NORTH DAKOTA
HEALTH INSURANCE STUDY
STATE PLANNING GRANT INITIATIVE

INTERIM REPORT for YEAR TWO

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Additional information may be obtained from:
John R. Baird, M.D.
State Medical Officer
North Dakota Department of Health
600 East Boulevard Ave - Dept 301
Bismarck, ND 58505-0200
(701) 328-2372
Fax: (701) 328-4727
jbaird@state.nd.us

TABLE OF CONTENTS

Appendices

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. In the 1994 study an uninsured rate of 9.9% was found. The efforts of the North Dakota Health Task Force 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. An uninsured rate of 8.2% was found in the current study. During this past year a second year of SPG funding was used to continue study and policy development.

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 two years, 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 second year of this project was spent largely on examining policy options and informing legislators and the public about the uninsured and possibilities for coverage. Legislation was passed during the 2005 session to exclude high-deductible health plans from mental health and substance abuse mandates in order to meet federal requirements for tax qualification of health savings accounts. A summit meeting is being planned for October 2005 to examine community approaches to health care coverage. This meeting will be facilitated by Communities Joined in

Action. During the next year of funding we hope to take a closer look at health insurance coverage among Native Americans and develop policy options to increase coverage and access to care for this population. Ultimately, these efforts are anticipated to further extend access to affordable health care for all residents of North Dakota.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

QUANTITATIVE RESEARCH

North Dakota Household Survey

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%.

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.

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. 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).

Geographic Location
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.

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. The number of insured North Dakotans not making a routine visit in more than four years was 7% 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 was 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. As the table below indicates, the number of hours worked (16.3%) and time employed (17.9%) also served as barriers to obtaining health insurance for the working uninsured.

Health Insurance 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.

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%).

Summary of North Dakota Household Survey findings

Demographic Factors

- *Gender*-Males were significantly more likely than females to be uninsured.
- *Age*-North Dakotans age 18-24 were significantly more likely to be uninsured than those between the ages of 25 and 54.
- *Race*-Native Americans were significantly more likely to be uninsured when compared to Caucasians and other races.

Enabling Factors

- *Education Level*-North Dakota adults who had not earned a high school diploma were significantly more likely to be uninsured when compared to those with a college degree.
- *Employment Status*-Self employed North Dakotans were significantly more likely to be without health insurance than those who were employed by someone, those who were not employed, or those who were unemployed.
- *Household Income*-North Dakotans indicating they resided in a household that earned less than 200% of the federal poverty level were significantly more likely to be uninsured when compared to those residing in a household at or above 200% of the federal poverty level.

Behavioral Factors

- *Visit to a health care provider in the past year*-North Dakota residents reporting they had not visited a health care provider in the past year were significantly more likely to be uninsured than those who had visited a health care provider in the past year.
- *Regular Health Care Provider*-North Dakotans reporting they did not have a regular health care provider were significantly more likely to be uninsured than those who did have a regular health care provider.
- *Self-reported Health Status*-Those North Dakotans reporting a health status of very good, good, or fair were significantly more likely to be uninsured than those who reported a health status of excellent.

Geographic Factor

- *Rurality*-North Dakotans residing in rural areas were significantly more likely to be uninsured when compared to those residing in urban areas.

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

Focus Groups with North Dakota residents

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 costs of health insurance plans were exceeding the benefits. Extending benefits between employments via COBRA coverage was also considered too costly.

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."

Telephone Focus Groups with Uninsured

Goals

The main goals of the telephone focus groups with uninsured North Dakotans were to examine the reasons why North Dakota residents were uninsured, determine the importance of health insurance to the uninsured, assess whether uninsured families in North Dakota were getting health care and to determine what it would take for uninsured North Dakotans to get health insurance.

Methodology

Ninety-one uninsured North Dakota residents identified through a prior telephone survey were invited to participate in the telephone focus groups. Five individuals, two men and three women, participated in one telephone focus group that originated from Grand Forks. The participants were given 20 dollars for their contributions. This focus group began at 7:00 AM on November 18th, 2005 and lasted for an hour. The participants were asked questions on health insurance status, their health care needs, and their ideas on potential solutions for solving the uninsurance problem.

Results

Regarding health insurance status, two participants reported never having it while one person had been without it for 15 years. Another participant had insurance but was speaking on behalf of his wife who did not. The fifth participant had acquired health insurance less than a month prior to the focus group.

It was noted that the participants' primary reason for not having insurance was cost. One participant noted: "*My husband and I just have never been able to afford it and we've just never been able to find a job that has offered it*". Employment related reasons included employers not offering insurance or offering those that require high deductibles; employers hiring only part-

time, non-benefited positions; employers excluding coverage that extends to families; and employers having mandated waiting periods for coverage. Some mentioned that the costs of participating in COBRA were too high, while some thought that inability to work due to a health condition rendered individuals unable to afford coverage. One participant believed that eligibility for IHS would meet his healthcare needs.

When asked how important health insurance was to the uninsured, the group resoundingly agreed that health insurance was extremely important to them. One participant commented, "*I think it's essential for everyone to have some health insurance coverage because… nobody is rich enough to be able to afford all those medical bills, and some of them can be astronomically high and break a whole family completely*".

Are the uninsured getting health care? To this all participants indicated that both they and their family members had foregone some form of healthcare because of their lack of insurance. No participant had a regular medical provider. One participant expressed frustration, feeling stigmatized by his lack of insurance. He said, "*I have medical problems, and I don't go [to the doctor] because I can't afford them. I'm asked every time if I have insurance and I don't have insurance*".

When asked what 'affordable health insurance coverage' meant to them, participants felt that they could afford between $25 to $150 per month with allowances made for income, family size, and type of plan offered. Participants also indicated that low cost, high deductible insurance is not especially attractive because: a) it does not provide enough coverage for things they want covered, b) if they did use their insurance, they would have to pay both the deductible and the insurance premium, and c) they have no assets to protect, except their health. Some mentioned that it was probably cheaper to pay the hospital on a monthly basis rather than spend on insurance.

Participants had different thoughts on potential methods for getting more uninsured health insurance coverage. These included sliding fee scales (both at doctor's office and for insurance), universal insurance coverage, a rich husband, and 'alternative insurance' programs where 'beneficiaries' pay a monthly fee for discounts on an array of healthcare services offered by network providers.

Take home messages

The telephone focus group had the following take home messages:

- Cost is the main issue.
- Health insurance and health care is desired by the uninsured, but unaffordable.
- Health care is often foregone because of a lack of insurance and high medical costs.
- High deductible, low cost plans are not especially attractive to low income purchasers.
- Employers are increasingly cutting back on their health benefits or not offering them.
- Participants reported that affordable plans would range from $25 - $150 a month.
- Solutions for health insurance offerings may include the use of income based scales.
- Education on purchasing and proper utilization of insurance is important.
- Continued efforts in outreach to make people aware of prevention and treatment services (both state funded and locally offered programs).

Future research activities

Future research activities would include a telephone survey of employers which will focus on collecting definitive information about coverage provided and types of employers providing insurance and also identifying employment settings where the uninsured work.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

QUANTITATIVE RESEARCH

Employer-based Health Insurance Study

Purpose

- To determine the number of North Dakota businesses that offer employer based health coverage to their employees,
- To identify factors influencing the likelihood of employer based health coverage being offered (e.g., firm size, industry type, and mean wage per employee,
- To examine alternative forms of employer based health coverage for North Dakota employers (e.g., Three-Share Programs), and
- To continue in the development and maintenance of an annual employer health coverage survey to measure trends concerning the availability of employer based coverage.

Background and Relevance:
Health insurance in the United States may be the most pressing issue facing health care today. According to the Kaiser Family Foundation (Rowland, 2004) approximately 43.6 million American's are without health insurance. From 2000 to 2002, the number of uninsured Americans increased by nearly 4 million or 9.8 percent. It is estimated that 61% of the uninsured are under the age of 35 and 91% of the uninsured are under the age of 55. The majority of the uninsured reside in households that earn less than 200% of the federal poverty level ($36,800 for a family of four). Eight of ten uninsured Americans reside in households with at least one member currently working.

The absence of health insurance is often perceived to be a result of not working. Empirical evidence contradicts this perception as the majority of the uninsured do work. Nationally, fifty-six percent of those without health insurance reside in a home that has at least one full time employee. According to a recent report (Garrett, 2004), employee sponsored health insurance covers 2/3 of all insured Americans under the age of 65. As stated earlier, the majority of uninsured workers are from low income families. Age is another factor to consider. The 18 to 24 age group comprises 10% of all workers yet account for approximately 21% of the working uninsured. Thirty-two percent of the working uninsured is of Hispanic origin yet they comprise 12% of working adults. Firm size is also important when discussing the working uninsured. Workers employed by firms with less than ten people represent 27% of the working uninsured yet represent on 11% of the total workforce. In comparison, 66% of the workforce is employed by large firms (more than 100 employees) yet represent only 39% of the working uninsured.

The North Dakota Household Survey administered in 2004 contained similar results. The number of uninsured North Dakotan's was reported 51,920 or 8.2 percent of the total population. Although this was a decrease from the number of uninsured reported in 1994 (9.2%), several

trends emerged. The survey discovered that the uninsured are overrepresented by males (9.6%) when compared to females (6.8%). Native Americans (31.7%) are nearly five times more likely to be uninsured than Whites (6.9%). Those North Dakotans reporting that they were married (5.1%) or widowed (4.8%) had the lowest prevalence of un-insurance when analyzing marital status. Those reporting they were separated (24.1%), living with a partner (21.9%), and single (16%) had the highest prevalence of un-insurance based on marital status.

More than one out of every five (11,311) uninsured North Dakotans was below the age of 18. Young adults (18-24) have a 15.9% uninsured rate, nearly double the state rate. Fifty-eight percent of uninsured North Dakotans are below the age of 35 and ninety percent are under the age of 55. 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.

As part of the current State Planning Grant, several employer focus groups were conducted in the state of North Dakota to collect qualitative data to assist in the development of an employer survey. The results of the household survey and focus groups enabled CRH researchers to customize a questionnaire that will be mailed out to North Dakota employers. The focus group findings indicated that 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; it’s also the other things that go along with it, whether it is 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 difficult economic times.

Hypotheses, Design and Analysis:
This study will address the following research questions:

- What are the types of health coverage plans offered to employees through their employer (e.g., individual, family, vision)?
- What are the primary reasons that North Dakota employers do or do not offer health coverage to their employees
- What is the length of time an employee must be employed at a particular firm before health coverage benefits take effect?
- Compared with prior years, have employer based coverage premiums increased or decreased? If so, by how much?
- Compared with prior years, have the terms of employer based coverage changed? If so, in what manner?
- Do factors such as firm size, industry, or geographic location significantly affect an employer's ability to offer health coverage to their employees?

The analytic approach will include the following components: 1) univariate and bivariate analyses of the survey data; 2) multivariate analyses to examine factors influencing the employer's ability/willingness to provide health coverage to their employees, 3) development of policy strategies.

For all analyses, SPSS 12.0 (base model, advanced models and advance regression packages) will be used to run the descriptive statistics, chi-square, and logistic regressions. These analyses were selected as most of the variables in the data sets are categorical in nature. A significance level of .05 will be used. Explanatory analyses will be employed to select bivariate correlations to be computed between the predictor variables. Odds ratios, confidence intervals and p-values will be interpreted and reported.

Pending Results:
The employer survey was created through a joint effort between the current North Dakota State Planning Grant team and Job Service North Dakota (Appendix A), a state agency that reports to Governor John Hoeven. Through a collaborative process, the employer based health coverage survey has been merged into the larger Employee Benefits Survey administered to North Dakota employers annually. In order to identify employer provided benefit trends in the state, 16 local regions have been identified by the Job Service North Dakota. Phase one of the survey occurred in April 2005 with 5,304 surveys being mailed to North Dakota businesses in eight of the state regions to include Beulah-Hazen, Bismarck-Mandan, Devils Lake, Dickinson, Fargo-West Fargo, Grafton, Grand Forks, Jamestown, Minot, Rolla – Rolette County, Valley City, Wahpeton and Williston. The first mailing was subsequently followed up by a second (May 11, 2005) and a third mailing (June 13, 2005) to those businesses who had yet to return a survey. There were a total of 2,660 surveys returned for a response rate of 50.2%. The original plan allowed for CRH to have completed preliminary survey analysis in time for this report. Unfortunately, Job Service North Dakota experienced personnel turnover which led to a delay in the delivery of the dataset to CRH. CRH staff has been in close contact with the Labor Market Information Director, who has been working diligently with his staff to deliver the dataset. Duane has assured the CRH that the complete dataset will be delivered no later than October 31, 2005. Once the dataset is delivered, CRH staff will analyze the information and provide a full report to this committee. Further, Job Service North Dakota has agreed to deliver this annual dataset to this committee free of charge, thus assuring the availability of this information for years to come. As with any large project, there are bumps in the road that need to be smoothed out. It is our opinion that the delays we are currently experiencing will lead to stronger working relationship with Job Service North Dakota and lead to a seamless process in future years.

QUALITATIVE RESEARCH

Employer Focus Groups

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

CURRENT HEALTH CARE DELIVERY SYSTEM

North Dakota's health care delivery system is influenced by a number of factors including being a very rural state. Over two-thirds of the counties (36 of 53) are considered frontier (having six or less people per square mile) by the federal government. The state's population from the 2000 Census is 642,200 people. From 1990 to 2000, 47 of the 53 counties lost population, including 31 counties that suffered population losses of 10-20 percent and six counties losing over 20 percent of their population.

There are approximately 1,380 licensed physicians practicing in North Dakota with 45 hospitals. Two of the hospitals are part of the Indian Health Service (IHS). 37 hospitals are rural and 28 are critical access hospitals.

The private insurance market in North Dakota is approximately 40% employer sponsored self-insurance plans regulated by ERISA and 60% individual, small group, and large group plans regulated by the state. In 2002 the number of companies marketing health insurance in North Dakota included 6 marketing individual insurance, 11 marketing small group insurance, and 9 marketing large group insurance, with one company, Noridian/Blue Cross Blue Shield receiving over 70% of the market share of insurance premiums in the state.

Some aspects of managed care (e.g., the preferred provider organization - PPO model and the exclusive provider organization - EPO model) have developed systematically throughout the state in both urban and rural areas. The Health Maintenance Organization (HMO) model has not been able to develop a strong presence. There are two licensed HMO's in North Dakota serving approximately 14,500 people (2% of the population). Blue Cross Blue Shield of North Dakota (which provides coverage to approximately 75 percent of the private health insurance market) reports that 52% of its members are covered under a group plan and receive benefits through the PPO or EPO models. In North Dakota's Public Employee retirement System (PERS) health plan, the largest group plan in the state, 17,992 lives (about 30% of the 54,944 lives covered) are covered under an EPO arrangement. EPOs tend to have the most restrictive network coverage and lowest co-payment and co-insurance options. Most other PERS members are covered by a less restrictive model, the PPO. PERS covers state employees but has been opened to allow other public employees to be served by the system. Attempts in the legislature to open the PERS program to private sector employees and others without health insurance have been defeated.

North Dakota participates in two state administered public coverage programs, Medicaid and State Children's Health Insurance Program (SCHIP). There are approximately 53,000 individuals enrolled in the Medicaid program and 2,400 children in the SCHIP program, know in North Dakota as Healthy Steps. Healthy Steps covers children 18 years of age and younger whose net family income is greater than Medicaid levels but less than 140% of the federal poverty level (FPL).

Medicaid and Healthy Steps are managed by the Department of Human Services. North Dakota provides a basic set of services to categorically eligible recipients of the program as well as

medically needy groups. North Dakota also provides 34 of the possible 38 optional services under the Medicaid State Plan. North Dakota provides the required coverage for children and pregnant women as follows: children less than 6 years of age below 133% of the federal poverty level (FPL), children between 6 and 18 years of age at or below 100% of FPL, and pregnant women at or below 133% of FPL. Households applying for coverage through children and family coverage are no longer subject to an asset test. The Department of Human Services instituted a 100-hour rule as of January 2003 to contain program costs. Adults in intact families who work more than 100 hours a month are not eligible no matter what their income. The federal government share of the costs of the Medicaid program is determined by a formula using a three-year average of per capita income in our state compared to the national average. The Federal Medical Assistance Percentage (FMAP) was 71.31% in early 2004. That percentage dropped to 68.31% on July 1, 2004 and further declined to 67.49% for the 2005 fiscal year beginning on October 1, 2004. The decreasing federal funds have made state legislative attempts to increase coverage of uninsured by raising the FPL criteria for Medicaid and SCHIP difficult.

North Dakota previously had a section 1915(b) waiver for a primary care management system and a "capitated" managed care program. In 2001 these waivers became part of the state plan amendment. Currently, there are about 33,000 individuals enrolled in the primary care case management program, requiring the individuals to select a primary care provider for services, who must also authorize certain other services. There are about 800 people in the capitated program. North Dakota has three section 1915(c) waivers for home and community based services. North Dakota has never applied for a section 1115 or a Health Insurance Flexibility and Accountability (HIFA) waiver, which could be used to cover additional individuals who would otherwise not be eligible.

North Dakota has 51 hospitals. 43 of these are community owned, two are Indian Health Service (IHS) hospitals, one is a state owned psychiatric hospital, one is a Veterans Administration hospital, and four are specialty hospitals. Safety net services are provided in North Dakota by federally funded community health centers, IHS clinics and hospitals, and through uncompensated care at other facilities. The American Hospital Association estimates that in 2000 North Dakota hospitals provided $32.5 Million in uncompensated care, or 2.4% of their total expenses. As of June 30, 2004 13 of 24 hospitals surveyed reported they lost money and eight of the 24 had financial losses at a level that if continued, puts their future viability in question. The first community health center in the state was started in Fargo, North Dakota/Moorhead, Minnesota, which is the largest urban area in the state. It serves a diverse group including special populations of refugees, Hispanic, and urban Indians. A Migrant Health Center serves people in Grafton. Three newly formed community health centers were approved in 2002 and 2003. They serve a more rural population with a total of 8 clinics. IHS provides services to Native Americans living on the four reservations in North Dakota with a 29-bed hospital, a 16-bed hospital, outpatient health centers and health stations. Referrals to contract facilities are done as funding allows. Native Americans comprise 5.5% of the state's population, and as a group, are much younger. About 43% of the Native Americans are under age 20.

EARLIER EFFORTS TO DEVELOP AND IMPLEMENT HEALTH CARE REFORMS

Over the last twenty years, North Dakota has attempted to address the issue of the uninsured through a number of both private sector health insurance market reforms and through modifications of the public sector programs such as Medicaid and the State Children's Health Insurance Program (SCHIP).

The 1981 North Dakota Legislative Assembly enacted legislation, which created the Comprehensive Health Association of North Dakota (CHAND). This program is essentially a high-risk pool. It offers comprehensive health insurance to people who have been denied coverage or have restricted coverage due to pre-existing conditions or high-risk status. The 1983 Legislative Assembly capped the premiums under the CHAND program at 135% of the average amount charged for standard coverage in the state. Insurance companies receive a premium tax credit equal to their losses under this program.

From 1990-1995, the North Dakota Health Task Force conducted field hearings, reviewed data, and conducted statewide studies on issues related to insurance coverage. The task force had representation from health providers, associations, government officials, and state legislators. The task force recommendations were introduced in the 1995 Legislative Assembly and, following legislative revision, a number were enacted. This Legislative Assembly produced some of the most significant health reforms on record. House Bill No. 1050, the omnibus health care reform legislation, was approved by the Legislature and signed by the Governor. Some of the key features of this legislation are provided below.

1. Established a health care data and quality review program that allows for the studying of health care expenditures trend, the utilization of health care resources, the outcomes of the procedures, and the health status of state residents.
2. Established insurance market reforms, which include limits on exclusion of coverage because of pre-existing health conditions; portability, which allows a person to maintain continuous coverage if they change jobs; guaranteed renewability of health insurance; and modified community rating, which limits the difference between the lowest and highest price health insurance premiums. In addition, gender was prohibited as a rating factor in group insurance.
3. Enacted medical malpractice reforms, which limit the amount of non-economic damages to $500,000 and requires parties to attempt non-judicial resolution of malpractice claims.
4. Expanded the Medicaid program by increasing the income eligibility level for children and increased the eligibility for the medically needy population.
5. Increased the lifetime benefit limit to $1 million for persons covered under a health insurance plan for those who cannot obtain commercial health insurance.
6. Required all health insurers to offer a standard and basic health insurance plan that must include the benefits of a standard and basic health benefit plan offered in the small group health insurance market.
7. Required all health insurers to cover dependents up to age 22 and dependents who are full time students up to age 26.
8. Authorized appropriations for the health care cost and quality review program.

The 1997 Legislature continued to explore options to address insurance coverage. The 1997 small employer health insurance reforms included many technical changes to conform to the federal Health Insurance Accountability Act (HIPPA) requirements. The most significant substantive change was to extend the size of the firms covered by the small employer protections from firms of up to 25 employees to firms with up to 50 employees. Other provisions imposing limits on pre-existing condition exclusions, providing for portability and guaranteed renewability of health insurance coverage, as required by HIPPA, apply to additional classes of health insurance policies.

In recent years, North Dakota has initiated efforts to expand public health coverage through the state Medicaid program and the State Children's Health Insurance Program (SCHIP), referred to as Healthy Steps. In 1998, North Dakota expanded its Medicaid eligibility to include all uninsured children who are age 18 with a family income at or below 100 percent of the Federal Poverty Level (FPL). In 1999, the Legislature established the Healthy Steps program which provides coverage to children who are not eligible for Medicaid but with family incomes below 140 percent of FPL. As of October 1, 2001, 21,000 children were covered by Medicaid while another 2,560 were covered by the Healthy Steps program.

The North Dakota Legislature, during the 2001 session, further expanded the Medicaid eligibility by removing the asset test for family and children coverage. Children, families, and pregnant women, who had assets such as a second car or savings accounts may have previously been ineligible even though they fell within the income boundaries. The change was implemented on January 1, 2002. It is difficult to fully assess the impact of this change. North Dakota Department of Human Services officials estimate that approximately 900 children will be eligible for Medicaid coverage after their Healthy Steps coverage ends. Another 700 children and adults are expected to apply for Medicaid coverage due to the simplification of the application process that occurred due to the removal of the asset test. Further efforts to simplify the application process are currently underway. The Department of Human Services is in the process of developing a joint application for Medicaid and Healthy Steps to facilitate and simplify the process for applicants.

During the 2005 legislative session a bill was passed exempting first-dollar mandates for high deductible health plans associated with Health Savings Accounts (HSA). This will allow insurance companies to start offering these plans in North Dakota.

Outreach efforts have been undertaken by North Dakota to increase awareness and enrollment of children in Medicaid and Healthy Steps. Examples of recent outreach activities include working with economic assistance programs in the state to identify children in families who may be eligible for these programs and distributing bulletins to all Medicaid providers and professional medical and health associations discussing the Healthy Steps program. A special initiative of the State Office of Rural Health grant program was used during the 2000-2001 grant cycle to conduct outreach to rural farm and ranch families on behalf of the Healthy Steps program. The state has also used financial resources from a Robert Wood Johnson Foundation Covering Kids grant to hire three full time outreach workers to assist in enrollment of children in Medicaid and Healthy Steps. This grant has placed recruitment efforts in rural counties hardest hit by the

agricultural crisis and to children living on Indian reservations. In 2001, The Northland Healthcare Alliance (a rural health based network covering central and western North Dakota) received a HRSA supported Community Access Program (CAP) grant. Each of the 13 rural hospitals and two IHS partners (two separate reservations) has hired a Community Resource Coordinator (CRC) who have a primary responsibility, by working with local/area social service programs, to assist in the enrollment of eligible children and families into Medicaid and Healthy Steps. The CAP program advisory board has membership from a number of state partners including the Department of Health, the North Dakota Community Healthcare Association, the North Dakota Community Action Association, I.H.S., the Center for Rural Health of the UND School of Medicine and Health Sciences and other key partner organizations. The program is strongly supported by the local hospital boards and is evidence of the commitment of Rural North Dakotans to support access to care opportunities. Dakota Medical foundation has now received a CAP grant for the rest of the state. They have CRCs at 16 sites and are closely coordinating with Northland Healthcare Alliance. Additional efforts have been initiated to provide outreach to Native Americans. Of the 61,966 North Dakotans who received Medicaid benefits in 2001, 14,420 were Native American. As reported earlier, Native Americans account for 4.5 percent of the states population, but they account for over 23 percent of the Medicaid recipients. Currently, one reservation has held three planning and discussion meetings on the feasibility of applying for a HRSA Rural health Outreach grant, administered by HRSA's Office of Rural Health Policy, in addressing access to care as well as Medicaid and Healthy Steps enrollment. Outreach grants require a network of three independent organizations working together to address a common problem. The anticipated network would consist of tribal health entities, IHS, and an off-reservation acute care hospital.

The Caring Program for Children was established in 1989 as a foundation by Blue Cross Blue Shield, which pays for all administrative costs. Donations are raised from businesses to pay for health and dental benefits for children 19 years of age and younger who do not qualify for Medicaid or SCHIP and are under 200% of FPL. This program does not provide full insurance coverage. It provides primary care, dental, and some initial hospital costs.

SUCCESS AND IMPLEMENTATION PROBLEMS OF EARLIER EFFORTS

Like many states facing the issues associated with insurance access and coverage. North Dakota has witnessed some success but has also encountered barriers. The 1995 insurance reform effort and the 1997 HIPPA refinements have ostensibly resulted in an increase in the total number of individuals covered under group contracts insured by Blue Cross Blue Shield of North Dakota (BCBSND). According to BCBSND, from 1994 to 1999, the percentage of all individuals with private health insurance covered under an "individual" non-group policy has declined from 16 percent to 10 percent. The number of persons insured under the CHAND (high risk pool) program is small, but stable (approximately 1,400 or 0.3% of the private insurance market as of January 1, 2002). Over the last five years, CHAND has had enrollments that fluctuate slightly, from 1,300 to 1,500. Although North Dakota can neither directly nor fully verify the cause of the decline in persons covered by individual private health insurance policies and the lack of any increase in the size of the high risk pool, the reasonable assumption is that the greater access to group health insurance coverage (portability, guaranteed renewal, rate bands, etc.) – combined with a substantial growth in employment – has led to more people being covered under group

health insurance plans. Overall, these formal policy efforts, enacted by the North Dakota Legislature to reform insurance access, have stabilized the market and enhanced access for North Dakotans, thus contributing to a relatively low rate of uninsured citizens. The serious effort made through state policy and private provider action to develop and implement outreach activities also portend success, both in public exposure to the opportunities and actual public enrollment in programs.

The enactment of state legislation, the creation of the Healthy Steps program, the advent of the Community Access Program- these are all actions demonstrating North Dakota's commitment to taking incremental steps to address the access problem. These reforms have maintained a stable health insurance market. These public and private actions (it is important to recognize the important contribution made by private providers to apply their own resources and commitment to addressing the problem) have contributed to North Dakota's relatively low rate of uninsured.

North Dakota has demonstrated an ability to plan and implement health reform. The overall rate of uninsurance is relatively low; however there are populations that continue to have barriers to coverage. Low income adults do not have good access to affordable coverage. A majority of very small employers do not offer health insurance as a benefit. Quality health care access is a problem for Native Americans. Financial barriers have been significant in finding ways to provide health insurance coverage for all. In the past a lack of quality data regarding those without health insurance has made implementation of reforms difficult. North Dakota's effort to address the issue of health insurance coverage has been significantly strengthened by the capacity to define the uninsured population, to accurately determine the reason why they do not have coverage, and to produce realistic estimates pertaining to the costs associated with the proposed strategies to address the issue.

The Medicaid program in North Dakota is approaching a $1 billion biennial state/federal appropriation. The governor recognized the importance of this program and its impact on the state budget. He appointed a Governor's Medicaid Working Group to specifically examine the Medicaid program for the 2005-2007 biennial budget. Of major concern for this committee was the declining FMAP and its impact on the program. Its recommendations addressed primarily management and administrative aspects of the Medicaid and do not include expansion of coverage options.

Healthy North Dakota is a unique statewide initiative started by the governor to build on grass roots support of healthy life styles. Personal behaviors are one of the factors that influence health more than any other factor. Several committees are working under Health North Dakota to raise awareness of health behaviors and to influence changes. Two of the committees are the Third-Party Payers Committee and the Health Disparities Committee. They have specific interests in individual's access to health insurance and health care.

SECTION 4 - OPTIONS AND PROGRESS IN EXPANDING COVERAGE

CURRENT POLITICAL, ECONOMIC, AND SOCIAL IMPEDIMENTS TO EXPANSION

Even though North Dakota has been able to maintain a balanced budget, money is very tight for any publicly funded programs. With the FMAP going down an estimated four percentage points in the next two years there is a great deal of pressure on the Medicaid and SCHIP programs to maintain current enrollments. The governor has asked that any policy recommendations from the Health Insurance Advisory Committee be budget neutral. This fiscal reality makes it very difficult to propose expansion options that require state money.

There does not seem to be political support in the state for a single payer, universal health plan. However, there is definite interest in measured incremental change that will increase the access to health care for the state's population. The rural, sparsely-populated nature of North Dakota with predominately very small employer firms makes it challenging to develop community-based coverage options.

A significant concern for the state is health care for Native Americans in North Dakota. They are a large part of our public coverage under Medicaid and SCHIP. Economic situations on the reservations make for high unemployment requiring people to fall back on safety net providers such as IHS. The IHS system in general has some major problems and is under funded. The state does what it can to help our citizens. However, the federal government has a significant responsibility to improve health care access and quality for Native Americans.

HOW THE PROPOSED GRANT ACTIVITIES SUPPORT EARLIER EFFORTS OR CREATE NEW INITIATIVES

North Dakota has made strides to cover its citizens with health insurance. The rate of uninsurance has dropped since the last major health care legislation in 1995. That legislation was influenced by the North Dakota Health Task Force. It is a hope that the current state planning grant program will be able to encourage further expansion of health care coverage building on what was begun by the Health Task Force. Having good information from the current studies done under the state planning grant and raising the awareness of the problem of lack of health insurance with policy makers and the public should help to expand previous efforts.

The state planning grant has been a good opportunity for North Dakota to gather valuable data about the uninsured and to develop policy options to incrementally address the problem with an ultimate goal of providing access to affordable health insurance for all citizens. In the proposed grant activities we will continue to gather data in areas where we don't have sufficient information. We will continue to refine options that have the greatest opportunity of producing good results in our state and work to gain collaborative partners and consensus on new options. We need to continue gathering support in the state for further changes.

The Governor's Health Insurance Advisory Committee for the State Planning Grant has looked at the following options for expanding coverage in North Dakota. Both, options considered as well as those not considered are listed below.

OPTIONS CONSIDERED

1) Health Insurance Premium Subsidies:

Target Population
Low income individuals and families.

What are health insurance premium subsides?
A health insurance premium subsidy is financial assistance provided by the government to an individual or a family to lower the amount of out-of-pocket spending on health insurance premiums.

Full subsidies: Participation will be significantly affected by the value of the subsidy relative to the cost of health insurance. The probability that an uninsured individual will participate will be greatest when the reduction in the health insurance premium is greatest (measured as a percent of income), and as the individual's income increases. Offering full subsidies for coverage has the greatest impact on participation. When people are required to pay part of the health insurance premium, experience indicates that participation falls off dramatically.

What works to increase enrollment in health insurance premium subsidy programs?

1. ***Making the enrollment barrier free:*** The likelihood that uninsured individuals will participate will be lower if they perceive any of the following conditions: application process is demeaning; the enrollment process is burdensome, or the quality of health care is questionable.

2. ***Providing the subsidy at the right time:*** Providing subsidies at year's end, rather than in advance, or adjusting subsidies provided in advance to reflect actual income at year's end, poses a significant obstacle to participation in a health insurance premium subsidy program.

Advantages
Health insurance premium subsidies have the greatest potential to increase enrollment in private health insurance plans.

Disadvantages
The cost of providing the subsidies can be expensive depending upon the level of subsidies and the number of people participating in the program.

Policy considerations for North Dakota
This policy option has been ruled out as a solution for North Dakota because it is not budget neutral.

2) Educational Programs/ Campaigns:

Target population:
The uninsured who could potentially afford health insurance, but do not have insurance due to lack of awareness and knowledge.

What are examples of educational programs and campaigns that have been used to inform people about health insurance?

1. Community-based education that focuses on the value and importance of health insurance.
2. Information on any recent health insurance reforms.
3. Language and cultural appropriate CHIP and Medicaid information.
4. A health insurance guide that informs consumers about the health insurance options available to them.
5. A state-based information system, which includes all of the health insurance plans available in the state, provides consumers with a valuable resource. Other pertinent information in the system could be health care quality information for consumers that is available in an easy and accessible way. Other agencies that routinely contact working families, such as the motor vehicle administration, the revenue department, or even local hospitals, could serve as a dissemination vehicle for the system or provide links to the system on Web pages and information that is routinely provided to consumers. [2]

Advantages:
The primary advantage of this approach is that it is relatively inexpensive, and provides a way to communicate information to health care consumers.

Disadvantages:
The major disadvantage of this option is that it does not address the problem of affordability.

Policy considerations for North Dakota:
The Governor's Health Insurance Advisory Committee is very interested in exploring this solution further. Based on findings from some of the focus groups, it was determined that additional education pertaining to health insurance coverage would be beneficial to consumers and employers.

3) Association Health Plans (AHPs):

Target population:
Small business employers and employers.

What are Association Health Plans?
Small businesses join together as a large purchasing group, or an Association Health Plan (AHP), for the purpose of competing for low-cost health insurance premiums. A health-care bill would need to be enacted by a state legislature to permit the development of AHPs.

Advantages: [3, 4, 5]

- AHPs may narrow the gap in benefits between small and large companies.
- Associations could offer an array of benefit plans and allow employees to choose the plan that best met their needs.
- Marketing efficiencies may be realized through a large purchasing pool of small businesses.
- Administrative costs are reduced by regulatory compliance costs; consistent regulations; and fewer mandated benefits.
- AHPs may increase access to affordable health care options for families employed by small businesses.
- AHPs may reduce health coverage costs by 15%-30% by allowing small businesses and the self employed to join together through professional societies to obtain the same economies of scale, purchasing clout, and administrative efficiencies from which employees of large employer and union health plans currently benefit.

Disadvantages: [3, 4, 5]

- In the absence of local regulations, AHPs will be free to charge customers with high premiums; would likely select only low-risk candidates; and worst of all, may destabilize the entire health-care industry.
- There may be only a temporary rate advantage and it is uncertain that the discount would be permanent.
- AHPs could enter a market with a low-price plan designed only to attract healthy groups, leaving small employer groups with bad medical experiences and high claims in the existing small group market. This type of adverse selection could result in the demise of the traditional small group health insurance market in a state.
- AHPs, which would not be subject to state-mandated benefit laws, would have a pricing advantage over the fully insured small group health insurance markets already operating in the states. This pricing advantage could have a negative impact on reforms already passed at the state level and on existing small employer markets.

Policy considerations for North Dakota:
Association Health Plans have been discussed by the Governor's Health Insurance Advisory Committee. AHPs appear to be one policy solution that merits further exploration; however, Committee members also point out that there are opportunities for people, such as members of the Greater North Dakota Chamber and farm groups (such as Farm Bureau and Farmers' Union), to join larger health insurance purchasing groups to get lower rates on health insurance premiums.

4) <u>Health Savings Account with High Deductible Health Insurance Plans:</u>

Target population:
Uninsured households with sufficient income to afford a Health Savings Account.

What is a Health Savings Account?
The health savings account is a tax advantaged savings plan available to tax payers to cover current and future medical expenses. It allows money to be put in before tax is paid on it and

then to withdraw the money tax free for qualified medical expenses. It is the new name for medical savings account (MSA) plans that were previously offered. This new plan decreased deductibles and extended the accounts to more people. The changes were made in legislation signed by George W. Bush on December 8, 2003. [6]

Advantages:

- Provides insurance coverage in a tax-advantaged way to help save for future medical expenses. [7]
- Gives a greater flexibility and discretion over how to use the health care dollars. [7]
- Provides incentive to be price conscious.

Disadvantages:
May discourage individuals from seeking preventive care.

Policy considerations for North Dakota:
The Committee was very favorable about the potential of this policy option. In particular, members believe it provides a viable option for the self-employed and the small business owner. A key aspect was that it provided greater incentive to manage how health care dollars were being spent. Yet, a concern raised by the Committee members was the limitation this solution would have in extending health insurance among the low-income due to the need for money upfront for a medical savings account.

5) <u>Three-Share Program</u>

Target population:
Low-wage workers in small firms that did not previously provide health insurance coverage.

What is a Three-Share Program? [8]
Three-Share is a community project designed to provide health care coverage to populations that normally would not have access to private health insurance. Three-Share programs are not considered health insurance in the traditional sense; rather, the program is primarily based on care provided by a managed care network. In addition, a Three-Share Program is community based. The program does not cover individuals who receive services outside of the designated community network. As the name implies, the cost of the premium is split among three parties. An example of "premium sharing" could include a cooperative model such as:

- 30% from the employers
- 30% from the employees
- 40% from the community

Advantages:

- Comparatively less expensive for the government than full subsidy plans as both the employer as well as the employee contributes.
- Enhances accountability

Disadvantages:
It may be difficult to identify a funding source for the government share.

Policy considerations for North Dakota:
The Committee heard a presentation about the 3-Share Program that has been successfully implemented in Michigan. The Committee members liked the concept, however, the government share component is cost prohibitive for the state based on its directive develop a state budget neutral solution.

OPTIONS NOT CONSIDERED AT THIS TIME

- State-subsidized insurance program like MinnesotaCare
- Expand CHAND – high-risk pool
- Publicly funded reinsurance for private insurance like NY
- Economic development – firms getting tax incentives have insurance
- Buy in to Public Employee Retirement System (PERS)
- Employer Mandate "Pay or Play"

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 twelve times in the last two years 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.

THE ROBERT WOOD JOHNSON FOUNDATION STATE FORUMS PARTNERSHIP PROGRAM

The State Planning Grant project leveraged the work of the Center for Rural Health (CRH) at the University of North Dakota School of Medicine and Health Sciences by participating in the State Forum Partnership Program sponsored by The Robert Wood Johnson Foundation of Princeton, N.J. The State Forums Partnership Program, administered by the Forums Institute for Public Policy, a non profit organization based in Princeton, N.J., sponsors activities that inform state leaders and policymakers about current health and medical care issues. The November 2004 forum focused on the impact of the uninsured and uncompensated health care costs to North Dakota. Dr. John Baird, State Planning Grant Project Director, provided an overview of findings from the household survey and the focus groups. In addition, he presented policy options that other states have implemented to increase access to health insurance coverage. The policy brief, "North Dakota's Uninsured and Uncompensated Care: Costs and Coverage Options," is attached.

TESTIMONY TO THE INTERIM BUDGET COMMITTEE ON HEALTH CARE

Dr. John Baird, SPG Project Director, provided testimony to the Legislative Interim Budget Committee on Health Care pertaining to the health care system. This opportunity gave visibility to the project's progress and also provided a forum for legislators to gather more information regarding a study resolution. Dr. Baird's testimony is attached.

INFORMATION DISSEMINATION

The Committee directed staff to develop a fact sheet on the findings of the Household Survey that could be distributed to legislators, state agency directors, community leaders, employers, and other interested consumers. The fact sheet has been distributed in hard copy and also is available on the SPG Web site. The fact sheet is attached.

Another vehicle for information dissemination has been the development of issue briefs pertaining to policy options. Two policy option briefs, one on the 3 Share Program and one on

Health Savings Accounts, have been developed for Committee members' review. These policy option briefs also have been distributed through the Web site and to policymakers. The briefs are attached.

SUMMIT MEETING FOR COMMUNITY LEADERS

The Governor's Health Insurance Advisory Committee (Committee) is exploring options to develop a feasible solution to address the uninsured in North Dakota. Governor Hoeven has directed the Committee to develop the solutions that are state budget neutral and fit North Dakota's unique situation. Members of the Committee recognize that local communities play an important role in extending access to care and expanding health insurance.

One component of the Committee's solution development is to seek input from North Dakotans. Because of the expertise and experience that Communities Joined In Action (CJA) has had in convening community members to address options for expanding access to health care, the Committee opted to have CJA facilitate a state-wide planning summit. As background, CJA is a membership organization of community leaders committed to 100% access to care and 0% health disparities. CJA facilitates learning and action among its members. It also holds learning conferences, high impact institutes and provides peer technical assistance.

CJA will assist in facilitating a forum, scheduled for October 18-19 in Bismarck, in which community and state leaders in North Dakota will develop a strategy for providing access to the uninsured. CJA will present information about community models that have worked successfully in other parts of the U.S.

The objectives of the statewide summit are to:

- inform community leaders about local efforts that have been successfully implemented to provide access to the uninsured;
- create the confidence at state and community levels that community-based solutions are practical and effective; and
- identify opportunities that can assist communities and the state in increasing the percentage of North Dakotans who are insured.

Invited summit participants include:

- leaders from all 53 counties in North Dakota;
- state government leaders including Governor Hoeven, legislators and state agencies;
- health care system stakeholders (health care providers, hospital boards, etc.);
- business leaders;
- educators; and
- uninsured North Dakotans.

Invitation letters from the Governor wnet out to over 1,500 North Dakotans. It is anticipated that a broad representation of the state's population will participate in the summit. A summit report, detailing the proceedings of the summit along with recommended strategies, will be developed and provided to Governor Hoeven, the state legislators, state and community agencies, and will be made available on the project Web site.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A key lesson learned for North Dakota in the policy planning process is that the Indian Health Services (IHS) is not well understood. Many people, including legislators and the members of the Governor's Health Insurance Advisory Committee, view IHS as guaranteed health insurance for Native Americans. However, IHS is the payer of last resort. North Dakota State Planning Grant staff, along with SPG states with Native American populations, participated in a SHADAC conference call to discuss IHS issues. At the conclusion of the discussion, we found the best way to describe IHS is that it provides access to health care, but not health insurance. For example, a Native American must be a member of a federally recognized tribe to qualify for IHS, and they must receive their health care from an IHS provider on their home reservation. These restrictions, along with the fact that IHS is funded at approximately 65% of need, provide significant challenges to those the IHS is intended to serve. This problem is exacerbated by the high uninsured rate of 32 percent among North Dakota's Native Americans. Thus, the health disparities between Native Americans and Caucasians continue to expand in North Dakota.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The Indian Health Care Improvement Act was intended to elevate the health status of American Indians and Alaska Natives to a level equal to that of the general population. Since 1976, IHCIA has been periodically reauthorized and amended until 2000 when it expired. A bill was passed in 2000 to extend IHCIA for one year to allow Congress time to consider reauthorization legislation. In 2004 the 108th Congress has yet to reauthorize IHCIA. Without reauthorization, the Indian Health Service will continue to operate under an outdated strategy for providing health care funds and services to American Indian and Alaskan Native people.

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

Predicting the Likelihood of Uninsurance in a Rural State. Poster Presentation given at the Academy Health Annual Research Meeting. Boston, MA. Located at: http://www.med.und.nodak.edu/depts/rural/presentations/pdf/academy_health_poster062705.pdf

Fact Sheet: Profile of the uninsured in North Dakota. University of North Dakota School of Medicine and Health Sciences Center for Rural Health. Located at: http://www.med.und.nodak.edu/depts/rural/pdf/fs-insurance.pdf

Who are North Dakota Uninsured? Poster presented at the National Rural Health Association's Annual Meeting, May 19, 2005, New Orleans, LA, by Alana Knudson, Kyle Muus, Michael Cogan, Garth Kruger, John Baird, and Kathryn Apostal. Located at: http://www.med.und.nodak.edu/depts/rural/presentations/pdf/nrha_uninsured_poster05.pdf

White Paper: Three-share programs as an alternative for comprehensive health insurance in North Dakota. University of North Dakota School of Medicine and Health Sciences Center for Rural Health.

White Paper: Health savings accounts and the implications for North Dakota. University of North Dakota School of Medicine and Health Sciences Center for Rural Health.

APPENDIX III. SPG SUMMARY OF POLICY OPTIONS

This will be addressed in the final report.

REFERENCES

1. Options for Expanding Health Insurance Coverage: Report on a Policy Roundtable. Available at http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13256
2. Covering the Uninsured: How States Can Expand and Improve Health Coverage. Available at http://www.heritage.org/Research/HealthCare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=38191
3. Association Health Plans: A Godsend, or a Recipe for Disaster? Available at http://www.entrepreneur.com/article/0,4621,306790,00.html
4. Association Health Plans – Part One: Lowering Small Group Costs. Available at http://www.ncpa.org/pub/ba/ba419/
5. Association Health Plans. Available at http://www.aiche.org/government/pdfdocs/healthplan.pdf.
6. Wikipedia: Health Savings Account. Available at http://en.wikipedia.org/wiki/Health_savings_account
7. High Deductible Health Plans (HDHP) with Health Savings Account (HSA). Available at http://www.opm.gov/hsa/faq.asp
8. Andrulis, D. & Gusmano, M. (2000). Community initiatives for the uninsured: How far can innovative partnerships take us? The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000. Available at http://innopac.nyam.org/search/aandrulis/aandrulis/1,1,10,B/frameset&F=aandrulis+dennis+p&1,,10

Literature Citations for Employer-based Coverage Survey Project

Garrett, B. (2004). Employer-sponsored health insurance coverage: Sponsorship, eligibility, and participation patterns in 2001: Kaiser Commission on Medicaid and the Uninsured.
Kaiser commission on Medicaid and the uninsured, uninsured in America, U.S. House of Representatives (2004).
(ACP-ASIM), A. C. o. P.-A. S. o. I. M. (1999). *No health insurance? It's enough to make you sick.* Washington, D.C.
(EBRI/CHEC/BCBSA), E. B. R. I. (2000). *Small employer health benefits survey*. Washington, D.C.
Buchmueller, T. C., & Lettau, M. (1997). Estimating the wage-health insurance trade-off: More data problems? *Unpublished Paper*.

Currie, J., & Madran, B. C. (Eds.). (1999). *Health, health insurance and the labor market.* (Vol. 3). New York: Elsevier.
Cutler, D. (Ed.). (1997). *Public policy for health care*. Cambridge, MA: MIT Press.
Invited testimony, expanding public programs to cover the sick and poor uninsured, Senate Finance Committee (2001).
Garrett, B. (2004). Employer-sponsored health insurance coverage: Sponsorship, eligibility, and participation patterns in 2001: Kaiser Commission on Medicaid and the Uninsured.
Hadley, J. (2001). *Sicker and poorer: The potential costs of a large uninsured population.* Washington, D.C.: Urban Institute.
Kaiser commission on Medicaid and the uninsured, uninsured in America, U.S. House of Representatives (2004).
Koopmanschap, M. A., & Rutten, F. F. (1996). The consequence of production loss or increased costs of production. *Medical Care, 34,* DS59-68.
Koopmanschap, M. A., Rutten, F. F., Van Ineveld, B. M., & Van Roijen, L. (1995). The friction cost method for measuring indirect costs of disease. *Journal of Health Economics, 14*, 171-189.
Levy, H., & Feldman, R. (2001). Does the incidence of group health insurance fall on individual workers? *U.S. Department of Labor/PWBA Conference "Why Do Employers Do What They Do?"* Washington, D.C.: April 27.
Monheit, A. C., Hagan, M. M., Berk, M. L., & Farley, P. J. (1985). The employed uninsured and the role of public policy. *Inquiry, 22*, 348-364.
Pauly, M. V. (1997). *Health benefits at work: An economic and political analysis of employment-based health insurance*. Ann Arbor: University of Michigan Press.
Peele, P. B., Lave, J. R., Black, J. T., & Evans, J. H. (2000). Employer sponsored health insurance: Are employees good agents for their employees? *Milbank Quarterly, 78*, 5-21.
Salisbury, D., & Ostuw, P. (2000). Value of benefits constant in a changing job environment: The 1999 world at work/EBRI value of benefits survey. *EBRI Notes, 21*, 5-6.
Simon, K. (2001, April 27). *Involuntary job change and employer-provided health insurance: Evidence of a wage-benefit trade off?* Paper presented at the U.S. Department of Labor/PWBA Conference "Why Do Employers Do What They Do?" Washington, D.C.
Summers, L. (1989). Some simple economics of mandated benefits. *American Economic Review, 79*, 177-183.
U.S. Congress, O. o. T. A. U. C. O. (1992). *Does health insurance make a difference?* Washington, D.C.: U.S Government Printing Office.

ATTACHMENTS

Uninsured Fact Sheet

Three-Share Overview

Health Savings Accounts – White Paper

RURAL HEALTH FACTS

Health Care Access in North Dakota: Characteristics of the Uninsured

Winter 2005

Health insurance has increasingly become a very important issue in the United States. It has been reported that 45 million Americans are without health insurance. Estimates indicate that in 2003, 15.6 percent of Americans were uninsured, an increase from 15.2 percent in 2002.[1] The lack of health insurance poses a great risk to the well being of North Dakotans and economic viability of the state. Uninsured children and adults do not receive the health care they need; they suffer from poorer health; and are more likely to die earlier than those with coverage.[2]

How Many North Dakotans are Uninsured?

In the spring of 2004, a random sample of North Dakota households were administered a telephone survey to determine the number of uninsured citizens in the state. Survey information indicated that overall, 8.2 percent of North Dakotans were without health insurance. The estimated number of uninsured (51,920) was similar to the population of Bismarck, the second largest city in North Dakota. Results were used to develop a profile of North Dakotans most likely to be uninsured.

How Many North Dakota Children are Uninsured?

There are 11,311 uninsured children in North Dakota, representing 22 percent of the uninsured.

How Many North Dakota Adults are Uninsured?

There are 40,609 uninsured adults in North Dakota, representing 78 percent of the uninsured.

Health Insurance Status by Gender

Males (9.6 percent) were more likely to be uninsured than females (6.8 percent).

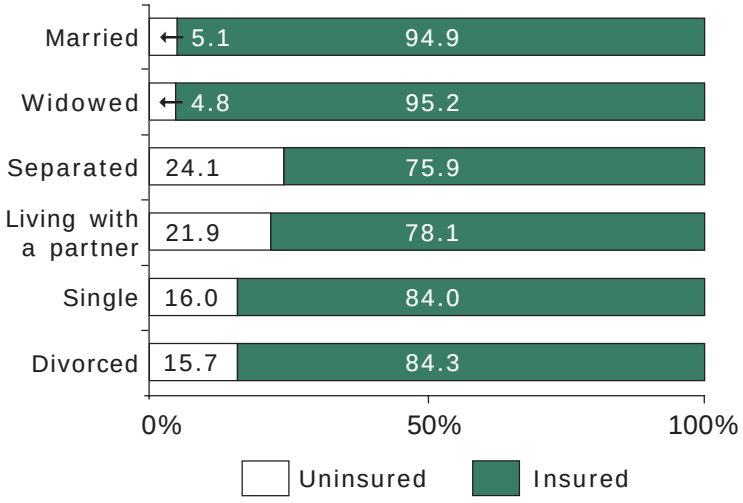
Health Insurance Status by Race

Native Americans (31.7 percent) were far more likely to be uninsured than Whites (6.9 percent).

Health Insurance Status by Marital Status

Individuals who were married or widowed were more likely to have health insurance than individuals who were single. Figure 1 illustrates the percentage of uninsured by each marital status category.

Figure 1. Percentage of Uninsured and Insured by Marital Status



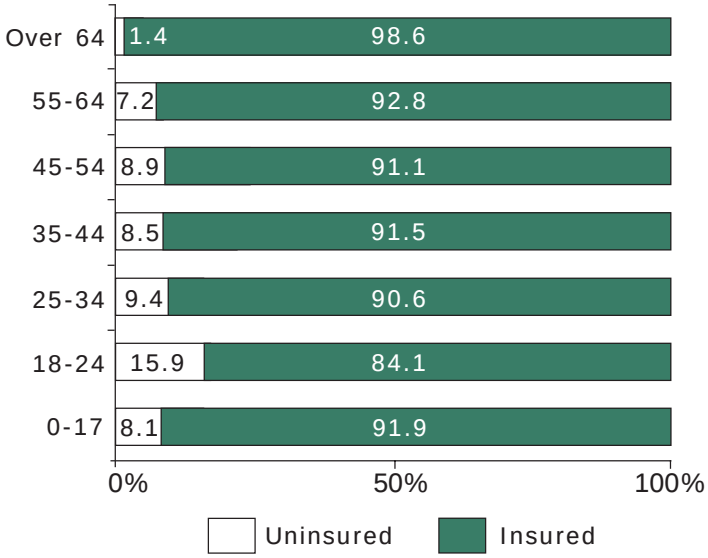
Health Insurance Status by Income

- A North Dakotan residing in a household with an income of less than $10,000 was more than twice (16.6 percent) as likely to be uninsured when compared to the overall state uninsured average of 8.2 percent.
- Nearly three-quarters of uninsured North Dakotans resided in a household with an income below 200 percent of the federal poverty level, which is less than $37,700 for a family of four.[3]

Health Insurance Status by Age

Young adults, between the ages of 18 and 24 years, were the most likely to be uninsured in North Dakota (16 percent). Young adults are more likely to be single, have incomes below the state average, and are more likely to be full time students. Figure 2 shows the distribution of uninsured North Dakotans by age.

Figure 2. Percentage of Uninsured and Insured by Age



Health Insurance Status Across the State

- The percent of uninsured varies by population density. To capture this variation, the state was divided into:
  - Urban (cities with a population greater than 16,700 people)
  - Large Rural (cities with populations between 5,000 and 16,699 people)
  - Small Rural (cities with less than 5,000 people).
- Individuals residing in small rural areas (9.1 percent) were more likely to be uninsured than those residing in urban (7.7 percent) and large rural (7.4 percent) areas.

Health Insurance Status by Employment Status

- The majority of uninsured (71.7 percent) and insured (82.3 percent) adults, over age 17 years, were employed at the time of the survey.
- Employees with temporary (21.6 percent) positions were more likely to be uninsured than those with seasonal (14.3 percent) and permanent (7.6 percent) positions.

Employee Health Insurance Status by Size of Business

Employees in smaller-sized businesses were more likely to be uninsured. One-person businesses had the highest uninsured rate (21.3 percent) while businesses with 500 or more employees had the lowest uninsured rate (3.8 percent).

Health Insurance Status by Perceived Health Status

North Dakotans without health insurance reported their health as excellent, very good or good 85.7 percent of the time. Those with health insurance reported their health as excellent, very good or good 91.2 percent of the time.

Footnotes:

[1] United States Census Bureau (August 2004).
[2] Institute of Medicine (2004).
[3] U.S. Department of Health and Human Services (2004).

The information contained in this fact sheet was compiled from various presentations comparing insured and uninsured North Dakotans. The original presentations by Alana Knudson, PhD, John Baird, MD, Mike Cogan, PhD, and Kyle Muus, PhD (2004) can be found at http://medicine.nodak.edu/crh

This factsheet is supported by a State Planning Grant, from the Health Resources and Services Administration, Department of Health and Human Services.

For more information, contact:
Mike Cogan, PhD, (701) 777-6046
mcogan@medicine.nodak.edu

Center *for* Rural Health
University of North Dakota
School of Medicine & Health Sciences
PO Box 9037
Grand Forks, ND 58202-9037
Tel: (701) 777-3848
Fax: (701) 777-6779
http://medicine.nodak.edu/crh
http://www.raconline.org

http://medicine.nodak.edu/crh

Community Health Care Coverage Option

Overview of Three-Share Programs

Prepared for the North Dakota Department of Health
March 2005

Connecting resources and knowledge to strengthen the health of people in rural communities.

What is a Three-Share program?

Three-Share is a community-based project designed to provide health care coverage to populations that normally would not have access to private health insurance. Three-Share programs are not considered health insurance in the traditional sense; rather, the program is primarily based on health care provided by a managed care network, and does not cover services used outside of the network. As the name implies, the cost of the premium is split among three parties. An example of "premium sharing" could include a cooperative model such as:

- 30% from the employers
- 30% from the employees
- 40% from the community

Who benefits from Three-Share programs?

The main focus of Three-Share programs is to provide access to health care services for uninsured workers (full-time and part-time) and their families. Communities and the state benefit by having jobs with better benefits available for their citizens. In addition, Three-Share programs benefit health care providers by minimizing collection activities and possible non-payment for health care services by those who would normally go without health insurance.

How does a community pay for their share of the Three-Share program?

Three-Share programs are reliant on external funding sources. They lack direct federal financial support found in public programs such as Medicaid and the Healthy Steps program in North Dakota. Three-Share programs have used community funding sources such as property taxes, sales taxes, private foundations, and health/hospital associations.

What services are available through Three-Share programs?

A Three-Share program is not considered health insurance in the traditional sense. It should be thought of as a community coverage plan that provides services in a particular medical network on a non-capitated fee-for-service basis. Costs are managed through measures such as defining available benefits, providing member focused education initiatives, strengthening community partnerships, and building a sense of community ownership and responsibility. Existing Three-Share programs do not normally deny enrollment or services because of pre-existing conditions; however, there is a need to set limits for the amount of services utilized by individuals and/or families. Potential services provided through a Three-Share program may include:

- Hospital services
- Physician services
- In-patient and out-patient services
- Emergency department services
- Ambulance services
- Prescription drugs
- Diagnostic lab services
- X-ray and imaging services
- Home health services
- Hospice care

What is the potential cost of a premium when considering a Three-Share program?

Enrollment in Three-Share programs is employer-based. An advantage to the program is found in the plan expenditures. The Michigan based Muskegon Health Project provides an example of the premium distribution for this type of managed care program. Participation in the program requires a total monthly premium of $186.34 per individual. Normally, the employer decides whether to include family members in the plan; however, the premium and share plan remain the same for each individual (e.g., worker and spouse would require a $372.68 premium). Children are typically encouraged to enroll in an alternative plan such as Medicaid. As indicated earlier, this premium would be split three ways with the employer responsible for 30 percent ($55.90), the employee responsible for 30 percent ($55.90), and the community responsible for 40 percent ($74.54)[1]. This premium is in comparison to the average private comprehensive health insurance premium of $350.00 in the same region. A breakdown of the Muskegon premium expenditures is listed in Table 1.

Table 1. Muskegon Premium Allocation by Available Services

Premium Allocation	Percent	Cost
Medical case management	1.5%	$2.80
Inpatient cost	8.5%	$15.84
Outpatient cost	43.0%	$80.13
Provider reimbursement	26.0%	$48.44
Pharmacy cost	9.0%	$16.77
Administration	12.0%	$22.36
Total	100.0%	$186.34

Does the Three-Share program encourage a co-payment plan?

A key component of the Three-Share program is the management of costs through member education and personal responsibility. Co-payment plans are designed to encourage consumers to make informed decisions when considering the utilization of services. Examples of co-payment plans may include the following:

- $7 for Primary Care Provider (PCP) visit
- $25 for a specialist visit
- $75 for emergency department visit
- $30 for urgent care
- $7 for formulary
- $5 for home care visits
- $0 for hospice care
- $20 for outpatient behavioral health
- 25% for outpatient hospitalization (maximum $300 per treatment)
- 25% for inpatient hospitalization (maximum $300 per admission)
- 50% for drugs not listed in formulary ($6,000 annual cap)

How can the Three-Share program address provider reimbursement levels?

A critical component of the Three-Share program involves careful consideration when setting provider reimbursement levels. The Three-Share program operates under a non-capitated fee for service model. Typically, these programs rely on a comparison to reimbursement levels of pre-existing programs such as Medicare. These reimbursement levels often are well below actual costs to providers for providing services. This discount from a provider's full fee for services can be considered a "fourth share" of the Three-Share program.

What are the eligibility requirements that enable a business to qualify for the Three-Share program?

Eligibility requirements should be personalized for the community benefiting from the Three-Share program. Examples of such guidelines utilized by current Three-Share programs include the following:

- Businesses must qualify as a small to midsize business. Criteria for business participation is unique to each Three-Share program
- The business must not have provided health benefits to its employees for a defined period of time. Although programs will vary, one Three-Share program defined this period as 12 months.
- Employees at the business must have a predetermined median hourly wage in order to participate in the plan. The Muskegon, MI plan requires $11.50/hr. and the St. Clair County Project in Illinois requires $15.00/hr. This median wage will vary from region to region. Decision makers must carefully consider the current economic base for that particular area prior to determining the median wage.

How can a Three-Share program assist health care providers?

The Three-Share program may assist health care providers on a minimum of four fronts, to include:

- Developing case management treatment plans
- Coordinating community resources for patients
- Engaging patient participation and responsibility
- Providing patient education for wellness (e.g., tobacco cessation, diabetes education, and weight management).

How important is it to develop a profile of members enrolling in a Three-Share program?

It is widely accepted that unhealthy life choices drive up the costs of health care. Developing a member profile within a Three-Share program is imperative to its success. A profile will enable program administrators to develop proactive plans with the intent of educating members who may be engaging in risky behaviors. Issues to be addressed may include:

- Tobacco use
- Depression
- Hypertension
- Heart disease
- Diabetes
- Overweight/Obesity

How does developing a profile of Three-Share program members minimize health care costs?

The Three-Share program is designed to move from the reactive episodic sick care model to the proactive wellness health care model. This is accomplished by providing member focused education programs to assist health care consumers in making the right choices between healthy and unhealthy behaviors. This wellness health care model will ultimately have positive short and long term effects on health outcomes. Examples of proactive models include weight reduction programs, tobacco cessation, and diabetes education.

Why would a community invest in a Three-Share program?

The recent report, *Community Initiatives for the Uninsured: How far can Innovative Partnerships Take Us?*[2], found that most Three-Share programs improve access to health care and, on average, lower the number of a community's uninsured residents by 15 percent. In addition, these programs should not be viewed simply as a "health plan." The successful Three-Share program is considered a vehicle for building community ownership in the following areas:

- Creating community infrastructure by bringing together governance, data systems, and case management
- Expanding coverage to the uninsured
- Reducing costs and inappropriate use of services
- Strengthening safety net capacity
- Expanding resources with new community partners
- Creating a framework for new health initiatives

Generally speaking, what are the pros and cons of implementing a Three-Share program?

Pros

- Program design can be creative and flexible since it need not adhere to federal rules and regulations.
- Community involvement and support help sustain the program
- Community programs can serve as models for replication

Cons

- Success requires political and financial support. Currently, the financing for many of these programs is unstable.
- The programs are limited in scope and do not cover large numbers of uninsured in the state.
- For many local programs, health coverage is limited to the geographic area and the local provider network.

Information for this overview was compiled primarily from the Muskegon Access Health Project and St. Clair County Pilot Project presentations delivered at the November State Planning Grant Program meeting in Arlington, VA. Additional information was provide by the State Health Access Data Assistance Center (SHADAC) and Academy Health. For more information, contact Mike Cogan, Ph.D., at (701) 777-6046 or by email at mcogan@medicine.nodak.edu.

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[1] The dollar amounts provided in the example are for an individual only. Each spouse or family member added to the plan will pay the same amount per individual. The Three-Share premium for an individual and a spouse would be split three ways with the employer responsible for 30 percent ($111.80), the employee responsible for 30 percent ($111.80), and the community responsible for 40 percent ($149.08). The Muskegon Three-Share plan discourages children from being included; however, they do admit small numbers at a discounted rate.

[2] Andrulis, D. & Gusmano, M. (2000). Community issues for the uninsured: How far can innovative partnerships take us? The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000. Retrieved on February 14, 2005 from http://innopac.nyam.org/search/aandrulis/aandrulis/1,1,10,B/frameset&F=aandrulis+dennis+p&1,,10.

Health Savings Accounts and their Possible Impact on North Dakota Health Care
January 2005
A White Paper from the North Dakota Governor's Health Insurance Advisory Committee

Introduction

In December 2003, the U.S. Congress enacted legislation allowing people to establish health savings accounts (HSAs) to work with qualifying high-deductible health coverage plans (HDHPs) to help people finance medical expenses. Beginning January 1, 2004, individuals or employers could begin contributing to these accounts. This white paper summarizes the key issues that North Dakota officials and policy makers should know about HSAs.

Tax Benefits, Eligibility, and Use of Funds

HSAs are tax-free accounts that can be set up by individuals or employers; they are personal accounts that are owned by individuals, even when employers establish and contribute to them. Interest earned is not taxed, and funds that are not used may carry over to following years. When individuals make contributions, they may deduct up to a statutory maximum of $2,600 from federal taxes (up to $5,150 for families).

High Deductible Health Plans (HDHP)

Currently, HSAs are required to be established in conjunction with HDHPs. This combination has been referred to as a Consumer Driven Health Plan (CDHP). A health plan qualifies as an HDHP if it has an annual deductible of at least $1,000 ($2,000 for families) and annual out of pocket expenses-including deductibles, co-payments, and coinsurance-that do not exceed $5,000 ($10,000 for family coverage). When enrollees use HSA funds to pay for out-of-pocket expenses, the fees they pay may be negotiated, depending on the type of high deductible plan and whether the plan has negotiated a reduced fee for the type of service a patient needs. Some services are not covered; therefore, unless a consumer negotiates a discount directly with the provider, he or she will pay the full fee.

Preventive Services

The IRS has ruled that HDHPs can cover preventive services such as physicals, immunizations, screenings, prenatal care, and tobacco-cessation programs without imposing a deductible. In recent guidelines, the IRS clarified that paying for treatment that is incidental or ancillary to a preventive care service, such as removing polyps during a diagnostic colonoscopy, is also allowed. The IRS has stated that it <u>will not</u> defer to states to determine which services can be considered preventive.

Other Health Insurance

People who have other health insurance in force would not qualify for an HSA, although policies for injury/accident, disability, vision, dental and long-term care are allowed. Those enrolled in Medicare also do not qualify; nor do individuals who can be claimed as a dependent on another's tax return.

HSA Funds Used for Other Purposes

If HSAs are used for other than medical purposes, the distributed amount would be included in a person's income and would be subject to a 10% penalty. The penalty does not apply to the heirs of a person with an HSA if he or she dies, becomes disabled, or becomes Medicare eligible; if such individuals use the HSA for non-medical expenses, the funds used would be taxed as income but the 10% penalty would not apply.

Who is most likely to contribute?

Some researchers estimate that individuals and families who now contribute to an individual retirement account (IRA) ---A group that tends to be at the higher end of the income scale---are also likely to establish an HSA. Those who earn more that $160,000 annually have the highest IRA participation rate (17%). In comparison, wage earners with an income below $20,000 have a participation rate of 2.4%. As an indication of activity of previously uninsured, the Coalition for Affordable Health Coverage recently reported that 43% of HSA applicants did not indicate any prior coverage and 46% of HSA purchasers have family incomes of less that $50,000.

Implications for North Dakota Policymakers

North Dakota's decision about whether to promote high deductible health insurance may affect the type and price of coverage that is available in the market. For example, encouraging people to buy high-deductible coverage further shifts the cost of health care from employers and health plans to individuals. With more of their own dollars at stake, consumers may make more cost efficient choices regarding their health care services. On the other hand, cost shifting might also result in people not getting or delaying necessary care. This could ultimately increase health care costs for employers and health insurers if people develop more serious conditions as a result of postponing services, and could perhaps increase costs for the state if people turn to safety net programs.

Mandated benefits

The state of North Dakota currently requires health insurance providers to cover services such as substance abuse and mental health services on all group health insurance plans; regardless, of whether a deductible has been met. An HSA-qualified HDHP must apply a deductible to these services. As indicated earlier, the IRS has stated that it will not defer to states to determine which services can be considered preventive. In North Dakota, the mandated benefits listed above do not apply to individual health insurance plans. The 2005 North Dakota Legislature is expected to see legislation that will formally enable HDHP's to exclude the substance abuse and mental health requirements when used in conjunction with HSA's.

Continued Affordability of Comprehensive Coverage

According to employer benefits consultants and researchers, when individuals are given a choice between low-cost, high-deductible coverage and more costly comprehensive health insurance, healthy people tend to choose high-deductible coverage. Thus, if HSAs become more widely available, fewer healthy people may remain covered under traditional insurance plans, and premiums could rise as a result of adverse selection. State policymakers may want to consider ways to ensure that traditional coverage stays affordable, whether through employer subsidies or other interventions. The National Federation of Independent Businesses (NFIB) has indicated that they would like their employees to have the option of choosing from an assortment of coverage's.

Impact on State Budget

The impact of HSAs on the North Dakota state budget is another factor that policymakers should take into account. Due to the tax break, HSAs are projected to cost the federal government approximately $7 billion in lost revenue over 10 years. The state of North Dakota may lose revenue since the state links their taxes to federal taxable income calculations. The potential amount of lost revenue is not known at this time. One way for the state to address this is to require people who take the HSA deduction on their federal return to add it back when calculating their income on the state return. The availability of HSA's could reduce the number of uninsured which may have positive implications on the state budget.

HSAs and State Programs

In its role as an employer, the state of North Dakota, with its PERS program, faces issues similar to those of private companies. Because HSAs are new, there are many unanswered questions about employers' responsibility in establishing them and the interaction between HSAs and other employee offered accounts (e.g., FSAs and HRAs). Policymakers in North Dakota must make an additional decision of whether to add HSA-qualified coverage to state programs such as the high-risk pool (CHAND) and public-private initiatives designed to offer health insurance to small businesses. There is no exclusion in the tax code for high-risk pool coverage and recently the IRS expressly stated that such coverage could qualify as an HDHP. The IRS further clarified that states may even contribute to an HSA in conjunction with coverage through a high-risk pool. Thus, high-risk pool coverage could likely be used in conjunction with an HSA if it meets the IRS's criteria for an HDHP.

Can HSAs Expand Coverage or Lower Costs

Whether HSAs can expand coverage, or lower health care costs, is a matter of debate. HSA supporters and detractors generally agree that HSAs will shift the cost burden for health care decisions onto consumers. Champions of HSAs believe that the accounts would help contain costs by creating a financial incentive for people to avoid over-utilizing services. Policymakers should consider the impact that HSAs may have on the health care economy. According to the ND Insurance Department, 85% of health insurance premiums go to hospitals, health care professionals, and prescription drugs. By increasing participation in HSAs, the state may decrease premium dollars which may lead to changes in the health care infrastructure.

Conclusion

Only experience will reveal the ultimate impact of HSAs on the health care system. In the meantime, if the state of North Dakota is interested in making HSAs available, they will need to fully explore the implications of the legislation on state laws, budgets, and insurance markets. In addition, officials will need to decide whether, and how, to add HSA-qualified coverage to state programs such as high-risk pools (CHAND) and public private initiatives. Finally, policymakers would do well to be aware that federal policy with regard to HSAs is subject to change. Due to the complexity of the new federal tax law and many unanswered questions, states will likely need additional federal guidance in the future.

Information for this White Paper was compiled from the North Dakota Insurance Department Web site, the State Coverage Initiatives Issue Brief 5(3), September 2004, Coalition for Affordable Health Coverage "Health Savings Accounts Myth vs. Fact (2004), and the National Federation of Independent Businesses, Health Care: Cost Versus Value, 2003.

SUMMARY

HSA vs. Other Tax Preferred Accounts

There are key differences among health savings accounts (HSAs), medical savings accounts (MSAs), flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs) with regard to eligibility rules, the tax benefit, and the type of health coverage that can be used to coordinate with the account.

	HSAs	MSAs	FSAs	HRAs
Health Plan Type	High deductible only	High deductible only	High deductible & comprehensive	High deductible & comprehensive
Carry over from year to year?	Yes	Yes	No	Yes
Individual owns the account	Yes	Yes	No	No (up to employer)
Type of coverage?	Individual and job based health coverage	Small business or self-employed health coverage	Job-based only	Job-based only
Who contributes?	Individuals, employees, and employers	Employee, self – employed person, or small business (<50)*	Employee	Employer
How is it taxed?	"Above-the-line" deduction**	"Above-the-line" deduction**	Not taxed as income	Not taxed as income

*Both employee and employer cannot contribute in a tax year.
**Employer contribution not taxed as income

HSA Summary

Tax Benefits and Limits on Deductions

- Amount contributed is not taxed and interest earned is not taxed
- Contributions to an HSA can be deducted from income even when a person does not itemize
- Individual deduction is up to $2,600; family deduction is up to $5,150

Eligibility

- HSAs are available to any individual covered under a high deductible health plan (HDHP) who is not simultaneously covered by other health insurance or Medicare

Who Can Contribute

- Employers, employees, self-employed, and people with non-job based health insurance

High Deductible Health Plan

- Individual health insurance and job-based health coverage (both self-insured and fully insured) can qualify
- The criteria for a qualifying HDHP are: an annual deductible of at least $1,000 for individual coverage and at least $2,000 for family coverage (except for preventive care allowed without deductible); annual out-of-pocket costs not to exceed $5,000 for individuals and $10,000 for families.

Qualified Medical Expenses & Other Expenses

- HSA pays for qualified medical expenses
- This account can also be used to pay COBRA premium and health coverage premium while unemployed, qualified long-term care insurance premium and Medicare-related expenses (except for Medigap premium).