

**State Options for Expanding Health Insurance
Coverage and Strengthening the Health Care Safety Net**

Prepared by

The Nebraska Health Insurance Policy Coalition

August 29, 2005

Table of Contents

Introduction.....	1
Purpose.....	1
Description of the Problem.....	3
Characteristics of the Uninsured	4
Results from the Employer Survey.....	4
The Lack of Insurance Coverage and the Impact on Individuals	5
The Problem of Underinsurance	7
The Lack of Health Insurance and the Impact on Providers and Government	8
The Lack of Health Insurance and the Impact on the Community.....	9
Process of Developing the Coverage Options	11
Methods for Obtaining Input from the Public and Key Constituencies.....	11
Description of the Insurance Coverage Options	13
Coverage Expansion Options, Group I: Strengthening the Health Care Safety Net	13
Option 1. Safety Net Commission	13
Option 2. Drug Discount Programs	16
Coverage Expansion Options, Group II: Expanding Medicaid and SCHIP Coverage	17
Option 3. Medicaid and Kids Count Enrollment	17
Option 4. Cost Savings.....	18
Option 4a. Disease Management Programs	18
Option 4b. Multi-state Purchasing Pools	19
Option 5. Medicaid Income Eligibility	20
Coverage Expansion Options, Group III: Improving Access to Private Health Insurance Coverage	21
Option 6. Public-Private Partnerships	22
Option 7. Reinsurance Program.....	23
Option 8. Pharmacy Clearinghouse	23
Option 9. Education and Training	24
Next Steps	27
Notes and References	29
Other State Planning Grant Reports.....	33
Appendix I: Nebraska Health Insurance Policy Coalition.....	35
Appendix II: Aggregate Ratings of Coverage Options by Participants in Town Hall Meetings	39

Introduction

In recent years, the number of individuals without health insurance coverage has become a serious concern for state policy makers. Although the number of uninsured in Nebraska is below that of most other states, at least 145,000 people in the state are without health insurance coverage. Many other people in Nebraska do not get needed health care services because of inadequate health insurance coverage. Unfortunately, the magnitude of the problem is growing, and the net result is that timely access to basic health care services for many individuals is severely threatened.

Purpose of the Project

In response to the growing number of uninsured, the Nebraska Health and Human Services System applied for and received a State Planning Grant from the U.S. Department of Health and Human Services in September of 2003. The purpose of the grant was to measure the number of uninsured in the state, identify the characteristics of those without insurance coverage, and develop coverage options to reduce the number of uninsured and strengthen the health care safety net.

The coverage options were developed by a 28-member Nebraska Health Insurance Policy Coalition. The Coalition members were appointed by Governor Johanns and included representatives from state government, the state legislature, the business sector, the insurance industry, advocacy organizations, and major health-related associations. A list of members is included in Appendix I.

This report (1) describes the nature of the problem, including the number of uninsured and underinsured, the groups that are most at risk of being uninsured, and the impact of insurance coverage on both individuals and providers; (2) discusses the process of developing the coverage options; (3) provides a description of the coverage options including the rationale, the advantages and disadvantages, the target populations, and the potential cost considerations; and (4) identifies the next steps in the process.

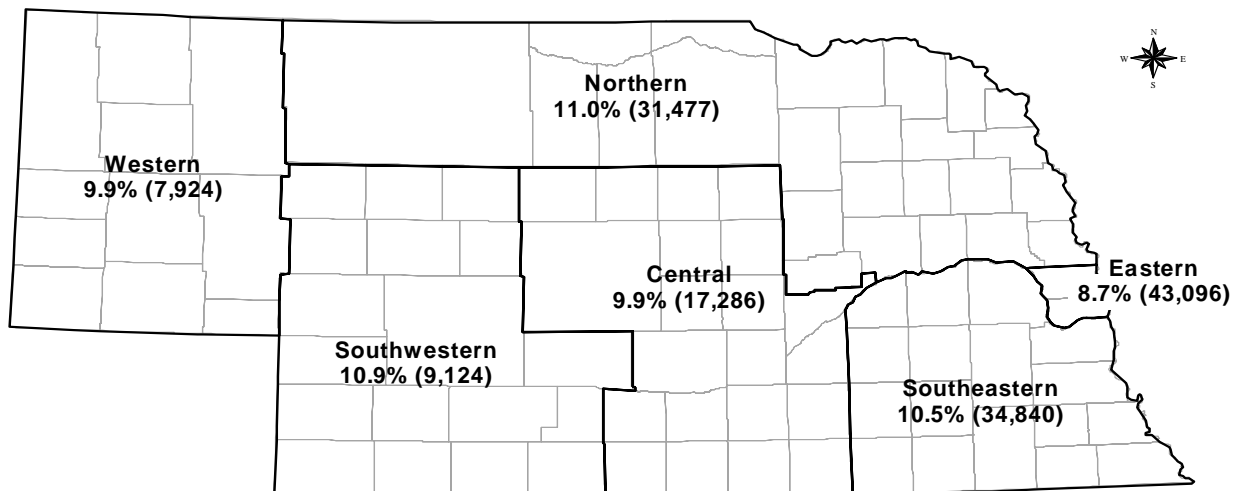
Description of the Problem

In order to determine the health insurance status and characteristics of the uninsured in Nebraska, the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center conducted a household telephone survey of 3,750 people in 2004.¹ The Center also organized 13 focus group interviews to provide greater insight about the barriers to obtaining health insurance coverage and the consequences of not having coverage.²

The household survey results showed that 145,000 Nebraskans (9.9 percent of the population under age 65) were uninsured in 2004. The number of uninsured under the age of 65 are highlighted throughout this report because Medicare covers nearly all people 65 and older. There was some variation among the regions of the state. Figure 1 shows that the percentage of uninsured under age 65 varied from 11 percent in the Northern region to 8.7 percent in the Eastern region, which includes the Omaha metropolitan statistical area. However, it should be emphasized that the largest number of uninsured were in the Eastern region.

Figure 1. Geographic Breakdown

Percent and Number* of Uninsured Younger Than 65 Years Within Health Planning Regions Nebraska 2004



Data Source: Nebraska State Planning Grant, NeHHSS, 2004

* Note: Numbers are approximations.

Nebraska Center for Rural Health Research, UNMC, 2004.

Characteristics of the Uninsured

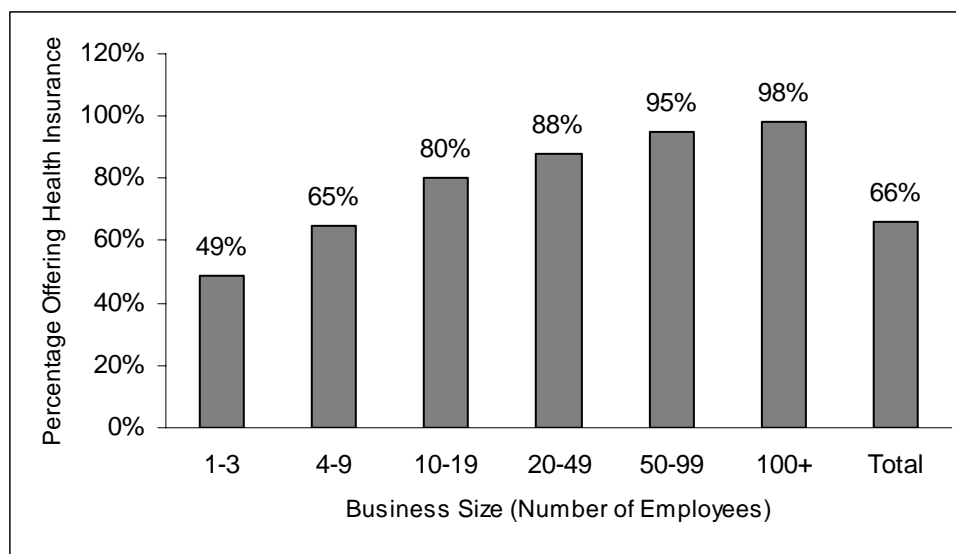
According to the results of the household survey, the majority of the uninsured had low incomes and worked for small employers or were self-employed. For example, over 63 percent of the uninsured had incomes below 200 percent of the Federal Poverty Level (FPL), and 79 percent earned less than 300 percent of the FPL.³ The survey also found that of the uninsured between the ages of 18 to 64, over 63 percent were employed or self-employed, 29 percent were unemployed, and eight percent were unpaid workers or full-time students.

The uninsured tended to have lower educational levels (58 percent with a high school education or less). Also, the percentage of uninsured was slightly higher in rural areas (11 percent) as compared to urban areas (9 percent). Finally, young adults (ages 19-34) constituted the largest uninsured group by age (34 percent), and 27 percent of the Hispanic population were uninsured.

Results from the Employer Survey

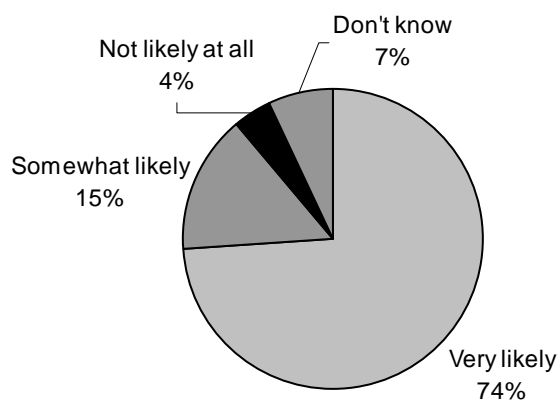
In order to gain a better understanding of the insurance plans offered by Nebraska employers, the Nebraska Department of Labor conducted a mail survey of over 13,000 employers in 2004.⁴ The results of the survey revealed that larger businesses (those with 100 or more employees) were most likely to offer health insurance coverage. In contrast, businesses with only one to three employees were considerably less likely to offer coverage. Figure 2 shows that 98 percent of large businesses offered insurance coverage while only 49 percent of very small employers provided insurance coverage.

Figure 2. Percentage of Businesses Offering Health Insurance, by Business Size



The survey findings also indicated that full-time employees were more likely than part-time employees to be offered coverage, and there was considerable variation by industry. For example, employers in the financial and information sectors tended to offer benefits at higher rates than businesses in other industries. Finally, almost 19 percent of the businesses surveyed were somewhat likely or not likely at all to continue offering health insurance coverage in the next two years (see Figure 3). These findings are not surprising given the fact that health insurance premiums paid by employers increased by an average of 57 percent over the past five years.⁵ Since many small employers have experienced even higher premium increases, it will be difficult for some of them to continue offering coverage.

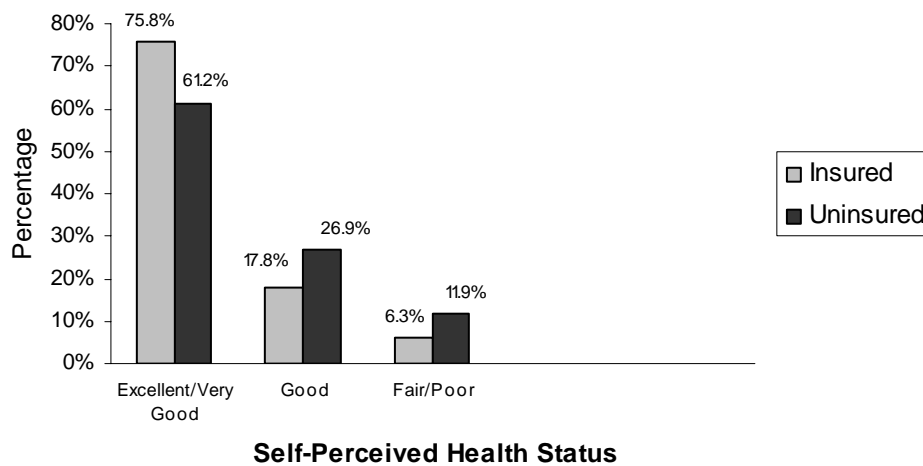
Figure 3. Likelihood That Businesses Will Continue Offering Health Insurance



The Lack of Insurance Coverage and the Impact on Individuals

Being uninsured appeared to have a significant adverse impact on an individual's health and quality of life. Figure 4 shows that people with insurance coverage tended to be healthier in that 76 percent of the household survey respondents rated their health as excellent or very good. However, only 61 percent of the uninsured respondents reported their health status as excellent or very good.⁶

Figure 4. Self-Perceived Health Status



People with insurance coverage were more likely than those without to have a usual source of care. The survey found that 94 percent of the insured, but only 73 percent of the uninsured, had a usual source of care. Without a regular source of care, the uninsured are less likely to receive timely preventive care and prompt medical attention for highly treatable conditions such as diabetes, asthma, and hypertension. The delay in treatment often leads to more intensive treatment and higher total costs.

Finally, the uninsured were more likely than the insured to delay care because of the cost. The survey results indicated that 14 percent of the uninsured did not get the care they felt was needed in the past twelve months compared to only three percent of the insured population. Several studies have found that delayed care results in poorer health outcomes.⁷

What we heard from the focus group interviews:

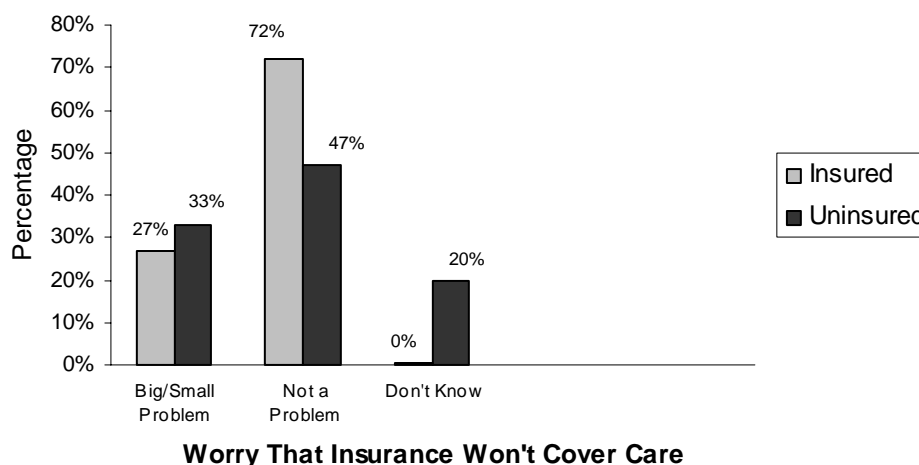
"My mother didn't see a doctor for an infection because she was afraid of how much it would cost. A bladder infection turned into a blood infection and that is what essentially killed her." – female urban employer

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

The Problem of Underinsurance

Although underinsurance is more difficult to measure than uninsurance, a significant number of people in Nebraska have inadequate health insurance coverage. The adequacy of health insurance coverage was defined as those individuals with health insurance coverage who do not delay or forego necessary care because of concerns about cost. Unfortunately, many people with health insurance coverage delay or forego care because their insurance plans have high deductibles and coinsurance payments relative to their incomes. Some may have inadequate prescription drug coverage or the plan may not cover some clinical preventive services such as immunizations or mammograms. Figure 5 shows that 27 percent of the insured were worried that their health insurance plan would not cover the cost of care, and 36 percent of the insured were worried that they would have to pay more than expected for care. A national study found that “underinsured adults were more likely to forego needed care than those with more adequate coverage and had rates of financial stress similar to those of the uninsured.”⁸

Figure 5. Level of Worry That Insurance Won't Cover Care, By Insurance Status



What we heard from the focus group interviews:

“Without adequate health insurance, you feel stuck, depressed, frustrated, worried, mad, hopeless, suicidal.”

The Lack of Health Insurance and the Impact on Providers and Government

The lack of health insurance coverage has a significant impact on health care providers and state and local governments. When the uninsured need health care services, they often show up in a hospital emergency room or visit a community health center or rural health clinic. In order to estimate the amount of uncompensated care (i.e., charity care and bad debt), provided by all hospitals, community health centers, and rural health clinics, a study was conducted by the Nebraska Center for Rural Health Research.⁹ In 2003, an estimated \$262.6 million in uncompensated care was provided by all hospitals, community health centers, and rural health clinics. Of this amount, almost \$257 million was provided by hospitals, \$2.5 million by rural health clinics, and \$3.3 million by community health centers. These estimates do not reflect the level of uncompensated care provided by other physician clinics and other health care entities such as home health agencies and community mental health centers. For hospital in-patient care, the estimated total expenses of patients without health insurance nearly doubled from \$13.7 million to \$26.2 million between 1996 and 2003.

The study also found that there was some variation across the state in the level of uncompensated hospital care. For example, residents living in the central and western part of the state had a statistically significantly higher per resident charge for hospital inpatient care of patients without health insurance than did residents living in the eastern part of the state. Finally, the Nebraska counties with a higher unemployment rate, a lower per capita income, and a greater percentage of population under Temporary Assistance for Needy Families (TANF) assistance incurred a statistically significantly higher per resident charge for hospital inpatient care of self-pay patients than did their counterpart counties.

For health care providers, the net impact of uncompensated care is less patient revenue, which could lead to greater financial instability and/or a reduction in services to the insured and the uninsured. Financial instability may ultimately result in closure of a facility or a reduced capacity to see additional patients. High uncompensated care costs may also mean that a hospital or clinic may not be able to purchase a new piece of equipment or offer a new service that would benefit the community.¹⁰

Uncompensated care costs have also contributed to higher levels of state and local spending. For example, Medicaid helps support hospitals that treat a large number of poor patients through the Disproportionate Share Hospital (DSH) program. Since Medicaid pays critical access hospitals, community health centers, and rural health clinics on a cost basis, larger uncompensated care costs increase the reimbursement levels.¹¹

Local governments are also impacted because they are responsible for indigent care. In addition, many county governments provide funds to maintain their local hospitals.

The Lack of Health Insurance and the Impact on the Community

Uninsurance may impact the community in many ways. For example, it may be more difficult to identify and slow an infectious disease outbreak if people delay or do not receive needed care because they are uninsured.¹² Because the uninsured tend to be less healthy, there is considerable lost productivity from absenteeism, which raises employers' costs and lowers tax revenue.¹³

Individuals and families are also directly impacted because their insurance premiums reflect some of the providers' uncompensated costs. A recent study found that health insurance premiums for families in Nebraska who have insurance through private employers were \$918 higher in 2005 due to the cost of health care for the uninsured that was not paid for by other sources. For individuals who have insurance through private employers, premium costs in Nebraska were \$343 higher. Both of these estimates are similar to the national average. These higher premium costs not only affect individuals and families, but they may also influence the location decisions of employers.¹⁴

The lack of insurance coverage can increase employee turnover and expand overall costs. For example, the results of a study conducted by the Coca Cola Retailing Research Council found that the average turnover cost of replacing a \$6.50 per hour cashier at supermarkets was \$3,637.¹⁵

Finally, a recent report from the Nebraska Center for Rural Health Research summarized the findings from the rural small employer focus groups interviews concerning the perceived effects of the high costs of health insurance on rural economic development. The following three effects were identified: (1) The high cost of insurance prevents small employers from offering it and thus discourages young families from taking jobs in rural areas. (2) The high cost of insurance and health care was perceived as diverting resources from other economic activities that would improve rural development. (3) The high cost of health insurance causes rural families to be uninsured and thus decreases access to health care.¹⁶

What we heard from the focus group interviews:

"They are looking for a job where they can get decent insurance for their families and that means moving to an urban area." – rural White female

"One of the very serious problems of living in central Nebraska as well as southwest Nebraska, are poor wages and lack of health care. And if there were ways that employers could have some help with the health care, they might hire more employees or they might invent more jobs and come here and start them." – rural White self-employed female

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

"To get young people to come back to these communities, you need financially viable businesses or they have nothing to come back to." – rural agricultural small employer

Process of Developing the Coverage Options

In this section, the process that was used by the Nebraska Health Insurance Policy Coalition to develop the coverage options for the uninsured is described. The Coalition began the process of developing various policy options after reviewing the results of the household and employer surveys as well as the initial focus group interviews. The next step was to develop a set of principles that would be used in consensus building and guiding the selection of policy options. These principles are as follows:

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

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

After formulating the guiding principles and identifying the target populations, the Coalition began developing the coverage options. The Coalition approved nine options that fell into the following three general groups: (1) strengthening the health care safety net, (2) expanding Medicaid coverage, and (3) improving access to private health insurance coverage. The specific options in each of these areas are described below, along with the advantages and disadvantages, the target populations, and cost considerations.

Methods for Obtaining Input from the Public and Key Constituencies

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

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

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

Focus group interviews were also used to obtain feedback on the coverage options. A total of nine focus group interviews were conducted in May of 2005 for the specific purpose of gathering input on the proposed options. For the most part, the nine focus groups were similar to the groups that were conducted in the spring of 2004. In the original focus group interviews, however, most of the discussion emphasized the magnitude of the problem and the barriers to accessing health insurance coverage. The second round of focus group interviews was held in both urban and rural areas and included the following groups:

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

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

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

Description of the Insurance Coverage Options

In this section we describe the insurance coverage options for expanding health insurance coverage and strengthening the health care safety net. As previously mentioned, the nine options fall into three general groups: (1) strengthening the health care safety net, (2) expanding Medicaid coverage, and (3) improving access to private health insurance coverage. The specific initiatives in each group are described along with the major advantages and disadvantages, key target populations, and general cost considerations.

When policy makers evaluate these coverage options, three factors should be considered. First, the experiences of other states have demonstrated that there is no single best solution for reducing the number of uninsured. At this time none of the states has covered everyone, but some states have made considerable progress using a variety of approaches.

Second, some of these coverage options can be implemented immediately at a relatively low cost to the state. However, some of the more comprehensive and more costly options will need considerably more study before they can be implemented. At this point, for example, it is not possible to determine how a particular program might be administered, what the total costs would be, what methods would be used to assure quality, and how many people would be covered.

Finally, it is important to emphasize that not all of the coverage options should be implemented at once. Expanding coverage for the uninsured and strengthening the safety net capacity will take some time and resources. Nevertheless, the options presented in this section have the potential for eliminating many of the financial access barriers.

Coverage Expansion Options, Group I: Strengthening the Health Care Safety Net

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

Option 1. Create a Safety Net Commission to develop a plan for expanding and supporting the number of community health centers, satellites of existing centers, and look-alikes.

Description and Rationale: Although many private providers, including hospitals and physician clinics, see a significant number of indigent patients, Nebraska has a very fragmented and uncoordinated safety net of health care providers. As a result, many patients do not have a regular physician and receive care in hospital emergency rooms.

When patients receive care in hospital emergency rooms, they are often sicker and the cost of health care services is more expensive.

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

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

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

In addition to new FQHCs, the plan should address potential expansions of existing centers relatively near their current locations. Finally, the plan should identify possible FQHC look-alikes. Although look-alikes do not receive a federal grant to cover the costs of treating uninsured patients, they are entitled to receive cost-based reimbursement from Medicaid. In some instances, look-alikes may evolve into FQHCs.

The safety net plan should make recommendations in the following areas:

- Which communities should be encouraged to seek FQHC grant funding?
- Which FQHCs should be encouraged to expand and where?
- Which agencies should be encouraged to become FQHC look-alikes?
- What types of technical assistance, start-up funds, and other state and local resources are necessary for Nebraska to have a strong safety net?
- What other models are under consideration at the federal level? For example, the Health Resources and Services Administration is exploring various hybrid models that may include rural health clinics and critical access hospitals. Since Nebraska

has over 100 rural health clinics and 60 critical access hospitals, it may be possible to become part of a demonstration project.

- Since FQHCs do not provide specialty or hospital care, what mechanisms need to be in place to contract with specialists and acute care hospitals?
- What types of information or tracking systems are needed to improve the continuity of care and prevent duplication of services between safety net providers and hospital emergency rooms?
- What types of capital improvements and other financial resources are needed in existing community health centers, and what options are available to fund these improvements?

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

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

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

Target Groups: Low income children and adults

Cost: Grant funds are available to cover most of the costs of providing technical assistance to communities that are interested in developing a new community health center. Nevertheless, some in-kind services are needed from various organizations at the community level. Because FQHCs receive cost-based reimbursement for Medicaid clients, Medicaid program costs may increase slightly in the short run. However, these short-run cost increases will be more than offset in the long run through a reduction in emergency room visits. Also, more timely preventive care will reduce specialty care referrals and result in fewer hospital stays. The Iowa/Nebraska Primary Care Association has estimated that community health centers in Nebraska have saved the state Medicaid program over \$1.5 million a year.¹⁷

Option 2. Expand the use of drug discount programs (e.g., the federal 340B program) so that all eligible organizations can purchase prescription drugs at lower costs.

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

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

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

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

Advantages: The 340B program can reduce the costs of prescription drugs by 10 to 70 percent. Although community health centers are already taking advantage of this program, many other eligible entities are not. Some technical assistance will need to be provided by the Nebraska Health and Human Services System, but no new state funds will be needed.

Disadvantages: For patients to qualify for the discounted prescription drugs, they must receive a range of services from the entity and the health records must be

maintained by the entity. As a result, some of the eligible entities may not qualify because they do not provide a wide range of primary care services.

Target Groups: Low-income children and adults

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

Coverage Expansion Options, Group II: Expanding Medicaid and SCHIP Coverage

The second major coverage expansion area is to expand the Medicaid and Kids Connection (State Children's Health Insurance Program [SCHIP]) programs. These options range from improving marketing and outreach efforts to enroll all eligible children and adults to expanding Medicaid income eligibility.

Option 3. Improve marketing and outreach efforts to enroll children and adults who are currently eligible for Medicaid and Kids Connection (the State Children's Health Insurance Program).

Description and Rationale: Eligibility for the Medicaid and Kids Connection programs is generally based on income and the value of assets. For example, all children are eligible for either Medicaid or Kids Connection if their family income is at or below 185 percent of the FPL and they are without insurance coverage. Despite the current marketing and outreach efforts, it is estimated that about 7,200 children are eligible but not enrolled in Medicaid or Kids Connection. There are also many adults who meet the Medicaid eligibility requirements but are not enrolled. By expanding current marketing and outreach initiatives, insurance coverage can be expanded at a modest cost to the state.

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

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

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

Cost: Costs can vary depending on the initiative. Nebraska has already implemented a simplified application form and has a six-month continuous eligibility policy for children enrolled in Kids Connection. Many other outreach efforts could promote these programs, including paid and unpaid radio, television, and print materials. Obviously, highly successful outreach efforts could expand the number of individuals enrolled in the program and thus increase Medicaid costs.

Option 4. Develop and implement initiatives that would reduce the cost of Medicaid and Kids Connection programs and use these savings to expand these programs (e.g., increase eligibility levels from 185 to 200 percent of the Federal Poverty Level for the Kids Connection program).

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

Although the Coalition considered several possible programs, including a greater expansion of home- and community-based long-term care services, the cost-reducing programs should focus initially on developing a disease management program and becoming part of a multi-state purchasing pool to negotiate lower prescription drug costs. Because both of these programs are complex, it is important to design them so that they are compatible with existing Medicaid policies and cost containment strategies.

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

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

Before implementing a DM program, some key questions must be answered, including the following:

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

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

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

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

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

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

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

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

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

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

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

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

Option 5. Expand Medicaid income eligibility levels.

Description and Rationale: One of the most direct ways of reducing the number of uninsured is to expand Medicaid and/or Kids Connection income eligibility levels. For example, some states now cover all adults who have incomes up to 100 percent of the FPL. Other states have expanded their SCHIP to cover all children who do not have health insurance coverage and whose family incomes are below 250 percent of the FPL. In contrast, the maximum income eligibility level for the Nebraska Kids Connection program is 185 percent.

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

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

Disadvantages: A major expansion would require an increase in state funds. Given the passage of LB 709, it does not appear that there is interest in expanding the program at this time. LB 709 requires the development of a Medicaid reform plan, which must include recommendations to moderate the growth of spending and ensure fiscal sustainability. The plan must be submitted to the governor and the legislature by December 2005.

Target Groups: Low-income children and adults

Cost: Depending on whether a waiver is needed, the state must pay up to 40 percent of the expansion costs. If a waiver is required, the amount of federal support does not increase, but there is greater flexibility in the eligibility, benefits, and cost sharing options.

Coverage Expansion Options, Group III: Improving Access to Private Health Insurance Coverage

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

Option 6. Create public-private partnerships between small employers and Medicaid.

Description and Rationale: Some states have expanded coverage by creating premium assistance programs. In these public-private partnership programs the state, the employer, and usually the employee share the cost of the premium. In a proposed Oklahoma plan, for example, the employer would pay 25 percent of the premium, the employee would pay 15 percent, and Medicaid would pay the remainder of the premium. The program is limited to employees and their spouses who have a household income at or below 185 percent of the FPL and work in firms with 25 or fewer workers. Unemployed workers who are seeking work are also eligible.

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

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

Disadvantages: These programs have high administrative costs for both state government and employers. In addition to higher administrative costs, new state funds are needed for Medicaid expansion. Finally, a waiver is needed from the federal government, and federal outlays must be budget neutral so the state must absorb all of the additional costs.

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

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

Three Share Models at the Community Level: A similar three-share model has also been implemented at the community level. In this model, the employer and the employee pay a share of the premium and the third share can be paid by a government entity or perhaps a private foundation. The benefit packages are more limited and the main target is small businesses (usually with less than 25 employees) that have not offered health insurance coverage for six months to a year. Several of these three share plans are now operating in Michigan and Illinois.

Option 7. Conduct a study to determine the feasibility of implementing a publicly funded reinsurance program.

Description and Rationale: A reinsurance program attempts to make insurance premiums more affordable for small employers and self-employed individuals. In such a program, public funds would be used to subsidize the purchase of a reinsurance policy that would cover claims above a certain threshold (e.g., \$25,000) for small employers of a certain size (e.g., under 10 employees). Because the state picks up a portion of the insurer's high cost claims, the premiums are likely to be lower and more stable from year to year. The availability of state-funded reinsurance should be linked to state approved plans that are targeted at low-income, uninsured individuals, and small employers.

Advantages: Reinsurance programs can leverage employer contributions to cover more people with public funds. These programs have been effective in a few states, and they have reduced insurer costs because they can be less aggressive in underwriting and marketing. Also, because of less risk of paying high-cost claims, insurers are likely to hold less surplus funds, which should reduce the premium costs.

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

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

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

Option 8. Create a pharmacy clearinghouse to assist eligible consumers in receiving medication discounts.

Description and Rationale: Currently, nearly all pharmaceutical manufacturers offer prescription drug discounts to low-income consumers. However, many eligible consumers lack the necessary information and perhaps the knowledge about how to access these programs. If a pharmacy clearinghouse was established, it could serve as

a resource for identifying discounted drugs and distributing them to qualified individuals. The clearinghouse could also assist physicians and other health care providers in preparing the appropriate forms and other necessary paperwork.

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

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

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

Target Groups: Low-income children and adults

Cost: There would be a cost to establish a central pharmacy clearinghouse. The start-up costs could be paid with state funds or possibly with grant dollars.

Option 9. Provide education and training to consumers and small employers about the benefits of health insurance coverage and the advantages and disadvantages of various policies.

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

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

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

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

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

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

Next Steps

The insurance coverage options discussed in the previous section have been approved by the Nebraska Health Insurance Policy Coalition and the Policy Cabinet of the Nebraska Health and Human Services System. The full report has been forwarded to the governor and members of the state legislature. A legislative briefing on the report will be held this fall.

Notes and References

1. The Nebraska 2004 Household Survey was a stratified random-digit-dial telephone survey sponsored by the U.S. Department of Health and Human Services' Health Resources and Services Administration State Planning Grants Program. The survey was conducted by the University of Nebraska Medical Center between March 10, 2004, and May 8, 2004, in both English and Spanish. Hispanics and African-Americans were over-sampled. The total response rate was 67 percent, and the total sample size was 3,750.
2. The 13 focus group interviews were conducted in both urban and rural areas from June 3, 2004, to July 27, 2004. Nine groups involved populations that were likely to be uninsured (e.g., racial/ethnic minority groups, low income, new refugees, and students), three groups targeted small business owners, and one group included the self-employed or micro-employers with five or fewer employees.
3. 2003 Federal Poverty Level (FPL) Income Guidelines

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

4. The 2004 Nebraska Employee Benefits Survey was mailed to employers who reported having at least one employee during the second calendar quarter of 2003. All employers subject to paying unemployment insurance taxes were included in the population universe from which the survey sample was selected. This excludes railroads, the self-employed, religious organizations, some non-profit agencies, some agriculture employers, and certain government agencies.

Each business location was treated as a separate entity, so employers with multiple locations were eligible to receive the survey at each site. A total of 46,603 employers were found to be within the scope of the survey. Of those, a stratified random sample was drawn, stratified by business size and industry. Overall, 13,847 employers were chosen to participate in the survey, and 9,005 business units were used in the analysis.

Surveys were mailed the second week of February 2004, with a requested return date of March 5, 2004. A second survey questionnaire was mailed to those

employers who had not responded by March 12, 2004. This survey form asked employers to respond by April 2, 2004. Contact was made with certain employers who had not responded by April 9. All surveys returned by April 30, 2004, were included in the final data set.

5. Smith, V. (2005, July 28). *Medicaid and SCHIP: Past, present, and future*. Presented at the State Coverage Initiatives Summer Meeting, Chicago, IL.
6. Several studies have found that a single-item general self-rated health status measure is a good predictor of an individual's health status, including hospitalizations and mortality rates. See, for example, DeSaloo, K., Fan, V., McDonell, M., Fihn, S., (August 2005). Predicting Morality and Healthcare Utilization with a Single Question. *Health Services Research*, pp. 1234 - 1246.
7. Jack Hadley. (May 2002). "Sicker and Poorer: The Consequences of being Uninsured." The Kaiser Commission on Medicaid and the Uninsured. Institute of Medicine, Committee on the Consequences of Uninsurance. (2004). *Insuring America's Health: Principles and Recommendations*. Washington, DC: National Academy Press. Joseph J. Sudon and David W. Baker (Volume 93, 2003). "Intermittent Lack of Health Insurance Coverage and use of Preventive Services." *American Journal of Public Health*, pp. 130-137.
8. Schoen, C., Doty, M., Collins, S., & Holmgren, A. (2005, June 14). Insured but not protected: How many adults are underinsured. *Health Affairs Web Exclusive*, W5-289.
9. Chen, L-W., Shambaugh-Miller, M., Zhang, W., Xu, L., Hesford, B., Skinner, A., Fraser-Maginn, R., & Mueller, K. (2005, July). *The cost of uncompensated health care and the expenditures of self-pay hospital inpatient care in Nebraska* (PR05-02). Omaha, NE: University of Nebraska Medical Center, Nebraska Center for Rural Health Research.
10. Hadley, J., & Holahan, J. (2003, February 12). How much medical care do the uninsured use, and who pays for it?. *Health Affairs Web Exclusive*, W3-66–W3-81.
11. Ibid., W3-73–W3-75.
12. Institute of Medicine, Committee on the Consequences of Uninsurance. (2003). *A shared destiny: Community effects of uninsurance*. Washington, DC: National Academy Press.
13. Ibid.

14. Families USA. (2005, July). *Paying a premium: The added cost of care for the uninsured* (Publication No. 05-101). Washington, DC: Kathleen Stoll.
15. Packingham, G. (2004, July). *How to speak to businesses and enroll them in community health plans*. Presented at the State Coverage Initiatives Summer Meeting, Chicago, IL.
16. Carlson, E., Fraser-Maginn, R., & Mueller, K. (2005). *Making the good life meaningful for all Nebraskans: The importance of health insurance* (Health Data Reporter 6[2]). Omaha, NE: University of Nebraska Medical Center, Nebraska Health Information Project.
17. This calculation was based on the average total Medicaid spending for each Medicaid patient in Nebraska's community health centers and then estimating the amount saved per beneficiary due to reduced specialty care referrals and hospital admissions that were avoided. The methods and estimates were obtained from e-mail correspondence from Mary Lee Fitzsimmons from the Iowa/Nebraska Primary Care Association.

Other State Planning Grant Reports

In addition to this report, the Nebraska Health and Human Services System and its contractors, the Nebraska Center for Rural Health Research at the University of Nebraska Medical Center and the Nebraska Department of Labor, have prepared several documents related to household and employer health insurance coverage in Nebraska. Links to all of these reports can be found at the following web site:

www.hhs.state.ne.us/puh/oph/grant.htm

1. Keith Mueller, Jane Meza, Erin Carlson, Katherine Jones, Roslyn Fraser-Maginn, Brandi Shay, and Liyan Xu, "Health Insurance Coverage in Nebraska: Results from the Nebraska State Planning Grant," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, December 2004.
2. Nebraska Department of Labor, "2004 Nebraska Employee Benefits Report," December 2004.
3. Liyan Xu, Jane Meza, and Keith Mueller, "Health Insurance Status of Nebraskans," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, May 2005.
4. Erin Carlson, Roslyn Fraser-Maginn, and Keith Mueller, "Making the Good Life Meaningful for All Nebraskans: The Importance of Health Insurance," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, May 2005.
5. Li-Wu Chen, Michael Shambaugh-Miller, Wanqing Zhang, Liyan Xu, Brian Hesford, Anne Skinner, Roslyn Fraser-Maginn, and Keith Mueller, "The Cost of Uncompensated Health Care and the Expenditures of Self-Pay Hospital Inpatient Care in Nebraska," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, July 2005.
6. Erin Carlson, Roslyn Fraser-Maginn, and Katherine Jones, "Reactions to Proposed Strategies to Increase Health Insurance Coverage in Nebraska: Results from the Nebraska State Planning Grant Year Two Focus Groups," Nebraska Center for Rural Health Research, University of Nebraska Medical Center, August 2005.
7. "Nebraska State Planning Grant to Expand Health Insurance Coverage," Office of Public Health, Nebraska Department of Health and Human Services," August 2005.

Appendix I: Nebraska Health Insurance Policy Coalition

Chair of the Coalition

Andrea Skolkin, Executive Director
OneWorld Community Health Centers
5155 South 36th Street
Omaha, NE 68107
(402) 734-4110
(402) 392-1538 (fax)
askolkin@oneworldomaha.org

Coalition Members

David Burd
Nebraska Hospital Association
1640 "L" Street/Suite D
Lincoln, NE 68508
(402) 458-4904
(402) 475-4091 (fax)
dburd@nhanet.org

Senator Dennis Byars
State Capitol Room 1208
Box 94604
Lincoln, NE 68509
(402) 471-2620
(402) 479-0930 (fax)
dbyars@unicam.state.ne.us

Bob Elwell
Seward County Commissioner
352 East Bek Avenue
Seward, NE 68434
(402) 643-6476

Judi Morgan gaiashkibos, Executive Director
Nebraska Commission on Indian Affairs
State Capitol/Box 94981
Lincoln, NE 68509
(402) 471-3475
(402) 471-3392 (fax)
jmkibos@ncia.ne.gov

Judy Halstead
Lincoln-Lancaster County Health Dept
3140 "N" Street
Lincoln, NE 68510
(402) 441-4603
(402) 441-6229 (fax)
jhalstead@ci.lincoln.ne.us

Theresa Holtzen, Vice President
Nebraska Chamber of Commerce
Overland Ready Mix
Box 307
Stromsburg, NE 68666
(402) 764-2371
(402) 764-2916 (fax)
terri@overlandconagg.com

Senator Jim Jensen
State Capitol Room 1402
Box 94604
Lincoln, NE 68509
(402) 471-2622
(402) 479-0920 (fax)
jjensen@unicam.state.ne.us

Sandy Johnson, Exec Vice President
Nebraska Medical Association
233 South 13th Street
Suite 1512
Lincoln, NE 68508
(402) 474-4472
(402) 474-2198 (fax)
sandyj@nebmed.org

John Klosterman
1197 34th Road
David City, NE 68632
(402) 367-3209
jcklos@dtinspeed.net

Pat Lopez
Public Health Assn of Nebraska
4521 Hill Drive
Lincoln, NE 68510
(402) 489-5090
jpnice75@aol.com

Steve Martin, President & CEO
Blue Cross Blue Shield of Nebraska
7261 Mercy Road
Box 3248
Omaha, NE 68124
(402) 390-1810
(402) 398-3836 (fax)
steve.martin@bcbsne.com

Kathy Bigsby Moore, Executive Director
Voices for Children in Nebraska
7521 Main Street/Suite103
Omaha, NE 68127
(402) 597-3100
(402) 597-2705 (fax)
kmoore@voicesforchildren.com

Marta Nieves
Human & Organizational Dev Consultant
2514 Sheridan Road
Bellevue, NE 68123-1966
(402) 291-3493
(402) 510-9714 (cell)
(402) 291-0781 (fax)
martarisuena@aol.com

Frank Peak, President
Nebraska Minority Public Health Association
Creighton University Medical Center
LaBaj Building
2500 California Plaza
Omaha, NE 68178
(402) 280-5852
(402) 280-5874 (fax)
fpeak@creighton.edu

Mary Beth Rathe, Executive Director
Community Action of Nebraska, Inc.
1120 "K" Street/Suite 100
Lincoln, NE 68508
(402) 471-3714
(402) 471-3481 (fax)
marybethrathe@canhelp.org

Becky Rayman, Executive Director
Iowa/Nebraska Primary Care Association
2282 East 32nd Avenue
Columbus, NE 68601
(402) 563-9224 x210
(402) 564-0611 (fax)
rrayman@ecdhd.com

Fred Salzinger, Associate Vice President
Creighton University Medical Center
Criss III 149
2500 California Plaza
Omaha, NE 68178
(402) 280-1821
(402) 280-4027 (fax)
salzin@creighton.edu

Tony Sanders
VP, Human Resources Business Center
ConAgra Foods Inc
Eleven ConAgra Drive
Omaha, NE 68102
(402) 595-5292
(402) 930-3378 (fax)
tony.sanders@conagrafoods.com

Cory Shaw, Exec Vice President & CEO
University Medical Associates
University of Nebraska Medical Center
984220 Nebraska Medical Center
Omaha, NE 68198-4220
(402) 559-7274
(402) 559-5008 (fax)
cdshaw@unmc.edu

Brad Sher, VP Managed Care/Public Policy
BryanLGH Health System
1600 South 48th Street
Lincoln, NE 68506
(402) 481-8020
(402) 481-8306 (fax)
bsher@bryanlgh.org

Mary Steiner, Administrator
Nebraska Health & Human Services
Medicaid Program
Box 95026
Lincoln, NE 68509
(402) 471-9567
(402) 471-9092 (fax)
mary.steiner@hhss.ne.gov

Galen Ullstrom, Sr VP - State Gov't Relations
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175
(402) 351-5235
(402) 351-5710 (fax)
galen.ullstrom@mutualofomaha.com

Tim Wagner, Director
Nebraska Department of Insurance
941 "O" Street/Suite 400
Lincoln, NE 68508
(402) 471-4631
(402) 471-2990 (fax)
twagner@doi.state.ne.us

Jim Watson
United Health Care of the Midlands
2717 North 118th Circle
Omaha, NE 68164-9672
(402) 465-6711
jim_watson@uhc.com

Cinda Zimmer
Nebraska Nurses Association
Madonna Rehabilitation Hospital
5401 South Street
Lincoln, NE 68506
(402) 486-8279
czimmer@madonna.org

Contractors

Scott Hunzeker, Research Analyst
Nebraska Department of Labor
550 South 16th Street/Box 94600
Lincoln, NE 68509
(402) 471-1025
(402) 471-9867 (fax)
shunzeker@dol.state.ne.us

Keith Mueller, Director
Nebraska Center for Rural Health Research
University of Nebraska Medical Center
984350 Nebraska Medical Center
Omaha, NE 68198-4350
(402) 559-4318
(402) 559-7259 (fax)
kmueller@unmc.edu

Senatorial Staff

Janet Anderson, Legislative Aide
Senator Dennis Byars' Office
State Capitol Room 1208
Box 94604
Lincoln, NE 68509
(402) 471-2620
(402) 479-0930 (fax)
janderson@unicam.state.ne.us

Jon Edwards, Legislative Aide
Senator Jim Jensen's Office
State Capitol Room 1402
Box 94604
Lincoln, NE 68509
(402) 471-2622
(402) 479-0920 (fax)
jedwards@unicam.state.ne.us

Staff to the Coalition

Patti DeLancey
Nebraska Health and Human Services
Financial Services
Box 95026
Lincoln, NE 68509
(402) 471-7898
(402) 471-7783 (fax)
patti.delancey@hhss.ne.gov

Meridel Funk
Nebraska Health and Human Services
Research & Performance Measurement
Box 95026
Lincoln, NE 68509
(402) 471-0198
(402) 471-7783 (fax)
meridel.funk@hhss.ne.gov

Dave Palm, Administrator
Office of Public Health
Nebraska Health and Human Services
Box 95044
Lincoln, NE 68509
(402) 471-0146
(402) 471-8259 (fax)
david.palm@hhss.ne.gov

Governor's Office

Jeremy Hosein, Policy Advisor
Governor's Policy Research Office
Box 94601
Lincoln, NE 68509-4601
(402) 471-2417
(402) 471-2528 (fax)
jhosein@pro.state.ne.us

**Appendix II. Aggregate Ratings of Coverage Options by
Participants in Town Hall Meetings**

Strengthening the Health Care Safety Net

**Option 1: Create a Safety Net Commission to Develop a Plan for Expanding the
Number of Community Health Centers ...**

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	12	18	10	1	1
Lincoln	54	19	22	8		2
Norfolk	18	4	9	5		
Grand Island	31	13	10	6		
North Platte	9	3	5	1		
Gering	17	7	8	1		
TOTAL	171	58/34%	72/42%	31/18%	1/1%	3/2%

Option 2: Expand the use of Drug Discount Programs

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	14	23	3	2	
Lincoln	54	25	22	2	3	
Norfolk	18	12	6			
Grand Island	31	16	13	2		
North Platte	9	4	5			
Gering	17	13	2	1		
TOTAL	171	84/49%	71/42%	8/5%	5/3%	

Expanding Medicaid and SCHIP Coverage

**Option 3: Improve Marketing and Outreach Efforts to Enroll Children
and Adults who are Currently Eligible for Medicaid and Kids Connection**

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	18	17	6		1
Lincoln	54	15	21	14	1	
Norfolk	18	7	5	5		
Grand Island	31	14	11	6		
North Platte	9	2	4	3		
Gering	17	10	5	1	1	
TOTAL	171	66/39%	63/37%	35/20%	2/1%	1/1%

**Option 4: Develop and Implement Initiatives to Reduce the Cost of
Medicaid and Kids Connection Programs**

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	18	14	6	2	1
Lincoln	54	17	19	11	2	1
Norfolk	18	6	6	4	1	
Grand Island	31	12	10	7	1	1
North Platte	9	2	5	1		1
Gering	17	9	5		2	
TOTAL	171	64/37%	59/35%	29/17%	8/5%	4/2%

Option 5: Expand Medicaid Income Eligibility Levels

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	19	13	6	2	2
Lincoln	54	13	17	15	5	3
Norfolk	18	6	7	5		
Grand Island	31	9	9	9	3	
North Platte	9	2	3	4		
Gering	17	8	4	2	3	
TOTAL	171	57/33%	53/31%	41/24%	13/8%	5/3%

Improving Access to Private Health Insurance Coverage

Option 6: Create Public-Private Partnerships Between Employers and Medicaid

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	13	19	8	1	
Lincoln	54	18	25	5	1	3
Norfolk	18	3	10	4	1	
Grand Island	31	8	15	8		
North Platte	9	2	5	1		
Gering	17	7	8	2		
TOTAL	171	51/30%	82/48%	28/16%	3/2%	3/2%

**Option 7: Feasibility of Implementing a Publicly
Funded Reinsurance Program**

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	16	19	5	2	3
Lincoln	54	8	25	15		3
Norfolk	18	1	6	8	2	
Grand Island	31	6	8	13	1	3
North Platte	9	3	3	2		
Gering	17	7	4	5	1	
TOTAL	171	41/24%	65/38%	48/28%	6/4%	9/5%

**Option 8: Create a Pharmacy Clearinghouse to Assist
Eligible Consumers in Receiving Medication Discounts**

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	13	17	7	3	1
Lincoln	54	24	20	5	2	
Norfolk	18	5	9	4		
Grand Island	31	10	12	7	1	
North Platte	9	3	5	1		
Gering	17	10	3	3	1	
TOTAL	171	65/38%	66/39%	27/16%	7/4%	1/1%

Option 9: Provide Education and Training to Consumers and Small Employers ...

Location	# of Replies	Strongly Support	Support	Neutral	Can't Support Will Step Aside	Can't Support Will Block
Omaha	42	17	20	5		
Lincoln	54	23	19	10		
Norfolk	18	4	8	2	3	
Grand Island	31	13	12	6		
North Platte	9	4	4			
Gering	17	9	5	3		
TOTAL	171	70/41%	68/40%	26/15%	3/2%	

NOTES

NOTES

NOTES