NORTH DAKOTA
HEALTH INSURANCE STUDY
STATE PLANNING GRANT INITIATIVE

INTERIM REPORT

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EXECUTIVE SUMMARY

North Dakota has historically been concerned about its citizens' access to affordable health care. In 1992, North Dakota was awarded a Robert Wood Johnson Foundation State Initiatives Project to examine its uninsured population and develop reform options to extend health insurance coverage. This effort led to the enactment of House Bill 1050 during the 1995 North Dakota Legislative Session. Many of the components of HB 1050 were incorporated by other states. In an effort to continue its commitment to expanding health insurance coverage, the North Dakota Department of Health was awarded the State Planning Grant (SPG) project in 2003, a project supported by the U.S. Department of Health and Human Services, Health Services and Resources Administration. The SPG provided funding to conduct state-based research on the uninsured and also technical assistance to assist North Dakota policy makers in identifying options to expand health insurance coverage.

Clearly, North Dakota is a model state for enacting incremental health insurance reforms that have contributed to it having an 8.2% uninsured rate, almost half of the rate of the uninsured in the U.S. Yet, North Dakota strives for **all** of its citizens to have access to affordable health care. During the past year, the Governor's Health Insurance Advisory Committee (Committee) deliberated about what options other states have developed to extend coverage. In addition, the Committee reviewed the state-based research conducted by the University of North Dakota School of Medicine and Health Sciences, Center for Rural Health. Research findings have assisted the Committee in identifying populations to target for health insurance coverage expansion.

A significant finding from the North Dakota Household Survey was that almost 32% of North Dakota's Native Americans are uninsured – almost five times the percentage of White North Dakotans. Because of health disparities among Native Americans, it is critical to determine if there are opportunities to leverage federal programs to increase the percentage of insured Native Americans. Another population lacking coverage is children (8.1%). The Committee is exploring how to improve outreach efforts to parents whose children are eligible for public programs. Young adults, ages 18 – 24, also have a high percentage of uninsured (15.9%). In addition, almost ¾ of the uninsured adults are employed and a majority work in firms with 10 or fewer employees. Based on this finding, the Committee is exploring options to assist small employers obtain access to health insurance pools. An unexpected finding was that there was little difference in the percentage of uninsured when comparing three North Dakota regions: urban, large rural, and small rural.

The next project year will focus on providing education to the legislature and North Dakota citizens. In addition, public forums will be conducted across the state to garner public input. Another vehicle for public input will be through a designated Web site. The culmination of the research findings and public input will be the development of recommendations by the Committee for the Governor and the 2005 North Dakota Legislature. In addition, it is anticipated that a demonstration project in the private sector will be supported to provide information for the 2007 North Dakota Legislative Session. Ultimately, these efforts are anticipated to further extend access to affordable health care in North Dakota.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Quantitative Research

The North Dakota Household Survey (NDHS) is an instrument developed to collect information about the uninsured in North Dakota. The NDHS survey was developed to determine if national estimates accurately depict the uninsured rate in North Dakota and provide specific data at the state level. The survey was adapted from the SHADAC Coordinated State Coverage Survey (CSCS) instrument. The information collected in the survey will assist the North Dakota Department of Health and the Governor's Health Insurance Advisory Committee to design policies to assist citizens in obtaining affordable health care coverage. The University of North Dakota Social Science Research Institute (SSRI) conducted the survey between February 9 and April 7, 2004. There were 3,199 respondents to the survey with a response rate of 61.9%. For telephone interviewing, we employed a list-assisted random digit dialing (RDD) frame for general population screening. The RDD frame was comprised of a list of all potential telephone numbers in working telephone banks in North Dakota.

Overall Level of Uninsurance

Overall, 8.2% of North Dakota residents were uninsured at the time of the North Dakota Household Survey. The actual number of uninsured North Dakotans (51,920) is similar to the population of Bismarck. In comparison, the 2002 Behavioral Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control and Prevention (CDC) indicated that 9.3% of North Dakotans were without health insurance. The 2002 Current Population Survey (CPS) indicated that 9.6% of North Dakotans were without health insurance.

Characteristics of the Uninsured

Income:

The NDHS data indicated that the percentage of uninsured increased as income decreased. When isolating adults between the ages of 18 and 64, more than 70% of those lacking health insurance made less than 200% of the federal poverty level. Of those that were insured, only 25.2% resided in households that reported an income of less than 200% of the federal poverty level. Nearly ¾ of uninsured North Dakotans were self employed or employed by someone. More than 61% of those employed worked 40 or more hours per week. Sixty-nine percent of insured North Dakotans receive health insurance through their employer. Nearly 15% of working uninsured North Dakotans had more than one job and more than 60% worked 40 or more hours a week. Eighty-four percent of the working uninsured reported that they had a permanent job compared to ten percent indicating their position was temporary and six percent indicating seasonal. Employees working at firms with 100 or fewer employees represented ¾ of the working uninsured. Further analysis showed that nearly half of all working uninsured were employed by a firm with ten or fewer employees.

Age:

The overall percentage of uninsured North Dakotans is 8.2%. NDHS data indicates that North Dakotans between the ages of 18 and 24 have the highest uninsured percentage (15.9%) of any group. The percentage of uninsured North Dakotans aged 65 years or older is the lowest in the state at 1.3%. Nearly three-fifths of the uninsured in North Dakota are under the age of 35. Children under the age of 18 have an uninsured percentage of 8.1% but represent 21.9% of the uninsured. Young adults between the ages of 18 and 24 represent less than 10% of the population in North Dakota, yet represent 19.3% of the uninsured. Children living in urban areas (34.8%) are nearly twice as likely to be uninsured than children living in small rural areas (18.8%). Children residing in urban areas are nearly six and one-half times more likely to be uninsured than children residing in large rural areas (5.3%). NDHS data indicates that the percent of children (0-17) and young adults (18-24) in urban areas represent 56.5% of the uninsured. This is in comparison to 38% for large rural and 20.1% for small rural. NDHS data indicates that adults (55-64) in small rural areas represent 13.8% of the uninsured. This is in comparison to 3.2% for urban and 1.8% large rural.

Gender:

According to NDHS data, 58.2% of the uninsured are male. The percentage of uninsured for males is 9.6%, among females 6.8%. Males are less likely to be uninsured when located in large rural areas (6.1%) when compared to urban (11.3%) and small rural (10.1%). Females are less likely to be uninsured when located in urban areas (4.3%) when compared to large rural (8.9%) and small rural (8.1%).

Family Composition:

Regarding marital status, NDHS data indicated that married (5.1%) and widowed (4.8%) North Dakotans are less likely to be uninsured when compared to separated (24.1%), living with a partner (21.9%), divorced (17.7%) and single (16.0%). According to NDHS data, the percentage of uninsured residing in households with six or more people is 30.1%. Yet the number of North Dakota citizens residing in a household with six or more people represent 6.3% (n=39,886) of the total population.

Health Status:

The Institute of Medicine reports that working aged (18-65) uninsured Americans report poorer health and die sooner than those who have health insurance. Children with health insurance are more likely to have negative health conditions diagnosed during wellness checkups leading to better long-term health than those without health insurance (Institute of Medicine, 2004). NDHS data showed that when separating North Dakotans by insurance status, those with insurance considered their health to be excellent, very good or good 91.1% of the time; the uninsured reported excellent, very good or good health 85.7% of the time. Respondents with health insurance were 34% more likely to indicate that their health was excellent than those who did not have health insurance. NDHS data also indicated that people without health insurance were nearly 38% more likely to describe their health as fair

or poor. Uninsured Native Americans were less likely to describe their health as excellent, very good or good as compared to White respondents (73.7% versus 88.1% respectively). Uninsured Native Americans (26.3%) were more than twice as likely to describe their health as fair or poor compared to whites (11.9%). Overall, NDHS data indicated that 77.3% of insured North Dakotans made a routine visit to the doctor in the past year compared to 56.9% of uninsured North Dakotans. More than one-fifth (21.6%) of uninsured North Dakotans had not made a routine visit to the doctor in more than four years. Nationally, people with health insurance are more likely to have a regular health care provider monitoring their health (Institute of Medicine, 2004). O'Connor, et al (1998) indicated that maintaining an ongoing relationship with a health care provider is a key to high quality care. In North Dakota, the percentage of uninsured with a regular doctor is 58.9% compared to 76.5% for those with health insurance. North Dakotans are more likely to have a regular doctor when residing in an urban region (79.9%) compared to those residing in large rural (76.3%) or small rural (73.4%). Uninsured North Dakotans residing in urban areas have a regular doctor 68.2% of the time compared to those residing in large rural (58.1%) or small rural (52.1%). NDHS data indicates that uninsured whites 64.5% are more likely to have a regular doctor than uninsured Native Americans (41.8%). Insured Native Americans (58.2%) are nearly one-third less likely to have a regular health care provider than insured whites (86.6%). Uninsured North Dakotans were less likely to have a regular place to obtain health care when residing in urban (30.5%) areas when compared to small rural (23.6%) and large rural (19.2%) areas.

Employment Status:

NDHS data showed the majority of both uninsured (71.7%) and insured (82.3%) adults above the age of 17 were employed at the time of the survey. The unemployed were more than three times likely to be uninsured (13.0%) than insured (4.1%). Self-employed (22.5%) respondents were nearly twice as likely to be uninsured than those employed by someone else (12.6%). Retired North Dakotans are twenty-six and one-half times more likely to be uninsured when residing in small rural areas (10.6%) than those residing in urban (0.4%) areas and nearly nine times more likely to be uninsured when residing in large rural (1.2%) areas. Females indicating they were retired and residing in rural areas are nearly twice as likely to be uninsured (13.5%) than retired males (7.7%) residing in the same region. In addition, retired females in small rural areas are nearly seven times more likely to be uninsured than retired females residing in large rural areas. Self-employed respondents from urban (16.7%) regions were slightly more likely to be uninsured when compared to those in large rural (13.8%) or small rural (14.0%). There is a higher percentage of working uninsured employed by firms with one (21.3%) person or two to ten (10.6%) people when compared to firms with 11 or more people. North Dakotans employed by firms with more than 500 employees had the highest prevalence of health insurance. A person working at a firm with only one employee was more than five and one-half times more likely to be uninsured than a person employed by a firm with more than 500 employees (3.8%). Employees indicating they were employed on a temporary (21.6%) basis were nearly three times as likely to be uninsured than an employee with permanent (7.6%) employment.

Availability of Private Coverage:

According to NDHS data, 77.3% of the working uninsured were employed by a firm that does not offer health insurance. In addition, the working uninsured, (16.9%) are nearly three times less likely to have access to health insurance through a spouse than the working insured (49.7%). Data show that 73.7% of the working uninsured are employed by a firm with 10 persons or less. Of the uninsured eligible for health coverage through their employer, approximately 55% reported cost as the primary reason for not enrolling in the insurance. In addition, 16.3% of the respondents indicated the number of hours worked was a barrier to obtaining health insurance while 17.9% of the respondents indicated the time employed served as a barrier to health insurance.

Availability of Public Coverage:

NDHS data indicates that 16% of North Dakotans are enrolled in Medicare while 6.8% are enrolled in Medicaid. Nearly three-quarters of North Dakotans indicated that they would enroll in a public health insurance program if they were eligible while 59% indicated that, if eligible, they would enroll in a Medicaid public program.

Race/Ethnicity:

The Native American (31.7%) population and North Dakotans indicating more than one race (11.5%) had the highest percentage of uninsured in the state. Whites (6.9%) and African Americans (1.6%) had the lowest percentage of uninsured. Native American children (27.7%) were four and one-half times more likely to be uninsured than white children (6.1%). Native American adults between the ages of 35 and 44 have a 50% un-insurance rate.

Geographic Location:

The state was divided into three sampling regions. The three regions separated by population: urban group (cities with a population of 16,718 or greater); a large rural group (cities with a population of 5,000 to 16,717); small rural group (towns with a population less than 5,000).

NDHS data showed individuals residing within different regions of the state experience varying uninsured percentages. Small rural regions had a higher uninsured percentage (9.1%) when compared with urban (7.7%) and large rural (7.4%) regions.

Other:

NDHS data indicates that North Dakotans with health insurance (52.1%) are nearly three times as likely to possess dental insurance as those who are uninsured (17.6%).

Population Groupings Targeted for Expansion Coverage

From research to this point several groups have been identified as needing consideration for increased coverage:

- Children (0-17 years old), who have the highest number of uninsured in an age group (11,312 or 8.1%)
- Young adults (18-24 years old), who have the highest percentage of uninsured in an age group (15.9% or 9,963)
- Self-employed and small employers. In uninsured adults, aged 18 to 64, 72% (39,289) have a job. Half of those are in firms of 1 to 10 employees. Only 5.2% of firms with 10 or fewer employees offered health insurance. In firms where uninsured work only 24% offer insurance compared to all firms where 74% offer insurance.
- Low income families. In adults aged 18-64 21% (7,462) have income < 100% FPL, and 51% (17,990) have income 101-185% FPL.
- Native Americans. 31.7% of those identified as Native American are uninsured (8,964). There are also another 1,020 identified as more than one race, which includes a number of Native Americans.

Qualitative Research

A total of 83 individuals participated in eight focus groups held across North Dakota beginning in January, 2004. Four focus groups were conducted assessing North Dakota residents' experiences obtaining health insurance. The remaining four focus groups were conducted with North Dakota employers and examined the status of current health insurance provisions and likely changes for the future. Four additional focus groups will be conducted during September and October 2004 with uninsured North Dakota residents.

Approximately 1,100 North Dakota residents were randomly invited to participate in the citizen focus groups; 47 residents participated. Groups were convened in Valley City, Hettinger, Tioga, and Grand Forks, ND. Participants were paid $20 and provided a light meal. In addition to participating in the focus group, each participant completed a brief demographic survey. Twenty-five females and 22 males participated with an average age of 58. All but two were white/Caucasian. Thirty-three participants were married, 14 were single. The average income of group participants was significantly higher than the statewide household average.

All participants talked at length about mechanisms for increasing coverage to more people. Potential solutions that were mentioned repeatedly included; adjusting rates for healthy individuals, placing a cap on malpractice/tort reform (which ND has), adding coverage for small things, education, fair pricing, greater access to group buy-ins, individual savings plans, individualized policies to fit needs better, lower prescription prices, more competition, managed medicine, nationalized healthcare, an increase in personal responsibility for health, preventive healthcare, removal of excess paperwork by insurance companies and hospitals, researching new technologies, increasing taxes, and working harder. There was a wide range of potential

solutions, none of which were espoused any more or less than any others with the exception of lowering prescription prices and individual savings plans.

Besides cost, North Dakota residents take into account the deductible, type of benefits, access to care, preventive benefits and the ability to understand the policy when purchasing health insurance. A few participants stated that they didn't need it or that their employer provided it, so choice was a non-issue for them.

North Dakota residents indicated that the cost of health insurance impacts them in a number of ways. Participants across several focus groups said people work longer into their retirement years for health insurance benefits as a result of high insurance costs. A number of participants stated that given increases in co-pays, the cost of health insurance plans were exceeding the benefits. Extending benefits between employments via COBRA coverage was also considered too costly.

Focus groups with the uninsured will be conducted Sept-Oct 2004. More data pertaining to how the uninsured are getting their medical needs met will be gathered from those groups. However, data collected via the resident and employer focus groups so far, has yielded interesting results. Six participants of the resident focus groups reported they had no health insurance. Two participants had gone without insurance for the past 12 months, four of them had gone for three years or greater. Those without insurance indicated that cost was the primary reason they did not have coverage. Those with high deductible insurance plans were significantly affected by cost as well as evidenced by one participant who stated, *"I have a $5,000 deductible. I've paid all year on the hospital bills that insurance doesn't cover…I let my insurance lapse because I can't afford it."*

Six percent of participants indicated that they had not seen a healthcare provider for a routine checkup over the last 12 months because of the cost. Fifteen percent of participants indicated it had been three years or greater since a routine checkup. This finding is similar to the 2000 Behavioral Risk Factor Surveillance Survey (BRFSS) which found that 16 percent of North Dakota residents had not had a routine checkup in five years or longer.

The concept of "basic coverage" for all participants in the resident focus groups really meant "comprehensive". Participants demonstrated a range of beliefs about health insurance. Many seemed to view it in terms of an investment versus protection. Everyone displayed some degree of confusion about their health insurance. More clearly structuring and presenting plans may help them to better understand what "adequate" or "barebones" is and what their plans will and will not do.

When employers were asked to describe their vision of 'adequate' for employee only health insurance and what it might cost, participants indicated that it would provide different coverage options for employees, protect against catastrophe, and that it depended on very specific individual circumstances. Employers talked at length about specific plans and costs related to their employees and past claim history. Most had difficulty agreeing at a group level what those plans might cost due to the variables involved.

In the North Dakota SPG study, under-insurance was defined as annual out-of-pocket health care costs greater than 10% of one's annual household income. Using this methodology, approximately 8.5% of insured North Dakotans were classified as 'under-insured."

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Qualitative Research

Approximately 1,200 North Dakota employers were randomly invited to participate in focus groups held in Fargo, Grafton, Bismarck, and Grand Forks. Thirty-six individuals total attended; each was a key health insurance purchasing decision maker within their organization. The average number of employees represented by each participating organization was 590, which means that on average, participants represented larger than average sized employers within the state. Attendees were provided a light meal for their participation and completed a brief demographic survey.

Participants of the employer focus groups indicated that offering health insurance was critical in helping ensure stability, minimizing turnover costs and attracting and retaining employees. Further queries about the desires of workers in this vein were not explored during the groups.

Costs were the number one consideration in determining whether or not to offer coverage. Employer size also seems to be positively correlated with whether or not insurance is offered as larger employers appear to be more likely to offer benefits. Offering health insurance was described as important in helping ensure stability, minimizing turnover costs and attracting and retaining employees. Employers who did not offer health insurance coverage indicated that cost was the number one reason they did not. All employers expressed an interest in being able to make insurance available to their employees.

Several employers expressed concern about the complexity of offering insurance plans as indicated by the following quote; "The only thing that concerns me is the complexity. It isn't just the rate of the plan any more, its also the other things that go along with it, whether it be disease management, [or] a Health Savings Account. That concerns me whether your average employer … is going to have staff on hand that can really even analyze that". Another participant stated "Employers have got to have somebody to go to that's an expert in it (insurance planning/purchasing) because you just can't do it yourself anymore. It's tougher and tougher"

Overall, employers felt they could provide adequate insurance at the present costs but were experiencing significant double digit percentage increases in insurance rate premiums annually. Many participants blamed a lack of competition in the insurance industry in North Dakota as part of the increase in costs, while others reported that organizations in other states with more competition in the insurance marketplace were paying much higher rates. All participants predicted significant changes in the immediate future such as employee contributions, raising deductibles, changing plan options, Benefits based more on tenure, elderly unable to retire, benefits such as vision and dental will be cut, etc.

The employer focus groups reveal that ND employers are struggling to maintain current levels of coverage and are increasingly frustrated with rate increases. Benefit cuts and cost sharing with employees will increase and will accelerate with any decline in the local, state or national economy. Employers are highly motivated to hold costs down and would likely be willing participants in activities to address rising healthcare costs; at a minimum, increasing communication between insurance companies, employer organizations and the larger medical community is crucial as there as there are a large number of issues contributing to rising health insurance costs. Employers realize that many older North Dakota residents may be working solely for health insurance benefits and if left unaddressed, these issues will continue to grow, especially during hard economic times.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

This section will be addressed in the final report.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

Now that the initial research has been done, the Governor's Health Insurance Advisory Committee for the State Planning Grant has begun to look at options for expanding coverage. This will be addressed in the final report.

SECTION 5. CONSENSUS BUILDING STRATEGY

The governor appointed a twelve member Health Insurance Advisory Committee for the State Planning Grant. http://governor.state.nd.us/boards/boards-query.asp?Board_ID=136 This committee represents the farming community, the business community, advocates for low income and the uninsured, the academic community, health care, and the health insurance industry. Also on the committee as ex officio members are representatives of the state departments of health, human services, and insurance.

The Committee has met six times in the past year to oversee research activities, conducted by the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, and to investigate options initiated by other states. Representatives of AcademyHealth and SHADAC have been very helpful in this process.

Now that some of our research has been completed presentations have been made to several groups in the state and discussions have been held with key legislative members.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

This will be addressed in the final report.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

This will be addressed in the final report.

APPENDIX I: BASELINE INFORMATION

Base line data for North Dakota:

Population- 633,837 (CPS, 2003)

Median age in North Dakota is 36.2 years compared to 35.3 nationally. 45 of the 53 counties have a median age that is higher than the state median age. Mcintosh County is the oldest in the state (5th in the country) with a median age of 51 years (Census, 2000).

2001-2002 data indicates that 91,860 (15%) of North Dakotans are at or below 100% of the federal poverty level. The national average at this time was 16%. Those North Dakotans living at or below 200% of the federal poverty level is 214,380 (35%) compared to the national average of 35% (KFF State Health facts, 2002).

In 2000, 39,388 (21.7%) of 0-17 year olds lived in poverty as defined by <100% FPL. In addition, 21.7% of all families with children under the age of 18 lived in a household with an income <149% FPL. (North Dakota State Data Center, 2003)

Primary industries include agriculture, tourism, energy, manufacturing, retail and services.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Several PowerPoint presentations describing the research findings may be found on the publications web site for the North Dakota Department of Health:

http://www.health.state.nd.us/ndhd/pubs/

And on the presentations web site for the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences:

http://www.med.und.nodak.edu/depts/rural//presentations/index.html