nebraska Health and Human Services System contracted with the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center to conduct a household survey and focus group interviews. Both the survey and the focus group interviews have been completed and the key findings were presented to the Nebraska Health Insurance Policy Coalition in August. The Center staff continue to analyze the data and they are preparing a report which will be widely distributed in October.

Based on a total of 3,750 telephone interviews of households in Nebraska, the percentage of uninsured in Nebraska was 9.9 percent or about 145,000 people under the age of 65. The groups that were most likely to be uninsured were individuals with low-incomes, those who are self-employed or who work for a small business, and the Hispanic population. The uninsured rates varied by region, ranging from 11.0 percent in the Northern region of the state to 8.7 percent in the state's largest metropolitan region.

In order to put a human face on the uninsurance issue, a total of 13 focus group interviews were conducted. The interviews primarily targeted the following eight populations that were most likely to be uninsured:

- Hispanics
- African Americans
- Urban Native Americans
- Low-Income
- Small Employers
- Self Employed
- Low-Income College-Age
- Refugees

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".

In addition to the household survey and the focus group interviews, a contract was signed with the Nebraska Department of Labor to survey Nebraska employers. Staff from the Department presented the preliminary results of the survey to the Coalition in August and they are preparing a detailed report, which will also be widely distributed in October.

A total of 13,848 surveys were mailed and 9,005 surveys were returned with usable information. The survey covered six regions and included large and small businesses. The key findings were:

- About two-thirds of all businesses offer health insurance coverage to their employees.
- Larger businesses are more likely than small businesses to offer health insurance to their employees. In fact, 98 percent of businesses with 100 or more employees offer health insurance benefits, but only 49 percent of employers with one to three employees offer coverage.
- About 20 percent of businesses indicated that they are only somewhat likely or not likely at all to continue to offer health insurance coverage in the next two years.

Development of Coverage Options

After the Nebraska Health Insurance Policy Coalition reviewed the information from the household and employer surveys as well as the focus group interviews, it developed some guiding principles that would be used to select the coverage options. Some of these principles include: (1) build on existing public and private programs, (2) promote individual responsibility and wellness, and (3) develop strategies that have reasonable costs and are affordable to individuals, taxpayers, employers, and the government.

After the guiding principles were established, the Coalition developed nine coverage options that basically fell into the following three categories: (1) strengthening the health care safety net (e.g., expanding the number of community health centers), (2) expanding Medicaid coverage, and (3) improving access to private health insurance coverage (e.g., creating a Medicaid premium assistance program and developing a reinsurance program).

Section 1. Summary of Findings: Uninsured Individuals and Families

This analysis is based on 3,750 responses from the Nebraska Uninsurance Survey. The survey was conducted between March 10, 2004, and May 8, 2004, to gather information on the uninsured population in Nebraska.

Survey Methodology

The survey was a random digit dial telephone survey that was conducted in both English and Spanish. One person in each household was randomly selected to complete the survey. An adult was asked to respond as a proxy in the event that the randomly selected person was a child (less than 18 years old). In order to obtain more precise estimates of the uninsurance rate for Hispanics and African Americans, certain geographic areas of the state were sampled with higher probability than other areas. In addition, the survey was stratified by planning region in order to obtain reliable estimates for each of the six state planning regions. To account for the complex sampling design, the data analysis incorporates statistical weights so that the results can be generalized for the entire population of Nebraska. More information regarding the survey methodology and statistical weights is included in Appendix 2. All of the results below use weighted estimates in order to account for the complex sampling procedure.

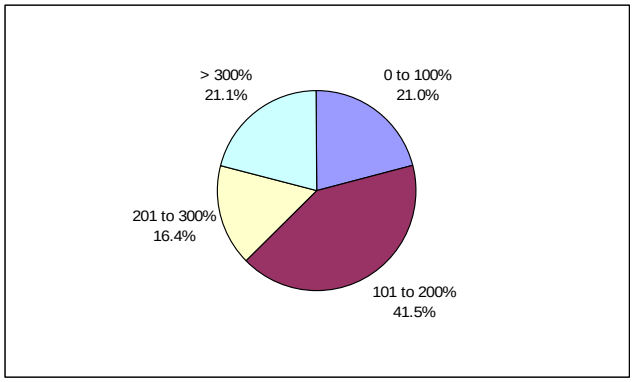
The Level of Uninsurance

The overall level of uninsurance was 8.5 percent. The uninsurance rate for the respondents under the age of 65 was 9.9 percent.

The Characteristics of the Uninsured

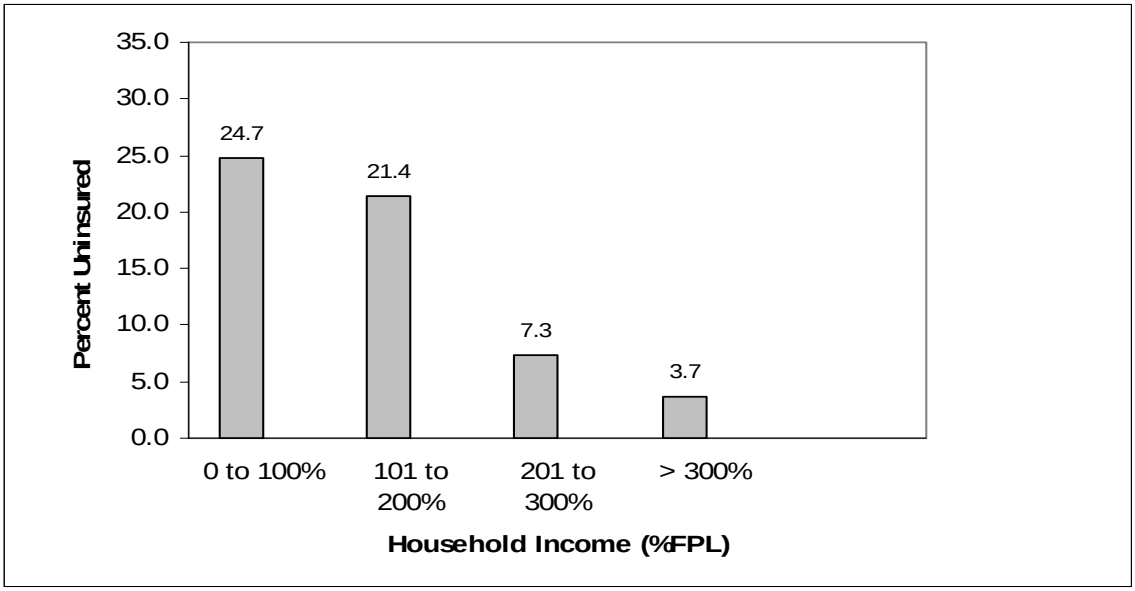
Income: Among those under age 65, approximately 21 percent of the uninsured had household incomes at or below 100 percent of the federal poverty level (FPL) based on the 2003 poverty guidelines and approximately 62.5 percent of the uninsured had household income levels at or below 200 percent of the FPL (Figure 1). Appendix 3 describes the methodology used to collect information on income for the survey.

Figure 1. Income Levels of the Uninsured Under the Age of 65



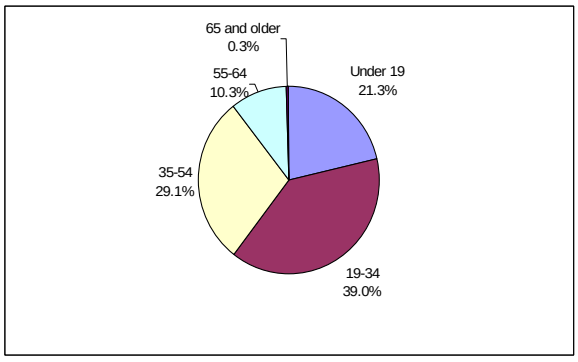
Within these income categories, almost 25 percent of the people living in households with incomes below 100 percent of the FPL and over 21 percent of all people with incomes between 101 and 200 percent of the FPL were uninsured. The rates are displayed in Figure 2.

Figure 2. The Proportion of Uninsured by Income Group Under the Age of 65



Age: Health insurance rates vary significantly by age. Figure 3 shows that adults between the ages of 19-34 comprise 39 percent of the uninsured. The next highest uninsured rate was found in the age group of 35-54 where the rate was 29 percent.

Figure 3. Distribution of Uninsured by Age



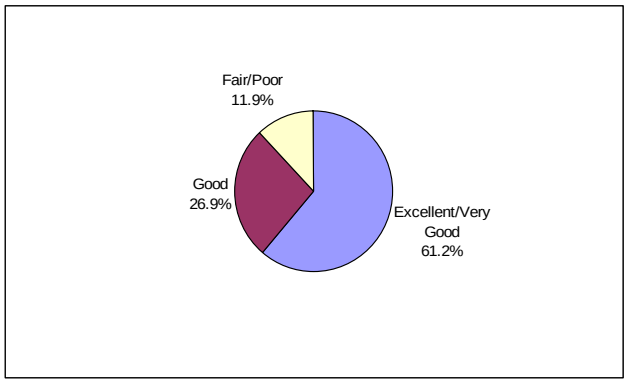
Gender: For individuals under the age of 65, almost 56 percent of the uninsured were male and 44 percent were female.

Family Composition: Married persons accounted for about 48 percent of the uninsured. The responses indicated that 31 percent of the uninsured were never married, 13 percent were divorced or separated, five percent were living with a partner, and three percent were widowed.

Within these categories, however, the uninsured rate is highest among widowed individuals (21.5 percent), those that have never been married (20.5 percent), individuals living with a partner (19.2 percent), and individuals who are divorced or separated (19 percent). It should be noted that the sample sizes are relatively low for widowed individuals (n = 65) and individuals living with a partner (n = 64).

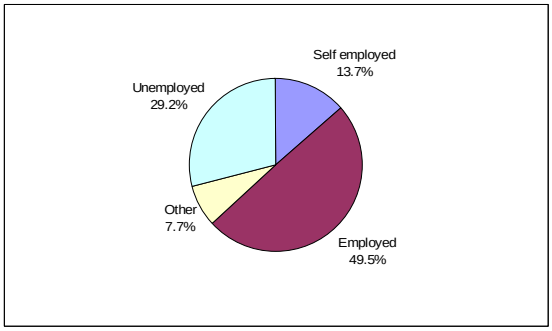
Health Status: The majority (61.2 percent) of the uninsured under the age of 65 reported that they were in excellent or very good health. Almost 27 percent indicated that they were in good health and nearly 12 percent were in fair or poor health (see Figure 4).

Figure 4. Health Status of the Uninsured Under the Age of 65



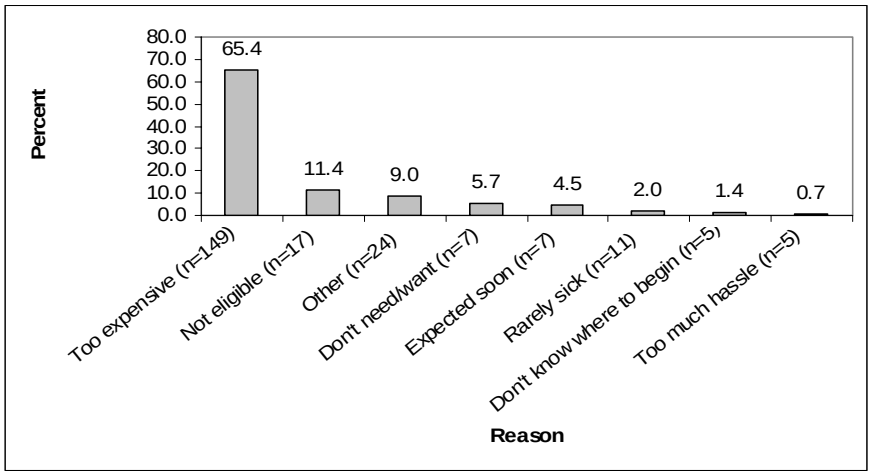
Employment Status: The majority of the uninsured under the age of 65 were employed. Almost 50 percent reported that they were employed by someone else, and 14 percent were self-employed. Over 29 percent were unemployed and almost eight percent had "other" employment (e.g., unpaid workers, retired individuals, and full-time students). These results are displayed in Figure 5.

Figure 5. Distribution of the Uninsured Aged 18-64 by Employment Status



Availability of Private Coverage: For the uninsured under the age of 65, about 65 percent had not purchased a health insurance policy because it was too expensive. Other reasons for not purchasing insurance coverage were not eligible (11.4 percent), did not want or need insurance (5.7 percent), and expected coverage soon (4.5 percent). Figure 6 provides a more complete list of reasons.

Figure 6. Reasons the Uninsured Under the Age of 65 Do Not Purchase Health Insurance on Their Own



Almost 24 percent of the uninsured under age 65 had health insurance available as a benefit from their employer (see Figure 7). Of those who had access to employer sponsored health insurance, 51.9 percent had the option of extending the coverage to cover dependents. The reasons given for not participating in the employer group plan were: too expensive (27 percent), not eligible (25.1 percent), not worked for the employer long enough (21.7 percent), did not work enough hours (13.9 percent), and other reasons (12.3 percent). These findings are shown in Figure 8.

Figure 7. Availability of Employer Sponsored Health Insurance For the Uninsured, Under Age 65

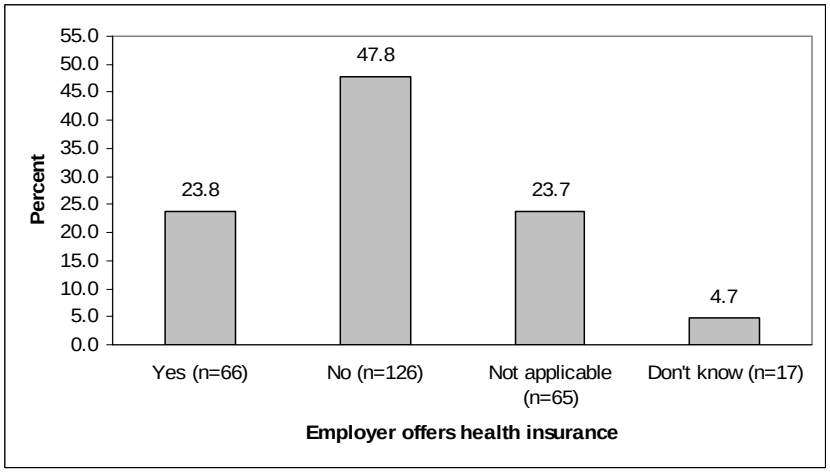
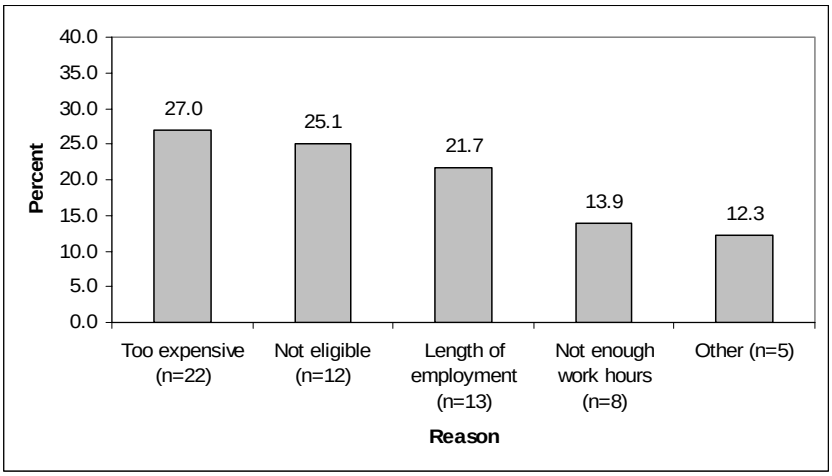


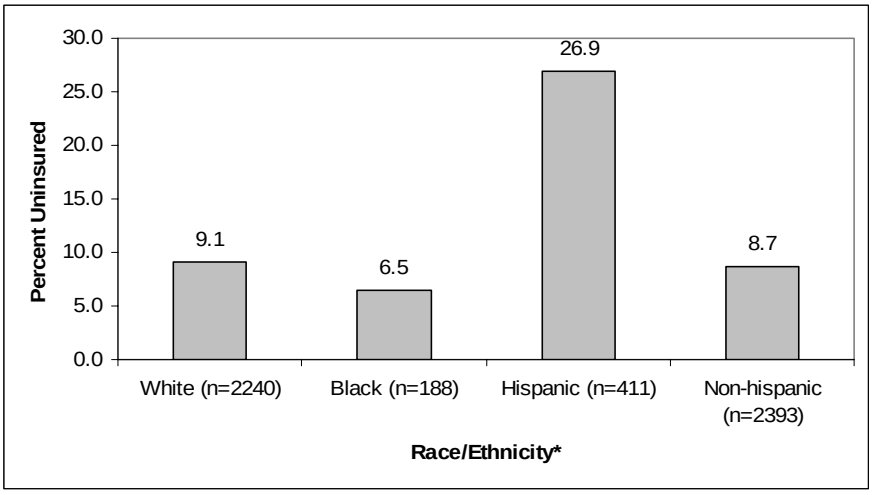
Figure 8. Reasons the Uninsured Do Not Participate in Employer-Sponsored Health Insurance



Availability of Public Coverage: The majority (57.4 percent) of the uninsured respondents under the age of 65 have not asked for or been given information about one of Nebraska's public insurance programs. Almost 39 percent have received information about one of the programs, and 3.6 percent did not know. About 71 percent of the uninsured would enroll in public health coverage if they learned they were eligible, 11.7 percent would not enroll, and 17.2 percent did not know if they would enroll. Nearly 85 percent of the uninsured would enroll in public health coverage if it was available at no cost, 5.1 percent would not enroll, and 10.3 percent did not know if they would enroll.

Race/Ethnicity: Individuals under age 65 who identified themselves as Hispanic were more likely to be uninsured as compared to non-Hispanics. Almost 27 percent of Hispanics were uninsured, compared with 8.7 percent for non-Hispanics. About 6.5 percent (95 percent CI: 0.0 percent, 13.9 percent) of individuals who identified themselves as black and 9.1 percent (95 percent CI: 7.5 percent, 10.7 percent) who identified themselves as white were uninsured (see Figure 9).

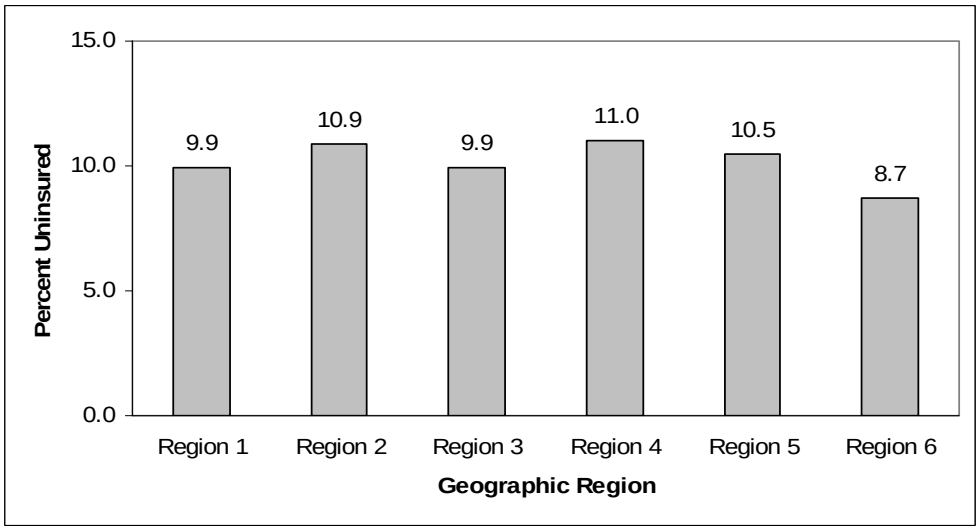
Figure 9. Uninsurance Rate by Race/Ethnicity Under the Age of 65



Immigration Status: No information is available.

Geographic Location: Among those under the age of 65, the uninsurance rates varied from 8.7 percent in Region 6 which includes the state's largest metropolitan area to 11 percent in Region 4 which includes several counties in north central and northeast Nebraska (see Figure 10). The corresponding uninsurance rates for those under age 65 in the metropolitan areas and the rural areas were 8.7 percent and 11.1 percent.

Figure 10. Uninsurance Rates by Region, Under Age 65

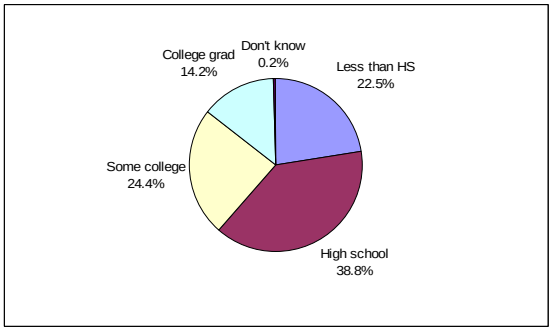


Duration of Uninsurance: For insured individuals under the age of 65, over five percent reported that they had been without coverage during part of the past 12 months. Of these, approximately 48 percent had been uninsured for less than six months and 52 percent had been uninsured for six or more months during the past year.

Other Characteristics of Insured and Uninsured

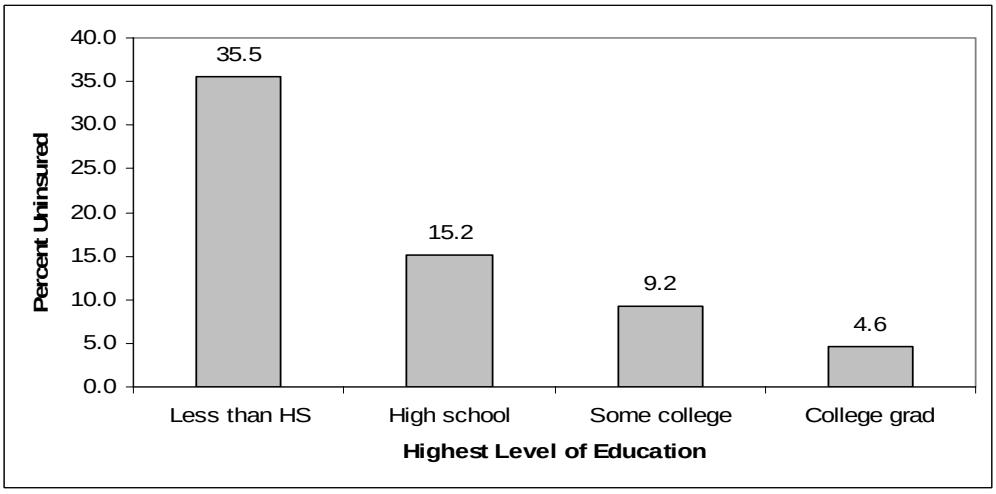
Education: Persons with a high school degree or less accounted for 61.3 percent of the uninsured. Approximately 24.4 percent of the uninsured had some college and 14.2 percent were college graduates (see Figure 11).

Figure 11. Distribution of Uninsured Under the Age of 65 By Highest Level of Education



Within each education category, the uninsurance rate varied considerably. For example, the rate for those with less than a high school education was 35.5 percent as compared to 4.6 percent for individuals with a college degree (see Figure 12).

Figure 12. Uninsurance Rate for Each Education Group Under the Age of 65



Prescription Drug Coverage: For the 1,651 insured respondents under age 65 who responded to this question, 90.4 percent had insurance that pays for prescription drugs, 8.7 percent did not, and one percent were unsure.

Dental Insurance Coverage: For the insured respondents under the age of 65, almost 70 percent had insurance that pays for dental care, 29 percent did not, and one percent were unsure. For the

890 insured respondents, age 65 or older, about 18 percent had insurance that pays for dental care, 80 percent did not, and two percent were unsure.

Utilization: The uninsured population for all age groups was less likely to have a regular source of care. Only 73 percent of the uninsured had a regular place they go for medical care as compared to 94 percent for the insured population.

Worry About Health Care: A larger percentage of the uninsured worry that their insurance will not cover care. Twenty-three percent of the uninsured reported that it was a "big" problem while only eight percent of the insured indicated that it was a "big" problem.

A similar worry for the uninsured is that they will have to pay more than expected. The percentage of the uninsured respondents who worry that their insurance will not cover care was 23 percent. The corresponding percentage for the insured respondents was eight percent.

High Risk Population Groups

The Nebraska Health Insurance Policy Coalition is in the process of identifying priorities for the population groups that are at highest risk for being uninsured and underinsured. Based on the results of the survey, these groups include the Hispanics, low-income, younger age groups, the self-employed, and employees of small businesses.

Qualitative Research Results

The remaining parts of Section 1 will focus primarily on the qualitative research work conducted by the state. From June 3 through July 27, 2004, 13 focus groups were conducted across the six Health Planning Regions. Tables 1 and 2 in Appendix 4 provide a summary of information regarding the participants in the 13 groups. Nine groups targeted populations likely to be uninsured, three groups targeted small business owners, and one group targeted the self-employed or micro-employers with five or fewer employees.

Defining Affordable Coverage

Affordable coverage is defined as coverage that does not require individuals and families to forgo basic needs such as food, clothing, and housing in order to pay for it. Affordable coverage also must provide value. If a significant part of a paycheck is used to pay for health insurance coverage, participants express the need to have access to services without incurring debt for significant deductibles, co-pays for office visits, or medications.

<u>Representative Quotes</u>

White male community college student: "If you can afford it, you'll have it. If you can't afford it, you're not going to make yourself go broke to get it."

Rural Hispanic female: "I got an estimate for myself and it was around $350 just for me per month, and $500 for the whole family... It's one of those from Blue Cross or Blue

Shield and those are only for emergencies because the deductible is around $2,000, and I would never be able to use it for the doctor, and the monthly payments are too high."

African American female: "Well kids can't eat lunch this week 'cause I've got to make a co-pay when we take John to the doctor Monday...stuff like that happens for real if you've got to make co-pays, okay? I can't put no gas in my car 'cause I've got to go to the doctor and I've got to make a co-pay for them to see me."

White male community college student: "If it's not serious, you're still going to be paying out-of-pocket because if you have like a $500 or $1,000 deductible and you gotta go to the hospital and there's a chance it's not going to cost you $500 or $1,000; so you're still going to have to pay out-of-pocket anyways. So, you're paying for insurance you can't even use if you're not getting above that deductible. And that's one of the reasons why I didn't get student insurance."

The uninsured are *willing* to pay from $50 to $200 per month for insurance coverage. Fifty dollars is equivalent to 12 percent of household income for those making $5,000 or less per year (26/133 participants). However, many focus group participants pointed out that what they are *willing* to pay is different from what they are *able* to pay. Sixty-seven percent of the 101 uninsured participants have an annual income that is 100 percent of Federal Poverty or below. Consequently, many are currently *able* to pay nothing toward insurance coverage because their current expenses for basic needs already exceed their incomes.

Representative Quotes

Urban Native American female: "Well what if you are not even making enough to cover all your stuff? I mean your expenses exceed your income. You're on a tight budget because you have to pay for food and all your personal needs each month."

Urban Native American female: "I'm a part time employee ya know, single parent. I think I would be *able* to afford $40 a month."

Low-income white female: "We could sit here and say all day long, yeah, that sounds good $40 to $50 [per month for health insurance coverage] but when you're just sitting on child support or maybe just unemployment because the amount of jobs in the area are minimal... I'm living off of child support right now, and I'll tell you what, $318 does not go very far! $318 for me to have to filter into different places and support my daughter because of the lack of jobs in the area... So, $50 a month sounds good if I was working."

Urban Hispanic male: "If they told me at work that the family insurance costs $70 or $80 every two weeks I would get it, but I can't afford $150 every two weeks."

Urban Hispanic female: "My husband and I have three daughters and we are not here legally, so when we get a bill at home we take it to the Chicano program and they take care of it because my husband works on the street so he doesn't have a permanent job; he only makes enough money to pay for rent and food."

Low-income white female: "It seems like the amount that you'd be willing to pay would be based on your income. If you had a job that was paying $15 an hour or around there, it would be a really high paying job, where at $6 or $7 [an hour] it's a struggle to come up with $50 [a month for health insurance]."

Reasons Why Uninsured Individuals and Families Do Not Participate in Public Programs for Which They Are Eligible

The overarching message from focus group participants is that the uninsured do not participate in public programs because they are *ineligible* or there is a perception that they are ineligible. In some cases, they are ineligible because their income is too great or because they are not citizens.

Representative Quotes

African American Female: "They took it [Medicaid] away, straight up... I didn't make no more money and no less; they just took it away. And I even went as far as telling my [social] worker... 'you know, just let my son stay on it, you know what I'm saying. I don't care about me too much. I'm concerned about my son, you know, with that asthma.'"

Rural Hispanic female: "I am a single mother and I used to have Medicaid for my son until he turned 18 and he had to start working part time, so they took away the Medicaid. That is absurd because if he gets sick he can't afford to go to the doctor."

Rural Hispanic female: "It is difficult to qualify for Kids Connection…to qualify and maintain it because they make a revision every 6 months and if you earn one more dollar they take it away."

Rural Hispanic female: "Also at Kids Connection if the children don't have social security numbers they can't be part of it. That's because it's part of the state. It's different because for that you have to be a citizen."

Urban Hispanic male: "The only option [to get health insurance] is to be legal in the United States."

Low-income white Female: "I was just diagnosed on May 9th with Stage III B terminal lung cancer and so knowing that I was going to have humongous hospital bills, medical bills; I basically went in and quit my jobs [neither of which offered health insurance] and took medical leave because I knew I had to try to get zero income so I could get Medicaid."

Reasons Why the Uninsured Individual and Families Disenroll from Public Programs

We did not hear of any instances in which uninsured individual and families voluntarily disenrolled from public programs.

Reasons Why Uninsured Individuals and Families Do Not Participate in Employer Sponsored Coverage for Which They are Eligible

Uninsured individuals and families do not participate in employer sponsored coverage for which they are eligible because it is too expensive. Many participants felt that employer sponsored coverage was specifically too expensive for the value they received from the coverage. Sacrificing a large proportion of a paycheck for coverage that still requires co-pays and significant deductibles was not perceived as valuable.

Representative Quotes

Female refugee: "Yeah, we cut it [our health insurance] two weeks ago because it [went up and now it is] too expensive. We don't have the money. It's not enough to pay for other bills and food... And we have three kids, you know. What are we going to feed them if we give them the whole check? It's difficult."

Low-income white female: "And then you pay for insurance and you still have to pay a $20 or $30 co-pay each time you go to the doctor, and honestly, sometimes it's easier not to have it. I mean, if I'm making $14,000 a year it's easier for me to not have any insurance and to qualify for a low payment at a public health facility than to try to squeak out of my budget money for the insurance and also, you know, rent."

Rural Hispanic female: "Because not all the employers are fair. If they charge you $40 a week, like [the meat packing plant], that's all right, but the smaller companies charge you a lot, as much as $300. If you get work in a smaller company you end up paying too much."

Low-income white Female: "My boyfriend, he works out at [Company X], and he brought home an insurance policy just a couple days ago and they wanted for family--for like me and him--$500 a month, and we can't afford that either. And they wouldn't take care of me for one year because of pre-existings, too."

Role of Employers in Providing Insurance Coverage

There are two major themes that emerged in regard to employer sponsored insurance. First, many that are uninsured and underinsured feel that our current health care system does not work and that they would be willing to consider an affordable plan regardless of the provider. However, there was also a strong feeling that employers should have some role in providing coverage. Part of the support for employer sponsored insurance related to the perception that employers have an obligation to provide care for their employees by providing insurance coverage.

Representative Quotes

White male community college student: "I had that [employer based insurance] before I came [to community college] and I worked full time for UPS, who has the best

healthcare I have ever heard of in my life. It was definitely affordable for me; I paid like $20 a check for insurance, it was really decent coverage. It was like $50 deductible for a year, and then they'd pay like 85 percent of your bills; then you had free prescriptions, and then it was another $50 for dental and they paid 85 percent of that, too... But you don't get benefits like that from a part-time job."

Rural Hispanic female: "Why don't all the jobs provide you with health insurance?"

Low-income white male: "What I'd like is maybe a law saying, maybe not a law, but somebody saying that every employer has to provide some sort of insurance for their employees and maybe that would drive prices down for insurance."

White male community college student: "Well, if an employer pays for your health insurance, they're investing in themselves 'cause if you injure yourself at home and can't show up for work, they're losing productivity, but if they insure you, you can get treatment and you can get back to work a lot faster."

White male community college student: "If you don't have the means or you're working part-time, not full-time, the government should probably step in with some type of program. If you're working full-time then the employer satisfies the obligation."

Low-income white male: "As long as we could get affordable insurance it could [come from] the man in the moon as much as I care. Just so long as the coverage would cover our medication and that's so we can live."

Urban Native American female: "They [federal government] promised us that they'd care for us when they took our land."

Urban Native American male: "Yes, under the treaty of 1868, the government said that they were gonna take care of us and it hasn't been done."

How Likely are Individuals to be Influenced By:

Availability of Subsidies

Low-income individuals preferred to receive benefits directly from their employer rather than to receive subsidies or cash that could be used to offset the cost of health insurance coverage. The need to research and buy insurance individually was perceived by low-income individuals, refugees, and immigrants to be a barrier to the use of subsidies or defined contributions. However, some working poor would appreciate any subsidy from the State that would help make necessary health care more affordable and prevent the accumulation of debt.

Representative Quotes

White male community college student: "It's a lot easier for someone else to take it [money from your check] than for you to have to write a check for $100 a month for it [health insurance]."

White male community college student: "Even when you work and your employer offers it to you and you try and find a cheaper place, it's not like it's in the yellow pages or anything. You really have to research it."

Female refugee: "Only from the job is all I know. I don't know [how to get health insurance] from another place."

Rural Hispanic female: "There was a case of a kid that lost all his teeth because they got rotten and he needed to be taken to an emergency room in Hastings. The boy was illegal and she [the mother] bought one of those health insurance plans from a TV ad, and she thought the boy would be covered, and he was not. So now she is trying to put together $2,000 to get him the help he needs because he's very sick."

Urban Native American female: "Why doesn't the State of Nebraska develop a system much like an insurance company or policy for low income families or single families who can't afford the bills? For example, Nebraska could help pay just like Medicaid, part of the medical bill, and then the person pay for the rest of it; just like it'd be an insurance policy. So, basically my question is, 'how can we develop a program for low income single families that is affordable so that the State is not stuck with all the bill or we are not in debt because of the bill?'"

Tax Credits or Other Incentives

Tax credits were particularly attractive to micro-employers who have experience with the complexities of tax law and the knowledge to research individual health insurance plans.

Representative Quote

Rural white female micro-employer: "[Tax credits] reduce the gross income, but they don't save you self-employment tax unless you have something structured like Mary, whose husband hired her in order to deduct the cost of her health insurance; so it doesn't reduce that part. It maybe saves you 15 percent on the federal, if that's the tax bracket [you are in], or you know five percent, six percent on the State, which is better than nothing; that helps. But a credit like the childcare credit, the tax credit, those things really have a lot of value."

Other Barriers that Prevent the Purchase of Health Insurance

Affordability is the primary barrier preventing the purchase of health insurance for low-income American citizens. However, refugees and Hispanic immigrants expressed ignorance of

the organization of the U.S. health care system. They expressed that access to basic primary care in their home countries is either free or relatively inexpensive. They are surprised to discover that access to basic primary care in the U.S. is through an appointment with a private physician who expects patients to be insured in order to pay for care. Refugees and Hispanics also experience difficulty obtaining reliable information about health insurance in general and employer plans in particular. Language barriers play a role in the difficulty understanding the U.S. health care system and the difficulty obtaining information about health insurance. Finally, for undocumented Hispanics living in the U.S., concerns about being deported prevent them from drawing attention to themselves by seeking information about health insurance.

Representative Quotes

Rural Hispanic female: "For the people living there [Mexico], there is social security, and that covers the majority of the people. That's why when they come here they don't think they have to pay for it, because in Mexico it's free."

Female refugee: "[In my home country], just come. Just come into clinic; no call, [and, you can talk] to many doctors."

Rural Hispanic male: "Sometimes there is information available but you cannot understand it. One example could be the deductible. What is that? If I go to the doctor and he checks my blood pressure and I have to pay $100, I thought I had health insurance. I don't understand why I still have to pay, but it's because of the deductible. This is difficult to understand."

Rural Hispanic female: "There is a big need for more information about the companies and people who provide health insurance. They need to explain to the beneficiaries what the real benefit is. Because if you go to the clinic and you go to the front desk, they ask you if you have health insurance, and they don't believe you and start asking for a letter and proof that you really have it."

Rural Hispanic male: "They [insurance plans at work] are well explained, because they show you a video and everything, but in their language [English]."

Rural Hispanic female: "Like [the meat-packing plant], where they give you insurance and its kind of illogical what they do, because when you start working there they give you the insurance information and you start paying it after three months but you are not covered until six months after being there."

Rural Hispanic female: "Another thing, I think is that people are shy to go get health insurance. Because you have to fulfill a lot of requirements and they ask a lot of questions. How much do you earn? Where do you work? How long have you been working? How many children do you have? So you get sick just thinking about that. So you think you don't qualify and you don't apply and feel like it's not for you."

Rural Hispanic female: "Another thing with [the meat-packing plant] is that if your children are not born here they can't get insurance. Even if the mother and father are both working there, they [the children] don't get coverage because they don't have social security numbers."

Rural Hispanic male: "For someone who is not legal, it's very frustrating not to have documents because you don't want to take any risks and so you don't seek help [looking for health insurance]; you shelter yourself because you are afraid of the law."

Urban Hispanic male: "The only option [to get health insurance] is to be legal in the United States."

Options for Meeting the Medical Needs of the Uninsured

The uninsured and underinsured often delay and forgo care. Home remedies such as herbals and medications from the black market are considered for fear of acquiring debt in the formal health care system. When they do seek care, their needs are met through formal safety net providers, such as Federally Qualified Health Centers, and the informal safety net, which consists of private providers who have agreed to provide care without an assurance of payment. Those with access to Federally Qualified Health Centers or other formal safety net providers are less likely to delay necessary primary care for fear of incurring debt. However, care provided by both the formal and informal safety nets was often described as limited in scope and uncoordinated. For the uninsured, seeking care in the emergency room was considered an option of last resort for fear of the cost incurred.

Representative Quotes

Rural Hispanic female: "They [the people that provide health services] ask you, why didn't you get here before you were so ill? But you think I don't have insurance or money. And if you have to get hospitalized and can't go to work, then your family can't eat. That's why you hold on [and don't seek care] until the last minute."

Rural Hispanic Female: "Yes, one is always looking for places where you can get medicine without a prescription, which normally comes from the country where you're from and that you know more or less what they're good for. Or natural medicine, and in a way you trick yourself into thinking that it will help you feel better, and for a while it works but if you go to the doctor they could diagnose what is what you really have and give you the right medicine."

Urban Hispanic female: "When my children get sick I take my four year old son and I tell them that he's the one that is sick, because he's the only one that has Medicaid. So they give me a prescription and I get the medicine and I give it to whichever one of my children is sick."

Urban Hispanic male: "I'll lie to help my children."

Self-employed rural female (has a major medical policy): "It's overwhelming. There's all these things that need to be taken care of and you just think, 'why don't I just do it?' Then you don't do it and then you think about it again. It's just like putting off something that you know intelligent people take care of. Like I had a cancer on my face and I did everything; I went all the routes that you can for herbs and everything like that (laughing) and I put it off and put if off. And then it was very serious. I should have been smarter, but I also resent it because it was a huge pot of money to get that taken care of."

Low-income white female: "Poor people die a lot faster; that's the truth of the matter."

Low-income white female: "The doctors' offices here [town in Southeast Nebraska] will let you make payments and they don't really hound you. If you come in and say all I can pay is $5 they are gonna be happy with it. They are not going to sue you if you try, is what I'm saying."

Low-income white male: "They [Federally Qualified Health Care Center in east central Nebraska] don't throw you out the door if you say you don't have the money. If you can't afford to give them nothing, they still treat you just like you had a $100 in your pocket."

Social worker at Federally Qualified Health Care Center in east central Nebraska: "We fax a lot of prescriptions to [grocery store pharmacy] and this last month only 20 percent of those faxed prescriptions got picked up and paid for, that's a lot."

Urban Hispanics: "We go to One World (Federally Qualified Health Center). There is no other place to help us in this community."

Urban Hispanic male: "But that clinic (One World) has no more capacity, as well as HOPE, they are both saturated."

Urban Hispanic female: "They (One World) find specialists that want to donate their time, that's part of their job. They are always looking for more people everywhere, but there are only a few [specialists] that want to do it so you have to wait."

Rural Hispanic Female: "You don't want to go to the emergency room and have to pay that bill there."

Features of an Adequate, Barebones Benefit Package

Access to basic primary care, preventive care, and medications are considered "bare bones." However, the majority of participants felt that access to mental health care and dental care were equally important.

Representative Quotes

Low-income female: "It [a barebones policy] definitely has to include preventive care and well child check-ups. I think I'd like to get a physical one day. I don't think I've had one since I was sixteen."

Rural self-employed female: "If you can ask, 'who should help pay just the minimum needs--like a diabetic needs insulin, I need to have a mammogram every year, I need to have a Pap smear every year, when my kids have strep throat they need to go in.' There are certain things people have to have to get on in this world--just basic things--then I think you can talk about it."

Native American female: "Mental health coverage is probably one of the most important aspects of our physical health and how much we thrive in this world. A lot of us aren't college educated ya know, we're just blue collar workers, hard motivated, and dedicated to our families. Some people work really hard all their life and they end up with a heart attack and then they have that responsibility and no employer anymore. I've seen it happen to a lot of families, especially Native American, where the person who earns the most amount of money in the family becomes disabled. It's a vicious cycle, it starts with one person, one illness and it snowballs into a family issue."

Rural small employer: "Dental care is so important and so many kids don't get it out here. My dentist told me about one kid where 23 of the 26 teeth in his head needed work."

Rural small employer: "The University dental school was just in Alliance for dental days. They brought so much technology with them. They saw so many kids. One kid had a cleft palate that they were able to take care of. Kids just don't get the preventive dental care they need. There isn't access to fluoride in the water or fluoride treatments."

Defining the Underinsured

Underinsurance has previously been defined in terms of the ratio of out-of-pocket health expenses to income. Farley (as cited in Comer & Mueller, 1992) defined the underinsured as those whose out-of-pocket expenses exceeded ten percent of their income. Taylor et al. (2003) have defined the underinsured as those who have high deductibles relative to their income. The household survey performed as part of the Nebraska State Planning Grant found that 27 percent of the insured in Nebraska were worried that insurance won't cover care, and 36 percent of the insured were worried that they will have to pay more than they expected for care. A global definition of underinsurance derived from the focus group findings is that the underinsured are those with health insurance plans who delay or forgo necessary care because of concerns about the cost.

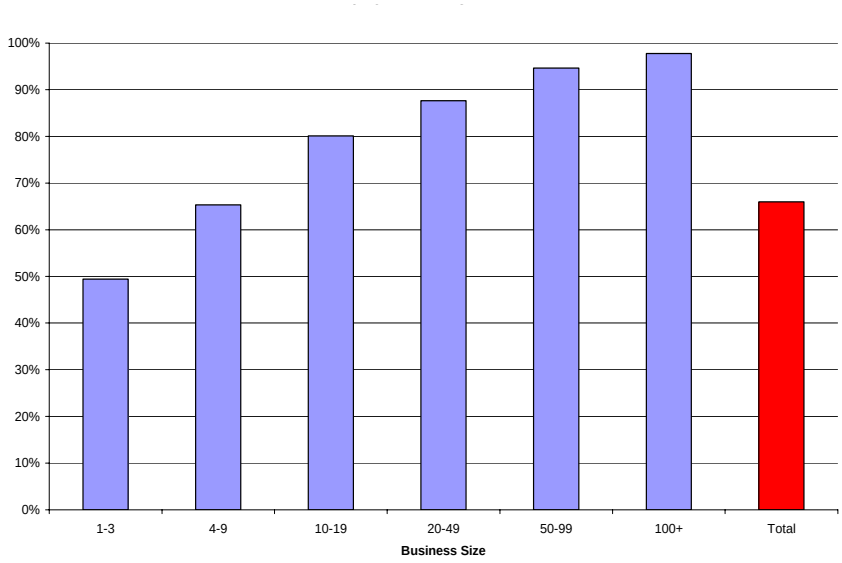
Section 2. Summary of Findings: Employer-Based Coverage

The information in this section is based on a mail survey of employers in Nebraska. A total of 13,848 surveys were mailed and 9,005 were returned with useable information. The response rate was 66 percent. The number of responses was adequate to disaggregate the data by business size, industry, and geographic region.

Characteristics of Employers Offering Insurance Coverage

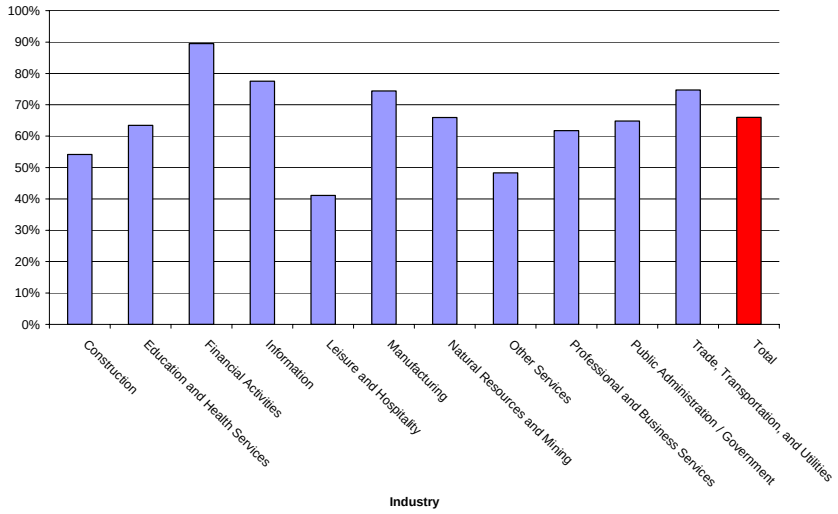
Employer Size: Business size is the greatest predictor as to whether an employer will offer health insurance. The largest employers (those with 100 or more employees) are nearly twice as likely as the smallest employers (those with fewer than four employees) to offer health insurance (see Figure 13). Overall, health insurance is offered by two-thirds of all businesses.

Figure 13. Percent of Employers Offering Health Insurance



Industry Sector: The number of employers offering health insurance coverage varies considerably by industry. Figure 14 shows that employers in the Financial Activities (90 percent) and Information (79 percent) industries are most likely to offer health insurance coverage. In contrast, the Leisure and Hospitality (40 percent) and Other Services industries (49 percent) are the least likely to offer health insurance coverage.

Figure 14. The Percentage of Employers Offering Health Insurance Coverage by Industry



Business size within an industry is not always a good indicator of whether an employer will offer health insurance coverage. For example, the average employment in both the Financial Activities industry and the Leisure and Hospitality industry is 17 employees. However, employees in the Financial Activities sector generally work in subunits of larger companies. As a result, employees who work in a small branch bank are likely to receive the same benefits as those who work in the main bank.

Employee Income Brackets: No information is available.

Percentage of Part-time and Seasonal Workers: Although it is not surprising, employers that have a higher composition of full-time workers are more likely to offer health insurance coverage. For example, in those industries where the percentage of workers that are working full-time is 25 percent or less, the percentage of employers offering health insurance coverage is only 19.5 percent. However, in those businesses where over half of the workers are full-time, the percentage of employers offering health insurance coverage is about 70 percent.

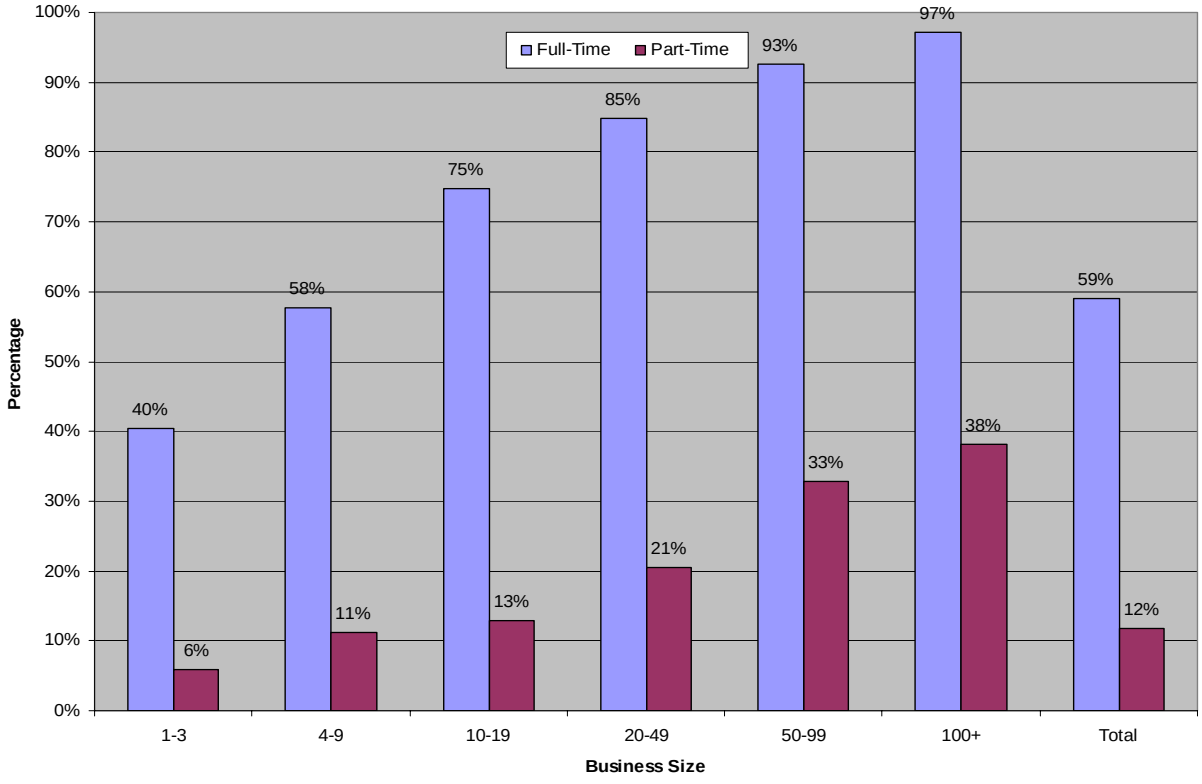
In Table 1, there is a comparison of full-time and part-time workers by industry. This table reveals that those industries with a greater percentage of part-time workers are generally less likely to offer health insurance coverage. A major exception is the Construction industry where 92.5 percent of the employees work full-time, but only about 55 percent of the firms in this industry offer health insurance coverage. However, major differences exist between the Financial Activities industry and the Leisure and Hospitality industry. Over 86 percent of the workforce in Financial Activities are employed full-time, but only 34 percent of the workforce in the Leisure and Hospitality industry work full-time. As discussed previously, 90 percent of the businesses in the Financial Activities sector offer health insurance coverage but only 40 percent of the companies in the Leisure and Hospitality sector offer coverage.

Table 1. Full-Time/Part-Time Status by Industry

Industry	% FT	% PT	% Offering Coverage
Construction	92.5%	7.5%	55%
Education/Health Services	67.3	32.7	65
Financial Activities	86.2	13.8	90
Information	78.2	21.8	78
Leisure/Hospitality	33.8	66.2	40
Manufacturing	94.8	5.2	75
Natural Resources/Mining	80.3	19.7	68
Other Services	59.2	40.8	59
Professional/Business Services	77.3	22.7	61
Public Administration/Government	76.7	23.3	65
Trade/Transportation/Utilities	80.5	19.5	75
Total	**75.2%**	**24.8%**	**66%**

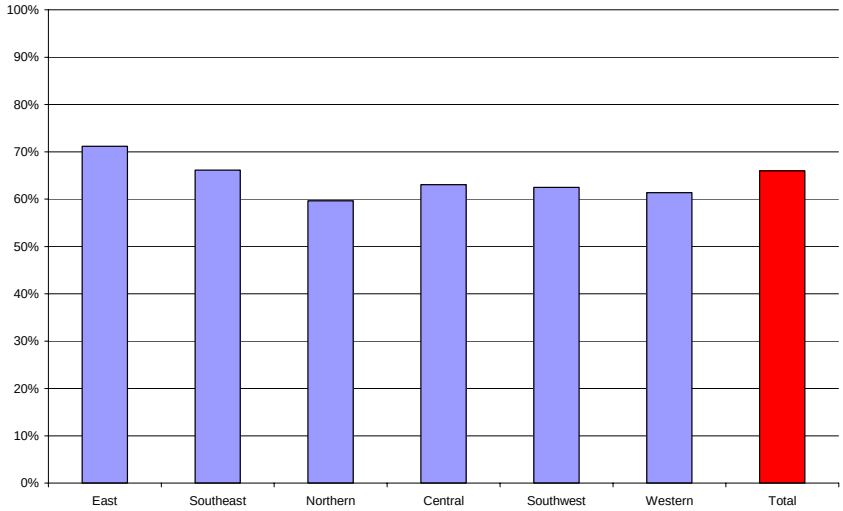
There are also significant differences by the size of employer and employment status. Figure 15 shows the percentages of businesses offering family health insurance by employer size. Overall, only 12 percent of employers offer family coverage to part-time workers as compared to 59 percent for full-time workers. When the data are disaggregated by business size, 38 percent of the employers with 100 or more employees offer family coverage to part-time workers. In contrast, only six percent of the businesses that have one to three employees offer coverage to part-time workers.

Figure 15. Percentage of Businesses Offering Family Health Insurance by Employment Status and Size



Geographic Location: Overall, there is very little variation in the percentages of employers offering health insurance by region (Figure 16). Those in the East region (which includes the state's largest SMA) are slightly more likely to offer health insurance, but this difference is not statistically significant.

Figure 16. Employers Offering Health Insurance by Region



Employers Offering Coverage

Cost of Policies: No information is available from the survey on the specific costs of the policies. However, a question was asked whether health insurance premiums had increased, decreased, or remained relatively steady over the past year. Ninety percent of employers reported that costs had increased; two percent reported a decrease in health insurance premiums, and the remaining eight percent reported premiums unchanged.

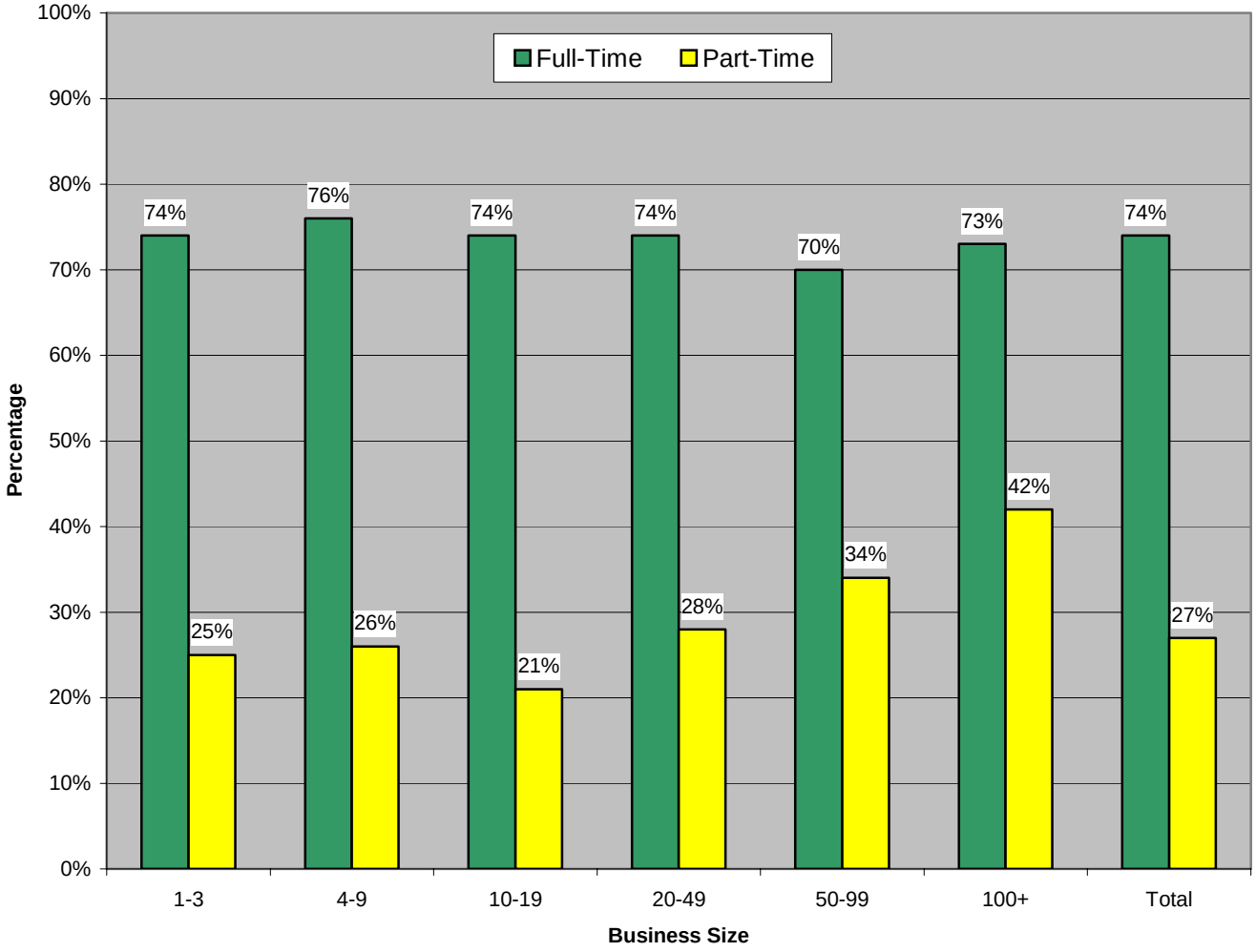
Of those with an increase in premiums, a follow-up question was asked to determine who paid the increase – the company, employees, or both. Only 10 percent of employers passed the entire health insurance premium increases on to their employees. Approximately 45 percent of businesses paid the entire premium increase, and the remaining 45 percent of businesses shared the premium increases with their workers. There were no more major differences when the data were analyzed by region of the state, but considerable variations were found by industry. Table 2 reveals the percentages by industry. Employers in the Natural Resources and Mining industry were most likely to pay the entire cost of insurance premium increases. Those in the Information and Manufacturing industries were most likely to pass some or all of the premium increases on to their employees.

Table 2. Percentage of Premium Increase Paid by Employees and the Employers

Industry	Employees Paid	Employer Paid	Increase Shared
Construction	10.0%	55.4%	34.6%
Education/Health Services	10.7	49.1	40.2
Financial Activities	17.7	37.1	45.2
Information	8.6	32.8	58.6
Leisure/Hospitality	12.7	35.8	51.5
Manufacturing	10.5	32.8	56.8
Natural Resources/Mining	7.8	68.2	24.0
Other Services	5.5	60.6	33.9
Professional/Business Services	10.0	50.3	39.7
Public Administration/Government	7.1	60.7	32.1
Trade/Transportation/Utilities	8.7	38.8	52.6
Total	**10.0%**	**45.8%**	**44.3%**

Level of Contribution: The survey asked what percentage of health insurance premiums were paid by employers. Figure 17 indicates that the average employer contribution was 74 percent for full-time workers but only 27 percent for part-time workers. There was little variation in the percentages for full-time workers by employer-size. In fact, employers with only one to three employers paid 74 percent of the premiums as compared to 73 percent for the largest employers. However, larger employers were more likely to pay a higher percentage of the premiums (42 percent) for part-time workers than were the smallest employers (25 percent).

Figure 17. Average Percentage of Health Insurance Premiums Paid by the Employer



Percentage of Employees Enrolled in Coverage: The percentage of employees who are enrolled in single coverage health insurance is 61 percent for full-time workers and 15 percent for part-time workers. For family coverage, 46 percent of full-time workers and 34 percent of part-time workers were enrolled in an insurance plan.

Factors Influencing Employer's Decision to Offer Coverage

In the focus group interviews, employers were asked to identify the factors that influence their decision to offer coverage. The employer participants indicated that the decision to offer health insurance coverage is based on “the bottom line” of cost, and secondarily on a sense of social obligation. Reasons given for not offering coverage include the cost, organized as a non-profit, the perception that some “blue collar” employees would rather have cash than benefits, the time required to investigate all of the options, and the knowledge that health insurance is not needed to recruit employees for certain jobs.

Representative Quotes

Rural agricultural small employer: "We look at the total package of what we offer over a year. How much does this employee cost us? We take into account worker’s compensation, what we provide for health insurance, wages, and other benefits. We look at what it costs us per year for that employee."

Urban small employer: "And it’s attracting quality people, too. If you intend to retain and attract professional employees, they expect it [health insurance]."

Rural agricultural small employer: "We try to employ quality people, family-oriented people that are concerned about insurance for their family; I think they make better employees if they know they are covered. If they get injured, it can cost 16 to 30 thousand dollars to pay the bill and they are trying to pay that off; that is a lot of stress, and so I think they work better if they know that they are covered."

Rural small employer: "I look at what it is going to take for them to get the insurance. If I have to, I will cut somewhere else such as in advertising in order to pay the cost. It is a social reason. If you don’t offer insurance, you are discriminating against the single person who might have a family to support."

Rural small employer: "I feel like I have a responsibility, as an employer, to make sure they’re [young employees] making good, long term decisions for themselves and for their young families, so we just make it [health insurance] part of the deal."

Rural small employer: "It is really difficult for non-profit firms to offer health insurance because we have very small workforces and pay very little amounts of salary."

Urban small employer: "Our Hispanic workers would be totally lost [if we took money out for health insurance]. They would just think I was stealing money out of their checks. They wouldn’t understand any of it. Just getting them to use it even if they did have it would be a challenge."

Urban small employer: "Well, that’s [referring to the situation described above] a matter of actual background. My Hispanic workers have the education and the knowledge,

therefore their exposure is on a different level; exposure has a lot to do with it. It's an informational situation. It's not ethnic; it is truly informational."

Urban small employer (construction): "They don't really see it [health insurance] as a benefit; there's no benefit to them if there's no cash, no physical cash dollars. I can say, 'You made $13 an hour but your benefits, your vacation I pay, your sick days, your holidays, your health insurance that adds up to another $2 an hour at least.' They don't think like that."

Urban small employer: "We don't have time to research all the policies."

Factors Influencing Employer Health Insurance Decisions

Employers make decisions about the health insurance they will offer based on the cost to their business, the industry standard for benefits, whether the work is seasonal, and what benefits are needed to stay competitive for the type of workers they are trying to recruit in their local job market. However, some small employers feel a sense of obligation to continue to provide insurance for employees, such as those with pre-existing conditions, despite escalating prices.

Representative Quotes

Rural agricultural small employer: "We did a survey of our employees and we asked them what was important to them. Time off was #1, wages was #2, and health insurance was #3. So we put in a time clock and every body went to an hourly wage instead of salary. We pay X amount of money to employees for their health insurance and then they go and get their own coverage but we don't know if they actually get insurance. We have Spanish people working for us. They don't care about health insurance, it isn't important to them."

Urban small employer (construction): "Now what I'm looking at next year is if I look at the big dogs in my industry, if I look at the HDRs and the Leo Dailys and the Kiewits - what they're doing is they have a level plan. You have like level one, two, or three and that first level is you have a $10 co-pay and its $250 deductible, and the second level is like a $1,000 deductible with a $20 co-pay, and the next level is $2,500. But as a small employer, I can't really offer that many products because you have to have so many people sign up for each product."

Urban small employer: "When we looked into it, all the people I talked to, it's pretty much standard if you're going to ask for a contribution. It's really hard to ask for more than half. One other thing we looked at was: you pay half for your insurance but if you're going to add your family on, you're going to have to pay for that."

Urban small employer: "That would be another issue. How do I get them to pay for that policy during the winter? We close down for 10 weeks. How are they going to pay for that policy? They'd want us to pay for it or else they want you to take that insurance premium and cut it."

Rural small employer: "Well, I sit down with my own pencil and paper and also make it realistic. I feel it's very important for everybody to have health insurance for all the reasons that we've talked about here; particularly to make sure that they are insurable in the future."

The Likely Response of Employers to an Economic Downturn or Continued Increases in Costs

Employers view decisions regarding health insurance as a continuous process of balancing what their businesses can afford to offer with what the market demands to retain workers. In general, deductibles and other out of pocket costs for employees are increased in order to make costs for the employer somewhat predictable. The inability to predict insurance costs from year to year is a source of economic uncertainty for small employers.

Representative Quotes

Rural small employer: "Years ago we decided to pay whatever the average person, employee cost was that's what we paid rather than paying the entire amount of all of the employees, because number one it's not fair to someone that's 20 years old compared to someone else that's 60 years old. It's not fair that the 20 year-old gets an $80 benefit and the 60 year-old gets a $500 benefit. And number two is that you're going to, you know you're going to have a 35 percent increase every year and all of a sudden your costs are totally out of whack. What you figure is I'm going to be paying this amount for this employee and all of a sudden it's 35 percent more every year."

Rural small employer: "You know, in the years we've been covering our employees, we've been asking them to pay a percentage and we pay a percentage. But one of the things we have done along the way to keep costs in line, is kept raising our deductible, so and as much as we've informed our staff as the deductible has been going up, I'm not sure they're even going to be aware of it. I think they're going to say, 'Oh I didn't realize it was $2,000 now or $1,500 now.' That's the way we've been trying to keep our costs in line to keep that percentage the same for our business."

The Employer and Employee Groups Most Susceptible to Crowd-Out

This concept was not explored in our focus groups. However, increasing the availability of public coverage by lowering income requirements would provide a means of covering the working poor who are least likely to have private coverage in the state of Nebraska.

Factors that May Influence Employers Who Do Not Offer Coverage

Expansion/Development of Purchasing Alliances

Small employers who do and do not offer health insurance both consider purchasing alliances as a strategy to pool risks, to decrease the cost of offering health insurance, and to increase the availability of health insurance for those with pre-existing conditions. A consistent

theme was the fact that small employers with 10 or fewer employees have little or no access to group policies.

Representative Quotes

Rural small employer: "Well I think these insurance companies from what we're seeing, they're trying to eliminate any risk that there is. (Group: right) So they want to eliminate any possible risk. So if we turn in when we're looking at group plans, and they look at pre-existing conditions and that's what they're basing those premiums on and they don't want, they want to eliminate their risk."

Rural small employer: "They'll charge you according to the risks you have. They want to know what risks they're going to be taking, so they will ask the employer, at least in our case, if you change companies, they will ask for a listing of employees or they will take a look at your loss runs and they'll determine your high risk employees...and if they find somebody in that group, they'll "laser 'em," and they will raise that specific amount from what the group pays to 4, 5, 6, 7 times that. So the company is taking on that additional liability on that employee. And I'm looking at one right now at $150,000 that I have to pay on this individual. So they know up front that there's 3, 4, 5 people in your group that they are going to have problems with. The rest of the group, you know, is just going to be probably pretty reasonable."

Rural agricultural employer: "I think these pools are the way to have the clout to control costs while bringing more people with high risks into the insurance system... People who have coverage might be reluctant to leave what they have. We would have to provide flexibility so that if you can pay more you can get more than a basic plan. We have to provide choices but we have to get control of these rates."

Rural agricultural employer: "A pool could cover medications and make it so that the same price was paid for a drug no matter where you were. The VA [Veteran's Administration] negotiates low rates for their medications and they use generic drugs. I think this approach would help control drug costs and premiums."

Rural agricultural employer: "It [purchasing pools] would help us expand benefits beyond the catastrophic coverage."

Individual or Employer Subsidies

Many small employers were suspicious of State subsidies to decrease the cost of premiums. They argued that money for premiums will require increased taxation of other economic activities to provide the funds, and that the subsidies would not address the problems of continually escalating costs that require high co-pays and deductibles or the inability to obtain insurance due to pre-existing conditions. However, participants were interested to know if by subsidizing premiums, the State would also accept responsibility for controlling the rising cost of health insurance premiums. This cost constraint aspect of subsidizing premiums was viewed positively.

Representative Quotes

Rural white self-employed female: "This is what I think; I think if the State is going to provide another service, your taxes are going to go up."

Rural white self-employed female: "Yes, your taxes would go up and the insurance would go up in another year or another six months, and so then you'd say, 'well, now are they going to increase it [the subsidy] again?' You just can't be sure."

Rural small employer: "It seems like you'd still be at a risk of, should I hire a full-time employee or should I just keep them part-time and not pay insurance?"

Rural small employer: "I think, to address your, you've asked about three times if the state was going to pay for half the insurance premium [how that would affect our decision to offer health insurance], in our case, yeah, it would make a difference. But also, if you think about it, it also would shift some of the responsibility to control cost to the state because they're going to pay half of the premium."

Rural agricultural small employer: "[If they help pay for premiums], the state could contract with health insurance companies to control the amounts of premiums and rates at which they go up. I like that idea of knowing from year to year what that cost of offering health insurance will be. The state…or several states, could represent small employers."

Additional Tax Incentives

Tax credits were generally viewed favorably with the caveat that they be refundable or represent a credit for those whose net taxable income may be negative. Tax credits were not perceived as helpful for non-profit organizations.

Representative Quotes

Urban small employer: "If we could get some sort of tax credit 'cause with us, it's the bottom line. It comes down to having enough money in the bank to pay for it and continue to grow and continue to grow our business and keep people employed and feed their families... I'm already laying out $3,500 a month in my workman's comp liability insurance so it's a cash-flow thing. If I could get some sort of a break on something else to ease that financial burden, it would make it a lot easier."

Rural small agricultural employer: "Well since the industry fluctuates so much, I would want a direct contribution since I don't know from year to year whether I will have net taxable income to deduct from."

Rural small agricultural employer: "But you could carry those deductions over to years where you do have a profit."

Rural small employer: "Credits are much more valuable of course than just the deduction off the front of the tax return like health insurance is now."

Rural small employer: "It [tax credits] doesn't work for non-profits. There's nothing for us."

Other Alternatives to Motivate Employers

Other alternatives that were suggested included the use of defined contributions and health savings accounts, and the need for the federal government to play a role in providing insurance for those with pre-existing conditions and to control the cost of premiums through reinsurance programs for catastrophic costs. The advantages of providing a defined contribution to an employee to purchase health insurance was that it made the cost to the employer predictable and it made the insurance portable for the employee. The disadvantage of a defined contribution was not knowing if the employee actually purchased insurance. The expectation of having insurance to pay for "dollar one" of the cost of health care services was perceived as a potential barrier to the use of health savings accounts.

Representative Quotes

Rural small agricultural employer: "Well at least, you know what your costs are going to be [with a defined contribution]."

Rural small agricultural employer: "You wouldn't have the hassle of looking at all kinds of insurance plans [with a defined contribution]."

Rural small agricultural employer: "The insurance is portable if the employee gets it on his own and then changes jobs, but the biggest [problem] is that you don't know if they actually use the money to buy insurance."

Rural small employer: "And really with this new HSA [health savings account], I think you're going to see a lot of group health insurance coverage changing. Because, I think with that availability to every person, there's probably going to be some additional laws passed that will allow you as an employer to say, 'okay, we are going to have health insurance with an HSA, and I'm going to take a certain amount of your payroll and that's going to go into this HSA, and if you don't use it this year, no problem, it rolls over.' But it may take two or three years but I think you're going to see that within a lot of group coverages."

Rural small employer: "We buy insurance for catastrophic things anyway. That's the way I've always looked at it."

Rural small employer: "But the average person who doesn't deal with it, doesn't (referring to comment above). They want their health insurance to pay for dollar one."

Rural small employer: "I think it's got to be the feds [to control escalating costs and provide insurance for those with pre-existing conditions]. Insurance companies practice in every state; they can decide to offer policies in this state or in that state depending - I think it would have to be the feds."

Rural small employer: "I think it would have to be federal, too, just for the fact that you know when we called in saying that all of a sudden we were out of coverage, the State was just like, 'Well, you know, the agent shouldn't have told you that you were insured.' Well that's great, but that doesn't do me a world of good at this point. And the fact that we're not insurable or that fact that the costs are so expensive, I mean… And nobody would pick us up because they couldn't diagnose what the problem was. You know the first year we paid out $27,000 out of our pocket for medical expenses. A lot of people will spend their entire life trying to pay off the medical debt. If my husband and I weren't in the position we were, that's why people file bankruptcy. We could struggle through it, but the average person cannot."

Impact on Economic Development

The rural small employers perceived three effects of the high costs of health insurance on rural economic development. First, the high cost of insurance prevents small employers from offering it and thus discourages young families from taking jobs in rural areas. Second, the high cost of insurance and health care was perceived as diverting resources from other economic activities that would improve rural development. Third, the high cost of health insurance causes rural families to be uninsured and thus decreases access to health care. The household survey did demonstrate that the rate of uninsurance was higher in rural areas of Nebraska than in urban areas. Among those under age 65, the uninsurance rate was 11.1 percent for individuals living in non-metropolitan counties and 8.7 percent for individuals living in metropolitan counties. Finally, participants expressed that there is a difference between providing access to health insurance and providing access to health care.

Representative Quotes

Rural white self-employed female: "I think if you noticed, and the first thing we said when we came in, one of the very serious problems of living in central Nebraska, as well as southwest Nebraska, are poor wages and lack of healthcare. And if there were ways that employers could have some help with the healthcare they might hire more employees or they might invent more jobs and come here and start them."

Rural agricultural small employers:

"Uninsurance is a crisis in rural America. The majority of people who don't have insurance are without it because of the cost."

"The cost just won't stay constant."

"And you can't just keep taking from the ranch to pay for something you don't have any benefit from."

"Spending all that money on insurance and health care impedes development. We don't have the money to put into something else in the community when it is all going to health care costs."

"To get young people, kids, to come back to these communities, you need financially viable businesses or they have nothing to come back to."

Rural self-employed female: "I think we need to separate health insurance versus healthcare here for your research. I don't believe in it [health insurance]. It's the only system we happen to have in this region, but I don't think it's the only one we hope for. There's other ways to get healthcare than paying for insurance that isn't going to pay for healthcare anyway."

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Section 3. Summary of Findings: Health Care Marketplace

This section provides a description of the health care marketplace in Nebraska and how the findings relating to the marketplace affected the development of policy options.

Adequacy of Coverage

Adequacy was generally defined as those with health insurance plans who do not delay or forego necessary care because of concerns about cost. As reported in Section 2, the household survey found that 27 percent of the insured were worried that health insurance will not cover care and 36 percent were worried that they will have to pay more than expected for care.

Existing insurance products appear to be inadequate for many employees who work for small employers or who are self-employed. Insurance policies sold in the small group market are usually more expensive and cover fewer services. As a result, many employers are forced to pass on some of the higher costs to their employees in the form of high deductibles and co-payments. Because of these higher costs, some low-income employees decide not to participate in the health insurance program.

Persons with pre-existing conditions have a particularly difficult time of finding health insurance coverage. Although Nebraska has a guaranteed issue for all employers who continue to purchase coverage, the cost of insurance products is not regulated. These conditions make it very difficult to find a reasonable cost insurance policy if they purchase it in the small group market.

Individuals with pre-existing conditions can join the Comprehensive Health Insurance Pool, but premiums are set at 135 percent, making it nearly impossible for those with low incomes (i.e., below 200 percent of the Federal Poverty Level) to purchase a policy.

In summary, adequacy of health insurance coverage was defined as those individuals with health insurance coverage who do not delay or forego necessary care because of concerns about cost. It was recognized that individuals and families with low incomes (i.e., less than 200 percent of the Federal Poverty Level) and/or those with pre-existing conditions have great difficulty in finding an affordable health insurance policy that has a reasonable deductible, co-insurance level, and major medical coverage.

Variation in Benefits

Nebraska does not have adequate information to compare the benefit levels among non-group, small group, large group, and self-insured plans. The greatest differences in benefit levels tend to occur between the large group plans and the non-group and small group plans. The latter plans tend to offer less coverage for mental health and substance abuse services, dental services, and prescription drugs. For example, the results of the employer survey found that only about 30 percent of very small employer plans (i.e., one to three employees) offered health plans that covered mental health and dental services as compared to about 80 percent of the large employer plans (i.e., greater than 100 employees).

Because of state mandates, there appears to be some difference in the level of benefits between self-insured employers and other employers. However, these differences appear to be fairly minor because most self-insured employers are large and the number of state mandates is relatively low.

Prevalence and Impact of Self-Insured Firms

According to the 2002 MEPS survey, self-insured firms in Nebraska comprise about 28 percent of the total. It is difficult to assess the impact of these firms in the state's marketplace because little information exists about the administration of these plans and the affiliated provider networks.

Impact of the State as a Purchaser of Health Care

The state is considered a large purchaser of health care services in that they cover a total of 278,042 lives. This total includes 259,000 people that are covered through Medicaid or the State Children's Health Insurance Program and 19,042 employees that are covered under the state group program.

For the most part, the state has not used its buying power to influence the market. In 1995, the state considered forming a large purchasing pool that would include all state employees, teachers, county and city employees, state university employees, and eventually Medicaid recipients and small employers. However, the principal players could not agree on a plan and the pool was never developed.

At the present time, the State is not part of any multi-state coalitions to negotiate lower rates. However, the Medicaid program is considering joining a multi-state purchasing pool to negotiate lower prices for prescription drugs.

Impact of Current Market Trends and Regulatory Environment

Recent market trends have made it more difficult to expand health insurance coverage. One of the trends that has had a significant impact on health insurance coverage is the substantial rise in health insurance premiums. Nationally, health insurance premiums have increased on average by 56 percent over the past five years and the expansion has been even greater for small employers. As a result, several small employers have dropped health insurance coverage or passed on a significant portion of these costs to their employees in the form of greater cost sharing. As employees have been forced to pay a larger share of the costs, many lower income employees have chosen to "opt out" of the plan.

Another major market trend is the number of insurers that offer plans in the individual and small group market. Although specific data are not available, anecdotal information suggests that at the present time less than ten insurance carriers offer coverage in the individual and small group markets in rural Nebraska.

Given these trends, it is highly unlikely that universal coverage can be achieved without federal intervention. Although the state's economy has improved in the past two years, the revenue gains are not sufficient to fund major expansions in state coverage initiatives. Changes in the regulatory environment are also unlikely at this time.

Universal Coverage and the Financial Status of Health Plans and Providers

Although it would be difficult to achieve universal coverage, it would have a positive financial impact on health plans and providers. Universal coverage would have a positive impact on health plans because the costs of the uninsured would not be shifted. Also, the costs to health care providers would decline because the uninsured would receive more timely preventive care and screening services which should reduce the overall costs. Of course, safety net providers would benefit the most because they see a disproportionate share of the uninsured patients.

Safety Net Providers

The Nebraska Health Insurance Policy Coalition spent considerable time discussing the role of safety net providers in providing health care services to the uninsured and underinsured. Nebraska has only five community health centers and relies heavily on critical access hospitals and certified rural health clinics to deliver care for the underserved. In rural areas where there are only two community health centers, participants at the town hall meetings encouraged state officials to work with the federal government to allow critical access hospitals and rural health clinics to be eligible for federal funds and the 340B drug discount program to cover some of the costs of providing care to uninsured.

In order to assess the impact of safety net providers, a study was conducted by the Nebraska Center for Rural Health Research. This study found that all hospitals, community health centers, and rural health clinics provided an estimated $262.6 million in uncompensated care (i.e., charity care and bad debt) in 2003. For hospital inpatient care the estimated total expenses of self-pay patients nearly doubled from $13.7 million to $26.2 million between 1996 and 2003. This dramatic increase in uncompensated care produced a very broad impact in that the average cost for every Nebraska resident increased from $8 in 1996 to $15 in 2003.

The study also found that there was some variation across the state in the level of uncompensated hospital care. For example, residents living in the central and western part of the state had a statistically significantly higher per resident charge for hospital inpatient care of self-pay patients than did residents living in the eastern part of the state. Finally, the Nebraska counties with a higher unemployment rate, a lower per capita income, and a greater percentage of population under Temporary Assistance for Needy Families (TANF) assistance incurred a statistically significantly higher per resident charge for hospital inpatient care of self-pay patients than did their counterpart counties.

Changes in Utilization with Universal Coverage

If there was universal coverage, utilization is very likely to increase because of health needs that are not being met. The results of the Nebraska Household Survey found that 14

percent of the uninsured and three percent of the insured population did not get needed care in the past year because of the cost. As previously noted, the survey also revealed that 27 percent of the insured and 36 percent of the uninsured were worried that insurance will not cover the cost of their care. However, it is anticipated that in most areas the early increase in utilization will begin to level off and then decrease as access to health promotion and disease prevention services improves.

In some rural areas there is a serious concern about whether the supply of health professionals is adequate to meet the rising demand. Some areas have experienced chronic shortages of physicians, dentists, nurses, and mental health professionals. Even when there is an adequate supply, there is sometimes a reluctance to see Medicaid patients and underserved populations. In some communities, for example, very few dentists are willing to treat Medicaid patients.

In some rural areas, Nebraska has a high concentration of racial and ethnic minority populations. With universal coverage producing a rising demand for services, it will become even more important to have a culturally competent training workforce.

Consideration of the Experiences of Other States

Expansion of Public Coverage

The Policy Coalition examined many of the policy options that were developed in other states. Staff from the State Coverage Initiatives Program presented both public and private options during the second meeting of the Coalition.

Staff followed up by examining these options more in depth and analyzing the advantages and disadvantages of the policy options. The following public coverage options were considered by the Coalition:

- Increase income eligibility levels for Medicaid and Kids Connection (the Nebraska SCHIP Program).
- Make parents of children currently eligible for the SCHIP Program.
- Establish a premium assistance program for Medicaid.
- Intensify marketing and outreach efforts to identify and enroll eligible individuals in the Medicaid and SCHIP Programs.
- Strengthen the health care safety net by expanding the number of community health centers.

Several states have implemented programs in these areas and no one particular state was studied in detail.

Public-Private Partnerships

The two main programs that were considered under public-private partnerships were a Medicaid premium assistance program and a government-financed reinsurance program. A

number of states have received a waiver from CMS to implement a premium assistance plan. A few states, including New York, Arizona, Idaho, and Connecticut, have implemented state reinsurance programs.

Incentives for Employers to Offer Coverage

Serious consideration was given to various state programs that provide incentives for employers to offer insurance coverage. These programs are primarily aimed at the small employers and the individual market. Some of these programs include the establishment of direct tax incentives and purchasing pools. Of course, premium assistance programs and reinsurance programs should reduce and stabilize the cost of health insurance premiums and thus provide an incentive to offer insurance coverage to their employees.

Regulation of the Marketplace

Some new regulations were reviewed by the Coalition. In addition, the sale of “limited” benefit or “mandate lite” plans, new regulations such as small group rating and shortening the initial waiting period policies were discussed.

Section 4. Options and Progress in Expanding Coverage

The Nebraska Health Insurance Policy Coalition began the process of developing various policy options after reviewing the results of the household and employer surveys as well as the initial focus group interviews. The first step in the process was to develop a set of principles that would be used in consensus building and guiding the selection of policy options. These principles include:

- Improve Access to Care
- Build on Existing Public and Private Programs
- Promote Individual Responsibility & Wellness
- Avoid Replacing Private Coverage with Public Coverage
- Develop a Strategy that has a Reasonable Cost and is Affordable to Individuals, Taxpayers, Employers, and the Government

Once the guiding principles were in place, the Coalition began to identify key target populations. It was obvious from the results of the surveys that the coverage options needed to address individuals and families with low incomes (i.e., less than 200 percent of the Federal Poverty Level). There was also strong evidence that the majority of the uninsured are employed by small businesses or are self-employed. According to the survey findings, for example, only 49 percent of employers that have between one and three employees offer health insurance coverage as compared to over 98 percent of employers that have over 100 employees. In addition, about 19 percent of small businesses were only somewhat likely or not likely at all to continue offering health insurance coverage in the next two years. Finally, the results of the survey strongly suggested that the Hispanic population with a 27 percent uninsured rate and young adults ages 19 to 34 should be target population groups.

After formulating the guiding principles and identifying the target populations, the Coalition began the development of policy options. The insurance expansion initiatives that have been approved by the Coalition fall into the following three general areas: (1) strengthening the health care safety net, (2) expanding Medicaid coverage, and (3) improving access to private health insurance coverage. The specific initiatives in each of these areas will be described along with the advantages and disadvantages, the target populations, and cost considerations.

Some of these coverage expansion options can be implemented immediately at a relatively low cost to the state. However, some of the more comprehensive and more costly options will need considerably more study before they can be implemented. As a result, it is not possible to discuss many of the key questions, such as how will the program be administered, what will be the benefit structure and cost sharing arrangements, what is the projected cost and how will it be administered, what methods will be used to assure quality, and how will the program be evaluated.

Coverage Expansion Options

Strengthening the Health Care Safety Net

Under strengthening the health care safety net, the Coalition recommended two coverage expansion options. The specific recommendations are described below:

I. Create a Safety Net Commission to develop a plan for expanding and supporting the number of community health centers, satellites of existing centers, and look-alikes.

Description and Rationale: Although many private providers, including hospitals and physician clinics, see a significant number of indigent patients, Nebraska has a very fragmented and uncoordinated safety net of health care providers. As a result, many patients do not have a regular physician and receive care in hospital emergency rooms. When patients receive care in hospital emergency rooms, they are often sicker and the cost of health care services is more expensive.

In order to develop a stronger safety net, a Safety Net Commission should be formed to develop a plan for increasing the number of new Federally Qualified Community Health Centers (FQHCs), satellites of existing centers, and FQHC look-alikes. The plan should also identify the levels of state and local support that are needed to develop new and existing centers. Currently, Nebraska has five FQHCs, including two in Omaha and one in Columbus, Gering, and Lincoln. FQHCs provide comprehensive primary and preventive care, low cost prescription drugs, mental health care, and usually dental care. Since they receive federal funds, they are required to provide care to all patients, regardless of an individual's ability to pay or health insurance coverage. They receive cost-based reimbursement from Medicaid and collect some fees on a sliding fee scale.

Community health centers are a critical link in the safety net for uninsured patients. In 2004, 62 percent of the patients who visited one of the five Nebraska centers were uninsured and 86 percent of the patients had family incomes at or below 200 percent of the Federal Poverty Level. The centers have also experienced a significant increase in the growth of uninsured patients. Between 2002 and 2004, there was a 51 percent increase in the number of uninsured users.

While community health centers receive federal grants to provide care to the uninsured, these funds have not kept pace with the rising number of uninsured seeking care at the centers. Limited resources often require centers to turn patients away. For example, in the month of February of 2005, OneWorld Community Health Centers, Inc. in Omaha was unable to schedule 1,000 appointments because they lacked the capacity to provide the care, both in terms of space and medical professionals.

In addition to new FQHCs, the plan should address potential expansions of existing centers relatively near their current locations. Finally, the plan should identify possible FQHC look-alikes. Although look-alikes do not receive a federal grant to cover the costs

of treating uninsured patients, they are entitled to receive cost-based reimbursement from Medicaid. In some instances, look-alikes may evolve into an FQHC.

The Safety Net Plan should make recommendations in the following areas:

- Which communities should be encouraged to seek FQHC grant funding?
- Which FQHCs should be encouraged to expand and where?
- Which agencies should be encouraged to become a FQHC look-alike?
- What types of technical assistance, start-up funds, and other state and local resources are necessary for Nebraska to have a strong safety net?
- What other models are under consideration at the federal level? For example, the Health Resources and Services Administration (HRSA) is exploring various hybrid models that may include rural health clinics and critical access hospitals. Since Nebraska has over 100 rural health clinics and 60 critical access hospitals, it may be possible to become part of a demonstration project.
- Since FQHCs do not provide specialty or hospital care, what mechanisms need to be in place to contract with specialists and acute care hospitals?
- What types of information or tracking systems are needed to improve the continuity of care and prevent duplication of services between safety net providers and hospital emergency rooms?
- What types of capital improvements and other financial resources are needed in existing community health centers and what options are available to fund these improvements?

Finally, in the development of the plan, the Safety Net Commission should consult with the Iowa/Nebraska Primary Care Association and the Office of Primary Care in the Nebraska Department of Regulation and Licensure.

Advantages: FQHCs provide comprehensive primary and preventive care, discounted prescription drugs, behavioral health care services, and dental care. Because they receive a federal subsidy, FQHCs must see all patients regardless of income or insurance status. They are also entitled to receive cost-based reimbursement from Medicaid and collect other fees through a sliding fee scale. Finally, funding for centers still remains a priority at the federal level.

Disadvantages: The grants for new centers are highly competitive where successful applicants often submit several grant applications. Also, there must be strong provider and community support because the federal grant will not cover all of the initial costs. Finally, since community health centers do not provide nor cover hospital and specialty care, agreements and contracts must be worked out with nearby hospitals and physician specialists.

Target Groups: Low income children and adults

Cost: Grant funds are available to cover most of the costs of providing technical assistance to communities that are interested in developing a new community health

center. Nevertheless, some in-kind services are needed from various organizations at the community level. Because FQHCs receive cost-based reimbursement for Medicaid clients, Medicaid program costs may increase slightly in the short run. However, these short-run cost increases will be more than offset in the long-term through a reduction in emergency room visits. Also, more timely preventive care will reduce specialty care referrals and result in fewer hospital stays. The Iowa/Nebraska Primary Care Association has estimated that the community health centers in Nebraska have saved the state Medicaid program over $1.5 million a year.

II. Expand the use of drug discount programs (e.g., the federal 340B Program) so that all eligible organizations can purchase prescription drugs at lower costs.

Description and Rationale: The 340B Program is a federal program that was created in 1992 in response to an increase in prescription drug prices. Under this program manufacturers are required to sell covered outpatient drugs at a lower cost to certain "covered entities" at a price determined by a statutory formula. The eligible covered entities include:

- Federally qualified health centers
- Migrant health centers
- Health centers for public housing
- AIDS clinics and drug programs
- Hemophilia treatment centers
- Urban Indian clinics/638 tribal centers
- 340s school-based programs
- Title X family planning clinics
- STD clinics
- TB clinics
- FQHC look-alikes
- Certain disproportionate share hospitals

Currently, the community health centers are taking advantage of the 340B Program, but there are over 60 other eligible entities in Nebraska that are not part of the program. With expanded technical assistance and support from the Nebraska Health and Human Services System, a larger number of low-income individuals could purchase outpatient prescription drugs and prescribed over-the-counter drugs at costs that are 10 to 70 percent less than the normal price, assuming the covered entities maintain a reasonable dispensing fee.

In order to qualify for the 340B Program, a patient of a covered entity must receive a range of health care services from the practitioner employed by the entity. In addition, the health records must be maintained by the entity.

Advantages: The 340B Program can reduce the costs of prescription drugs by 10 to 70 percent. Although community health centers are already taking advantage of this program, many other eligible entities are not. Some technical assistance will need to be

provided by the Nebraska Health and Human Services System, but no new state funds are needed.

Disadvantages: For patients to qualify for the discounted prescription drugs, they must receive a range of services from the entity and the health records must be maintained by the entity. As a result, some of the eligible entities may not qualify because they do not provide a wide range of primary care services.

Target Groups: Low-income children and adults

Cost: Since this is a federal program, the cost to the state would be minimal. Some technical assistance would be needed about how to implement the program and to inform patients about the benefits of the program.

Expanding Medicaid and SCHIP Coverage

The second major coverage expansion area is to expand the Medicaid and Kids Connection (SCHIP) programs. These options range from improving marketing and outreach efforts to enroll all eligible children and adults to expanding Medicaid income eligibility.

III. Improve marketing and outreach efforts to enroll children and adults who are currently eligible for Medicaid and Kids Connection (the State Children's Health Insurance Program).

Description and Rationale: Eligibility for the Medicaid and Kids Connection programs is generally based on income and the value of assets. For example, all children are eligible for either Medicaid or Kids Connection if their family income is at or below 185 percent of the Federal Poverty Level and they are without insurance coverage. Despite the current marketing and outreach efforts, there are still many children and adults who meet the eligibility requirements of these programs but are not enrolled. By expanding current marketing and outreach initiatives, insurance coverage can be expanded at a modest cost to the state.

Advantages: This strategy is an inexpensive way to expand health insurance coverage. Also, it would build on existing strategic initiatives that have been very successful in enrolling eligible individuals.

Disadvantages: Because of the overall success in enrollment, the marketing and outreach efforts must become more targeted. Also, some additional costs would be incurred by enrolling more individuals in the Medicaid or Kids Connection programs.

Target Groups: Low income children and adults eligible for Medicaid and Kids Connection but not enrolled

Cost: Costs can vary depending on the initiative. Nebraska has already implemented a simplified application form and has a six-month continuous eligibility policy for children

enrolled in Kids Connection. The continuous eligibility period was dropped from twelve months to six months during the 2003 legislative session, which affected about 7,000 children and saved about $8 million in state general funds. There are many other outreach efforts that could promote these programs, including paid and unpaid radio, television, and print materials. Obviously, highly successful outreach efforts could expand the number of individuals enrolled in the program and thus increase Medicaid costs.

IV. Develop and implement initiatives that would reduce the cost of Medicaid and Kids Connection programs and use these savings to expand these programs (e.g., increase eligibility levels from 185 to 200 percent of the Federal Poverty Level for the Kids Connection program).

Description and Rationale: The basic premise of this recommendation is that there are initiatives than can be implemented where direct cost savings can be identified. Once these savings have been generated, they will be used to expand Medicaid and/or Kids Connection eligibility without a reduction in benefits. The net result is a direct increase in health insurance coverage.

Although the Coalition considered several possible programs, including a greater expansion of home and community-based long-term care services, the cost-reducing programs should focus initially on developing a disease management program and joining a multi-state purchasing pool to negotiate lower prescription drug costs.

A. Disease Management Programs

Disease Management (DM) programs have the potential to reduce health care costs by reducing fragmentation and unnecessary use of services, preventing avoidable conditions, and promoting self-care. DM programs identify high-risk patients with selected chronic conditions such as diabetes, asthma, heart disease, mental health, and cancer and target interventions based on the level of severity. These interventions should be based on evidenced-based practice guidelines that have been well-documented in clinical studies. Once the guidelines are in place, a rigorous evaluation would be conducted to measure the impact on health outcomes and the cost effectiveness of the interventions. The cost savings would be used to expand the number of individuals who are eligible for the Medicaid and Kids Connection programs.

In 2004, the Centers for Medicare and Medicaid (CMS) decided to pay for direct medical services that are provided under disease management. Direct medical services, which include medical assessments, disease and dietary education, and instruction in self-management, are matched at the regular medical assistance rate (i.e., about 60 percent federal and 40 percent state). However, administrative expenses are only matched at 50 percent.

Before implementing a disease management program, some key questions must be answered, including:

- What disease categories should be included?
- What evidenced-based standards should be used? Ideally, there should be consistent and common standards for both public and private plans.
- What incentives should be used to encourage physicians and other health care providers to follow the standards?
- Should a vendor be hired or should the DM program be developed and administered within the state Medicaid program? If it is administered internally, what additional capacity is needed?
- What is the likely return on investment in the program? How can the potential savings be identified?

Advantages: By targeting high-risk patients with chronic conditions, disease management programs have the potential to reduce Medicaid costs and improve the quality of care. Also, these programs are relatively inexpensive to set up and there are federal matching funds available.

Disadvantages: Even though Medicaid clients tend to be less healthy, not all disease management programs have produced savings. In addition, appropriate incentives are needed to encourage providers to participate in the program. Finally, some start-up state funds are needed to develop and administer the program.

Target Groups: Low income children and adults that are not currently eligible for Medicaid and Kids Connection

Cost: Although the early studies did not find evidence of cost savings for DM Medicaid programs, the results of more recent studies suggest that DM programs save money. These programs generate savings by avoiding unnecessary hospitalizations and expensive diagnostic tests. They also improve the quality of care and increase patient satisfaction by providing the most clinically relevant treatments at the most appropriate time.

B. Join a Multi-State Purchasing Pool to Negotiate Lower Prescription Drug Costs

Because rising pharmaceutical costs are a major contributor to the growth of Medicaid expenditures, several states have joined multi-state pools in an effort to gain increased program purchasing power, improve benefits management, and generate cost savings.

By joining together, states can greatly enhance their bargaining power, usually through a common pharmacy benefits manager (PBM), when negotiating drug prices with manufacturers. The potential savings to states grow as more states join the pool because prices and rebates are tied to volume. Although pooling initiatives use formularies and preferred drug lists, each state establishes a

separate contract, usually with a common PBM, and makes its own decisions about preferred drugs.

Group purchasing arrangements that use PBMs can also improve the quality of care because PBMs are in a better position to identify best practices in disease and benefit management. For example, PBMs have access to state-of-the-art evidence-based preferred drug lists and/or formularies. PBMs may also have the capacity for enhanced drug utilization review, which allows for a more accurate analysis of prescriber habits and monitoring the treatment of patients with complex needs.

Advantages: There are documented savings from joining a multi-state purchasing pool. For example, Alaska has saved over $1 million a year, and West Virginia has saved over $7 million the first year. In addition, the quality of care may improve, particularly for patients with complex medical needs.

Disadvantages: At this time it is uncertain if any cost savings will result from joining a multi-state purchasing pool. In addition to negotiated rebates, the Nebraska Medicaid program has significantly reduced pharmaceutical costs in the past three years by expanding the use of generic drugs and requiring prior authorization. The Nebraska program may not be compatible with the requirements of a multi-state pool because most other states that have joined pools have relied on a strictly administered formulary and a preferred drug list. However, formularies and drug lists reduce provider prescribing flexibility and limit client medication choices. In addition, PBMs often charge high administrative costs (e.g., about $1 million in Alaska).

Target Groups: Low-income children and adults who are currently not eligible for Medicaid and Kids Connection

Cost: It is difficult to estimate the potential savings from joining a multi-state purchasing pool. Pools have generally attempted to control costs through formularies and preferred drug lists. In contrast, the Nebraska cost containment strategies have emphasized prior authorization and the use of generic drugs, and this approach has generated greater than average cost savings. However, it may be possible for Nebraska to become part of a multi-state pool and negotiate its own drug prices without having to adopt a formulary or a preferred drug list.

V. Expand Medicaid income eligibility levels.

Description and Rationale: One of the most direct ways of reducing the number of uninsured is to expand Medicaid and/or Kids Connection income eligibility levels. For example, some states now cover all adults that have incomes up to 100 percent of the Federal Poverty Level. Other states have expanded their State Children's Health Insurance Program to cover all children who do not have health insurance coverage and family incomes below 250 percent of the Federal Poverty Level. In contrast, the

maximum income eligibility level for the Nebraska Kids Connection program is 185 percent.

Several states have taken advantage of the flexibility in the federal law to implement new coverage options. In order to expand coverage to more low-income populations, states may change the benefit packages and perhaps require cost sharing for "higher" income populations. In most cases, however, a federal waiver is required. In exchange for greater flexibility in the Medicaid program, the waiver application must demonstrate that more people can be covered without increasing the federal share of expenditures. When the waiver requests are budget neutral, the financial burden falls on the state. However, there are other cases where income eligibility levels increase (e.g., expanding income eligibility levels for Kids Connection from 185 percent to 250 percent of the Federal Poverty Level) where a waiver is not needed and the federal government would pay its normal share of the cost.

Advantages: Expanding income eligibility for Medicaid and/or Kids Connection is an effective strategy for providing insurance coverage for low-income individuals. Also, the administrative structure is already in place. Finally, there are several expansion options where the federal government will pay at least 60 percent of the cost.

Disadvantages: A major expansion would require an increase in state funds. Given the passage of LB 709, it does not appear that there is sufficient political support to significantly expand the program at this time. LB 709 requires the development of a Medicaid Reform Plan, which must include recommendations to moderate the growth of spending and ensure fiscal sustainability. The Plan must be submitted to the Governor and the Legislature by December of 2005.

Target Groups: Low-income children and adults

Cost: Depending on whether a waiver is needed, the state must pay up to 40 percent of the expansion costs. If a waiver is required, the federal share remains budget neutral although there is greater flexibility in the eligibility, benefits, and cost sharing options.

Improving Access to Private Health Insurance Coverage

A third major coverage expansion direction is to provide incentives that will encourage small employers and self-employed individuals to offer coverage. Small employers and self-employed individuals in the non-group market generally pay higher than average premium costs and have less coverage. As a result, coverage expansion strategies are needed to stabilize the cost of insurance premiums and provide incentives to small employers and self-employed individuals to offer insurance coverage.

VI. Create Public-Private Partnerships Between Small Employers and Medicaid

Description and Rationale: Some states have expanded coverage by creating premium assistance programs. In these public-private partnership programs the state, the employer,

and usually the employee share the cost of the premium. In a proposed Oklahoma plan, for example, the employer would pay 25 percent of the premium, the employee would pay 15 percent, and Medicaid would pay the remainder of the premium. The program is limited to employees and their spouses that have a household income at or below 185 percent of the Federal Poverty Level and work in firms with 25 or fewer workers. Unemployed workers who are seeking work are also eligible.

Of course, there are many variations depending on the state. For example, the share paid by the employer, the employee, or the Medicaid program can be higher or lower. Also, in some states, the program includes employers with 50 or fewer employees and the income levels may be higher or lower.

Advantages: Several states have been successful in expanding coverage with premium assistance programs. Also, the state's share of the costs is lower because the employer and employees are paying for part of the cost of the premium. In addition, these types of programs have less "stigma" than programs that are totally subsidized by the government. Finally, these programs reduce "crowd out" (i.e., replacing private health insurance coverage with a public program).

Disadvantages: With these programs, there are high administrative costs for both state government and employers. In addition to higher administrative costs, new state funds are needed for Medicaid expansion. Finally, a waiver is needed from the federal government and federal outlays must be budget neutral.

Target Groups: Low-income adults and employers with low-wage workers

Cost: Although the costs are shared among employers, employees, and state government, some new state funds are needed. Also, the administrative capacity of the Medicaid program would need to be expanded.

VII. Conduct a Study to Determine the Feasibility of Implementing a Publicly-Funded Reinsurance Program

Description and Rationale: A reinsurance program attempts to make insurance premiums more affordable for small employers and self-employed individuals. In this program, public funds would be used to subsidize the purchase of a reinsurance policy which would cover claims above a certain threshold (e.g., $25,000) for small employers of a certain size (e.g., under ten employees). Because the state picks up a portion of the insurer's high cost claims, the premiums are likely to be lower and more stable from year to year. The availability of state-funded reinsurance should be linked to state approved plans that are targeted at low income, uninsured individuals, and small employers.

Advantages: Reinsurance programs can leverage employer contributions to cover more people with public funds. These programs have been effective in a few states and they have reduced insurer costs because they can be less aggressive in underwriting and

marketing. Also, because of less risk of paying high cost claims, insurers are likely to hold less surplus funds which should reduce the premium costs.

Disadvantages: Publicly funded reinsurance programs require state subsidies and substantial marketing efforts are needed to advertise the program. Finally, a complex study is needed to determine which employer groups should be eligible, what should be the threshold levels, what policies are needed to limit the problems of adverse selection, how can "crowd out" be eliminated, and how will the program be financed.

Target Groups: Small employers that purchase health insurance in a small group market and have significant numbers of uninsured and low-wage workers. Self-employed individuals who purchase in the non-group market.

Cost: A comprehensive study must be undertaken before the actual costs can be calculated. Based on the experience of other states, the cost of reinsurance programs vary depending on the scope of the program. For example, changing the threshold level from $25,000 to $40,000 would result in a lower cost. Also, a narrow definition of the target employer groups could significantly change the cost. However, it appears that substantial subsidies may be needed as an incentive for employers to participate in the program.

VIII. Create a Pharmacy Clearinghouse to Assist Eligible Consumers in Receiving Medication Discounts

Description and Rationale: Currently, nearly all pharmaceutical manufacturers offer prescription drug discounts to low income consumers. However, many eligible consumers lack the necessary information and perhaps the knowledge about how to access these programs. If a pharmacy clearinghouse was established, it could serve as a resource for identifying discounted drugs and distributing them to qualified individuals. The clearinghouse could also assist physicians and other health care providers in preparing the appropriate forms and other necessary paperwork.

The clearinghouse could be financed by state government, but it would not be a government agency. It would not compete with local pharmacies nor would it decide the type of medications that should be taken.

Advantages: The clearinghouse can serve as a resource for identifying discounted drugs and assist qualified individuals in accessing these medications. It is relatively inexpensive to organize and is not part of state government.

Disadvantages: Other than the cost of establishing the program, there are no major disadvantages.

Target Groups: Low-income children and adults

Cost: There would be a cost to establish a central pharmacy clearinghouse. However, many of the start up costs could be paid with state funds or possibly by grant dollars.

IX. Provide education and training to consumers and small employers about the benefits of health insurance coverage and the advantages and disadvantages of various policies.

Description and Rationale: Based on the focus group interviews, it became clear that some small employers, new refugees, and consumers in general lack the knowledge and information that is needed to make good decisions about health insurance policies. For example, some employers wanted to know what options are available to them and what are the potential costs. For new refugees and other immigrants who have recently settled in Nebraska, some did not understand the terms coinsurance and deductibles as well as the services that are covered. Many of these individuals have come from countries where the government provided health care services and our "private" system was confusing to them. In designing education programs for new refugees, it is important to have face-to-face contact as much as possible and have presenters who are able to speak the appropriate language. Educational materials should also be translated into several languages.

In addition to these groups, a statewide information campaign is needed to inform people, especially young adults, about the need for health insurance coverage. Perhaps as part of a financial management class or a health class, a module could be developed about the importance of health insurance coverage. It would be an opportunity for students to learn about how the health insurance system operates in the United States and the definitions of certain terms (e.g., premium, deductible, co-insurance).

Advantages: Depending on the scope, education and training programs for consumers and employers should be relatively inexpensive. It also provides an opportunity to teach people about the health insurance system.

Disadvantages: Although there is interest in these programs, it may be difficult to reach the key target audiences (young adults, new refugees, and small employers).

Target Groups: Primarily small employers, self-insured individuals, new refugees and immigrants, and young adults

Cost: Depending on the magnitude and frequency of the programs, the cost should be fairly minimal.

Implementation Efforts

The coverage expansion options previously discussed have recently been approved by the Nebraska Health Insurance Policy Coalition. Until they are approved by the Policy Cabinet of the Health and Human Services System, however, no implementation efforts will be initiated. The recommendations approved by the Policy Cabinet will be forwarded to the Governor and the Legislature. It is likely that legislation will be proposed on some of the less expensive options.

Policy Options Not Selected

Several options were considered by the Coalition, but they were not included in the final recommendations. The primary reasons for eliminating these options were because of the current political and economic environment or they did not appear to be very effective based on the experiences in other states. For example, creating a purchasing pool that would allow small employers and self-employed individuals to buy-in to an existing pool such as the state employee's plan was not politically feasible. Individual or employer mandates were also considered politically unfeasible. Limited benefit or "mandate-lite" policies and small group market reforms did not seem to be effective in other states nor has Nebraska's experience with these coverage options given any indication that they would be successful in the future. Tax incentives at the state level also have not been very successful in other states.

The Problem of Eligible But Not Enrolled in Public Programs

One of the major recommendations of the Coalition is to expand outreach and marketing efforts to enroll all eligible children and adults in the Medicaid or Kids Connection programs. These efforts will build on existing initiatives and involve a variety of public and private partnerships.

Section 5. Consensus Building Strategy

Effectiveness of the Governance Structure

The 28-member Nebraska Health Insurance Policy Coalition was organized soon after the State Planning Grant was received. It included representatives from state agencies such as the Health and Human Services System, the Medicaid program, the Department of Insurance, and the Department of Labor. It also included key state legislators, insurance companies, large and small businesses, the Chamber of Commerce, the State's two academic medical centers, and the major associations such as the hospital, medical, public health, minority health, and nurses. The Governor's Office was represented by the Chief Medical Officer of the Health and Human Services System, which was also the lead agency. The Coalition was responsible for overseeing and guiding the project as well as developing the final recommendations.

This diverse Coalition has brought a variety of different perspectives to the planning process. Many Coalition members informed their constituents of the issues that were debated at various meetings. As a result, the meetings were highly interactive and several viewpoints were expressed.

Methods for Obtaining Input from the Public and Key Constituencies

Several methods were used to obtain input from the public and key constituencies. One of the methods used was to organize six town hall meetings across the state. The purpose of the meetings was to present the rationale and the advantages and disadvantages of each of the proposed coverage expansion options during the first part of the meeting. After the formal presentation, participants were asked to provide comments and feedback on the proposed options. A local facilitator led the discussion and the comments were carefully recorded.

A total of 275 people attended the town hall meetings. A wide variety of comments and perspectives were expressed which have been placed on the following web site: www.hhs.state.ne.us/puh/oph/grant.htm. Local media were also generally present at the meeting.

In addition to the comments from the meeting, participants were asked to rate each of the nine proposed coverage options by indicating their level of support. Although there was some variation, the vast majority of the respondents either strongly supported or supported all of the options. The range was 91 percent for expanding the use of the 340B drug discount program to 62 percent for developing a publicly funded reinsurance program. In the case of the reinsurance program, about 28 percent of the respondents were neutral and several people commented that they did not fully understand the benefits of the program.

Another method that was used to obtain feedback on the policy options was through focus group interviews. A total of nine focus group interviews were conducted in May of 2005 for the specific purpose of gathering input on the proposed options. For the most part, the nine focus groups were similar to the groups that were conducted in the spring of 2004. In the original focus group interviews, however, most of the discussion emphasized the magnitude of the

problem and the barriers to accessing health insurance coverage. The second round of focus group interviews was held in both urban and rural areas and included the following groups:

- African Americans
- Rural Hispanics
- Urban Hispanics
- Micro/Self-Employed
- Young Adults
- Urban Small Employers
- Rural Small Employers
- Agents and Brokers
- Advocates of Refugees

The participants in the focus group interviews generally expressed strong support for the proposed coverage options, but there were some concerns about the proposals. For example, some small employers were concerned about the administrative burden of implementing a premium assistance program. Also, a reinsurance program should be available to all small employers of a certain size, regardless of whether they currently offer insurance coverage.

A final method of obtaining feedback on the proposed coverage options was for staff to make presentations at conferences (e.g., Nebraska Rural Health Association). Also, both staff and Coalition members met individually with selected groups.

Once the town hall meetings and the focus group interviews were completed, all of the information was given to the Coalition members. Because of the strong support for the coverage options, the Coalition formally approved them with some minor editing changes.

Other Activities to Build Public Awareness and Support

The State Planning Grant staff has worked actively with the media in promoting the town hall meetings. Several interviews were conducted before and immediately after the town hall meetings. Also, a general press release was issued.

In addition, a web site has been established that includes information for accessing key reports (e.g., household and employer surveys) as well as the comments from the town hall meetings and the final report.

Impact of the Planning Effort on the Policy Environment

Prior to the start of the planning initiative, there was no coordinated effort in Nebraska to expand insurance coverage. Based on the number of legislative bills introduced in the past several years, it appeared that this issue was a relatively low priority for the Governor, the Legislature, and major health associations. Although a strong state champion still does not exist, this planning effort has created an awareness of the key problem areas and the potential state solutions. It is obvious from the discussion in the Coalition meetings, the town hall meetings, and

the focus group interviews that this is an issue that many people in Nebraska are very committed to finding a solution.

The Coalition has always operated under the premise that although a few of the recommendations can be implemented in a short period of time at a low cost, it will take a few years to build the support that is needed to finance a major coverage expansion option. However, if the Nebraska state budget continues to improve, it is possible that some of the more comprehensive options could be implemented.

Section 6. Lessons Learned and Recommendations to States

Importance of State-Specific Data to the Decision-Making Process

The availability of state specific data has been very valuable in designing targeted policy solutions. Until the household and employer surveys were conducted, Nebraska had to rely on national and state surveys which were more limited in scope and had considerably smaller sample sizes. The survey data associated with this project have enabled staff to develop more detailed profiles of the uninsured at both the state and regional levels. The profiles allowed the Coalition to develop more targeted coverage options.

The qualitative research components were very helpful in putting a "human face" on the uninsured problem and providing greater understanding of the information provided in the household and employer surveys. For example, some of the barriers faced by small employers and new refugees provided significant insights. Also, the more recent focus group interviews with small employers, racial and ethnic minorities, and others were helpful in confirming that the proposed policy options were realistic and mainly on target.

Most Effective Data Collection Activities

All of the quantitative and qualitative data collection activities were very useful. The information obtained from the household and employer surveys as well as the focus group interviews were used to develop the coverage expansion options. Because of the large amount of information that was generated from the project, considerably more analysis needs to be done to fully analyze the data.

Data Collection Activities Proposed but not Conducted

All of the data collection activities that were proposed in the original grant and the one-year no cost extension were completed.

Strategies to Improve Data Collection

Several strategies were employed to improve the data collection activities. The first strategy was to use local contractors that have both experience and expertise. For example, the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center conducted the household survey and all of the focus group interviews. Staff at the Center not only have excellent skills and knowledge, but also the experience of working in Nebraska. The familiarity with some of the unique problems and barriers in the state was especially helpful in conducting the 22 focus group interviews. Also, the Nebraska Department of Labor conducted the employer survey. In the past, the Department has completed numerous employer surveys although the survey for this project contained many more health insurance questions. Since many employers have participated in many of the Department's surveys, the overall response rate was probably higher than if some other organization had done the survey.

Another successful strategy was to ask members of the Coalition to suggest key contacts for the focus group interviews. These contact suggestions were particularly important in recruiting racial and ethnic minority participants and small business representatives.

A final strategy was to translate the household survey into Spanish so that a greater number of Hispanics could participate in the survey. Translators were also used in a few of the focus group interviews. Because of the translators, it was possible to recruit a more diverse group.

Additional Data Activities Needed

Although a fairly extensive employer survey was conducted, it would be helpful to have additional information about the factors that influence employers to offer coverage and the types of plans that appeal to them. For example, another planning grant proposal was recently submitted that would provide funding to survey small employers and self-employed individuals who currently do not offer health insurance coverage to identify what would be an acceptable benefit package(s) and what costs would they be willing to pay for various plans. These questions would also be asked of employees who currently do not have health insurance coverage. With more complete information, it would be easier to develop more targeted and acceptable coverage expansion options such as premium assistance or publicly funded reinsurance programs.

It would also be advantageous to routinely collect household and employer health coverage data. Regular surveys would provide documentation of the problem on a longitudinal basis and, of course, it would allow a more accurate evaluation of how successful the coverage expansion programs and policies have been.

Organizational and Operational Lessons Learned

No major structural changes were made as a result of the State Planning Grant. During the course of the grant, it became obvious that a closer day-to-day working relationship is needed between the Nebraska Health and Human Services System, the lead agency, and the Department of Insurance. Although a combination of public and private strategies has been proposed, many of the private strategies would directly or indirectly involve the Department of Insurance.

Lessons Learned about the Insurance Market and the Employer Community

The Nebraska project provided useful information about the magnitude of insurance coverage across the state and in the six health planning regions. It was learned that few insurers offer plans in the small and non-group markets. In addition, the plans that are offered tend to cost more and have fewer benefits. As a result, fewer employees purchase the policy and more are underinsured. The problem of underinsurance appears to be growing, given the dramatic use in the level of uncompensated care provided by safety net providers.

At this point, it is difficult to predict how the health plans will respond to the proposed coverage expansion options. However, in the discussions with some of the major insurers (e.g.,

Blue Cross Blue Shield of Nebraska and Mutual of Omaha) in the state, there appears to be a willingness to explore the development of new products that offer good benefits at a reasonable cost.

The most important lesson in working effectively with the employer community is to involve them in the process. Both large and small employers as well as the Chamber of Commerce were represented on the Coalition. Input was also received from small employers through the focus group interviews and the town hall meetings.

Key Recommendations for Other States

One of the major recommendations for other states is to use qualified local contractors whenever possible. Local contractors are more likely to understand the political environment and they usually have greater credibility with stakeholders. A second recommendation is to find and/or develop champions across the political spectrum. Without strong champions, it is not possible to move comprehensive coverage options forward.

Some other recommendations include:

- Before developing coverage expansion options, it is important to identify a set of guiding principles and the target populations.
- National experts and the experiences of other states can be very helpful.
- In a state where covering the uninsured has not been a high priority for policy makers, it takes time to build a consensus on coverage options.

Changes in the State's Political and Economic Environment

There were some changes in the state's political and economic environment during the course of the grant. In the political environment, the most significant change was that a new Governor took office in January of 2005. This change was unexpected because Governor Johanns' term did not end until January of 2007. However, he was nominated by President Bush to be the Secretary of Agriculture. When Governor Johanns was confirmed, Dave Heineman became the new governor. A few months later, Richard Raymond, the Chief Medical Officer and the member of the Coalition representing the Nebraska Health and Human Services System and the Governor's Office, resigned to become the Undersecretary of Food Safety in the Department of Agriculture. Although all other key staff remained the same, the sudden change in the Governor made it difficult to determine the level of support for the policy options.

In terms of the economic environment, some positive changes have occurred. When the State Planning Grant was awarded in September of 2003, the state was experiencing a serious budget shortfall. By the summer of 2005, the budget situation had improved significantly. However, rising Medicaid outlays threaten the stability of the budget, making a major public expansion unlikely for the next couple of years.

Changes in Project Goals

The basic project goals did not change during the grant period. The one-year no cost extension allowed the Nebraska Center for Rural Health Research to conduct a study of the safety net providers and the changes in the levels of uncompensated care for inpatient hospital services, community health centers, and rural health clinics. This study was not part of the original proposal nor were the nine additional focus group interviews that were completed in order to obtain feedback on the proposed coverage options.

Next Steps

At this time the proposed coverage expansions are under review by the Governor's Office and the legislature's Health and Human Services Committee. It is anticipated that there will be strong support for some of the recommendations and project staff will be involved in helping to organize the implementation efforts.

As previously mentioned, a new planning grant proposal was submitted a few months ago and a decision on this application should be made soon. If the grant funds become available, they will be used to survey selected small employers in both rural and urban areas who do not offer health insurance coverage and employees who do not have an insurance plan. The purpose of the surveys is to determine what types of benefit packages would be acceptable to employers and employees and then consult with insurers to determine what the premium costs would be.

It is recognized that the desired level of benefits would probably not match what employers and employees would be willing to pay for the plan. At this point the Coalition will make further recommendations as to the types of coverage expansions (e.g., premium assistance reinsurance, etc.) would be the most effective in expanding insurance coverage.

Section 7. Recommendations to the Federal Government

Coverage Options Requiring Federal Waivers or Other Changes

Several of the proposed coverage options may require federal waivers or other changes. For example, federal waivers may be needed if a decision is made to expand Medicaid enrollment by increasing the income eligibility requirements. Also, if a premium assistance program is proposed, a federal waiver will be needed.

In terms of other changes, it would be desirable for HRSA to fund demonstration projects that allow more flexibility in the types of entities that qualify for community health center funding. For example, rural health clinics and/or critical access hospitals serve many patients without health insurance coverage. Although both of the hospitals and clinics receive cost-based reimbursement from Medicare and Medicaid, they are not eligible for federal grant funding nor do they qualify for the 340B prescription drug discount program. Funding and eligibility decisions should be made primarily on the basis of which entities are treating uninsured patients.

In addition to more flexibility in the community health center program, the federal government needs to continue its strong financial support for community health centers. This support is essential for both new and existing centers. Finally, the federal government should fund federal demonstration programs to support innovative approaches for purchasing prescription drugs under the Medicaid program.

Changes in Federal Laws for Coverage Options Not Selected

Based on the experience in Nebraska and other states, a purchasing pool for small businesses was one of the options that was not selected. In Nebraska it has been extremely difficult to organize large pools of small employers. Also, when pools have been formed, generally only one or two insurers have submitted competitive bids so it has been difficult to negotiate significantly lower rates. As a result, the federal government could fund demonstration projects that encourage the organization of large multi-state purchasing pools for small businesses.

Several other options could become more viable if there was greater federal support. For example, state tax incentives could become a more effective strategy if there was a federal tax credit for employees who work for small businesses. Also, employer mandates could be a viable option with strong support and subsidies for small businesses that employ mostly low-income workers.

Other Federal Support

Access to state and regional level data is critical for developing relevant state coverage options. These data can now serve as a baseline to compare similar survey information in subsequent years. Comparable data can be used to analyze changes in insurance status and evaluate the impact of various policy options that have been implemented.

Additional Research on the Uninsured

Additional research is needed on the factors that are driving health care costs, including Medicaid costs. The dramatic rise in Medicaid expenditures has made it difficult for Nebraska to balance its state budget. Although policymakers understand that Medicaid costs are rising rapidly and threaten other priority programs, the main reasons why these costs are increasing are not well understood.

A second area where additional research is needed is underinsurance. In many parts of the state the problem of underinsurance appears to be almost as severe as the uninsured. Having a better understanding of the problem could result in more effective policy solutions.

Finally, more research is needed to determine the factors that influence small employers to offer coverage. Also, what benefits must be included in the plan and how much can they afford to pay for these plans. For Nebraska to be successful in reducing the number of uninsured, more small employers must offer acceptable plans to low-wage workers.

APPENDIX 1

Baseline Information

Population:

2001 - 1,711,263
Source: U. S. Census Bureau

Number and Percentage of Uninsured (Current and Trend):

2001	162,570	9.5%
2002	164,281	9.6%
2003	177,971	10.4%

Source: U. S. Census Bureau, Current Population Survey

Average Age of Population:

35.3
Source: U. S. Census Bureau

Percent of Population Living in Poverty (<100% FPL):

2003 9.9%
Source: U. S. Census Bureau

Primary Industries:

Manufacturing, Trade, Services, and Agriculture
Source: Nebraska Department of Labor

Number and Percent of Employers Offering Coverage:

2004 66%
Source: Nebraska Department of Labor, Survey of Employers, 2004

Number and Percent of Self-Insured Firms:

Number of firms - 14,014; Percent - 28.3%
Source: MEPS-IC, 2002

Payer Mix:

Employer	58.5%
Public	25.0%
Self-Insured	8.0%
Individual	8.5%

Source: Nebraska State Planning Grant Survey, Nebraska Center for Rural Health Research, 2004

Provider Competition:

Limited managed care plans are available in Nebraska. Currently, there are only three HMO companies that are licensed in Nebraska and there is only one company that provides a managed care option to Medicare beneficiaries. The estimated enrollment is less than ten percent of the total population.
Source: Nebraska Department of Insurance

Insurance Market Reforms:

- Creation of the Nebraska Comprehensive Health Insurance Pool (CHIP) in 1985.
- Enactment of small employer insurance reforms in 1994. These reforms were designed to spread adverse risks among all carriers writing small group policies in Nebraska. The law also required insurers to sell and renew insurance for employers that have between three and twenty-five employees, as long as the premium is paid. Insurers must offer both a standard and a basic plan for small employers without riders or endorsements that limit coverage. Another provision required that group policies be sold on a "guaranteed issue" basis. If a person applies for coverage, he or she cannot be turned down. Finally, the law set limits on premium increases for small employer plans and waiting periods for coverage of pre-existing conditions for people who move from one small employer to another are waived.
- Amendments to the anti-group statutes in 1994 allowed voluntary insurance buying groups. This amendment enables a group of individuals as small as 25 persons to purchase health insurance at group rates through purchasing pools.

Eligibility of Existing Coverage Programs (Medicaid/SCHIP/Other):

Medicaid

- Children under age six are eligible if income is less than 133 percent of the Federal Poverty Level (FPL).
- Children under age one are eligible if income is less than 150 percent of the FPL and pregnant women are covered up to 185 percent of the FPL.
- Children between the ages of six and 18 are eligible if income is less than 100 percent of the FPL.
- Individuals and families receiving cash assistance through ADC are automatically eligible.
- Disabled adults with net incomes of less than 250 percent of the FPL can "buy in" to the program.

State Children's Health Insurance Program

Nebraska covers children aged 18 and under whose family income is at or below 175 percent of the FPL. SCHIP is an expansion of the Medicaid program so the benefit package is the same.

Use of Federal Waivers:

Nebraska received a 1915(b) waiver to create a Medicaid managed care program in 1997.

APPENDIX 2

Survey Methodology and Weighting

Sampling Methodology

The survey was a stratified random digit dial telephone survey. One of the goals of the survey was to estimate the uninsurance rate for each of the six planning regions in the state. The sampling strategy was designed to obtain a sufficient number of completed interviews in each of the six geographic regions. In order to do this, the survey was conducted as a stratified random sample, where the strata were geographic areas.

Another goal of the survey was to estimate the uninsurance rate for African Americans and Hispanics. To obtain sufficient sample sizes for these two minority groups, certain sub-county areas that were estimated to contain higher than average concentrations of these groups were over-sampled.

The sample for the survey was telephone numbers stratified by telephone exchange. Within each telephone exchange stratum, each telephone number had an equal probability of selection. Within each household that participated in the survey, one person was selected at random to participate in the survey.

Response Rate

A total of n = 3,750 interviews were completed. The overall response rate was 70 percent, calculated as the number of completed interviews divided by the number of eligible reporting units in the sample. The eligible reporting units included completed interviews, partially completed interviews, termination in questions, refusals, language barrier, unable to communicate, hang up, telephone answering device, technical barriers, no answer and busy. For the stratified sample, a total of 3,192 interviews were completed with a response rate of 70 percent. For the minority over-sample, a total of 558 interviews were completed with a response rate of 67 percent.

Weighting of Survey Responses

When data are analyzed without weights, each record counts the same as any other record. This requires the assumption that each record has an equal probability of selection and that non-response rates are equal among all segments of the population. When these assumptions are violated, weighting each record appropriately can help to adjust for assumption violations.

Thus, survey weights were used to adjust for the complex sampling design, in which telephone numbers were sampled with different probabilities of selection in order to obtain reliable estimates for the six planning regions and African Americans and Hispanics. Additionally, households with more than one telephone line had a higher change of being selected than households with one telephone line. Further, the probability of selection within each household varied depending on household size. The statistical weights were constructed to account for each of these factors that influence the probability of selection to participate in the survey. The statistical weights also take into account differences among the geographic strata and non-

response rates. The survey weights will force the total number cases within each geographic stratum to equal the population size for that stratum. Analysis was conducted using SUDAAN (REF) in order to obtain unbiased estimates of the standard errors.

In the U.S., approximately 95 percent of households have telephones. No direct compensation for non-telephone coverage has been used, however post-stratification weights were used and may partially correct for any imposed by non-telephone coverage. These weights adjust for differences in probability of selection and non-response, as well as non-coverage.

Detailed Description of Survey Weights

Sampling Strata

For constructing the survey weights, the strata are aggregations of telephone exchanges, combined to form the six geographic regions**.** We assume that within each strata (combination of area code + exchange telephone numbers), each telephone has an equal probability of selection.

The following formula reflects all the factors taken into account in the survey weights. If a factor does not apply, its value is taken to be 1.

PHH (probability of selecting a household)

PHH accounts for the differences in the basic probability of selection among strata (subsets of area code/prefix combinations). Each telephone number within a stratum has an equal probability of selection; however, two numbers from different stratum have different probabilities of selection.

PSPN (probability of selecting a phone number) =
(total number of phone numbers selected into the sample, whether it's a working phone line, fax, business line or not connected)/(number of 100 banks used by Genesys for sampling within a strata *100)

To determine the probability of selecting a household, the number of phone lines within a household needs to be taken into consideration.

PHH (probability of selecting a household) = number of phone lines within a household*PSPN.

The maximum allowed value of PHH is 3.

PHHADJ (non-response adjusted probability of selecting a household) =
PHH* [Response rate for geographic strata RSTRAT (region 1 through region 6)]

The response rate is the number of completed surveys (respondents) divided by the number of eligible phone numbers. The number of eligible phone number does not include business lines, fax lines, disconnects and any other known ineligible numbers but does include number for which eligibility could not be determined and also includes refusals.

BPP (Basic Person Probability)

Within in each household, one person was randomly selected to complete the survey. The basic person probability is the probability of selecting a person and is calculated by

BPP = PHHADJ/number of people in the household

BPW (Basic Person Weight)

The basic person weight is the inverse probability of selecting a person and is given by BPW = 1/BPP.

Post-stratification Weight

Post-stratification is used to adjust the basic person weights to match known population distributions in a given group.

FINALWT = BPW * (County population/Sum of the basic person weights in a post-stratified grouping)

Post-stratifying the basic person weights ensures that the sum of the person weights will equal known population distributions. For example, the number of people within a county can be used as the known population distribution. The county population totals from the Census 2000 were used for calculating the post-stratification weights.

APPENDIX 3

Income: Data Collection and Reporting

The target (or proxy) was asked to report their household's gross, pretax income from all sources for the year 2003, including money from jobs, net income from business, farm or rent, pensions, dividends, interest social security payments and any other money income received by members of the family who are 15 years or older. If the respondent was self-employed or owned their own business, they were asked to report their net income. Income reported as one million dollars or more was recorded as $999,996.

If the target refused or could not estimate their household's income, they were provided the list of income categories below and asked to indicate the appropriate income category for their household. The specific wording of the question was:

"How about if I give you some categories? Would you say your income is:

Less than $5,000
$ 5,000 and $ 7,499
$ 7,500 and $ 9,999
$10,000 and $12,499
$12,500 and $14,999
$15,000 and $19,999
$20,000 and $24,999
$25,000 and $29,999
$30,000 and $34,999
$35,000 and $39,999
$40,000 and $49,999
$50,000 and $59,999
$60,000 and $74,999
$75,000 or more"

A total of 2,533 of the 3,750 (68 percent) respondents reported their income using the first question (continuous response). The median income was $40,000 (minimum: 1, maximum: $999,996, 90 percent central range: $10,000, 120,000).

Of the 1,217 respondents that did not report their income as a continuous value, 666 reported their income using the categorical response question (see Table A.2.1 for the distribution of income for these 1,217 respondents). Thus, information on income was available for 3,199 respondents (85 percent) and was missing for 551 respondents (15 percent). For reporting purpose, income is reported as the percentage of poverty level using the 2003 Federal Poverty Level Income Guidelines (Table A.2.2). For respondents who only provided a categorical income response, the federal poverty level was determined based on the income range specified. If the income range covered more than one FPL category, the midpoint of the income range was used to determine the FPL category. For example if a household of one reported an income of $7,500 to $9,999, we cannot determine whether the true FPL category is 0-100 percent FPL or 100-200 percent FPL. Since the midpoint of the reported income range is $8,750, the FPL was taken to be 0-100 percent FPL.

Table A.2.1. Distribution of Income for 1,217 respondents who did not report income as a continuous response

Income Category	n (%)
Less than $5,000	40 (3%)
$ 5,000 and $ 7,499	23 (2%)
$ 7,500 and $ 9,999	36 (3%)
$10,000 and $12,499	36 (3%)
$12,500 and $14,999	29 (2%)
$15,000 and $19,999	58 (5%)
$20,000 and $24,999	74 (6%)
$25,000 and $29,999	47 (4%)
$30,000 and $34,999	48 (4%)
$35,000 and $39,999	37 (3%)
$40,000 and $49,999	56 (5%)
$50,000 and $59,999	46 (4%)
$60,000 and $74,999	51 (4%)
$75,000 or more	85 (7%)
Don't know	231 (19%)
Refused	320 (26%)
Total	1217

Table A.2.2. 2003 Federal Poverty Level Income Guidelines

Family Size	100% FPL	200% FPL	300% FPL
1	$8,980	$17,960	$26,940
2	$12,120	$24,240	$36,360
3	$15,260	$30,520	$45,780
4	$18,400	$36,800	$55,200
5	$21,540	$43,080	$64,620
6	$24,680	$49,360	$74,040
7	$27,820	$55,640	$83,460
8	$30,960	$61,920	$92,880

Source: "The 2003 HHS Poverty Guidelines," United States Department of Health and Human Services and Federal Register, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.

APPENDIX 4

Table 1. Summary of Nebraska State Planning Grant Uninsured and Underinsured Focus Group Participants

Focus Group	Location	Health Planning Region	Number of Participants	Number of Female Participants (%)	Number of Uninsured Participants (%)	Mode of Annual Household Income Range of Participants (number responding)	Number of Participants at 100% FPL or below[4] (% of those responding to income question)
Uninsured Hispanic	Lexington	II	10	9 (90%)	9 (90%)	$10,000 – $12,449 (10)	7 (70%)
Student	Milford	V	12	1 (8%)	12 (100%)	less than $5,000 (12)	8 (67%)
African-American	Omaha	VI	8	7 (88%)	8 (100%)	$10,000 - $12,499 (7)	6 (75%)
Uninsured Hispanic	Norfolk	IV	18	7 (39%)	14 (78%)	$10,000 – $12,449 (12)	9 (82%)
Urban Native American	Omaha	VI	10	6 (60%)	10 (100%)	$10,000 - $12,499 (8)	7 (88%)
Low Income	Columbus	IV	12	8 (67%)	12 (100%)	$7500 – $9999 (12)	10 (83%)
Refugee	Lincoln	V	7	5 (71%)	5 (71%)	$15,000 - $19,999[1] (5)	3 (60%)
Low Income	Tecumseh	V	10	8 (80%)	10 (100%)	$5000 – $7499 (10)	8 (80%)
Urban Hispanic	Omaha	VI	14	10 (71%)	14 (100%)	$10,000 – $12,499 (11)	10 (91%)
TOTALS			101	61 (60%)	94 (93%)	Less than $5000[3]	68 (67%)

1. The median was used because there was not a mode. Each respondent reported a different income range. Responses ranged from categories "less than $5000" to "$40,000 to $49,999."
2. Three people reported an income range of $65,000 or more. However, one participant reported an income range of $10,000 to $12,499, two participants reported an income range of $35,000 to $39,999, one participant reported an income range of $40,000 to $49,999, and another participant reported a range of $50,000 to $59,999.
3. The reported incomes from the focus group comprised of full-time students lowered the overall mode. When the student group is not considered, the overall income mode is $10,000 - $12,499.
4. See Table A.2.2 on page 44 for a description of the Federal Poverty Level (FPL) Guidelines.

Table 2. Summary of Nebraska State Planning Grant Small Employer Focus Group Participants

Focus Group	Location	Health Planning Region	Number of Businesses Represented	Average Number of Employees	Average Annual Salary Range of Employees	Number of Businesses Offering Insurance (%)	Average Range of Employee Participation in Employer Health Plan (of those offering coverage)	Participants Reporting that Coverage is "Very Important" or "Important" to Employees (%) [1]
Small Urban Employers (construction and service)	Omaha	VI	6	23	$15,000 - $19,999	4 (67%)	50% - 74%	4 (67%)
Small Rural Employers (agriculture)	Gering	I	6	13	$25,000 - $29,999	5 (83%)	75% - 99%	5 (83%)
Self-Employed/ Micro- Employers	Holdrege	III	8	4	$20,000 - $24,000	3 (38%)	100%	6 (75%)
Small Employers	Kearney	III	12	18	$30,000 - $34,999	9 (75%)	75% - 99%	11 (92%)
TOTALS			32	14	$25,000 - $29,999	21 (66%)	75% - 99%	26 (81%)

1. Categories to choose from were: "Very Important," "Important," "Somewhat Important," "Not at all Important," and "Don't Know."