Health Resources and Services Administration

New Hampshire State Planning Grant

Interim Report

March 2002

NEW HAMPSHIRE HRSA STATE PLANNING GRANT REPORT

TABLE OF CONTENTS

March 2002

Appendix H: Healthlink Program
Appendix I: Family Insurance Survey and Methodology
Appendix J: Consumer Focus Group Report
Appendix K: Employer Insurance Survey and Methodology
Appendix L Employer Focus Group Report
Appendix M: Legislative Briefing
Appendix N: Primary Care Case Management Conference Workbook
Appendix O: State Baseline Information
Appendix P: The Insurers' Perspective on the Health Care System, Insurance and the Uninsured
Appendix Q: Supplemental Bivariate Analyses of the Family and Employer Surveys

EXECUTIVE SUMMARY

In this first year of New Hampshire's State Planning Grant, our efforts have focused on clarifying our understanding of the gaps in insurance coverage. At the same time, the HRSA grant's advisory committee, the Senate Bill 183 Adult Coverage Subcommittee, has attempted to shift the debate towards a discussion that would lead to support for, or at least consensus on the issue of, the uninsured and expansions in coverage. We have collected information that brings to light some of the ways in which public and private efforts to expand coverage can be integrated. Finally, the information collection process, the communications strategies, and the attempts to build consensus that have occurred in the last year will help provide the Secretary and other states with the experience and insight that New Hampshire has been able to glean from these initial efforts.

Key Findings

The Uninsured:

- Lower-income individuals are much more likely to be uninsured than those with higher incomes.
- Adults 18 years of age or older account for more than three quarters of the uninsured in New Hampshire.
- Though younger adults are more likely to be uninsured, all ages are represented in the pool of the uninsured.
- Uninsured adults are largely working full-time (more than 30 hours per week) and a significant share has children.
- Geographic variation remains: The more rural parts of NH have significantly higher rates of uninsurance than urban areas.
- Uninsured individuals in both the consumer focus groups and the family survey indicated an interest in participating in a plan to extend coverage to working adults.

The Uninsured and Ability to Purchase Insurance:

- According to participants in the consumer focus groups, people are unable to afford insurance coverage though they are willing to buy insurance if they saw a benefit package at a reasonable price.
- A livable wage study indicated that individuals would have to make roughly 200% of the federal poverty level (varying by family characteristics and child care needs) before individuals can begin to pay for health insurance coverage. As a result, for most low-income uninsured, purchasing insurance is beyond their means.

The Uninsured and Employment:

- Eighty percent of uninsured working adults are either in firms that do not offer insurance coverage or are ineligible for that coverage.
- For those uninsured working adults with access to employer sponsored insurance coverage, the cost is prohibitive and benefits may be insufficient to meet the needs of employees.

- A significant portion of the uninsured work in small firms and these firms (those with 2-10 employees) are the least likely to offer insurance.
- Although individuals expressed interest in the state providing coverage in both the family survey and consumer focus groups, individual's ability and willingness to pay is relatively limited. Only 23% of uninsured working adults would participate in a program that cost $90 per month.

The Employment Based System of Insurance: While in some cases statistically insignificant, the bivariate analysis of the demand for insurance coverage among employers generally indicates that those employers not offering insurance coverage are unlikely to do so. Conversely, relatively small changes in premiums could significantly affect the offering behavior of those employers currently offering insurance coverage to their employers. Further multivariate analysis is being designed to further illuminate the impact of market changes on employers offering behavior.

- Relatively little can be done to induce small businesses to increase their offer of insurance coverage. Fifty percent of small businesses not offering coverage indicated that nothing could be done which would change their offer behavior.
- Relatively small increases in costs of private coverage could significantly erode private coverage. Almost 20% of employers indicated that a 20% increase in premiums would result in a termination of benefits or a decline in offer rates.
- Employers who participated in the focus group work indicated that cost is the major issue that affects their offer decisions and believe that competition – and the hypothesized resultant reduction in premiums – is the only mechanism that will expand coverage in New Hampshire.
- Employers in the focus group work were generally not supportive of a state/private partnership in expanding insurance coverage as they felt the tax burden of such initiatives would fall firmly on businesses.
- Employers in the focus group work felt that tax credits may be a viable policy model to expand coverage, however, some participants felt that the high cost of premiums would result in little take up.

Private Insurers Cost Control Measures: Interviews with key administrator from the three largest group insurers in the State (CIGNA HealthCare, Anthem Blue Cross Blue Shield of New Hampshire Inc, and Harvard Pilgrim Health Care) and the largest non-group insurer (American Republic Insurance Company) reinforced the importance of cost and suggested that the insurers may have exhausted what they considered viable options for controlling those costs. (See Appendix P). In general, the insurers indicated that:

- Cost was the primary factor that affected the decision to purchase coverage
- The rising cost of health insurance premiums were determined primarily by the increasing prices providers charged (i.e. physicians, hospitals and suppliers)
- They had relatively limited ability to negotiate more significant provider discounts or restrict patient access to services. Therefore, they felt that reductions in premiums could only be achieved by increasing the patients' financial obligations (that is, through increased deductibles, coinsurance and co-pays).

- The non-group market is the most expensive market to operate in.
- Increasing competition by increasing the number of insurance carriers would not solve the cost problem and might, in fact, aggravate it by producing a market with more carriers who have relatively less buying clout.
- Making the patient and employer more aware of the prices charged for services in the form of explanation of benefits and patient education had been tried in the past with only limited success.
- They were willing to work with regulators, elected officials and other carriers to develop less expensive insurance.

State Action on the Issue of Uninsurance

The advisory committee has been able to reach consensus on the need for action. This is embodied in the action statement:

"While most New Hampshire residents are able to take advantage of the state's strong employment based insurance coverage system, there are a significant number of low income adults in New Hampshire who cannot access or have difficulty accessing insurance coverage through an employer. As un-insurance and under-insurance have an impact on the use of timely and appropriate services and thus on the costs of the health care system as well as worker productivity, lower-income individuals need affordable health care coverage that emphasizes preventive services and care coordination. State policy should promote the development of creative solutions to address this significant need."

The most significant factor affecting insurance status is the financial ability of individuals to purchase health insurance. Recognizing this, the committee searched for quantifiable data to determine at what income level a family or individual has the resources to pay for health coverage. The committee reviewed research published in a report, "New Hampshire Basic Needs and Livable Wage," by the Josiah Bartlett Center for Public Policy (See Appendix A). The report reveals the level of wages necessary for families in New Hampshire to meet basic needs. Basic needs are identified as food, rent and utilities, basic telephone service, clothing and household expenses, transportation, childcare, health care, and a small allowance for personal expenses. The resulting "livable wage" varies based on family characteristics such as size and the need for outside childcare.

The committee further developed this data by excluding savings and expenditures for health coverage to calculate the minimum income needed before an individual or family can begin to pay for health coverage. The data shows that New Hampshire families need to earn wages at about 200% FPL or higher to meet their basic needs. These findings confirm that low-income households do need financial assistance in purchasing health care insurance. Households with incomes below 185% of the federal poverty level would require a great deal of financial assistance while those with incomes above that level would require less.

State Policy Considerations
Over three quarters of the uninsured are adults. Given expansions in coverage up to 300% of the federal poverty line for children through the state's Healthy Kids program, significant outreach

efforts, and a decline in the uninsurance rate for children, the findings from the first year of the State Planning Grant confirmed the need to target programs initially on adult coverage for the working poor.

The Committee has identified the need for action and targeted potential programs to those with the highest need. Three primary models have been identified which will be reviewed over the course of the next year. These three models are:

- Models which build on the employer market including
  - The One-Third Model, a quasi subsidy model,
  - Market reform which would expand commercial coverage,
  - Tax changes that would provide small businesses with incentives to offer insurance coverage, and
  - Multi-state regional insurance pooling for insurance products.
- Traditional subsidy expansions including an expansion of SCHIP to parents in families with incomes <= 185% of the federal poverty level.
- Safety net expansions that would expand access, but not coverage
  - Coordinated Care Management for the Uninsured and Medicaid recipients.

The HRSA State Planning Grant has substantially benefited New Hampshire. It has sustained New Hampshire's public policy attention and discussion regarding the uninsured. It has resulted in research that has presented policymakers, key stakeholders, and state agencies with an excellent understanding of the problem. In the second year of the HRSA State Planning Grant, the grant will benefit New Hampshire through our work to frame the possible policy and operational models.

Through the HRSA State Planning Grant Advisory Committee and consensus building strategy identified in the HRSA Grant, substantial time and effort will be dedicated to furthering state policy and building political will for improving access to care and insurance for the uninsured. While, this will no doubt be a difficult task at a time when state and federal resources are being redirected to stabilizing the economy and protecting its citizens from terrorism, the issues of the uninsured and health care costs will remain high on the public policy agenda. The issues will remain high on the agenda because employer insurance premiums continue to escalate and because an increasing number of employees are losing their jobs and health insurance coverage.

Federal Policy Considerations

Medicare Reimbursement. The root of the problem of uninsurance in part lies with federal policy. Federal Medicare reimbursement policy has shifted substantial public responsibility for health care costs to the private sector and resulted in rising private-sector insurance premiums. Insufficient Medicare reimbursements to the non-profit New Hampshire hospitals have resulted in millions of dollars of shortfalls that are being paid by private employers. Medicare hospital reimbursements must be improved to eliminate the need for cross-subsidization which in turn might reduce some of the pressure to eliminate the offer of coverage that businesses feel as a result of rising premiums.

Pharmaceuticals. Federal policy is also needed to address the rising cost of pharmaceuticals.

The cost and utilization of pharmaceuticals is driving substantial premium increases in Medicaid and private-sector insurance premiums. States such as New Hampshire have done everything short of extremely costly state-sponsored subsidy programs to improve access to pharmaceuticals for seniors and low-income adults. A Medicare benefit is needed for seniors who are choosing between food and maintaining their regimen of their doctor-prescribed medications. The 340B Drug Pricing program that benefits patients of Community Health Centers should also be expanded to other two other groups of safety net providers – Rural Health Clinics and Critical Access Hospitals. Combined, these policy changes could free up state resources to expand coverage to those in highest need.

Chronic Care Management. Further, federal policy is needed to foster best practices in chronic care management. A recent Institute of Medicine report demonstrates that protocols need to be developed and implemented for many chronic diseases if we are to improve quality of care and manage rising health care costs.

Fact Based Decision Making*:* Like other small states across the country, New Hampshire has historically relied very little on survey work to justify action (or inaction) with respect to public policy on the uninsured. In large part, this was due to the fact that current New Hampshire based estimates of the uninsured were unavailable. Those estimates that were available, for example from the Current Population Survey, often lagged two and sometimes three years behind the policy debate and lacked precision. At the same time, state staffs – untrained in statistical analysis – were often unable to analyze the information in a manner that was responsive to policy makers concerns. As a result, estimates like those produced by CPS have had little impact on the policy debates.

The State Planning Grant, however, has allowed New Hampshire to solidify its attempt to base decision-making on empirical evidence. First, the state-planning grant provided financial support for two surveys. Second, and perhaps more important, the State Planning Grants provided New Hampshire with the resources necessary to purchase the analytic resources required to be responsive to policy makers' questions. In the fast paced state policy environment, the ability to respond quickly to policy makers' questions has a large impact on whether the information can be used within policy debates.

While the information collection and consensus development activities have been helpful with respect to the issue of traditional expansions in coverage through subsidies, the work has also been helpful outside of this arena. Information gathered on the lack of pharmacy coverage facilitated the development of a waiver for pharmacy coverage for all New Hampshire citizens below 300% of the federal poverty level. In addition, the information was used to shed light on the potential impact of proposed legislation that would have repealed significant aspects of the state's health care reform efforts in the mid 1990s. While these aren't traditionally understood as public efforts at expanding coverage, they have sustained coverage that might have eroded.

In order to maintain the momentum developed with the first year grant activities, New Hampshire must develop the internal or external resources to continue being responsive to state policy makers' need for current information that is state specific. The federal government can support these initiatives in a variety of ways including providing additional funds for universities to provide these analytic skills or provide states with enhanced matching rates for efforts related to policy development in these areas.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

1.1 What is the overall level of uninsurance in New Hampshire?

The overall rate of uninsurance in New Hampshire in 2001 was 8.3 percent. **(See Table 1-1.)** The uninsurance rate was estimated with a confidence level of ?0.5 percentage points at a significance level of 5 percent. For the 5,177 insurance families surveyed under the HRSA State Planning Grant, results were enumerated for 13,808 individuals. Applying post-stratification weights based on 2000 census data, an estimated 89,813 individuals out of a total non-elderly state population of 1,087,815 did not have health insurance in New Hampshire in 2001.

1.2 What are the characteristics of the uninsured?

The characteristics of the uninsured in New Hampshire in 2001, based on a variety of demographic, income, family, employment and regional characteristics, are presented in Table 1-2 through Table 1-26.

Insurance Status by Gender

The uninsurance rate in New Hampshire was the same for males and females at 8.3 percent. **(See Table 1-2.)** In 2001, 45,056 males and 44,756 females were uninsured in the state. Uninsurance rates by gender were estimated with a confidence level of ?0.8 percentage points at a significance level of 5 percent.

Insurance Status by Age

Uninsurance rates by various age categories in New Hampshire are presented in Table 1-3 and Table 1-4. According to the survey results, the uninsurance rate among children below the age of 17 was significantly lower than the uninsurance rate among adults in the state. **(See Table 1-3.)** The uninsurance rate among children aged 0-17 was 5.1 percent (estimated with a confidence level of ?0.7 percentage points). In contrast, the uninsurance rate among adults aged 18-64 was 9.5 percent (estimated with a confidence level of ?0.6 percentage points.) In 2001, 15,891 children and 73,922 adults in New Hampshire did not have health insurance. Chi-square tests indicate that the difference in the uninsurance rate between children and adults was highly statistically significant.

Within the child population, the uninsurance rate was lowest for the very young. **(See Table 1-4.)** The uninsurance rate was 4.6 percent for children between the ages of 0-5 (estimated with a confidence level of ?1.3 percentage points), 5.3 percent for children between the ages of 6-11 (estimated with a confidence level of ?1.1 percentage points), and 5.3 percent for children between the ages of 12-17 (estimated with a confidence level of ?1-2 percentage points). However, differences in insurance rates between these childhood age groups were not statistically significant.

Among the adult population, the rate of uninsurance declined with age. Young adults were the most likely age group to be uninsured in the state. Individuals between the ages of 18-24 had an uninsurance rate of 16.0 percent, estimated with a confidence level of ?2.0 percentage points. The uninsurance rate begins to falls dramatically once adults reach the age at which they are most likely to enter the professional labor force on a full-time basis. The uninsurance rate was 12.9 percent for adults between the ages of 25-34 (estimated with a confidence level of ?1.5 percentage points), 8.1 percent for adults between the ages of 35-44 (estimated with a confidence level of ?1.0 percentage points), and 7.2 percent for adults between the ages of 45-54 (estimated with a confidence level of ?1.1 percentage points). By the time non-elderly adults reach the age of 55, the likelihood of their being uninsured was only 5.2 (estimated with confidence level of ?1.2 percentage points). Statistical testing reveals that these differences in uninsurance rates within the adult population are significant.

Insurance status by Income

The survey results further suggest that the likelihood of having health insurance in New Hampshire from any source, including both private and public payers, among the non-elderly population is strongly and negatively correlated with annual family income. **(See Table 1-5.)** The uninsurance rate among the lowest family income group (less than $25,000 per year) was 23.2 percent, estimated with a confidence level of ?1.9 percentage points. By the time families are earning at least $25,000 per year, the uninsurance rate is reduced by half at 11.6 percent, estimated with a confidence level of ?1.0 percentage points. The uninsurance rate continues to decline with income, reaching 4.9 percent among families with annual incomes between $50,000-$74,999 (estimated with a confidence level of ?0.7 percentage points) and 1.9 percent among families with incomes above $75,000 per year (estimated with a confidence level of ?0.4 percentage points). Population-based estimates suggest that there were 35,183 uninsured residents in New Hampshire with annual family incomes below $25,000, compared with only 6,554 uninsured individuals with family incomes above $75,000. Differences in the proportion of uninsured across family income categories are statistically significant.

Insurance Status by Family Composition

Uninsurance rates by family composition are presented in Table 1-6 through Table 1-9. Uninsurance rates were highest in single occupant households and decreased as household size increased up to four occupants. Once a family had four members, the uninsurance rate began to rise again. **(See Table 1-6.)** The uninsurance rate was 16.7 percent for households with one member (estimated with a confidence level of ??? percentage points), 7.8 percent for households with two members (estimated with a confidence level of ?0.9 percentage points), 8.1 for households with three members (estimated with a confidence level of ?1.0 percentage points) and 5.5 for households with four members (estimated with a confidence level of ?0.7 percentage points). The rate of uninsurance was 6.7 percent for households with five members (estimated with a confidence level of ?1.1 percentage points), 11.8 for households with six members (estimated with a confidence level of ?2.4 percentage points), and 11.8 percent for households with seven members (estimated with a confidence level of ?4.5 percentage points).

The survey results further show that likelihood of being uninsured was significantly influenced by the presence of a spouse in the household. The uninsurance rate for those

families where no spouse was present was 15.8 percent (estimated with a confidence level of ?1.3 percentage points). **(See Table 1-7.)** Chi square tests indicate that this number was statistically significant when compared to the uninsurance rate of 6.1 percent (estimated with a confidence level of ?0.5 percentage points) for families where a spouse was present.

Similarly, the presence of children in the family had a significant impact on uninsurance rates. Families without children had an uninsurance rate of 9.4 percent estimated with a confidence level of ?0.9 percentage points, compared with 7.8 percent estimated with a confidence level of ?0.5 percentage points in households with children. **(See Tables 1-8.)** The difference in uninsurance rates among families with and without dependent children was statistically significant. More specifically, the rate of uninsurance for households with one child was 8.9 percent (estimated with a confidence level of ?1.1 percentage points), 6.4 percent for households with two children (estimated with a confidence level of ?0.8 percentage points), and 8.8 percent for households with more than two children (estimated with a confidence level of ?1.0 percentage points). **(See Table 1-9.)** Differences in the probability of being uninsured based on the number of children in the family were statistically significant.

Insurance Status by Geographic Location

According to the family insurance survey, rates of uninsurance were also highly contingent upon where in the state the family resides. Uninsurance rates were significantly higher in rural areas of the state compared to urban areas. **(See Table 1-10.)** The uninsurance rate in rural areas was 11.1 percent, estimated with a level of confidence of 0.9 percentage points. In contrast, the rate of uninsurance in urban areas of New Hampshire was 6.7 percent, estimated with a level of confidence of 0.5 percentage points. Similarly, uninsurance rates in the northern region of the state were significantly higher than they were in the southern region. **(See Table 1-11.)** An estimated 13.0 percent of the population in the northern region is uninsured, compared to only 7.4 percent in the southern region. The rates were estimated with a confidence interval of ?1.4 and ?0.5 percentage points, respectively. Both geographic differences were statistically significant.

Uninsurance rates vary substantially across the ten counties in New Hampshire. **(See Table 1-12.)** Carroll County possessed the highest rate of uninsurance in the state. As estimated 6,090 of the county's 35,895 residents did not have health uninsurance in 2001, resulting in an uninsurance rate of 17.0 percent (with a confidence level of ?3.5 percentage points). The other five counties with uninsurance rates above the statewide average (in descending order) are Sullivan (12.5 percent), Grafton (11.8 percent), Belknap (11.5 percent), Coos (11.2 percent), Strafford (10.0 percent) and Merrimack (9.0 percent). At the other end was Rockingham County with the lowest rate of uninsurance in the state. An estimated 14,750 of the county's 249,521 residents lacked health insurance, resulting in a rate of uninsurance of only 5.9 percent (with a confidence level of ?0.8 percentage points). The other two counties with an uninsurance rate below the statewide average (in ascending order) are Hillsborough (6.5 percent) and Cheshire (7.9 percent). County uninsurance rates were estimated with a maximum confidence interval of ?3.5 percentage points.

Insurance Status by Type and Source of Insurance

Of the estimated 998,003 non-elderly residents in New Hampshire who are covered by health insurance, a full 92 percent (918,134 individuals) have private insurance and only 8 percent (or 79,869 individuals) are covered by public plans. **(See Table 1-13 and Figure 1-1.)** The rates of privately and publicly insured residents are estimated with confidence levels of 1.6 and 0.7 percentage points, respectively. The publicly insured population excludes elderly Medicare beneficiaries. An estimated 79.6 percent of the state's residents receive coverage through an employer-based plan, estimated with a confidence level of 0.8 percentage points. **(See Table 1-14 and Figure 1-2.)** An additional 4.0 percent of residents are covered by an individual or COBRA plan, estimated with a confidence level of 1.6 percentage points. The number of individuals on Medicaid in New Hampshire is relatively small. Only 5.5 percent or 59,906 of the state's residents rely on Medicaid for their primary health insurance needs. The rate of Medicaid coverage is estimated with a confidence level of 1.6 percentage points.

Although the overall number of individuals with public health insurance coverage in New Hampshire is relatively small, certain sub-groups in the state depend more on Medicaid and other forms of public insurance for access to care. For example, young children in New Hampshire are much more likely to be enrolled in Medicaid than older children and adults. **(See Table 1-15.)** An estimated 17.5 percent of children between the ages of 0-5 and 15.1 percent between the ages of 6-11 are currently enrolled in Medicaid. This includes both the New Hampshire Healthy Kids and Katie Beckett programs. In contrast, less than five percent of the 25-54 age group is enrolled in public plans. Similarly, low-income families are much more dependent on public health insurance coverage than wealthier families. **(See Table 1-16.)** Of the estimated 151,422 individuals in New Hampshire who reside in families whose annual incomes fall below $25,000, slightly over one-quarter receive their health insurance coverage through a public plan and another one-quarter is uninsured. That proportion of publicly insured individuals falls to 8.6 percent among individuals in families with incomes of between $25,000 and $49,999 and 3.1 percent among individuals in families with incomes between $50,000 and $74,999.

Insurance Status by Employment

The 2001 insurance survey further reveals that nearly three-quarters of all uninsured adults in New Hampshire are currently employed. **(See Table 1-17.)** An estimated 48,509 uninsured individuals between the ages of 19 and 64 who are not full-time students (representing 72 percent of the non-elderly uninsured adult population in the state) are engaged in full-time, seasonal or temporary employment. Clearly, employer-based coverage in New Hampshire is not benefiting all adult workers in New Hampshire. Only 28 percent of uninsured adults (totaling 19,021 out of 67,530 individuals) are also unemployed. Given the smaller sample size of the uninsured population, the rate of the working uninsured cannot be measured with the same degree of precision as in the previous tables. The rate of the working uninsured was measured with a confidence level of ?3.0 percentage points.

The working uninsured adults appear to be concentrated in just a few industries. **(See Table 1-18.)** Nearly half of all surveyed uninsured employed adults are split evenly into just two industries: construction (23.8 percent) and retail service (21-6 percent). A surprising 8.1 percent of the surveyed uninsured employed adults are currently working in the health care industry. In addition, the working uninsured are most likely to be either self-employed or working in small

firms. **(See Table 1-19.)** One-quarter of all working uninsured are self-employed. The high prevalence of working uninsured among the self-employed in the state reflects the difficulty of finding affordable individual health insurance in New Hampshire. Another 37.4 percent of the working uninsured is employed by firms with ten or fewer employees and 21-2 percent in firms with between 11-50 employees. In contrast, only 8.1 percent of the working uninsured are employed in firms with between 51-100 employees and only 8.8 percent in firms with more than 100 employees. The shares of the uninsured by firm size were estimated with confidence levels of between ?2-4 percentage points.

Moreover, among the estimated 48,509 uninsured employed adults in New Hampshire, nearly 80 percent (38,685 individuals) report working at least 30 hours per week, and 35.3 percent report working at least 40 hours per week. **(See Table 1-20.)** Less than 10 percent report working only on a part-time basis (defined as less than 20 hours per week). These results suggest that the lack of employer-based health insurance coverage among working adults does not seem to stem from part-time employment status. This finding is further evidenced in the distribution of the working uninsured by type of position. **(See Table 1-21.)** The survey data indicate that a full 83.9 percent of the working uninsured are employed on a full-time basis. Only 4.8 percent of the working uninsured report working on a temporary basis and 10.3 percent on a seasonal basis. The shares of working uninsured by type of position are estimated with a confidence level of ?1-3 percentage points.

Availability of Private Coverage

The high percentage of the employed among uninsured adults appears to stem more from low firm offer rates, rather than employee ineligibility. Well over half (57.7 percent) of all uninsured employed adults in New Hampshire report working for firms that do not offer health insurance benefits to their employees. **(See Table 1-22.)** Another 22.5 percent of the working uninsured report working for firms that offer insurance, but are not eligible to participate in their company's plan. Only 19.8 percent of the surveyed uninsured adults report that they are eligible for a workplace plan, but chose not to participate. Among the uninsured adults who work for firms that offer a health insurance plan to their employees, 30.7 percent report that they are ineligible because they do not work enough hours per week to qualify. **(See Table 1-23.)** An additional 30.7 percent report that they have not yet been with the company for a long enough period to qualify for health benefits. Presumably many of these latter individuals will eventually sign up for their workplace health plan. Another 27.1 percent of the uninsured who work for a company that offers a health plan give some other unspecified reason for ineligibility.

Duration of Uninsurance

An estimated 23.8 percent of uninsured adults had some form of health insurance coverage during the six months prior to the survey interview. **(See Table 1-24.)** The remaining 76.2 percent of the uninsured adults had no health insurance coverage during the previous six-month period. The rate of prior coverage among the currently uninsured non-elderly adult population was estimated with a confidence level of 2.7 percentage points. Of those uninsured adults with some previous insurance coverage, 81.1 percent were covered either through their own or their spouse's employer. **(See Table 1-25.)** An additional 10.8 percent was covered through an individual plan and 2.0 percent through a COBRA plan. Less than 5 percent of the uninsured adults with prior health insurance received their coverage through Medicaid. Finally, among

currently uninsured adults with some previous coverage, 22.6 percent had coverage for the entire six month period, 13.8 percent for five months, 18.2 percent for four months, 16.0 percent for three months, 14.3 percent for two months, and 15.0 percent for one month. **(See Table 1-26.)**

1.3 Summarizing the information provided above, what population groupings were particularly important for New Hampshire in developing targeted coverage expansion options?

Similar to most states, the results from the family survey indicate that the pool of uninsured individuals are largely in the poor and near poor income brackets. At the same time, more than three quarters of the uninsured are adults. Given the state's significant efforts at expanding insurance coverage to children (up to 300% of FPL through its Healthy Kids program), the results above suggest that expansions in coverage should focus on lower income adults with incomes less than 200% of the federal poverty level.

The information developed through the survey also suggests that there is an opportunity for a phased approach to expanding coverage to adults. As much of the pool of the uninsured is in the lower income bracket, expanding to very low-income individuals (less than 100% of FPL) and later to those with higher incomes makes sense from a target efficiency perspective. Moreover, because of the growing recognition that the insurance status of parents affects the insurance status of children, the appropriate place to begin expanding coverage for adults may be to first develop options that would provide coverage for adults with children who are eligible for the CHIP program. An expansion which first provided coverage to the very low-income adults with children both targets the highest risk population and potentially increases the enrollment of children.

Two other findings from the survey work provided some guidance as to targeted coverage expansion options. First, compared to most other states, the penetration of private coverage among the low-income remains relatively high in New Hampshire. However, there are specific pockets of employers that do not offer insurance coverage to lower income individuals. Specifically, more than half of the uninsured adults work in firms of 10 or fewer employees. This suggests the need to focus expansion efforts either on the individuals who are employed in such firms or on the firms themselves. Second, the survey suggests that there is significant geographic variation in the uninsurance rate. Although in absolute terms the majority of the uninsured live in the southern part of the state, the northern parts of the state have significantly higher uninsurance rates. Just as the federal government has targeted efforts to states based on the uninsurance (and unemployment rates), this geographic variation suggests the need for targeting within a state as well.

1.4 What is affordable coverage?

The 2001 New Hampshire family insurance survey further asked respondents whether they or their resident spouse would be willing to enroll in state-sponsored health insurance programs for adults at various levels of cost sharing. While the vast majority of respondents reported that they would probably enroll in a public program for adults, the proportion of likely enrollees drops

dramatically as monthly premiums rise. **(See Table 1-27.)** For example, a full 75 percent of the adults in the survey responded that they and their resident spouse would definitely enroll and another 15 percent would probably enroll in a state-sponsored plan for adults if the premium were $30 per member per month. Only 10 percent reported that they would probably or definitely not enroll at this premium level. However, the proportion of likely enrollees falls to 44 percent (definitely enroll) and 31 percent (probably enroll) at $60 per adult per month. At a premium of $90 per adult per month, the share of definite enrollees falls to 23 percent and the share of probable enrollees falls to 37 percent. An estimated 40 percent of adult respondents said that they and their resident spouse would either probably or definitely not enroll in a state-sponsored plan for adults if the premium were $90 per month.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

When respondents were asked why they or their resident spouse would not participate in a state-sponsored health plan for adults, the overwhelming reason was lack of affordability. **(See Table 1-28.)** An estimated 57.0 percent reported that a public program for adults would still be too expense to purchase. The second most frequent response was a general lack of interest in state-sponsored health plans. An estimated 10.0 percent said that they were simply not interested in buying health insurance at any price. Other stated reasons, in order of importance, were lack of a need for health insurance (4.2 percent), uncomfortable with public programs (3.7 percent), uncomfortable with welfare in general (2.2 percent) and uncomfortable with application process (1.8 percent). The remaining 21.1 percent of adult respondents gave another unspecified reason for not wanting to participate in public health insurance program.

1.6 Why do uninsured individuals and families disenroll from public programs?

The state, working with the Healthy Kids corporation collected information on disenrollment from two sources: a consumer focus group in which individuals were asked why they did not participate as well as a survey of Healthy Kids enrollees who disenrolled from the Healthy Kids program. Consumer Focus Group participants indicated that they were no longer eligible or became frustrated with eligibility requirements.

Based on telephone surveys, Healthy Kids families report a variety of reasons for disenrollment. About fifteen percent of Healthy Kids Gold families (Medicaid) and twenty-five percent of Healthy Kids Silver (Title XXI) report that they obtain other insurance. About twenty percent of all families indicate it is difficult to stay enrolled or that they did not renew.

For Title XXI families, 45% report their children are no longer eligible (31% are over income and 14% age out). This is comparable for Gold families with about one third report their income is too high and 15% report their children aged out. Additionally some Gold families (10%) believe they are ineligible because they are not in the welfare to work program.

Premiums represent a barrier for some Title XXI families, with 11% indicating they were dissatisfied with the premium and 13% indicating they were terminated for nonpayment of premium.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

When uninsured respondents were asked the primary reason why they or their spouse did not currently have health insurance, the most common primary reason given was again lack of affordability. **(See Table 1-29.)** An estimated 57.2 percent said they could not afford the plan that was available from their employer. 42.5 percent of respondents reported that poor benefits from their workplace plan was the secondary reason whey they did not have insurance. An additional 12.2 percent of respondents said that their employer did not offer health benefits and another 6.9 percent reported that they were ineligible for the workplace plan that was offered. An estimated 6.0 percent of respondents claimed that they lost their existing employer-based coverage because of job loss. An estimated 2.5 percent of respondents reported that they did not have insurance because of the poor benefits offered by their workplace plan and an additional 1.1 percent claimed that their workplace plan did not meet their health care needs. Finally, 1.1 percent claimed that they had been denied coverage upon application.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Information was not collected which would answer this question.

1.9 How likely are individuals to be influenced by availability of subsidies and/or tax credits or other incentives?

Individuals would be influenced by subsidies, but these subsidies would have to be relatively large. In the family survey, respondents were asked whether or not they would participate in a program and if so, how likely they would be to participate under different assumptions about the cost they would experience. Only 23% of uninsured adults indicated that they would participate in a plan that cost them $90 dollars a month. On the other hand, 90% of uninsured adults indicated that they would participate in a plan that cost them $30 dollars a month. Clearly, the greater the subsidy, the more likely individuals will be influenced.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

As stated above in Section 1.7, the survey results show that lack of health plan affordability is single most important cause of uninsurance in New Hampshire. **(See Table 1-29 above.)** Additional primary reasons for being uninsured are that employers do not offer a health plan or employers offer a workplace plan but the employee is not eligible for those health benefits. Other less frequently stated barriers preventing the purchase of private health insurance were job loss and inadequate workplace health plan benefits.

1.11 How are the uninsured getting their medical needs met?

The state of New Hampshire has a relatively established safety net comprised primarily of 24 community based hospitals and 8 FQHCs, FQHC look-a-likes as well as a variety of rural health clinics. As part of the state-planning grant, the state developed a survey that sought information from each community hospital and community clinic that would clarify eligibility rules for free care as well as the market area for each entity. The intent of the study was to provide some context for understanding access to medical care for the uninsured.

Preliminary analysis has been conducted on these surveys that indicates there is significant variation in the income eligibility for free care across the state of New Hampshire. Figure 1 in Appendix B, for example, documents by hospital, the eligibility levels for free inpatient (and in some cases outpatient) care. Figure 2 in Appendix C, documents the market areas for each of the CHCs. While further analysis is necessary, these two figures suggest that free care is available but that access is likely to vary significantly across geographic areas.

Among uninsured adults and resident spouses in New Hampshire an estimated 60.2 percent (27,443 individuals) report that they had no unmet medical needs during the six-month period prior to the interview. **(See Table 1-30.)** However, 36.2 percent report that they and their resident spouse experienced between one and ten unmet medical needs in the past six months. Only four percent of the survey population reported having more than ten unmet medical needs in the past six months.

Out-of-pocket health care expenditures at community health centers during the previous six months were also relatively low. **(See Table 1-31.)** An estimated 59.1 percent of the survey respondents reported having out-of-pocket health care costs at community health centers of between $1 and $100 for themselves and their resident spouses. An additional 16.9 percent of respondents reported having between $101 and $500 of out-of-pocket expenditures and 15.5 percent between $501 and $1,000. Only 8.5 percent of respondents reported having out-of-pocket medical costs at community health centers greater than $1,000 during the prior six-month period.

The uninsured adult population relies on a variety of facilities to obtain the medical care that they need. An estimated 36.6 percent of the uninsured respondents reported visiting a community health center between 1-10 times during the six-month period. (**See Table 1-32.)** Similar proportions of the uninsured reported between 1-10 private physician office visits and 1-10 emergency room visits during the same period. (**See Tables 1-33 and 1-34.)** However, two-thirds of all uninsured adult respondents claim that they and their resident spouses had no physician visit and no emergency room visit during the six months prior to interview. Few respondents report having more than 10 medical encounters in the six-month period.

Finally, the survey results reiterate that the most important factor explaining unmet health care needs among the uninsured population in New Hampshire is the inability to afford payment. **(See Table 1-35.)** Over 70 percent of all uninsured respondents report that the primary reason they have unmet medical needs is their inability to pay for health care. The second most

important factor is the lack of health insurance. An estimated 22.2 percent of all uninsured respondents report that a lack of health insurance led to their inability to meet their health care needs. Other, less important reasons, include a lack of insurance coverage for necessary services, lack of medical referral, medical treatment was not required, and inconvenience of appointment. Several respondents reported that the physician they sought did not accept Medicaid payment. These results reinforce the overall conclusion that lack of affordability and lack of insurance are the greatest barriers to accessing the health care system in New Hampshire.

1.12 **What is a minimum benefit?**

A minimum benefit is baseline set of health benefits. Consumer Focus Group participants indicated that they would not purchase a "minimum benefit" plan, instead, preferring comprehensive benefits.

1.13 How should underinsured be defined?

The underinsured should be defined as any insured population that does not have access to a full range of benefits to meet individual needs and or has a policy that includes prohibitive co-pays, deductibles and caps. For the purposes of simply analyzing the information, any individual with a deductible of greater than $2,500 or who did not have access to mental health, pharmacy, dental or vision benefits was identified as underinsured.

How many of those defined as "insured" are underinsured?

According to the 1999 survey of families conducted in NH, having health insurance is not a guarantee of coverage. Although only 9% of the population was uninsured in 1999, slightly less than 22 percent of state residents under age 65 were reported to have prescription coverage. For those with prescription benefits, employment-based insurance was the most common source by far (89 percent), with Medicaid, including the Healthy Kids, program a distant second (7 percent), and other sources of private and public coverage combined representing an additional 4 percent. A total of some 223,500 individuals reported being without drug coverage at the time of the survey compared to roughly 96,000 uninsured.

The 2001 survey confirmed and expanded on these results. Insured survey participants were asked to indicate whether or not their primary family health plan covers counseling/mental health, prescriptions, vision care, preventive health, and routine dental care. Five percent (N=238) of the insured report their plan does not cover counseling/mental health, or prescription drugs (N=202). Twenty-four percent (N=1052) of insured respondents indicate that their plan does not cover vision care. Preventive care is not covered by four percent (N=181) of the respondents' health plans, while twenty-five percent (N=1106) of the respondents indicate that routine dental care is not covered or offered as a separate plan.

Table 1-1

New Hampshire Insurance Rate, 2001

	Number	Percent	CI (±)
Uninsured	89,813	8.3	0.5
Insured	998,003	91.7	0.5
Total	1,087,815	100.0	

NOTES:
Chi square=9585.37; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-2

New Hampshire Insurance Rate by Gender, 2001

	Male			Female		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	45,056	8.3	0.8	44,756	8.3	0.8
Insured	500,496	91.7	0.8	497,506	91.7	0.8
Total	545,553	100		542,263	100	

NOTES:
Chi square=0.0; p=0.991
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-3

New Hampshire Insurance Rate by Adult/Children, 2001

	Age (in years)					
	0-17			18-64		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	15,891	5.1	0.7	73,922	9.5	0.6
Insured	293,605	94.9	0.7	704,398	90.5	0.6
Total	309,496	100		778,320	100	

NOTES:
Chi square=70.36; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-4

New Hampshire Insurance Rate by Age, 2001

	Age (in years)											
	0-5			6-11			12-17			18-24		
	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	4,246	4.6	1.3	5,833	5.3	1.1	5,728	5.3	1.2	16,518	16.0	2.0
Insured	87,677	95.4	1.3	104,347	94.7	1.1	101,666	94.7	1.2	86,775	84.0	2.0
Total	91,923	100		110,180	100		107,393	100		103,293	100	

	Age (in years)											
	25-34			35-44			45-54			55-64		
	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	20,593	12.9	1.5	17,913	8.1	1.0	13,242	7.2	1.1	5,656	5.2	1.2
Insured	139,617	87.2	1.5	203,194	91.9	1.0	170,806	92.8	1.1	104,005	94.8	1.2
Total	160,210	100		221,107	100		184,048	100		109,661	100	

NOTES:

Chi square=231.52; p=0.0001

Confidence Level (CI) based on 0.05 significance level.

Chi Square test of differences in distribution across the three lowest age categories = 0.61 with p=0.736.

Chi Square test of differences in distribution across the five highest age categories = 141.674 with p=0.0001.

Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.

Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.

Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-5

New Hampshire Insurance Rate by Family Income, 2001

	Income											
	$0-24,999			$25,000-49,999			$50,000-74,999			$75,000+		
	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	35,183	23.2	1.9	33,335	11.6	1.0	14,741	4.9	0.7	6554	1.9	0.4
Insured	116,239	76.8	1.9	253,607	88.4	1.0	284,606	95.1	0.7	343550	98.1	0.4
Total	151,422	100		289,942	100		299,347	100		350104	100	

NOTES:

Chi square=914.75; p=0.0001

Confidence level (CI) based on 0.05 significance level.

Chi square test of differences in distribution across the lowest two income categories = 127.36 with p=0.0001.

Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.

Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.

Estimates have been adjusted for probability of selection.

There were 867 (16.7%) missing records for annual family income. Insurance families with missing values were assigned a mean imputed value based on respondent's gender, education, and spouse living in same household.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-6
New Hampshire Insurance Rate by Family Size, 2001

Number in	Uninsured			Insured			Total	
Family	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent
1	18,700	16.7	1.9	93,217	83.3	1.9	111,917	100
2	20,128	7.8	0.9	239,320	92.2	0.9	259,448	100
3	17,309	8.1	1.0	195,846	91.9	1.0	213,155	100
4	15,678	5.5	0.7	271,405	94.5	0.7	287,083	100
5	9,696	6.7	1.1	134,485	93.3	1.1	144,181	100
6	6,438	11.8	2.4	48,348	88.3	2.4	54,785	100
7	1,865	11.8	4.5	13,904	88.2	4.5	15,768	100
8+	0	100.0	0.0	1,478	100	0.0	1,478	100

NOTES:
Chi square=193.87; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire,

2001.

Table 1-7

New Hampshire Insurance Rate by Spouse Resident in Household, 2001

	Spouse			No Spouse		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	51,606	6.1	0.5	38,206	15.8	1.3
Insured	793,805	93.9	0.5	204,198	84.2	1.3
Total	845,411	100		242,405	100.0	

NOTES:
Chi square=293.23; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-8

New Hampshire Insurance Rate by Children Resident in Household, 2001

	No Children			Children		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	29,892	9.4	0.9	59,920	7.8	0.5
Insured	288,906	90.6	0.9	709,097	92.2	0.5
Total	318,798	100		769,017	100	

NOTES:
Chi square=9.45; p=0.0022
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-9
New Hampshire Insurance Rate by Number of Children in Family, 2001

	No Children			1 Child			2 Children			3 or More Children		
	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	29,892	9.4	0.9	18,982	8.9	1.1	20,554	6.4	0.8	20,384	8.8	1.0
Insured	288,906	90.6	0.9	194,646	91.1	1.1	302,789	93.6	0.8	211,662	91.2	1.0
Total	318,798	100		213,628	100		323,342	100		232,047	100	

NOTES:
Chi square=28.65; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-10

New Hampshire Insurance Rate by Urban Versus Rural Location, 2001

	Urban			Rural		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	47,584	6.7	0.5	42,229	11.1	0.9
Insured	661,261	93.3	0.5	336,742	88.9	0.9
Total	708,845	100		378,970	100	

NOTES:
Chi square=80.89; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Urban = Merrimack, Hillsborough & Rockingham Counties;
Rural = Belknap, Carroll, Cheshire, Coos, Grafton, Strafford, & Sullivan Counties.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-11
New Hampshire Uninsurance Rate by Region, 2001

	North Region			South Region		
	Number	Percent	CI (±)	Number	Percent	CI (±)
Uninsured	21,698	13.0	1.4	68,115	7.4	0.5
Insured	145,894	87.0	1.4	852,108	92.6	0.5
Total	167,592	100		920,223	100	

NOTES:
Chi square=73.29; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
North Region = Coos, Grafton, Carroll & Sullivan Counties;
Southern Region = Belknap, Cheshire, Hillsborough, Merrimack, Rockingham & Strafford Counties.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey,* Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-12
New Hampshire Insurance Rate by County, 2001

	Uninsured			Insured			Total	
County	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent
Carroll	6,090	17.0	3.5	29,805	83.0	3.5	35,895	100
Sullivan	4,266	12.5	3.1	29,786	87.5	3.1	34,052	100
Grafton	8,329	11.8	2.1	62,436	88.2	2.1	70,765	100
Belknap	5,513	11.5	2.5	42,406	88.5	2.5	47,918	100
Coos	3,012	11.2	3.4	23,869	88.8	3.4	26,881	100
Strafford	9,985	10.0	1.7	89,707	90.0	1.7	99,692	100
Merrimack	10,691	9.0	1.4	108,466	91.0	1.4	119,157	100
Cheshire	5,033	7.9	1.9	58,735	92.1	1.9	63,768	100
Hillsborough	22,143	6.5	0.7	318,024	93.5	0.7	340,167	100
Rockingham	14,750	5.9	0.8	234,771	94.1	0.8	249,521	100

NOTES:
Chi square=129.28; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-13

Distribution of Insurance Status in New Hampshire by Type of Insurance, 2001

	Number	Percent	CI (±)
Public	79,869	7.3	1.6
Private	918,134	84.4	0.7
Uninsured	89,813	8.3	1.6

NOTES:
Chi square=13,751.99; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-14

Distribution of Insurance Status in New Hampshire by Source of Insurance, 2001

	Number	Percent	CI (±)
Employer-Based	865,621	79.6	0.8
Medicare	9,614	0.9	1.7
Medicaid	59,906	5.5	1.6
Military	10,349	1.0	1.7
Individual Plan or COBRA	43,080	4.0	1.6
Other	9,432	0.9	1.7
Uninsured	89,813	8.3	1.6

NOTES:
Chi square=13,751.99; p=0.0001
Confidence Level (CI) based on 0.05 significance level.
Individuals covered by Medicare are the non-elderly disabled.
Individuals over 64 years of age were excluded from survey and do not appear in counts of insured
or uninsured.
Population-based estimates are derived from post-stratification weights for age, sex and county of
residence obtained from 2000 census data.
Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and
Human Services, New Hampshire, 2001.

Table 1-15

Distribution of New Hampshire Health Insurance Coverage by Type of Insurance and Age, 2001

	Public			Private			Uninsured			Total	
Age in Years	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent
0-5	16,103	17.5	2.2	71,490	77.8	2.4	4,330	4.7	1.2	91,923	100
6-11	16,655	15.1	1.9	87,692	79.6	2.1	5,833	5.3	1.2	110,180	100
12-17	11,823	11.0	1.7	89,843	83.7	2.0	5,728	5.3	1.2	107,393	100
18-24	5,865	5.7	1.3	80,909	78.3	2.2	16,518	16.0	2.0	103,293	100
25-34	6,560	4.1	0.9	133,057	83.1	1.6	20,593	12.9	1.5	160,210	100
35-44	6,152	2.8	0.6	197,042	89.1	1.2	17,913	8.1	1.0	221,107	100
45-54	7,370	4.0	0.8	163,437	88.8	1.3	13,242	7.2	1.1	184,048	100
55-64	9,341	8.5	1.5	94,664	86.3	1.8	5,656	5.2	1.2	109,661	100

NOTES:

Chi square=696.29; p=0.0001

Confidence Level (CI) based on 0.05 significance level.

Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.

Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.

Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-16

Distribution of New Hampshire Health Insurance Coverage by Type of Insurance and Family Income, 2001

	Public			Private			Uninsured			Total	
Family Income	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent	CI (±)	Number	Percent
$0-24,999	41,317	27.3	2.0	74,922	49.5	2.2	35,183	23.2	1.9	151,422	100
$25,000-49,999	24,611	8.6	0.9	228,996	80.1	1.3	33,335	11.6	1.0	286,942	100
$50,000-74,999	9,183	3.1	0.6	275,423	92.0	0.9	14,741	4.9	0.7	299,347	100
$75,000+	4,758	1.4	0.3	338,792	96.8	0.5	6,554	1.9	0.4	350,104	100

NOTES:

Chi square=2,585.59; p=0.0001

Confidence Level (CI) based on 0.05 significance level.

Individuals over 64 years of age were excluded from survey and do not appear in counts of insured or uninsured.

Population-based estimates are derived from post-stratification weights for age, sex and county of residence obtained from 2000 census data.

There were 867 (16.7%) missing records for annual family income. Insurance families with missing values were assigned a mean imputed value based on respondent's gender, education, and spouse living in same household.

Estimates have been adjusted for probability of selection.

SOURCE: *Insurance Family Survey*, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 1-17

Distribution of Uninsured Adults in New Hampshire by Employment Status, 2001

	Number	Percent	CI (±)
Employed	48,509	71.8%	3.0
Unemployed	19,021	28.2	3.0
Total	67,530	100	

NOTES:
Chi square = 36,272.40; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 854 individuals.
Uninsured adults include 19-64 year old adults who are not full-time students.
Employed adults include an estimated 4,277 self-employed.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-18
Distribution of Working Uninsured Adults in New Hampshire by Industry, 2001

Type of Industry	Number	Percent	CI (±)
Construction	11,465	23.8%	3.4
Retail Services	10,440	21.6	3.3
Health Care	3,799	7.9	2.1
Manufacturing	3,213	6.7	2.0
Transportation	2,929	6.1	1.9
Agriculture	2,319	4.8	1.7
Communication and Technology	2,277	4.7	1.7
Financial Services	1,163	2.4	1.2
Childcare	992	2.1	1.1
Other	9,662	20.0	3.2
Total	48,259	100	

NOTES:
Chi square = 30,487.97; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county
of residence based on 2000
census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 610 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-19

Distribution of Working Uninsured Adults in New Hampshire by Size of Firm, 2001

Number of Employees	Number	Percent	CI (±)
Self employed	10,576	24.5%	3.6
Between 2-10 employees	16,137	37.4	4.1
Between 11-50 employees	9,151	21.2	3.4
Between 51-100 employees	3,508	8.1	2.3
More than 100 employees	3,786	8.8	2.4
Total	43,158	100	

NOTES:
Chi square = 12,756.21; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 546 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-20

Distribution of Working Uninsured Adults in New Hampshire by Number of Hours Worked per Week, 2001

Hours/Week	Number	Percent	CI (±)
Less than 11	1,537	3.2%	1.4
Between 11-20	2,645	5.5	1.8
Between 21-30	5,642	11.6	2.5
Between 31-40	21,554	44.4	3.9
More than 40	17,131	35.3	3.8
Total	48,509	100	

NOTES:
Chi square = 33,870.20; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 613 individuals.
Uninsured adults include 19-64 year old adults who are not full-time students.
Employed adults include an estimated 4,277 self-employed.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-21

Distribution of Working Uninsured Adults in New Hampshire by Type of Position, 2001

Type of Position	Number	Percent	CI (±)
Full time	40,706	83.9%	2.9
Temporary	2,334	4.8	1.7
Seasonal	5,010	10.3	2.4
Other	459	0.9	0.8
Total	48,509	100	

NOTES:
Chi square = 90,660.71; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 613 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-22

Distribution of Working Uninsured Adults in New Hampshire by Insurance Offer Rate, 2001

	Number	Percent	CI (±)
Workplace health plan not offered	27,084	57.7%	4.0
Workplace health plan offered, ineligible	10,581	22.5	3.4
Workplace health plan offered, eligible	9,303	19.8	3.2
Total	46,968	100	

NOTES:
Chi square = 12565.00; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 594 individuals.
Uninsured adults include 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-23

Reasons for Workplan Ineligibility Among Working Uninsured Adults in New Hampshire by , 2001

	Number	Percent	CI (±)
Does not work enough hours per week	3,193	30.7%	7.9
Has not worked long enough for company	4,394	42.2	8.4
Other	2,817	27.1	7.6
Total	10,404	100	

NOTES:
Chi square = 391.06; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 132 individuals.
Uninsured adults include 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-24

Number of Uninsured Adults in New Hampshire with Coverage During Previous Six Months, 2001

	Number	Percent	CI (±)
Prior Coverage	17,565	23.8%	2.7
No Prior Coverage	56,269	76.2	2.7
Total	73,834	100	

NOTES:
Chi square = 256.49; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 933 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-25

Primary Source of Prior Coverage During Previous Six Months Among Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
Own employer	9,441	57.3%	6.7
Spouse employer	3,916	23.8	5.8
Individual plan	1,782	10.8	4.2
Medicaid	742	4.5	2.8
Cobra	335	2.0	1.9
Medicare	150	0.9	1.3
VA or Champus	98	0.6	1.0
Total	16,464	100	

NOTES:
Chi square = 374.22; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 208 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-26

Number of Previous Months Covered among Uninsured Adults in New Hampshire, 2001

Months	Number	Percent	CI (±)
1	2,473	15.0%	4.8
2	2,361	14.3	4.7
3	2,636	16.0	5.0
4	2,991	18.2	5.2
5	2,274	13.8	4.7
6	3,720	22.6	5.7
Total	16,455	100.0	

NOTES:
Chi square = 2,955.72; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 210 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-27

Willingness to Enroll in State Sponsored Health Plan for Uninsured Adults in New Hampshire, 2001

Per Member Per Month Premium of:	**Premium Per Month**		
	$90	$60	$30
Months			
Definitely would	23.3%	44.4%	74.9%
Probably would	36.6	30.7	14.6
Probably would not	20.5	15.7	4.4
Definitely would not	19.7	9.2	6.1
Number Reporting	552	558	565

NOTES:
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-28

Reason for Not Participating in State Sponsored Health Plan for Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
Plan too expensive	2,529	57.0%	13.0
Not interested in health insurance	443	10.0	7.8
Do not need health insurance	187	4.2	5.3
Uncomfortable with public programs	166	3.7	5.0
Uncomfortable with welfare	98	2.2	3.8
Uncomfortable with Application process	82	1.8	3.5
Other	935	21.1	10.7
Total	4,440	100	

NOTES:
Chi square = 7,455.71; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 56 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-29
Reasons Why Working Adults in New Hampshire Do Not Participate in Employer-Sponsored Health Plan, 2001

	Primary Reason Given	Second Reason Given	Third Reason Given
Cannot afford workplace plan	57.2%	2.1%	2.3%
Employer does not offer plan	12.2	10.9	6.2
Not eligible for workplace plan	6.9	5.3	8.0
Lost coverage due to job loss	6.0	3.3	3.0
Poor benefits from workplace plan	2.5	42.5	25.0
Ineligible for Medicare	1.7	1.6	1.9
Workplace plan did not meet my needs	1.1	5.8	10.5
Insurance carrier denied coverage	1.1	9.9	6.1
Lost coverage due to divorce	0.3	0.5	2.5
Lost coverage due to being reduced to part-time position	0.2	0.7	1.0
Prefer to rely on community health center	0.1	1.6	6.5
Other	10.7	15.9	26.9
Individuals reporting	931	187	46

NOTES:
Estimates have been adjusted for probability of selection.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-30

Number of Unmet Medical Needs in Previous Six Months Among Uninsured Adults in New Hampshire, 2001

Number of Unmet Needs	Number	Percent	CI (±)
None	27,443	60.2%	4.0
1-10	16,467	36.1	3.9
11-20	1,151	2.5	1.3
21-30	194	0.4	0.5
31-40	298	0.7	0.7
Total	45,553	100	

NOTES:
Chi square = 67,028.61; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 576 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-31

Out-of-Pocket Health Care Costs at Community Health Centers in Previous Six Months Among Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
$1-100	3,418	59.1%	11.3
$101-$500	974	16.9	8.6
$501-$1,000	894	15.5	8.3
More than $1,000	494	8.5	6.4
Total	5,780	100	

NOTES:
Chi square = 3,682.75; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 73 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-32

Number of Community Health Center Visits in Previous Six Months Among Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
No visits	27,010	62.2%	3.9
1-10 visits	15,912	36.7	3.9
11-20 visits	-	-	-
21-30 visits	194	0.4	0.5
31-40 visits	298	0.7	0.7
Total	43,414	100.0	

NOTES:
Chi square = 47,141.30; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 458 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-33

Number of Private Physician Visits in Previous Six Months Among Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
No visits	27,592	60.1%	4.0
1-10 visits	16,549	36.0	3.9
11-20 visits	1,297	2.8	1.3
21-30 visits	194	0.4	0.5
31-40 visits	298	0.6	0.7
Total	45,930	100.0	

NOTES:
Chi square = 66,956.88; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 581 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-34

Number of Emergency Room Visits in Previous Six Months Among Uninsured Adults in New Hampshire, 2001

	Number	Percent	CI (±)
No visits	27,276	59.9%	4.0
1-10 visits	16,492	36.2	3.9
11-20 visits	1,297	2.8	1.4
21-30 visits	194	0.4	0.5
31-40 visits	298	0.7	0.7
Total	45,557	100.0	

NOTES:
Chi square = 66,143.60; p=.0001.
Population estimates are derived from post-stratification weights for age, sex and county of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Confidence intervals are based on a sample size of 576 individuals.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

Table 1-35

Reasons for Unmet Medical Needs Among Uninsured Adults in New Hampshire, 2001

	Primary Reason	Second Reason	Third Reason
Could not afford payment	70.3%	30.0%	17.1%
Did not have health insurance	22.2	47.5	0.0
Medical service was not covered	3.8	6.8	35.8
Other	2.1	6.7	36.3
Provider did not accept Medicaid	0.6	0.0	0.0
Did not have medical referral	0.5	0.0	0.0
Medical condition not serious enough	0.4	3.2	0.0
No convenient appointment	0.2	0.9	0.0
Did not have time off work	0.0	0.5	5.7
Provider not accepting patients	0.0	2.2	0.0
Did not know where to go for treatment	0.0	0.7	0.0
Provider too far away	0.0	1.5	5.1
Number Reporting	282	106	15

NOTES:
Population estimates are derived from post-stratification weights for age, sex and county
of residence based on 2000 census data.
Estimates have been adjusted for probability of selection.
Uninsured adults are based on 19-64 year old adults who are not full-time students.

SOURCE: *New Hampshire Family Insurance Survey*, Department of Health and Human Services, Office of Policy and Research, 2001.

SECTION 2: EMPLOYER BASED COVERAGE

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

A sample of 642 firms was surveyed in 2001 under the HRSA State Planning Grant. Firms which include self employed, single site, headquarter, franchise and branch locations were eligible to participate in the survey. Education and government industries were excluded from the survey.

The overall rate of firms in New Hampshire that do offer health insurance in 2001 is 71.2 percent. (See Table 2-1) The confidence interval for the insurance offer rate is $\pm$ 3.5 percentage points at a significance level of 5 percent. From the sample of employers surveyed, approximately 94.3 percent of employees work in companies that offer health insurance. This represents 13,264 out of a total of 14,057 employees (See Table 2-2).
The specific characteristics of firms that do not offer health insurance in New Hampshire in 2001 versus those that do, based on a employer size, industry sector, employee income brackets, percentage of part-time and seasonal workers, geographic location, cost of policies, level of contribution, and the percentage of employees offered coverage who participate in employer insurance program are presented in Table 2-3 through Table 2-20.

Employer Size:

Health Insurance offer rates for New Hampshire employers by various firm size are presented in Table 2-3. According to survey results, companies which offer health insurance range from a low of 56.8 percent for firms with 2-10 employees (estimated at a confidence interval of ? 5.1 percentage points) to 100 percent of companies with 100 or more employees. Table 2-4 shows the percentage of employees at firms that offer health insurance by firm size. The results are similar to those in Table 2-3. For example, for people at firms of size 2-10 employees, 63.9% work at a firm that offers health insurance to its employees.

Industry Sector:

The health insurance offer rates for New Hampshire employers by various industry sectors are presented in Table 2-5. The categories of industry sectors include: agriculture, construction, manufacturing, transportation, wholesale trade, retail trade, financial services, business services, professional services, healthcare, and childcare. Though an option in the survey questions, no firms queried represented the mining or communication/high-tech industry sectors. The greatest number of firms surveyed classified themselves as retail trade, with 231 affirmative responses. These 231 employers represented the lowest rate of firms which offered health insurance to employees, 60.8 percent (estimated at a confidence interval of ? 6.2 percentage points). In contrast, the childcare industry sector, which offered health insurance to employees 100 percent of the time, was only represented by 11 firms. The manufacturing sector includes the highest number of employees in the survey, which is 4,151 (see Table 2-6).

The offer rate for firms in this sector is 78.2 percent (estimated at a confidence interval of ? 10.1 percentage points). Table 2-6 shows the percentage of employees at firms that offer health insurance by industry sector. The percentage of employees working at a firm that offers health insurance is about 90 percent for most sectors. One outlier is the construction sector, with only 80.6 percent of employees working at a firm that offers health insurance.

Employee Income Brackets:

Survey results for Table 2-7 indicates what percent of employees work full-time in firms and earn less than $17,180 (200 percent of the federal poverty level in 2001). A total of 564 employees are represented in 153 firms. The analysis of the survey data presented in Table 2-7 indicates that approximately 79 percent of individuals who work full-time and earn less than $17,180 (200 percent of the federal poverty level in 2001) are employed by firms that offer health insurance.

Percentage of Part-Time Employees:

Survey results for Table 2-8 indicates what percent of part-time employees work in firms that offer health insurance. A total of 1,983 employees are represented in 322 firms. As indicated in Table 2-8, approximately 86 percent of part-time employees work in firms that offer health insurance.

Seasonal Employees:

Survey results for Table 2-9 indicates what percent of employees are employed at firms which offer health insurance. A total of 617 employees are represented in 147 firms. As indicated in Table 2-9, approximately 81 percent of individuals are employed at firms which offer health insurance to employees and hire seasonal employees.

Geographic Location:

Health insurance offer rates for New Hampshire employers by geographic location are presented in Table 2-10 through 2-15. Table 2-10 is the proportion of firms offering insurance distributed by county. Table 2-11 is the percentage of employees at firms that offer health insurance by county. Table 2-12 is the proportion of firms offering health insurance in the state separated by the grouping of northern and southern counties. Table 2-13 is the percentage of employees at firms that offer health insurance grouped by northern and southern counties. Table 2-14 is the proportion of firms offering health insurance grouped according to rural and urban counties. Table 2-15 is the percentage of employees at firms that offer health insurance grouped by urban and rural counties.

The breakdown of firms offering insurance by county (Table 2-10) reflects a fairly consistent proportion of employers offering insurance to those that do not. In most counties, the proportion is approximately 70 percent of employers offering health insurance. The one county that is significantly lower is Coos County where only 48.6

percent of the firms offer insurance (estimated only at a confidence interval of ? 22.3 percentage points). It is important to note the sample size
is 20 employers for Coos County and the results may not be statistically reliable. However, of these 20 firms, 93.7 percent of the employees were offered health insurance (Table 2-11) and this percentage is consistent with insurance coverage for employees in counties with a larger sample size.

The second geographic analysis was conducted by separating the counties by northern and southern areas. The northern area consists of Coos, Grafton, Carroll, and Sullivan counties; the southern area is Cheshire, Merrimack, Belknap, Strafford, Hillsborough, and Rockingham counties. The Southern area is the more populous region in the state. The proportion of employers offering health insurance to employees is consistent with the previous two analyses; approximately 73.78 percent (estimated at a confidence interval of ? 3.92 percentage points) of firms in the southern part of the state offer health insurance to employees and 63.26 percent (estimated at a confidence interval of ? 7.46 percentage points) of firms in the North offer health insurance to employees (Table 2-12). The percentage of employees who receive health insurance in each region is 91.86 and 95.05 percent respectively (Table 2-13). This indicates the rate of health insurance being offered by employers throughout the state is consistent.

The final analysis of employers offering insurance by rural or urban area is consistent with the proportion of employers offering health insurance by county. The urban portion of the state are the counties of Hillsborough, Merrimack, and Rockingham. The counties that the rural area is comprised of are: Belknap, Carroll, Cheshire, Coos, Grafton, Strafford, and Sullivan. For rural counties, the proportion of firms offering health insurance is 66.29 percent (estimated at a confidence interval of ? 5.57 percentage points), and the proportion for the urban counties is 74.83 percent (estimated at a confidence interval of ? 4.4 percentage points) (Table 2-14). In both regions, the percentages of employees who work at firms that offer health insurance is 94 percent (Table 2-15). These findings reinforce the hypothesis that similar rates of health insurance are offered throughout the state.

Cost of Policies:

The cost of policies for individual and family coverage at New Hampshire firms offering health insurance are detailed in Tables 2-16 and 2-17, respectively. The average monthly premium for individual policies is broken into four ranges of premium costs: $110-$184, $185-$224, $225-$289, and $290-$485. About 25% of responding employers are in each group. Those polices in the lowest category of the premium costs have a range of $74. The second tier of premium costs has a $39 spread. The third tier ranges $64. The fourth, and most expensive premium category, has a range of $195. The confidence intervals for each premium category are all approximately ? 6 percentage points.
From Table 2-17, the average monthly premium for family coverage for New Hampshire firms offering health insurance is also broken down into four groups, with about 25% of employers in each group. The groups are $215 - $399, $400- $559, $560- $734, and
$735- $1300. The spread of costs in each group is similar, with the exception of the last group, with a spread of $565. The confidence intervals for each premium category are all approximately ? 6 percentage points.

Level of Contribution:

Table 2-18 details the percent of employer contribution to employee's health insurance. The contributions are divided into three categories: 0-64%, 65-84% and 85-100% of the cost of health insurance paid by the employer. Over half of the firms, 178 out of 327, pay between 85 and 100 percent of the cost of employer-based health insurance. The confidence intervals for each premium category are all approximately ? 6 percentage points.

Percentage of employees offered coverage who participate:

Two tables, Table 2-19 and Table 2-20, represent the analysis of data to determine the percentage of employees eligible for insurance coverage at New Hampshire firms and those that opt to "take up" or purchase health insurance coverage through their employer. From a total sample of 13,264 individuals reported in the survey, 76.75 percent, or 10,181 employees, are eligible to receive coverage (Table 2-19). Of those individuals eligible to receive coverage, 86.05 percent, or 8,761 individuals, opted to take-up coverage from their firm (Table 2-20).

2.2a What influences the employer's decision about whether or not to offer coverage?

In order to understand the factors that influence an employer's decision about whether or not to offer coverage, a number of survey questions were designed and asked of each respondent. These questions asked if each of the following was a major, minor, or not a reason for offering health insurance: if offering health insurance to employees was used to recruit new employees, if offering health insurance was used to retain current employees, if offering health insurance increased productivity by keeping employees healthy, if offering health insurance creates tax advantages for the company, and if one or more of the employees has a chronic medical condition. The total unweighted frequency for all responses, along with the percent of employers and the corresponding confidence interval are listed in Table 2-21.

Employers in New Hampshire indicate that the presence of health insurance is an important factor to attract and keep quality employees. From the sample of 364 employers surveyed, approximately 51 percent indicated that offering health insurance is useful when recruiting new employees. (A confidence interval of ? 5.38 percentage points at a significance level of 5 percent was used to determine this rate.) Similarly, 69 percent of firms surveyed indicated that offering health insurance is helpful to retain existing employees. (A confidence interval of ? 4.69 percentage points at a significance level of 5 percent was used to determine this rate.) This represents 264 out of a total of 361 firms. However, when asked if offering health insurance was influenced by the fact
one or more of the employees had a chronic medical problem, 78.3 percent of firms indicated this was not at all a reason. (A confidence interval of ? 4.49 percentage points at a significance level of 5 percent was used to determine this rate.)

2.2b What are the primary reasons employers give for not electing to provide coverage?

A series of questions were asked in the survey to elicit the reasons why an employer chooses not to provide health coverage. These questions asked if each of the following was a major, minor, or not a reason for not offering health insurance: setting up a plan is too complicated and time consuming, revenue is too uncertain to commit to a health insurance plan, the business cannot afford it, the employees cannot afford it, employees are healthy and do not need it, employees would rather earn a high wage than receive health benefits, employees have coverage elsewhere, the company does not need to offer health insurance to attract and retain employees, employee turnover is too high, the owner has coverage elsewhere, employer does not know where to go or who to talk to setup an employer sponsored health plan, and the company is too small or does not have enough employees. The total unweighted frequency for all responses, along with the percent of employers and the corresponding confidence interval, are listed in Table 2-22.

Financial stability of the company is a significant factor for employers deciding not to offer health insurance. According to the employer survey, a major reason for electing not to provide coverage for 45.8 percent of the employers was that revenue is too uncertain to commit to a health insurance plan. (A confidence interval of ? 7.2 percentage points at a significance level of 5 percent was used to determine this rate.) Additionally, a total of 69 percent of employers stated the business could not afford to provide health insurance. This represented 116 out of 168 firms responding. (A confidence interval of ? 6.66 percentage points at a significance level of 5 percent was used to determine this rate.) Size of the company is of concern to employers as 48.3 percent of employers stated this was a major reason for not providing coverage. (A confidence interval of ? 7.2 percentage points at a significance level of 5 percent was used to determine this rate.)

The responses that employers indicated were not a reason for electing not to provide health coverage are noteworthy in that there is not one specific reason evident. Survey results indicate 69.3 percent of employers stated setting up a plan as too complicated and time consuming was not a factor in their decision not to offer coverage. (A confidence interval of ? 6.66 percentage points at a significance level of 5 percent was used to determine this rate.) When asked if the reason for not offering health insurance was because the employees are healthy and do not need the coverage, 72.6 percent of employers responded that was not the reason. (A confidence interval of ? 6.42 percentage points at a significance level of 5 percent was used to determine this rate.) Firms were asked if high employee turnover was a factor and 78.7 percent stated this was not a reason in the decision not to offer coverage. (A confidence interval of ? 5.89 percentage points at a significance level of 5 percent was used to determine this rate.) Additionally, 60.3 percent of the firms surveyed did not feel the company did not need to offer health insurance to attract and retain employees. This represented 100 out of 166 employers responding. (A confidence interval of ? 7.08 percentage points at a significance level of 5 percent was used to determine this rate.)

2.3 What criteria do offering employers use to define benefit and premium participation levels?

In order to determine the criteria offering employers use to define benefit and premium participation levels, the following questions were asked of survey respondents. What the amount of out-of-pocket expense for a co-payment a member has to pay for seeing their primary care

physician and for admission to a hospital for the health plan with the highest number of employees enrolled. In addition, if the health plan with the highest number of employees enrolled offers mental health services, prescription drug coverage, vision care, and preventive health services. The results of the findings are detailed in Tables 2-23 through 2-25. The total unweighted frequency for all responses, along with the percent of employers and the corresponding confidence interval are listed in each table.

Table 2-23 lists the range of co-payments an individual would pay for a visit with a primary care physician (PCP). The range is $0 to $25. A total of 323 employers responded to this question. Over half of the employers, 53.4 percent, indicated employees have to pay a $10 out of pocket expense to see their PCP. (A confidence interval of ? 5.73 percentage points at a significance level of 5 percent was used to determine this rate.) Survey results indicate 27 percent of the employers, 89 total, stated employees have a $15 co-payment. (A confidence interval of ? 5.10 percentage points at a significance level of 5 percent was used to determine this rate.) Only 0.7 percent of employer's required a $25 co-payment of employees. (A confidence interval of ? .95 percentage points at a significance level of 5 percent was used to determine this rate.) A total of 6 employers, or 2.2 percent, did not require a co-payment from employees for a PCP visit. (A confidence interval of ? 1.68 percentage points at a significance level of 5 percent was used to determine this rate.)

The results of employers being asked what the co-payment amount for employee hospitalization are listed in Table 2-24. For this question, a total of 251 employers responded. For 25.9 percent of employers, employees taking up insurance are not responsible for any co-payment. (A confidence interval of ? 5.75 percentage points at a significance level of 5 percent was used to determine this rate.) A $50 co-payment is required of employees in 19.2 percent of the firms. (A confidence interval of ? 5.17 percentage points at a significance level of 5 percent was used to determine this rate.) On the other end of the spectrum, for 2.8 percent of employers, employees are responsible for a $1000 co-payment upon admission to the hospital. (A confidence interval of ? 2.16 percentage points at a significance level of 5 percent was used to determine this rate.)

Table 2-25 lists the type of coverage available to individuals in the health plan with the largest number of enrolled members. The types of coverage include mental health services, prescription drug coverage, vision care and preventive health services. An average of 341 employers responded to this series of questions. For approximately 94 percent of employers, plans offer mental health services, prescription drug services and preventive services. (A confidence interval of approximately ? 2.5 percentage points at a significance level of 5 percent was used to determine these rates.) Only 68.4 percent of employers offer a plan which includes vision care. (A confidence interval of ? 5.2 percentage points at a significance level of 5 percent was used to determine this rate.)

2.4 What would be the likely response of employers to an economic downturn or continued increase in costs?

To determine what the response might be of employers to an economic downturn or continued increase in costs, firms offering health insurance were asked two questions. The first is what the percentage increase in health plan costs would cause a possible switch in plans (Table 2-26) and

the second is what percentage increase in the cost of health insurance would cause the employer to stop offering health insurance (Table 2-27). In contrast, companies who currently do not offer health insurance were asked what percentage decrease in the cost of health insurance would cause the company to offer coverage to employees (Table 2-28). The total unweighted frequency for all responses, in addition to the percent of employers and the corresponding confidence interval, are listed on the table.

Table 2-26 details what the percentage of increases in health plan costs would induce employers to possibly switch plans. A total of 241 employers responded to this question. If a 10 percent increase in costs occurred, 27.7 percent, of employers might switch plans. (A confidence interval of ? 10.7 percentage points at a significance level of 5 percent was used to determine this rate.) This is followed by 23.5 percent of employers indicating they might switch plans if a 20 percent increase in costs occurred. (A confidence interval of ? 5.59 percentage points at a significance level of 5 percent was used to determine this rate.) It is interesting to note that 3 employers would not consider switching plans. This represents 1.6 percent of the total number of employers. (A confidence interval of ? 1.65 percentage points at a significance level of 5 percent was used to determine this rate.)

A reporting of a follow up question occurs in Table 2-27. Two hundred and eighteen employers responded to the question "what percent increase in the cost of health insurance would cause the firm to stop offering health insurance altogether?" The survey results indicate that for 50.1 percent, or 113 firms, no increase in the cost would cause employers to stop offering insurance to employees. (A confidence interval of ? 6.94 percentage points at a significance level of 5 percent was used to determine this rate.) The next largest grouping of employers is 16 percent that would consider no longer offering health insurance if the costs increased by 50 percent. This figure represents a total of 34 employer groups. (A confidence interval of ? 5.08 percentage points at a significance level of 5 percent was used to determine this rate.) Were a 15 percent increase in costs to occur, than 9.3 percent of employees would consider no longer offering health insurance to employees. (A confidence interval of ? 4.03 percentage points at a significance level of 5 percent was used to determine this rate.) Table 2-28 lists the percentage decrease in the cost of health insurance that would cause employers to offer health insurance to employees. A total of 168 employers responded to this question. The survey results indicate 54.1 percent of firms, or 89 employers surveyed would not offer health insurance, no matter the amount of decrease in cost. Additionally, 21.2 percent of employers, or 36 in total, would offer health insurance if a 50 percent decrease in costs occurred. The rest of the employers are spread between the remaining percentage values, all less than 4 percent of the total employers responding.

2.5 What employer and employee groups are most susceptible to crowd-out?

The employer groups most susceptible to crowd-out are businesses with a high percentage of low-wage workers. The smaller the business the less likely they are to continue to offer coverage as costs increase. Employee groups most susceptible to crowd-out are low-wage earners who opt to decline employer offered coverage for a more "affordable" product.

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?

Employers will be more likely to offer coverage through purchasing alliances that result in reasonably priced premiums with cost control mechanisms. The economics of scale suggests potential benefits from multi-state pooling.

Individual or employer subsidies?

Employers may be interested in a subsidy that comes from federal funds versus state funds. Many Employer Focus Group participants indicated that a one-third subsidy would be inadequate to make premiums affordable for their lower wage employees, given current prices and price increases.

Additional tax incentives?

While the self-employed tended to prefer an immediate 100% income tax deduction for their own health insurance premiums, most employers of all sizes were receptive to the proposal of a refundable federal income tax credit of $1,000 or $2,000 as a way of inducing the uninsured to obtain health insurance. Many contended that the money must be available up front, like the Earned Income Tax Credit, and the uninsured would need to be educated about the program for it to make a difference.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Employer Focus Group participants expressed the greatest enthusiasm for attracting more insurers to the State to stimulate a competitive insurance market. Given literature which indicates that increasing the number of plans doesn't necessarily translate into lower costs, it is clear that further analysis and potentially education is required of both policymakers and employers.

Employer Survey respondents who currently do not offer, indicate that it would take significant changes in the cost of coverage (as much as 50%) to encourage them to offer coverage. Given this response, it is unclear what mechanisms could induce employers who are not offering insurance coverage to offer insurance coverage.

Table 2-1

Health Insurance Offer Rates for New Hampshire Employers, 2001

	N	Percent of Employers	CI (±)
Offer Insurance	474	71.2	3.5
Not Offer Insurance	168	28.8	3.5

NOTES:
Chi-square = 114.854; Prob = 0.001.
Confidence intervals based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-2

Percentage of Employees at New Hampshire Firms that Offer Health Insurance, 2001

Offering Firms		Not Offering Firms	
N	Percentage of Employees	N	Percentage of Employees
13,264	94.3	793	5.7

NOTES:
N=Number of employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-3

Health Insurance Offer Rates for New Hampshire Employers by Firm Size, 2001

	Firm Size														
	1 Employee			**2-10 Employees**			**11-50 Employees**			**51-99 Employees**			**100 + Employees**		
	N	Percent of Employers	CI (±)	N	Percent of Employers	CI (±)	N	Percent of Employers	CI (±)	N	Percent of Employers	CI (±)	N	Percent of Employers	C
Offer Insurance	107	88.8	5.2	204	56.8	5.1	109	89.3	5.9	23	100.0	0.0	30	100.0	
Not Offer Insurance	13	11.2	5.2	142	43.2	5.1	13	10.7	5.9	0	0.0	0.0	0	0.0	

NOTES:

Chi-square = 87.340; Prob = 0.001.

Confidence interval based on 0.05 significance level.

Weighted to adjust for unequal response rates based on firm size.

N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-4

Percentage of Employees at New Hampshire Firms that Offer Health Insurance, by Firm Size, 2001

	Offering Firms		Not Offering Firms	
Firm Size	N	Percentage of Employees	N	Percentage of Employees
1 employee	107	89.1	13	10.9
2-10 employees	1,026	63.9	578	36.1
11-50 employees	2,499	92.5	202	7.5
51-99 employees	1,659	100.0	0	0.0
100 + employees	7,873	100.0	0	0.0

NOTES:
N=Number of employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-5

Health Insurance Offer Rates for New Hampshire Employers by Industry Sector, 2001

	Industry Sector																	
	Agriculture			**Construction**			**Manufacturing**			**Transportation**			**Wholesale**			**Retail Trade**		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	18	76.4	17.2	30	69.4	12.3	63	78.2	10.1	16	64.3	18.6	7	74.5	28.1	146	60.8	6.2
Not Offer Insurance	5	23.6	17.2	15	30.6	12.3	13	21.8	10.1	8	35.7	18.6	2	25.5	28.1	85	39.2	6.2

	Industry Sector														
	Financial Services			**Business Services**			**Professional Services**			**Healthcare**			**Childcare**		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	53	85.3	8.7	49	73.8	10.4	29	80.5	13.2	39	82.8	11.4	11	100.0	0.0
Not Offer Insurance	8	14.7	8.7	16	26.2	10.4	6	19.5	13.2	7	17.2	11.4	0	0.0	0.0

NOTES:
Chi-square = 30.644;
Prob = 0.001
Confidence interval based on 0.05 significance level
Weighted to adjust for unequal response rates based on firm size

N=Unweighted sample frequency of employers.

Table 2-6

Percentage of Employees at New Hampshire Firms that Offer Health Insurance, by Industry Sector, 2001

	Offering Firms		Not Offering Firms	
	N	Percentage of Employees	N	Percentage of Employees
Industry Sector				
Agriculture	301	94.3	18	5.7
Construction	362	80.6	87	19.4
Manufacturing	4,151	98.9	44	1.1
Transportation	255	90.7	26	9.3
Wholesale	76	91.5	7	8.5
Retail Trade	3,116	87.6	439	12.4
Financial Services	382	92.7	30	7.3
Business Services	525	87.9	72	12.1
Professional Services	426	94.8	23	5.2
Healthcare	3,529	98.9	37	1.1
Childcare	98	100.0	0	0.0

NOTES:
N=Number of employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-7

Percentage of Employees (Full-time Only) Earning Less than $17,180/Year at New Hampshire Firms that Offer Health Insurance

Offering Firms		Not Offering Firms	
N	Percentage of Employees Earning Less than $17,180/Year	N	Percentage of Employees Earning Less than $17,180/Year
564	78.66	153	21.34

NOTES:
200% of the federal poverty level in 2001 is $17,180/year.
N=Number of employees(full-time only) earning less than $17,180/year reported in the survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-8

Percentage of Part-time Employees at New Hampshire Firms that Offer Health Insurance, 2001

Offering Firms		Not Offering Firms	
N	Percentage of Part-time Employees	N	Percentage of Part-time Employees
1,983	86.03	322	13.96

NOTES:
N=Number of part-time employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-9

Percentage of Seasonal Employees at New Hampshire Firms that Offer Health Insurance

Offering Firms		Not Offering Firms	
N	Percentage of Seasonal Employees	N	Percentage of Seasonal Employees
617	80.76	147	19.24

NOTES:
N=Number of seasonal employees reported in the survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-10
Health Insurance Offer Rates for New Hampshire Employers by County, 2001

	County														
	Belknap			**Carroll**			**Cheshire**			**Coos**			**Grafton**		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	28	70.9	14.5	30	76.3	13.4	30	73.6	13.6	11	48.6	22.3	45	60.2	11.2
Not Offer Insurance	10	29.1	14.5	9	23.7	13.4	9	26.4	13.6	9	51.4	22.3	27	39.8	11.2

	County														
	Hillsborough			**Merrimack**			**Rockingham**			**Strafford**			**Sullivan**		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	133	78.3	6.4	52	74.8	10.5	100	70.9	7.5	26	66.7	15.0	19	63.3	17.6
Not Offer Insurance	32	21.7	6.4	15	25.2	10.5	37	29.1	7.5	11	33.3	15.0	9	36.7	17.6

NOTES:
Chi-square = 15.315; Prob = 0.083
Confidence interval based on 0.05 significance level
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-11

Percentage of Employees at New Hampshire Firms that Offer Health Insurance, by County, 2001

	Offering Firms		Not Offering Firms	
	N	Percentage of Employees	N	Percentage of Employees
County				
Belknap	710	93.1	52	6.9
Carroll	531	93.4	37	6.6
Cheshire	433	91.9	38	8.1
Coos	603	93.7	40	6.3
Grafton	1,360	90.6	140	9.4
Hillsborough	4,229	96.7	144	3.3
Merrimack	1,292	93.9	83	6.1
Rockingham	1,643	90.1	181	9.9
Strafford	2,133	97.9	45	2.1
Sullivan	330	90.9	33	9.1

NOTES:
N=Number of employees reported in the survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-12

Health Insurance Offer Rates for New Hampshire Employers by Northern and Southern Counties, 2001

	Northern Counties			Southern Counties		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	105	63.26	7.46	369	73.78	3.92
Not Offer Insurance	54	36.74	7.46	114	26.22	3.92

NOTES:
Chi-square = 6.485; Prob = 0.011.
Confidence interval based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
The northern area consists of Coos, Grafton, Carroll, and Sullivan counties.
The southern area is Cheshire, Merrimack Belknap, Strafford, Hillsborough, and Rockingham counties.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-13

Percentage of Employees at New Hampshire Firms that Offer Health Insurance by Northern and Southern Counties, 2001

	Offering Firms		Not Offering Firms	
	N	Percentage of Employees	N	Percentage of Employees
Northern Counties	2,824	91.86	250	8.14
Southern Counties	10,440	95.05	543	4.95

NOTES:
N=Number of employees reported in survey.
The northern area consists of Coos, Grafton, Carroll, and Sullivan counties.
The southern area is Cheshire, Merrimack Belknap, Strafford, Hillsborough, and Rockingham counties.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-14

Health Insurance Offer Rates for New Hampshire Employers by Urban and Rural Counties, 2001

	Urban Counties			Rural Counties		
	N	Percentage of Employers	CI (±)	N	Percentage of Employers	CI (±)
Offer Insurance	285	74.83	4.44	189	66.29	5.57
Not Offer Insurance	84	25.17	4.44	84	33.71	5.57

NOTES:
Chi-square = 5.592; Prob = 0.018.
Confidence interval based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
The urban counties are Hillsborough, Merrimack, and Rockingham.
The rural counties are Belknap, Carroll, Cheshire, Coos, Grafton, Strafford, and Sullivan.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-15

Percentage of Employees at New Hampshire Firms that Offer Health Insurance by Urban and Rural Counties, 2001

	Offering Firms		Not Offering Firms	
	N	Percentage of Employees	N	Percentage of Employees
Urban Counties	7,164	94.61	408	5.39
Rural Counties	10,440	94.06	543	5.94

NOTES:
N=Number of employees reported in survey.
The urban counties are Hillsborough, Merrimack, and Rockingham.
The rural counties are Belknap, Carroll, Cheshire, Coos, Grafton, Strafford, and Sullivan.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-16

Monthly Premium for Individual Health Insurance Policy at New Hampshire Firms Offering Coverage, 2001

Average Monthly Premium for Individual Coverage ($'s)	N	Percent of Employers	CI (±)
110 – 184	73	24.5	5.94
185 – 224	76	24.1	5.90
225 – 289	74	24.8	5.96
290 – 485	74	26.7	6.11

NOTES:
Chi-square = .528; Prob = 0.913.
Confidence intervals based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N = Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-17

Monthly Premium for Family Health Insurance Policy at New Hampshire Firms Offering Coverage, 2001

Average Monthly Premium for Family Coverage ($'s)	N	Percent of Employers	CI (±)
215 - 399	48	21.3	5.65
400 - 559	66	25.7	6.03
560 - 734	59	24.4	5.93
735 - 1300	59	28.7	6.25

NOTES:
Chi-square = 2.52; Prob = 0.472.
Confidence intervals based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N = Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-18

Employer Percentage Contribution to Health Insurance for Offering New Hampshire Firms, 2001

Employer Contribution to Health Insurance (%)	N	Percent of Employers	CI (±)
0 – 64	81	25.10	4.93
65 – 84	68	17.70	4.34
85 – 100	178	57.20	5.63

NOTES:
Chi-square = 78.2; Prob = 0.001.
Confidence intervals based on 0.05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N = Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research,

Table 2-19

Percentage of Employees Eligible for Coverage at New Hampshire Offering Firms, 2001

Eligible Employees at Offering Firms		Not Eligible Employees at Offering Firms	
N	Percent of Employees	N	Percent of Employees
10,181	76.75	3083	23.24

NOTES:
N = Number of employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-20

Percentage of Eligible Employees at New Hampshire Offering Firms that Take-up Coverage, 2001

Eligible Employees that Take-up Insurance		Eligible Employees that Don't Take-up Insurance	
N	Percent of Employees	N	Percent of Employees
8,761	86.05	1,420	13.95

NOTES:
N = Number of employees reported in survey.

SOURCE: Survey of New Hampshire Employers, Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-21
Influences on New Hampshire Employer Decisions About Whether or Not to Offer Coverage, 2001

	N	Percent of Employers	CI (±)
Helps recruit new employees			
Major reason	203	51.3	5.38
Minor reason	73	21.1	4.39
Not a reason	88	27.6	4.81
Chi-square = 50.131; Prob = 0.001			
Helps retain current employees			
Major reason	264	69.0	4.69
Minor reason	46	14.3	3.55
Not a reason	51	16.7	3.78
Chi-square = 188.002; Prob = 0.001			
Increases productivity			
Major reason	127	34.1	5.15
Minor reason	142	39.3	5.30
Not a reason	90	26.7	4.80
Chi-square = 7.834; Prob = 0.020			
Creates tax advantages for company			
Major reason	68	20.2	4.44
Minor reason	139	39.8	5.41
Not a reason	137	40.0	5.42
Chi-square = 24.408; Prob = 0.001			
One or more of employees has a chronic medical problem			
Major reason	36	9.9	3.25
Minor reason	59	16.2	4.01
Not a reason	259	78.3	4.49
Chi-square = 240.483; Prob = 0.001			

NOTES:
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-22
Primary Reasons New Hampshire Employers Give for Electing Not to Provide Coverage, 2001

	N	Percent of Employers	CI (±)
Setting up a plan is too complicated and time consuming			
Major reason	14	7.7	3.85
Minor reason	38	23.0	6.08
Not a reason	115	69.3	6.66
Chi-square = 113.573; Prob = 0.001			
Revenue too uncertain to commit to a health insurance plan			
Major reason	76	45.8	7.20
Minor reason	34	20.2	5.80
Not a reason	57	34.0	6.84
Chi-square = 18.039; Prob = 0.001			
The business cannot afford it			
Major reason	116	69.0	6.66
Minor reason	17	10.0	4.32
Not a reason	35	21.0	5.86
Chi-square = 109.478; Prob = 0.001			
Employees cannot afford it			
Major reason	70	43.7	7.31
Minor reason	27	16.6	5.48
Not a reason	63	39.7	7.21
Chi-square = 22.615; Prob = 0.001			
Employees are healthy and do not need it			
Major reason	10	6.4	3.52
Minor reason	35	21.0	5.86
Not a reason	122	72.6	6.42
Chi-square = 133.845; Prob = 0.001			
Employee would rather earn a high wage than receive health benefits			
Major reason	28	17.9	5.73
Minor reason	33	20.8	6.07
Not a reason	94	61.3	7.29
Chi-square = 60.543; Prob = 0.001			
Employees have coverage elsewhere			
Major reason	66	40.6	7.17
Minor reason	38	22.7	6.12
Not a reason	59	36.7	7.04
Chi-square = 9.650; Prob = 0.008			

Table 2-22 (continued)
Primary Reasons New Hampshire Employers Give for Electing Not to Provide Coverage, 2001

	N	Percent of Employers	CI (±)
Company does not need to offer health insurance to attract and retain employees			
Major reason	32	19.2	5.70
Minor reason	34	20.5	5.84
Not a reason	100	60.3	7.08
Chi-square = 59.922; Prob = 0.001			
Employee turnover is too high			
Major reason	11	6.0	3.42
Minor reason	27	15.3	5.18
Not a reason	130	78.7	5.89
Chi-square = 174.128; Prob = 0.001			
The owner has coverage elsewhere			
Major reason	78	47.0	7.20
Minor reason	19	10.6	4.44
Not a reason	70	42.3	7.13
Chi-square = 43.460; Prob = 0.001			
Employer does not know where to go or who to talk to setup an employer sponsored health plan.			
Major reason	6	3.6	2.68
Minor reason	22	13.6	4.93
Not a reason	140	82.8	5.43
Chi-square = 206.227; Prob = 0.001			
Company is too small, or does not have enough employees			
Major reason	80	48.3	7.20
Minor reason	32	19.2	5.67
Not a reason	56	32.5	6.74
Chi-square = 23.625; Prob = 0.001			

NOTES:
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-23

Individual Co-Payment for Primary Care Physician Visit for New Hampshire Employers Offering Coverage, 2001

$	N	Percent of Employers	CI (±)
0	6	2.2	1.68
5	20	6.1	2.75
10	174	53.4	5.73
15	89	27.0	5.10
20	32	10.7	3.55
25	2	0.7	0.95

NOTES:
Chi-square = 361.328; Prob = 0.001
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
Co-payment for health plan with highest employee enrollment at the firm.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-24
Individual Co-Payment for Hospital Admission for New Hampshire Employers Offering Coverage, 2001

$	N	Percent of Employers	CI (±)
0	67	25.9	5.75
50	49	19.2	5.17
100	13	5.6	3.02
150	1	0.4	0.82
200	41	17.2	4.95
250	16	6.1	3.14
300	33	13.4	4.47
350	1	0.4	0.82
400	3	0.7	1.09
500	19	7.5	3.46
750	2	0.7	1.09
1000	6	2.8	2.16

NOTES:
Chi-square = 218.341; Prob = 0.001
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
Co-payment for health plan with highest employee enrollment at the firm.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-25

Health Plan Services for New Hampshire Employers Offering Coverage, 2001

	N	Percent of Employers	CI (±)
Mental Health Service			
Yes	303	94.4	2.66
No	17	5.6	2.66
Chi-square = 226.084; Prob = 0.001			
Prescription Drugs			
Yes	344	94.9	2.39
No	15	5.1	2.39
Chi-square = 260.654; Prob = 0.001			
Vision Care, Including Vision Check Ups			
Yes	235	68.4	5.2
No	107	31.6	5.2
Chi-square = 41.473; Prob = 0.001			
Preventive Health Services			
Yes	327	94.5	2.54
No	17	5.5	2.54
Chi-square = 244.622; Prob = 0.001			

NOTES:
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.
Services offered by health plan with highest employee enrollment at the firm.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-26

Percentage Increase in Health Plan Costs that Would Cause New Hampshire Firms Offering Coverage to Switch Plans, 2001

Percentage Increase	N	Percent of Employers	CI (±)
None (never switch)	3	1.6	1.65
5	27	11	4.13
10	64	27.7	53.9
12	1	0.4	0.83
15	27	10.7	4.08
17	1	0.4	0.83
20	57	23.5	5.59
25	30	12.2	4.32
30	19	7.5	3.47
35	2	0.4	0.83
40	5	2	1.84
50	5	2.5	2.06

NOTES:
Chi-square = 249.453; Prob = 0.001
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-27

Percentage Increase in the Cost of Health Insurance that Would Cause New Hampshire Employers Offering Coverage to Stop Offering, 2001

Percentage Increase	N	Percent of Employers	CI (±)
None (never stop)	113	50.1	6.94
10	6	3.0	2.36
15	18	9.3	4.03
20	10	4.8	2.96
25	15	7.5	3.65
30	8	3.8	2.65
35	1	0.4	0.87
40	9	3.7	2.62
45	2	0.8	1.23
50	34	16.0	5.08
55	2	0.6	1.07

NOTES:
Chi-square = 451.394; Prob = 0.001
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

Table 2-28
Percentage Decrease in the Cost of Health Insurance that Would Cause New Hampshire Employers Not Offering Coverage to Start, 2001

Percentage Decrease	N	Percent of Employers	CI (±)
None (never start)	89	54.1	7.17
10	2	1.0	1.43
20	6	3.8	2.75
25	5	2.8	2.30
30	3	1.7	1.86
33	1	0.5	3.14
35	2	1.1	1.50
40	7	3.9	2.78
50	36	21.2	5.88
60	1	0.6	1.11
66	1	0.6	1.11
70	1	0.5	1.01
75	5	3.0	2.45
80	3	1.7	1.86
90	1	0.6	1.11
100	5	2.7	2.33

NOTES:
Chi-square = 834.767; Prob = 0.001
Confidence interval based on .05 significance level.
Weighted to adjust for unequal response rates based on firm size.
N=Unweighted sample frequency of employers.

SOURCE: Survey of New Hampshire Employers Office of Planning and Research, Department of Health and Human Services, New Hampshire, 2001.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Recent trends in the health insurance marketplace

The problems? At present, the two most notable trends in New Hampshire's individual and small group health insurance markets are:

1. **Acceleration in premium increases**? After an unprecedented period of low inflation in the health care sector from 1994 to 1998, recent years have seen an acceleration in premium increases in New Hampshire as in the rest of the nation.[i] Premium increases have exceeded inflation for the third year in a row in New Hampshire, with annual increases averaging between 20-25% in the individual market, and 5-15% in the small group market.

2. **Reduction in the number of participating insurers**? Through a combination of mergers, acquisitions and market exits, health insurers are declining in number. Both the individual and group health insurance markets in New Hampshire are now essentially duopoly markets, with two players in each case holding the majority of the market. In the individual market two insurers hold approximately 81% of the market. In the small group market, two insurers hold approximately 75% of the market.[ii]

Number of Market Participants With Significant Market Participation								
	1994	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Individual Market	6	5	5	5	3	3	3	2
Small Group Market	26	28	24	24	19	15	12	9

Market Share of Two Largest Insurers			
	1998	**1999**	**2000**
Individual Market	65%	78%	81%
Small Group Market	72%	68%	75%

The primary factors driving the acceleration in premium increases? Nationally, most analysts attribute the acceleration in premium increases not to the health insurance reforms of the early 90s but to the following two factors: (1) the recent surge in the underlying health care costs and utilization of covered services, and (2) the health insurance underwriting (or profitability) cycle.[iii]

1. **The recent surge in health care costs**? In the early and mid-1990s, inflation in the cost of health care slowed which reduced the pressure on health insurance premiums. However, beginning in 1996/1997, there has been an increasing upward trend in the key components of health spending.[iv] The following factors are most often cited as contributing to this recent surge in health care costs and expenditures:

   a. Prescription drug costs

   b. Hospital costs

c. Physician costs

d. New medical technologies

e. Increasing utilization

Between the Spring of 1999 and Spring of 2000, premium equivalents for self-insured plans nationally increased by nearly the same amount as fully insured plans (7.1% versus 8.3%).[v] This suggests that premium increases may be driven by increased health care costs, not reform laws.

2. **The health insurance underwriting (or profitability) cycle**? From 1995-1998 health insurers competed on price for market share. In response to mounting losses in 1997 and 1998, health insurers have largely stopped buying market share and now are focusing on premium pricing and other strategies for returning to profitability. This reflects an historical pattern of pricing and profitability for the health insurance industry. When insurers are earning underwriting profits (profits before investment income), they strive to enlarge their market share by under pricing their insurance products. Premiums rise more slowly than medical claims expenses do. Eventually, price competition eliminates underwriting profits, and insurers shift their strategy to restoring profitability by raising premiums? the catch-up phase of the underwriting cycle.[vi] A significant portion of the recent price increases may be attributable to an effort by insurers to make up for ground lost in the 1995 – 1998 period of competition for market share.

Other factors that may be affecting the acceleration in premium increases:

1. **The cost shift from public to private payers**? The Balanced Budget Act of 1997 significantly reduced reimbursements to hospitals under the Medicare program. This has put pressure on hospitals to make up for reductions in Medicare reimbursement by cost shifting to private insurers. Below cost Medicaid reimbursement rates to providers have similarly resulted in higher rates charged to private insurers. A recent study conducted by Health Economics Research for the New Hampshire Department of Health and Human Services shows evidence that reimbursement rates paid by private insurers have been significantly affected by the lower Medicare rates, as well as by the historically low Medicaid rates. Hospitals in New Hampshire enjoyed margins from private payers of 9.7% in 1998 compared with an average Medicare margin of –2.0% and an average Medicaid margin of –1.5%.[vii]

2. **Consolidation in the health care provider market**? Nationally and in New Hampshire, the health care provider market has been consolidating. Hospitals and doctors have been affiliating vertically and horizontally. Hospital ownership of physician practices is common. The 1987-97 decade saw 2,753 mergers and acquisitions involving health service companies nationally.[viii] In New Hampshire, the health care provider market in some parts of the state is approaching monopoly status.

   The Center for Health Economics Research and the Harvard School of Public Health

recently completed two studies of New Hampshire's hospital markets.[ix] The studies found that most hospitals in New Hampshire control the local geographic and service markets and have few competitors. For example, the typical hospital outpatient market is characterized by a single provider controlling over three-quarters of all outpatient visits. Although average costs and net revenues per discharge in New Hampshire hospitals are among the lowest in New England, this may be attributable to low Medicare and Medicaid rates. New Hampshire hospitals are generating relatively higher margins from private payers. Hospital margins from private payers in New Hampshire were 9.7% in 1998, compared with 6.1% regionally and 5.5% nationally. New Hampshire hospitals have been able to take advantage of their strong market position to at least partially avoid the discounts and cost-sharing arrangements typically associated with managed care plans. While the HMO share of admissions ranged from 20% to 50%, the actual share of hospital revenue exposed to risk sharing or capitated contracts was less than 10% on average.

3. **The managed care backlash**? The managed care backlash may be affecting premiums in a number of ways. First, it may be giving health care providers a stronger hand in influencing the political and regulatory environment for managed care. Secondly, concern on the part of managed care insurers over tort liability, Board of Medicine review, and further bad publicity may lead managed care insurers to distance themselves from the medical decision-making process which is an important tool for controlling costs.

Factors contributing to the decline in the number of participating insurers:

1. **The continuing trend toward insurance market consolidation**? Over the last decade, and concurrently with the advent of managed care as the dominant mode of health insurance,[x] health insurance markets across the country have experienced a number of mergers and acquisitions as insurers have sought to gain premium volume, market share, and economies of scale.[xi] The 1987-97 decade saw 162 mergers and acquisitions involving HMOs.[xii] In many states, large national firms have acquired smaller domestic insurers. These changes have been more disruptive in small population states such as New Hampshire that have few insurers in either the group or individual market. In all states, however, the economic incentive for insurers to become larger (and fewer in number) is likely to grow as public concern about health insurance costs and coverage escalates.[xiii]

2. **The decline of indemnity health insurance**? Among Americans with job-based coverage, the percentage of employees with indemnity insurance coverage declined from 95% in 1978 to 71% in 1988, then to 14% in 1998.[xiv] This decline in indemnity health insurance had been a factor contributing to the overall decline in the number of health insurers. Interestingly, the decline in indemnity market share contributed to the slowing of growth in health insurance premiums that occurred in the mid-90s.[xv] Managed care insurers have been more successful in controlling premium growth, in part by achieving operating efficiencies not available to indemnity insurers.

3. **Insurer concerns about adverse selection in the individual market**? The individual market seems to be the one area where the decline in the number of participating insurers is in part attributable to the guaranteed issue and community rating provisions of New Hampshire's 1994 reforms. Based on "exit interviews" conducted by the New Hampshire Insurance Department, a number of insurers that have left the market in recent years stated that, a factor in their decision-making process was their concern that the guaranteed issue requirement and the rating restrictions did not leave insurers with enough tools to protect themselves against the tremendous potential for adverse selection that exists in the individual market. The Wake Forest study of individual market reforms in other states supports this observation.

Squeezing the balloon: Limitations on state regulatory strategies that aim to pool risks in a particular market? State health insurance markets consist of three distinct segments? individual, small group, and large group? each governed by different economic and regulatory structures. In addition, purchasers can leave the state regulated markets altogether by self-insuring under ERISA, by deciding to go without coverage, or by switching to public coverage, if eligible. A complicating factor in any state's efforts to maintain the stability of its health insurance markets is the permeability of the market borders? healthier persons often can get out of the pool, if better or cheaper coverage is available elsewhere.

A. **The ERISA problem**? The federal Employee Retirement Income Security Act (ERISA) provides that a state's authority to regulate insurance does not extend to employers who self-fund their health benefits program. An employer can avoid participating in any state regulated market by self-funding. The Insurance Department estimates that approximately 40-50% of the employer market is self-insured and exempt from state regulation.

B. **The problem of the voluntary nature of our system of coverage**? In a voluntary system that is supplemented by various public coverage plans, an individual can decide to go without coverage or switch to public coverage (if eligible) if the perceived value of the coverage available in the state regulated market becomes too low.

   In a system of voluntary coverage with permeable borders among market segments, it is not easy to keep the healthy in the same risk pool as the sick. The healthy can obtain coverage less expensively by finding a pool that excludes high-risk individuals. This is because of the huge disparity in the cost of caring for the healthy versus the sick: the healthiest 50% of the population generate approximately 3% of health care spending, while the sickest 1% of the population account for 30% of health care spending. Market permeability limits a state's options for addressing market problems through risk pooling techniques.

The 2001 Legislative Session

On June 26, the Legislature passed two important health insurance reform bills affecting the individual market (SB 118) and the small group market (SB 119). House and Senate leadership sponsored these two bills at the behest of the Coalition for Better Health Insurance, representing:

? NH Association of Health Underwriters (NHAHU),

- NH Association of Insurance and Financial Advisors (NHAIFA), and
- Independent Insurance Agents of NH (IIANH).

The stated purpose was to "create a favorable regulatory environment that will attract insurers back into the state to increase competition and hopefully stabilize premium rates."

The bills proposed to roll back the guarantee issue and community rating rules passed in 1995 affecting both health insurance markets. Initially, last fall, the sponsors' concern was attracting more insurers into NH's *individual* market, which has been chronically unstable with only three insurers writing expensive high-deductible products for an estimated 1% of New Hampshire's covered lives (less than 10,000 individuals).

By December, Senate and House leaders decided to press for changes in the *small group* market as well, which writes insurance for an estimated 41% of NH's covered lives. The small group market has not been considered to be particularly unstable. Currently, nine insurers participate in this market, with Anthem Blue Cross and CIGNA Healthsource providing over 75% of the coverage. However, sponsors argued that "more competition" would curb fast-rising health insurance premiums for small businesses, a promise that resonated far and wide in the business community. At the same time, insurers within and outside the state saw the opportunity to create a more profitable climate in NH's small group market.

Individual Market – SB 118

In the Senate, the Governor intervened with Senate leaders to broker a compromise on SB 118, and that compromise also passed intact through the House. The new law will roll back guarantee issue in the individual market and create a high risk pool in 2002 for "uninsurable" (high cost) individuals rejected for coverage by commercial insurers -- namely, individuals with serious chronic illnesses, disabilities, and other costly health conditions. SB 118 will also relax community-rating rules to allow insurers more leeway to target their insurance products at younger and healthier individuals and either reject outright or make their products less attractive to older and sicker persons (risk avoidance/"cherry picking").

Small Group Market – SB 119

No compromise could be reached on SB 119 in the Senate, and it passed on a contentious party-line vote. The House Commerce Committee, however, rejected virtually the entire Senate bill, after over 10 hours of hearings. Research and policy analysis from DHHS and others showed that the Senate bill would not address underlying cost drivers. Instead, it would divide the small group market into "winners" and "losers" and "literally wreak havoc on many small business owners" whose group has worse than average health (Commerce Committee report in 6/1/01 House Calendar).

Accordingly, the Commerce Committee diverged with the Senate on the following major issues:

- It rejected the Senate provisions to allow insurers to rate on the basis of health status, tobacco use, industry type, and geographic location. The Committee recognized that those provisions would allow all group insurers to "cherry pick" out of the general

pool those with the best health risks, while charging sharply higher rates to older and sicker groups.

? It also rejected lowering the definition of "small group" from 1-100 individuals to 1-50. At first, on a party line vote, the Committee approved a small group definition of 1-75. But then Reps. Hunt and Fraser retreated, themselves questioning the policy advantage. As Vice-Chair Leo Frazer wrote in the 6/1 House Calendar report, "Everyone on the committee was deeply concerned about exposing employers of groups between 51 and 100 to what in all likelihood would be strict underwriting requirements."

The Committee did see fit to make a few small changes:

? *Age rating*: Retain the 3:1 differential in rates based on age (allowed in current law), but eliminate the youngest age bracket (0-18) since that group will likely be able to obtain coverage at a lower rate. The impact on all the other age bands (starting with 19-24 and continuing on up to 65+) is similar to increasing the existing age differential from 3:1 to 4:1.

? *Employer size*: Allow insurers to rate up smaller groups by a small differential to account for administrative efficiencies of covering larger groups. This provision merely makes explicit what is already permitted under current law.

? *Group of 1*: Establish two open enrollment periods a year for small employers who are self-employed. This will make it harder for "group of 1" families to take advantage of guarantee issue to switch in and out of coverage -- i.e., foregoing coverage when their health costs are low but then re-entering the market in the face of higher costs (e.g., a pregnancy).

The first two changes are effective August 25, 2001. The open enrollment restriction for "groups of 1" is effective July 1, 2002, the same effective date as the high-risk pool for the individual market.

3.1 How adequate are the existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

The existing insurance products are inadequate for adults with incomes less than 200% of the federal poverty level. The products are inadequate because they are unaffordable. See the Josiah Bartlett Report on Livable Wage in Appendix A.

In addition, there is some evidence that the products that are available or being offered by employers are inadequate either because they are too costly or because the benefits being offered are inadequate. Of the working uninsured, only 19.8 percent of the surveyed uninsured adults report that they were eligible for a workplace plan, but chose not to participate. Those respondents indicated that the primary reasons they chose not to participate is because the plans

were too expensive or because the benefit plan was inadequate. On the employer side, one of the primary reasons for not providing insurance coverage was the cost of that coverage.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

There is substantial variation in benefits between non-group, very small group, small group, large group, and self-insured plans.

Non-group products: These are indemnity products generally with high deductibles.

Very small group products: Very small employers were the least likely to offer any health insurance coverage at all to their full-time employees. Those who do offer are likely to have catastrophic or major medical plans with high deductibles. Most report deductibles in the range of $2,000 per individual, $5,000 per family. Very small employers are experimenting with Medical Savings Accounts with mixed results.

Small group products: Small employers provide Health Maintenance Organization (HMO) coverage to their employees. Small employers have increased office visit and emergency room co-payments, prescription drug co-payments, and the deductible for inpatient services to contain cost increases. Small employers are unable to offer a choice of health plans to their employees.

Large group products: Larger employers usually offer more than one health plan to their employees. They offer a Health Maintenance Organization (HMO) or a catastrophic coverage product with high cost sharing, along with traditional indemnity and Preferred Provider Organization (PPO) plans. Larger employers are increasing co-payments for prescription drug coverage to combat rising costs. Larger employers are shifting from underwritten to self-insured products.

Self-insured products: Self-insured firms offer a mix of benefits to their employers. Some firms include preventive care and on-site wellness programs as part of their overall benefits package.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

Nearly one half of employer-based insurance is provided through self-insured groups. According to estimates prepared in 1998, insured employer groups cover approximately 635,000 lives, and self-insured groups cover approximately 300,000 lives.

The prevalence of self-insurance does impact the marketplace by reducing the size of the group market. Generally, an employer will choose to self-insure only when the employee group is healthy. This causes some level of adverse selection against the small group market. New Hampshire's small group market covers employee groups of one to one hundred employees. The option to self-insure may allow larger groups, particularly those between 50 and 100 employees in size, to exit from the small group market when their employees are healthy, and to reenter the

small group market and obtain the advantage of community rating when the group is less healthy. This may result in higher overall premium rates in the small group market.

Another impact relative to self-insurance is that employer groups of smaller sizes are choosing to self-insure in order to reduce their health insurance premiums. Groups with sizes as small as 25 are now choosing to self-insure.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

Out of the 635,000 insured lives in New Hampshire, the State as purchaser or health care for Medicaid, SCHIP and the State employees insures approximately 5-7%. As a result, New Hampshire's impact as a purchaser of health care is limited.

The State purchases coverage for approximately 40,000 lives from Cigna, and coverage for almost 35,000 retirees from Anthem. The State's purchase of insurance for active employees and retirees constitutes nearly one-fourth of Cigna's covered lives in New Hampshire

Children (under certain categories) and pregnant women have had the option of voluntarily enrolling in a managed care plan through Anthem Blue Cross and Blue Shield. Until about one year ago, this option was not heavily promoted. Enrollment had been averaging about 4,000 but has recently grown to over 6,000 as a result of bundling private dental coverage and increased marketing efforts. The State's Title XXI program was set up as a managed care product, also through Anthem Blue Cross and Blue Shield. The current enrollment is 4500 children, including 650 covered through a full cost buy-in. The combined total of just over 10,000 lives, however, is not significant enough to give the State real clout as a health insurance purchaser.

As a direct payer of services, the State does have an impact on health care with many providers indicating that reimbursement rates are insufficient to cover costs. Recent expansion of coverage for kids, however, has provided a source of reimbursement for services that were unlikely to be fully collected on a self-pay basis.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

This will be addressed in the year two report.

3.6 How would universal coverage affect the financial status of health plans and providers?

Universal coverage would improve the financial status of community hospitals and community health centers.

In 1999, New Hampshire hospitals contributed 5% of their gross patient service revenues or $111M to free care and bad debt. These contributions, along with public sector program

subsidies, have resulted in substantial cost shifting to the private sector. Hospitals are offering health plans smaller discounts and are realizing larger profits on the private sector. See *The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis* in Appendix D.

In 1999, 41% of New Hampshire Community Health Centers patients were uninsured. Between 1994-1999, New Hampshire's CHCs experienced a decline in financial health. See *Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers* in Appendix E.

3.7 How did the planning process take safety net providers into account?

The planning processes accounted for safety net providers in a variety of ways. First, the Department conducted a survey of community clinics and community hospitals to assess the extent to which uninsured individuals had access to subsidized care. Each community clinic and community hospital was asked about their free care eligibility determination process. This information is currently being reviewed and was unavailable at press time.

Second, the Department conducted an analysis of the financial strength of both community health centers and the community hospital system. Please see *Strengthening the Safety Net: A Financial Analysis of New Hampshire's Community Health Centers*, and *The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis* in Appendices D and E.

Third, safety net providers participated directly in the work that was conducted through their trade association's participation in the HRSA Adult Coverage Advisory Committee.

3.8 How would utilization change with universal coverage?

It is expected that utilization of primary care services, diagnostic testing services, chronic disease management services, and pharmaceutical services would increase.

In New Hampshire, emergency room utilization and hospital inpatient admissions for ambulatory care sensitive conditions is relatively limited. However, it is expected that utilization of the hospital emergency room would decrease as would hospital admissions for ambulatory care sensitive conditions.

3.9 Did you consider the experience of other States with regard to expansion options?

Yes, the experience of other States is being considered. It will be used substantially in New Hampshire's year two-model development work.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus groups and survey results). What factors ultimately brought the State to consensus on each of these approaches?

The Advisory Committee was able to come to consensus on the need for action surrounding the issue of health insurance coverage. Consensus on the need for action was in large part a result of the availability of quantitative information that eliminated a number of myths about the uninsured. The survey work established that the uninsured were largely working adults of all ages (not solely 18-30) who were working in firms that did not offer insurance coverage. In addition, it was broadly recognized that expanding coverage to the parents of CHIP eligible children was likely to both expand coverage for adults and expand coverage for children. As a result of these factors, the Advisory Committee was able to come to consensus on the need for action. (See the SB 183 Adult Coverage Subcommittee Report in Appendix F for the advisory committee's mission statement).

Despite this general consensus on the need for action, the HRSA Development Team and Advisory Committee have not reached consensus on the proposed approaches to coverage expansion. The primary policy consideration that has worked in favor (and in most cases against) various models was financing. Given the growth in the state's Medicaid pharmacy budget, the potential for decline in revenues associated with an economic downturn, and the possibility of losing rather than gaining ground in existing public policy, it was difficult to bring significant expansions in coverage to the policy table.

As a result, this year's work has concentrated on conducting the surveys, focus groups and research on four options. Those options are: 1) Expansion of SCHIP to parents, 2) the One-Third Model, 3) the HealthLink Program, and 4) Federal tax credits.

The major political and policy considerations are described below for each of the four options:

Expansion of SCHIP to parents. The 65% federal match works in favor of this option. The 35% state share works against this option. Consumer focus group results support this option. A copy of the Adult Coverage Subcommittee Report to the Legislature dated January 2001 recommending this option is included as Appendix F.

One-Third Model. Employer and employee cost sharing work in favor of this option. Employer Focus Group results work against this option. See Section 2 for specifics.

The HealthLink Program. The private sector nature of this free care, coordinated care program work in favor of this option. The administrative cost and provider capacity/willingness to participate work against this option. See Appendix G for a description of this program model.

Federal Tax Credits. Employer focus group results were mixed relative to the value of federal tax credits. That federal tax credits would improve retention of insurance for families that can

afford to purchase it works in favor of this option. That tax credits would not result in greater uptake or offer of health insurance coverage works against this option. See Section 2 for specifics.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

The state of New Hampshire has significantly expanded coverage for lower income children. Despite these expansions, children remain uninsured in New Hampshire. According to information from the New Hampshire Health Insurance Coverage and Access Survey, there are approximately 27,000 children under the age of 19 that were uninsured in 1999. This analysis has not yet been conducted for 2001.

Given the important role of insurance coverage on children's long-term well-being and recognizing current efforts to improve outreach for both the Healthy Kids Gold and Silver programs, it is important for policy-makers to understand the size and characteristics of those uninsured children in New Hampshire that are eligible for, but do not participate in, existing public programs. As a result, the state working with the Healthy Kids Corporation has attempted to develop quantitative measures of the eligible but not enrolled population of children.

The Eligible But Not Enrolled Population of Children

The data for this analysis of the eligible but not enrolled children come from the 1999 New Hampshire Health Insurance Coverage and Access survey. Individuals interviewed in the survey were not directly asked if they were Medicaid eligible. As a result, eligibility for public programs was not directly observable from the information that was collected. In order to determine the number of eligible but not enrolled children, a simulation of program eligibility was required.

The Healthy Kids Program provides subsidized insurance coverage for all children in families of all types with income under 300% of the federal poverty level. In simulating eligibility, we were interested in differentiating between those children eligible for the Healthy Kids Gold, Healthy Kids Silver and Healthy Kids Silver Unsubsidized programs. Data on individuals and families regarding age, income, and insurance coverage in the past year were used to simulate eligibility for these two programs.[1]

Eligibility for each of the programs was determined based on the child's insurance status at the point the survey was fielded, age, how long the child was uninsured over the course of the previous year and family income. A hierarchical eligibility category was developed in which children were first tested to see if they met the income requirements of the Healthy Kids Gold program, then the income and previous insurance coverage requirements of the Healthy Kids

[1] We were not interested in simulating eligibility within the Healthy Kids Gold program. This would require simulating eligibility for AFDC, the Ribbicoff Children program, and the AFDC-UP program, and the medically needy program using information on family structure, employment status, and marital status.

Silver subsidized program, and finally whether or not they met the income and previous insurance coverage requirements of the Healthy Kids unsubsidized coverage program.[2]

Determining those that are eligible but not enrolled with precision is difficult for a variety of reasons. First, eligibility determination is a complex process involving many different programs, including Transitional Assistance for Needy Families, federally mandated expansions (which expanded coverage to children born after 30 September 1983), AFDC-UP programs, as well as New Hampshire specific expansions beyond the federal mandates. Second, people are often reluctant to report household income, which requires the imputation of income to allow policy makers to use all available information. Third, there is a methodological debate about the degree to which household surveys under-report those that are Medicaid covered. Thus, simulating those that are eligible but not enrolled has some error.

Eligibility and Insurance Coverage

The state's efforts to expand coverage have increased the pool of eligible children considerably. In total, an estimated 52% of children in the state of New Hampshire are eligible for either the Healthy Kids Gold, Silver or Silver unsubsidized program. Approximately 27% of all children were eligible for subsidized coverage through the Healthy Kids Gold or Healthy Kids Silver subsidized program. Another 25% were eligible for the Healthy Kids Silver unsubsidized program.

Not surprisingly, given the broad coverage options, a significant share of the uninsured population is eligible for some component of the Healthy Kids program based on 1999 survey data. Of the 27,000 uninsured children, 45% were eligible for the Healthy Kids Gold program, 16% for the Healthy Kids Silver program, and 19% for the Healthy Kids Silver unsubsidized program. The remaining 20% of uninsured children were not eligible for the Healthy Kids program. Together, approximately 80% of the estimated 27,000 uninsured children in New Hampshire are eligible for either the Healthy Kids Gold, Healthy Kids Silver, or Healthy Kids Silver unsubsidized programs.

As a result of this pool of eligible but not enrolled children, the State and it's partners have developed an aggressive outreach effort. Below is a discussion of these outreach efforts.

Healthy Kids - Children's Health Insurance Program. New Hampshire has implemented a multi-faceted outreach strategy and adopted best practices to simplify and coordinate enrollment in its Children's Health Insurance Program. This program encompasses Title XIX/Medicaid and Title XXI/S-CHIP for children. New Hampshire is one of six states offering the highest income eligibility levels with no asset test. Free coverage is available to families with incomes up to 185% FPL and subsidized coverage is available to uninsured children with household incomes up to 300% FPL. Additionally, uninsured children with family incomes up to 400% FPL, can buy-in to the program without direct government subsidies.

[2] For more information on the eligibility simulations, please see Appendix H.

Simplification. In launching its Title XXI program, New Hampshire introduced a mail-in application process with a shortened application (1¼ pages) and reduced verifications. Assistance with the application process is available via a toll-free hotline.

Following a November 2000 Summit to review progress in expanding coverage, the Commissioner of Health & Human Services approved recommendations to eliminate certain verifications. These changes are currently undergoing the State rules process and are being integrated into a State plan amendment. Additionally, further revisions to the application will eliminate unnecessary language and include a prominent easy-to-understand list of documents needed to verify eligibility.

Coordination. Although New Hampshire elected to implement a separate program for Title XXI, all coverage programs for children are marketed under the Healthy Kids name. Medicaid for children is marketed as Healthy Kids Gold, with Healthy Kids Silver used as the name for the Title XXI program. The use of the Healthy Kids name and access through the nonprofit has been effective in dispelling the stigma perceived to be associated with Medicaid.

A single application is used for both programs. The State contracts with the nonprofit Healthy Kids Corporation to conduct marketing and outreach, provide customer service, manage the mail-in eligibility unit, and administer the premium-based Title XXI program.

Families, who check a box on the application indicating they have a child with special health needs, are referred for additional support services through the Bureau of Special Medical Services.

Outreach and Marketing. New Hampshire's outreach and marketing efforts include broad-based promotion and direct marketing. A significant component of the outreach strategy is to work through community partners – individuals and organizations that provide direct services to families and children.

Healthy Kids Corp. was established by legislative act in 1993 to address the problem of uninsured children. The organization began covering kids in 1995, without the benefit of state and federal funds. During that time, the organization relied heavily on the involvement of community partners in creating awareness of the program. The premise is that people with established, trusting relationships are in the best position to encourage families to apply, especially hard-to-reach families. Today, a three-person outreach team has been placed in the field to encourage the involvement of community partners and to support their outreach efforts.

Representatives from many of the community partner constituencies serve in advisory capacities to the program. The Healthy Kids Corporation Board of Directors includes representatives from the NH Children's Alliance, the School Nurses Association, the Hospital Association, the School Boards Association, the Pediatric Society, the NH Academy of Family Physicians and the NH Childcare Association. Additionally, a CHIP Outreach Workgroup, comprised of a variety of community partners and program officials, meets quarterly to coordinate and plan outreach activities. A list of more than 3,500 community partners is maintained in a database which is used to promote the program through quarterly progress reports and events.

Schools. Outreach through public and religious schools has been the most effective source of referral to the program. Promotional information is blanket-distributed to the school age population through the schools on a biannual basis. Field outreach coordinators frequently call on school nurses to brief them on program details or changes and provide promotional materials for display. As these relationships have evolved there is movement toward specific outreach activities to identify and target uninsured children in addition to general broad-based promotion. Three types of activities have emerged:

? Insurance status – Through enrollment forms or emergency information cards, the insurance status of the child is requested. Uninsured children can then be identified. Families of uninsured children are encouraged to apply through personal follow-up by the school nurse or other school official.

? School lunch pilot – Coordinating Healthy Kids eligibility with eligibility for free or reduced school lunch is currently being tested in two schools. These pilots allow the approval for free or reduced school lunch to be used as verification for income, age and residency. This project is being coordinated through the State's RWJ Covering Kids grant which funds an education systems coordinator to work with schools to introduce system changes that will institutionalize outreach efforts.

? Nurse referral projects – Another pilot is testing the concept of promoting Healthy Kids when the school nurse must refer a child for follow-up medical care.

Hospitals/Community Health Centers (CHCs). Hospitals and CHCs play a significant role in identifying uninsured children without a usual source of care. Of the state's 26 hospitals, most have full or part time positions with responsibility for helping eligible families apply for coverage. Through the State's RWJ Covering Kids grant, a systems change coordinator has been working with hospitals to identify outreach opportunities and quantify the economic and community benefit that accrues to the hospital through such activities. An enrollment and outreach counselor employed by the state's primary care association provides outreach support to the states eight community health centers.

Primary Care Physicians. Healthy Kids outreach coordinators make site visits to primary care physician offices to work with intake and business office staff, provide promotional materials and brief office and medical staff on the programs.

Media. Television and radio PSA's are supplemented with modest amounts of radio and television advertising to promote Healthy Kids. Advertising is maintained on New Hampshire's limited public bus system and in movie theatres in rural communities. More often media attention comes in the form of feature articles and reports that arise with public interest in the program and the release of program milestones. Governor Jeanne Shaheen and the Kids Cabinet, comprised of many of the State's commissioners, have adopted Healthy Kids outreach as a priority. This has helped dramatically increase the public visibility of the program and its media appeal.

Child Care Centers**.** Child care centers are mailed promotional flyers for posting and brochures for distribution to all clients on an annual basis.

Social Service Agencies. CAP agencies, WIC sites, Headstart programs, prenatal programs and many other social service agencies are included in our outreach initiatives.

KIDOS Awards. Some give kudos, we give KIDOS. This annual awards program has been implemented to recognize individuals or organizations who make exceptional efforts to identify and enroll eligible children. Awards are presented by the Governor at an annual luncheon which celebrates the importance of community partners.

Promotional Materials. Colorful, easy to read promotional materials have been developed for the program. In surveys of prospective and enrolled families, these materials have been rated as easy to understand and effective in communicating messages that encourage families to enroll. Such messages include emphasizing that the program is for working families, that income can be higher than they think, that health coverage is not connected to welfare and that insurance brings peace of mind.

Direct Marketing. Direct mail coupon packets have been effective in reaching families. Additionally, families who have previously inquired but did not apply are remarketed routinely.

Evaluation. A comprehensive program to evaluate quality in the Healthy Kids programs has been implemented. Its components include identifying the most effective outreach methods and messages and family satisfaction with the application and enrollment process. These data are used to improve our outreach strategies.

Enrollment Progress to Date. A 1999 Household Insurance Survey indicated that about 27,000 or 9% of New Hampshire children are not insured. Of those, about two-thirds were estimated to be eligible for Healthy Kids. Since that time, more than 10,000 children have been enrolled. The 2001 Family Insurance survey estimates 5.3% of children in New Hampshire are uninsured and that approximately 34,000 children are covered by Healthy Kids.

Future Outreach Initiatives. Input from our community partners is currently being sought as the State develops a proposal for the upcoming Robert Wood Johnson Covering Kids and Families Initiative. Among the activities that are considered priorities and are likely to be incorporated in the State's proposal are the following:

Presumptive Eligibility. New Hampshire is one of five states to implement presumptive eligibility for Medicaid. Recommendations to improve this process include increasing agency reimbursement, updating the training curriculum and centralizing the process under Healthy Kids Corp. to enhance communication with supporting agencies.

Electronic Application System. Currently families can print the Healthy Kids application off the internet through a website called the Wired Wizard. A PC-based version of the software allows the application to be populated but there is no capability to electronically submit it. A study to examine the feasibility of developing the system into a true electronic application system is planned for 2002.

Minority and Refuge Outreach. New Hampshire has a small but rapidly growing minority population. The diversity of minorities groups, combined with the small numbers, are a further challenge to effective outreach. For example, 82 languages are spoken in schools in the state's largest city. Recently there has been an effort to inventory the numerous public and private

organizations serving these groups. Securing resources to assist these groups in reaching out to eligible children is a goal for the near future. A subcommittee of the CHIP Outreach Workgroup has been created to focus on minority and refuge outreach.

Community Based Projects. With a declining number of uninsured children, outreach must become more focused. Specific activities to identify uninsured children at the community level, led by trusted members of the community, are seen as the most effective way to reach to "hard-to-reach."

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved?

The Department of Health and Human Services (DHHS) is the lead agency for the HRSA Grant. During grant proposal development the DHHS invited the NH Insurance Department, the Governor's Office, and the NH Healthy Kids Corporation to partner in the grant proposal development and submission. The DHHS office partners are: the Office of Planning and Research, the Office of Community and Public Health, and the Office of Knowledge Management and Decision Support. Upon grant award, these partners became the HRSA Development Team that provided day-to-day project oversight and implementation under the direction of the Co-Project Directors. The HRSA Development Team held project meetings every other week throughout the year.

The governance structure is the HRSA Adult Coverage Advisory Committee. The Advisory Committee is comprised of key representatives from business, the NH Legislature, the health care delivery system, the insurance industry, the state university, state agencies, and the Governor's office. The Chairperson of the HRSA Adult Coverage Advisory Committee is also the Chairperson of the NH House of Representatives Commerce Committee. The Commerce Committee has responsibility for insurance matters. The Advisory Committee met x times providing project advice and guidance. The Advisory Committee has been an important vehicle for sharing information and seeking input. The Advisory Committee will be critical to examining the feasibility of different models in year two of the project. The effectiveness of the advisory committee could be enhanced through the consistent participation of the state's two primary insurers. Insurer participation has been limited as their policy development and decisions are controlled at out-of-state national headquarters.

In addition to the HRSA Development Team and Advisory Committee, the Project Directors regularly met with Commissioner of the Department of Health and Human Services to review the project status and seek advice and guidance.

5.2 What methods were used to obtain input from the public and key constituencies (e.g. town hall meetings, policy forums, focus groups, or citizen surveys)?

In addition to the Advisory Committee, public input was obtained through: a Family Insurance Survey, Employer Insurance Survey, Consumer Focus Groups, Employer Focus Groups, a Legislative Briefing, and Primary Care Case Management Workshop. Substantial public input is also planned for year two – legislative briefings, public meetings, and district health council meetings.

Family Insurance Survey. 5,177 respondents. See Executive Summary of Appendix I and Section 1 for specifics.

Consumer Focus Groups. 50 businesses. See Executive Summary of Appendix J for specifics.

Employer Insurance Survey. 642 respondents. See Executive Summary of Appendix K and Section 2 for specifics.

Employer Focus Groups. 50 participants. See Executive Summary of Appendix L for specifics.

Legislative Briefing. 71 participants. See the Briefing Materials included in Appendix M.

Primary Care Case Management Workshop: 87 participants. See the Conference Workbook included as Appendix N.

5.3 What other activities were conducted to build public awareness and support (e.g. advertising, brochures, web site development)?

The other activities that were conducted to build public awareness and support included: a press release, media interviews, legislative hearings and orientations, letters to legislators, one-on-one meetings with legislators, meetings with Executive Directors of the Chambers of Commerce, letters to members of the District Health Councils and building the work into the meetings of the District Health Councils.

In addition, a Primary Care Case Management Workshop was held to explore the potential role for disease and care management within our current system of public coverage and models being considered.

All reports generated at the end of year one will be broadly communicated to the public through a multi-faced communication strategy employing the use of presentations, issuance of reports, placement of the reports on the web, press releases and media interviews or briefing sessions.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The primary public policy debate before the 2001 Session of the NH Legislature and public was that of funding public education and the State Budget for the biennium. The individual and small group health insurance market regulations were also strenuously debated in this session because of rising health insurance premiums.

This planning effort has affected the policy environment by allowing the public policy dialogue concerning the uninsured to continue to receive policymaker and stakeholder attention and discussion. In the 2001 Legislative Session, SB118 established a subcommittee of the NH Healthy Kids Corporation to: a) review information on the characteristics of the uninsured, b) identify the population groups and geographic areas that are most appropriately targeted, d) examine models for affordable health coverage, e) develop cost projections, f) identify potential sources of funding, and g) make an annual report to the legislature each year. Passage of this bill was a significant accomplishment in that an infrastructure has now been created to sustain this policy development work.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

The 1999 Health Insurance Coverage and Access Survey and 2001 Family Insurance Survey information have been critical to the public policy discussion and development.

The Family Insurance Surveys have dispelled many myths about the uninsured. It is now well known and understood that the majority of the uninsured are working adults of all ages, that they are largely self employed or work for employers with 2-10 employees, that the majority of the uninsured have incomes less than 200% of the federal poverty level, and that they live in all parts of our state. While the rural areas of the state have higher rates of uninsurance, the largest numbers of uninsured reside in the urban areas of the state. The 2001 Family Insurance Survey validated the characteristics of the uninsured as identified in 1999. The Family Insurance Survey served to target the population most in need of insurance coverage.

Like other small states across the country, New Hampshire has historically relied very little on survey work to justify action (or inaction) with respect to public policy on the uninsured. In large part, this was due to the fact that current New Hampshire based estimates of the uninsured were unavailable. Those estimates that were available, for example from the Current Population Survey, often lagged two and sometimes three years behind the policy debate and lacked precision. At the same time, state staff – untrained in statistical analysis – were often unable to analyze the information in a manner that was responsive to policy makers concerns. As a result, estimates like those produced by CPS have had little impact on the policy debates.

The state planning grant, however has allowed the state to solidify its attempt to base decision-making on empirical evidence. First, the state-planning grant provided financial support for two surveys. Second, and perhaps more important, the state planning grants provided states with the resources necessary to purchase the analytic resources required to be responsive to policy makers' questions. In the fast paced state policy environment, the ability to respond quickly to policy makers' questions has a large impact on whether the information can even be used within policy debates.

While the information collection and consensus development activities have been helpful with respect to the issue of traditional expansions in coverage through subsidies, the work has also been helpful outside of this arena. Information gathered on the lack of pharmacy coverage facilitated the development of a waiver for pharmacy coverage for all New Hampshire citizens below 300% of the federal poverty level. In addition, the information was used to shed light on the potential impact of market reforms that would have repealed significant aspects of the state's health care reform efforts in the mid 1990s. And while these aren't traditionally understood as public efforts at expanding coverage, they have the impact of sustaining coverage that might have eroded.

The Employer Insurance Survey was conducted for the first time under the HRSA grant. It confirmed the results of the Family Insurance Survey. It also identified two very important points: 1) that relatively small increases in costs of coverage could significantly erode private coverage, and that 2) 52% of the surveyed employers that do not offer insurance coverage would never start offering coverage. These results have raised significant concern regarding the ability to develop private sector options to expand insurance coverage.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Quantitative surveys were the most effective data collection activity. However, these services were difficult to manage as they were resource intensive from the state's perspective. At the same time, the skill sets required for analysis of the data are generally not those that exist in state governments.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

All of the data collection activities that were originally proposed were conducted.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

Employer Insurance Survey: A strategy that we believed increased the response rate of employers to the Insurance Survey was a letter from the Governor sent to employers in advance of the telephone survey.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under the HRSA grant? Does the State have plans to conduct that research?

The HRSA Development Team believes that four additional data collection activities are needed: 1) A Medicaid Enrollee Survey, 2) A Public Opinion Survey, and 3) Insurer Interviews, 4) Additional Employer Focus Groups, and 5) Health Care Expenditure Analysis. HRSA Expansion funds for year two were requested for three of these activities.

Medicaid Enrollee Survey. The data for analyses of insurance coverage are based on self-reported health insurance coverage. As other analyses have documented, however, individuals sometimes do not accurately report their actual coverage particularly when covered by public insurance. This issue of under-reporting of public coverage can have a significant impact on estimates of both the rate of insurance coverage and estimates of factors related to insurance coverage such as the eligible but not enrolled population. For example, to the extent that parent's under-report Medicaid coverage for their children, estimates of the number of children eligible for public coverage but not insured will be higher than in the population generally.

To test the extent to which under-reporting is an issue in the New Hampshire family survey, we propose to conduct a survey of known Medicaid recipients asking a very limited set of questions around their enrollment in Medicaid. Aspects of the original Family Survey instrument will serve as the interview tool for analyzing the level of perceived uninsurance. The HRSA development team in conjunction with the contractor will develop the sample parameters.

Public Opinion Survey. The survey will be based on a systematic telephone survey of residential households in New Hampshire. A random digit dial sample will be used to ensure that the survey is fully representative of all adults in the state. An in-house enumeration procedure will be used to ensure that respondents are randomly selected from all adults (age 18-64) in each household contact.

The proposed Opinion Survey will provide us with a tool to assess the beliefs, values and opinions of the residents of New Hampshire relative to health coverage. We realize that in order to move forward with health coverage expansion, it must be a value of the residents of our state. The results from this survey will provide clear information about how important this issue is to the public. This will assist us in working with legislators around policy development.

Insurer Interviews. Interviews with be held with the dominant three insurance carriers in New Hampshire to solicit their views of what can be done to address rising health care costs and to reduce the number of people without health insurance coverage.

Additional Employer Focus Groups. The proposed Employer Focus Groups will test specific models of coverage related to the HCFA Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative. The initiative was announced in mid August 2001. It will provide additional flexibility beyond what was previously available during year one of the State Planning Grant project.

Focus group participants will be small employers who do not currently offer coverage to their employees.

Health Care Expenditure Analysis. A better understanding of Medicaid and New Hampshire health care expenditures is needed to align a cost management strategy that will bolster private sector enrollment with a coverage expansion strategy. The project would benefit from the willingness of insurers to come to the table and discuss their analysis of expenditure trends and projections.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The organizational and operational lesson that the HRSA Development Team learned during the course of the grant is that a grant of this size requires a full-time, grant funded, project director and a contract manager/financial coordinator. External contractors can be difficult and time-

consuming to manage. They also lack the political sensitivity required to work with stakeholders.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

The key lesson about the New Hampshire insurance market and employer community resulting from the HRSA planning effort is that many private sector employers are not organized or informed purchasers of insurance with purchasing power.

The health plans participation in the Advisory Committee has been minimal.

The key lesson in how to work most effectively with the employer community has been to work through the Executive Directors of the Chamber of Commerce.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The key recommendations that New Hampshire would offer to other States regarding the policy planning process are to:

- Engage the Governor's Office and Legislative Leadership from the Health and Insurance Committees every step of the way.
- Allow substantial time for Advisory Committee dialogue as well as presentation by contractors and staff.
- Find ways to engage the insurers.
- Invite every key stakeholder group to the Advisory Committee table.
- Carefully plan your report communications strategy and roll out to the public and media. Put private sector partners and legislators out front. Simplify the key messages.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The root of the problem of uninsurance in part lies with federal policy. Federal policy surrounding Medicare payment policy has shifted substantial public responsibility for health care costs to the private sector and resulted in rising private-sector insurance premiums. Insufficient Medicare reimbursements to the non-profit New Hampshire hospitals have resulted in millions of dollars of shortfalls that are being paid by private employers. Medicare hospital reimbursements must be improved to eliminate the need for cross-subsidization which in turn might sustain both our hospitals and reduce some of the pressure to eliminate offer coverage that businesses feel as a result of rising premiums.

Federal policy is also needed to address rising health care costs. The cost and utilization of pharmaceuticals is driving substantial premium increases in Medicaid and private-sector insurance premiums. States such as New Hampshire have done everything short of extremely costly state-sponsored subsidy programs to improve access to pharmaceuticals for seniors and low-income adults. A Medicare benefit is needed for seniors who are choosing between food and maintaining their regimen of their doctor-prescribed medications. The 340B Drug Pricing program that benefits patients of Community Health Centers should also be expanded to other two other groups of safety net providers – Rural Health Clinics and Critical Access Hospitals. Combined, these policy changes could free up state resources to expand coverage to those in highest need.

Further, federal policy is needed to foster best practice in chronic care management. A recent Institute of Medicine report demonstrates that protocols remain to be developed and implemented for many chronic diseases which are necessary if we are to improve quality of care and manage rising health care costs.

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

One coverage expansion option that New Hampshire is considering that will require waiver authority is an 1115 Waiver for SCHIP Expansion to Parents and Childless Adults utilizing the Health Insurance Flexibility Act (HIFA). Flexibility may be needed to phase in coverage based upon geographic areas of the state in economic distress.

Other changes in Federal law that are recommended include:

- Establish federal tax incentives to encourage small businesses to offer employer-based health insurance to their employees;
- Implement a Medicare prescription drug benefit for seniors;
- Expand 340B Drug Pricing to Rural Health Clinics and Critical Access Hospitals;
- Improve Medicare reimbursement to hospitals to reduce cost shifting to the private sector that is increasing private sector health insurance premiums and contributing to lack of affordability;
- Allow federal Medicaid match for employer and employer cost sharing for Adult Coverage Expansion options.

- ? Incent insurers and physicians to implement best practice management protocols to manage chronic diseases thereby improving the quality of care and managing health care costs for patients with chronic diseases.
- ? Allow small employers to buy into the Federal Employees Program insurance products.
- ? Allow an enhanced state match rate for SCHIP and Medicaid eligible but enrolled that are hard to reach, minority populations.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

The Federal government should provide states and university-based Policy and Research Institutes with the resources (both dollars and skills) to implement state based surveys as they have done with the HRSA grants.

7.4. What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion options?

The federal government should establish demonstration projects allowing businesses with less than 10 employees to "buy in" to the Federal Employees Program.

The federal government and foundations should assist small employers and the states to establish multi-state regional purchasing pools to purchase health insurance.

The federal government and foundations should partner with health plans and physicians to invest in the development and implementation of care management programs for chronic diseases.

The federal government should support states by offering technical assistance and training relative to analyzing Medicaid and State health care expenditures.

SECTION 8: RESOURCES

Please refer to the following appendices:

Appendix A:	Josiah Bartlett Livable Wage Report
Appendix B:	Figure 1-Free Care Eligibility in New Hampshire
Appendix C:	Figure 2-Community Health Center Market Areas
Appendix D:	The Health of New Hampshire's Community Hospital System: A Financial and Economic Analysis
Appendix E:	Strengthening the Safety Net: A Financial Analysis of New Hampshire Community Health Centers
Appendix F:	SB183 Adult Coverage Subcommittee Report
Appendix G:	Healthlink Program
Appendix H:	Eligibility Simulations
Appendix I:	Family Insurance Survey and Methodology
Appendix J:	Consumer Focus Group Report
Appendix K:	Employer Insurance Survey and Methodology
Appendix L	Employer Focus Group Report
Appendix M:	Legislative Briefing
Appendix N:	Primary Care Case Management Conference Workbook
Appendix O:	State Baseline Information

[i] Nationally, premiums for group coverage rose 8.3% from spring 1999 to spring 2000, a sharp upsurge from the 4.8% figure for 1998-1999 and 3.7% for 1997-1998. Premiums for firms located in the Northeast grew most rapidly (8.9%), while those in the West grew more slowly (7.6%). J. Gabel, L. Levitt, J Pickerign, H. Whitmore, E. Holve, S. Hawkins, and N. Miller. "Job-Based Health Insurance In 2000: Premiums Rise Sharply While Coverage Grows." Health Affairs, Volume 19, Number 5, September/October 2000.

[ii] Small group market penetration was based on group market penetration statistics in total.

[iii] See, J. Gabel, L. Levitt, J Pickerign, H. Whitmore, E. Holve, S. Hawkins, and N. Miller. "Job-Based Health Insurance In 2000: Premiums Rise Sharply While Coverage Grows." Health Affairs, Volume 19, Number 5, September/October 2000.; The Kaiser Family Foundation, "Employer Health Benefits: 2000 Summary of Findings," (a summary of which can be found at www.cnn.com/200/HEALTH/09/07/insurance.premium/); and Laurie Ledgard, "HMO rate to rise 10 to 13 percent in 2001, surveys say," (www.insure.com/health/hmorates1000.html) summarizing the results of two surveys conducted by the actuarial firms of Milliman & Robertson Inc. and Hewitt Associates LLC.

[iv] Jon R. Gabel, Jeremy D. Pickerign, "Factors Driving Increases in Health Insurance Premiums." Unpublished report prepared by Health Research and Education Trust for the American Hospital Association Foundation. June 1, 2000.

[v] The Kaiser Family Foundation, "Employer Health Benefits: 2000 Summary of Findings," supra.

[vi] See, Gabel, Levitt, Pickerign, Whitmore, Holve, Hawkins, and Miller, supra. at pp. 145, 146.

[vii] Center for Health Economics Research, "Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals," December 2000 Table 7-2.

[viii] Larry Levitt, Janet Lundy, "Trends and Indicators in the Changing Health Care Marketplace," The Kaiser Changing Health Care Marketplace Project, August 1998, p. 47.

[ix] Center for Health Economics Research, "Assessing the Competitiveness of New Hampshire's Health Care Markets: A Focus on Hospitals." December 2000. Nancy M. Kane, DBA, "Analysis of Health Care Charitable Trusts in the State of New Hampshire: The Hospital Sector." December 2000.

[x] In recent years, managed care has become the dominant form of health insurance for privately insured persons in New Hampshire as well as in the rest of the country. New Hampshire has the largest managed care enrollment of the three northern New England states, with approximately 400,000 fully insured members in 1998.

[xi] Deborah J. Chollet, Adele M. Kirk, Marc E. Chow, "Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets, 1995-1997." December 2000, p. 27 (available at: http://statecoverage.net/mapping.pdf).

[xii] Larry Levitt, Janet Lundy, "Trends and Indicators in the Changing Health Care Marketplace," The Kaiser Changing Health Care Marketplace Project, August 1998, p. 47.

[xiii] *Ibid.*, p. 27.

[xiv] Jon R. Gabel, Paul B. Ginsburg, Heidi H. Whitmore, and Jeremy D. Pickerign, "Withering on the Vine: The Decline of Indemnity Health Insurance." Health Affairs – Volume 19, Number 5, September/October 2000.

[xv] *Ibid*. at pp. 155, 156.

TO: Bruce Spitz
Lori Real, DHHS
Steve Norton, DHHS
Cris Purdum, DHHS
Tricia Brooks, NHHK

FROM: Joe Burton, HER
Boyd Gilman, HER

CC: Jerry Cromwell, HER

RE: Interim Report to HRSA on New Hampshire Employer Survey

DATE: March 28, 2002

MEMORANDUM

Attached is the interim report to HRSA on the employer survey. The report includes the results of the additional analyses requested by the State subsequent to its review of the preliminary findings presented last September. Each analytic task includes a table or a series of tables with the appropriate rate or mean, together with an indication of statistical precision as measured by its confidence interval. Chi-square tests showed that the distribution of firms across the various bivariate groupings was generally insignificant. As a result, the results of the chi-square tests have been omitted from the tables. A brief discussion of the main findings from each of the tables is also provided.

Several of the individual estimates presented in this report were not statistically significant and could lead to inappropriate policies if used independent of other more important factors. Nonetheless, including all of the results from all of the additional analyses requested by the State in this report should help identify priority areas for future policy discussion. A more probing analysis focusing on the important findings and their policy implications will be presented in the final report to be completed and submitted to the State in September.

Additional Analyses: New Hampshire Employer Survey

Under the HRSA State Planning Grant for the Uninsured, the State of New Hampshire surveyed 642 firms in 2001. Self-employed, single site, headquarter, franchised and branch location businesses located in New Hampshire were eligible to

participate in the survey. Firms with one employee are typically self-employed individuals. Because self-employed respondents are both employer and employee, questions about insurance offer for self-employed individuals are also questions about the same individual's decision to purchase health insurance. Therefore, the "offer potential" of a self-employed individual is conceptually different from the "offer potential" of other businesses with many employees. Firms of size one are thus excluded from these analyses.[xv] Education and government industries were also excluded from the sample frame. The overall response rate of completed interviews for the employer survey was 66.3 percent. An interview was considered complete if all major questions were answered. No adjustments were made for item non-response.

The preliminary results of the employer survey were described in the preliminary final report submitted to HRSA in October of 2001. This interim report provides the results of additional analyzes requested by the state during the first six months of the contract extension period. The additional analyses include questions about (1) the sensitivity non-offering firms are to premium subsidies; (2) the sensitivity of offering firms to premium increases; (3) differences in premiums and employee contributions by firm size and type of industry; (4) the substitution of copayments and deductibles for employee premiums; and (5) the importance of information about tax benefits and eligibility regulations for firm offer decisions. A more complete discussion of the strengths and weaknesses of employer-based coverage in New Hampshire will be provided in the final report to HRSA.

E-1 Sensitivity of Firms Not Offering Insurance to Premium Decreases

According to the results presented in Table E-1.1, a premium subsidy of up to one-half of the cost of the benefit would induce only one out of every seven firms in New Hampshire currently not providing coverage to offer health insurance to their employees. The 14.8 percent of firms that said they would offer coverage in response to a 1-49 percent premium subsidy was estimated with a 95% confidence interval of ?5.3 percentage points. Hence, the true insurance "take-up" rate from a sizable premium subsidy likely lies between 9.5% percent and 20.1 percent.

Over one-half (57.1 percent) of all firms in New Hampshire currently not providing health insurance to their employees reported either that they would require health insurance to be free (a "100 percent" subsidy) or that they would "Never" offer such a benefit. These two responses are combined in the bottom rows of Tables E-1.1 through E-1.3 and are considered conceptually equivalent for the purposes of these analyses. It is not clear what firms meant by responding that they would "Never" offer health insurance coverage. Perhaps they felt that the State would eventually require them to assume some of the costs of an insurance benefit. Alternatively, they may have felt that insurance was not necessary or desired by workers, or that the costs of administering such a benefit would be too burdensome.

The responsiveness of firms to various levels of a premium subsidy across firm size (Table E-1.2) and industry group (Table E-1.3) was remarkably consistent. The survey findings suggest that larger firms may be more responsive to partial (less than the full cost) premium subsidies than smaller firms, and that firms in manufacturing and related industries may be more responsive than firms in other industries.[xv] However, lack of statistical precision among the firm size and industry type estimates makes any conclusions quite tentative.

The estimates provided in Tables E-1.1 through E-1.3 imply that efforts to induce employers to offer coverage by lowering the premium through a state-sponsored subsidy would have a very modest effect on health insurance coverage in New Hampshire.

E-2 Sensitivity of Firms that Offer Insurance to Premium Increases

According to the survey responses summarized in Table E-2.1, one out of every four firms in New Hampshire currently providing health insurance coverage to their employees would discontinue the benefit if premiums were to increase between 10 and 25 percent.[xv] One-half of all firms would eliminate their insurance benefit if premiums increased by 55 percent. Each of these proportions was estimated with a confidence level of ?6.0 percentage points. A premium increase of less than 10 percent would have no effect on current offer rates.

The survey findings further reveal a core group of firms that would "Never" drop their health insurance benefit regardless of the cost of coverage. Firms with 50 or more workers and firms in the financial/professional service industries are the most likely to be in this core group (Tables E-2.2 and E-2.3). Again, differences in firm sensitivity of offer rates to premium increases across firm size and industry type were estimated with a low degree of statistical precision and should be used in policy discussions with caution.

The estimates provided in Tables E-2.1 through E-2.3 imply that health insurance coverage in New Hampshire is fairly vulnerable to sustained increases in insurance premiums. This is due to the very large reliance on employer-based coverage in New Hampshire (an issue addressed in the preliminary report), as well as to the sensitivity of firms that offer coverage to increases in premiums.

E-3 Average Total Monthly Premiums for Individual Coverage by Firm Size, Industry Group and Plan Type

According to the results presented in Table E-3.1, total premiums for individual coverage were higher for small firms than for large firms. Firms with 2-9 employees had an average total monthly premium of $251 compared with $214 for firms with 50 or more employees. This difference was statistically significant

and suggests that small firms may be less able to obtain the premium discounts enjoyed by large firms. Average total monthly premiums were also slightly higher for firms in financial and other professional industries than for firms in retail and manufacturing sectors.

The survey responses further indicate that average total monthly premiums were higher for HMO plans than for POS, PPO and indemnity plans. However, none of these estimates controls for differences in the scope of covered benefits or the amount and type of employee copayments. HMO plans, for example, are typically characterized by a wider scope of benefits and lower enrollee copayments. However, none of the differences in average total monthly premiums by industry group and plan type was statistically significant.

Tables E-3.2 through E-3.4 present the distribution of firms currently offering health insurance benefits by the amount of the average total monthly premium in $100 incremental amounts. The results reflect the findings presented above. However, once again, the frequency distributions across firm size, industry group and plan type are not statistically different.[xv]

E-4 Average Monthly Employee Contributions for Individual and Family Coverage by Firm Size, Industry Group and Plan Type

Tables E-4.1 through E-4.4 show the distribution of firms offering insurance by average monthly employee contribution ranges (in $100 intervals) for individual and family policies.[xv] Four out of five firms (80.9 percent) in New Hampshire reported that their employees pay less than $100 per month for individual coverage and nearly three out of five firms reported that their workers pay less than $200 per month for family coverage. (See Table E-4.1.) Still, a small number of firms (about two out of ten) reported that their employees pay over $400 per month for family coverage, an amount that might be unaffordable to some working families.

The proportion of firms requiring employees to pay $100 or less per month for individual coverage or less than $200 per month for family coverage is fairly consistent across firm size (Table E-4.2), industry group (Table E-4.3) and plan type (Table E-4.4). As shown in Table E-4.2, large firms are more likely (88.9 percent) to have monthly worker contributions for individual coverage under $100 than small firms (79.9 percent). In addition, no large firms have monthly worker contribution for individual coverage in excess of $200. These and other between-group differences will be explored further in the final report. Small sample sizes and lack of statistical precision preclude making meaningful comparisons across categories within each of these firm and plan characteristics.[xv] However, it should be noted that a significant proportion (23.9 percent) of small firms (between 2 and 9 employees) reported making employees pay more than $400 per month for family coverage. High employee contributions may thus limit the ability of a state health insurance system based on employer-sponsored coverage to reach

families who work for small firms. Most firms reported that HMO's were their dominant type of health plan. Firms with HMO's as the dominant type of health plan were also more likely (13 percent) to have monthly worker contributions for family coverage of over $500. Growth in the penetration of HMO plans may also carry unique implications for workers of small businesses.

E-5 Total Monthly Premiums by Copayment and Deductible Amounts

Tables E-5.1 and E-5.2 explore the relationship of premium amounts to physician copayments and hospital deductibles. According to the results presented in Table E-5.1, there was no statistically discernable trade-off between physician copayments and premium amounts. Almost all of the firms offering coverage reported having physician copayments of $10 or $15. The survey findings suggest, however, that higher hospital deductibles may offset reductions in the growth rate of total premiums or employee contributions. For example, 29 percent of firms whose most popular plan had a zero hospital deductible had an average monthly premium of $100-$199, compared with half (49.4 percent) of firms whose dominant plan had a hospital deductible of $500-$1,000 (See Table E-5.2).

E-6 Knowledge Index by Offer

Finally, evidence from the employer survey suggests that firms with a better understanding of both the tax benefits of offering insurance as well as the legality of restricting coverage are more likely to offer a health insurance benefit to their employees. Table E-6.1 shows the distribution of offering versus non-offering firms based on a "knowledge index" created from survey responses. The knowledge index is based on a count of correct answers to six true-false questions (one for correct answers, zero for incorrect). The six questions were the following:

1. Health insurance premiums paid by an employer are tax-deductible to the employer?
2. Health insurance premiums paid by an employee are tax-deductible to employees?
3. Employees have to pay tax on the share of their health insurance premium paid by their employer?
4. Employers can choose to offer or not offer health insurance based on the number of hours an employee works each week?
5. Employers can choose to offer or not offer health insurance based on whether or not employees are paid hourly versus salary?

6. Employers can provide employees with access to an employer sponsored health insurance plan without contributing any amount to the cost of employee premiums?

One-quarter of all firms offering insurance answered fewer than 3 questions correctly, compared with over 40 percent of the firms that do not offer insurance. Conversely, over one-half of the firms offering insurance could answer four or more of the questions correctly, compared with only one-third of those that do not offer coverage. The results suggest that an educational campaign designed to encourage firms to provide health insurance benefits would have a limited effect. Approximately one of every ten firms not offering insurance knew the correct answer to at least five questions and still chose not to offer coverage. An information campaign is unlikely to induce these firms to provide a health insurance benefit to their workers.

Family Survey

F-1 Geographic (County) Analysis of the Uninsurance Rates for Dependents

Tables F-1.1, F-1.2, and F-1.3 present a geographic analysis of uninsurance rates in New Hampshire. Table F-1.1 lists the uninsurance rates for children by county. It is similar to Table 1-2 in the New Hampshire State Planning Grant Interim Report, but lists data for dependents ages 0-18, and ages 0-22 that includes dependents in college. Respondents or spouses under 19 (young heads of households) are not included. The areas of the state were divided into three regions as presented in Table F-1.2: a northern region and two southern regions. One southern region comprises the cities of Manchester, Nashua, and Portsmouth; the second southern region comprises all other areas in the South.[xv] The rates presented in this table include rates for adults and rates for children. In all areas, the uninsurance rates for children are lower than the rates for adults, a finding that is consistent with national estimates, and not surprising with the availability of New Hampshire Healthy Kids. Both the southern urban region and the northern region have a marked difference (about 6 percent) between the estimates for children and adults.

Children

For children ages 0-18, the rates range from a high of 12.8 percent in Carroll County to a low of 3.1 percent in Rockingham and Hillsborough Counties (see Table F-1.1). The 95 percent confidence intervals do not overlap between Carroll and Rockingham and between Carroll and Hillsborough Counties, indicating that the differences in uninsurance rates are statistically significant at the 5 percent level.[xv] The rates are similar for dependents ages 0-22. The uninsurance estimate for children under 19 living in the southern urban region is just 1.3 percent as shown in Table F-1.2. The differences in rates across counties (Table F-1.1) and across regions (Table F-1.2) are not due to measurement error as indicated by the chi square statistics. The estimates for the northern and southern rural areas are 7.9 and 4.9 percent, respectively. The high rates of uninsurance in Carroll County appear to drive the high rates for the northern region as a whole. The New Hampshire Health Kids Program appears to be much more successful at covering children in the southern urban region than in the other regions.

Adults

The adult rate in Table F-1.2 includes persons 19-64 who are not students. The northern region has the highest uninsurance rate at 13.8 percent; over 5 percentage points higher than either southern region, where the estimated rates are about 8 percent. The confidence interval for the northern region does not overlap with those for either southern region.

Table F-1.3 presents rates of uninsurance for all non-elderly individuals by region and family income level. While the uninsurance rate is consistently higher in the northern region at any given income level, having a low income is the primary cause of being uninsured (uninsurance rates by income is discussed below). In

addition, the confidence intervals for the northern region overlap with the intervals for the other regions. The uninsurance rate in the southern urban region is almost zero (.6 percent) for families with incomes over $75,000. The uninsurance rate is also low (3 percent) for wealthy northerners.

F-2 Uninsurance Rate by Education Level of the Adult Respondent

Education is correlated with other determinants of coverage such as income, as presented in Table F-1.3.[xv] While education appears to be inversely related to the rate of uninsurance within any income group, the estimates lack statistical precision. For example, very few individuals report living in a family with an income of greater than $75,000 and where the adult respondent had less than a high school education. The 95 percent confidence interval for this estimate is over 40 percentage points.

Table F-2.1 describes the uninsurance rates of individuals by the education level of the adult respondent in the family. Only respondents were asked about their education level, race, and ethnicity. The survey did not include these data for spouses or dependents (although one can assume that most children under 18 have not completed high school). Two sets of estimates are presented: (1) the uninsurance rate for adult respondents; and (2) the uninsurance rate for all individuals by the education level of the adult respondent.

The more education adults have, the less likely they are uninsured, and the less likely that their family members are uninsured. The estimates for adult respondents decrease from 21.4 percent for those without a high school diploma to 3.5 percent among those with some graduate education; the estimates for individuals in the adult respondents' families decrease similarly. The uninsurance rate for individuals in families with an adult holding a college degree is under 4 percent. This is less than half of the rate among individuals who did not complete college or vocational school.

F-3 Uninsurance Rates for All Individuals by Family Income as a Percent of the Federal Poverty Level.

Table F-3.1 describes the uninsurance rate by the 2001 federal poverty level (FPL). The federal poverty level varies by household size and is closely related to the eligibility levels for public assistance programs such as Medicaid and Food Stamps. The federal poverty levels for 2001 appear in Table F-3.2. The ranges chosen in Table F-3.1 correspond to the levels used for the New Hampshire Healthy Kids program, which are listed in Table F-3.3. For example, New Hampshire's Healthy Kids Silver program is available to qualifying children in families with incomes up to 400 percent of the FPL; the Healthy Kids Gold program is available to qualified children in families earning up to 185 percent of the FPL.[xv] As shown in Table F-3.1 (as well as Table F-1.3) the uninsurance rate decreases markedly as family income increases: from 25 percent in families living below the poverty line, to 2.9 percent for families with incomes above 400 percent of poverty. The difference in rates between the 100-185% and 185-300%

groups is 12.4 percentage points (21.9 minus 9.5). This difference is significant, with a 7.3 percentage point gap between the confidence intervals.

Lower income individuals are less likely to be able to afford coverage, even when offered to them through work. Affordability is often the primary reason cited for the lack of insurance. In fact, this survey found that 57 percent of the non-elderly, working uninsured adults cited affordability as the primary reason for not participating in a job-based insurance plan (Table 1-28 of the Interim Report).

F-4 Rate of Benefit Coverage for Dental, Pharmacy, and Mental Health

Table F-4.1 presents estimates for mental health, pharmaceutical, and dental coverage. The New Hampshire Family Survey of Health Insurance asked respondents with a privately-sponsored health plan a series of questions about the family's primary insurance policy. Families insured through public insurance programs were not asked about their health plans. For families with a privately-sponsored plan, the policy may not cover all individuals in the family: some family members may have benefits through a different policy or be uninsured.

Almost all (94.4 percent) individuals in families with a privately-sponsored health plan have coverage for mental health. The same is true for drug coverage (95.9 percent). About one quarter (23.8 percent) do not have dental coverage, however.[xv] These results suggest that most people with health insurance have comprehensive coverage. These estimates assume that all insured individuals in the family are covered by the primary insurance policy. If the non-elderly, uninsured individuals in these families are assumed not to be covered by their families' primary plans, then the estimates drop slightly.

The estimates provided in the "All Individuals" column are population estimates that include all individuals, not just those in families with a privately-sponsored plan. The population rates for mental health, pharmaceutical, and dental coverage are estimated by supplementing the responses for families with a privately-sponsored plan with expected coverage for all other individuals in the sample. Individuals with publicly-sponsored health plans are assumed to have coverage for all three services, and uninsured individuals are assumed not to have coverage for these services. Almost 90 percent of non-elderly individuals have coverage each for mental health services and for drugs; 72.3 percent are covered for dental services.[xv]

F-5 Work Status, Offer Rates, and Other Characteristics Among Families with Uninsured Individuals.

Most (93.6) non-elderly, uninsured individuals are in families where at least one adult works 30 hours or more per week ("full-time" for the purposes of this analysis), as described in the last column of Table F-5.1.[xv] Only 6.4 percent of the non-elderly, uninsured are in households where there is no adult working full-time. Even among the non-elderly uninsured in low-income (under $25,000) groups, very few (8.5 percent) are in families in which no adult is working full-

time. Almost one quarter (22.8 percent) of the non-elderly uninsured are in families where two adults work full-time. In families with household incomes greater than $50,000, roughly one third have two fully employed workers; in the two lower income groups, only 16.1 and 19.6 percent are in families with two full-time workers.

Although most of the non-elderly uninsured are in families where at least one adult works full-time, just over half of the adult workers are employed in companies that offer health insurance. Only one quarter are in families that turned down insurance while 42.8 percent were in families where the workers did not have health insurance offered to them. There is no significant difference in the distribution of health plan availability across income groups as indicated by the chi square statistic. The estimates are slightly different for each income group, and the confidence intervals are very large. This is due to the decrease in sample size that occurs when estimating characteristics for subgroups, such as those presented in Table F-5.1.

Table F-5.2 presents various characteristics of non-elderly, uninsured individuals in four different income groups and in total. It is important to note that these income levels are based on *family* income, which, unlike the federal poverty level, is not adjusted for household size. The mean family size for uninsured individuals in the highest income group is 3.2 persons, compared to 2.7 in the lowest income group. In addition to having larger family sizes, the non-elderly uninsured in higher income groups tend to have more adult workers in their families. About two-thirds (63.1 percent) of the uninsured individuals in New Hampshire live in the rural south; another one quarter live in the north. Wealthy uninsured individuals disproportionately live in the rural south and live in a family where the respondent graduated from college. The poor uninsured individuals were least likely to live in a family where the respondent graduated from college.

F-6 Simulation of Children Eligible for New Hampshire Healthy Kids Who Are Not Enrolled, and Their Use of Services.

The enrollment status of children who are eligible for New Hampshire Healthy Kids appear in Table F-6.1. The estimates were derived by comparing the self-reported family incomes of all children 0-18 in the sample to the Healthy Kids income eligibility guidelines for the year of the survey, 2001. The income guidelines are different for different family sizes, and appear in Table F-3.3.

In addition, the New Hampshire Healthy Kids program allows a $90 per month income exclusion for each working parent and requires a child to be uninsured for at least six months before becoming eligible for the program. In cases where an adult in the family had positive work hours, the $90 income exclusion was applied in estimating eligibility. The estimates of eligibility do not account for the six-month uninsurance rule. As a result, the estimates of eligible but unenrolled

children will be biased upwards. Applying the six-month uninsurance criterion would lower the number of eligible but unenrolled children in New Hampshire.

As shown in Table F-6.1, about two-thirds of all children ages 0-18 are eligible for New Hampshire Healthy Kids. Among the eligible, three-quarters are already insured, typically through a privately-sponsored health plan, and 15.2 percent are enrolled. The remaining 7 percent of eligible children are still not enrolled, however. New Hampshire Healthy Kids is a safety–net program, targeting low-income children who would otherwise be uninsured. Among these children, 68.5 percent are enrolled in the program and 31.5 percent are uninsured. This simulation estimates that the program covers between 62.6 and 73.8 (the 95 percent confidence interval) of its target population.

It is important to note that the estimates provided above include both the unsubsidized (children in families with incomes between 300 and 400% of FPL) and the subsidized Healthy Kids programs. To fully understand the eligible but unenrolled population, and to accurately assess whether state financial participation is reaching the true target population, these two programs need to be evaluated separately. As a result, the estimates provided in this report should be used to assess the target efficiency of state funds in covering uninsured children.

Table F-6.2 presents the estimated utilization rates among uninsured children in families where at least one of the children is eligible for New Hampshire Healthy Kids, but not enrolled. It is important to note that the questions about healthcare utilization for uninsured children were not asked at the individual level. For example, the number of emergency room visits reported by families with uninsured children refers to *all* uninsured children in the family. Very few uninsured children in families with eligible-but–not-enrolled uninsured children had visits to either a community health center or emergency room: only 6.9 percent had one or more visits to a community health center, and only 18.1 percent had one or more visits to an emergency room. It is difficult to interpret the low utilization rates at these settings. The low rates may represent a lack of access to needed care, or an indication of good overall health. Unlike visits to emergency rooms or community health centers, about half of the children in this analysis are estimated to have had at least one visit to a doctor's office. These children appear to have had access to primary care in spite of being uninsured. Insofar as these children have access to physicians and are in good health, it may explain why they (their parents) have not participated in New Hampshire Healthy Kids.

THE INSURERS' PERSPECTIVE ON THE HEALTH CARE SYSTEM, INSURANCE AND THE UNINSURED

By

Bruce Spitz

March 12, 2002

Spitz Consulting Group
80 Gilbert Road
Belmont, MA 02478
617-484-0490

The State of New Hampshire has always recognized that a solution to the uninsured must involve private insurance

carriers and health plans. In order to incorporate these perceptions and insights into the HRSA project, Bruce Spitz and Deborah Chollet[xv] conducted a series of comprehensive, structured interviews with representatives of the four major insurers in New Hampshire:

1. Rod Turner, Vice President for the American Republic Insurance Company (Republic).
2. Brian Wells, President and General Manager for CIGNA HealthCare (Cigna).
3. Gray Somers, Vice President and General Manager for Anthem Blue Cross Blue Shield of New Hampshire Inc. (Anthem).
4. Beth Roberts. Director, NH Operations and Development, Dr. Alan Freeman, Associate Medical Director, Dr. David Cochrane, Senior Vice President of Strategic Development and Denise McDonough, Sales Manager, for Harvard Pilgrim Health Care of New England (Harvard).

The interviews were conducted in February 2002. The insurers were told that the purpose of the discussions was to make them a part of the HRSA study and include their observations, experiences and perceptions on the:

1. The structure of the New Hampshire health care market
2. The cost of health care and insurance in New Hampshire.
3. The factors they thought affected the decision to purchase health insurance.
4. Options for reducing the number of individuals without insurance.

The interview process was fluid and conversational. While all the questions were asked, the order in which they were asked invariably changed and issues that were not explicitly raised in the questionnaire were also discussed. (See Appendix A. Insurance Questionnaire). Further, since none of those interviewed saw the questions prior to our meetings, some of their responses were based on their estimates and sense of what was occurring, and not on data they had collected for our discussions. In general, the insurers' responses reflected the products they sell in New Hampshire's health insurance market.

The Individual and Non-group Markets

American Republic Insurance Company of Iowa, a national insurer that specializes in non-group insurance, serve approximately 6,000 of the 20,000 individuals who purchase non-group insurance in the New Hampshire market. Compared to the three large group insurers in this survey (Anthem, Cigna and Harvard), Republic said they offer a product with:

1. Relatively high administrative costs than the other plans interviewed. Thirty five percent or of the premium dollar is allocated for administrative functions, such as marketing and servicing the product, compared to 15 percent or less of the administrative dollar of the large group insurers.
2. Relatively high deductibles (their current products for new enrollees have $2,000 deductibles whereas the large group carriers typically offer insurance with $500-$1,000 deductibles)
3. Reliance on indemnity coverage.
4. No provider discounts on prices or charges. They are currently interviewing prospective PPO networks for the purpose of "renting" a discount network. Negotiated discounts have been one of the more effective methods that the large group insurers have used to reduce their costs.
5. No attempt to control patient utilization or provider behavior through managed care or point-of-service products.

The Large Group Market

Anthem, Cigna and Harvard are the principle large group health insurers in New Hampshire. Anthem and Cigna sell coverage throughout the state, while Harvard concentrates its business in southern New Hampshire. In 2001, Anthem represented 242,069 lives or 55.9 percent of the privately insured individuals in the State's large group market. Cigna represented 154,157 lives (35.6 percent of the privately insured large group market) and Harvard represented 3,218 lives (5.4 percent). Neither Cigna nor Harvard provided non-group insurance. Anthem and Cigna insure individuals throughout the State. Harvard only provides coverage in the more densely populated Southern portion of the State.

All of these large-group insurers negotiate discounts and reimbursement arrangements with providers. All use utilization review of some sort. Cigna and Harvard offer products that either provide beneficiaries with financial

incentives to use less expensive carriers or that exclude expensive carriers from their networks. Harvard said they specialize in managed care products that rely on monitoring or requiring adherence to medical protocols, although they admitted that in actuality they have only limited impact on how providers diagnose, treat and refer.

Common Themes

Although the insurers' responses differed somewhat based on their market share and product lines, they voiced a number of common themes:

1. The insurers said they believe the current rate of increases in health insurance premiums is probably not sustainable. They did not specify when the "bubble" would burst, but all said that the current rate of increase is worrisome
2. They also said they may have reached the limits of what they can do to control costs by negotiating further price discounts.
3. Their ability to maintain their existing utilization controls - let alone impose more stringent controls - has met with strong beneficiary, employer and media resistance.
4. Each individual insurer has been unable to impose their specific protocols on providers because of the lack of uniform disease treatment protocols (e.g., treatment of diabetic or asthmatic patients) across all insurers; the product of resistance on the part of medical professionals to paradigms imposed by insurers, and public and media resistance to managed care in general.
5. Similar to number 4 above, the insurers said that the public does not want significant limitations placed on their choice of providers or the services that are covered. Most employers and patients, they said, are unwilling to accept an insurance product with a restricted (or selected) group of providers.

6. All of the insurers referred to John Wennberg's work on the variation of physician practice patterns within similar populations, but none of the insurers said they know exactly how to use that information to control costs.
7. For the most part, the insurers said they believe the most effective way left to control costs is to make the patient more directly responsible for the cost of obtaining medical care by increasing their first-dollar financial obligations through increased. deductibles, coinsurance and co-pays.
8. All insurers felt it is more difficult to control costs and function in the non-group market than the small or large group markets.
9. In general, the insurers do not believe that increasing the number of carriers selling health insurance is a solution to the problem or rising premiums. Anthem, Cigna and Harvard raised concern that the opposite effect might occur. More competing insurers might raise costs by diminishing their negotiating clout with physicians, hospitals and suppliers. Republic said they believe the non-group market should have at least 10 insurers to make it competitive, while the large group insurers believe that 2 to 3 insurers is probably ideal.
10. All of the insurers said they are willing to work with government to craft solutions. However, all were distrustful of additional costs that government might create through additional mandates, regulations or reporting requirements. Nonetheless, if solutions could be created that imposed uniform burdens across all insurers, then they were more than willing to work cooperatively to create a less expensive product. Most of the insurers indicated that a regional solution engaging all three Northern New England states could be very promising.

System Characteristics: The Structure and Cost of the Health Care Market

Physicians and Hospitals. In 1998, the Department of Health and Human Services, the Insurance Department and the Attorney General's Office began working jointly to implement a State health plan. Part of that project has involved gaining a more detailed understanding of the nature and operation of the health care market. Initial studies have involved financial and economic analyses of the state's hospitals and community health centers. The analysis of the health plans and insurers is underway. In 2001, the legislature asked the Attorney General's office to examine the financial and legal relationships that existed between physicians and hospitals. To compliment both the completed hospital economic analysis and Attorney General's physician hospital analysis, we asked the insurers to estimate the percentage of participating primary care physicians and specialists that were controlled by Physician Hospital Organizations (PHOs), hospital employment or other hospital arrangements.

The insurers had mixed perceptions on the impact of hospitals on physicians. Republic does not negotiate discounts with providers and therefore was unaware of the specific financial relationships between hospitals and providers. Harvard believed that hospitals' controlled 80 percent of the physicians – a perception that could have mirrored the nature of the contracts that Harvard preferred to write (that is, managed care contracts with local integrated hospital physician delivery systems), as well as the fact that Harvard only deals with providers in the Southern part of the State. Cigna and Anthem estimate that hospitals exert control over 20 to 30 percent of the primary care physicians and a much smaller percentage of the specialists. They also said they feel that physician hospital organizations are not the primary channel through which hospitals influence physician behavior. Instead the hospitals' control occurs primarily when they employ physicians directly within the hospital or have purchased the physicians' practices. No numbers were given to document the number of physicians actually employed by hospitals that these plans currently contract with. Thus, based on these interviews it is not clear how important this factor is in the state's health care market. However, Anthem did say their impression is that hospitals might have overstated their influence on physician behavior. In their words, the hospitals "think they have more control than they do."

The most problematic parts of the State to establish a network and negotiate with physicians are in the North Country and the Seacoast. Cigna noted that the Littleton area is one of these problems areas. They gave the example that one physician group in the area didn't like capitation, so Cigna switched to a fee-for-service billing arrangement. Then, the physician group didn't like the Cigna fee schedule. Previously, Cigna had capitated primary care physicians and some PHOs. Now it has a statewide fee-for-service arrangement. The Seacoast, they said, also poses some special difficulties in contracting. Cigna indicated that they had to give the Exeter physician group a higher fee schedule in order to get them into their network. According to Cigna, "The employers wanted them in the network, so we didn't have a choice."

According to the insurers, physician self-referrals within multi-specialty physician groups have not posed a significant problem to their patients. The insurers felt the referral practices are consistent with behavior that existed prior to managed care and capitated arrangements. Physicians are always inclined to refer to other doctors with whom they have pre-existing, trusted relationships. Despite the fact that beneficiaries have complained to legislators and State agencies, the insurers stated that they had not received complaints from beneficiaries about these practices. Harvard felt that these referral networks are actually beneficial. For example, Harvard noted that working with the Dartmouth-Hitchcock physician group offers patients a higher quality product and at reasonable cost.

Costs. Historically, New Hampshire has been one the insurers' lower cost New England states. Now, New Hampshire was Republic's and Cigna's most expensive state. Anthem and Harvard noted that Maine is more expensive. Harvard acknowledged that its costs are influenced by the fact that it primarily operates in the relatively lower cost Southern region of New Hampshire and does not contract with Exeter Hospital, which is one of the more expensive hospitals in the State. Three of the insurers said the North Country and the Seacoast are the most difficult regions for negotiating with physicians or hospitals, and these areas are the most expensive regions within the State. However, during these interviews none of the insurers singled out inpatient hospitalization as causing an

unusual increase in expenditures. Instead, the insurers identified outpatient care and the cost of pharmaceuticals as the primary cost culprits. Cigna indicated that pharmaceuticals now account for a greater portion of their costs than hospitalization.

New technology has been a principle cost driver for medical services. However, none of the insurers said they review their costs under the category of *New Technology.* New procedures and interventions can be and are identified by new CPT and ICD-9 codes, and these costs are tracked. The insurers also said they examine spikes in utilization and "drill down" to determine specific causes.

The most detailed discussion that we had on new technology was with two physicians from Harvard. Since this is a topic of interest for this project, we have elaborated and expanded upon that exchange. Restricting our attention to a new intervention or equipment inevitably under estimates the impact that new technology, new knowledge and new marketing techniques have on the cost of medicine. A more appropriate review would include the new technology and the:

1. Expansion of the definitions of illnesses. Over time, the definitions of common medical conditions – more specifically the threshold for those conditions - changed, become more demanding and consequently included more individuals (e.g., high blood pressure or high cholesterol).
2. Screening creep. The frequency and age and medical conditions of the individuals that should be screened for specific diseases changes. The result is often that more people are examined more frequently. Screening carries the danger of false positive results as well as the discovery of non-lethal abnormalities. Both conditions can prompt further tests, medical interventions and costs.
3. Application Creep. Technology that was designed for a highly specific purpose finds has been applied to conditions that it was never intended to examine or cure. The MRI, for example, is a minimally invasive diagnostic marvel that was originally designed to reveal critical information about hard to reach soft tissue

(e.g., the brain). Now MRIs are being used to provide full body scans or review the conditions of arthritic knees. Each new application adds to the cost of health care.

4. Demand creep. New technology can solve a medical condition. New marketing techniques can also create the demand for goods and services that may have an inordinately small marginal benefit but add considerably to the cost of care. Some critics have argued that direct TV marketing for Clariton and other drugs are an example of this type of demand creation.

Competition. American Republic, which does not negotiate fee schedules at this time with providers, hypothesized that the State needs at least 10 competitors (6 strong plans and 4 "niche" players) in order to produce effective competition in the non-group market). The question is what kind of efficiencies would be realized and what kind of cost reductions would consumers experience if there were an additional 9 plans competing for the 20,000 lives in the nongroup market - particularly if Republic maintained its 6000 clients? The remaining plans would be competing for 14,000 individuals or approximately 1,555 enrollees per competitor. This number is so low that based on what Republic said during the interview - if Republic had a similar number of beneficiaries, it would consider exiting the market. We had one other competition related response from Republic that referred to whether or not it would be willing to meet with State officials to discuss developing products that could solve the problem of the uninsured. The Republic representative hesitated and then when further questioned indicated that he would not want to meet with the State without the other non-group insurers present, that the non-group insurers often shared information elsewhere in the country, that they had established relationships and that it would not be appropriate to meet alone. None of the large group insurers suggested that they would turn down a one on one meeting with the State to discuss products or solutions.

In general, the large group insurers do not think that increased competition in the form of adding more health plans in the state will lead to a solution for the problem of rising medical costs or the uninsured. This is because they believe the problem is not due so much to their administrative inefficiencies (the only factor of production they have direct control over), but in their inability to exact greater savings in the form of provider price discounts or utilization controls, and the consumers' (patient and employers) unwillingness to buy products with restricted provider panels or strong controls on patient utilization.

The large group insurers were not as sanguine about the benefits of competition. They felt that three competitors were ideal. . Three competitors can keep each player honest in terms of the conditions that they demand from employers, patients, and providers. Also, the presence of three health plans – as the Anthem representative noted - gets any one insurer "out from under the microscope" of constant public review and inspection. If the number of competitors increased to more than 3 then the ability for each individual competitor to negotiate price discounts or gain provider compliance with any case-management requirements would be markedly diminished.

Lowering Insurance Premiums. One of the central questions for the interviews concerned the actions that insurer could take to produce a lower cost insurance product. Most said they believe the current medical prices increases are unsustainable, but they feel they may have reached the limits of what they can do to control costs.

The insurers are familiar with the financial and economic analyses on the hospital sector that the State commissioned. One report found that the hospitals were financially stable, comparatively profitable and offered very limited discounts to commercial payers.[xv] Another report indicated that the hospitals' average costs and net revenues per admission were low (compared to other New England states) and that competition between the hospitals was very limited.[xv]

The insurers indicated that the strong position of the hospitals made it difficult to demand deep discounts and that it is unlikely that they will be able to negotiate significant discounts in the future. The insurers also indicated that physicians and other providers expect their rates to increase at least at the rate of inflation and more often at the higher medical care component of the consumer price index. Rising costs therefore had an inexorable quality to it that was compounded by the insurers inabilities to penetrate other aspects of medical care.

In addition to rising provider prices is the insurers' difficulties controlling utilization. In recent years, beneficiaries, employers and politicians have displayed strong opposition to utilization limits. The insurers noted there has been an attack on managed care in the media. And, the lack of uniform disease treatment protocols (e.g., treatment of diabetic or asthmatic patients) across insurers make it difficult for any single insurer to have their protocol adhered

to. In addition, the public does not want significant limitation on their choice of providers. Therefore, most employers are unwilling to purchase an insurance product with a restricted (or selected) group of providers. All of the insurers referred to Jack Wennberg's work on the variation of physician practice patterns within similar populations, but none knew exactly how to use that information to control costs. Employers might inform employees more fully about the total cost of health care through reporting premium payments on their pay stubs, providing a complete explanation of benefits after bills are paid, or holding seminars on medical costs. Some insurers thought it might be useful. Others were less optimistic. Harvard noted that "in Canada they sent out dummy bills, but it didn't matter." The specter was also raised that once employees understand how much money is being spent for their insurance premiums they might be spurred on to use as much services as they can.

Increasing First-Dollar Patient Costs

For the most part, the insurers said they believe the most effective way left to control costs is to make the patient a more direct part of the purchasing decision by increasing the patient's first-dollar financial obligations (e.g. deductibles, coinsurance and co-pays). This would be a way of "unshielding" the patients from the economic implications of their utilization. This could be done by either increasing specific financial levers: hiking co-pays to reduce office visits, offering catastrophic coverage that held the patient responsible for everything but high cost care or adopting some form of a Medical Savings Account. The concern was raised that these policies have a potential negative effect if individuals refrain from seeking out and receiving needed medical care. The insurers also raised some concern that that the healthy and more affluent might purchase lower coverage options, which in turn might mean that premium costs would rise even more for the sick. This would have a particularly adverse effect on the less affluent in the pool who would have to pay especially high premiums.

The Cost of State Regulations

Insurers felt that insurance costs could be reduced if government mandates, regulations and reporting requirements were minimized. All of the insurers questioned the wisdom of some mandates, but few specific illustrations were offered. Republic cited a national study indicating that mandates account for between 15-40% of insurance costs. Republic also suggested that the State should avoid mandating additional benefits and possibly make the mandates optional for the individual market. In that case, the individuals that were both paying for and using the policy could

decide what benefits they wished to purchase and insurers could write policies that met specific needs. Cigna was also cautious about the need for mandating benefits. Brian Wells indicated that he might not entirely eliminate them but urged that they be carefully reviewed and reconsidered. As an example he cited State mandated bone marrow transplants for women with breast cancer even though this has not been proven effective.

There were three common objections to regulations. First, there are regulations that award special privileges to providers. As Cigna observed, "The legislature should not be the bargainer for providers. We have a prompt pay mandate of 15 days. Why does a medical provider have to be paid in 15 days when the plumber waits 30 days?" Harvard objected to limitations imposed on retroactive claim adjustments. "We have 90 days to file a claim and now only 90 days to adjust it for eligibility. We are not able to deny a claim after its paid even if the patient was not eligible for benefits. The providers won this regulation by saying their claims for payment were being denied. But, let's say we paid the bill for a person who was no longer eligible under our plan. They switched employment so that Anthem got the premiums, but we paid the bills."

Second, they objected to regulations that promote adverse selection. The insurers were not objecting to guaranteed issue or modified community rating (although Republic would have liked to have had greater leeway to set its rates). They disliked the fact that different rules apply to the non-group market and the one-person small group insurance market. Harvard said that they have "a special problem with the one-person group, including the high-risk pool, where individuals buy insurance who know they will need medical care. An individual will incorporate just to buy group health insurance, so we get the high cost cases." The feeling expressed is that the rules governing the non-group and one-person small group insurance policies should be the same.

Third, some regulations impose costs that appear to have little benefit for patients. . For the most part these objections were directed at the frequency of reporting requirements and obtaining approvals (e.g., the need to request approval for every rate increase rather than allowing insurers to work within a range of approved rates) or the nature of the reporting requirements (e.g, a recent demand that the insurers report at the zip code level, a requirement that is expensive and whose use is not clear to the insurers).

Finally, some government costs were dedicated taxes that benefited everyone but were borne only by the insurance companies. Harvard indicated that in New Hampshire it has to reserve 17% of its premium dollars for programs like immunization, assessments for running a state agency, the high-risk pool and mandates.

The Decision to Purchase Care

The rate that individuals and families disenroll, i.e. let their insurance lapse, appears to be heavily related to the type of insurance they buy and to a lesser extent product loyalty. Republic indicated a much higher lapse rate than the other insurers with a disenrollment rate of 35-40% in the first year. During the second year, the lapse rate falls to 25 to 30 percent, the third year to 20 percent and approximately 15 percent thereafter. In part this reflects the transitional function that non-group insurance plays – a form of bridge insurance for individuals between jobs or other sources of coverage (e.g., people taking early retirement who are not yet eligible for Medicare). At the other extreme Harvard claimed that no more than 2 percent of their beneficiaries disenroll. Anthem indicated only a 5 percent lapse rate percent.

When premiums rise rapidly, individuals and employers can attempt to limit those premium increases by either reducing the benefits that are covered or increasing the patient's financial obligations (e.g., higher deductibles, coinsurance and co-pays). The cost reductions have primarily taken the form of increased patient payments and - when available – increased reliance on HMO and point-of-service arrangements. These efforts to "buy down" the premiums have been occurring for some time. Republic noted that it was a 30-year trend that had not recently been accelerating. Cigna observed that, "at every renewal, our customers are asking how they can reduce premium costs. We suggest buy-downs as a way to keep business….The brokers are asking for higher deductibles. Employers rarely drop a benefit entirely, but choose cost shifting options through re-structuring the plan's co-pays, for example increasing drug coverage from $5 to $15, setting co-pays at $10, $20 and $40 per provider visit or shifting the co-pay on mental health visits so that the first 10 visits cost less than the second 10 visits." Harvard indicated that they are "nervous" about buy down trends because they might financially isolate the 5 percent of the population that accounts for 50 percent of the health care expenditures. In this setting, the monetary contributions the healthy make for those who are ill decrease, thereby potentially making the first-dollar coverage prohibitively expensive for some people.

New Insurance Products

The discussion of new products focused on what currently exists, what might be created for the general public and what might be targeted to the low-income uninsured population. Two general products were examined. Both would involve working with State government.

The first area of questions asked insurers whether they might be willing to join the state in bulk purchasing pharmaceuticals, eyeglasses, medical devises or other goods and services. The rationale is that large purchasing entities might realize greater savings and discounts from manufacturers. The second set of questions inquired into the more novel idea of whether insurers would be interested in bidding on a large block of business based on the pool of State and municipal employees, Medicaid, Workman's Compensation, etc.. The structure of the program was left relatively open with regard to whether this meant administrative services only or includes underwriting risk, but there were two provisos:

1. The winning company(s) would offer state and local government products at the same or lower costs than currently exists and

2. The companies had to offer insurance products to all the residents in the State at a lower cost than was currently available in the non-group and small group markets

The advantage of doing this for State government is that it would **not increase** State costs or financial obligations and would help to restructure and reduce costs in the existing market (e.g., by making the individuals in the non-group market part of a much larger population with access to insurance products that has lower administrative costs and higher purchaser discounts built into them.). The advantage to the insurer is that the system would be more lucrative and less volatile than the current non-group market currently is.[xv] The question was would the insurer be interested.

Bulk Purchasing Arrangements. The bulk purchasing proposal evoked positions that ranged from interested (Cigna's stated that this might be an extension of what managed care companies, the CDC and the State already do with the vaccine program) to interested but skeptical. Some insurers' were wary that the State would create onerous administrative requirements. Republic stated that it would join the State, "as long as it works with our administrative processes. We'd be interested in working on this on a multi-state basis with Vermont, New Hampshire and Maine. We'd be interested in selling the same product in three states. It's a shame the momentum to get this going died. We would need an agreement on reciprocity for rates and licensure, although this might not have to be with one governing body…. We would work with the states even if it involved administrative changes, as long as the changes are positive and reasonable with regard to our business."

Concern was raised as to whether such a program would offer an advantage over their existing bulk purchasing arrangements. Anthem observed, "As an eight-state health plan we already try to get leverage by scale. We did not opt to participate with New Hampshire, Vermont and Maine on a pharmacy program because of our concerns about the administration of the program."

The Public Private Insurance Consortium. The question concerning putting all of the State's health care business out to bid was cautiously considered by all of the insurers. They were concerned that it would reach beyond their established product lines in health insurance (e.g. Republic felt that companies tend to specialize and do not offer an entire product line for one state) as well as extend beyond what is typically considered health insurance (Workman's Compensation). They were concerned about the high risks in the non-group market, even if it was folded into a larger population. They also raised concern about adverse selection among small groups. They felt that there was no way to insure continued leverage with providers on rates and quality. And they felt that government had not been

a good business partner in the past. All that said, the large group insurers were willing to review and consider this proposal if it were developed by the State.

New Products for Low Income Uninsured Individuals and Families. Republic indicated they are developing a PPO network product with high deductibles they hoped would be attractive to low-income individuals. All of the insurers indicated that they would consider a primary care network product for low-income individuals. Harvard stated that it is in the process of developing a primary care network product in Massachusetts and would consider doing it New Hampshire.

Republic offered a list of issues that should be addressed.

- Products should be developed that require that all insurers work under the same conditions with same obligations. "All the carriers would have to work together. I'd object to anyone getting preferential treatment."
- Competent market research is essential to target the products people will actually buy. Government should ask insurers to develop only those products that people want.
- Public and private subsidies should broadly spread the burden and allow for private voluntary actions (from provider discounts to corporate cash assistance).
- Some things must be mandatory, like the high-risk pool assessments. In fact, the high-risk pool should be spread across all markets. Equity is the main thing people in the industry look for.
- Provisions should be made so that when individuals are sick their insurance coverage will not lapse. Coverage should lapse only if the individual's spouse got insurance or the individual died.

These interviewees suggested other options for expanding coverage that include exploring the application of the Hawaii model that share risk between the employer and the insurer; and designing a product based on the $1,000 federal refund tax credit, by creating premiums based the patients' choice of their own referral network hospital and PCP.

Summary and Conclusions

The State of New Hampshire has recognized that a solution to the uninsured must involve private insurance carriers and health plans. Most people, including the uninsured, want private health insurance, a wide choice of providers and affordable premiums. However, many of the uninsured do not have health coverage because they cannot afford the premiums. This interview study was conducted in an environment of rising premiums that many worry threatens to increase the number of New Hampshire residents without health insurance.

In order to incorporate the perceptions and insights of insurers into the HRSA project, in February 2000 Bruce Spitz and Deborah Chollet conducted a series of comprehensive, structured interviews with representatives of the four major insurers in New Hampshire: American Republic Insurance Company (Republic), CIGNA HealthCare (Cigna), Anthem Blue Cross Blue Shield of New Hampshire Inc. (Anthem), and Harvard Pilgrim Health Care (Harvard). The interviews occurred in February 2002.

All the insurers interviewed registered similar concerns about the rising cost of health insurance premiums, which they said are determined primarily by the increasing prices being charged for the services they must reimburse. They said they feel they have relatively limited ability to negotiate more significant provider discounts or restrict patient access to services. Therefore, the insurers said that reductions in premiums could only be achieved by increasing the patients' financial obligations increased deductibles, coinsurance and co-pays. The large group insurers believe that adding more insurance carriers will not address these underlying realities and might actually aggravate it by producing a market with more carriers who each have relatively less buying clout.

The most costly form of insurance is in the individual, non-group market due to relatively higher administrative costs and limited provider discounts. The insurers also argued that guaranteed issue and adverse selection made this an inordinately risky group in which many individuals buy insurance when they were sick and drop it when they are healthy.

The interviewees also stated there is widespread patient, employer, public and media resistance to limiting access to services and providers, restricting physician referral, or in other ways significantly limiting utilization of medical services. In order to sell a product that employers or individuals will purchase, the insurer must meet the desire of beneficiaries who, when they are ill, want the best care available and the provider of their choice. According to the insurers we spoke with, these factors make it difficult for insurers to hold down costs.

The insurers anticipated increasing patient costs near term in reaction to statewide health care inflation. This would translate into higher deductibles and co-pays, and the likelihood that employers in the group market will require their employees to pay more of the basic premium. They suggested making the patient and employer more aware of the prices being charged for services in the form of explanation of benefits and patient education, but acknowledged this had been tried before with only limited success. No new or alternative strategies were offered.

The insurers registered concern about state regulations, such as guaranteed issue, data reporting, taxes, and mandated benefits, but gave no hard numbers for what specific regulations translate to in terms of premiums costs. They want to maintain a viable competitive marketplace for health care insurance and in that environment are willing to engage with regulators, elected officials and other carriers to developing solutions to the problem of rising health care premiums and the problem of the uninsured. Several insurers encouraged the consideration of regional solutions involving New Hampshire, Vermont and Maine.

Appendix A.

INSURANCE QUESTIONNAIRE

The Structure and Cost of the Health Care Market and Insurance

We are investigating the relationships between hospitals and physicians and the impact that those relationships have on competitive markets.

1. What is your estimate of the percentage of your participating primary care physicians (GP, FP, IM, Peds, etc) that are controlled by:
    a. PHOs
    b. Hospital employment
    c. Other hospital arrangements (please specify)

2. What is your estimate of the percentage of participating physician specialists that are controlled by:
    a. PHOs
    b. Hospital employment
    c. Other hospital arrangements (please specify)

3. How prevalent is the practice of multi-specialty group practices that do not allow health plan enrollees to select physicians outside of their group even though those outside physicians are within your provider network?

4. Are there any regions in the State where you find it difficult to sign physicians to your network? Do you have any idea what the reasons are for that difficulty?

States have been reconsidering the nature and extent of competition within their health insurance markets as well as the impact that competition has on those markets.

5. What is the minimum number of health plans that NH needs in order to have a competitive health insurance market?

6. How does the cost of health care in New Hampshire compare with other states?

7. Could you rank health care costs by geographic region? Or, what 3 geographic regions in the State have experienced the largest rate increases? What 3 have received the lowest?

8. How many hospital contracts have you renewed or re-negotiated in the past 2 years?

9. Have you increased the rates that you pay to hospitals for services?
    a. If yes, what is the range of the percentage increases? What are the 3 most expensive regions in the State?

b. If no, have you decreased the rates you pay to hospitals? What is the range? What are the least expensive regions in the State?

10. How do the premiums you offer in New Hampshire compare with the premiums you offer in other states (higher, lower or the same)? What are the key reasons for the differences?

11. What is the dollar or percentage breakdown of your premium costs by:
    a. Inpatient services
    b. Outpatient services
    c. Physician services
    d. Pharmacy and supplies
    e. Other medical services
    f. Marketing your products
    g. Fees paid to brokers
    h. Claims administration (claims payment and oversight/auditing)
    i. Profits
    j. Other administrative costs
    k. Taxes

12. Do you track the impact that new technology (new pharmaceuticals, new diagnostic equipment, etc.) is having on your costs? If so, how do you define new technology? What impact has new technology had on your costs between 1999 and 2000? Between 1995-2000?

13. What factors would help you develop a health insurance product with lower premiums?

14. A number of state regulations have an impact on your premiums or costs.
    a. Which ones would you change?
    b. Why?
    c. How would you change them?

15. Many think that if employers made their employees more aware of the cost of health care, that their employees would be more conscientious in their consumption of health care services. What effect do you think the following would have on employee behavior:
    a. Indicating the employer and employee's premium contribution on the employees' paycheck? What percentage of your clients currently does this?
    b. Employee seminars on health care costs? What percentage of your clients currently does this?
    c. Explanation of Benefits? What percentage of your clients currently does this?
    d. Other employer actions you would recommend? What percentage of your clients currently does this?

The Decision To Purchase Insurance

16. What percentage of individuals disenroll each year?
    a. Has that rate changed compared to the previous five years?
    b. Why are consumers disenrolling from coverage?

c. Have you analyzed the relationship between changes in the premium rate and disenrollment?
d. If so, what is that relationship?

17. What are the benefit buy-down trends?
    a. What percentage of your clients opted to buy down last year?
    b. Has this trend changed over time?
    c. What percentage of your buy-downs involve
        i. Increased co-pays?
        ii. Increased coinsurance?
        iii. Increased deductibles?
        iv. Reduced benefit coverage?
        v. More restrictive utilization controls?
        vi. Other (Please specify)?

New Products for the General Public

18. A Low Cost Option. If you were not constrained by any State laws or regulations what is the least costly health insurance product that you think would be attractive to the public at large? What benefits would that product offer? What financial requirements would it place on the consumer?

19. Public/Private Pooling of Risk and Purchase of Services. While the State is a major purchaser of health care, its ability to negotiate discounts with providers would be enhanced if it could expand the number of covered lives involved. As a major carrier in this State would you be willing to work with the State to jointly negotiate and purchase:
    a. Pharmaceuticals?
    b. Eyeglasses?
    c. Medical devises?
    d. Other goods and services?

20. Under what conditions would you open enrollment for the public at large into a large group policy at the large group rate?

New Products for Low Income Uninsured Individuals and Families

A 1999 New Hampshire Survey estimated the number of uninsured residents at 96,000. Most of these individuals are in families with at least one full time worker who either cannot afford or is not offered coverage.

21. Do you have any plans for developing a product for low-income adults?

22. Would you consider offering a primary care product for low-income individuals?

23. If not, why not?

24. Do you have any recommendations for increasing insurance for the uninsured?

Interviewers Background

Bruce Spitz is a health economist and President of the Spitz Consulting Group. For the more than thirty years, he has examined alternative approaches for organizing, financing and reforming health care services. The Spitz Consulting Group has a multiyear contract to assist the State of New Hampshire redesign the way it: monitors and manages the health care system for all the residents in the State; works with its communities on health care issues; and provides information on market performance. Mr. Spitz has worked with the federal government, more than 20 states and a half dozen major cities (e.g., New York City, Boston, Cleveland and Denver). He has assisted several of the largest Foundations in the country (e.g., The

W.K.Kellogg Foundation, Robert Wood Johnson Foundation, The Pew Memorial Trust) and participated in a number of international programs. Prior to founding the Spitz Consulting Group, he was a Management Professor at Brandeis University's Institute for Health Policy for 13 years.

Deborah Chollet is a Senior Fellow at Mathematica Policy Research, Inc. in Washington, D.C. She is responsible for leading research projects related to health insurance coverage, markets, and financing. She was previously a vice president at Alpha Center in Washington, D.C. Ms. Chollet has managed and conducted research on health insurance coverage and markets, the conversion of nonprofit hospitals to for-profit status, and Medicare supplemental insurance regulation, as well as provided technical assistance to state governments on related issues. She is a well-known and widely published researcher in her field.