STATE PLANNING GRANTS PROGRAM:
SYNTHESIS OF STATE EXPERIENCES

INTERIM REPORT

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2000 Grantees
Arkansas Department of Health
Delaware Health Care Commission
State of Illinois
Iowa Department of Health
Kansas Insurance Department
Massachusetts Division of Medical Assistance
Minnesota Department of Health
New Hampshire Department of Health and Human Services
Office for Oregon Health Plan Policy and Research
Vermont Agency of Human Services
Wisconsin Department of Health and Family Services

2001 Grantees
Arizona Health Care Cost Containment System
California Health and Human Services Agency
State of Colorado
Connecticut Office of Health Care Access
Idaho Department of Commerce
South Dakota Department of Health
Texas Department of Insurance
Utah Department of Health
Washington Office of Financial Management

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The recommendations that follow were derived from the individual state grantee reports and should be read solely as these states' recommendations to the federal government. These recommendations are not a statement of the Administration's position and are conveyed without Department of Health and Human Services comment.

The Health Resources and Services Administration State Planning Grants (SPG) Program provided grants to states to develop plans to provide access to health care insurance for all citizens. The program provided significant resources to allow states to analyze their own uninsured populations and health care marketplaces, support community and stakeholder involvement in the planning process, and determine the best strategies to reduce the uninsured. Twenty (20) states were selected for grants ranging from $800,000 to $1.6 million: 11 grants were awarded in fiscal year (FY) 2000 and 9 in FY 2001.

This is an Interim Report that consolidates and synthesizes information on the processes and findings of the state grantees as reported to the Secretary of Health and Human Services in October of 2001. It represents the findings and views of the states themselves, as expressed in their individual reports, without endorsement or comment by the Department of Health and Human Services. It should also be read as primarily reflecting the progress and experiences of the first 11 grantees. Although the second nine grantees submitted progress reports, their work was not far enough along to enable them to provide significant details on their uninsured populations or options to expand coverage.

Even for the initial 11 states, the reports reflect a process still in the beginning stages of policy development. Most states are still winnowing the options under consideration and where policy options have been identified, there is still much work to do to flesh out the details of financing and implementation and to secure public and private support for implementation. As reflected in their requests for no-cost extensions and funding for additional research, most states view the policy development and consensus-building processes as milestones rather than end points. A follow-up report on the 20 grantees' experience will be prepared in mid-2002 and should also provide the opportunity for more analysis of the SPG Program results and the impact on state and federal efforts to expand health care coverage.

Diverse States and a Supportive Process Provide State and National Lessons

The 20 states selected for grants are a diverse group reflecting most regions of the country and different demographic and economic circumstances. In brief, they included

representatives of both the most and least populous states, states with both high and low minority populations, and states with very different health care marketplaces. States are included that have some of the nation's highest rates of uninsured populations, as well as states with the lowest rates of uninsured. The diversity of the states and the challenges they face in sustaining and increasing health insurance coverage to their citizens represents a rich source of information about the significant sub-populations that are the most likely to be uninsured and the geographic variations in health insurance coverage.

The states collected quantitative and qualitative information on their sub-populations and used it to develop strategies targeted to these specific sub-populations. The work accomplished under these grants demonstrates the need for a more detailed understanding of the problem of uninsurance, including understanding the behavioral and value issues that play an important role in creating successful solutions. The complexity of the health care system and the demographic, economic and political diversity of every state led each state to conclude that no single policy tool will accomplish their goal. Rather, each state is developing specific strategies to target specific problems. It also reinforces the value of flexibility for states to design and implement their own strategies based on state characteristics and culture and their capability and willingness to do so.

In addition, the work that the states have done to understand their markets and employers will give national policy leaders clues to the effect of the economic downturns and increases in health insurance costs on coverage and access to health services.

Although states used various combinations of qualitative and quantitative data collection approaches, there were no major surprises learned about the general characteristics of the uninsured that could not be discerned from national data. Rather, it was the detail that states uncovered about substate areas and subpopulations that proved invaluable in terms of better understanding both the problems of the uninsured and the solutions that need to be tailored to those problems. The uninsured are made up of mostly low-income workers in all states. However, the states found that being able to put specific numbers to places and populations helps to give policy makers ownership of the issue. State-specific, detailed information underscored the saliency of the problem and helped the states challenge myths that undermine productive policy debate.

The SPG Program grantees created an opportunity for states to learn from each other on process and structural issues. States reported that the technical assistance and funding that allowed them to meet regularly and to share and collaborate with each other was extremely valuable. Key lessons on data collection, the planning process, and organizational and operational issues are listed, including:

- The importance of state-specific information to a state; many states chose to spend a majority of their grants on primary state-level data collection and all states made the development of a base of information about the quantitative and qualitative

dimensions of the problem a foundation for their work. Each state believes that its challenges, although similar to other states, are ultimately unique to their state.

- The value of including both quantitative and qualitative research in providing a more comprehensive picture for policy makers; the qualitative data allowed states to test options as well as understand the values and attitudes that shape behavior of the uninsured, employers and key members of the health care industry.
- The ability of states to assist each other by sharing what they have learned on improving data collection and their recommendations, as well as the practical problems of data collection.
- Ways to achieve a credible data-driven process and manage a complex planning process.
- Advice to each other on involving stakeholders effectively. Although the organizational structures and the ways states identified and involved stakeholders reflected past experience in state health care expansion efforts and their state political environments, they offered each other ideas for ensuring a credible data driven process.
- In spite of how much states have learned, there are still additional research needs, particularly with regard to employers, uncompensated care and the safety net, and the insurance market. There is also the important issue of keeping the information base that supported the policy process current. States are concerned with how to maintain and monitor their work.
- A one-year time frame has both advantages and disadvantages, but the policy process requires a longer timeframe. States were creative in their use of strategies to get around barriers in their bureaucracies and complete needed activities. States reported that the advantage of the short timeframe was the sense of urgency that it brought to the policymaking process. The major disadvantage was the inability of some states to use this funding to build or strengthen their own infrastructure in order for them to sustain efforts in the future.

Policy Options Under Consideration

The SPG states are currently in the process of refining and selecting coverage options for their plans. Guiding principles and assumptions were established by many states to allow them a framework for targeting and selecting expansion options. However, the causes and challenges of double-digit cost and premium increases in both the public and private markets are limiting the options that states have to provide more coverage and sustain or improve access.

One of the themes that runs throughout the individual state reports is the changing financial circumstance of the states. Most critical has been the slowing economy that has fundamentally changed the planning environment. The combination of increasing insurance premiums, changes in employer willingness and ability to offer insurance, market place issues, and declining state revenues has created a challenging environment for implementation.

The policies and financial support of the federal government are also viewed as critically important factors in the potential for state health care coverage expansions. The events of September 11 have served to reinforce and solidify these trends and to present the state and federal governments with additional challenges and resource demands.

The variety of options states developed is described in detail within the report, along with options that the states rejected. Options are included that are possible within the current federal framework, as well as options that would require federal reform. In general, states are:

- Building on and enhancing existing public programs, including taking advantage of all waiver flexibility within the Medicaid program and pushing the envelope on benefits and cost-sharing to create affordable options.
- Building on and enhancing private coverage with strategies such as consumer and employer education, pooling and purchasing strategies, and reinsurance and tax credits.
- Targeting most states' options to the uninsured below 200 percent Federal Poverty Level (FPL). Many states are addressing the pockets of uninsured and specific geographic, demographic and occupational subgroups. States with options already covering this population concentrated on outreach and enrollment strategies.
- Targeting most states' options to the working uninsured. State-specific data highlighted the large percentage of the uninsured in households with a worker. Public-private partnerships and insurance market reforms targeted at small employers and low-wage workers are the result.
- Recognizing the importance of the safety net as they design options and some states are recommending strategies that rely on the safety net and use multiple funding streams and non-traditional benefit packages.

The themes identified that help to explain the options being considered include:

- States' selection of options depends on the extent to which they have already used public program coverage expansions and the stability of the private sector market.
- States are responding to the recent economic downturn by shifting focus from expansion to maintenance of current levels of coverage.
- States are focusing on incremental strategies built on the existing system rather than attempting to transform it. States are thinking in terms of broad plans that they can use to establish a framework for expansions and progressing in a sequential fashion as resources and political support are available.
- States have been influenced both by their quantitative and qualitative data in developing options.

State Recommendations for the Federal Government

Finally, the states have preliminary recommendations for the federal government that reflect the changing times and the differences in the states' approaches.
State recommendations fall within the following broad categories:

- Support ongoing state-conducted research on the uninsured and state planning for coverage solutions.
- Improve the ability of the states to use existing federal data resources such as the Current Population Survey (CPS) and the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) by making these resources easier to use, more available, and more sensitive to state needs for information.
- Consider federal tax changes to encourage employers and individuals to purchase health care insurance and provide comparable tax support for both health care insurance and expenses.
- Consider changes to Medicare and other federal programs that would make them more effective in meeting the needs of Americans for health care coverage such as a Medicare drug benefit.
- Provide additional waiver flexibility to states for multi-state strategies, community-level projects, and new benefit designs. Make state-specific waiver information more easily accessible to all states.
- Provide additional federal financial support including ideas such as incentive match and more flexibility for state matching funds.
- Strengthen and coordinate the federal leadership role in health systems issues through research, dissemination and supporting best practices.
- Continue to support additional health services research on the uninsured and health coverage issues, including longitudinal research on how the uninsured use the health care system, self-insured firms, adequacy of coverage, cost-sharing, take-up rates and crowd-out.

Organization of the Report

This Interim Report synthesizes the experience to date of the SPG Program grantees and includes detail on the existing insurance coverage programs and research work of the grantee states in appendices. Each chapter focuses on a key element of grantee work under the SPG Program and the table of contents provides the reader a guide to sections that may be of particular interest within a chapter. Material included in each chapter is briefly noted below.

- Chapter 1 is an overview of the program and states.
- Chapter 2 covers the diagnostic work of the states, including the quantitative and qualitative research.
- Chapter 3 includes the analysis of the states' health care marketplaces and related issues.
- Chapter 4 covers the consensus-building strategies used by the states.
- Chapter 5 includes the options developed and under consideration by the states.
- Chapter 6 includes the lessons learned by the states and recommendations to other states.
- Chapter 7, the final chapter, covers the recommendations of participating states to the federal government and the Secretary of Health and Human Services.

CHAPTER 1

OVERVIEW OF PROGRAM AND PARTICIPATING STATES

Program Goals and Background

In March of 2000, the Health Resources and Services Administration (HRSA) announced the State Planning Grant (SPG) Program. Initially funded by Congress at $15 million, the program was designed to help states create plans to provide access to health insurance coverage for all of their citizens. The program responded to the high rates of uninsured in the United States and the expressed interest of the states in reducing the number of uninsured citizens by supporting state analysis and development of solutions to the complex problem of the uninsured. Congress included the first round of funds within the FY 2000 Labor-Health and Human Services Appropriations Act and placed the administrative responsibility with HRSA. The Appropriations language specified that up to 10 states could be funded and that the program would give preference to funding states with lower rates of uninsured or states that could clearly show a potential for a significant decrease in their uninsured population. Preference was also given to states that presented diverse characteristics and represented a variety of geographic areas.

States were expected to use these funds to:

- Collect and analyze data to describe the characteristics of their uninsured population.
- Develop a plan to provide all uninsured citizens access to insurance meeting quality benchmarks such as the Federal Employees Health Benefit Plan, Medicaid, or state employee benefits through an expanded state, federal and private partnership.
- Report to the Secretary of Health and Human Services on their findings and coverage expansion proposals.

The program's goals were to assist states in the work of collecting and analyzing data, developing options, and working with key constituency groups and the public to create viable insurance expansion options. From the beginning, the SPG program was seen not just as a benefit to grantee states, but as a program that could offer new information to non-grantee states and to the Department of Health and Human Services. To increase the potential of reaching near universal coverage, the language in the Federal Register's Notice of Availability of Funds reflected the Appropriation's language on funding preferences. Diversity among the states and inclusion of states that had made significant progress in reducing the numbers of the uninsured were factors likely to increase the national opportunity to learn from the SPG investment.

Program Partners

From the beginning of the grant program, HRSA reached out to maximize the resources available to the states by making national experts available to grantees and by supporting collaborative working relationships. This strategy effectively leveraged the resources of the federal agency responsible for the program and provided a link for State grantees to additional technical and funding resources.

A significant feature of the SPG program was the definition of key relationships with private non-profit organizations that shared the program's objective of helping the states in their efforts to expand coverage to the uninsured. Both The Robert Wood Johnson Foundation's (RWJF) *State Coverage Initiatives* (SCI) program and the National Governors Association's Center for Best Practices were identified in the Federal Register's description of the program. The SCI program was authorized shortly before the SPG program and continued the earlier efforts of RWJF to support states with technical and policy assistance as well as by underwriting demonstration programs to expand coverage. This program was able to partner with HRSA to assist the states in their planning process. In addition to these programs, in the fall of 2000, RWJF added a new tool for states with expertise in data collection and analysis, the *State Health Access Data Assistance Center* (SHADAC). The SHADAC program was available to provide expert technical assistance to states on their specific survey efforts as well as to facilitate information sharing among the states on both household and employer surveys.

The Grant Application Process

In order to increase the probability for the applicant to be successful in a difficult task, the SPG grant specified one application per state and asked the Governor to designate the individual or agency responsible for the state's application. The applicant was expected to demonstrate commitment to the goal of providing coverage for all citizens through a comprehensive proposal and a clear operational plan for accomplishing that goal. An ideal applicant was also expected to demonstrate working relationships with all state government health-related agencies, have established partnerships and collaboration with the private sector and the state's legislative leadership, and have demonstrated the ability to complete the technical analysis and prepare the report to the Secretary.

Thirty-five states and territories submitted applications to the program in July of 2000. The large number of states that expressed interest, even with the lure of federal funding, was a surprise to many. It provided ample evidence that states were deeply concerned about the uninsured and interested in additional research and planning to better understand and respond to the issues. Geographically, more applications were received from states in the Northeast, Midwest and West; fewer applications were received from States in the Mid-Atlantic region and the South. External reviewers for SPG found that 20 of the states had submitted applications that met the grant criteria for

an award. The reviewers found most successful applicants presented a comprehensive proposal or a clearly defined, well-developed project plan. Conversely, unsuccessful applicants' proposals did not present comprehensive or well-developed project plans. In addition some applications presented projects that were outside the scope of a SPG grant. The top-ranked 11 were awarded FY 2000 State Planning Grants.

In FY 2001, the SPG program was also funded at $15 million to support the remaining nine state applications that reviewers judged met the criteria and could not be funded under the FY 2000 appropriation. Awards for the second round of grantees were announced effective March 1, 2001. In FY 2002, the President requested and Congress appropriated another $15 million to fund up to 10 new state planning grants.

The Planning Grant States

The 20 grantee states reflect the diversity that the originators of the program envisioned. The addition of the second nine states to the original 11 grantees significantly increased diversity and the ability of the program to add to the national insight on potential solutions. The tables and discussion in the following pages provide basic demographic, economic, and health coverage information on the SPG states. Appendix A also includes detailed information on the states' health reform and coverage expansion efforts to date. The purpose is to create a context and starting point for each of the states as they met the challenge of how to expanding health care coverage.

The states have economic, political and cultural differences that may be extremely important to the way they approach the problem of the uninsured and developing options. Thus, a solution that works well in one state may not be transferable to another for reasons far more complex than economic capacity. These differences, while difficult to describe with analytical precision, are certainly one of the reasons many policy makers recognize the value of developing and supporting state-based solutions for the uninsured.

The states and their grant awards are detailed in Table 1-1.

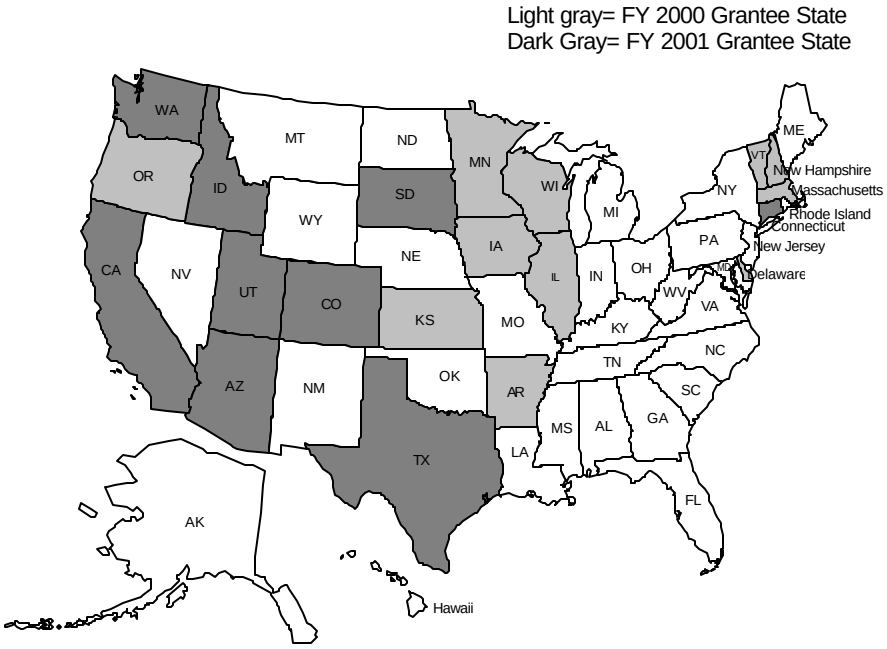
Table 1-1. FY 2000 and 2001 SPG Grantee Award Amounts

FY 2000 Grantee	Award	FY 2001 Grantee	Award
Arkansas	$1.4m	**Arizona**	$1.2m
Delaware	$800k	**California**	$1.2m
Illinois	$1.2m	**Colorado**	$1.3m
Iowa	$1.3m	**Connecticut**	$700k
Kansas	$1.3m	**Idaho**	$1.2m
Massachusetts	$1.1m	**South Dakota**	$1.1m
Minnesota	$1.6m	**Texas**	$1.4m
New Hampshire	$1.0m	**Utah**	$1.1m
Oregon	$1.3m	**Washington**	$1.3m
Vermont	$1.3m		
Wisconsin	$1.3m		

Regional Distribution and State Population

The SPG states are identified on the map below. The program has attracted and funded more states from the west, the northeast and the midwest. If one looks at the grantee states in terms of population, there are states representing every gradation from the least to most populated. The program includes the two most populous states, California and Texas, and three of the least populous, Delaware, South Dakota and Vermont, each with populations under a million. The area between the extremes is also well represented, with states like Connecticut (3.3 million), Wisconsin (5.2 million) and Illinois (12 million).

The states selected also include non-metropolitan, rural and frontier populations as well as states whose populations reside primarily in metropolitan areas.



Median Family Income, Minority Populations, and Population Under 200 percent of Federal Poverty Level (FPL)

Table 1-2 compares the SPG states on the basis of three important dimensions. The percentage of state population from a minority group and the percentage of low-income (under 200 percent of the FPL) are included given that both groups are consistently over-represented in the ranks of the uninsured. Median family income is also included as a key indicator of state financial capacity. For consistency, the data used are drawn from the Kaiser Family Foundation's *State Health Facts*. Later in this report, more complete data are presented from the work of the states themselves. Because the

methodologies used to acquire the data vary, the data can not be used to provide a consistent picture of the differences between the SPG states.

The SPG grantees include some of the nation's richest and poorest states in terms of family income, with more than a $15,000 difference between the highest and lowest state. The percentage of the population under 200 percent FPL varies from lows of 26 percent in Connecticut, Minnesota, and New Hampshire to five states at 40 percent or over (Arkansas, Arizona, Texas, California, and Idaho). The percentage of minorities within the population of the states also varies quite dramatically from the lows of 3 percent in New Hampshire and Vermont to over 33 percent in Texas, California and Arizona. In all three of those border states, the Hispanic population comprises the bulk of the minority population.

Table 1-2. SPG Program Grantee Demographic and Economic Characteristics

FY 2000 Grantees	1997/99 Percent Under 200 percent FPL (%)	1997/99 Percent Minority (%)	Rank 1997/99 Median Family Income	1997/99 Median Family Income ($)
Arkansas	46	21	51	24,998
Delaware	34	30	11	36,458
Illinois	32	29	9	37,550
Iowa	31	7	23	31,889
Kansas	32	16	24	31,868
Massachusetts	31	14	15	34,500
Minnesota	26	11	5	38,449
New Hampshire	26	3	7	37,916
Oregon	36	15	25	31,682
Vermont	32	3	26	31,492
Wisconsin	27	11	14	36,000
FY 2001 Grantees				
Arizona	43	35	46	27,330
California	41	50	33	30,592
Colorado	27	21	13	36,020
Connecticut	26	22	4	40,000
Idaho	40	13	39	29,946
South Dakota	34	8	43	28,450
Texas	42	49	40	29,800
Utah	33	12	8	37,692
Washington	29	12	6	38,006
National Avg.	35	30	N/A	33,154

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Survey. Total US numbers are based on March 2000 estimates, all found at: Kaiser Family Foundation State Health Facts Online, http://www.statehealthfacts.kff.org.

Health Insurance Coverage and the Uninsured

The SPG grantees include states with the highest and lowest rates of uninsured. Coverage patterns vary depending on the state's employer base and public coverage programs. Table 1-3 presents basic information on insurance status for all 20 grantees.

In addition to differences in the rates of uninsured, the twenty states show significant differences in the percentage of the population covered by an employer. The highest rates of employer coverage are New Hampshire, Utah and Wisconsin at 66 percent and the lowest rate of employer coverage is Arkansas at 50 percent, closely followed by Arizona and California at 51 percent. Also of note is the importance of the individual market in Iowa, Kansas and South Dakota, a difference probably associated with agriculture and family owned farms. The differences in public coverage rates reflect the states' economies, rates of employer-based coverage, and most important, policies.

Table 1-3. SPG Program Grantee Population Insurance Status

FY 2000 Grantees	Percent Uninsured 2000 CPS* (%)	Percent 1997/99 Uninsured (%)	Percent 1997/99 Employer Coverage (%)	Percent 1997/99 Individual Coverage (%)	Percent 1997/99 Medicaid Coverage (%)	Percent 1997/99 Medicare Coverage (%)
Arkansas	14.7	19	50	5	12	14
Delaware	11.4	13	60	2	11	13
Illinois	14.1	14	63	4	9	11
Iowa	8.3	10	62	8	7	14
Kansas	12.1	11	60	8	7	14
Massachusetts	10.5	11	59	4	13	12
Minnesota	8.0	9	65	6	10	10
New Hampshire	10.2	11	66	4	8	11
Oregon	14.6	14	58	5	13	10
Vermont	12.3	11	56	6	17	10
Wisconsin	11.0	10	66	5	8	11
FY2001 Grantees						
Arizona	21.2	23	51	5	9	12
California	20.3	21	51	5	13	9
Colorado	16.8	16	65	5	5	9
Connecticut	9.8	11	64	4	7	14
Idaho	19.1	18	56	7	8	11
South Dakota	11.8	13	56	11	8	13
Texas	23.3	24	53	4	10	9
Utah	14.2	14	66	6	6	8
Washington	15.8	13	61	6	11	9
National Avg.	14.0	16	58	5	10	11

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Survey, Total US numbers are based on March 2000 estimates, all found at: Kaiser Family Foundation *State Health Facts Online*, http://www.statehealthfacts.kff.org

*Source: 2000 Current Population Survey.

Health Care Costs, Employer Premiums and Managed Care

The SPG grantees also show different patterns in state per capita health care expenditures and employer spending for health care, as well as in managed care penetration. States with very high managed care penetration rates such as the top three ranked states California (54 percent), Massachusetts (53 percent), and Connecticut (45 percent) are included as well as states with a very small managed care presence like Vermont (5 percent), Iowa and South Dakota (both 7 percent). The SPG states are also diverse in their rankings in state health care expenditures per capita. They include states with expenditures significantly above national averages such as Massachusetts, Connecticut and Delaware, all of whom are in the top ten, as well as four states in the bottom ten rankings, Utah, Idaho, Colorado and Arizona. The average annual cost for an employment-based family coverage policy is one last indicator. Of the 20 states, 11 had an average annual premium cost in 1999 below the national average and 8 were above the national average of $6,058. The information was unavailable for one state. Table 1-4 details the states on these three dimensions.

Table 1-4. SPG Program Grantee Marketplace Characteristics

FY 2000 Grantees	HMO Penetration (Jan 1, 2000)[1]	FY 1999 State Health Care Expenditures per Capita[2]	1999 Average Annual Family Premium Cost for Employment Based Insurance[3]
Arkansas	10%	$943.91	$5,368
Delaware	22%	$1190.57	$5,975
Illinois	21%	$772.42	$6,456
Iowa	7%	$718.69	$5,191
Kansas	18%	$696.64	$5,910
Massachusetts	53%	$1455.21	$6,547
Minnesota	30%	$807.83	$6,218
New Hampshire	34%	$762.35	$6,185
Oregon	41%	$774.18	$5,466
Vermont	5%	$838.67	$6,358
Wisconsin	30%	$766.58	$6,475
FY 2001 Grantees			
Arizona	31%	$666.45	$5,509
California	54%	$779.77	$5,838
Colorado	40%	$575.08	$5,822
Connecticut	45%	$1,201.77	$6,958
Idaho	8%	$545.54	$5,140
South Dakota	7%	$744.48	N/A
Texas	19%	$764.36	$6,209
Utah	35%	$519.23	$5,420
Washington	15%	$954.07	$5,928
National Avg.	28%	$872.62	$6,058

Sources: All facts can be found at Kaiser Family Foundation *State Health Facts Online*, http://www.statehealthfacts.kff.org The original sources are delineated below.

[1]The Interstudy Competitive Edge 11.1, Part II: HMO Industry Report, April 2001. http://www.interstudypublications.com

[2] Expenditures from Milbank Memorial Fund, National Association of State Budget Officers, and The Reforming States Group, 1998-1999 State Health Care Expenditure Report, Copyright 2001, Milbank Memorial Fund, Table 13, p. 23. See www.milbank.org. Population data used to calculate per capita expenditures is from Urban Institute March 2000 CPS, which estimates the US population in 1999, excluding active duty military.

[3] Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 1999 Medical Expenditure Panel Survey - Insurance Component. Tables II.D.1 and II.D.2, and II.D.3

The SPG States' Existing Coverage Programs

Since starting points are critical to determining options and strategies for expanding coverage, Appendix A shows the existing coverage programs of the SPG states. Again, they are a diverse group including many of the states that would be considered leaders in state health reform. A significant number have used Medicaid waivers such as Section 1115 demonstrations to expand coverage and create nationally recognized programs such as:

- Wisconsin's BadgerCare, which serves uninsured children and parents up to 185 percent of FPL
- The Vermont Health Access Plan, which serves previously uninsured non-custodial adults (18-65) up to 150 percent FPL and custodial adults up to 185 percent FPL
- The Oregon Health Plan, which serves uninsured under age 65 up to 100 percent FPL
- Minnesota Care, which serves pregnant women and children under 19 up to 275 percent FPL
- Massachusetts' MassHealth serving the working poor (to 200 percent FPL) with access to employer coverage. Other target populations include low-income children, families and the disabled; low-income long-term unemployed; and pregnant women and infants.

State policies and use of Section 1931 earnings disregards, transitional Medicaid, SCHIP eligibility, state-only coverage programs, state high-risk pools, and state tax incentive programs for the HRSA states are also found in Appendix A. Each of these mechanisms to expand and/or stabilize health insurance coverage has been used by one or more of the SPG grantees.

Challenge of the SPG Timeframe

A theme echoing throughout the state reports is that one year is not adequate to complete the planning process. The states believe this is particularly true because of the extensive quantitative and qualitative research efforts included in their work and the amount of time quality research requires. This report includes appendices detailing the research program by state, including a matrix of the qualitative and quantitative research proposed by each state updated for changes made over the course of the grant (Appendix B). Individual state profiles for each of the 11 FY 2000 grantees on the uninsured (Appendix C) and individual state profiles for each of the 11 FY 2000 grantees on employer based coverage (Appendix D). Although this synthesis report

and its appendices provide significant data, additional detail on the extensive work states have undertaken under the SPG program can be found in the individual state reports.

In addition to the time and complexity of the research effort, most states have been unable to complete the detailed development of options including administration and financing strategies. All of the original 11 states requested extensions to allow them to complete their original work program and contribute to the final report. Seven states also requested and received supplemental funding for additional research, updating their demographic information, completing their selection of alternatives, additional public input, or dissemination of the planning results to stakeholders and the public.

Collaborative State Data Base

In addition to state-specific proposals, HRSA is funding the development of a data base project for the SPG grant states to allow the states to use state surveys, national data resources, and other state data more effectively in the planning process. As a part of its SPG activities, Arkansas developed a prototype online data base that allowed it to use its data resources more effectively and gave policy makers immediate access to data. As a result, Arkansas will lead a collaborative effort with other SPG states and the State Health Access Data Assistance Center to develop a multi-state data base system.

SPG States Caught in a Changing Environment

The amount of change the 20 SPG grantees have seen during their planning process is unprecedented. The slowing economy that worried many of the states became a more acute issue with the national tragedy of the September 11 terrorist attacks. The final scope of national and individual state implications for these events is still unknown, but the economic implications for states include, at a minimum, falling state revenues and increased public assistance caseloads. In addition to the human and economic losses, the national, state and local governments are facing new and unexpected costs for a war on terror, including bioterrorism. Many states have turned their focus toward maintaining coverage and/or making the best use of their current state resources for health coverage. Most of the HRSA SPG states believe that recommendations to expand coverage that require additional state resources cannot be implemented without an economic recovery or a greater role by the federal government in financing or providing incentives for the purchase of health care services.

Organization of this Report

This report is based on the individual reports of the SPG grantees. The template that the states used for reporting has been included as Appendix E. The template was based on the questions identified by the states themselves in their grant applications and created a general guide for their report to the Secretary of Health and Human Services. This report includes six chapters in addition to the Executive Summary and Overview.

- Chapter 1 is an overview of the program and states.
- Chapter 2 covers the diagnostic work of the states including the quantitative and qualitative research.
- Chapter 3 includes the health care marketplace and related issues.
- Chapter 4 covers the consensus-building strategies used by the states.
- Chapter 5 includes the options developed and under consideration by the states.
- Chapter 6 includes the lessons learned by the states and recommendations to other states.
- Chapter 7, the final chapter, covers the recommendations to the federal government and the Secretary of HHS.

CHAPTER 2

THE DIAGNOSTIC WORK OF THE PLANNING STATES

The HRSA State Planning Grant program provided financial support for state data collection activities to support the development and implementation of policies to expand health insurance coverage. A central aim of the HRSA program was to assist states in identifying their uninsured populations at a level of detail that would allow them to target their coverage expansion efforts more effectively. Existing federal surveys such as the Current Population Survey (CPS) were not designed to provide reliable state-level estimates and the level of detail needed for program design. Consequently, state policy makers have often had limited information upon which to assess the uninsured problem and to design appropriate solutions. State policy makers are also reluctant to accept the national data as an adequate underpinning for the state policy process. State data, with its responsiveness and specificity, often created insights and understandings about the uninsured that dispelled myths. One such myth is that the uninsured are either out of the workforce or in a short-term workforce transition. It is not that state data were always fundamentally different than national data, but that they were specific to the state, more detailed and descriptive, and, as a result, more convincing.

Through the SPG program, the federal government provided financial support for grantee states to conduct surveys of individual households and employers, and to hold focus groups and interviews with state citizens. Through quantitative and qualitative research, states were able to gain more detailed information on the characteristics of the uninsured, including variations by geographic location, ethnic group, employer size, and other characteristics. The grantees gained a better understanding of who is uninsured in the state and the practices and characteristics of their employer community. They also could explore why people were uninsured, what coverage options consumers and stakeholders would be willing to support, who would be willing to sell them, and what type of government assistance might be required to make them affordable to the consumer and acceptable to other key stakeholders. This information assisted the grantee states in designing and evaluating their coverage expansion options.

Chapter 2 provides an overview of the state data-collection activities and highlights the key findings. The chapter provides a synthesis of these activities and their findings, including both the qualitative and quantitative work. There is more specific quantitative detail on each of the 11 FY 2000 grantee states in the Appendices.

The chapter is organized into five sections. Section 1 includes an overview of the state data-collection activities, highlighting the main approach used to obtain information. Section 2 provides a description of the key quantitative findings focusing on the uninsured and their families, followed by Section 3, containing a discussion of the qualitative research on individuals and families. Section 4 contains the key findings related to employer-based coverage and Section 5 concludes with the qualitative

research on employer choice and incentives that might prompt employers to offer coverage. To provide a cross-state comparison, we include results from two national surveys on uninsurance rates using CPS and employer-based coverage rates using MEPS-IC.

Section 1: Overview of State Data-Collection Activities

The SPG grants allowed states a unique and invaluable opportunity to collect in-depth state and local-level data on the uninsured that is not currently available from national surveys. Table 2-1 provides an overview of all the data-collection activities undertaken by the first 11 state grantees. Most states used a multi-method data collection strategy combining core household and employer surveys with focus group, key informant interviews, and other opinion-generating mechanisms. For six states, HRSA funds were used to augment current state data-collection activities. In Minnesota, SPG funds were used to increase the sample for certain population groups for an existing state survey to allow estimates of coverage for rural/urban regions of the state, and by race/ethnicity. Wisconsin used its SPG funds to support a redesign of their ongoing annual household survey, which has been conducted since 1989. They also purchased additional sample cases to add new questions and report findings from the revised survey. All states chose to collect information from both citizens and employers.

Table 2-1. Overview of SPG-funded Data-Collection Activities

State	Household Survey	Individual Focus Groups	Employer Survey	Employer Focus Groups
Arkansas	•	•	•	•
Delaware		•	•	•
Illinois	•	•		•
Iowa	•	•	•	•
Kansas	•			•
Massachusetts	•		•	
Minnesota	•	•	•	
New Hampshire	•	•	•	•
Oregon	•	•		•
Vermont	•	•		•
Wisconsin	•	•	•	•

All but one of the 11 FY 2000 state grantees conducted a household survey. For four of these states, it was their first time conducting a household survey of health coverage. Without a state-specific survey, states must rely on national data sources. The most commonly used national survey for state estimates of health coverage is the Census Bureau's Current Population Survey (CPS). Although the CPS provides state estimates of insurance coverage rates, it does not provide the level of detail needed to make informed state health policy decisions. The decision of nearly all FY 2000 grantees to

conduct household surveys was based on the need for more state-specific information about health insurance coverage. For example, many states would like to know how health insurance coverage varies by race or geographic area. States are also interested in learning more about the dynamics of health insurance coverage and the attitudes of the uninsured toward health insurance coverage.

Description of State Household Surveys

Table 2-2 summarizes the variety of approaches used by state grantees for their household surveys. All of the states used telephone surveys to collect the data. One state also used in-person surveys to reach certain individuals. The sample size of the surveys varied from approximately 1,500 (Iowa) to 27,310 (Minnesota) individuals. Response rates ranged from 39 percent (Oregon) to 68 percent (Vermont). Several of the states employed sample designs that would allow them to obtain estimates of health coverage by region or county. Some states over-sampled in low-income areas and/or areas with a high proportion of citizens from certain racial and ethnic groups. A majority of grantees hired survey researchers from their state university to collect the data, while a few hired national survey research firms.

Table 2-2. Summary of State Household Surveys

State	Year	Methodology	Sample Size	Sample Design	Response Rate	Vendor(s)	Agency Overseeing Survey	Budget and Funding Source(s)
Arkansas	2001	Telephone	2,572 households; (6,596 individuals)	Stratified statewide RDD[1] sampling design; 75 counties were stratified into three regions (Delta, Mountain, and Other); over-sampled in Delta and Mountain regions	62%	Center for Survey Research (CSR), University of Massachusetts	Arkansas Center for Health Improvement (ACHI)	$270,000; HRSA State Planning Grant
Illinois	2001	Telephone	25,735 individuals	Disproportionate stratified random sample with five strata: Northwestern Illinois, Central Illinois, Southern Illinois, Cook County	52%	University of Illinois-Chicago, Health Research and Policy Centers (HRPC) and the Survey Research Laboratory (SRL)	Illinois Department of Insurance	Budget not available; HRSA State Planning Grant
Iowa[2]	2001	Telephone	1,500 uninsured	RDD with oversampling in lower income areas	Not available	The Lewin Group and Baselice and Associates	Iowa Department of Public Health	$200,000; HRSA State Planning Grant
Kansas	2001	Telephone	8,004 households; (22,691 individuals)	Stratified random sample with over-sampling of Hispanics, Blacks, and Low-income	Not Available	University of Florida	University of Kansas	$359,100; HRSA State Planning Grant
Massachusetts	2000	Telephone	2,632 households (7,069 individuals); Urban over-sample of another 2,132 households (5,535 individuals)	RDD stratified by regions; RDD for select urban areas	62% statewide; 63% over-sample	Center for Survey Research (CSR), University of Massachusetts	Massachusetts Division of Health Care Finance and Policy (DHCFP)	$450,000; HRSA State Planning Grant and Division of Health Care Finance and Policy

[1] RDD stands for random digit dial.
[2] See Appendix C for information on additional survey activity

State	Year	Methodology	Sample Size	Sample Design	Response Rate	Vendor(s)	Agency Overseeing Survey	Budget and Funding Source(s)
Minnesota	2001	Telephone and in-person	27,310 individuals for telephone; 2,085 individuals for in-person	Stratified random sample, stratified by geography for telephone; Clustered random sample, clustered by geography for in-person	65% telephone; in-person survey is still in the field	University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Survey Research Center	Minnesota Department of Health, Health Economics Program	$785,379 for telephone; $193,680 for in-person; HRSA State Planning Grant
New Hampshire	2001	Telephone	5,700 families	Proportional sample: 1,000 uninsured and 4,700 insured	73%	Health Economics Research, RKM Research and Communications, University of New Hampshire	NH Department of Health and Human Services	$350,000; HRSA State Planning Grant
Oregon	2001	Telephone	709 households	Simple random sample	39%	Survey Research Laboratory, Portland State University Portland, Oregon	HRSA State Planning Grant Team	$25,000; HRSA State Planning Grant
Vermont	2000	Telephone	8,623 households (22,258 individuals)	Disproportionate random sampling aimed at meeting precision targets at the state, county and subpopulation levels	68%	Market Decisions, Inc as survey contractor; Mathematica Policy Research, Inc. for technical assistance	Banking, Insurance, Securities and Health Care Administration (BISHCA)	$200,000; HRSA State Planning Grant; $50,000; Office of Vermont Health Access; $50,000; BISHCA:
Wisconsin	2001	Telephone	2,436 households (6,368 individuals)	Disproportionate random sample, stratified by five health regions. Oversampled telephone prefixes in City of Milwaukee known to have higher-than-average concentrations of black households.	66%	University of Wisconsin Survey Center	Wisconsin Department of Health and Family Services	$133,470; HRSA State Planning Grant and state funds (Jan-June 2001)

Description of Individual Focus Groups

Many states chose to complement their household surveys with focus groups of state citizens. The reasons states chose to use focus groups included:

- Putting a face or human dimension on the issues.
- Listing options and preferences.
- Explaining the factors, such as affordability, considered in complex decision making on insurance.
- Understanding values and attitudes of different groups about insurance.

The qualitative information generated by these focus groups was often used to provide a context for the quantitative findings of the states' household surveys. Although focus groups were the primary qualitative research tool, states did use other methods of collecting qualitative information, such as key informant interviews.

Table 2-3 provides a description of the individual-level focus groups states conducted. The use of focus groups varied dramatically across states with some conducting only a few (Vermont) while others conducted over 20 (Minnesota, Arkansas). The target population for most of the focus groups was uninsured, low-income individuals. Arkansas also targeted low-income, insured individuals who were at-risk for losing their health coverage. States were interested in learning more about what barriers to health insurance people face, how people make decisions about obtaining coverage, and what people's opinions were of different strategies to increase coverage in the state. The majority of states contracted with their local university, while a few contracted with consultants.

Table 2-3. Summary of State Individual Focus Groups

State	Purpose of Focus Groups	Target Populations	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Focus Groups	Budget and Funding Source(s)
Arkansas	To understand circumstances influencing adults' rationale when making decisions regarding health insurance	Geographically diverse participants, including the uninsured and insured with incomes > and < 200% FPL, rural farmers, African Americans, and Hispanics.	Participants recruited by community based organizations across the state via posted notices and phone using screener form to identify eligible participants	26	8-10	Arkansas Advocates for Children and Families (AACF) & University of Arkansas at Pine Bluff (UAPB)	Arkansas Center for Health Improvement (ACHI)	$60,000 to AACF and $20,000 to UAPB; HRSA State Planning Grant
Illinois	To provide texture and nuance to the quantitative findings and literature reviews	Health care providers, insurance representatives, health and social service agents, local government representatives, and the uninsured	Not available	19	4-6	Southern Illinois University at Carbondale (SIUC) in conjunction with Program Evaluation for Education and Communities (PEEC)	Illinois Department of Insurance	Budget not available; HRSA State Planning Grant
Iowa	To understand the reasons why individuals are uninsured and what alternatives for health coverage may be appealing to them	Uninsured individuals (including 3 groups targeting Hispanics)	Offered a meal and snacks, as well as a stipend of $65 (or more)	12	8-10	Personal Marketing Research, Inc. and American Public Opinion Survey & Market Research Corporation	Iowa Department of Health	Budget not available; HRSA State Planning Grant

State	Purpose of Focus Groups	Target Populations	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Focus Groups	Budget and Funding Source(s)
Minnesota	To identify barriers to medical care and health insurance coverage in the private and public sectors	Farmers, American Indians, Hispanics/Latinos, Hmong, and Somali individuals	Community leaders were used to recruit participants. Participants were paid $25. Childcare and transportation were also provided.	22	6-8	University of Minnesota Crookston, Center for Cross-Cultural Health; University of Minnesota Twin Cities, HACER (Hispanic Advocacy and Community Empowerment through Research)	Minnesota Department of Health, Health Economics Program	$148,533; HRSA State Planning Grant
New Hampshire	To provide context for the quantitative analyses and address specific models and implementation	Uninsured individuals, parents of children eligible but not enrolled in SCHIP, and uninsured individuals who use safety net providers	Used a screening tool to identify desired demographics, a subset of whom were identified via the Community Health Centers. All participants were under age 65, had household incomes below 250% of the FPL, and had no health insurance coverage.	9	8	Strategic Opinion Research	New Hampshire Department of Health and Human Services	$65,000; HRSA State Planning Grant
Oregon	To discuss current options, what are adequate benefits, affordability, etc.	Low-income, uninsured individuals	Purposeful - informal social networks, professional contacts	10	9	Department of Anthropology, Oregon State University, Corvallis, OR	HRSA State Planning Team	$40,345 (for all focus groups including 8 uninsured, 6 employer groups, 4 provider groups); HRSA State Planning Grant

State	Purpose of Focus Groups	Target Populations	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Focus Groups	Budget and Funding Source(s)
Vermont	To understand the various reasons that the uninsured are without health insurance, and to obtain their views on opportunities to expand health insurance in the state	Low-income, uninsured individuals	The Vermont Coalition of Clinics for the Uninsured recruited participants; participants were offered stipends of $30	2	8	Action Research, and The Lewin Group, Inc.	Office of Vermont Health Access (OVHA)	$225,000 (includes focus groups of employers, insurance providers, medical care providers, workgroups and in-depth interviews); HRSA State Planning Grant
Wisconsin	To explore workers' perceptions about obtaining health insurance through their workplace; To study health insurance coverage where access to health insurance may be restricted due to language or other cultural barriers; To explore young adults' decision making about health coverage	Uninsured low-wage workers in small firms; minority racial and ethnic groups; and uninsured 18-24 year olds	Used the QPL program (developed by GAO and modified by IHPS) as a screening tool to recruit low-wage workers. Recruitment for Latino, Hmong and African American focus group participants was not random, in most cases, the participants knew their recruiter. Representatives from medical centers, community groups, churches, and community leaders assisted in the recruitment process.	11	8-10	Employee focus groups were done by the Institute for Health Policy Solutions, subcontracting with Consumer Pulse in Milwaukee and Delve in Appleton. Latino, Hmong, African-American, and 18-24 year old focus groups were carried out under a memorandum of agreement between the Wisconsin Department of Health and Family Services and the Dane County Department of Human Services.	Wisconsin Department of Health and Family Services	$109,490 for both the low-wage worker groups and employer groups (see Table 2-5); HRSA State Planning Grant $21,000 for the minority and 18-24 year old groups; HRSA State Planning Grant and the United Way of Dane County

State	Purpose of Focus Groups	Target Populations	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Focus Groups	Budget and Funding Source(s)
			Participants were offered stipends of $25 and child care was provided. Recruitment of 18-24 year olds was conducted by phone and mail. Madison area hospitals also recruited patients to participate. A stipend of $50 was provided to participants.					

Description of State Employer Surveys

Four states conducted employer focus groups and an employer survey, two states conducted an employer survey only, and five states opted to conduct employer focus groups only. It is notable that six of the states undertook the arduous task of conducting an employer survey. Employer surveys are difficult to design and administer. Often it is difficult to locate the appropriate person to interview. Once the respondent is identified, it may be difficult to reach the person, particularly if there is an administrative assistant who acts as a gatekeeper. In addition, questions about employee benefits are complex and may require the respondent to check company files. This respondent burden may take time and act as a disincentive for participation.

Many states rely on state estimates of employer coverage from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC). This survey is conducted by the Census Bureau and sponsored by the Agency for Healthcare Research and Quality (AHRQ) of the Department of Health and Human Services. It collects information on employer-provided health insurance and publishes state-specific estimates.[3] Tables of results are made available on the AHRQ MEPS Web site. However, there are some limitations to the usefulness of these MEPS-IC data for state-specific policy work. The data collected in the MEPS-IC may not be aligned with the interests of state policy makers. In addition, the sample sizes may not be large enough for some state analyses. Furthermore, there is a cumbersome process for states that want to do their own analyses due to confidentiality constraints on the availability of micro level data.

Table 2-4 provides an overview of the state grantees' employer surveys. All of the states used telephone surveys to collect the data with the exception of one state that used a mail survey. The sample size of the surveys varied from approximately 400 (Iowa) to 5,000 (New Hampshire). Some of the states only surveyed small businesses (i.e., less than 50 employees), while other states attempted to get a representative sample of different size firms and/or different regions of the state. Most of the states contracted with their local university to collect the data and a few worked with consultants. At least two of the states have not yet completed their employer surveys. Two states (Arkansas and Wisconsin) chose to spend their budget on increasing their state's sample size for the MEPS-IC, rather than conduct their own state survey.

[3] Small states are rotated in and out of the MEPS-IC sample each year. North and South Dakota have not yet been included.

Table 2-4. Summary of State Employer Surveys

State	Year	Methodology	Sample Size	Sample Design	Types of Employers Surveyed	Response Rate	Vendor(s)	Agency Overseeing Survey
Arkansas	2001	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	1,800[4]	Stratified nationally representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate and large business establishments and governments	70%	Agency for Healthcare Research and Quality (AHRQ), conducted by the US Census Bureau	Arkansas Center for Health Improvement (ACHI)
Delaware	2001	Mail	1,600	Stratified by number of employees	Small businesses (less than 50 employees) that do and do not currently offer health coverage	45%	University of Delaware, Center for Applied Demography and Survey Research, and the Institute for Public Administration	Delaware Health Care Commission
Iowa[5]	2001	Telephone	Approx. 400	The American Business Directory and other databases were used for the sampling frame; stratified into four geographic regions	All private businesses (non-government) with at least one employee	Not available	The Lewin Group, Baselice and Associates, and the State Public Policy Group and the Selzer Company	Iowa Department of Health

[4] Arkansas plans to use the 2001 MEPS-IC for data on employers. Arkansas increased the MEPTS-IC standard sample size of 800 Arkansas employers to 1,800
[5] See Appendix D for information on additional survey activity.

State	Year	Methodology	Sample Size	Sample Design	Types of Employers Surveyed	Response Rate	Vendor(s)	Agency Overseeing Survey
Massachusetts	2001	Telephone with mail follow-up to non-responders; premium tables could be filled out separately by fax	1,000-1,200	Sample stratified by size of employer (2-49, 50-149, 150-249, 250+)	All non-government employers (this includes schools and libraries) with at least two employees	Survey not completed yet; rate not known	Center for Survey Research at the University of Massachusetts, Boston	Division of Health Care Finance and Policy
Minnesota	2001	Telephone	2,400	Stratified random sample, stratified by employer size, geographic region, and single or multi-establishment firm	All non-government employers with at least one employee	The employer survey has not yet gone into the field	University of Minnesota, School of Public Health, Division of Health Services Research and Policy, Survey Research Center	Minnesota Department of Health, Health Economics Program
New Hampshire	2001	Telephone	4,800	Random sample	Self-employed; Single site, headquarter, franchise and branch locations; Education and government industries were excluded	66%	Health Economics Research and RKM Research and Communications	New Hampshire Department of Health and Human Services

State	Year	Methodology	Sample Size	Sample Design	Types of Employers Surveyed	Response Rate	Vendor(s)	Agency Overseeing Survey
Wisconsin	2001	Pre-screening interview, followed by mail survey with telephone follow-up for non-responders	1,600[6]	Stratified nationally representative sample of business establishments and governments derived from lists maintained by the US Census Bureau	Small, moderate and large business establishments and governments	70%	Agency for Healthcare Research and Quality (AHRQ), conducted by the US Census Bureau	Wisconsin Department of Health and Family Services

[6] Wisconsin plans to use the 2001 MEPS-IC for data on employers.

Description of State Employer Focus Groups

Table 2-5 provides a description of the state employer focus groups. The number of employer focus groups conducted by the states varied from 2 (Delaware) to 16 (Vermont). The target population for several of the focus groups was small business owners. Examples of other types of employers who were recruited to participate in the states' employer focus groups include: employers from mid-size to large firms, those who hire seasonal workers, and those who do not offer health benefits to their employees. States were more likely to hire professional consultants to conduct the employer focus groups than university-based research centers. States conducted employer focus groups to learn more about how employers make decisions about offering coverage and what their opinions were of different state programs and policy options for expanding coverage.

Table 2-5. Summary of State Employer Focus Groups

State	Purpose of Focus Groups	Types of Employers Participating	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Data Collection	Budget and Funding Source
Arkansas	To understand circumstances influencing employers' rationale when making decisions regarding employer sponsored health insurance	Small- to moderate-sized employers (included one health insurance broker group)	Participants were recruited by the Arkansas Center for Health Improvement, the Arkansas Farm Bureau and the Arkansas Chapter of the National Federation of Independent Business (NFIB)	7	7-10	State Planning Grant staff conducted all employer focus groups	Arkansas Center for Health Improvement, Arkansas State Planning Grant Roundtable, Arkansas Department of Health	$30,000; HRSA State Planning Grant
Delaware	To understand the hardships of employers, what would motivate them to offer coverage, and to obtain employers' reactions to different strategies to increase coverage	Firms with less than 50 employees who do not offer coverage, or did not within the past two years	State and local Chambers provided members who fit eligibility criteria based on firm size; vendor completed recruitment calls	2	4-6	Health Management Associates	Delaware Health Care Commission	Focus groups factored as expense within an overall $395,000 health policy consulting agreement; HRSA State Planning Grant

State	Purpose of Focus Groups	Types of Employers Participating	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Data Collection	Budget and Funding Source
Illinois	To provide texture and nuance to the quantitative findings and literature reviews	Businesses who do and do not offer health coverage	Not available	8	5-6	Southern Illinois University at Carbondale (SIUC) in conjunction with Program Evaluation for Education and Communities (PEEC)	Illinois Department of Insurance	Not available; HRSA State Planning Grant
Iowa	To identify factors that influence employers' decisions to offer or not to offer health insurance to employees and to understand from the perspective of employers what options are the most appealing for increasing affordable coverage in the state	Attempted to get geographic representation; organized groups by specific employer types (e.g., mid-size employers that offer insurance, small employers not offering insurance, and self-employed workers)	Offered a meal and snacks, as well as a stipend of $90 (or more)	12	8-10	Personal Marketing Research, Inc. and American Public Opinion Survey & Market Research Corporation	Iowa Department of Health	Not available; HRSA State Planning Grant
Kansas	To determine what would motivate small employers to offer coverage, what barriers they face, and what actions by the state would be of assistance.	Small employers (less than 50 employees)	Used state and local business associations and Steering Committee member contacts	8	Not available	Michael Bailitt, Wellesley, MA	Kansas Insurance Department	$60,900; HRSA State Planning Grant

State	Purpose of Focus Groups	Types of Employers Participating	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Data Collection	Budget and Funding Source
New Hampshire	To provide context to information collected in the employer survey and to ask about specific program and policy models	Large employers, large seasonal employers, small employers (<50 employees) and a large number of "micro" employers (<10 employees)	Chambers of Commerce	8	10	Institute for Health, Law & Ethics, Franklin Pierce Law Center; Facilitator: Capitol Health Strategies	New Hampshire Department of Health and Human Services	$37,000; HRSA State Planning Grant
Oregon	To investigate why employers do or do not offer coverage, employer trends, and interest in state expansion programs, etc	Small employers (Fewer than 25 employees)	Purposeful	6	5-6	Department of Anthropology, Oregon State University	HRSA State Planning Team	$40,345; HRSA State Planning Grant
Vermont	To identify the factors that influence employers' decisions about whether to offer health insurance, and to obtain employers' ideas regarding possible ways to expand health insurance coverage	Employers who do not offer insurance (all sizes); Employers who do offer insurance including small firms (1-9 employees), medium firms (10-50 employees), and large firms (51+ employees)	High-level employees responsible for the administration of employee benefits (frequently the owner, president, vice-president or human resources director) were recruited to participate; all participants were offered a $100 stipend	16	8-12	Action Research and The Lewin Group	Office of Vermont Health Access (OVHA)	$225,000 (includes focus groups of employers, insurance providers, medical care providers, workgroups and in-depth interviews); HRSA State Planning Grant

State	Purpose of Focus Groups	Types of Employers Participating	Participant Recruitment Process	Number of Groups	Number of Participants per Group	Vendor(s)	Agency Overseeing Data Collection	Budget and Funding Source
Wisconsin	To assess small employer attitudes toward health care coverage, and to explore the likelihood of employers who do not offer coverage being influenced by the development of purchasing alliances, individual or employer subsidies/tax incentives or an economic downturn	Employers having between 2 and 50 employees, that did and did not offer health insurance, that have at least 2 full-time employees, and that have at least one full-time employee earning less than $10 per hour	Relied upon professional consultants to assist with recruiting: Mazur-Zachow of Brookfield, WI, Lien-Spiegelhoff also of Brookfield, and Delve of Appleton, WI. The Wisconsin Chapter of the National Federation of Independent Business and the Wisconsin Department of Workforce Development also provided recruiting assistance.	9	7	Institute for Health Policy Solutions	Wisconsin Department of Health and Family Services	$109,490 for both the employer groups and the low-wage worker groups (see Table 2-3); HRSA State Planning Grant

While surveys and focus groups account for most of the data collection activities of the state grantees, some states collected additional information through key informant interviews (AR, IL, KS, VT, WI), regional policy forums (IA, OR, WI), opinion surveys (IA), smaller surveys of select groups (MA, MN, OR, WI) and in-depth interviews with individuals from specific populations (DE, KS, WI).

Summary of States' Data-Collection Experiences

States enlisted a number of different methodologies in their efforts to describe the status of uninsurance among individuals and families as well as the extent of employer-based coverage. State-initiated surveys allowed states to develop reliable and accurate estimates of the number of uninsured as baseline data to inform decisions, to respond to policy makers' questions, and to monitor changes over time. State surveys in general had larger sample sizes than most national surveys allowing states to develop estimates of important subpopulations. Such information allows better targeting of new policy and access expansion options. This level of detail at the state level is not available in the CPS or other national surveys.

States also used a variety of sources of data on employer-based coverage. Many relied on MEPS-IC. The states that pursued primary data collection with employers are still working on design and implementation. Massachusetts is currently completing data collection and analysis. State-level data have allowed and will allow states to examine their own employer behavior in developing state options. The data will also provide the added benefit of serving as a baseline for any future assessment of employer-based coverage. In spite of varied data collection methods, state findings about employer sponsored coverage are generally consistent with national findings.

Section 2: Uninsured Individuals and Families in SPG States

The estimates of health insurance coverage rates derived from the individual state surveys cannot be compared across states because states used different methodologies to collect their data. To provide a context for rates of coverage across states, this report includes a table of state estimates of uninsurance from the Current Population Survey (Table 2-6). Specific profiles of the SPG states are included in Appendix B.

The uninsurance rates among the 11 FY 2000 states vary from 8.2 percent in Minnesota and Iowa to 15.3 percent in Arkansas. The national rate of uninsurance during this same time period was 14.4 percent. A review of the states' reports demonstrated that of those states that utilized a state survey to estimate the number of uninsured, overall rates were consistently lower than the CPS. Nonetheless, as was the case using the CPS data, Arkansas, Oregon, and Delaware were among the states with the highest uninsurance rates while Massachusetts, Minnesota, and Wisconsin evinced the lowest rates based on their state surveys.

Table 2-6. CPS Estimates of Rates of Uninsurance

State	CPS Estimate 1998-2000 3-year average *	Standard Error
United States	14.4%	0.1
Arkansas	15.3%	0.5
Delaware	11.2%	0.5
Illinois	13.3%	0.3
Iowa	8.2%	0.4
Kansas	11.0%	0.5
Massachusetts	9.2%	0.3
Minnesota	8.2%	0.4
New Hampshire	8.6%	0.5
Oregon	13.7%	0.5
Vermont	10.3%	0.5
Wisconsin	9.3%	0.4

Source: *1999-2001 CPS March Supplements*

* CPS estimate is based on whether the individual had coverage anytime during the year.

Quantitative Research Findings from the States: Uninsured Individuals & Families

In addition to providing overall insurance rates, states were asked to identify the population groupings that were particularly important when developing targeted coverage expansion options for the uninsured. In responding to the query, most states used surveys conducted in their state with the support of the HRSA SPG funding. Many states took specific steps to over-sample population groups that have historically contained the greatest percentages of uninsured individuals--a specific benefit state-sponsored surveys afford. As a result, states obtained access to a depth of information on important subgroups that federal surveys often do not provide. The following is an overview of some of the state-specific findings pertaining to key population groupings.

Many of the Uninsured are Above the Poverty Line: Not surprisingly, all of the SPG states found that low-income citizens have uninsurance rates disproportionately higher than their moderate- and upper-income counterparts. At least two states (Massachusetts and Oregon) found particularly high rates of uninsurance among moderate-income citizens who utilize health care safety net services, however. Delaware also found that many of their uninsured were well over the federal poverty line.

Uninsured Rates for Young Adults are Higher Regardless of Income*:* Vermont offers a cautionary note suggesting that a focus on income level solely may be overly simplistic

and might possibly lead to misplacement of effort. Vermont analysts encourage states to better understand how income interacts with age when formulating and evaluating coverage options because of their observation that regardless of income level, younger adults are more likely to be uninsured than older adults. In fact, Vermont found that higher-income adults age 18-29 years are about as likely to be uninsured as lower-income adults who are older. As a result, Vermont, and several other states (Illinois, Kansas, Minnesota, and Wisconsin) intend to develop coverage options geared toward young uninsured adults as well.

More Adults than Children are Uninsured*:* Many states found that there were many more uninsured adults than children, a finding that at least partially reflects the success of the states in insuring children and programs such as the State Children's Health Insurance Program (SCHIP). This finding was particularly troublesome for New Hampshire and Kansas, who indicated that many of their coverage programs currently focus on enrolling children. Few programs center on adults with or without children and federal funding is more difficult for states to obtain for adults, especially single adults. To address this, New Hampshire, Kansas and several other states (Delaware, Illinois, Massachusetts, Oregon, and Wisconsin) are considering options to expand coverage to adults with children as a mechanism to increase insurance rates of both. Arkansas' proposed option would expand this coverage through a SCHIP waiver to income qualifying employed adults and their spouses, regardless of their parental status.

Many Uninsured are Eligible for Coverage: Most states found that many of the uninsured have access to coverage either through their employer or through a public program. Seven of the eleven SPG states (Delaware, Illinois, Iowa, Massachusetts, New Hampshire, Oregon, and Wisconsin) identified uninsured workers, especially part-time employees and those employed in small firms as a primary focus of their coverage expansion efforts. States are considering a range of options geared at increasing employer-based coverage including different forms of private-public partnerships. Deeper analysis of the issue such as that undertaken by Delaware suggests that, although many of the uninsured are employed, the types of jobs they have and their marital status (often single) may complicate designing programs.

Other Target Populations*:* Other population groupings that have been focused on include: populations of color (Illinois, Kansas, Massachusetts, Minnesota, Oregon, and Wisconsin); geography – both rural areas (Arkansas, Delaware, Minnesota, and New Hampshire) and urban areas (Massachusetts); farmers (Minnesota and Wisconsin); and those who experience temporarily breaks in coverage (Oregon).

More complete descriptions of variations in coverage rates among population groupings in the SPG states are provided in the state-by-state uninsurance profiles in Appendix B.

Section 3: Qualitative Research Findings from the States on Individuals and Families

States enriched the household survey information with qualitative methods such as focus groups to try to more fully understand decisions that the uninsured make about coverage. Issues studied included why people do not take public or employer insurance for which they are eligible, what is affordable for low-income uninsured and where people actually obtain care when they do not have insurance. This work increased states' understanding of the problem by illuminating attitudes of the uninsured and others and what would be effective in programs designed to cover specific populations.

Qualitative Research on the Failure to Enroll When Eligible

Policy makers and advocates have been frustrated when their efforts to create health insurance options go unnoticed. By examining the factors involved in making an insurance decision, the states attempted to understand the reasons that individuals do not enroll in public programs or take up employer-sponsored insurance.

Failure to Enroll in Public Programs: For those individuals who are eligible, but did not enroll, the states found that these individuals were:

- Unaware of the existence of public programs or misunderstood eligibility guidelines. Minnesota found that 42 percent of those who were eligible, but not enrolled had no knowledge of public health insurance programs in the state. Immigrants and others less likely to be reached by outreach efforts were particularly unaware of their options.
- Frustrated by the administrative and bureaucratic burden of enrolling in a public program and a process felt to be overly invasive. Many respondents indicated that they could not get the time off from work in order to enroll. Some ethnic groups in Illinois did not feel culturally comfortable answering particular questions to determine eligibility for public assistance. Many immigrants were unclear as to what paperwork was required and whether applying for the program would jeopardize their citizenship status.
- Bothered by the stigma they felt was attached to participation in a public program. Some felt that they were freeloading by participating. Many individuals cited poor treatment in past experiences with public programs. Though not widely cited, the perception of limited access to providers caused some not to enroll.
- Convinced that they did not need insurance. Many 18-24 year olds and singles felt that they were in good enough health that insurance was unnecessary. Some populations, such as Native Americans, believed that they were entitled to health services because of treaties between their tribes and the U.S. government and did not feel that they needed insurance.

Why People Leave Public Programs: The states reported that those individuals who enrolled but consequently left public programs were:

- No longer eligible. By crossing either an income or age eligibility threshold, they lost eligibility. Single mothers, in particular, lost eligibility when they became employed. Both Oregon and Iowa pointed out that the way in which income was determined often caused certain populations, such as seasonal workers and those whose income fluctuates throughout a year, to become ineligible.
- Unable to pay the premiums. Some of those who did not pay, however, indicated that it was out of frustration with the system, instead of a financial inability. These respondents pointed out that they did not view this behavior as a risk because they would still be able to receive care, if needed, while uninsured.
- Covered by alternate plan.

Failure to Enroll in Employer-Sponsored Insurance: Individuals cited a variety of reasons for not participating in employer-sponsored insurance. These employees:

- Were not eligible for their employer's plan, because they did not work the minimum number of hours.
- Could not afford the premiums and other cost-sharing involved. Many employees could pay for their own cost-sharing, but not the amount required to insure family members. Idaho found that some individuals chose to keep the money that would go towards a premium, since they would not be able to pay the high deductible. Other individuals had previously incurred large debts from being uninsured and could not afford to put more money towards health care costs.
- Were frustrated by the administrative burden of enrolling.
- Felt that since they were already in good health, insurance against health risks was "not a good bet." The 18-24 year old population indicated that unless the loss from not being insured was "in [their] face," they would not take up employer-sponsored insurance if the employer paid for less than 100 percent of the premiums.
- Had pre-existing conditions that they thought would make them ineligible for insurance. Many individuals were unaware of their HIPAA protections. Some employees were informally discouraged in the workplace by other employees who felt that their participation would drive up costs for the rest of the group.
- Preferred the stability of the public programs, since they often changed jobs.

Qualitative Research on Insurance Costs and Other Barriers

Affordability: Since cost is overwhelmingly the greatest barrier for the uninsured in accessing health insurance, understanding what is affordable for the low-income uninsured is critical. The majority of states used their focus group data to address this issue. As a baseline, they looked to the current literature that indicates between 3-5 percent of disposable income is used for health insurance.[7] Despite the fact that, as one state mentioned, "there is no easily drawn line that divides [those] groups that can afford coverage and groups that cannot," states found an overall willingness on the part

[7] Urban Institute and U.S. Bureau of Labor Statistics Consumer Expenditure Survey

of the uninsured to pay something for their coverage. State assessments of affordability of coverage and willingness to pay also demonstrated similarities.

- The threshold for individual premiums across the states peaked at $100 per month. This reflects the difference between very low-wage earners and part-time employees that may only be able to afford premiums of $10 to $30 per month while others in higher-income brackets can pay between $50 and $85 per month.
- When looking at affordable family coverage, respondents indicated that a reasonable premium would cost between $100 and $150 per month for a comprehensive policy without additional cost-sharing.
- Several states found that monthly premium payments based on income were popular.
- In general, as monthly premiums increased, the proportion of those willing to enroll decreased.

Incentives to Purchase Insurance: States also looked at what incentives might be most effective. When evaluating subsidies and tax credits, a few states felt that these incentives should be targeted to maximize effectiveness.

Subsidies were felt to be especially appropriate for the low-income consumer.

- Although the level of subsidies was not specifically defined by the states, given the findings on affordability and willingness to pay, focus group results indicate that subsidies would have to be set at a relatively high level to ensure that individuals and families with low incomes have access to a plan.
- Two states, Wisconsin and Vermont, found their focus group participants less inclined to want subsidies due to the stigma associated with receiving public benefits. Wisconsin found, however, that the amount of subsidy as a share of cost was the primary concern. Others were concerned that cost, quality and choice will be negatively affected with greater government involvement.

Tax credits were seen as a potential strategy targeted for individuals with higher incomes; however, states also observed some skepticism about the impact of this incentive.

- Untargeted tax credits would benefit both those who currently buy insurance as well as the uninsured that might find the credit an incentive to purchase. The benefit in reducing the numbers of uninsured seemed uncertain for the investment.
- Tax credits may fail to cover the cost of coverage or be packaged in a manner that is not appropriate for the consumer who needs up-front funding.
- The administrative burden and difficulty in educating consumers about the credit were seen as problems. Consumers would prefer to have an intermediary to facilitate the process.

Where the Uninsured Receive Care

The state reports provided little new insight into the ways in which the uninsured meet their medical needs. They found that the uninsured:

- Go to hospital emergency rooms;
- Use community clinics and other safety-net providers;
- Apply home and alternate remedies;
- Pay out of pocket and utilize private providers and may incur substantial debt; or
- Go without care.

The state conducted research added unique perspectives that help in understanding the challenges of accessing medical care without insurance.

- Most respondents try to "get by" without primary or preventative services, using emergency rooms and safety-net providers for only acute conditions.
- Cultural differences may influence choice in this area. Wisconsin found that Latino respondents preferred using community clinics, while African American focus group participants preferred using hospital emergency rooms.
- Those who preferred hospital emergency rooms cited their reasons as: faster care, later billing for services, less expensive, and better care. Those who favored clinics, however, indicated the same reasons.
- Those who had accrued debt from emergency rooms did not plan to pay their bills. The average amount of debt of focus group participants in Wisconsin was $5,000 per person.
- 36 percent of respondents in New Hampshire reported that they and their spouse experienced between one and ten unmet medical needs in the past six months.
- One third of the 18-24 year old respondents in Wisconsin reported having long-standing relationships with local clinic physicians and in some cases had set up payment plans to pay for their regular care in absence of insurance coverage.
- Medical debt was reported the primary reason for bankruptcy by Arkansas households.

Section 4: Quantitative Research on Employer-Based Coverage in SPG States

Just as states took different approaches to measuring rates of health insurance coverage, states also used different strategies to collect information on employer offerings. Therefore, estimates of employer offerings derived from the state grantee surveys cannot be compared across states. To provide a context for estimates of employer offerings across states, this report includes a table of state estimates of uninsurance from the Medical Expenditures Panel Survey – Insurance Component (MEPS-IC) (Table 2-7). The results of the MEPS-IC analysis shows that the percent of private sector employers offering health insurance coverage benefits ranges from 42.4

percent in Idaho to 66.1 percent in New Hampshire. The national average is 58.4 percent.

Table 2-7. MEPS-IC Estimates of Employer Offerings

State	Percent of Private-Sector Establishments Offering Coverage *	Standard Error	Year of Estimate
United States	58.4%	0.4%	1999
Arkansas	43.9%	2.4%	1999
Delaware	58.0%	2.6%	1998
Illinois	60.0%	1.6%	1999
Iowa	50.7%	2.0%	1999
Kansas	58.1%	1.4%	1999
Massachusetts	65.7%	2.0%	1999
Minnesota	55.8%	2.4%	1999
New Hampshire	66.1%	3.2%	1998
Oregon	57.1%	2.2%	1999
Vermont	60.2%	3.1%	1999
Wisconsin	61.4%	2.0%	1999

* Source: *1998 and 1999 MEPS-IC*
NOTE: The table contains the estimates from 1999 and 1998 because smaller states are rotated into and out of the sample each year.

In their year-end reports, states were asked to provide overall rates of employer-based coverage in their state. In response, some used MEPS-IC (Arkansas, Oregon, and Wisconsin) while others drew from state surveys of employers (Delaware, Iowa, Massachusetts, and New Hampshire), state household surveys (Illinois, Kansas, Vermont, and Wisconsin) and the Current Population Survey (Delaware and Iowa). Other sources of employer information included the Kaiser Family Foundation Employer Health Benefits 2001 Annual Survey (Oregon) and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey (Minnesota).

Quantitative Research Findings from the States: Employer-based Coverage

States were asked to summarize the characteristics of the employers who do and do not offer health care coverage. Within the SPG states, offer rates among firms varied according to type of business. The discussion that follows briefly highlights these characteristics. Selected attributes of those firms that do offer health care coverage are briefly reviewed as well. More complete descriptions of states' employer-based results are provided in the state-by-state profiles of employer-based coverage in Appendix D.

Attributes of Firms Offering Coverage Versus Those Who Do Not: *States* found that the characteristics that most consistently distinguish firms that offer health care coverage from those that do not were company size, employee income brackets, percentage of full-time versus part-time and seasonal employees, and industry sector.

A number of themes emerged from the states' research activities related to employer-based coverage:

- Larger firms were more likely than smaller firms to offer coverage.
- Higher wage firms were more likely than lower-wage firms to offer coverage. Wisconsin discovered that high-wage firms had a large percentage of employees who had access to "no cost" coverage where employees were not required to contribute anything to the cost of coverage.
- Firms that offer coverage tend to have a higher percentage of full-time employees than those with smaller complements of full-time workers.
- Industry sector was a significant determinant of offering health care coverage, although not consistently in the same direction. For the most part, persons employed in the public sector (e.g., public administration, state government, local government, etc.) were the most likely to be offered coverage. Persons working in the manufacturing, finance, insurance, real estate and wholesale trade sectors were oftentimes offered coverage as well.
- Those employed in the entertainment and recreation, agriculture/forestry/fishing, and construction industries were among those least likely to be offered coverage. Regarding the construction industry, although they were among the least likely to be offered coverage, Wisconsin found that when those employed in that sector (as well as manufacturing) are offered coverage, it is likely that the employees did not have to contribute to the cost of coverage.
- State data collection efforts also showed that the likelihood of employer coverage was related to geography; firms located in rural areas were found by some states to be less likely to offer coverage than urban firms (Kansas, Minnesota, and New Hampshire)

Employer Premium Contributions: For those firms that offer coverage, states found that employers contribute to the majority of the health insurance premiums, with the level of contribution contingent upon coverage type. For example, Minnesota employers pick up about 82 percent and 70 percent of the premiums for single and family coverage, respectively. Iowa observed a slightly greater differential with employers contributing 81 percent to single coverage and only 50 percent to family coverage.

States also found that:

- There appears to be an equivocal relationship between firm size and employer contribution level. Wisconsin and Oregon observed that when compared to their larger counterparts, smaller firms contribute less to *family* coverage than larger firms, Wisconsin also found that smaller establishments had a higher percentage of eligible employees who did not have to pay anything toward their coverage.
- Wisconsin was the only state to observe that employees at high-wage firms pay less for their coverage. In fact, they found that employees at low-wage firms were asked to contribute more than two times as much for coverage on average than employees at high-wage firms.

Employee Take-up Rates: High percentages of employees offered coverage opt to enroll. Take-up rates ranged between 74 percent to 89 percent in Kansas, Massachusetts, Minnesota, Oregon, and New Hampshire with some variability observed depending on firm income bracket (take up rates higher in high wage firms), expense of premium (take-up rates inversely related to premium cost), and size of firm (take-up rates higher in larger firms).

Section 5: Qualitative Research on Employer Decision-Making and Incentives

States made a concerted effort to collect quantitative and qualitative data on employers. Through the use of focus groups, interviews, and surveys, the voice of this essential group of stakeholders was included in the states' analyses. Some states also surveyed employers using some of the same questions raised in the more dominant focus group model. Focus groups and individual interviews provided an arena for employers to voice their concerns and describe the barriers they are currently experiencing. Several states, including South Dakota, Kansas, and Wisconsin, used the focus group model to assess the difficult situation faced by small businesses.

Employers are Inclined to Provide Coverage: The process by which employers determine whether they will offer coverage depends on several significant factors:

- Many employers feel a great sense of obligation to provide coverage for their employers. As a focus group participant in Kansas stated, "it was the right thing to do."
- The provision of coverage allows employers to stay competitive in the market by attracting and retaining loyal, quality employees. Coverage may also be necessary as a result of contractual agreements when workers are part of a labor union.
- Employers believe health coverage is linked to greater productivity because of a healthier workforce.

Cost is the Major Deterrent: States found that cost is the most important factor in an employer's decision not to provide coverage. All states that have addressed employers' decisions for not purchasing health insurance found this to be the case. Furthermore, it was not surprising to find that those hardest hit are small and low-wage businesses that are unable to find group plans or purchase affordable policies for the small number of employees they have. A quote from a small business owner that participated in a focus group in Oregon illustrates this problem:

> *"Providing employee health coverage is a concern. I would like to be able to do it. It has not been an option for me so far. I spend every dime that comes in that door. I spend it on wages and taxes, parts purchases, rent and the general overhead…so, really, providing insurance for employees has not been an option."*

Especially in today's turbulent economic environment, employers are gravely concerned about rate increases in health coverage. Consequently, with uncertain revenues, many employers feel they simply cannot risk purchasing coverage.

Others elect not to provide coverage because they know that their employees are covered by other mechanisms (e.g., spouse, public programs, etc.) or may not want it.

For those employers that do provide coverage, they must also go through a decision process to select the benefit and premium participation levels. There was quite a bit of variation from employer focus groups within the states as to what criteria they use to determine these levels. Not surprisingly, however, the greatest factor influencing this process was also cost. Other factors that are assessed in an employer's strategy include competitiveness of the market, employee feedback, as well as industry norms. In general, states did not demonstrate a trend in the levels of employee contribution as they vary across the nation from 0-100 percent depending on the profitability of business, size, and other environmental factors.

Anticipated Responses to an Economic Downturn: States found that employers, concerned with the current economic environment, are very clear as to the choices they will have to make in an economic downturn:

- Employers indicated, mostly through focus group discussions, that they would have to reduce benefits and/or increase the employees' share of the cost with increased deductibles, co-payments, or share of premium. Other changes could include substituting increases in wages for greater coverage, or eliminating coverage for dependents.
- Some states did not directly address the question, but speculated that certain businesses may have to eliminate coverage completely. Interestingly enough, Iowa found it highly unlikely that employers that currently provide insurance would stop offering coverage. Likewise, data from the Minnesota Employer Health Insurance Survey indicated that when 218 employers were asked "what percent increase in the cost of health insurance would cause the firm to stop offering health insurance altogether," 50.1 percent (113 firms) answered that no increase in the cost would cause employers to stop offering insurance. Some Wisconsin focus group respondents, however, did indicate that they would drop coverage.
- Oregon indicated that especially in uncertain economic times, employers will look for innovative solutions such as purchasing pools, public solutions, and other creative ideas such as "company doctors."
- Businesses that do not offer coverage, but are interested in doing so may have to delay the decision even further.

Getting to Yes—What Will Influence Employers to Offer Health Coverage or an Individual to Purchase?

Small firms and firms with large numbers of low-wage employees comprise the majority of companies that do not offer coverage. Given the cost of coverage and the economic pressures small businesses face, the existing incentives of tax deductibility have not proven adequate to move many of these firms to offer insurance. State programs providing tax incentives, subsidies, or specially designed benefit plans have had limited success as have both public and privately sponsored purchasing cooperatives for small businesses. Examining the attitudes of small business, understanding their perspective, and involving them in a discussion about potential incentives was an important part of many of the SPG grantees' work to develop options to expand coverage. The material that follows includes what states, primarily the FY 2000 grantees, learned in their qualitative research about how employers might respond to popular options under discussion to expand employer coverage. It also provides ideas for solutions and perspectives on the issues from employers themselves.

Expansion/Development of Purchasing Pools or Alliances

- Employers Generally Favor Purchasing Pools. Pooled purchasing remains an option that employers generally feel favorable toward according to focus group and other discussions with employers by Kansas, Illinois, Oregon, Wisconsin, New Hampshire and Iowa. Two states, Massachusetts and Texas, asked this question in employer surveys and also found significant interest. The key to influencing these employers, however, is whether or not pooled purchasing would mean better rates. Employers in Kansas and Wisconsin also hoped that cooperative purchasing would improve their frustrations with the market and mean that they would be treated like large group employers or as Kansas small employers put it, a "real group."
- Employers Differ on How to Handle Risk Issues. Some states found employers favorable to the concept of spreading risk across the pool, but both Wisconsin and Iowa found other employers concerned that a pool needed rules and policies similar to private insurance companies to compete effectively. They were afraid that community-rated pools would force the better risk groups to leave and seek lower rates elsewhere.
- But Employers Have Concerns about Purchasing Pools. Delaware, Kansas, Wisconsin, and Oregon all found employer skepticism on whether purchasing pools could reduce costs. Oregon employers cited high administrative costs as a barrier along with the difficulty of often short-lived small businesses providing the long-term commitments needed for a successful alliance. Wisconsin found small businesses very skeptical about whether alliances could be started in their state given some prior experience with the lack of interest from carriers. Some Delaware employers saw purchasing pools as too complicated and "another level of bureaucracy." In Kansas, Oregon and Wisconsin, small employers shared concerns about whether purchasing alliances would limit their choice of insurers and their ability to tailor policies to their employees. Wary of government involvement and wanting oversight

and control, employers saw potential, but no guaranteed solution in purchasing pools.

Linking Tax Credits and Purchasing Pools

Only one state, Wisconsin, made the concept of linking tax credits and purchasing pools part of its qualitative research with employers. Most employers could support the idea if:

- The pool offered "reasonable coverage and contracted with credible health plans."
- Administrative costs were reasonable.
- The pool was accountable to participating employers.

While some employers felt that a policy to restrict tax credits to purchasing pool participants would be discriminatory and unwarranted government intervention in employer choice, other employers saw advantages. Advantages identified to linking the pool and tax credits were increased credibility to help attract insurers and small employers and to serve as an incentive for better risk employers to stay in the pool and avoid selection issues. Linking tax credits and purchasing alliances has been seen by many as a way to strengthen both strategies for small groups and individuals.

Employer Responses to Employer or Individual Subsidies

Employer preferences regarding individual and employer subsidies as an incentive to provide health care coverage varied by state. States also used different techniques to generate responses. Illinois and Iowa found employers favorable to both individual and employer subsidies. The Illinois Assembly concluded that a direct subsidy to individuals for health insurance was potentially very promising, particularly if it was paid prospectively. However, in Kansas small employers simply did not like the idea of subsidies. Kansas employers with large numbers of low-wage workers thought help with the employee premium was needed, but preferred a large enough tax credit for the employer to assume all of the premium cost. In New Hampshire, employers seemed more interested in federally funded than state-funded subsidies and many of their focus group participants felt that even a one-third subsidy would not make premiums affordable for low-wage workers.

Oregon also found that employers were interested in subsidies. A quotation from one of their focus group participants captures the feelings of small employers who favor the idea of subsidies:

> *"...so many bigger companies offer [health coverage] and a lot of people with families say that is the biggest thing they look for in a job. They say that they have to have health insurance before they would consider a job. And if you are employing the head of the household, definitely. So if we as small-business employers were given an opportunity like tax breaks or a subsidy, it would be extremely helpful. The only realistic way most small businesses are going to be*

able to give health insurance to their employees is if we do it in cooperation with the government."

Employer Concerns about Subsidies*:* As Minnesota put it, "how much subsidy" is, is a key issue. Massachusetts, a state with an existing employer subsidy program for eligible employers with 50 or fewer employees, found 42 percent of employers that were aware of the program and employed low-wage workers, felt the existing subsidy was too small. Delaware found that 40 percent of small businesses not currently offering health insurance might be influenced if the subsidies were substantial, up to 50 percent of the premium. The administrative issues of a subsidy are also of concern to employers. Oregon focus group participants made it clear they "don't want to have to create a new audit trail, worry about tax implications and keep tabs on how much their employees have in the way of financial resources." Oregon employers also felt that subsidies might stabilize the problem of meeting mandatory participation rates from insurers since employee participation, particularly family participation, goes down as employee costs increase.

Employer Response to Tax Incentives

States found significant support among employers for both employer and individual tax credits. A number of issues and attitudes that would be important in creating effective tax credit programs were identified by the states that used employer focus groups and other mechanisms to solicit reactions.

Current tax policies supporting employer coverage: Illinois participants were skeptical that current tax deductions provided significant help to businesses contributing to health insurance, and they thought that existing policies did not respond adequately to rising costs. Oregon also found that many small employers really didn't seem to understand the full tax implications of offering health insurance to their employees. New Hampshire found the self-employed most concerned that 100 percent deductibility be extended to that group as soon as possible.

Employers generally favor tax credits for employers: While state qualitative research tended to support tax credits as an incentive for employers to offer coverage, the amount required, whether or not they are refundable, and which employers are eligible are all issues states have struggled with while considering these programs. Employers in Kansas, a state with a tax-credit program, felt tax credits could be a motivator for employers. However, they would be most effective if "adjusted annually for inflation, were in effect more than five years, applied to all businesses (not just new businesses), and covered at least 50-75 percent of the premium." Small employers also expressed concern that the administrative work required didn't exceed the value of the credit. Wisconsin employers interested in tax credits shared many of these concerns and also felt that the credit would need to be substantial – varying between one third and 75 percent to 80 percent of the premium depending on their assessment of their employees' ability to contribute. Some Wisconsin employers also clearly favored the

employer rather than employee receiving the tax credit as a method to provide more incentive for employees to stay with the employer.

Some employers do not support tax credits: Wisconsin's focus group work with employers provided an interesting insight into the reasons that some employers do not favor government tax credits. Reasons cited for not being interested in an employer tax credit included:

- Concerns about structure of a credit such as administrative workload, ability to keep up with inflation, longevity.
- More government intrusion into employers' lives and more government intrusion in health care coverage, potentially, "the beginning of a slippery slope towards 'socialized medicine.'"
- Wrong way to solve the problem of employees' lacking coverage with a focus on reducing health care costs seen as a better approach.

In spite of these concerns, if the tax credit was large enough, employers indicated that they would probably use it.

Individual Tax Credits

Employer concerns with structuring effective individual tax credits: The most consistent theme found by the states discussing individual tax credits with employers was the factors needed to make it effective. In general, concerns included the size of the credit relative to the cost of the premium and people's income with particular concern expressed for the older worker. In addition to the size of the credit, most felt it had to be refundable and must have a way to make the funds available when needed to make premium payments. In addition to those concerns, employers felt the program must be easy to understand and apply for and there should be a program to make people aware of the credit.

Wisconsin, a state that spent a significant amount of effort discussing tax credits with employers, uncovered some different issues. In addition to being skeptical about low-wage workers being influenced by a tax credit, some employers were concerned that employees would misuse the credit and would not purchase appropriate policies given the complex market and the various policy options. Employer concerns persisted in spite of explanations on how a tax credit would work.

Other Alternatives and Perspectives from Employers

The state discussions with employers also yielded some other ideas on what might motivate or help employers purchase health care coverage for employees, which ranged from market solutions to more regulatory options.

Cost of Health Insurance and Health Care: Employers in several states expressed their opinion that reducing costs is the key to expanding coverage. In Delaware cost concerns were important enough that they asked the state to reframe the issue to

include maintaining affordable coverage. Wisconsin focus group employers even went so far as to suggest that government should focus on controlling costs rather than expanding coverage, although they "disagreed as to what sector's costs needed to be controlled—insurance companies, providers, drug companies, etc." The importance of cost control and employer perspectives on what works can be seen in many of the ideas that follow.

Limited Benefit Design Options: Eliminating mandated services and creating an affordable basic plan was attractive to Vermont employers who purchase in a community-rated market. Some Iowa employers would go further and recommend a "barebones" subsidized policy. Past experience has shown "barebones" policies were not widely bought and Delaware's focus groups responded to a limited benefit plan in a similar way with concerns about uncovered benefits and the potential of doctors avoiding surgery because patients can't pay.

The Health Care Marketplace: In spite of the fact that focus groups often expressed skepticism about governmental solutions, employers suggested a number of basically regulatory strategies to control costs and make health insurance more affordable. By far the most dominant theme, however, was a more competitive market.

- Encourage a more competitive insurance market by attracting more insurers. Although as noted by the New Hampshire report "increasing the number of plans doesn't necessarily translate into lower costs" (Vermont, New Hampshire).
- Permit insurers to charge less for groups who utilize less care (Vermont)
- Provide rebates to employees who maintain good health and employers whose groups have good health overall (Vermont).
- Reduce the variability in insurance costs, including year to year, company to company, and employee to employee, by more effectively regulating insurers (Kansas).
- Tort reform to lower premium and health care costs (Iowa).

Information and Education Strategies: Many states found gaps in knowledge by both employers and individuals who participated in focus group and other opportunities to provide input to the state planning process. Some of the areas for additional education or information included:

- Enhancing education about insurance and its role in the health care system. There was concern in Illinois about the inappropriate use of health insurance and both Illinois and Oregon found that some of the uninsured do not value health insurance and they and employers need to be educated about the benefits of being insured.
- Making more information available on products and coverage opportunities (Illinois).
- Providing understandable plan information to facilitate comparison of coverage alternatives (Vermont).
- Encouraging employers to provide annual compensation summaries to employers detailing the benefit components (Arkansas).

Requiring Employers to Offer Coverage: A minority of employers in Vermont and Kansas felt that government should consider mandatory strategies. Vermont supporters suggested that either the employer or the individual could be the focal point, but that health insurance should be required. Some Kansas employers were willing to support a mandate for employers because they "believed all employers should 'carry their weight.'" Arkansas' Health Insurance Expansion Roundtable considered requiring participation in employer sponsored coverage, but felt the political issues made it reasonable to table that idea until voluntary strategies were exhausted. Iowa employers on the other hand were very firm in their belief that government should not require employers to offer health insurance coverage.

Pools and Buy-in Strategies: Employers suggested other buy-in or pooling options:

- Form a pool of all people in the state to negotiate favorable rates with providers and insurers (Vermont).
- Allow employees of small business (including owners) to buy in to the state employees' health plan using employer contributions and a sliding-scale subsidy (Delaware). The state employee package is viewed as a good benefit at an affordable cost given the negotiating power of the group.

Other suggestions: Other employer-suggested options are variations of tax incentives or subsidy programs.

- Target individual tax incentives such as Medical Savings Accounts and tax deduction for out-of-pocket medical expenses, regardless of the amount (Vermont).
- Offer catastrophic health insurance to those without insurance, including part-time and temporary employees (Vermont).
- Provide subsidies to "level the playing field" between large and small businesses to cover the difference in premium cost (Kansas).

CHAPTER 3

THE HEALTH CARE MARKETPLACE AND RELATED ISSUES

After nearly a decade of strong state revenue growth and budget surpluses, the fiscal status and economic outlook for nearly all states has changed dramatically. State revenues are down significantly in the current slowing economy and are coming in below forecasted levels in the opening months of state fiscal year 2002. With Medicaid programs accounting for a relatively large share of state budgets (15 percent on average), states reported that Medicaid and other public health programs would be a likely focus of efforts to reduce budget shortfalls. Reductions in eligibility, provider or health plan reimbursement or other program cutbacks would exacerbate the cost, coverage and access pressures on the states' health care markets.

Major Trends

In assessing their health care markets, states identified nine primary trends, in addition to their deteriorating state budgets:

- Publicly financed health programs and employer-based health coverage expenditures are experiencing double-digit growth rates.
- Employers of all sizes are concerned about the unpredictability of their cost increases.
- Rising unemployment will cause increases in enrollment for publicly financed health programs along with a growing number of persons who are uninsured.
- Labor shortages in all sectors of the health care system are adding to cost increases and reducing the number of options available to control health care expenditures or maintain/increase access to health services.
- Fewer insurers are serving the individual and small group markets (less than 50 employees) in many states leading to limited competition among health plans and a lack of choice of health plan products. Many smaller states have only 1-3 insurers serving these markets.
- In spite of the changing labor market and the increasing number of seasonal, temporary or part-time uninsured workers, there is a lack of non-traditional group health coverage products that employers can purchase.
- There is an increasing focus in state health care markets on consumer responsibility and consumer-driven health care products to both stifle rising premiums and create a more efficient health system.
- There continues to be significant differences in the adequacy and availability of public and private health coverage and access between urban and rural health markets within many states.
- States are concerned about the vulnerability of their safety-net providers and their capacity to meet the demand for health services (both hospital and non-hospital) in this slowing economy.

State Health Market Assessments

In those states that completed health market assessments, a number of quantitative and qualitative research projects and information-gathering strategies were used. Several states used outside consultants to perform detailed assessments. These consultants used existing state-based and national data sources and surveys. Grantees also relied on: 1) employer, health plan and provider surveys; 2) employer, provider, employee and uninsured focus groups; and 3) key informant interviews. Many states also compiled and reviewed existing administrative data, market, labor, regulatory and health spending reports. A number of grantee states have not yet completed their state health market assessments but will be doing so as part of their ongoing options discussions and analysis.

In their assessments, most grantees focused on information that would assist them in understanding their state's health care market in order to examine options that build upon existing employer-based coverage and other private sector resources. Because of the complexity and diversity of the problems of the uninsured and underinsured, states do not believe that they can craft an effective single policy solution.

Understanding their state markets also has helped grantees focus their efforts on stabilizing and expanding access to "adequate" health coverage (as defined by each state) to the following target groups:

- Small employers (under 50 employees);
- Low-income persons and families not eligible for state-funded programs;
- Persons purchasing coverage in the individual market;
- Persons with pre-existing conditions who access health coverage in the small group or individual markets;
- Persons nearing 65 years and not eligible for Medicare; and
- Persons who have Medicare coverage but do not have coverage for prescriptions.

Adequacy of Existing Insurance Products

Adequacy of existing public and private insurance products is a difficult concept for grantee states to define. The starting point for some grantees was to develop a definition of "inadequate insurance coverage" or underinsurance. States considered several factors in their definition of adequacy of existing insurance products. A few grantees began by defining adequacy from the perspective of affordability and accessibility of coverage options based upon income levels and pre-existing conditions. A couple of states expanded their definition of adequacy to include a regulatory definition. Grantees recognized that there were wide differences in adequacy depending upon a person's income, employment status, age, health status and residence. Adequacy of insurance products also includes an assessment of eligibility requirements for public programs such as Medicaid, SCHIP and "high-risk pools".

In defining adequacy, several states included the specific concerns of their citizens, employers and health care providers when assessing the adequacy of insurance products offered. Higher deductibles, co-pays and other cost-sharing requirements decreased the value of the product, especially to low-income individuals. Affordability and accessibility also impact those persons with pre-existing conditions who don't often have any options except high-risk pools. Adequacy of coverage options is rated good by grantees for those persons who are middle to upper-income, under the age of 60 years and with no pre-existing conditions. The definition of adequacy changes as a person's medical condition goes from routine to emergency and on to chronic. Adequacy is also impacted by one's ability to access health care services similar to others in his or her community or socio-economic status.

Most states are still discussing an agreed upon definition of "adequacy" as they further develop and refine their options and plans.

Variation in Benefits

Most states do not keep specific data about the variation of benefit levels among non-group, small groups, and large groups that offer insured products and/or non-insured products offered by firms that self-insure. Grantee states were aware of the wide range of coverage plans available in their states, from stripped down to extremely costly coverage. There usually is greater flexibility and choice available in benefits offered to employees of large, self-insured groups who may offer both insured and non-insured products. There often is not much diversity in insured products between groups. Most groups cover major medical with the largest differences being in prescription drug coverage. The greatest variation is between insured products offered to individuals and small groups and non-insured products offered by firms that self-insure. Even these differences in benefits offered were not sizable, as reported by those states that did employer surveys, and usually represented differences in cost-sharing expected of employees. States concluded that self-insured firms do tend to include state-mandated benefits in their health plans.

Prevalence of Self-insured Firms

Among firms that offered health insurance to their employees, states reported that a smaller percentage of companies were self-insured (estimates by states of approximately 25 percent) but that these companies, because of their size, represented a significantly larger percentage of employees with employer-sponsored coverage. These estimates by the SPG states also mirror information from the 1999 MEPS-IC tables that the percentage of firms nationwide that offered at least one self-insured plan was 26.5 percent and that the percentage of employees enrolled in self-insured plans was 48.9 percent. States also reported that the number of self-insured firms offering at least one self-insured product to their employees also seems to be increasing.

Impact of State Purchasing

Most states did not assess the state's impact on the health care market as a large purchaser. Grantees reported anecdotally that there have been changes in the state's purchasing strategy, primarily for state employees. Those changes reported included a shift by the states to self-insure and an increase in cost-sharing requirements. Minnesota has discussed using direct purchasing of health services from large provider systems as an option under investigation for both employees and their Medicaid program. A number of states (Vermont, New Hampshire, Connecticut and Massachusetts) have formed coalitions with other states to implement a competitive joint negotiating and procurement process in their geographic region, initially for pharmaceuticals. Some states, including Massachusetts, have joined large private-sector purchasing coalitions to seek fundamental changes in the health care market. One of those changes discussed most often by states is the move to control costs and improve quality through greater consumer involvement in health care decisions.

As a result of increasing health care costs and budget problems, states also reported discussions about changes in Medicaid and SCHIP benefits and purchasing. Grantees also are using their purchasing clout to control pharmaceutical costs and manage the care of persons with chronic diseases. Other discussions by the states include the trimming of benefits under public health programs to more closely resemble the private sector and use the state's purchasing power to increase the availability and affordability of health plans available to small employers and individuals.

Impact of Current Market Trends and Regulatory Environment

Current market trends are making many state efforts to increase the availability and affordability of health coverage more difficult. Recent and planned annual premium increases of 20 percent or more in the small group and individual insurance markets are not uncommon in most states and are causing some employers and individuals to reduce or drop health insurance coverage. Consistent with a softening economy, grantees expect an increase in the number of unemployed and uninsured and as well as in the number of persons enrolling in existent public programs. States report that the information generated by the State Planning Grant was helpful in assisting them in responding to efforts to reduce state-funded program eligibility and benefits.

The market trend towards increasing consolidation and a reduction in the number of insurance carriers and health providers in many states, particularly smaller ones, has caused some states to examine the viability of the competitive market absent state intervention. Individual states are assessing whether the market is working given limited competition.

A shortage of health care workers, especially nursing staff, nursing assistants and home health care workers, is also impacting the state's ability to increase coverage and access to health care services, especially among safety-net providers and underserved

communities. These labor shortages are also increasing health care costs and necessitating specific initiatives by the states to increase the supply of qualified workers.

Universal Coverage and the Financial Status of Health Plans and Providers

Most states did not directly assess the impact of universal coverage except to discuss its likely financial impact on safety-net providers and others who provide uncompensated care. A few states struggled with a definition of universal coverage in light of their current high levels of insurance and availability of public programs. Most states recognized that there would always be a residual number of individuals that would remain uninsured and in need of services.

Safety-Net Providers

All the grantees reported being concerned about the vulnerability of their safety net providers given current fiscal and market trends. Most states included safety-net providers in their steering and advisory committees and solicited their input through interviews and focus groups. Also, most states recognized the importance of recognizing and including non-hospital-based safety-net providers in their planning process.

Grantees recognized the need for adequate and consistent funding in order to be able to meet the increasing and unpredictable demand for safety-net services. Grantees also recognized the importance of protecting safety-net providers when states decide to reduce provider reimbursements to balance budgets. Grantees are also concerned about the viability and differences in the safety-net among different geographic areas.

Increasing Coverage and Access to Health Service

Typically in most states, the supply of health care professionals is either inadequate or not equitably distributed to areas with the most needs and demands for health care services. States reported being concerned about increasing health coverage and the capacity of their current providers to respond to increased demands for services. Although the focus of the grant was not specifically on increasing access to health services, SPG states recognized the reality that access to services will not necessarily increase because more persons have health coverage. This is especially the case for underserved sub-populations. States recognized the importance of increased capacity in the health care system for the delivery of oral health services, mental health services, pediatric services, home health and specialty services. States also recognized that their health care workforce is a diverse and critical occupational industry that requires attention and oversight to ensure not only increased access but also equal access that is not dependent upon geography, gender or race. Growth in the demand for services by the newly insured will look like other insured populations once their initial need for care is met.

The Question of Crowd-out

As states have extended health insurance options to higher-income individuals and families, both states and the federal government have been concerned that certain employees and employers would choose to replace private health insurance with public coverage, the phenomenon commonly referred to as crowd-out. When states addressed the issue of which employer and employee groups were most susceptible to crowd-out, the states uniformly felt that low-wage workers and employers who employ large numbers of low-wage workers are the most likely to drop coverage.

The second consideration for state and federal policy makers is how much of a threat crowd-out actually represents. Minnesota pointed to earlier research, the 1997 Robert Wood Johnson Foundation funded survey of employers, to answer that question. This survey found that of all employees working for firms offering coverage, "only 6 percent were in establishments that are primarily very low-wage (less than $7 per hour) and an additional 17 percent worked for establishments where the majority of workers earn between $7 and $10 per hour." With only 23 percent of establishments having a majority of workers at $10 per hour or less and with coverage closely related to wage, Minnesota concluded that crowd-out does not represent a significant threat. Oregon also notes that their employer focus groups supported the conclusion that they would not drop coverage simply because a public alternative was available since employers viewed coverage as critical to attracting and keeping a quality workforce.

The qualifier to this argument for both employers and employees was the affordability of coverage. Employers are worried about their ability to maintain coverage with costs significantly above inflation. States are concerned that low-wage employees may find public coverage more affordable for themselves or their dependents even when employers offer a package if cost and the employees' share of the costs continue to rise. In the next report, Utah, an FY 2001 grantee, hopes to offer some unique information to help assess the likelihood of crowd-out by using discrete choice analysis. They will give a range of benefit and price options to both employers offering coverage and currently uninsured employees to test how both groups make decisions as cost and coverage change.

Massachusetts, a state with a variety of programs to support employer coverage for low-wage workers, concluded, "The challenge for policy makers is to create an environment that encourages private-market coverage perhaps by partially subsidizing low-wage employees and employers while possibly expanding eligibility for some public programs."

CHAPTER 4

CONSENSUS-BUILDING

Each of the 20 SPG states established governance structures to coordinate the administration of their grant activities. Typically, these structures included an executive branch lead agency assigned by the governor and various committees formed to oversee data collection and the assessment of policy options.

In developing these grant structures, states also outlined a process for developing and winnowing policy options to reach coverage for all citizens of the state. The grantees designed strategies for obtaining input from all the major stakeholders needed to support this policy objective and sought to enlist their participation and support.

The various organizational structures devised by the grantees reflected the differences in their policy environments. In some states, the SPG grant provided an opportunity to begin a new process for designing a major coverage expansion. These states often enlisted prominent political figures, lobbyists, and other key stakeholders to participate in the process. Other states had structures already in place to assess or to implement coverage expansions, and they based their SPG grant activities on these structures.

Lead Agencies

The SPG states selected various entities to serve as lead agencies for their projects (see Table 4.1). The most commonly selected was the state Medicaid agency (6 states). A number of states (including Arkansas, Connecticut, Minnesota, New Hampshire, and Oregon) used existing policy and research centers to coordinate the grant activities. These policy centers were experienced in collecting and analyzing health care data and were well suited to oversee the activities conducted under the SPG grants.

Table 4-1. SPG Grant Lead Agencies

State	Lead Agency
AR	Arkansas Center for Health Improvement [Health Policy and Research Center]
AZ	Arizona Health Care Cost Containment System [Medicaid agency]
CA	Health and Human Services Agency
CO	Office of the Governor
CT	Office of Health Care Access [Executive branch research and policy center]
DE	Delaware Health Care Commission
ID	Department of Commerce
IL	Department of Insurance
IA	Department of Public Health

State	Lead Agency
KS	Department of Insurance
MA	Division of Medical Assistance and the Division of Health Care Finance and Policy
MN	Department of Health (Health Economics Program)
NH	Department of Health and Human Services (Office of Planning and Research)
OR	Office for Oregon Health Plan Policy and Research
SD	Department of Health
TX	Department of Insurance
UT	Department of Health (Division of Health Care Financing)
VT	Agency of Human Services (Office of Vermont Health Access)
WA	Office of Financial Management (Governor's Budget Office)
WI	Department of Health and Family Services (Division of Health Care Financing)

A state's decision as to which entity would serve as the lead agency often provided a reflection of its current political and policy environment. For example, Washington, which was facing a potential biennium deficit of $1 billion at the time the SPG grant was awarded, elected to have the Governor's budget office serve as the lead agency. Idaho's Governor placed responsibility for the SPG grant in the Department of Commerce, reflecting Idaho's preference for a coverage expansion strategy centering on employer-based coverage, rather than public entitlement programs.

Key Stakeholders

Once the administrative structure for the grant was established, states sought to identify the key stakeholders to involve in the process. The structure of this involvement varied considerably, based on the state's political history, the size of the coverage expansion being considered, and other factors. However, the types of organizations and individuals that states sought to include were broadly similar (see Table 4.2).

Table 4-2. Types of Stakeholders Involved in SPG Grant Projects

State Government	Private Sector Stakeholders
Governor's office	Hospital association/local hospitals
Department of Health	Medical society/private physicians
Department of Human Services	Nurses association/individual nurses
Medicaid agency	Health plans/associations
Other coverage program agencies (e.g., SCHIP, high-risk pool)	Brokers/agents
Department of Insurance	Employers/Chambers of Commerce
Department of Commerce	Employer purchasing pools
Department of Labor	Employees/labor unions
State employees	Farmers/farming groups

State Government	Private Sector Stakeholders
Health policy shop (within department)	Advocates
Independent health care commission	Community Health Centers/FQHCs
Legislators/key committee staff	Local communities
Health insurance task force	Religious groups/leaders
	Philanthropic foundations
	Universities
	Research community

Some of these stakeholders were involved directly in the SPG project through committee membership. Others were engaged by the project teams in other venues, including:

- Focus groups,
- Surveys,
- Key informant interviews,
- Special briefings/add-ons to external group meetings,
- Ad hoc discussions/meetings,
- Policy/community forums, or
- Summits/Assemblies on the uninsured

Each state structured its public input processes differently. States varied along several dimensions, including not just *who* had a say in developing policy recommendations, but also *how* and *when* their input was obtained (before or after the option had been framed and/or selected).

In most states, surveys and focus groups were designed to collect diagnostic information from employers and individuals regarding the existing insurance market. Key informant interviews and special briefings were often conducted with legislators, insurers and key employer groups to obtain their input on particular policy options for coverage expansion. States such as Illinois and Utah conducted large summits not only to gauge the reactions of the interest groups, but to provide a formal voting opportunity on expansion options being considered for recommendation.

The most direct form of involvement in the SPG project was through committee membership. Typically, states designed committees to serve several core functions, including data collection and analysis, and development of policy recommendations. Some states also established subcommittees to perform more detailed functions.

Options Development and Analysis

A number of states (e.g., Arkansas, Idaho, New Hampshire) developed working groups to provide technical data and expertise to inform the policy recommendation process. These committees were often responsible for data collection activities and applying data to the options development work. For example, the working groups used data to determine how many citizens would qualify for a particular coverage expansion program

and, if possible, what the estimated cost would be. In addition, these working groups often provided policy analysis and background information. They assessed whether federal waivers would be required for particular expansion approaches, the likelihood of receiving federal approval, and administrative challenges that might accompany a particular strategy.

Some states had already established centers for conducting health care research and policy analysis and were able to build upon that capacity in the course of their grant activities. In Oregon, the Office of Oregon Health Plan Policy and Research had already developed significant experience in assessing the state's uninsured population and examining options for expanding coverage in the state. Minnesota's Health Economics Program within the state's Department of Health performed a similar function. In other states (e.g., Idaho and Utah), the SPG grants provided an opportunity to develop a new, or broader vehicle for conducting health data and policy analysis.

Other states elected to seek outside support in developing or analyzing options. For example, California issued an RFP for private stakeholders to develop new coverage expansion options and received numerous entries. Vermont hired a private contractor to cost out particular expansion strategies.

Selection of Policy Recommendations

Most SPG states established committees to assess the various policy options and to make recommendations on appropriate (or viable) strategies. Examples included the following:

- Arkansas' "Health Insurance Expansion Roundtable," 21 members representing multiple stakeholders (purchasers, consumers, providers, and risk managers/insurers) and chaired by a retired U.S. Major General who is a practicing dentist.

- Iowa's "Citizen's Alliance," 15 members representing business and the private sector, insurers, providers, government agencies, and the public at large. Formally chaired by the Lieutenant Governor, but led by the Director of Public Health and the Director of the Iowa Farm Bureau.

- Kansas' 22-member Steering Committee, chaired by the insurance commissioner and including representatives from the legislature, governor's office, hospital association, medical society, nursing profession, Hispanic community, Chamber of Commerce, small employers, consumers, a philanthropic foundation, the research community, governmental agencies, and academic institutions.

- Washington's "Management Oversight Panel," based on the Governor's Sub-cabinet on Health, including top aides from the Governor's budget office, the Medicaid agency, the Health Care Authority, Governor's policy office, Department of Health, and the office of the Insurance Commissioner.

The composition of these committees varied by state, especially with regard to legislative involvement and the number of interest groups represented. Many states sought to achieve a demographically representative group of public and private stakeholders that included all the state's major interest groups on health care. Other states, such as Illinois, Massachusetts and Washington, established steering committees made up entirely of state officials, and then sought input from private stakeholders in other venues.

The composition of the policy committees often reflected the state's position in terms of previous coverage expansions. In Idaho, the committee that was formed to make policy recommendations included the lieutenant governor, key legislative leaders on health care, representatives of major corporations, the state hospital association, and other key interest groups. Momentum to pass a significant coverage expansion is building in the state, and the state was able to bring together all the major players under the auspices of the HRSA grant to discuss options.

In Minnesota, however, the group that was formed to make recommendations on policy options consisted primarily of historically underrepresented individuals and groups, including American Indians, immigrant populations, and migrant workers. The state selected this group because it had already implemented a major coverage expansion in the 1990s (covering all families up to 275 percent of poverty), and it is now focused on addressing the remaining gaps in coverage.

Arkansas' Roundtable was selected to reflect the racial, geographic and demographic stratification of the state. As a result, over 15 percent of the Roundtable members were uninsured, closely mirroring the uninsurance rate for the state.

Consensus-Building Strategies

In the process of developing and winnowing policy options for expanding coverage, states employed a number of strategies for achieving consensus. Several states sought to meet individually with key interest groups, rather than form large committees. For example,

- Washington, which has a long history of coverage expansion efforts, decided to pursue a "less formal and less structured" approach, which involved going out to speak with groups individually.

- Delaware, which originally pursued this type of approach, found that they needed a method to obtain "simultaneous input" from stakeholders so that each interest group would have the benefit of knowing how their views affected one another. As a result, the state designed a series of public forums tailored after the Illinois Assembly approach (see below). The SPG project team also held "sounding board meetings" to obtain input from key health care interest groups on the options under consideration.

- The Illinois Assembly on the Uninsured was a modified version of the American Assembly Model, created by Dwight Eisenhower when he was president of Columbia University. The Illinois Assembly brought together almost 200 key stakeholders in a structured, mediated environment with the aim of reaching as much consensus as possible, first on the basic facts and data related to the problem of uninsurance, and then on ways to reduce the number of uninsured. Illinois found that reaching consensus was difficult because some groups wanted to receive input from their membership before voting on particular policy solutions. Participants also supported the formation of a subcommittee to develop more detailed strategies for reducing uninsurance.

- Arkansas employed an innovative approach for achieving consensus among its Roundtable members that was well received. The HRSA team used Audience Response System (ARS) technology, hand-held wireless polling devices, which allowed members to make their opinions known on issues during the course of discussions. According to the state, the instant response system maximized participation by promoting discussion, helped in measuring the group's comprehension of the subject matter, and allowed the group to see an unbiased representation of their policy preferences. The strategy helped Roundtable members build a sense of unity among diverse committee members and fostered team-building.

Achieving consensus for a major coverage expansion is obviously a challenging undertaking for states. This challenge has become even more difficult in the aftermath of September 11 and the recent economic downturn. However, states continue to move forward in seeking consensus and many will use the results of their SPG planning process to improve hard decisions on health care priorities and to bring new options for coverage to 2002-2003 legislative sessions.

CHAPTER 5

POLICY OPTIONS

This section provides an overview of how states developed options, what options they chose to further explore, and in some cases, options they chose to no longer consider. The chapter is divided into four sections:

- Guiding Principles
- Policy option themes
- Policy options
- Options "off the table"

The guiding principles, themes and options below reflect the point in time at which the states submitted their reports (October 31, 2001). It is important to note that while the majority of states are looking at a range of options, with some in the process of narrowing the options under consideration, few have decided to move forward on specific options. This reflects both the short timeframe in which they have had to work (especially the FY 2001 grantees, whose recommendations are preliminary), and the sense of uncertainty caused by the economic downturn. For those states that are moving forward with options, much design, modeling and actuarial work remains. Finally, where we identify a state as proposing, considering, researching, or recommending an option, it is in fact the SPG steering committee or working group that is doing so. In no way does this imply that the state government itself endorses these options. In fact, since the report, a number of states have removed or modified options given political or economic challenges.

Section 1: Guiding Principles

Several states (Arkansas, Arizona, Delaware, Iowa, Kansas, Massachusetts, Oregon, Utah and Washington) established guiding principles to assist stakeholders and others in the consensus building and option development processes. These have helped focus on desired outcomes and have facilitated understanding of the breadth of options and strategies to address the uninsured. The list below represents a compilation, grouped by theme; each state did not necessarily adopt every principle. These states moved forward with their research and coverage expansion strategies with the belief that options should:

State capacity

- Reflect that state governments cannot fully solve the problem of the uninsured; states will require increased federal funding and flexibility to address the uninsured more comprehensively;
- Be politically acceptable and serve the needs of all citizens, whether currently insured or not;

- Reflect that even under optimal circumstances, reaching 100 percent coverage in the current system is difficult, if not impossible (some states examined health care systems outside the U. S. to better understand the meaning of 'universal': Vermont decided that its goal would be 95 percent coverage for adults, 97.5 percent for children);
- Reflect the economic changes that have occurred during the course of the grant; and
- Reflect that health care should be accessible, affordable, and provided for seamlessly and in cooperation with all stakeholders involved (e.g., providers, employers, public sector, etc.).

Program features

- Promote individual responsibility and self-reliance and include prevention and wellness to avert avoidable costs;
- Be incremental and maintain gains of the past: Build on existing public and private structures but allow for changing existing programs if necessary or appropriate;
- Be implemented within a short timeline of one to three years; and
- Reduce existing system complexities and encourage cost and quality-consciousness.

Building on private coverage

- Maintain employer-based system as the foundation upon which the system is built and build on public-private partnerships where applicable;
- Target the working uninsured and small employers, where the majority of uninsured are employed; and
- Avoid replacing private coverage with public coverage.

Financing

- Maximize available state and federal dollars;
- Produce the highest ratio of people covered per state dollar spent; and
- Be properly financed, including clearly identifying the costs and ensuring long-term solvency.

Target groups

- Reflect the needs and characteristics of the different subgroups of uninsured (e.g., Hispanic, black, rural);
- Address those affected by state policies such as state contracted workers and those who are employed by organizations that are primarily dependent on state funding (e.g., nursing facility employees);
- Educate consumers, employers and other stakeholders of the health care system and their options within it;

- Target the most financially needy, particularly those below 200 percent FPL (some states stipulated that many of these individuals would need to be publicly subsidized through existing or new programs);
- Target the uninsured first and those at risk of becoming uninsured or who are underinsured; and
- Reflect that it is better to cover more people with a scaled-back benefits package than to cover fewer people with a more comprehensive package.

In addition to a set of guiding principles about how to expand coverage, Arkansas also established a set of assumptions about families and employers upon which they built their research agenda and expansion options:

Families

- Most families need health insurance coverage;
- Some families will not participate in health insurance programs;
- Families can afford to pay three to five percent of their total income toward health insurance costs;
- An income threshold exists below which families have limited capacity to contribute to health insurance premiums (approximately 200 percent FPL); and
- An income threshold exists below which families have no capacity to contribute to health insurance premiums (approximately 100 percent FPL).

Employers

- Most employers want to provide employer-based health insurance;
- Some employers will not offer health insurance to their employees;
- A cost threshold exists above which some employers have limited capacity to support employer-sponsored health insurance; and
- A cost threshold exists above which some employers have no capacity to support employer-sponsored health insurance.

With these guiding principles in mind, states used quantitative and qualitative research tools to drill down and identify possible ways to address access, affordability and coverage.

Section 2: Policy Option Themes

With the help of the guiding principles described above, states developed a wide range of options to expand coverage to the uninsured. (See Table 5-1 on page 73) A number of themes emerged from the options selected by the SPG states.

States see the uninsured below 200 percent FPL as a key target group

Many of the SPG states are developing options that will address pockets of uninsured across the state and target specific geographic, demographic, socio-economic, and

occupational subgroups, many of whom live below 200 percent FPL. A number of states that already cover citizens in public programs up to or above 200 percent FPL are calling for improved public program outreach and enrollment. Using survey and focus group results, states will be better equipped to reach out to subpopulations with appropriate messages about the value and need for coverage.

Several states are examining expanding existing programs to parents and childless adults, offering scaled-back benefits and increased cost-sharing rules under new federal flexibility rules. Health Insurance Flexibility and Accountability (HIFA) 1115 waivers allow states to alter benefits packages and cost-sharing allowances for non-mandatory populations in Medicaid and use these savings to expand coverage. Several states are researching what level of benefits and cost-sharing are appropriate for different groups.

Several states are examining affordability issues, identifying the uninsured's ability to pay at different income levels. New Hampshire conducted a study of what constitutes a "livable wage" and found that individuals would have to earn roughly 200 percent FPL before being able to afford to buy health insurance for their family. This study confirmed that low-income individuals need financial assistance in purchasing insurance. As a result, New Hampshire's advisory committee recommended that state policies targeted to low-income individuals include an affordable health care package that emphasizes preventive services and care coordination.

States want to support the working uninsured

Localized data has helped highlight that over 75 percent of uninsured are working or are connected to a household with a working individual. These data are mobilizing policy makers and legislators to propose solutions such as public-private partnerships and insurance market reforms that will target small employers and low-wage workers.

Generally, focus groups and surveys of uninsured workers and employers found that they were willing to buy insurance if offered an affordable and reasonably generous benefit package. Delaware found that the $50 per month level seems to be a threshold above which a substantial proportion of employers and employees are likely to decide against buying coverage.

The options states are considering vary by their prior public program coverage expansions and the vitality of their private insurance market

A number of the SPG states have already made significant progress in increasing access to health coverage over the last decade. Many have expanded coverage beyond federally mandated levels for children, pregnant women, and adults. These include Medicaid/SCHIP expansions, state-only programs, and premium assistance programs to buy into employer-sponsored coverage. In addition, many of these states enjoy high levels of employer-sponsored coverage levels.

States such as Connecticut, Delaware, Massachusetts, Minnesota, Oregon, Vermont and Wisconsin have some of the highest eligibility levels for public programs, high rates of employer-based coverage, and lead the nation in lowest number of uninsured (see coverage Table 1-3, page 11). Because these states do not have as far to go as others, opportunities to continue to build on the private market – through subsidized buy-ins to employer-sponsored coverage or implementing market reforms to improve the competitiveness of the individual and small group markets – may yield further progress in decreasing the number of uninsured.

> *"[b]y increasing the prevalence of coverage among small employers and committing private employer contributions towards coverage, the state may be able to better weather reductions in state and federal outlays for coverage through public programs."*
>
> *-Connecticut*

> *"The fiscal environment has also served to re-emphasize the importance of Wisconsin's strong private health coverage as well as the complexities of extending health coverage in a cost-effective manner to the relatively small remaining pockets of uninsured residents."*
>
> *-Wisconsin*

States such as Arkansas, Arizona, California, Idaho and Texas have lower levels of employer-based coverage, lower eligibility levels for public programs, and lead the nation in the proportion of uninsured individuals. With some of the lowest adult eligibility levels in the country, many of these states are exploring how to support the medically needy, such as non-custodial adults and parents of Medicaid-eligible children. The dilemma for these states, however, is that expansions of public programs require funds they do not have. While they are also looking to build on employer coverage and develop public-private partnerships, there is recognition that these steps will not dramatically increase coverage for lower-income citizens.

Many states are shifting their focus from expansion to maintenance of coverage

Although states are contending with their own progress over the past decade, there is little distinction among states in terms of their short-term fiscal outlook. States such as Washington, which was a leader in the 1990s, are looking at maintenance strategies *at best*. As noted in Chapter 7, Recommendations to the Federal Government, many states are hesitant to expand programs significantly without new federal flexibility and funding. Instead, many are focusing on maintaining and enhancing existing structures.

States noted that expanding coverage is difficult in the best of times. With the economic challenges facing states, policy makers are turning their attention to maintaining the progress made over the past decade.

> *"Given the growth in the state's Medicaid pharmacy budget, the potential for decline in revenues associated with an economic*

downturn, and the possibility of losing rather than gaining ground in existing public policy, it was difficult to bring significant expansions in coverage to the policy table."

–New Hampshire

Almost all of the states are looking at how they can fine tune and enhance existing public programs and educate consumers and employers of their choices in the private market. For example, MinnesotaCare, Minnesota's Medicaid 1115 waiver program has one of the highest eligibility levels in the country, and the SPG team is recommending several strategies to simplify outreach, enrollment and retention in the program. Minnesota also is exploring how to communicate the value of and need for health insurance coverage.

"Education and marketing of insurance programs and products is expected to be a politically attractive policy alternative. The cost of new programs would be significantly larger than the cost of enhancing efforts to publicize existing programs. The cost factor alone should make this attractive to policy makers."

-Illinois

In addition to budget shortfalls, states also are facing crises in their health care delivery system, including workforce shortages and the increasing reluctance of providers to participate in public programs. Also, states' small group and individual insurance markets face double-digit premium inflation, forcing some employers to drop coverage or healthy individuals to decline coverage due to cost, leaving existing pools with older and sicker individuals.

The events of September 11 are expected to affect state coverage programs in at least two ways: economic fallout lowers the state's ability to fund public programs; and the increasing focus on the public health system could eventually shift limited health care dollars away from insurance coverage efforts.

Given the current economic environment and existing status of the federal-state partnership, states are building incrementally on the current system rather than transforming it

Comprehensive, sweeping reform has remained elusive over the past decade. Although these planning grants are intended for designing ways to reach universal coverage, the range of options under consideration continue to follow the incremental coverage trend. That states have recommended expansion or maintenance strategies that "tinker around the edges," points to the fact that states have built on their existing base of programs and that almost every state is currently facing a budget deficit. In Texas, where working group members ranked a set of 20 policy options in terms of their interest, simplification and educational modifications were top choices.

"A major finding is that the remaining hard-to-reach cases are part of a diverse group of individuals, ranging from the 36 percent of

uninsured who are eligible for public programs and not enrolled to those working adults who reject employer-sponsored health insurance. As such, recommendations from this project address the varying pockets of uninsured individuals with incremental solutions rather than a single policy initiative."

-Vermont

However, there was also recognition that it is possible to develop a broad plan and move toward it in a sequential fashion.

"Therefore, while it may not be possible to immediately implement agreed-upon strategies, there is a strong commitment to develop a plan as to how the system should look and then to build that system over time."

-Arizona

States are using SPG research to recommend a range of options, each resulting in an incremental decrease in the uninsured. They are cobbling together new programs with old programs and rethinking market reforms for modifications. States are looking to new relationships with the federal government to make the patchwork of cross-subsidized programs work better with the employer-based system, from which the majority of their citizens get their coverage. Many are moving forward on new federal flexibility opportunities, but are awaiting new thinking on the federal-state partnership.

"Absent federal initiatives to expand access to health insurance coverage, future state policies will most likely seek to strengthen partnerships with local government and community agencies to provide basic primary health care services and prevention programs."

-Wisconsin

States recognize the continuing importance of the safety net

States increasingly are concerned with the impact the uninsured have on the safety net and the cost-shift to the private market caused by uncompensated care. By covering preventive care and inpatient stays for indigent and low-income adults, states hope both to provide a medical home for individuals and help safety-net facilities with more consistent financial support.

Some states are recommending strategies that address the immediate needs of uninsured individuals who receive their care at safety-net providers. These models rely on the safety net to provide basic services until a stable source of insurance or financing becomes available. Many of these programs take advantage of existing state and local funding streams, and if possible, employer and employee contributions. While not as comprehensive as traditional Medicaid benefit packages, states are exploring packages that effectively serve the medical needs of the uninsured and relieve strain on the safety net.

Data collection activities have informed the policy-development process

As mentioned above, states are using data and research to craft targeted solutions designed to address specific geographic, demographic, socio-economic, and occupational subgroups. States have found that their sponsored research helped inform policy and program design, and assisted the "mining" of data to better understand populations and systems. For example, through surveys and key informant interviews with employers and their workers, a number of states have come to understand that subsidizing private coverage has the potential to reach a large number of working uninsured.

Many states reported that quantitative research gave real-time, localized information on uninsurance, affordability, access and a host of other issues relevant to the uninsured. New Hampshire, among others, reported that quantitative data helped eliminate a number of myths about the uninsured. Using survey work, the SPG team has been able to show that the uninsured are largely working adults of all ages – not solely between the ages of 18 and 30 – many of whom are working in firms that do not offer coverage. Arkansas addressed the issue of the chronically uninsured and the prevalent belief that most of the uninsured are without insurance for brief episodes (i.e. between jobs). The Arkansas household survey found that ~35 percent of the uninsured in that state reported being without health insurance for more than three years and ~31 percent never had health insurance. Kansas noted that while empirical evidence was important, it was the personal stories from the focus groups that were invaluable in sending a message to stakeholders, policy makers and legislators of the urgency of the issue.

Section 3: Options for Expanding Coverage

Within the realm of expansion options, states recommended the gamut of possibilities – from signing up eligible but not enrolled individuals into public programs to creating entirely new approaches to health coverage and insurance security. While many states noted the importance of a market-based approach and building on the employer-based system, they also recognized the opportunity to maximize federal and state allotments for public programs. Where there are innovative approaches to insurance market reforms and community-based strategies, there are strategies to continue building on programs that have covered vulnerable individuals for the past 35 years.

As illustrated in Table 5-1, we have also divided the range of options into four broad categories:

- Options that build on and enhance existing public programs;
- Options that build on and enhance the private market;
- Options that require significant federal reforms; and
- Other options.

Table 5-1.

OPTIONS UNDER CONSIDERATION BY HRSA STATE PLANNING GRANT PROGRAM GRANTEES

	Building On/Enhancing Public Programs					Building On/Enhancing Private Market					Federal Reforms	Other Reforms
	Maximize enroll-ment in existing public programs	Expand eligibility in existing public programs[1]	Subsidize private coverage[2]	1115 Waiver[3]	Support safety net	Educate consumers and employers	Purchasing pool/State employees plan buy-in	Reinsurance Mechanisms	State tax credits	Other insurance market modifi-cations	Federal reforms	
FY 2000 Grantees				FY 2000 Grantees			FY 2000 Grantees				FY 2000 Grantees	
AR	✓	✓		✓✓		✓	✓	✓		✓	✓	
DE			✓	✓	✓✓		✓					
IL	✓			✓		✓	✓	✓				
IA		✓✓✓		✓			✓	✓			✓✓	✓
KS	✓✓✓	✓	✓✓✓		✓	✓	✓	✓		✓		
MA	✓✓✓	✓	✓	✓✓		✓	✓		✓	✓	✓	✓
MN	✓✓✓✓ ✓✓	✓✓	✓✓			✓				✓✓		
NH				✓	✓✓						✓	
OR			✓✓	✓✓	✓							
VT	✓	✓✓	✓					✓	✓			✓
WI	✓											
FY 2001 Grantees				FY 2001 Grantees			FY 2001 Grantees				FY 2001 Grantees	
AZ	✓	✓	✓	✓		✓	✓✓			✓✓✓✓		
CA	✓✓	✓	✓✓									✓✓✓
CO*												
CT			✓✓						✓			
ID*												
SD*												
TX**	✓✓					✓✓	✓		✓	✓	✓	
UT		✓		✓✓	✓							
WA	✓		✓	✓	✓		✓	✓		✓	✓	

Notes: Where a state has outlined multiple ways to implement an option, each strategy is delineated on the matrix with a check (e.g., Illinois' incentives for small employers could include purchasing pools or a reinsurance mechanism – both are included in the matrix). In addition, some states are looking at multiple strategies within a category, each receiving a check. Where an option does not fit within any of the categories, they are categorized as "Other Reforms." For further details on options, see Section 4 of each Final Interim Report, available electronically at http://www.hrsa.gov/osp/stateplanning/granteelist.htm and http://www.hrsa.gov/osp/stateplanning/granteelist01.htm.

[1] Includes Medicaid Section 1931, buy-ins to public programs, and other eligibility expansions.

[2] Includes through SCHIP, Medicaid, and other mechanisms.

[3] Includes HIFA, SCHIP, and Medicaid waivers.

* These states (CO, ID, SD) have not established options for consideration during the report period.

**Texas Working Group members ranked their level of interest in 20 proposals; in the interest of space, we chose to highlight the top seven, all of which received a score over 80 points. For details on all 20, see Texas' Interim Final report at http://www.hrsa.gov/osp/stateplanning/tx2001.pdf.

Options to build on and enhance existing public programs

Improvements in Program Administration and Outreach

Several states have proposed simplification and improved outreach for existing public programs. Quantitative analysis has been effective in identifying subpopulations eligible but not enrolled in public programs. States are particularly interested in maximizing federal matching funds.

- Illinois is calling for the periodic examination of public programs to maintain "bare-bones" simplification, such as increasing the number of languages used to communicate options or identifying the proper media for conferring messages.
- Minnesota is proposing a number of programmatic changes in public programs, including: changing eligibility criteria for seasonal workers and farmers; dropping premium payments for American Indian children; increasing administrative flexibility in application processes and in collecting premium payments; and reducing recertification requirements. In addition, the state is considering outreach and education campaigns to reduce stigma associated with public programs. Both Iowa and Vermont are considering data that show that eliminating premium requirements for children may boost enrollment in their SCHIP programs. However, given fiscal issues, Vermont is going to raise premium requirements.
- California's Cal Health Proposal offers expanded eligibility under the Medi-Cal and Healthy Families (SCHIP) programs with increased outreach.
- Both Kansas and Texas are exploring better coordinating SCHIP and Medicaid to maximize enrollment in both plans. In ranking 20 options for consideration, Texas' working group members scored two program improvement options highly: improving coordination; and minimizing language barriers in SCHIP/Medicaid.
- Kansas is exploring enhancing the yet-to-be-implemented Kansas Business Health Partnership, a pool for combining employer and employee contributions with a state tax credit and federal/state funds. The state also is examining enhancing and potentially expanding its tax credit for small businesses.
- Massachusetts is proposing to maximize outreach and enrollment activities to sign up all eligible citizens. These activities would be targeted to groups with a high uninsured rate, including minority populations. The state is also proposing the long-term good of having a single application process for all public programs using a centralized database.
- Wisconsin has researched several statutory changes to its Health Insurance Premium Payment (HIPP) program, including: simplifying application and insurance verification procedures; eliminating minimum employer premium contribution; establishing BadgerCare eligibility as a "qualifying event" for immediate enrollment; and increasing employer awareness of the HIPP program.

Public Program Eligibility Expansions

Like simplification, expanding eligibility in public programs allows states to build on existing structures and maximize state and federal funding. Several states have proposed expanding eligibility to parents of Medicaid-eligible children through Section 1931. A few states have proposed expanding eligibility in public programs to individuals

with higher incomes, although these might be less feasible given current economic circumstances.

- California is funding a proposal to expand eligibility within Medi-Cal and Healthy Families.
- The following states have proposed or are considering Section 1931 expansions to parents of Medicaid-eligible children: Utah (to 100 percent FPL); Iowa; Kansas (unemployed to 100 percent FPL); Vermont (to 300 percent FPL).
- Minnesota is exploring expanding eligibility in MinnesotaCare to uninsured individuals with access to employer-based coverage where the employer pays less than 70 percent of the premium.
- Vermont is proposing to allow individuals and employers to buy in at full cost to its Medicaid program, the Vermont Health Access Plan. Buy-in participants would benefit from lower premiums than available in the private market due to discounted provider arrangements and lower administrative costs.
- Massachusetts is researching the possibility of the elimination of categorical eligibility below an as yet undetermined income level and allowing people below that level to enroll in Medicaid. Under the plan, categorical eligibility above the income level would remain. The option would assist the poorest non-custodial adults.
- Massachusetts is also exploring building on the Insurance Partnership, a program that provides small businesses with up to $1,000 per year to cover low-income employees. One or more of the following program modifications may be made: raising the maximum employer size from 50 to 100 workers; raising maximum income eligibility from 200 to 250 percent FPL; increasing the subsidy amount for employers.
- Iowa is examining how to extend short-term coverage for unemployed workers through the unemployment insurance program. Workers and their dependents would receive similar benefits to the state employees plan and would not have to pay premiums.

Supporting Employer-Based Coverage

A number of states are looking at how they can support low-income individuals who have access to employer-based coverage. Data from many states show that subsidizing private coverage has the potential to reach a large number of working uninsured. States primarily are doing so through the Medicaid Health Insurance Premium Payment (HIPP) and SCHIP programs. States also hope to couple these expansions with HIFA flexibility to decrease the cost of providing generous Medicaid and SCHIP benefit packages and being confined by strict cost-sharing rules.

- Hoping to expand and improve upon its employer tax credit program ($35/employee/month), Kansas is exploring linking this with its HIPP program. The state also is proposing a SCHIP premium subsidy for eligible working families.
- Minnesota is proposing a premium subsidy for uninsured individuals below 275 percent FPL without access to or unable to afford coverage. Those eligible for public programs may be given the choice to enroll in either the public program or employer-sponsored coverage. The state has yet to determine whether Medicaid or SCHIP match may be available for these individuals.

- With public program eligibility levels among the highest in the country, Vermont is considering subsidizing employer-based coverage for Medicaid- and SCHIP-eligible children and their parents.
- Connecticut is modeling the use of subsidies to buy in workers to employer-sponsored coverage. Working with the Connecticut Business and Industry Association, the state would use the organization's small employer purchasing pool designed for companies with 3-50 employees to enroll uninsured workers. Three possible options for this strategy include sending subsidies directly to the employee, sending directly to the purchasing pool, or utilizing a tax credit approach.

1115 Waivers: Taking Advantage of HIFA Flexibility and Medicaid/SCHIP Innovation

Several states have begun to think through how they can take advantage of new federal flexibility through the Health Insurance Flexibility and Accountability (HIFA) 1115 waiver guidance. HIFA allows states to adjust scope of benefits and amount of beneficiary cost-sharing for optional or expansion populations in public programs. Using savings generated from these changes, states are hoping to expand coverage, decrease uncompensated care, and minimize cost-shifting in the system. Several states also are considering waivers to cover parents of SCHIP-eligible children.

- Non-Medicaid eligible recipients in Utah's Primary Care Network (PCN) model would receive basic and general health care services akin to a "family physician" model. Non-categorical eligibles below 200 percent FPL would receive the scaled-back package, whose focus would be on preventing illness and managing chronic disease. Cost-sharing would be equivalent to approximately one-half of what is required under the state employees' health plan with a low annual enrollment fee. With a waiver, the state hopes to leverage $25 million annually in federal and state funds, in addition to $8 million of free care donated by Utah's hospitals.
- Delaware proposes to build on an existing 1115 expansion for adults and children with a waiver for parental coverage up to 200 percent FPL. Using flexibility under a HIFA SCHIP waiver, the state hopes both to enroll parents of eligible children and reach additional families that are eligible but not enrolled. The state is proposing to take advantage of the allowance of capped enrollment under SCHIP, using unspent SCHIP dollars to fund the expansion to up to 7,700 newly insured individuals.
- Arkansas is proposing to use HIFA flexibility to extend Medicaid benefits to adults below 100 percent FPL. Beginning with approximately 30,000 food stamp beneficiaries, the state proposes a limited package of clinic visits, outpatient surgeries and prescriptions, and up to seven days inpatient coverage. State funding would be through tobacco settlement funds. The state also is exploring an 1115 SCHIP waiver with a limited benefits package for employed individuals and their spouses. The state would enter into a voluntary partnership with employers, which would provide the state's SCHIP match and would require 100 percent employee participation. The state would draw down the federal SCHIP match in return.
- Oregon is moving forward on OHP2 (Oregon Health Plan 2), an effort to enroll more than 40,000 Oregonians by creating a second Medicaid benefit plan for adults based on income. Savings from this new benefit plan will be reallocated to finance expansion for adults and children at higher incomes than those currently covered.

To complement this, the state has submitted an SCHIP 1115 waiver to CMS for CHIP Too, a direct payment plan using $5 million of unused SCHIP allocation to fund care for presumptively eligible children at qualified safety-net clinics. The waiver would allow Oregon to directly pay for primary care and preventive services for uninsured children, creating a "bridge" between coverage and access to health care.

- Iowa is exploring using savings generated from a scaled-back benefits package and unused SCHIP funds to expand coverage to non-custodial parents and others currently ineligible for Medicaid coverage.
- Utah, Illinois, Massachusetts, and New Hampshire are considering expanding SCHIP to parents through an 1115 waiver.

Supporting the Safety Net

A number of states simultaneously are addressing the dependence many low-income and poor individuals have on safety-net services and the affordability issue for employers and their workers. Several of the options below strengthen the safety net, create a "medical home" for individuals, and leverage employer, employee and community funds to create preventive care packages for the uninsured. With some states finding out in focus groups that access matters more than coverage, these plans address the need for affordable, primary care services.

- Delaware is proposing two approaches that strengthen the safety net. The first would be a state-funded limited benefit package that builds on the state's Community Access Program (CAP) grant. Eligibles include those between 100 and 200 percent FPL (non-Medicaid/SCHIP eligible) who seek and receive community-based care. The benefits package would be scaled back, without hospital care and restricted pharmaceuticals. Kansas also is proposing a similar facility-based option**.** Delaware's second proposal builds on the one-third share model, which leverages employer, employee and state/community funds. The option targets low-wage workers and small firms that often do not offer coverage. Beneficiaries would receive a limited benefit package costing between $1,500 and $1,800 per year. Both New Hampshire and Utah have proposed variations of the one-third share model.

Options that build on and enhance private coverage, including reforming the insurance market

Consumer and Employer Education

Several states are pursuing options that improve communication and education about existing options within the private insurance market. States hope to improve knowledge and use of tax credit programs, purchasing pools, and recent regulatory reforms or publish and disseminate information on available carriers and plan rates. Whether educating small employers of their options or individuals of eligibility criteria, states are identifying this as an ongoing need.

- Two of Texas' options under consideration are informing the public of recent insurance market reforms and producing a group/individual health insurance rate guide.
- Massachusetts is recommending an option that would educate and inform consumers of all health coverage options available to them.
- Several states are exploring initiating or improving community-based education on the value of insurance: Arizona, Illinois, Minnesota. States singled out the following groups least likely to be insured: young adults, populations of color, American Indians, and new immigrants.

Pooling/Purchasing Strategies

By aggregating purchasing power to negotiate lower prices with providers and reducing administrative costs through common administrative mechanisms, states hope to increase small group coverage by reducing premiums and/or increasing choice of alternative plans for small groups. States are exploring establishing or enhancing existing purchasing pools or allowing small businesses and individuals to purchase coverage through state employees' purchasing pools.

- Iowa is examining pooling small employers with state employees by rating them separately or by setting the premium the same for all pooled individuals.
- With fewer than 30 percent of the state's small employers offering coverage, Arkansas hopes that establishing community-based purchasing pools/cooperatives will help employers with the efficiencies associated with bulk purchasing. The state already has authorized community-based pools with defined benefits and hopes to expand the option using community resources, including local providers, and using local community and county taxes to draw down federally matched Medicaid funds.
- Legislation exists in Kansas to include selected employment groups in the state employees plan. The state may target small employers in the agricultural sector for inclusion in the pool.
- Illinois and Texas are exploring small employer purchasing pools.
- Massachusetts is exploring allowing long-term (>12 months or work >18.75 hours/week) contractors for the state to participate in the Group Insurance Commission Plans available to state employees. The state would remove a portion of the 25 percent add-on that contractors receive in lieu of benefits.

Reinsurance

Concerned with the instability in their individual and small group markets, several states are addressing premium increases and carrier exit by decreasing the risk associated with a small number of sick enrollees. In Vermont, Lewin Group found that 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. Reinsurance mechanisms pay a substantial percentage of costs above or between a defined limit. Reinsurance is a recommended strategy of the National Association of Insurance Commissioners (NAIC).

- Vermont examined but discarded from consideration a reinsurance mechanism used in New York, which uses state subsidies to pay 90 percent of costs between $30,000

and $100,000 per low-income member per year. New York hopes to see premiums decrease 15 to 20 percent in the individual and small group markets as a result of the subsidy and the scaled-back benefit packages. Iowa also is exploring the Healthy New York model.
- Arkansas is considering legislation to enroll high-risk individuals in a reinsurance mechanism funded through an assessment of all insurance companies in the state. Illinois and Kansas also are exploring reinsurance plans.

State Tax Credits

States are exploring the use of tax credits to incentivize the offering or take-up of health insurance. A credit would defray the cost or portion of the cost of premiums paid for individual or group coverage. Combining federal and state tax incentives would make options more affordable.

- Vermont is exploring employer tax credits for small firms with low-income workers. The credit would be available to all non-offering firms with 25 or fewer workers and would be equal to up to 40 percent of what the employer spends for employee coverage.
- In recommending that the federal government provide tax credits and full tax deductibility for the full cost of self-insured individuals and those without access to employer-sponsored coverage, Massachusetts also is considering a complementary credit should the federal government take action in this area.

Other Insurance Market Modifications

States are examining their private insurance markets for opportunities to increase their competitiveness and efficiency by tweaking regulations or leveraging previously unavailable public or private funds.

- Arizona's technical advisory committee is exploring the development of a scaled down "basic" benefit plan that would be affordable to the working uninsured. The state currently has a basic health plan that is neither affordable, nor basic. The state also is looking into modifying HealthCare Group, a small employer subsidy program. In addition, Arizona is exploring the creation of a high-risk pool for uninsurables using multiple funding sources.
- Hoping to boost participation in the individual market, Minnesota is considering market reforms, including guaranteed issue, risk adjustment, and pooling. The proposal would create a single pool for coverage in the individual market, with individuals receiving a choice of plans and providers through the pool. The state may be able to leverage subsidies for individuals eligible for but not enrolled in public programs and other low-income citizens. The state also is exploring extending eligibility in their parents' plan for adults ages 18 to 24 regardless of school enrollment. This option would address a portion of the "young invincible" uninsured, potentially reducing the number of young adults in public programs, and bringing healthier people into the risk pool. In Kansas, one of every five young adults between 19 and 24 is uninsured. The SPG team is exploring a similar modification

as Minnesota as well as addressing short-term uninsurance of workers by shortening the initial waiting period for coverage that is commonly 120 days or more.
- Massachusetts is exploring combining Medical Savings Accounts (MSAs) with catastrophic policies in the individual and group markets. The state hopes that the two combined would give individuals a low-cost insurance option, more choice regarding allocating health care dollars, the preventive care needed, and the assurance that they would be covered in a catastrophic event. In this area, Arkansas specifically recommends that federal legislation requires that MSAs be tied to group catastrophic policies rather than individual policies, as the former are less expensive to administer, maintain pooling mechanisms for risk, and insulate against risk segmentation.

Options that require significant federal reform

Several states are considering options that would require reform at the federal level.

- As noted above, Massachusetts is exploring complementary tax credits should the federal government implement refundable tax credits for the uninsured. The state also is calling on the federal government to allow the deduction of the full cost of health insurance for the self-employed and all individuals and families that lack access to employer-sponsored coverage. Iowa is researching the impact a federal tax credit would have on uninsured families and on employers not offering coverage. Modeling of a combined federal credit and Medicaid/SCHIP expansion also is occurring.
- New Hampshire and Texas hope to build expansions based on federal tax credits.

Other options under consideration

States are exploring a number of ideas that combine strategies previously tried or establish new approaches to the problem of the uninsured in their state.

- Massachusetts is recommending that preference be given in the bidding process for state contracts to organizations that both offer health insurance and pay for at least 50 percent of the premium. In addition, Massachusetts is examining the possibility of going a step further to require employers, as a condition of bidding for a state contract, to offer insurance and pay for at least 50 percent of the premium. Other research is underway to study certain industries that are primarily supported by state dollars.
- Vermont researched but discarded a single-payer model in which all citizens would be covered under a single public program funded with an employer payroll tax and with funds from discontinued public programs. Employers would pay two-thirds of the payroll tax at 5.8 percent, employees one-third at 2.9 percent. Lewin Group estimated that the approach would cost $2.2 billion in Vermont in 2001. California also is modeling three single-payer proposals.
- Combining several different proposals, Iowa is exploring a voluntary assessment system whereby all employers ($10/worker/month) and employees ($10/month)

would fund a "trust" to help pay for the following expansion strategies: an unemployment insurance program; Medicaid and SCHIP expansions to adults below 200 percent FPL; refundable tax credits to small employers of low-wage workers; pooling state employees and small employers with less than 25 workers. A unique supplementary feature of this 'trust' is that all employee members would be guaranteed health security, which is defined as: when any trust member loses their health insurance coverage by exceeding their maximum benefit, or by losing their employment-based insurance, the member can purchase coverage from the trust, with the premium based on a sliding fee scale according to household income.

Section 4: Options "Off the Table"

Many SPG grantees have undergone significant economic turmoil since beginning the grant. In many cases, this has forced a re-evaluation of priorities and ability to carry out large-scale expansions for the foreseeable future. Some states were able to eliminate options early in the process, while others have adjusted expectations due to declining state resources. Although several states had eliminated options by October 2001 (Arkansas, Connecticut, Delaware, Massachusetts, Oregon, Utah), the majority continue to evaluate the gamut of options. Rejected options are listed below, followed by the states that took them off the table and the reason(s) why.

<u>Access/buy-in to existing insurance pools such as state employees plan, FEHBP, public programs</u>

- Delaware (politically unfeasible)
- Massachusetts (financially unfeasible)
- Utah (financially unfeasible)

<u>Purchasing pool</u>

- Delaware (may destabilize the current system)
- Massachusetts (financially unfeasible)

<u>SCHIP/Medicaid expansions</u>

- Delaware (financially unfeasible)
- Massachusetts (financially unfeasible)
- Oregon (financially unfeasible)

<u>Tax credits/incentives/withholdings</u>

- Connecticut (increases administrative complexity)
- Delaware (financially unfeasible and may destabilize the current system)
- Massachusetts (financially unfeasible)
- Oregon (financially unfeasible and increases administrative complexity)

<u>High deductible primary care/catastrophic coverage plan</u>

- Delaware (may destabilize the current system)
- Utah (may destabilize the current system)

Subsidies for individual insurance
- Arkansas (may destabilize the current system)
- Massachusetts (may destabilize the current system)
- Oregon (may destabilize the current system)

Small group/individual market reforms
- Delaware (may destabilize the current system)

Individual and/or employer mandates
- Arkansas (politically unfeasible)
- Delaware (politically unfeasible)
- Kansas (politically unfeasible)
- Massachusetts (politically unfeasible)
- Oregon (politically unfeasible)

Single-payer system
- Arkansas (politically unfeasible)
- Delaware (politically unfeasible)
- Massachusetts (politically unfeasible)
- Utah (politically unfeasible in the short-term but will continue to investigate)

CHAPTER 6

LESSONS LEARNED

Capturing the lessons learned and the advice and observations of the grantee states was one of the goals of the consolidated report on the states' experience. Both other SPG grantees and states analyzing and planning health insurance coverage expansions should find the material in this chapter useful. State advice ranges from extremely practical suggestions such as avoiding fielding a survey during an election to ideas designed to ensure a credible data-driven process and help leadership manage under difficult time constraints. States have reported recommendations or lessons in three major sections: data collection and research, the planning process, and the organization and operations of health care programs.

Section 1: Data Collection Activities and Recommendations

The SPG program provided for a variety of data collection activity across the participating states. In general, states used a combination of quantitative and qualitative data in their planning and policy development activities around access to health care coverage. This section highlights state perspectives on the usefulness of data in the state policy process and highlights the contribution that state-initiated data collection, both quantitative and qualitative, plays in the planning process.

The Importance of State-Specific Data

All of the states found state-specific data collection and analysis critical to the policy development process. Most of the FY 2000 grantees pursued a combination of quantitative and qualitative data collection activities focused around households and employers targeted to state-specific policy issues and options. All found the combination or mix of methods provided a much more comprehensive, or "richer," picture than any one method could provide.

States used their data in four primary areas of policy development:

(1) To develop reliable and accurate estimates of the number of uninsured as a baseline to inform decisions, to respond to policy makers questions, and to monitor changes over time;
(2) To define demographic, economic and health-related characteristics of the uninsured to target new policy and access expansion options;
(3) To collect information about opinions and attitudes to facilitate the design of an effective communication plan to gain political support for policy options; and
(4) To understand the motivations of uninsured populations and to help develop targeted outreach activities.

The quantitative state-generated data were typically used to obtain detailed state estimates not available from national data sources such as CPS, BRFSS, and MEPS-

IC. In general, state-specific primary data collection included much larger sample sizes than the national data that allowed states to conduct more detailed and focused analyses of the characteristics of the uninsured and coverage rates.

States were able (many for the first time) to estimate coverage rates by geographic area, e.g., urban vs. rural and by county or region in the state. Other states were able to oversample by race and ethnicity allowing them to estimate the levels of coverage based on race, ethnicity, and other subcategories generally not available through the national surveys.

Several states also commented that the data were helpful to dispel myths about the uninsured, such as the common belief that the uninsured are uniformly poor and without jobs. The availability of state-specific data proved critical to policy makers and stakeholders understanding their state's uninsured populations. Using state-level data often reassures decision makers that the information presented by state analysts accurately reflects the unique characteristics of their state.

Qualitative data collected through focus groups, key-informant interviews, and stakeholder meetings allowed states to evaluate current policy considerations, understand the decision-making process of participants, and obtain feedback regarding current health insurance programs. It was used to gauge opinion, and identify stakeholders' real or perceived issues or problems. In addition, qualitative methods were useful in projecting the potential impact of a given policy or the level of support for various proposals. Focus groups and interviews augmented the quantitative data with real stories that were often pivotal in engaging policy makers in developing and evaluating policy options.

The data-collection activities funded under the SPG also benefited states by enabling many state analysts to be involved in data-collection activities, some for the first time. Designing and implementing data-collection activities not only allowed state analysts to provide input to the content, but also provided hands-on training in data collection and use of data.

Multi-Method Strategies Proved Most Useful

Most of the HRSA SPG states seemed to agree that a multi-method approach was beneficial to the policy development process and that this approach led to the development of sound, practical policy options. The multi-method approach typically involved state-specific household and/or employer surveys supplemented with individual interviews, focus groups, and key stakeholder meetings. Each data-collection activity was intended to complement the others, providing a rich, comprehensive picture of coverage, as well as opinions on policy options for expansion of coverage within each state.

Despite the appeal of multi-method data collection strategies, several states stressed the importance of state-specific household surveys to provide critical, state-specific,

detailed data on the characteristics of the uninsured. For several states, the SPG-funded household surveys provided the first quantitative information on the uninsured. In these states (e.g., Arkansas), this SPG-funded household survey will be used to drive and shape decision-making for many years to come.

One state, Oregon, conducted an actuarial analysis and found it to be a critical component of sound data collection and analysis. Finally, some states reported concern over the level of resources (i.e., time and availability of key personnel) to fully analyze the wealth of data available to states.

Data Collection Activities with the Least Pay-off

Data collection activities reported in this category were unique to particular states and frequently included strategies that proved difficult to design and implement. Several of the more complicated tasks involved employer data collection—both surveys and focus groups. Delaware reported having difficulty recruiting employer focus group participants; Minnesota was unable to carry out its household to employer survey data link; and Oregon's employer survey took a great deal more time than expected. States found it difficult to reach and engage employers. In addition, employer survey design proved to be more complex and difficult than some states anticipated. Household surveys were more readily implemented primarily through contracts with notable survey research entities. Arkansas found that several focus groups generated duplicative information and could have conducted fewer sessions overall without impacting the total information yield.

Recommendations to Improve Data Collection

Because the SPG states set out to complete multiple, complex quantitative and qualitative data-collection activities within a short, one-year time frame, states had to act quickly and be creative in the use of resources to get the job done. Almost all states reported the importance of "partnerships" both with researchers and with stakeholders to implement data-collection strategies. States recommended that contracts with local and national researchers be set up as a partnership with states, as opposed to independent contracts with limited state involvement. This allows states to build internal capacity and knowledge. Effective community partnerships were also noted as critical to successful focus groups of the uninsured, racial/ethnic populations, and employers.

The following are state-specific recommendations:

- *Contract with Local University Experts*: Using local experts and analysts to both conduct survey work and undertake analysis was helpful to many states. Local experts provided the opportunity for communication, but also allowed states to capitalize on the experts' background and knowledge of state issues, perspectives, and culture.

- *Contract with Notable Survey Vendors*: Relying on vendors who have done surveys in the past and have a notable track record was essential to many states; as was specifying in the contract specific elements of survey work, e.g., call-back attempt rates, required response rates, and regular updates with state staff.

- *Use Governor Request Letter for Employer Surveys and Focus Groups*: In order to obtain employer interest and buy in, a letter from the governor may open doors and provides an entry to focus group or survey work.

- *Use Community-Based Groups and Contacts for Recruiting Focus Groups Participants and Facilitators*: This is critical to obtaining input from different racial and ethnic populations. It is also important with recruiting employer participation. States used local Chambers of Commerce or Farm Bureau, as well as the National Federation of Independent Business.

- *Engage Stakeholders/Steering Committees During Planning Phase*: Getting timely input from an oversight committee during the planning phase can provide needed insight to the type of policy questions that are relevant and should be integrated into the data-collection tools. Doing this early in the design phase is critical to ensuring that relevant data, which can be used to inform the policy-decision making process, are collected.

- *Payment to Employer and Employees Increased Response Rates:* Several states found that paying employers to fill out survey forms and also to participate in focus groups increased participation in state data-collection activities. Payments ranged from $10 in Massachusetts for the employer survey to $100 in Vermont for the employer focus groups.

- *Use Experts to Develop Sampling Strategies*: Using experts to help develop sampling strategies was needed to develop accurate and reliable estimates of the uninsured by race/ethnicity, as well as by geographic regions and other categories of interest. These include development of appropriate strata for sampling, as well as oversampling techniques.

- *Translate Surveys to Other Languages*: In order to obtain needed response rates of Latinos, Hmong and other population groups, having surveys conducted in home languages is critical to increase response rates and develop accurate estimates of coverage for target populations.

- *Conduct Cognitive Testing of Surveys*: Make sure that pre-tests with relevant populations are conducted with a member of the research team present to improve the quality of the data collected and to improve response rates.

- *Build on Existing State Survey Expertise*: Many states used surveys that had been fielded and tested previously in other states. Others reviewed state and national household and employer surveys in the development phase of their research.

Practical tips from SPG states on data-collection activities are listed below:

Dealing with Contractors

- Build checkpoints into your contracts at different phases of the project.
- Do not take a "hands-off" approach with your contractor in order to ensure that you get the information and reports you need by the deadlines you have established.
- Designate a state analyst/point person who tracks the activities of contractors throughout every step of the project.
- Limit the number and variety of your contracts to facilitate coordination and tracking.
- Include the name of your contractor in your proposal whenever possible to expedite the award process.

Employer Surveys and Focus Groups

- Be careful about including insurance brokers or agents in the employer focus groups, as they could derail the discussion and bias the outcome.
- Send personal contact letters to employers so they know what the project is about and where the requests for information are coming from. Without making these connections, the reason and purpose may not be clear and it may seem like it's just another phone/mail solicitation.
- For some, a modest incentive can improve the participation of employers and employees.

Timing

- Be careful about conducting a survey when an election is going on because it could skew results and reduce response rates.
- Try to time your survey to provide results when the legislature is in session to maximize the effectiveness of the data in the policy process.
- Time pressures in a project can be both good and bad. While time pressures may force a survey into the field quickly, rushing may compromise the quality of the data collected and its ability to address the policy issues of concern. On the other hand, time pressures provide states with data more quickly so it can be put to use more quickly.

Recommendations for Data Collection and Research at the State Level

The states recommended a number of ideas for additional, state-level data collection and research activities. These recommendations have clustered around several themes, described below:

Uncompensated Care/Safety Net

Many states noted that they would like to have better information on the capacity of state safety-net providers. Several states mentioned that additional research activity is needed to quantify the amount of uncompensated care being delivered by the health care system in each state. There is also a need to collect data to amplify the states' understanding of the inter-relationships between uncompensated care, the safety net and health insurance coverage (e.g., cost-shifting and safety net capacity analysis).

Underinsured/Adequacy of Coverage/Eligible but not Enrolled

Several states identified the need to collect data to address questions related to the adequacy and availability of different benefit packages, to aid in the design of affordable benefit packages, and improve states' understanding of underinsurance. And finally, additional information about those who are eligible for public coverage but not enrolled, as well as about the population who move on and off of public coverage was identified as an area for additional research.

Costs/Actuarial Analysis

Some states suggested that actuarial modeling of different state coverage expansions would be very helpful for state policy makers making decisions on the best allocation of resources in the face of fiscal constraints. States would appreciate having a better understanding of the financial impact of proposed policy options, specifically the size of the population that would be affected and the estimated crowd-out effects.

Monitor the Insurance Market

States would also like to conduct actuarial analyses to monitor the individual health insurance market. There is limited information available to determine the incentives that attract and retain carriers in the individual market. States would also like to better understand the stability of the individual market and explore the role of public subsidies in that market.

Longitudinal Data

A number of states would like to routinely collect health coverage data. Having a source of longitudinal data would allow state analysts to examine trends in coverage, changes in the demographics of the uninsured population, and the impact of public program expansions. States are interested in evaluating how changes in their health policies have affected employer offerings, enrollment in public programs, the utilization of medical care, and health care expenditures.

Information on Employers

Slightly more than half of the states thought it would be useful to have more information on employers (Kansas, Massachusetts, Minnesota, New Hampshire, Oregon, Vermont, and Wisconsin). Many want to embark on investigations that would round out their complement of studies and provide a more comprehensive, or "richer," picture of the state of employer-based coverage in their states. For example, Massachusetts, Minnesota, and New Hampshire undertook quantitative investigations of employers in the first year but would like to do additional qualitative research as a follow-up. They desire further information on the motivations and situations of employers, the factors that influence their decisions to offer coverage, their views of the importance of health care coverage as an employee benefit, and what employers expect from competition among insurers. The additional qualitative research would also be used to test out new models of health care coverage from the employer ("supply side") perspective.

On the flipside, Kansas and Oregon conducted qualitative investigations in the first round and would like to follow up with more quantitative studies. Examples of what they hope to gain include additional information about employer contribution levels, benefits offerings, and willingness to work with the state to expand the employee subsidy program.

States also identified different employer populations on which to focus. For example, Minnesota intends to focus on small employers, New Hampshire will work with small employers who do not offer insurance, and Oregon will initiate work on employers with high offer rates but low take-up rates.

Section 2: Recommendations to Other States Engaged in Planning Health Insurance Expansions

In every complicated process, particularly one with large numbers of stakeholders and a difficult task to accomplish, there is a great deal to learn from others who have completed or are engaged in similar work. In spite of the differences among the states, this area is one in which there were strong themes and a great deal of similarity in the advice states offered to each other. The details of their individual processes varied, but the issues and values underlying their key recommendations reflected a concern for the common factors of leadership and political support, involving key stakeholders effectively, and a credible and data-based process within a very tight timeframe.

Advice for Achieving a Credible, Data-Driven Process

- Make sure no particular interest group drives or is perceived to drive your process and the work remains data and option driven. Strategies to achieve this may vary including use of multilevel processes that put vested group representatives and state administrators in a clearly technical support role.
- Make sure an unbiased group leads the analysis to achieve buy-in across all groups and avoid questions about the validity of the information and the importance of the research.
- Try to reach agreement among state agencies, legislators and the governor's office on the process, as well as the final decisions.
- Involve key policy makers every step of the way. Briefings and other ways of keeping them involved and educated about the effort are a critical investment.
- Expect and seek support across the political divides. Identify champions and rely on them—work with your critics and respect them.
- Partner with others working on similar and related issues and look for synergies that can be a basis for future consensus building and cross-pollinated efforts.
- Create cross-sectional groups between opinion leaders and the broader stakeholder communities to keep aspirations linked with practical solutions.
- Focus on goals; be flexible on how to achieve them. Ownership is critical and stakeholders feel more ownership when they are allowed to influence the process and how goals are achieved.

- Let the research findings guide the policy process. Give policy makers the ability to query the data and do it in the timeframe of the discussion. Information at the right time will often dispel anecdotal information and myths and support empirical decision making.
- Understand your information and realize that it may take multiple presentations in different media and varied contexts to make it understandable and accessible to the variety of audiences you need to reach. The effective dissemination of information builds support.
- Information does include compelling individual stories.
- Use modeling as a tool to allow policy makers and stakeholders to compare variables such as increased coverage and costs and clarify trade-offs across an array of options.
- Develop guiding principles to communicate, set expectations, and jump start discussions.

Advice for Leadership with a Difficult Task and a Tight Timeframe

- Don't reinvent the wheel. Use national experts and learn from other states' successes and mistakes.
- Consultants (outside experts) can be a valuable asset to your process both in ongoing work such as clarifying policy approaches and suggesting alternatives, and when a fresh face is needed to facilitate a process at a critical time. However, build them into your initial proposals given the time state contracting processes take and don't underestimate the investment in time and communication you will need to work with them effectively.
- Each state is different, know your state's political values and health care market history and take it into account when deciding which options to pursue. What works in one state may not work in another.
- Timing is critical and you must coordinate your process with key events like legislative sessions and look for windows of opportunity.
- Exercise patience. Accept that it will take a significant commitment of time and resources and do not underestimate the work that will need to done during the process or what will be required in cost and buy-in to implement any recommendations.
- Give your policy or advisory committee the substantial time they need for dialogue and presentations by staff and contractors.
- One year is not enough for building consensus on state-specific information. Some issues will require sequential not concurrent processing and sometimes key constituencies will want data answers prior to giving their input. You have to learn to deal with some inefficiency.
- Be both disciplined and flexible--disciplined on goals and the substance of the work, but flexible in engaging others, changing strategies, and responding to environmental change.
- Acknowledge larger forces and things you can't control that may explain success or failure—it will improve your credibility.

Advice for Involving Stakeholders and the Public

- Inventory your stakeholders at the beginning of the planning process. Create a plan for engaging them and get them involved early.
- Use the governor's letterhead and support to ensure high-level participation.
- Think through and know how to answer "what's in it for me" for stakeholders.
- Be inclusive. A broad variety of stakeholders with different perspectives on the issue, including populations being studied, and different political backgrounds will both help keep people on a realistic nonpartisan track and make sure that key differences, even from seemingly homogenous groups, will emerge.
- Empower stakeholders to create greater cooperation between competing interests and allow them to identify points of agreement and work on compromise positions.
- Find ways to engage your state's insurers.
- Involve the safety-net providers inside your process. The process needs their input and impact assessment.
- Be open in listening to the community or population you are studying. The concept of insurance for some individuals has little or no value given their economic reality.
- Devote resources to developing public leadership and public education campaigns and carefully plan your communications strategy and roll out of information to the public and media.
- Put private-sector partners and key political leaders out front.
- Simplify the key messages.

Section 3: Organizational and Operational Lessons, Including the Structure and Coordination of Health Care Programs

The completion of the HRSA SPG goals within the timeframe stretched the institutional frameworks of many of the states and created some significant management challenges just in terms of defining and accomplishing the task. The level of difficulty varied with the scope and ambition of the grantee. As noted previously, some states involved a broad range of state agency and community players in their policy process and may have also added major efforts to inform and involve the public and communities of special interest. Other states simplified their planning structure and limited or eliminated consensus-building activities. Both strategies may have produced some lessons of interest.

The SPG process also put major new data in front of policy groups and the community. The review of specific information on a state's health programs, major new qualitative and quantitative data on the uninsured and the health care marketplace, and the activities of other states were a part of most state SPG processes along with the inclusion of many perspectives and broad community representation. This mix could create a fertile environment for "rethinking." In several cases, qualitative and quantitative data changed the way people perceived the issues and opened new possibilities for how the state might target programs, work with the broader community, or organize itself.

The broader issues of coordinating and structuring state health care programs and their interplay with an effort like the SPG certainly will vary by state and will typically be one of the later issues that grantees examine. The 2001 grantees uniformly feel that it is too early to draw conclusions on these types of changes, but the initial observations of the first eleven states may be useful to all 20 grantees as they finalize their work.

Outreach and Simplification

The effort to better understand existing programs and the reality of the number of uninsured who appear to qualify for existing health coverage programs have led both Vermont and Delaware to put more focus on effective outreach strategies and simplification of enrollment processes to eliminate barriers. Vermont, for example, found in their data analysis that 35 percent of all uninsured people in the state appeared to be eligible for a state program, but had not enrolled. Massachusetts, after discussing the eligibility requirements for state programs, concluded that the system was extremely complex and new strategies should be considered. During their extension period, they will research opportunities to simplify the administrative systems for eligibility in Massachusetts. The long-term goal is the creation of a single point of entry system to manage eligibility and enrollment for all state programs.

In a very different program area, the Steering Committee in Kansas found that the sharing of responsibilities for the tax-credit program between two state agencies has created some structural and coordination problems. The state believes that its final report will contain recommendations for operational changes.

Rethinking the Relationship with the Safety Net

Delaware, Vermont and Oregon all struggled with issues of access and the safety net during their grant process and have concluded that the safety net is and will continue to be a vital part of meeting the needs of the uninsured. Two of these states, Oregon and Delaware, were also recipients of Community Access Program Grants (CAP) and there was collaboration between the planning efforts. The rethinking of the role of the safety net in these three states as a result of the planning effort has both some similar characteristics and some elements that are unique to each state. In all three states, the need to provide more organized systems for persons using the safety net providers has led to considering some new strategies. The concept of a medical home in Delaware would link the uninsured with a regular source of primary care. The appeal of this strategy, research indicates it both lowers costs and improves care, is echoed in Vermont's rationale for expanding the direct care programs initiated by some of their hospitals. In these Vermont hospitals, individuals with chronic conditions are given regular appointments with members of the hospital owned practices to provide preventive care and reduce emergency room visits.

In Oregon, the state is considering how it can support efforts to strengthen and organize the safety-net providers and help them better integrate with the traditional delivery system. One concept under consideration by the Oregon Health Division, the Medical

Assistance Program, the Office for Oregon Health Plan Policy and Research and the safety net providers is the creation of a state safety-net office. A second concept is one of the health coverage options discussed in the options section of this report, the Access Model, which would compensate these providers for care delivered to eligible, but not enrolled children. This idea is also linked to requiring participating safety-net providers to meet criteria and become Oregon Qualified Health Centers or OQHC's (Maryland, West Virginia and the District of Columbia have similar programs). The state is also working with safety-net providers to integrate care by working to create formal relationships with secondary and tertiary providers in the community.

Other Observations on the Planning Grant and Planning Process

Management of the Grant

New Hampshire found that their decision to administer the SPG without a full-time project director created major problems for existing staff and the size and scale of the effort merited a project director. They also noted that external contractors require far more time to manage than initially thought and often lack the political sensitivity needed for work with stakeholders.

The Short Timeframe

The problem of the short time line for creating, analyzing and using information in a strategic planning process is a comment heard from many states in various potions of this report. It stretches the institutional resources of the state and asks citizens involved in the planning process to make a real commitment to the process. Arkansas learned that you can get private citizens to work with government on such an intensive basis if they see the issue as important to their lives and if they are well supported by the staff. The state's concern for making data accessible to the committee and responsive to committee inquiry helped their Roundtable to become data driven and to change some of their preconceptions. The example used was the belief of several Roundtable members that most uninsured were simply in a brief transition phase. When the data revealed that most uninsured were full-time employees who had been without coverage for extended periods of time, the committee was able to quickly change its focus to different solutions.

Working with Stakeholders

States also had some significant lessons as they worked with interest groups, their health care industry representatives and the general public. Minnesota learned the value of making the time investment necessary to understand and work with the minority communities who were the focus of their study and of finding credible community partners. This intensive effort meant much better participation and results from their research efforts. Iowa learned that reaching out to the public and stimulating public discussion about the uninsured can be more difficult than anticipated in a state with a high level of coverage. They also learned that the public easily confuses health care and health insurance and materials need to be clear about the project's goals and assumptions.

CHAPTER 7

STATE RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The recommendations that follow were derived from the individual state grantee reports and should be read solely as these states' recommendations to the federal government. These recommendations are not a statement of the Administration's position and are conveyed without Department of Health and Human Services comment.

Preliminary Nature of the State Recommendations

These state recommendations should be regarded as preliminary and primarily representative of the FY 2000 grantees. Even in the case of the FY 2000 grantees, these recommendations are somewhat conceptual since most of the states have not finalized the details of their options, identified all federal implications, nor have had time to fully reflect on what they have learned. Those states approved in the second round of the program, the 2001 grantees, generally felt that it was premature to make specific recommendations at this stage of the process. State Planning Grant (SPG) grantee recommendations to the federal government will also benefit from more time for the states to work together and continue to explore the issues collectively. The states have just begun to discuss the results of their research efforts, their different strategies for coverage and public consensus, and their perspectives on the role of the federal government and the state-federal partnership for health care coverage.

Changing Fiscal Circumstances of the States

Falling state revenues, increasing caseloads, and escalating costs are pressuring all states and those SPG states that have expanded coverage to the uninsured over the last decade to maintain, rather than expand, existing coverage. Since the legislation that authorized the SPG program gave preference to states that had made significant progress in reducing the numbers of the uninsured, the 2000 grantees include many of the states that have been in the forefront of health care reform and health coverage expansions. Even states with long-standing commitments to expanding coverage are pessimistic about the ability to generate state match. States are seeking low- or no-cost options that stay within existing state resources, or are regarding this planning effort as setting long-range directions and creating options for a better economic environment. The recommendations reflect the current fiscal realities of the states and the need to stabilize public and private health coverage.

Variation in State Approach to the Issue

The approach of the states to this section of the report was varied in terms of the scope of recommendations. There were a number of areas of significant agreement, but there was not overwhelming consensus other than for the concept of continued federal support for research and planning at the state level and the need for additional time to

complete the planning process. As states share more of their thinking with each other, ideas generated by several may appear more broadly in the written material from each.

Even with these qualifications, the recommendations in this Interim Report should provide a number of areas for serious consideration and can be considered a starting point for more detailed discussions between the states and the federal government on their partnership to provide health care coverage.

State Research on the Uninsured and State Planning

Data and information played a critical role in the SPG grantees' planning and policy work. State research, both qualitative and quantitative, on the unique characteristics and dynamics of health insurance coverage in each state were used to understand the problem, to evaluate policy options, and to inform and engage stakeholders on the planning process. For many states, this was the first time state-specific data were available and these data became an integral part of the policy making process. Extending health insurance to all state citizens will be a lengthy, incremental process given the current economic constraints. As states proceed to implement and adapt plans to changing circumstances, they are concerned about maintaining skills and infrastructure they have developed.

The most consistent theme from the states was the importance of state surveys and other state-level research on the uninsured as a tool to inform the policy discussion and guide state planning. The failings of the national CPS to serve state planning needs expressed by the states included its timeliness and the fact that the small sample size in any one state precluded regional, county, or special population estimates. Almost uniformly, the states felt that CPS was useful only for monitoring broad trends and, even there, most found it inadequate for responsiveness and state-specific information. As a result the SPG states made the following recommendations to the federal government:

- Support continued development of state coverage solutions and expertise in health coverage issues. Federal collaboration with the states can assist states in understanding and responding to the problem of the uninsured.
- Support on-going monitoring of the uninsured at the state level by providing support and technical assistance to states and university-based policy and research institutes.
- Convene states to collaborate on information and research issues and fund mechanisms for sharing information between the states.
- Disseminate the experience and findings of the SPG states to help other states craft solutions and research the issues.

Improve the Ability of the States to Use Existing Federal Data Resources

Many of the SPG states used the MEPS-IC (Medical Expenditure Panel Survey) data as a key part of understanding employer-sponsored insurance and employee behavior. In some states, such as Arkansas, the state partnered with this survey to expand the

sample and increase its usefulness to the planning process. The recommendations that follow deal primarily with this important national survey and to some extent the relationship between the states and federal government on major data resources:

- Encourage more timely and accessible release of state-specific estimates from federally collected data sources. State analysts want the ability to work with unaggregated data.
- Increase the distribution of MEPS-IC data, consider repackaging in an easier-to-use format, and provide the data in an unaggregated form. States such as Illinois note that the small sample size and aggregation make the data much less useful to policy makers.
- Provide more analysis and publication of the portion of the MEPS survey providing information on the types of coverage available to the uninsured.

Federal Tax Incentives to Expand Health Insurance Coverage

Six of the FY 2000 grantees (Vermont, Massachusetts, New Hampshire, Minnesota, Arkansas, and Delaware) made specific recommendations to the federal government for changes in tax policy to create new incentives for individuals and employers to purchase health care insurance. State policy makers believe there is greater potential for federal tax incentives to change the behavior of currently uninsured individuals and small businesses that do not offer coverage and that the current tax system should make the tax treatment of health insurance costs more comparable for all payers. Both of these perspectives are reflected in the following state recommendations addressing federal tax policy on health insurance and health care costs.

- Create additional tax incentives directed at small employers including support for a refundable tax credit to small employers not providing coverage. One state (Delaware) added the modifier "meaningful" to tax incentives to indicate their belief that a substantial incentive will be needed. State experience with tax credit programs for small businesses should help in identifying issues to be considered if the federal government were to initiate such a program.
- Offer federal tax credits sufficient for individuals to purchase health insurance.
- Extend tax credits for individuals purchasing insurance beyond those buying in the individual market to individuals purchasing through community purchasing pools. Arkansas feels that this policy would create an incentive for the creation of larger purchasing pools and give individuals some of the advantages enjoyed by large purchasers.
- Allow full tax deductibility for the cost of health insurance for the self employed and those who lack access to employer-sponsored coverage (Massachusetts).
- Make tax policy neutral for health care insurance and medical costs. Current tax policy allows employers offering insurance benefits and some individuals with cafeteria plans to cover both health insurance and medical costs with pre-tax dollars while those without these options must use after tax funds. This difference in treatment led Arkansas to recommend that the federal government should make all of these costs either tax exempt or taxable.

- Modify current federal laws on Medical Savings Accounts (MSAs) to tie the qualifying high deductible plan to a group rather than an individual policy (Arkansas) and encourage the commercial development of catastrophic plans when combined with Medical Savings Accounts (Massachusetts). The rationale is to spread the catastrophic risk to limit premium increases or cancellation, but maintain the cost containment and personal savings features that MSA advocates support.

Medicare and other Federal Health Care Insurance Programs

State policy makers realize that federal policy and funding for non-Medicaid health programs can have a profound effect on both state health expenditures and the larger health care marketplace. Medicare is, of course, the federal program outside of Medicaid whose benefit design and reimbursement policies have the most significant impact on the states, individual state health care providers, and insurers. Many of the recommendations that follow demonstrate the states' belief that changes in federal policy for Medicare and other federal programs could free resources and political energy, and allow the states to focus on other health coverage issues.

- Establish a Medicare Drug Benefit. Vermont, New Hampshire and Arkansas encourage enactment of a drug benefit for Medicare recipients. All three believe states have increasingly used political energy and state resources creating programs to address drug coverage for Medicare beneficiaries and that pharmaceutical coverage is part of a basic benefit package. As of October 2001, 31 states had authorized or passed legislation establishing pharmaceutical assistance for low-income seniors and other designated citizens. This is in addition to state funding for Medicare beneficiaries whose income is low enough (SSI) to make them eligible for a Medicaid wraparound. Other designated groups of low-income Medicare beneficiaries with state Medicaid impact include the Qualified Medicare Beneficiaries (100 to 120 percent FPL) who receive funding for Part B premiums and cost-sharing and Special Low-Income Medicare Beneficiaries (120 to 135 percent FPL) funded for Part B premiums only.
- Improve Medicare reimbursement to hospitals to reduce cost-shifting to the private sector exacerbating increasing private-sector premiums and problems of affordability (New Hampshire).
- Expand Medicare Eligibility through buy-in options for the disabled and near elderly (55+) populations. Other recommended changes would include allowing the SSI disabled to access Medicare immediately, as the elderly do, rather than the current two year waiting period and relaxing the handicapped definition for SSI eligibility.
- Provide adequate funding for the Indian Health Service (IHS). Minnesota, a state with 55,000 Native Americans within its borders, found the lack of satisfaction with IHS funding within that community to be a clear research finding prompting this recommendation.
- Expand the 340B Drug Pricing program to rural health clinics and critical access hospitals. The 340B program currently benefits patients of Federally Qualified Community Health Centers, designated federal grantees, and certain DSH hospitals.

Expansion of this program to other safety net providers would also help their clients with needed pharmaceuticals.
- Continue federal support of Federally Qualified Health Centers. Delaware, a state that also was a Community Access Program (CAP) grantee, supported the administration's expansion of access points provided by these centers.

Federal Flexibility/Federal Demonstration Waivers

The states began their work on the SPG prior to the announcement of the new Health Insurance Flexibility and Accountability (HIFA) waiver program for SCHIP and Medicaid. This program does promise new flexibility for the states and incorporates many of the recommendations of the National Governor's Association policy for health reform. States are, however, uncertain of exactly how much flexibility the new waivers will allow, particularly in areas such as benefit design where the states have traditionally found the federal government reluctant to move beyond accepted benchmarks. State flexibility remains a critical issue on the states' agenda with the federal government. The following recommendations deal with waiver flexibility and identify other suggested changes in existing federal practice and policy on demonstration waivers.

- Provide a central place where states can access critical information such as submitted and approved waiver requests. The easy availability of this information will allow the states to build on the experience and waiver negotiation process of other states (Oregon).
- Maintain the existing commitment of federal participation in 1115a waivers that have achieved coverage expansions by including them in the Medicaid spending base when states apply for new waivers. Making these 1115a expansion populations permanent would eliminate the need to include them in budget neutrality negotiations. As a state that has made very significant coverage expansions under 1115a waivers, Vermont now is concerned about maintaining these commitments.
- Provide waiver flexibility to states to implement SPG-developed options. Although the states are still in a preliminary stage of their work on options, several of the states are already able to identify areas where their SPG strategies will require more flexibility than any federal waivers granted to date (Oregon, Utah, Arkansas). Other states (Delaware and Minnesota) have made more general recommendations for federal waiver flexibility. As SPG states consider what waivers their options will require to allow federal funding, the following issues will undoubtedly be raised in negotiation. Reduced benefits and increased cost-sharing will be proposed for both new and existing Medicaid populations to expand coverage in an affordable way and allow better coordination with employer based insurance. States have also indicated that they will need waivers for eligibility, and to provide enrollment caps. Utah may also propose a waiver for cost-based reimbursement to FQHCs to allow a new less costly benefit option using these providers as a base for expanding services to adults.
- Consider community-based demonstrations. Three states (Arkansas, New Hampshire, and Oregon) have recommended more flexibility in community-based or

targeted strategies. Either because of economic realities or the complexity of issues, it may make sense to focus on a community rather than a state. Arkansas feels that community strategies to establish purchasing pools may result in more stability than association-based pools that have been often unsuccessful. Oregon believes single funding stream or models that combine access and coverage may be possible if focused on those communities with greater capacity to undertake such projects. New Hampshire wants the flexibility, in a time of reduced resources, to propose targeting expanded eligibility for state programs to those communities particularly hard hit by economic hardship.

- Support multi-state experimental approaches such as the multi-state regional purchasing pools for small business proposed by New Hampshire.
- Support regional solutions to help states with common issues that cross state lines such as the needs of the lower Mississippi delta. The challenges of this low-income, economically challenged area are shared by Arkansas, Tennessee, Mississippi, and Louisiana. Collaboration is complicated by the fact that it is also divided into two Department of Health and Human Services regions. Arkansas recommends improved collaboration from the federal government when states' solutions cross federal regional lines.
- Consider large demonstrations of innovative approaches that require substantial investments such as the individual mandate. Oregon makes this recommendation in the belief that the investments needed for program design, implementation and subsidies are so substantial that no state will undertake the experiment without a significant federal commitment.
- Conduct a federal demonstration with small business that would allow businesses with fewer than 10 employees to buy into the insurance coverage program for federal employees (New Hampshire).
- Work with states across human services programs to achieve efficiencies and create uniform points of entry into public programs. The Massachusetts Steering Committee believes that operational and administrative efficiencies as well as improved services are possible in state-federal partnership programs. If Massachusetts and other states are to achieve such long-term goals as redesign of administrative systems that support eligibility and enrollment, they will need the cooperation of the federal government to work across existing federal funding lines.

Other State Recommendations Affecting Federal Financial Support

In addition to the federal resource issues already identified in earlier recommendations, states made more general comments recognizing the critical role of the federal government in financing incentives for health coverage expansions. States have to balance their annual and biennial budgets and they often face declining revenues and increasing caseloads simultaneously. The federal government has both the strongest revenue generation ability and more ability to counter economic downturns. While states are looking to the federal government for assistance in financing, some states such as Wisconsin have raised the issue of whether, in today's economic environment, simply providing additional matching programs for expansion is enough. States, as already noted, face difficulties finding funds to match current health programs in a

declining economy and the post-September 11 world. Some specific options from individual states follow.

- Increase SCHIP allotments to provide states an incentive to provide services to the parents of SCHIP eligible children (Massachusetts). SCHIP's enhanced match, increased state flexibility, and target group have proven to be a powerful incentive for the states.
- Provide an incentive match for enrollment of hard to reach minority populations (New Hampshire).
- Allow federal Medicaid match for employer and employee cost-sharing for adult coverage expansion options (New Hampshire). Arkansas proposes a variation of this strategy by recommending a voluntary tax on employers to be matched by federal funds to make basic coverage more affordable for employers with low-wage workers. (Arkansas' proposal is discussed in more detail in the options section of this report.)

The Big Picture—Cost, Access, Quality and Beyond

A number of the FY 2000 states pointed out the critical linkages between cost, access and quality in the nation's complex and inter-related health care system. Focusing on one piece of the puzzle can cause a failure to recognize the economic and social linkages that influence the system. The recommendations that follow urge the federal government to strengthen its leadership role in health system issues through research, dissemination, and providing incentives for best practice. (Arkansas, New Hampshire, Wisconsin, Delaware and Oregon all had recommendations in this area)

- Support additional research on the interrelated clinical, economic, and social factors influencing the United States health care system. Additional research should include the delivery systems, appropriate utilization, costs and quality of health care including issues such as the impact of direct pharmaceutical advertising and cost effectiveness of new versus existing technologies and medications.
- Support additional research on the factors driving current cost trends and what strategies effectively contain costs. This should include technical assistance and training to the states in analyzing Medicaid and state health care expenditures.
- Provide incentives to insurers and physicians to implement best practice management protocols for chronic disease management and foster evidence-based medicine.
- Encourage inclusion of scientifically supported clinical prevention services and additional research on prevention and promotion of healthy lifestyles. Several states noted the potential for advancing health that lies in increased access to preventive services and lifestyle changes to reduce deaths and disabilities from preventable causes.
- Support additional research on health manpower issues to provide better state, regional and local data, and help states assess what capacity/manpower is adequate to serve new populations, and how different delivery system options affect health care workforce issues.

- Support studies to help forecast the state impact of coverage expansions on health plans, delivery systems, providers, and other key components.
- Systematically reassess the federal strategies to address the health needs of all citizens, particularly programs dealing with economic disparity. The test for policies such as federal Medicaid match policies, designation of medically underserved areas, graduate medical education funding, allocation of research dollars and all other federal investments should be whether they support the highest priority population-based health needs and the nation's Healthy People 2010 goals (Arkansas).

State Recommended Additional Research on the Uninsured and Current Health Coverage Programs

The states' agenda for additional research is directed to the federal government, foundations and other organizations with the capacity and interest in sponsoring additional work in the following areas identified by SPG states.

- Additional longitudinal studies to better understand the issues associated with enrolling and leaving public programs. Issues identified by Oregon include the link between health insurance and health status and how persons leaving Medicaid meet their long-term health needs.
- Additional longitudinal research on cohorts of the uninsured to track and understand their actual encounters with the health care system (Minnesota).
- Additional research on measuring affordability including the effect of different cost-sharing strategies (Minnesota and Oregon).
- Additional research on defining underinsurance and adequacy of coverage (Minnesota and Oregon).
- Continued research and dissemination on state programs and state-specific research to address the problem of the uninsured (Oregon).
- Surveys/additional research focused on specific target populations of the uninsured such as low-income employed eligible for employer sponsored insurance or individuals eligible for public or private programs who do not enroll.
- Additional research and detailed information about self-insured firms available at a state level (Kansas).
- Development of a central clearinghouse on health and insurance related topics with common definitions to allow comparative analysis across states (Kansas).
- Additional research on design features that influence take-up rates and crowd-out to help state develop more effective partnerships with the private sector (Delaware).
- Research on whether differences in individual health status are associated with health insurance coverage versus direct service delivery models (Delaware).

APPENDICES

Appendix A

Existing Coverage Programs of HRSA Grantee States

Grantee States	Medicaid			
	Section 1115			Section 1931*
	Name of Program	Implementation Date	Eligible Population	Earnings Disregard (for applicants unless noted)
Arizona	Arizona Health Care Cost Containment System	4/1/2001	100% FPL for childless adults; medical bills spend down to 40% FPL	$90 and 30% of the remainder (for recipients only); 100% for families with children (as of 7/1/01)
Arkansas	ARKids First	9/1/1997	Uninsured children under age 19 =200% FPL	20% of applicant's and recipient's earnings plus 60% of recipient's earnings
California				All income between the old AFDC standard level and 100% is disregarded for applicants and recipients, or recipients may disregard $240 and 50% of remaining earnings, whichever is more advantageous to the family
Colorado				All income between old AFDC standard and 150% FPL
Connecticut				
Delaware	Diamond State Health Plan	1/1/1996	Adults under age 65 =100% FPL	
Idaho				
Illinois				
Iowa				20% of earnings and 50% of remainder

Kansas				$90 plus 40% of remaining earnings for recipients
Massachusetts	MassHealth	7/1/1997	Employees =200% FPL; children, families and disabled =150% FPL	
Minnesota	MinnesotaCare	7/1/1995	Pregnant women and children under age 19 =275% FPL	$120 and 1/3 of remaining earnings
New Hampshire				20% of earnings
Oregon	Oregon Health Plan (OHP)	2/1/1994	Uninsured under age 65 =100% FPL	$90 plus $30 and 1/3 of remaining income or 50% of earnings
South Dakota				
Texas				
Utah				
Vermont	Vermont Health Access Plan (VHAP)	1/1/1996	Previously uninsured non-custodial adults (age 18-65) to 150% FPL, and custodial adults to 185% FPL	$150 in earnings and 25% of the remainder of earnings from an unsubsidized job and $90 per month of earnings from a subsidized job
Washington				50% of earnings, plus actual child care costs and child support paid out by the family**
Wisconsin	BadgerCare	4/1/1999	Uninsured children and parents =185%	$90 plus $30 and 1/3 of remaining income for 12 months

*States included here are those that have expanded beyond 1996 AFDC standards.
**Figures for Washington state TANF family medical program.

Existing Coverage Programs of HRSA Grantee States

Grantee States	Medicaid		State Children's Health Insurance Program	
	Health Insurance Premium Payment (HIPP) program	Transitional Medicaid Assistance (TMA)	Upper Eligibility	Family Coverage
Arizona		24 months	200% FPL	
Arkansas		12 months	200% FPL	
California		24 months	250% FPL	
Colorado		12 months	185% FPL	
Connecticut		24 months	300% FPL	
Delaware		24 months	200% FPL	
Idaho		12 months	150% FPL	
Illinois		12 months	185% FPL	
Iowa	Implemented 1991	12 months	200% FPL	
Kansas		12 months	200% FPL	
Massachusetts		12 months	200% FPL	Yes*
Minnesota		12 months	280% FPL	Yes
New Hampshire		12 months	300% FPL	
Oregon		12 months	170% FPL	
South Dakota		12 months	200% FPL	
Texas	Implemented 1996	18 months	200% FPL	
Utah		24 months	200% FPL	
Vermont		36 months	300% FPL	
Washington		12 months	250% FPL	
Wisconsin	Implemented 1999	12 months	185% FPL	Yes

* Parents are not technically eligible for SCHIP, but some parents are covered due to cost-effectiveness determinations.

Existing Coverage Programs of HRSA Grantee States

Grantee States	**State-Only: Coverage Program**		
	Name of Program	Type	Eligible Population
Arizona	1. Premium Sharing Program 2. State Emergency Services Program 3. Primary Care Program 4. Community Health Center Programs 5. HealthCare Group	1.Insurance Subsidy Program 2. Direct Coverage 3. Direct Coverage 4. Direct Coverage 5. Subsidy	1. To 250% FPL or below 400% FPL if chronically ill 2. Undocumented individuals, not eligible for Medicaid up to 40% FPL 3. Low income at risk individuals in rural or medically underserved areas 4. Indigent/uninsured Arizonans families below 200% FPL 5. Small employers with less than 50 employees
Arkansas			
California			
Colorado			
Connecticut			
Delaware			
Idaho			
Illinois	KidCare	Employer Buy-In	Children between 133% - 185% FPL
Iowa			
Kansas			
Massachusetts	The Children's Medical Security Plan	Direct Coverage	Uninsured children under age 19 not eligible for MassHealth
Minnesota	MinnesotaCare	Direct Coverage	Adults 21 and over 175% FPL
New Hampshire			
Oregon	Family Health Insurance Assistance Program (FHIAP)	Insurance Subsidy Program	Uninsured for past 6 months =170% FPL
South Dakota			
Texas			
Utah			
Vermont			

Washington	Basic Health Plan Medicaid State Only Programs include: a. Children's Health Program b. Medical Care Services (GAU and ADATSA) c. State Family Assistance Program d. Medically Indigent	Direct Coverage	BHP: Adults and children under 200% FPL, not eligible for Medicare Medicaid: a. Non-citizen children under 100% FPL b. Unemployable/disabled adults under 45% FPL c. Parallel to TANF for non-eligibles under 45% FPL d. Adults with emergency medical needs, under 49% FPL (short term- 3 months with inpatient, ER, etc.)
Wisconsin			

Existing Coverage Programs of HRSA Grantee States

Grantee States	**State-Only: High-Risk Pool**			
	Name of Program	Year Operational	% of Average Individual Market Rate	Finance Mechanism
Arizona				
Arkansas	Arkansas Comprehensive Health Insurance Plan	1996	150%	Assessment to participating members
California	California Major Medical Insurance Program	1991	125% of the "standard average individual rate," unless a plan exceeding the average cost to the state is selected, in which case the premiums are 137.5%	Major Risk Medical Insurance Fund in the California State Treasury. The fund is compromised of cigarette and tobacco tax revenues.
Colorado	Colorado Uninsurable Health Insurance Plan	1991	150%	Business Association Unclaimed Property Fund; Unclaimed insurance funds
Connecticut	Connecticut Health Reinsurance Association	1976	125% at initial enrollment; 150% maximum	Association members are assessed for plan losses
Delaware				
Idaho	Idaho Individual High Risk Reinsurance Pool	2001		Assessment to insurers; General Revenue
Illinois	Illinois Comprehensive Insurance Plan	1989	125 - 150%	General Revenue and Insurance Industry Assessment funds
Iowa	Iowa Comprehensive Health Association	1987	150%	Assessment to association members; Health Insurance Trust Fund; Premium taxes or other forms of taxes payable to the state

Kansas	Kansas Uninsurable Health Insurance	1996	"Reasonable" relative to benefits, risk and profile	Assessment to association members; Premium taxes
Massachusetts				
Minnesota	Minnesota Comprehensive Health Association	1976	125%	Assessment to association members; State "Health Care Access Fund" (funded through a 1.5% health care provider tax)
New Hampshire				
Oregon	Oregon Medical Insurance Pool	1990	125%	Assessment to association members; Insured premiums; Expenditure limitation
South Dakota				
Texas	Texas Health Insurance Risk Pool	1998	First year premium cap of between 125% and 150% of standard rate for comparable individual health insurance and 200% of standard rate for renewal years. The first year's rate was set at 137.5% of the standard rate.	Regular and interim assessments on insurers and HMOs, based on percentage of health premium written in Texas by each health insurer/HMO.

Utah	Utah Comprehensive Health Insurance Pool	1991	Utah Senate Bill 60 of 1997 requires an adjustment to the pool premium rate each July 1st. The increase is based on the average increase of the small employer rates for the five largest insurance companies that provide health plans to small employers.	State Comprehensive Health Insurance Pool Enterprise Fund; Legislature appropriations
Vermont				
Washington	Washington State Health Insurance Pool	1988 (revitalized in 2000)	150% for fee-for-service; 125% for managed care	Association members are assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments are offset against premium taxes in year of assessment or following years.
Wisconsin	Wisconsin Health Insurance Risk Sharing Plan	1981	150 - 200%	Assessments to Wisconsin health insurers, general purpose revenue, and provider payments in the form of discounted rates

Existing Coverage Programs of HRSA Grantee States

Grantee States	**State-Only: Tax Incentives**			
	Effective Date(s)	Eligible Population	Deduction or Credit	Amount
Arizona				
Arkansas				
California	1/1999	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Colorado	5/25/2000	Individual, spouse, dependents	Deduction	100% of premium expenditures, but not >$500
Connecticut				
Delaware	1997	Self-employed	Deduction	100% of premium expenditures
Idaho	4/18/2000	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Illinois	1/1/1996 - 12/31/2004	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Iowa	1/1/1996	Individual, spouse, dependents	Deduction	100% of premium expenditures
Kansas	1/1/2000 - 12/31/2001	Small employers	Credit (refundable)	$35 per eligible employee per month
Massachusetts				
Minnesota				
New Hampshire				
Oregon				
South Dakota				
Texas				
Utah	1/2001	Individual	Deduction	100% of premium expenditures
Vermont				
Washington				
Wisconsin	1993	Self-employed workers, spouse, dependents	Deduction	100% of premium expenditures
		Employees without employer coverage, spouse, dependents	Deduction	50% of premium expenditures

Appendix B

Health Resources and Services Administration
State Planning Grant Quantitative and Qualitative Research Matrix

Arkansas
Arizona
California
Colorado
Connecticut
Delaware
Idaho
Illinois
Iowa
Kansas
Massachusetts
Minnesota
New Hampshire
Oregon
South Dakota
Texas
Utah
Vermont
Washington
Wisconsin

Glossary

BRFSS: Behavioral Risk Factor Surveillance System

CATI: Computer Assisted Telephone Interview

CPS: Current Population Survey

DOI: Department of Insurance

ESI: Employer-Sponsored Insurance

MEPS-IC: Medical Expenditure Panel Survey-Insurance Component

NSAF: National Survey of America's Families

RDD: Random Digit Dial

Arkansas State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Arkansas' State Planning Grant.

Goals of Arkansas SPG:

1. Establish the Arkansas Health Policy Roundtable to guide the State Planning Grant Program, which will be staffed by a multi-disciplinary project team.
2. Examine and summarize existing information on health insurance status in Arkansas.
3. Collect and analyze primary qualitative data obtained from key informant interviews with large employer and insurance company representatives, and from focus groups with employers and households.
4. Collect and analyze qualitative data from employers and household members through new state data collection efforts using surveys available nationally to further inform and guide the development of viable options for expanding insurance coverage.
5. Identify, evaluate, and prioritize options for health insurance coverage under the guidance of the Health Policy Roundtable.
6. Generate and submit final reports to the Arkansas Governor and General Assembly and to the Secretary of DHHS, and initiate recommendations of the Roundtable.

ARKANSAS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Summarize existing data for socioeconomic & business profiles	• Secondary data from the following: BRFSS, MEPS-IC, Census 1990 and 2000, Arkansas BCBS, Hospital Discharge data, and other country-specific utilization and cost data.		• Key informant interviews	• 10 personal, open-ended, tape recorded interviews of largest state-based employers, 5 personal, open-ended, tape recorded interviews with the major health insurers in the state; *Employers*: review ESI decision-making process, benefits, issues threatening coverage, impact on ESI of expansion options under consideration; *Insurers*: review experience in large, small, individual markets, failed efforts to expand market share, attractive options to expand markets, impact on insurers of expansion options under consideration
• Conduct state-wide revised survey of Insurance Status (originally developed by UMASS-Center or Survey Research household survey)	• RDD stratified CATI telephone interview of 2300 eligible households to obtain regional and state-level information to assess availability and uptake of insurance, health status and health care utilization for adults and children, SES, and employment history.			
• Sub-contract AHRQ to increase existing sample size of Arkansas MEPS-IC employer survey	• Increased MEPS-IC 2001 mail survey sample size from 800 to 1800 Arkansas employers, stratified by region and industry type and size, to obtain data regarding employer sponsored health insurance participation.		• Household focus groups	• 26 focus groups of 8-10 household decision-makers per group stratified by federal poverty levels, race, insurance status, and region
			• Employer focus groups	• 7 focus groups with 6-8 participants stratified by industry size, industry type, and region
			• Employer and household focus group data	• Collect focus group data to understand decision-making process related to uptake/disenrollment of health insurance for self, household members, and employees, including insurance history, current needs, perceived current and future barriers and solutions, and past and projected

ARKANSAS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
				efforts to maintain/adopt health insurance.

Arizona State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Arizona's State Planning Grant.

Goals of Arizona's SPG:

1. Through a nine-member Statewide Health Care Insurance Plan Task Force conduct public hearings, consider staff research results and recommendations, establish guiding principles, assess the feasibility of various strategies to address accessibility/affordability of health care and submit a final report with recommended actions steps to the Legislature and Governor by 12/15/01.
2. Form a Technical Advisory Committee in collaboration with the Task Force to provide guidance in the design and selection of options to enhance health coverage in Arizona.
3. Review and compile information on population characteristics and employer composition, available health care coverage, characteristics of uninsured population, health insurance costs and strategies to overcome barriers to coverage.
4. Review current approaches/best practices being used by other states and their experience in adopting such approaches.
5. Analyze and test proposed strategies, including soliciting input via community meetings/focus groups.
6. In addition to the Task Force report, prepare and submit to HRSA a final report on the results of the SPG activities and state recommendations by 3/31/02.

ARIZONA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Summarize and analyze existing data regarding health care coverage in Arizona.	· Use national (e.g., CPS, MEPS-IC) and state (e.g., DES, AHCCCS) data sets in order to provide information on population characteristics and employer composition, available health care coverage, characteristics of uninsured population, health insurance costs and strategies to overcome barriers to coverage.		· Create a series of policy issue papers	· Summarize current approaches/best practices being used by other states and their experience, evaluating the pros and cons of the approaches and identifying issues that need to be considered in adopting various approaches. Topics addressed include: purchasing pools, high-risk pools, incentives and regulatory mandates to increase health insurance coverage, international approaches, identification of key sub-populations of uninsured and strategies to address needs, self-insurance, basic benefit plans, and improve access to rural health care services.
· Compile inventory of Arizona strategies to address rural health care infrastructure	· Summarize current programs/strategies in Arizona that improve rural health care delivery by increasing the number of rural practitioners, minimizing geographic isolation, improving viability of health care facilities including hospital solvency and/or supporting financially rural-based health care service programs.		· Statewide Health Insurance Plan Task Force	· Develop an affordable health care insurance plan for all Arizonians by December 2001. (Task Force consists of 3 members of the AZ House of Representatives, 3 members of the AZ Senate, 1 health care provider, 1 consumer advocate and 1 business community member.) Public testimony is taken at each Task Force meeting.
			· Technical	· Provide guidance in the design

ARIZONA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
			Advisory Committee	and selection of options to enhance health coverage in Arizona. (Committee is composed of representatives from the physician community, insurance companies, hospitals and state agency directors.)
			· Community meetings/focus groups	· Obtain input on Task Force recommended strategies for addressing health care accessibility/affordability in Arizona.

California State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of California's State Planning Grant.

Goals of California's SPG:

1. Determine the range of viable strategies for attaining universal health coverage based on the specific issues in California.
2. Develop and analyze a full range of alternatives in order to define workable models for California.
3. Determine how these strategies can be financed.
4. Identify the institutional changes that would occur with each alternative approach for achieving universal health coverage.
5. Identify effects that can be expected on benefit levels, access, quality, range of services, reliance on preventive care, and the stakeholders.
6. Develop a report to the Secretary that describes options for universal health care in California.

CALIFORNIA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· State administrative databases	· Access a variety of databases to obtain state-specific information. These databases include: hospital and other health facility financial, encounter and utilization, patient data, Medicaid Eligibility Determination System (MEDS) data, and Healthy Families (SCHIP) databases.			
· Federally and privately funded surveys	· Use 1996-97 Medical Expenditures Panel Survey (MEPS) to gather insurance and expenditure data, as well as individual and household demographic data. The Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) will provide demographic, economic, employment, and health insurance coverage information.			
· Foundation funded surveys	· Use the California Work and Health Survey and the Kaiser Family Foundation survey of California employers for information on employment-related insurance.			
· State funded surveys	· Use the California Census Research Data Center to match State administrative or other survey data with Census Bureau surveys (e.g. match California's MEDS file with CPS and SIPP survey data to perform analyses of well known undercounting of Medicaid and public assistance use as reported by those Census surveys.)			

CALIFORNIA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Household survey	· Survey of 39,000 households, the California Health Information Survey (CHIS) will provide information to be used in subsequent activities since its information will not be available for this planning grant.			

Colorado State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Colorado's State Planning Grant.

Goals of Colorado's SPG:

1. Develop reasonable options for expanding access to affordable health insurance coverage to all citizens of Colorado. The options developed will both address the unique issues and challenges faced by the population in various regions of the state, and will include both the public and private sectors. The benefits offered by the options proposed will be similar in scope to the Federal Employees Health Benefit Plan, Medicaid, or coverage offered to Colorado State employees.
2. Build on the initiatives and collaborations currently in place in order to provide a well-integrated approach to the problem, rather than parallel developments.
3. Examine and address the access and coverage disparities that currently exist among Colorado's various sub populations—e.g. race and ethnic disparities, and disparities between those living in urban and rural (or frontier) settings.
4. Examine the interplay between access to affordable health care and economic impact in various regions of the state.
5. Design a series of coverage and financing options for heath insurance that meet the overarching goal of the initiative.
6. Build upon the efforts of the Coalition, the state's efforts to provide affordable medical access to families transitioning from welfare to work, and other efforts currently underway to increase access to health care.
7. Provide a detailed report to HRSA on Colorado's needs, and specific proposed strategies/models to address those needs.

COLORADO STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Colorado specific data breaking down uninsurance data by region (Urban Institute 2000)	· Consultant will use SPSS software to analyze the Urban Institute's National Survey of American Families database to answer detailed questions for Colorado.		· Colorado and Oregon Medicaid plans	· Compare Colorado's benefits to those of Oregon in order to identify cost effective approaches in Colorado.
· TABOR analysis	· Analyze the impact of TABOR on each of the proposed coverage options and whether or not there is a way to structure options to avoid TABOR impact.		· Household surveys	· Use survey to determine additional information from the uninsured: how long uninsured; what kind of previous coverage; barriers to coverage; if eligible for an existing program (i.e. Medicaid or CHP+), why not accessing; rural/urban status; employer characteristics; price elasticity of take-up rates
· Alternative revenue sources	· Identify alternative revenue sources to fund each selected option and the feasibility of each potential source analyzed.			
· Five option cost impact analysis	· Conduct simulations of the five options to estimate impact of each on health spending by type of provider, employers, households, and federal, state, and local governments. Also estimate the impact of alternative financing mechanisms.		· Employer surveys	· Use surveys to gain additional information from employers: are employers dropping coverage; are employees opting not to participate; what are employers' eligibility rules; data on the underinsured; status/activity of the small group market; activities to control premium costs; knowledge about insurance options (purchasing co-ops, etc.)
· Analysis of cost impact of Refundable Tax Credits	· Determine the cost impact by analyzing tax payments and uninsurance by income levels.			

COLORADO STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
			· Focus groups	· Follow-up to survey information on health insurance market, responses to price increases, intentions to add coverage, responses to subsidies or tax credits
			· Federal Employees Health Benefits Plan model	· Analyze impact of a FEHBP model and perform analysis to complete criteria checklist.

Connecticut State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Connecticut's State Planning Grant.

Goals of Connecticut's SPG:

1. Develop a plan to provide access to affordable health insurance coverage to all Connecticut citizens, providing the opportunity of all individuals or families to purchase or participate in an adequate, affordable health insurance program.
2. Identify the characteristics of Connecticut's remaining uninsured citizens.
3. Identify eligible populations and explore the feasibility of premium subsidies.
4. Design proposals to provide all uninsured citizens with access to health insurance through insurance expansion options.
5. Submit a Report to the Secretary outlining the findings of these grant activities.

CONNECTICUT STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Connecticut Family Health Care Access Survey (by telephone)	· The University of Connecticut Center for Survey Research and Analysis (CSRA) will determine sample size and will use RDD databases and software. In-person interviewing will be conducted as needed. Data to be collected is current and prior 12-month health insurance coverage, access to health care, use of health care, health status, satisfaction with the health care system and insurance coverage, family composition, demographic data, employment characteristics, and family income. Opinion information on acceptable premium amounts and take-up interest will also be gathered. Survey results will be used to update the 1995 version's results.		· Secondary data on insurance markets	· The Office of Health Care Access will utilize this data to conduct a comprehensive study of current Connecticut insurance market characteristics.
· Survey of employers	· Five to six questions will be added to the existing periodic surveys conducted by CSRA for the CT Department of Economic and Community Development (DECD) and the CT Department of Labor (DOL).			
· Agency for Healthcare Research and Quality (AHRQ) MEPS-IC	· Staff will analyze most recent Connecticut-specific information generated by this survey to gather information on health insurance plans obtained through employers, unions, and other sources of private health insurance, such as number and types of private insurance plans offered, the benefits associated with these plans, premium contributions by employers and employees, employer characteristics, and			

CONNECTICUT STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
	insurance take-up rates.			

Delaware State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Delaware's State Planning Grant.

Goals of Delaware's SPG:

1. Gain a thorough understanding of the characteristics, demographics, and patterns of Delaware's uninsured population.
2. Fully explore the optimal balance between private and public sector activities and the most effective partnering strategies.
3. Explore and develop politically and financially feasible options for providing affordable health insurance coverage to all Delaware citizens.
4. Build sufficient public and political will and awareness to assure success for any recommended strategy(s).
5. Prepare a final report to the U.S. Secretary of Health and Human Services and state of Delaware leaders.
6. Evaluate the outcomes of the planning process.
7. Share experiences with other states

DELAWARE STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Summarize existing data collection and analysis · Obtain additional information where gaps exist · Identify specific characteristics of target subpopulations · Define income brackets to target · Identify levels and costs of coverage for employers	· CPS, BRFSS, state-level reports on cost-shifting, cost of health care, accessibility to individual market, small business alliance survey, state-maintained data · Coordinate with state Community Access Program to better understand demographics and utilization behaviors of target populations. · Further analysis of age and income bands, where the government's responsibility lies in offering coverage/subsidies · Academic research completed by University of Delaware · Retained health policy and actuarial analysis services.		· Focus groups and employer surveys · Focus groups · Travel · Key informant interviews, sounding board meetings, series of public health policy conferences.	· Determine employer attitudes and behaviors about providing health insurance. · Determine employee attitudes about accessibility of health insurance. · Learn experiences of other states in planning/implementing similar activities. · Learn attitudes of key health care stakeholders; including health plans, legislators, hospitals and physicians.

Iowa State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Iowa's State Planning Grant.

Goals of Iowa's SPG:

1. Build a complete and data-driven picture of Iowa's uninsured population.
2. Build a complete and data-driven picture of Iowans' beliefs on expanding access to health insurance.
3. Design coverage options that will incorporate data on the uninsured and Iowans' beliefs regarding expanding access to health insurance.
4. Create a strategy to achieve the goal of expanding access to health insurance.
5. Prepare a report to the Secretary which can be used by other states to expand their citizens' access to affordable health insurance.

IOWA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Data collection and analysis • Telephone surveys • Strategic planning surveys	• Evaluate existing data and create a baseline for coverage option simulations • 2 Surveys to gather data on uninsured • 4 surveys to determine "active public"* and employer beliefs regarding coverage expansion and potential opposition to expansion; first survey for incorporation into coverage simulations, second survey to test opinions regarding draft simulations		• Focus groups of uninsured • Focus groups of employers • Strategic planning focus groups	• Attitudes towards insurance coverage and uninsured status • Determine "active public"* and employer beliefs regarding coverage expansion and potential opposition to expansion

*"Active public" is defined as persons who voted in the last two Iowa general elections and who are covered under a health insurance policy.

Idaho State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Idaho's State Planning Grant.

Goals of Idaho's SPG:

1. Undertake a coordinated process of data collection, policy analysis and evaluation of potential insurance strategies in conjunction with a structured dialogue among Idaho political, health care and business leaders about policy options in order to develop a comprehensive plan for providing access to insurance for all Idahoans.
2. Assemble a Data Collection Team to collect and analyze relevant Idaho data.
3. Review existing programmatic structures and develop a series of policy options.
4. Assemble a Model Development Team that will develop and finalize a low-cost insurance strategy for small businesses.
5. Assemble a Strategic Planning Team to develop a statewide plan for providing access to all of Idaho's uninsured, to be presented at community forums.
6. Develop dialogue among Idaho's community leaders.
7. Present the resulting comprehensive plan in the form of a Report to the Secretary.

IDAHO STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· State population data · Sources: people internal to the project, mainly Boise State University's Center for Policy	· Data collection team will review this existing data on Idaho's population in order to develop a picture of the state's uninsured. Gaps in the data will also be identified. · BSU project assistants will assist the group in identifying relevant external sources of data that will aid in estimating the total cost of insurance for all currently insured Idahoans and for covering the uninsured Idahoans identified in the profile. It will also provide a comparison of the rates of uninsured between Idaho's rural and urban areas, the demographic characteristics of people served by the County Indigency and State Catastrophic programs, an analysis of the number of Idaho small businesses and large businesses which do not provide health insurance, the average cost and co-pay of insurance for an Idahoan and a prototype of the benefit package provided, an identification of a benchmark at which point insurance becomes affordable for both employers and employees and a determination of a target wage level of an employee to whom a subsidized package should be targeted.		· Existing state structures and other states' programs	· Policy team will review existing structures within the state to provide coverage and access to the uninsured population. National expert will also present on the programs and policies of other states and lead the team in determining the pros and cons of those options for Idaho. Such review may include such documents as approved Medicaid 1115 waivers.

Illinois State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Illinois' State Planning Grant.

Goals of Illinois' SPG:

1. Assure 100 percent access to health insurance benefits for all citizens.
2. Determine and understand who is uninsured in Illinois.
3. Determine, through a study of the uninsured population and the employer community, what types of programs will best address the barriers to insurance found in an analysis of the uninsured, to what extent products currently available through private and public sector providers address those barriers, and what gaps between the uninsured and providers must be bridged.
4. Examine programs currently available in Illinois and any possibilities present for expansion.
5. Identify the best partnering structure to achieve the goal of 100 percent access to health insurance for all citizens.

ILLINOIS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Population-based survey	• RDD telephone survey of 300 households per region, 900 total; use of screening and main instruments to find at least one uninsured individual in the household; in main instrument, ask questions about demography of household, take-up of public and private coverage, perceptions, etc.		• Key stakeholder focus groups	• Groups of 7-10 conducted in each of 5 regions of employers and unions, medical groups, local government agencies, public health and social service agencies, insurance agents, uninsured people; region including Chicago oversampled with additional focus groups; ask about factors related to uninsurance, factors preventing coverage, willingness to pay percentage of coverage, incentives needed to cover employees, awareness of public programs, best ways of communicating availability of public coverage
· BRFSS expansion	• For 6-month period, size expanded to a monthly sample of 350, yielding a total of 2,100 interviews; additional questions on reasons for declining ESI coverage, awareness of alternative forms of coverage; seek longitudinal trends such as demographics, geographic distribution, health status of uninsured vs. insured, trends in reasons for being uninsured, etc.			
• Analysis of existing data sets	• CPS, University of Illinois Chicago data set developed for Illinois Department of Public Aid (health status, insurance, income and family composition about 1,000 low-income families), and BRFSS		· Personal interviews	• 15-20 interviews of high profile individuals including CEOs, leaders of insurance industry, general business and industry, legislative leaders; ask about perceptions of uninsurance, why ESI is declining, incentives to increase ESI, characteristics of ideal insurance program, cost estimates of this, ideal partnering structure to achieve statewide coverage

Kansas State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Kansas' State Planning Grant.

Goals of Kansas' SPG:

1. Gather policy-relevant demographic and socio-economic data about the characteristics of insured and uninsured Kansans.
2. Identify what alternative structures and conditions would motivate Kansas employers who do not now provide or contribute toward health insurance for their workers to participate in purchasing pools or other arrangements that would allow their workers to receive health coverage through the workplace.
3. Develop several alternative approaches for subsidizing coverage for uninsured Kansans and otherwise creating more favorable conditions for obtaining health insurance, and estimate the cost and likely effectiveness of each of these approaches.
4. Provide enhanced technical analysis and support to facilitate the development of program rules, policies, and structures necessary to effectively reach uninsured workers in small firms.

KANSAS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Data analysis of critical issues and high priority populations (pre-grant)	• Review and analysis of existing state- and national-level data and studies and review of prior efforts to expand insurance		• Individual consumer interviews	• 50+ interviews conducted from the telephone interview sample cells associated with employment and general demography associated with uninsurance; topics include insurance/health status, eligibility for ESI, perceived insurance options, perceived importance of insurance, etc.
• Household telephone survey	• RDD telephone survey of 8,000 households with an estimated 22,000 individuals (derived from Florida Health Insurance Survey questionnaire); may require oversampling and stratification of subpopulations		• Small employer focus groups	• 6-10 groups in at least 3 different geographic areas, including one rural area; employers of different size, industry, wage structures
			• Individual business interviews	• 20-30 interviews with individual small business owners in at least 3 different geographic areas

Massachusetts State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Massachusetts' State Planning Grant.

Goals of Massachusetts' SPG:

1. Define "affordable" for residents based on income and family status.
2. Determine the most appropriate level of insurance coverage (benefits and deductibles) to serve as a "benchmark" based on the most prevalent insurance products in various categories of subscribers.
3. Identify existing barriers to the benchmark level of insurance coverage.
4. Develop proposals for achieving universal access to affordable insurance that support and enhance the private insurance market while ensuring that the safety net of public programs is available to those who need it.

MASSACHUSETTS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• New survey to address gaps in current data	• Conduct employer survey to assess employer behavior with respect to health insurance. • Conduct survey of purchasers in non-group market to assess motivation for purchase and demographic characteristics		• Stakeholder focus groups	• Union representatives, small and large employers, chambers of commerce, consumers in individual market, uninsured; assess reactions to various expansion options
• Analyze and synthesize existing survey data and market data	• Conduct survey of physician offices to assess who seeks care and what services are utilized on a free and/or sliding scale basis in a Doctor's office			
• Define and analyze key characteristics of local insurance markets and utilization of uninsured and underinsured	• Determine risk factors/predictors of uninsurance, including consumer demographics and consumer preference issues through analysis of CPS, NSAF, Division of Health Care Finance and Policy data, MEPS, Department of Employment and Training (DET) data sets • Sources include Uncompensated Care Pool Eligibility, hospital claim submissions, DOI data on insurance product costs, DET reports on prevalence of insurance products in group market, demographic data stratified by insurance product, survey of non-group market subscribers; these data will provide comprehensive picture of insurance market, uninsured,			

MASSACHUSETTS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
	and barriers to affordable coverage			

Minnesota State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Minnesota's State Planning Grant.

Goals of Minnesota's SPG:

1. Expand knowledge of health insurance status for populations of color and rural communities and use this knowledge to adapt current programs and/or create new initiatives designed to reduce the number of uninsured people within these populations.
2. Evaluate the effectiveness of MinnesotaCare and Medicaid in reducing the number of uninsured people in the state and make recommendations for adjustments to the programs to increase their effectiveness at reducing the uninsured in Minnesota.
3. Expand knowledge of conditions in the private market that have an impact on the number of uninsured people in the state.

MINNESOTA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Household survey	• RDD telephone survey of 30,000 households designed after the MN Health Access Survey; stratified sampling design for oversampling of low-income, people of color and rural communities; ask questions pertaining to insurance/health status, affordability, access, source of care, utilization, take-up		• In-person follow-up to the household survey	• Sampling of African-Americans, Hispanics, Southeast Asians, Native Americans
			• Focus groups of minority populations	· Populations of color and refugee and immigrant populations to assess the degree to which these groups have difficulty navigating the health care system
· Sampling of MinnesotaCare enrollees	· Random sample drawn from administrative enrollment data and asked to respond to a set of questions on the household survey; also asked about their current health insurance status		• Focus groups of farmers	• Farmer populations to determine barriers to coverage in this population.
· Employer survey	• Random survey based on 1993 and 1997 RWJF Employer Health Insurance Surveys; additional questions to address crowd-out, options for workers most likely to be uninsured, trends in benefits, eligibility requirements, enrollment, cost-sharing, premium contributions		• Key informant interviews with health care providers, administrators, caseworkers, and advocates	• Interviews focused on exploring barriers to gaining and/or keeping insurance, problems that result from being uninsured, and possible actions that the State of Minnesota can take to reduce the rate of uninsurance.

New Hampshire State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of New Hampshire's State Planning Grant.

Goals of New Hampshire's SPG:

1. Prepare concise information on the uninsured and their willingness to participate in health insurance arrangements.
2. Expand support and consensus around the issue of the uninsured in the state and bring fact-based decision-making to the forefront in policy debates relating to the uninsured.
3. Address shortcomings in historical efforts to expand coverage.
4. Develop an implementation plan that will provide coverage to all groups not currently eligible for health insurance or enrolled in health insurance for which they are eligible.
5. Implement health care reforms that will expand coverage and access to health care services for the uninsured based on a public/private process of collaboration and education regarding options and recommendations.
6. Provide the Secretary and other states with the experience and insight that New Hampshire has been able to glean from their initial efforts at expanding coverage.

NEW HAMPSHIRE STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Revision of New Hampshire Health Insurance and Access Survey (NH-HICAS)	• RDD telephone survey oversampling minority populations, rural areas, 3 high population centers; data on coverage, reasons for lack of coverage, participation in public programs, underinsurance, relationship between coverage, employment and health status		• Employer focus groups on insurance offering	• Members from local Chambers of Commerce, NH Business and Industry Association, former NH Healthcare Purchasers Roundtable; to discuss factors that affect offering
			• Employer focus groups on crowd-out	• Assess potential for crowd-out and develop mechanisms for measuring and limiting crowd-out
• Revision of NH Office of Employment Security survey of wages and benefits	• Survey to produce estimates of insurance offer rates by firm size, industry type, labor market area		• Consumer focus groups on take-up of public insurance	• Two-part process to better understand why families do not take up public program coverage and why families do participate in them (including value of coverage, marketing, etc.); also ask about expansion of public programs for adults and opinions on coverage for childless adults; look at perceived ability or willingness to pay (accompanied with living wage data review)
• Revision of living wage data	• Help validate outcomes of consumer focus groups			
			• Construct market profiles	• Develop profiles of insurance and provider products, prices and competitiveness; conduct interviews of supply-side players to test models for coverage expansion; understand key market trends; develop regulatory

NEW HAMPSHIRE STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
				recommendations; develop recommendations for models to provide subsidized coverage based on these profiles

Oregon State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Oregon's State Planning Grant.

Goals of Oregon's SPG:

1. Increase health insurance through the expansion of both public and private financing.
2. Increase the proportion of eligible people who apply for and receive Medicaid coverage.
3. Improve the capacity and capability of Oregon's safety-net clinics to provide needed care to the uninsured population.

OREGON STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Determine who is uninsured and how many	• Analyze existing data sources, including: CPS; Oregon Population Survey (2000)		• Focus groups	• Learn more about the coping strategies of the uninsured. Find interest in expansion options.
• Establish patterns of ESI coverage and benefit offerings	• Existing data sources: KFF/HRET Employer Health Benefits 2000 Annual Survey; MEPS (1996-1998)		• Focus groups	• Learn more about small employer market and what it would take for them to offer coverage.
• Determine viability of Family Health Insurance Assistance Program (FHIAP) as an expansion model	• Surveys of FHIAP enrollees, those on FHIAP reservation list, FHIAP leavers.		• Focus groups	• Determine how providers and administrators view expansion options.
			• Town hall and stakeholder meetings	• Engage the state in a conversation about expansion options.
			• One-on-one interviews	• Determine employer interest in FHIAP
• Determine level of statewide support of expansion options	• Statewide household survey			
• Compare current OHP benefits to standard benefit packages (FHIAP, Mandated Medicaid, PEBB, typical commercial plans)	• Actuarial modeling using Oregon Health Plan utilization and cost data to represent target populations.			

The matrix below outlines the quantitative and qualitative research topics and methods of South Dakota's State Planning Grant.

Goals of South Dakota's SPG:

1. Convene an Interagency Work Group of state governmental officials charged with directing the data gathering and analysis activities, and recommending specific options for providing the state's uninsured population with access to affordable and quality health insurance coverage.
2. Gather and analyze the necessary data regarding the state's uninsured population through comprehensive state-wide surveys, focus group meetings and personal interviews involving private households, employers and potential interest groups.
3. Formulate viable coverage options and identify potential funding sources for providing access to quality health insurance coverage.
4. Submit report to the Secretary outlining the state's plan for providing access to affordable, quality health insurance coverage for South Dakota's uninsured population.

SOUTH DAKOTA STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· BRFSS and CPS data · Statewide telephone survey of households · Statewide survey of employers	· Compile relevant information from these pre-existing data sources. · Using RDD, survey 20,000 households, oversampling target vulnerable populations such as Native Americans, small employer groups, farmers, ranchers, and migrant workers, in order to identify and study the uninsured population in South Dakota. · Survey 400 employers statewide to obtain data as to coverage, benefits and attitudes toward offering insurance if none is offered presently. · Facilitate at least 8 focus groups featuring the urban low-income, urban and reservation Native Americans, small employers, farmers and ranchers, self-employed, and the elderly.		· Public input · Focus groups · Stakeholder interviews	· Solicit public input once coverage expansion options are generated by the Work Group, based on survey and data analysis. · Direct interviews with a variety of private sector organizations having particular interest in health insurance issues to obtain commentary and perspective on issues surrounding expansion of coverage. · In-person or phone interviews soliciting opinions on: populations that are likely to be uninsured; receptivity to possible options for expanding coverage; and the role their organization played/could play in expanding coverage.

Texas State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Texas' State Planning Grant.

Goals of Texas' SPG:

1. Determine quantified social, economic, and administrative obstacles to reducing Texas' uninsured rate.
2. Identify specific benefit plan options with associated enrollee costs and state funding.
3. Determine steps necessary to assure maximum enrollment while reducing crowd-out.
4. Develop stakeholders understanding and support of the project's findings and recommendations.
5. Prepare a Report to the Secretary outlining the findings of the planning grant activities.

TEXAS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Survey of uninsured	· Survey will be modeled on successful surveys conducted in other states. Questions will be developed to obtain the following information: demographic information about uninsured and potential program enrollees, access to employment-based coverage, and attitudes/perceptions regarding insurance.		· Small employer focus groups	· Focus groups representing small employers, their employees, insurers, and agents will assist with development of the small employer survey; they will review the findings from previous survey of small employers in other states under the Robert Wood Johnson Foundation Health Care for the uninsured Program (HCUP) and a follow-up survey; group will also review the small employer reforms enacted in Texas between 1993 and 1997 to determine what information is needed to understand their limited success and to develop plans for increasing insurance access and affordability for small employers.
· Statewide small employer survey	· Survey will be developed based on the recommendation of the small employer focus group; questions will generate: basic demographic information regarding the employer's business, whether employer has attempted to purchase insurance within last 5 years or ever, reasons that insurance is not offered, level of interest in offering insurance, employer's knowledge of previous small employer insurance reforms and their impact on employer's decision to/not to insure, financial contribution employer believes is reasonable towards insurance, attitude towards a private coverage buy-in, willingness to assist in promoting and/or administering a private coverage buy-in with generous subsidy provisions, level of knowledge of purchasing alliance concept, and level of interest in state tax credit program for employers offering premium assistance for low-income eligible workers.		· Public and private programs previously implemented	· Consultants and staff will examine existing private and public programs within the state as well as those of other states'; examined in regards to benefit levels and service delivery mechanisms, participation rates, including who will most likely enroll and how they might be affected by price, barriers to enrollment and people's willingness to participate under different plan requirements, financing costs and funding
· Survey of insurers and HMOs	· Survey will be directed to 40 of the largest insurance carriers, writing about 80 percent			

TEXAS STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
	of all group health insurance in the state and all licensed basic service HMOs; questions will be designed to determine basic demographic information on those insured under group health plans, detailed information on cost of coverage for employee only, employee-spouse, employee and children and family coverage, benefits covered, percentages that have comprehensive coverage, typical provisions for co-pays, deductibles, and coinsurance, participation requirements, and insurers' willingness to participate in subsidy/buy-in programs and concerns and perceived obstacles of doing so.		mechanisms, and cultural issues affecting access. · Responses of interested parties	· Results of the surveys will be compiled in a detailed report that will be provided to the oversight and implementation working group; report will also be posted on the project's website, distributed to various focus groups, and presented in various local presentations; responses of interested parties will be used to determine the reaction to the options, the level of support of each proposal and ways to improve recommendations. · Participants will include state lawmakers and staff, policymakers and regulators, health policy analysts and researchers, health care consumers including uninsured citizens, providers, advocacy groups, employers, business and industry representatives and other stakeholders; participants will be encouraged to voice concerns and suggestions regarding proposals; comments will be summarized in a report to the Oversight and Implementation Working Group and will be used in developing the final report to the secretary.
			· Statewide planning conference forum	

Utah State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Utah's State Planning Grant.

Goals of Utah's SPG:

1. Enhance statewide data collection efforts by conducting Utah Health Status Survey of 2000-2001, community needs assessments, community focus groups—as needed; to develop coverage options for uninsured groups with an understanding of all potential impacts for each coverage option.
2. Establish a public-private partnership for the systematic study and development of an implementation strategy that increases access to health care coverage and reduces the number of uninsured Utahns; and to work in partnership with Utah State legislators, legislative committees, and the Governor to develop any legislation and budget recommendations that will be needed to implement health care coverage options.
3. Seek creativity in the design of a seamless, integrated statewide system of health care delivery to the uninsured; to integrate strategies for improving access to health care coverage with other human service needs of the low-income uninsured; and to formulate, from the best practices of other states, a system of health care coverage that is culturally and geographically accessible to communities in need.
4. Build on recent successes in Utah's SCHIP program and community-based efforts to manage the Medicaid-TANF de-linking processes; and to develop implementation strategies that build on relationships of trust between community-based organizations and their uninsured and under-enrolled constituents.
5. Develop a financially sound business plan for the financing of each health coverage option (or strategic combination of options).
6. Identify desired outcomes by uninsured group and set performance indicators that allow the Partnership to determine measurable improvement in reduction of uninsured in Utah.

UTAH STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· Telephone survey	· General population household survey of 7200 Utah households to gather information on insurance status, demographic information and Utah's target populations.		· Key informant interviews	· Questions to uninsured to focus on reasons for lack of insurance, reasons some uninsured persons do not take advantage of employer-provided insurance, barriers faced in attempts to get insurance, level of desire for heath insurance coverage, and reasons that eligible persons do not take advantage of public programs; questions to employers to focus on barriers faced in getting ell employees health insurance coverage and begin to identify potential solutions to these employers' situations.
· Employer survey	· Used to understand important characteristics of employer, such as whether they offer health insurance to their employees, the situations in which insurance is offered, employer insurance costs, any problems employers currently have in offering health insurance to all employees, the value that employers put on offering insurance to employees, the types of things that they look for in a health insurance plan for their workers and whether employers would welcome a public/private partnership focused on provision of health insurance to all employees.			
· Discrete choice survey	· Representative samples of the employers and individuals who answered the first survey given this secondary survey which will take the attributes that have been determined as central to the health insurance decision (using the individual and employer surveys) and vary them, requiring the respondents (both employer and individual) to choose which plan they would want.			

UTAH STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Discrete choice analysis	• From the responses generated by the discrete choice survey, demand for a program will be determined; a scenario's overall utility is a measure of consumer demand for that scenario.			

Vermont State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Vermont's State Planning Grant.

Goals of Vermont's SPG:

1. Design and conduct in-depth quantitative and qualitative research of Vermont's population at both the statewide and local (sub-state) levels, to better understand the uninsured's demographic characteristics, basis for insurance, and their likely response to various coverage strategies.
2. Design and conduct in-depth qualitative research of Vermont's employer, health insurer, and provider communities, to better understand their perceptions of public and private health coverage in the state, and to gauge interest and likely responses to various coverage strategies to improve access to care.
3. Perform actuarial analyses to assist in pricing coverage options and for evaluating financing issues.
4. Facilitate collaboration across various state agencies and private organizations participating in the development and/or regulation of coverage options within Vermont.

VERMONT STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• General population survey	• Oversampling of specific sub-populations based on 1993 RWJ Family Survey and 1997 Vermont Family Health Insurance Survey; will determine number of residents uninsured, duration, and characteristics such as demographics, income, employment, education level, health status, family size/structure, rural residence; also assess those "at risk" of losing insurance, underinsurance, burden of prescription drug costs, trends in employer offering of coverage, take-up, (including of public programs); methods to include households without telephones; results augmented by merging data with BRFSS		• Focus groups of users of safety net clinics	• Two sessions targeting users of 12 clinics, which serve 7,500 people; assess factors leading to uninsurance, willingness to pay for specific coverage options, attractiveness of other options (subsidies, tax credits, etc.)
			• Employer and association focus groups	• Segmented by employee size (1-10, 11-24, 25-50, 51+) and insurance status; explore perceptions of insurance market and health delivery system in terms of affordability and accessibility, determine future trends in offering coverage, define criteria by which employers make decisions (e.g., benefits, premium thresholds, etc.), awareness among employers of public subsidy programs, gauge interest in programs to make insurance more accessible/affordable (e.g., purchasing pools, tax credits, etc.), identify rating/benefit model options that would encourage coverage offering; supplemented by one-on-one interviews
			· Consumer focus groups/employer interviews	• Coverage options and designs market-tested; focus testing on those population segments and employers toward whom option is

VERMONT STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
				targeted

Washington State Planning Grant, FY 2001

The matrix below outlines the quantitative and qualitative research topics and methods of Washington's State Planning Grant.

Goals of Washington's SPG:

1. Develop a comprehensive understanding of the social, cultural, economic, demographic and health status characteristics of uninsured population, including the reason for their status as uninsured and how Washington's uninsured compare to those in other states.
2. Develop a strategic plan to impose economic and administrative discipline on purchasing, payment, and delivery systems to secure additional money for subsidized health coverage and to provide more affordable coverage for the general market.
3. Develop a detailed approach to test the viability of community-based delivery and financial flow arrangements that involve public and private purchasers in partnership with local communities and their health care delivery systems.
4. Create a six-year "full access" plan.
5. Create the Report to the Secretary outlining the results of the planning efforts and lessons learned through the effort. The report will also include the final six-year plan.

WASHINGTON STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
· 2000 Washington State Population Survey (SPS)	• Phone interviews of 7,279 Washington households from the state's biennial population survey will provide the basis for analysis of the state's uninsured population including in-depth profiles of uninsured individuals and families; additional national population and employer–based surveys will complement the analysis; specific work will focus on supplementing SPS with SIPP data as well as creating baseline information to which routinely collected data (MEPS) can be compared in the future.		· Focus groups	· Groups will serve to fill data gaps determined from review and analysis of existing population and employer-based data. In particular groups will focus on understanding the profiles of employers who offer and do not offer coverage, including their values, decision-drivers and areas of ambivalence
			· Structured interviews	· Interviews with informed experts will provide the basis for understanding opportunities for joint private/public partnerships to reduce the burden of administration of health care services.
· National Surveys	Broad review and analysis of existing data and population survey question batteries will help identify opportunities for improving Washington's biennial household survey. · Survey of Income and Program Participation (SIPP) · Current Population Survey (CPS) · Behavioral Risk Factor Surveillance System (BRFSS) · Community Tracking Survey (CTS) · Family Health Insurance Survey (FHIS) · Medical Expenditure Panel Survey-Household and Insurance Components (MEPS-HC; MEPS-IC) · National Health Interview Survey (NHIS) · National Survey of American Families (NSAF) · Employer Health Insurance Survey			· Interviews with informed experts will provide the basis for building partnerships with community-based efforts to create a more affordable system.
			· Ad-hoc groups; conference work session; regional public meetings	· Various methods will be used to broadly solicit input and feedback from the public and key constituencies; these include: groups focused on the substantive work of the project; a special work session at the annual health policy-legislative conference;

WASHINGTON STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
	(EHIS) · Survey (and follow-up focus groups) of insurance carriers and third party administrators to understand the variety, complexity and cost of product offerings in the market (individual, small group, large group—fully insured and self insured); results will support analysis of the potential to distill the range of products into a finite set that would maintain consumers' choices while reducing complexity and cost to the system. · Comparison of what individuals can afford to pay for coverage and care, (using *Self-Sufficiency Standard* for Washington state) with the reality of coverage available to them (based on results from the survey of private payers).			public/private collaboration to conduct a series of regional meetings around the state and collaboration on a community-based survey testing a public dialogue approach.
· Survey of Private Payers · Affordability analysis				

Wisconsin State Planning Grant, FY 2000

The matrix below outlines the quantitative and qualitative research topics and methods of Wisconsin's State Planning Grant.

Goals of Wisconsin's SPG:

1. Design a state-of-the-art health and health insurance survey.
2. Modify current health survey and analyze results.
3. Attain and analyze enriched data sample from national employer insurance survey.
4. Provide technical support and research to design and implement public/private programs that expand access to health insurance.
5. Conduct original research on private employer-based health insurance.
6. Analyze and recommend policy options to improve the use of public funds that support a buy-in to employer health benefit programs.
7. Conduct original research with various groups of uninsured with certain characteristics on barriers to health insurance coverage.

WISCONSIN STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			**QUALITATIVE**	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
• Additional sample of 2000 MEPS-IC	• Enhanced sample of 800 completed cases; will measure employer coverage by cost and type of coverage, type and size of employer, and according to worker wages		• Small employer focus groups	• 8 groups in various geographic regions of small employers who have never offered coverage, previously offered coverage but no longer do so, and who offer coverage but experience a low take-up rate
• Additional questions on WI Family Health Survey (FHS)	• FHS is an annual stratified random sample telephone survey of 2,400 households comprising 6,300 individuals; double the sample size during January-June 2001; Ask employed adults about employment status (number of jobs, hours worked, type of employer, job tenure) and employer-sponsored insurance (offers, take-ups, family coverage, premiums); Ask unemployed adults about reasons for not having insurance and length of time uninsured; Conduct analysis of results.		· Small employer interviews	· One-on-one interviews of 30 small employers in various geographic regions, similar to the target groups above; seek insights into small employers' perceptions about their role in the insurance system and their reaction to alternative structures
· Additional information from WI FHS	· Further analysis of FHS data to: (a) learn more about the relationship between health insurance coverage and health care utilization; and (b) provide a more detailed description of the characteristics of the uninsured with attention to specific subgroups (i.e. working-age adults not eligible for Medicaid because they are not parents of minor children)		· Employee telephone interviews	· Telephone interviews of coverage perceptions of 30 modest-income (150-200% FPL, potentially BadgerCare enrollees) workers in various geographic regions; specific topics include reasons for decline of coverage, role of employer in making coverage available
· Develop, design, prepare new statewide health survey	• Consult with stakeholders, conduct technical design process, develop and test survey question modules, survey protocols, and interviewer training materials, and develop a		· Research on rural population and subgroups	• Develop projects with stakeholders that use focus groups and interviewing to gather information on health status of cultural and ethnic minorities access to coverage for cultural

WISCONSIN STATE PLANNING GRANT RESEARCH MATRIX				
QUANTITATIVE			QUALITATIVE	
RESEARCH TOPIC	METHOD		RESEARCH TOPIC	METHOD
	plan for transition from existing WI FHS; Translate new instrument into Spanish, draw an oversample of Hispanic Wisconsin residents and conduct survey interviews in Spanish and English.			and ethnic minorities; collaborate with WI Primary Health Care Association to develop data-sharing and collection on uninsured and underinsured persons in rural areas and young adults.

Appendix C: State-by-State Profiles of the Uninsured

The following information is provided for each of the 11 FY2000 HRSA SPG-funded states:

- Summary of the state's strategies used to obtain information on uninsured individuals and families;
- Overall uninsurance rates and characteristics of the uninsured; and
- Population groupings that were particularly important to the state in developing coverage expansion options.

Arkansas Uninsured

Summary of Arkansas' Strategies Used to Obtain Information on Uninsured Individuals and Families

The principal source of Arkansas' information on uninsured individuals and families is the 2001 Arkansas Household Survey of Health Insurance Status of 2,625 households, covering approximately 6,000 individuals. The primary purpose of the household telephone survey was to obtain state-level and regional estimates of uninsured adults and children in Arkansas. The survey was conducted by the Center for Survey Research (CSR) at the University of Massachusetts and employed a revised version of an instrument developed by the CSR and the State of Massachusetts Division of Health Care Finance and Policy. Of contacted individuals, the response rate for the long interview ranged from 93 percent of uninsured households to 98 percent of insured households.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

Approximately 15.2 percent of all Arkansas residents are without health insurance. However, there are notable variations to this. Uninsured rates vary depending on geographic location (ranging from 9.6 percent in the central Urban Region to 18.4 percent in the north central Mountain Region), age (~13 percent of children ≤ 18 years, ~20 percent of adults age 19-64 are uninsured and ~25 percent of adults age 19-44 are uninsured), and income level (largest number of uninsured individuals are in families with household incomes of 100-200 percent FPL).

Income

Family Income as a % of the Federal Poverty Level	% of Uninsured
Less than 100%	27%
100%-200%	45%
201%-400%	21%
400% or greater	8%
Total	100%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Age

Age	% of Uninsured
0-18	24%
19-44	51%
45-64	25%
≥65	1%
Total	100%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Gender

Gender	% of Uninsured
Male	48%
Female	52%
Total	100%

Source*: 2001 Arkansas Household Survey of Health Insurance Coverage*

Family Composition

Marital Status	% of Uninsured
Live with Spouse or Partner and Children	49%
Live with Children and/or Grandchildren and No Spouse or Partner	19%
Live with Spouse or Partner and No Children	17%
Live Alone or with Non-Relatives	15%
Total	100%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Health Status

Arkansas' report did not provide detailed information regarding the health status of the uninsured.

Employment Status of Uninsured

Employment Status of Uninsured Adults (Age 19-64)	% of Uninsured
Work for One Employer Full-time (≥35 hrs/wk)	30%
Work for One Employer Full-time (≥35 hrs/wk) and Work for More Than One Employer	5%
Self-Employed	14%
Employed Part-time	15%
Unemployed or Not in the Workforce (includes stay-at-home spouses)	34%
Total	Reported information does not total 100%.

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Availability of Private Coverage

Arkansas' report did not provide information on the availability of private coverage. The report indicated that analysis of this information is currently underway.

Availability of Public Coverage

Arkansas' report did not provide information on the availability of private coverage. The report indicated that analysis of this information is currently underway.

Race/Ethnicity

Race/Ethnicity	% of Population
Caucasian	78%
African American	17%
Other	5%
Total	100%

Source: *2000 Behavioral Risk Factor Surveillance Survey*

Immigration Status

Arkansas' report did not provide information on immigration status. The report indicated that this information would be available following the analysis of the household focus group qualitative data.

Geographic Location

Region	% Uninsured
Mountain	18.5%
Delta	14.5%
Other Rural	14.5%
Central Suburban	10.3%
Northwest	10.2%
Urban (Pulaski County)	9.6%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Duration of Uninsurance for Adults 19-64

Uninsureds' Length of Time Without Insurance	% of Uninsured
Never had insurance	31%
More than 3 years	35%
1-2 years	24%
Less than 12 months	11%
Total	100%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

Duration of Uninsurance for Children

Uninsureds' Length of Time Without Insurance	% of Uninsured
Never had insurance	28%
More than 3 years	18%
1-2 years	35%
Less than 12 months	20%
Total	100%

Source: *2001 Arkansas Household Survey of Health Insurance Coverage*

What Population Groupings Were Particularly Important for Arkansas in Developing Targeted Coverage Expansion Options?

Primary populations assessed included:

- Adults (19–64 yr) with incomes <100 percent of FPL (non employer-based options) who comprised 26 percent of the uninsured adults (~78,000).
- Adults (19–64 yr) with incomes 100–200 percent of FPL (employer-based options)—42 percent of the uninsured adults (~124,000).
- Children (0–18 yr) with family incomes <100 percent of FPL—27 percent of uninsured children (~25,000).

- Children (0–18 yr) with family incomes 100–200 percent of FPL—54 percent of uninsured children (~50,000).

Among other target populations assessed were:

- Adults (55–64 yr) (near elderly)—10 percent of the uninsured adults (~37,000).
- Adults (19–44 yr) (peak working-age adults)—67 percent of the uninsured adults (~200,000).

Delaware Uninsured

Summary of Delaware's Strategies Used to Obtain Information on Uninsured Individuals and Families

Delaware's research draws on a series of survey research data sets collected in Delaware. There are three principal sources. First, there is the Census Bureau's March Current Population survey with a sample of between 600 and 700 households in Delaware analyzed between 1982 and 2000 when health insurance questions were asked. Second, the Behavioral Risk Factor Survey System has been conducted monthly since 1989 in Delaware with sample sizes increasing from approximately 1800 adults to 3500 adults today. The third source of information is the Consumer Assessment of Health Plans Survey or CAHPS, which in Delaware is a sample of 1800 adults that has addressed these issues since 1996."

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

Delaware's population was 783,600 in 2000 according to the decennial census. Of those 759,017 are found within households. In addition there are 13,073 persons who live in non-institutional group quarters who could be eligible for the surveys. According to the most recent CPS data released on September 28, 2001 11.2 percent (3-year average) of Delawareans were uninsured during 2000. This would suggest that approximately 86,500 people were in that status.

Income

Family Income as a % of the Federal Poverty Level	% Uninsured (1998 – 2000)
Below 100%	27.1%
100 – 150%	22.6%
150 – 250%	19.6%
Above 250%	7.7%

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.

Age

Age	% Uninsured (1998 – 2000)
0 - 4	15.1%
5 - 17	11.8%
18 - 29	23.5%
30 - 64	13.2%

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.

Gender

Delaware's report did not provide information regarding uninsurance by gender.

Family Composition

Marital Status	% Uninsured (1998 – 2000)
Widowed	6.1%
Married	7.6%
Divorced	12.5%
Separated	27.8%
Never Married	10%

Source: *Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1998 – 2000.*

Health Status

Status	Uninsured %	Insured %
Excellent	20.3%	27.1%
Very Good	30.5%	38.8%
Good	36.8%	24.5%
Fair	9.5%	7.4%
Poor	2.9%	2.1%

Source: *Center for Applied Demography and Survey Research, University of Delaware, Delaware Health and Social Services, 1998 – 2000 Behavioral Risk Factor Survey.*

Employment Status of Uninsured

Percent of Persons Without Health Insurance by Class of Worker	
Class of Worker	% Uninsured (1998 – 2000)
Private	13.2%
Government	7.7%
Self-employed	22.1%

Source: *Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.*

Availability of Private Coverage

Availability of Private Coverage for Uninsured [8]	Percent
Covered by private insurance	7.2%

Source: *Delaware Health Care Commission, "Health Resources and Services Administration State Planning Grant – Final Report," (10/29/2001).*

Availability of Public Coverage

Program Type	Number
Medicare	107,000
CHAMPUS	19,000
Medicaid	73,000
Public Sector	64,000

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1998 – 2000.

Race/Ethnicity

Race/Ethnicity	% Uninsured (1998 – 2000)
White	11.7%
Black	16.3%
Other	22%
Hispanic	27.7%

Source: *Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1993 – 2000.*

Immigration Status

Status	% Uninsured
Native-born	13.4%
Naturalized citizens	17.9%
Non-citizens	42.6%

Source: *US Bureau of Census, Current Population Survey, 2000.*

Geographic Location

Region (counties)	% Uninsured (1998 – 2000)
Kent	16.4%
New Castle	12%
Sussex	13.4%

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1998 – 2000.

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	Percent
1 to 6 months	23.9%
7 – 12 months	13.5%
> 13 months	62.6%

Source: Center for Applied Demography and Survey Research, University of Delaware, Delaware Health and Social Services, 1998 – 2000 Behavioral Risk Factor Survey.

[8] The final report of the Delaware Health Care Commission states that the "indicator used for suggesting the availability of private coverage is the percentage of the population covered in this manner."

What Population Groupings Were Particularly Important for Delaware in Developing Targeted Coverage Expansion Options?

Delaware identified three groupings for possible targeted coverage expansion:

- Those with incomes between 100-200 percent FPL who are ineligible for a public insurance program. There are approximately 11,000-14,000 uninsured individuals in this bracket of eligibility.
- Parents of children who are enrolled in Delaware's Healthy Children Program (DE SCHIP).
- Children eligible for DE SCHIP who are currently not enrolled.

Illinois Uninsured

Summary of Illinois' Strategies Used to Obtain Information on Uninsured Individuals and Families

The information on the uninsured in Illinois is based on a random digit dial population based survey that was developed and administered by the University of Illinois-Chicago (UIC), in collaboration with the Health Research and Policy Centers (HRPC) and the Survey Research Laboratory (SRL) at UIC. The sample design was a disproportionate stratified sample with 5 strata: Northwestern Illinois; Central Illinois; Southern Illinois; Cook County; and the Collar Counties of Cook County. Interviews were conducted by telephone throughout the state. The sample of 25,735 telephone numbers was released over a period of about three months, from mid-January through mid-April, 2001. Data collection ended May 6, 2001 with a final response rate of 52 percent.

In addition to the telephone survey, Illinois used data collected from the Behavioral Risk Factor Surveillance System (BRFSS). This on-going state-based survey of the non-institutionalized population 18 years of age or older was enhanced to include questions regarding: insurance availability; reason(s) for declining employment-based coverage if available; and awareness of alternative sources of health insurance.

The Illinois Center for Health Statistics (ICHS), in the Illinois Department of Public Health (IDPH), was responsible for ongoing survey enhancements and expanded data analysis. ICHS used the BRFSS analysis of certain data obtained from the Illinois Health Care Cost Containment Council and analysis of data pertaining to the uninsured in Illinois from the March 2001 Supplement of the Census Bureau's Current Population Survey.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

According to the UIC household survey, 9.7 percent of Illinois residents or 1,204,671 individuals were uninsured at the time of the survey.

Income

Family Income as a % of the Federal Poverty Level	% of the Uninsured
<45%	20.1%
45%-100%	31.9%
100%-185%	25.0%
185%-250%	11.8%
250%-300%	1.8%
300%-350%	2.7%
350%-400%	.2%
>400%	6.6%
Total	100%

Source: *2001 UIC Survey*

Age

Age	% of the Uninsured
18-24	8.4%
25-34	29.0%
35-44	23.3%
45-64	36.1%
65 and older	3.2%
Total	100%

Source: *2001 UIC Survey*

Gender

Gender	% of the Uninsured
Male	35.7%
Female	64.3%
Total	100%

Source: *2001 UIC Survey*

Family Composition

Marital Status	% of the Uninsured
Single-person	34.7%
Multi-person	65.3%
Total	100%

Source: *2001 UIC Survey*

Health Status

Illinois' report did not provide information regarding uninsurance rates by health status.

Employment Status of Uninsured

Employment Status	% of the Uninsured
Currently employed	64.3%
Same employer over one year	62.2%

Source: *2001 UIC Survey*

Availability of Private Coverage

Availability of Employment-Based Coverage for Uninsured	% of the Uninsured
Offered coverage	53%

Source: *2001 UIC Survey*

Availability of Public Coverage

Illinois' report did not provide information regarding availability of public coverage.

Race/Ethnicity

Race/Ethnicity	% of the Uninsured
Black	22.1%
Hispanic	21.2%
White Non-Hispanic	56.7%
Total	100%

Source: *2001 UIC Survey*

Immigration Status

Immigration Status	% of the Uninsured
Citizen	85.9%
Non-citizen	14.1%
Total	100%

Source: *2001 UIC Survey*

Geographic Location

Region	% of the Uninsured
Northwest	12.8%
Central	11.0%
Southern	12.2%
Cook	49.0%
Collar	15.1%
Total	100%

Source: *2001 UIC Survey*

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	% of the Uninsured
<6 months	25.7%
6-12 months	11.1%
12-24 months	14.8%
24-60 months	15.9%
>60 months	32.6%
Total	100%

Source: *2001 UIC Survey*

What Population Groupings Were Particularly Important For Illinois in Developing Targeted Coverage Expansion Options?

Based on preliminary information available prior to the Illinois Assembly meeting in July regarding the quantitative and qualitative results of our research, as well as the literature review and other research conducted by the State Planning Grant staff, five target populations were identified to be analyzed in depth during the Illinois Assembly: the working uninsured, Hispanics and other racial/ethnic minority groups, young adults, small employers, and children. National data, other state data, and information from other state agencies indicated the population groupings chosen to be considered were those which would contain the greatest percentage of uninsured individuals. The Medical Expenditure Panel Survey (MEPS) and Illinois' own researchers reconfirmed these choices.

Iowa Uninsured

Summary of Iowa's Strategies Used to Obtain Information on Uninsured Individuals and Families

Iowa used three methods of collecting quantitative data on the uninsured: 1) analysis of the Current Population Survey (CPS) data; 2) two surveys of the uninsured; and 3) structured interviews.

The Lewin Group pooled March CPS data for the years 1996 through 1999 to obtain a sufficient sample size for detailed analyses of the uninsured in Iowa.

Baselice & Associates conducted a survey of the uninsured in January 2001 using a questionnaire designed by The Lewin Group. The survey captured information on the characteristics of the uninsured including demographic makeup and health and financial consequences of living without insurance for a representative sample of 1,500 uninsured Iowans. Respondents were contacted by phone using random digit dialing.

In addition, a telephone survey of the "active public" was conducted by SPPG and designed by the Selzer Company. It was administered at two points in time (April 12-May 4, 2001 and July 2000.) Each survey included 550 telephone interviews. The purpose was to determine attitudes about the uninsured and opinions about Iowa's proposed options to reduce the number of uninsured persons.

Structured in-person and telephone interviews were carried out with several targeted groups including immigrant groups, African Americans, and representatives of the meatpacking industry. Through the interviews information on interviewees' experiences with health insurance and the health system was collected.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

The overall uninsurance rate for Iowa is 9.1 percent. This estimate was based on pooled March CPS data for the years 1996 through 1999.

Income

Distribution of Uninsured in Iowa by Income as a Percentage of FPL	
Federal Poverty Level	Percent of Uninsured
≤100%	17.5%
100%-149%	18.4%
150%-199%	13.5%
200%-299%	23.4%
≥300%	27.2%
Total	100.0%

Source: *CPS data*

Distribution of Uninsured in Iowa by Family Income	
Family Income	Percent of Uninsured
Less than $10,000	15.6%
$10,000-$19,999	21.0%
$20,000-$29,999	23.1%
$30,000-$39,999	12.9%
$40,000-$49,999	8.0%
Over $50,000	19.4%
Total	100.0%

Source: *CPS data*

Age

Age	% Uninsured
Less than 19	6.0%
19-24	19.4%
25-34	11.7%
35-44	11.1%
45-54	10.9%
55-64	12.0%
Age 65 and Over	0.6%

Source: *CPS data*

Gender

Gender	% Uninsured
Male	9.9%
Female	8.2%

Source: *CPS data*

Family Composition

Marital Status	% Uninsured
Married	7.2%
Widowed	2.6%
Divorced/Separated	14.4%
Never Married	10.8%
All Unmarried	10.7%

Source: *CPS data*

Health Status

Self-reported Health Status of Uninsured	
Status	Percent
Excellent	26%
Good	48%
Fair	20%
Poor	6%
Total	100%

Source: *Iowa Survey of Uninsured*

Employment Status of Uninsured

Distribution of Iowa's Uninsured by Labor Force Status (Age 18-64)	
Status	Percent
Employed	80.6%
Unemployed	5.2%
Working w/o	3.2%
Unable to work	11.0%
Total	100.0%

Source: *CPS data*

Availability of Public/Private Coverage

Distribution of Iowa Population by Primary Source of Insurance Coverage (All Ages)	
Availability of Employment-Based Coverage for Uninsured (Age 18-64)	Percent
Employer	62.2%
Uninsured	9.1%
Medicare	13.5%
Medicaid	5.1%
CHAMPUS	0.6%
Non-Group	8.7%
Retiree	0.8%
Total	100.0%

Source: *CPS data*

Race/Ethnicity

Race/Ethnicity	% Uninsured
Black	9.0%
White	11.7%
Other	10.0%
Hispanic*	22.2%
Non-Hispanic*	8.7%

**Persons who declared themselves Hispanic could be of any race.*
Source: *CPS data*

Immigration Status

Iowa's report did not provide information regarding immigration status.

Geographic Location

Iowa's report did not provide information regarding geographic location.

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	Percent of the Uninsured
Unsure/Refused	5%
Less than 6 months	18%
6 months – 1 year	13%
1-2 years	13%
2-5 years	18%
5-10 years	13%
10 years or more	20%
Total	100%

Source: *Iowa Survey of Uninsured*

What Population Groupings Were Particularly Important for Iowa in Developing Targeted Coverage Expansion Options?

Iowa policy options under consideration target uninsured workers, children eligible but not enrolled in Medicaid/hawk-i (SCHIP), and low-income uninsured. Access to health insurance in Iowa is strongly connected to employment, with approximately 62 percent of the population receiving health insurance through employment. Nearly 81 percent of the uninsured of working age are employed. Forty-three percent work at places that do not offer coverage to employees, 31 percent work at places where coverage is offered to some but not to them, and 26 percent decline the coverage. Iowa has 45,200 children eligible but not enrolled its Medicaid/hawk-i programs. The majority of uninsured individuals in Iowa live in low-income families. Nearly 37 percent of uninsured persons lived in families with incomes less than $20,000. About half of Iowa's uninsured had family incomes below 200 percent of the FPL.

Kansas Uninsured

Summary of Kansas' Strategies Used to Obtain Information on Uninsured Individuals and Families

Kansas collected data on their uninsured through the Kansas Health Insurance Survey. The survey was conducted through collaboration between researchers from KUMC and the Department of Health Services Administration at the University of Florida. Telephone interviews were conducted with 8,004 Kansas households (households composed of individuals over age 65 were not included in the survey). The households were comprised of 22,691 individuals. Fieldwork for the survey was done between March 2001 and June 2001. The household survey was intended to gather broad-based information that would enable estimation of differing rates of health insurance coverage among various geographic, demographic, socio-economic, and occupational categories in Kansas. Estimates were developed for ten regions of the state.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

Overall, 10.5 percent (224,880) of Kansans under age 65 are without health insurance.

Income

Family Income as a % of the Federal Poverty Level	% Uninsured*
100% or less	41.7%
101%-150%	33.5%
151%-200%	18.9%
201%-150%	13.2%
250% or greater	4.8%

*Age 19-64
Source: *Kansas Health Insurance Survey*.

Age

Age	% Uninsured
0-5	6.8%
6-11	8.0%
12-18	8.4%
19-24	19.8%
25-34	15.7%
35-44	10.4%
45-54	7.5%
55-64	6.4%

Source: *Kansas Health Insurance Survey*.

Gender

Gender	% Uninsured
Male	10.7%
Female	10.4%

Source: *Kansas Health Insurance Survey*.

Family Composition

Marital Status	% Uninsured*
Married	7.9%
Widowed	15.2%
Divorced	19.1%
Separated	27.9%
Never Married	15.8%
Living with a partner	33.5%

*Age 19-64
Source: *Kansas Health Insurance Survey*.

Health Status

Status	Uninsured*	Insured*
Excellent	28.2%	42.4%
Very Good	23.5%	29.8%
Good	31.4%	21.2%
Fair	13.0%	5.0%
Poor	3.9%	1.6%

*Under age 65
Source: *Kansas Health Insurance Survey.*

Employment Status of Uninsured

Employment Status	Percent*
Work for employer full-time	8.1%
Work for employer part-time	15.4%
Exclusively self-employed	15.8%
Unemployed	38.2%
Not in workforce	12.8%

*Age 19-64
Source: *Kansas Health Insurance Survey*.

Availability of Private Coverage

Availability of Employment-Based Coverage for Uninsured	Percent*
Not offered	46.2%
Employee ineligible	12.8%
Declined due to cost	12.3%
Declined for other reasons	28.7%

*Age 18-64
Source: *Kansas Health Insurance Survey.*

Availability of Public Coverage

Family Income as a % of the Federal Poverty Level	Children Under Age 19 % Uninsured
All income levels	7.8%
100% or less	18.1%
101%-150%	15.8%
151%-200%	9.5%
201%-250%	7.1%
251% or greater	2.6%

Source: *Kansas Health Insurance Survey*.

Race/Ethnicity

Race/Ethnicity	% Uninsured*
Black	15.0%
Hispanic	26.0%
White Non-Hispanic	8.3%
Other	11.6%

*Under Age 65
Source: *Kansas Health Insurance Survey*.

Immigration Status

Kansas' report did not provide information regarding immigration status.

Geographic Location

Region	% Uninsured *
1	16.4%
2	5.4%
3	9.3%
4	6.7%
5	12.8%
6	11.5%
7	10.9%
8	9.9%
9	9.4%
10	16.8%

*Under Age 65
Source: *Kansas Health Insurance Survey*.

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	Percent*
Never had insurance	16.3%
More than 2 years	34.8%
1-2 years	15.8%
7-12 months	8.9%
1-6 months	18.1%
Less than 1 month	6.1%

*Under Age 65
Source: Kansas Health Insurance Survey.

What Population Groupings Were Particularly Important for Kansas in Developing Targeted Coverage Expansion Options?

Based on Kansas Health Insurance Survey results, Kansas found the following groups are particularly important in developing targeted coverage expansion options:

- Those who are employed but not currently insured, particularly those who work for small employers and/or are employed in low wage jobs.

- Adults in the 19-24 age group.
- Children who are eligible for public coverage but are not currently enrolled.
- Uninsured parents of children who are enrolled in public programs.
- Minority groups.

Massachusetts Uninsured

Summary of Massachusetts' Strategies Used to Obtain Information on Uninsured Individuals and Families

Massachusetts primarily uses findings from the Division of Health Care Finance and Policy (DHCFP) 2000 Survey of Health Insurance Status of Massachusetts Residents for information on the uninsured and their families. The survey included a sample of 2,632 households (7,069 individuals), with an urban oversample of an additional 2,132 households (5,535 individuals). The response rate for the survey was 62.1 percent statewide and 63.2 percent for the oversample. Massachusetts also included data from the 1998 Survey of Health Insurance Status of Massachusetts Residents. Additional data sources used for the purposes of the State Planning Grant include: the Urban Institute 's National Survey of American Families (NSAF) findings for Massachusetts (1999), Massachusetts hospital discharge data from the Uniform Hospital Discharge Data Set (1999), eligibility data from individual applications to the Massachusetts Uncompensated Care Pool (2001), and data from outpatient claims of the Boston Medical Center, the state 's highest volume hospital provider to the uninsured, were analyzed.

Massachusetts also draws upon the findings of DHCFP's 2001 Survey of Massachusetts Employers and the Massachusetts findings from the Agency for Health Care Research and Quality's Medical Expenditure Panel Survey (IC: 1996-1999), for information regarding employment status and availability of coverage.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall level of Uninsurance

According to findings from the DHCFP 2000 Survey of Health Insurance Status of Massachusetts Residents, the overall rate of uninsurance for all ages including the elderly is 5.9 percent. The rate of uninsurance excluding the elderly is 6.5 percent.

Income

Household Income (%FPL)	% Uninsured
0-133%	12.5%
134-150%	11.9%
151-200%	14.3%
201-400%	8.0%
>400%	2.0%

Note: Age range = 0 – 64 years
Source: *Massachusetts 2000 Household Survey*

Age

Age	% Uninsured
0-5 Years	3.0%
6-18	2.9%
19-39	11.3%
40-64	4.9%

Source: *Massachusetts 2000 Household Survey*

Gender

Gender	% Uninsured
Male	7.8%
Female	5.2%

Source: *Massachusetts 2000 Household Survey*

Health Status

Massachusetts' report did not provide quantitative data regarding health status.

Family Composition

Marital Status	% Uninsured
Married	3%
Never Married	16%

Source: *Massachusetts 2000 Household Survey*

Employment Status of Uninsured

Employment Status	% of Uninsured
Employed	71.7%
Employment Status	**% of Working Uninsured**
Employed in a small firm (< 50 employees)	>76%
Self-employed	29.4%

Source: *Massachusetts 2000 Household Survey*

Availability of Private Coverage

Availability of Private Coverage	% of Uninsured
Employees eligible	25%

Source: *Massachusetts 2000 Household Survey*

Availability of Public Coverage

Availability of Public Coverage	% of Residents
Residents enrolled	12%

Source: *Massachusetts 2000 Household Survey*

Race/Ethnicity

Race/Ethnicity (adults)	% Uninsured
Hispanic	24.2%
White	6.0%
Asian	3.2%
Black	16.2%

Race/Ethnicity (Child)	% Uninsured
Hispanic	5.5%
White	2.7%
Black	2.8%

Source: *Massachusetts 2000 Household Survey*

Immigration Status

Immigration Status	% Uninsured
US-born adult	7.9%
Foreign-born adult	11.2%

Source: *1999 National Survey of America's Families (NSAF)*

Geographic Location

Region	% of Uninsured
Metro Boston	32%
Northeast	20%
Southeast	20%
West	12%
Worcester	12%
Total	96%

Note: Massachusetts' report does not specify why the total percentage of uninsured does not equal 100%.
Source: *Massachusetts 2000 Household Survey*

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	% of Uninsured
Covered at one time within the last year	>32%
Covered at one time within the last decade	32%
Never been covered	30%

Note: Massachusetts' report indicated that over 32% of all uninsured adults were covered at one time within the last year. The report does not specify the total percentage of uninsured regarding the duration of uninsurance.
Source: *Massachusetts 2000 household survey*

What Population Groupings Were Particularly Important for Massachusetts in Developing Targeted Coverage Expansion Options?

The Massachusetts 2000 household survey, combined with the other data sources reported above, revealed several groups that could be targeted. Consistent with recent expansions in MassHealth, we found that most uninsured people in Massachusetts living in moderate-income households (200-400 percent FPL) and working. Of those working uninsured, 75 percent were either not offered or were ineligible for employer-sponsored insurance, and the rest simply could not afford it. As a result, it was reasonable to develop options specific to this group.

In addition, the Massachusetts 2000 household survey revealed that over 40 percent of the uninsured resided in low-income households. Analysis of our free care application data indicated that the low-income applicants who appear to have been eligible for MassHealth based on income were "characteristically" or "categorically" ineligible for public insurance. That is, they were not pregnant, disabled, HIV positive, children or did not belong to some other "category" that would enable them to qualify. This group presents an opportunity to examine what changes could be made to the eligibility requirements of public insurance programs to better cover our most financially needy. There may also be some outreach opportunities in this group, particularly targeted at minority populations. However, one must note that the state is still in the early stages of free care application data collection, therefore the results are preliminary and may change.

DHCFP data revealed that minorities were disproportionately uninsured and 1999 NSAF findings indicated that the state's immigrants were, as well.

Therefore, it was apparent that any option that was developed needed to include an outreach component specifically targeted at minority and immigrant groups in the urban areas in which they most likely live.

Minnesota Uninsured

Summary of Minnesota's Strategies Used to Obtain Information on Uninsured Individuals and Families

The information on the rate of, and characteristics associated with, uninsurance in Minnesota are based on the Minnesota Health Access Survey, a random digit dial household telephone survey of approximately 27,000 Minnesotans. The survey instrument used was based on the Minnesota Health Access Survey developed by the University of Minnesota, School of Public Health, Division of Health Services Research and Policy. Previous versions of this survey were conducted in 1990, 1995 and 1999.

For the State Planning Grant, the survey was modified to add questions related to household insurance status, dental insurance, public program stigma, reasons for lack of insurance coverage, health service utilization, country of origin, and employment. The sampling design was structured to allow for adequate sample sizes from various regions of the state, populations of color, and American Indians. The survey used a stratified random digit dial sample design; this strategy was chosen to allow for oversampling of certain geographic regions, populations of color, and American Indians. Within each stratum, households and individuals within households were randomly selected to participate in the survey. The University of Minnesota, School of Public Health, Division of Health Services Research and Policy fielded the survey from November 2000 through May 2001. The total response rate for the survey was 65 percent.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

Approximately 5.4 percent of Minnesotans (or 266,000 people) were uninsured at the time the survey was administered.

Income

Family Income as a % of the Federal Poverty Level	% Uninsured
= 100%	13.6%
101%-200%	16.0%
201%-300%	7.4%
301%-400%	3.7%
401% +	1.5%

Source: *2001 Minnesota Health Access Survey*

Age

Age	% Uninsured
0-17	4.5%
18-24	13.9%
25-34	9.2%
35-54	4.9%
55-64	2.9%
65+	0.4%

Source: *2001 Minnesota Health Access Survey*

Gender

Gender	% of the Uninsured
Male	52.5%
Female	47.5%
Total	100.0%

Source: *2001 Minnesota Health Access Survey*

Family Composition

Marital Status	% of the Uninsured
Single	39.5%
Married	40.2%
Living with Partner	10.4%
Divorced/separated/widowed	9.9%
Total	100.0%

Source: *2001 Minnesota Health Access Survey*

Health Status

Health Status	% of the Uninsured
Excellent	29.6%
Very Good	31.9%
Good	26.8%
Fair	9.3%
Poor	2.4%
Total	100.0%

Source: *2001 Minnesota Health Access Survey*

Employment Status of Uninsured

Employment Status	% of the Uninsured
Self Employed	19.1%
Employed by Someone Else	54.3%
Unemployed	21.0%
Retired	1.3%
Full-time Student	4.4%
Total	100.0%

Source: *2001 Minnesota Health Access Survey*

Availability of Coverage

Availability of Employment-Based and Public Coverage for Uninsured	% of the Uninsured
Employer-based	22.7%
Public Program Eligible	49.6%
No Access or Eligibility	33.1%
Total	100.0%

Note: Total is > 100% due to multiple program eligibility.
Source: *2001 Minnesota Health Access Survey*

Race/Ethnicity

Race/Ethnicity	% Uninsured
White	4.6%
Black	15.6%
Asian	7.2%
American Indian	15.9%
Other Race	10.0%
Hispanic	17.6%

Source: *2001 Minnesota Health Access Survey*

Immigration Status

Country of Origin	% Uninsured
US Born	4.9%
Hispanic Nation	36.6%
African Nation	24.3%
Asian Nation	7.4%
Other Nation	6.4%

Source: *2001 Minnesota Health Access Survey*

Geographic Location

Region	% Uninsured
1	5.5%
2	9.4%
3	6.3%
4	7.6%
5	8.8%
6	6.5%
7	5.4%
8	5.1%
9	4.2%
10	5.3%
11	4.5%
12	3.4%
13	5.4%

Source: 2001 Minnesota Health Access Survey

Duration of Uninsurance

Minnesota's report did not include information on duration of uninsurance.

What Population Groupings Were Particularly Important for Minnesota in Developing Targeted Coverage Expansion Options?

Minnesota's survey data showed that a large proportion of the uninsured already have access to coverage, either through an employer or a public program. Therefore, a major focus of Minnesota's options was finding ways to improve take up of employer-based coverage and to increase enrollment in public programs by people who are already eligible. Minnesota also targeted some of their options specifically to people who do not have access to employer coverage and are also not eligible for public programs (an estimated 33.1 percent of the point-in-time uninsured in Minnesota).

In developing coverage expansion options, Minnesota also paid particular attention to disparities in uninsurance rates across different populations. Given the disproportionately high uninsurance rates experienced by populations of color, American Indians, and foreign-born Minnesotans, several of the coverage expansion options being considered are specifically aimed at increasing health insurance coverage for these populations. Coverage options being considered in Minnesota have also been targeted for young adults and rural populations, who experience disproportionately high uninsurance rates.

New Hampshire Uninsured

Summary of New Hampshire's Strategies Used to Obtain Information on Uninsured Individuals and Families

The principal source of New Hampshire's information on uninsured individuals and families is the New Hampshire Health Insurance Coverage and Access Survey of approximately 12,000 households and 28,000 individuals. The sampling design was structured to allow for adequate sample sizes from different hospital service areas within the state. The survey was fielded by Macro International in 2001. The overall response rate for the survey was 66.3 percent. The survey was conducted once before in 1999 and achieved a response rate of 76 percent.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall Level of Uninsurance

Approximately 8.3 percent of New Hampshire residents (or 89,813 people) were uninsured at the time the survey was administered.

Income

Annual Family Income	% Uninsured
< $25,000	23.2%
$25,000-$49,999	11.6%
$50,000-$74,999	4.9%
$75,000 +	1.9%

Source: *2001 New Hampshire Family Insurance Survey*

Age

Age	% Uninsured
0-5	4.6%
6-11	5.3%
12-17	5.3%
18-24	16.0%
25-34	12.9%
35-44	8.1%
45-54	7.2%
55-64	5.2%

Source: *2001 New Hampshire Family Insurance Survey*

Gender

Gender	% Uninsured
Male	8.3%
Female	8.3%

Source: *2001 New Hampshire Family Insurance Survey*

Family Composition

Children Resident	% Uninsured
No Children	9.4%
1 Child	8.9%
2 Children	6.4%
3 + Children	8.8%

Source: *2001 New Hampshire Family Insurance Survey*

Health Status

New Hampshire's report did not provide information regarding uninsurance rates by health status.

Employment Status of Uninsured

Employment Status	% of Uninsured
Employed	71.8%
Unemployed	28.2%
Total	100.0%

Source: *2001 New Hampshire Family Insurance Survey*

Availability of Private Coverage

Availability of Employment-Based Coverage for Uninsured	% of Employed Uninsured
Not offered	57.7%
Employee ineligible	22.5%
Employee eligible	19.8%
Total	100.0%

Source: *2001 New Hampshire Family Insurance Survey*

Availability of Public/Private Coverage

Coverage	Percent
Public	7.3%
Private	84.4%

Source: *2001 New Hampshire Family Insurance Survey*

Race/Ethnicity

New Hampshire's report did not provide information regarding race/ethnicity.

Immigration Status

New Hampshire's report did not provide information regarding immigration status.

Geographic Location

Location	% Uninsured
Urban	6.7%
Rural	11.1%

Source: *2001 New Hampshire Family Insurance Survey*

Duration of Uninsurance

Coverage During the Previous Six Months	% of Uninsured
Prior coverage	23.8%
No prior coverage	76.2%
Total	100.0%

Source: *2001 New Hampshire Family Insurance Survey*

What Population Groupings Were Particularly Important for New Hampshire in Developing Targeted Coverage Expansion Options?

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

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

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

Oregon Uninsured

Summary of Oregon's Strategies to Obtain Information on Uninsured Individuals and Families

Since 1990, Oregon has relied on a state-sponsored biennial survey called the Oregon Population Survey (OPS). The survey is jointly administered by the state Office of Economic Analysis and the Oregon Progress Board with assistance from the Oregon Population Survey Task Force. The OPS measures socioeconomic characteristics of Oregonians including health insurance status. For purposes of the State Planning Grant, Oregon primarily used the OPS as the primary source of data. The OPS samples about 5,600 households, and is designed to oversample certain populations in order to provide meaningful data regarding minority populations in Oregon. The OPS collects point-in-time estimates regarding insurance status and other information on each member of the surveyed household generating a total database of more than 10,000 individuals.

In addition to using the OPS, Oregon's HRSA Team completed two quantitative research projects that measured health status as a function of insurance status:

- A survey of the Family Health Insurance Assistance Program (FHIAP), subsequently referred to as the *FHIAP Study*
- A statewide household survey of Oregon's general population, subsequently referred to as the *Household Survey*

Oregon also used Oregon-only estimates from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC) for information regarding employment status.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall level of Uninsurance

Based on the Oregon Population Survey findings, Oregon's overall level of uninsurance was 12.3 percent (423,149) in 2000.

Income

Family Income as a % of the Federal Poverty Level	% Uninsured
≤ 100%	26.4%
101%-200%	18.9%
201%-300%	9.4%
+300%	5.3%

Source: OPS 2000

Age

Age	% Uninsured
0-18	9.0%
19-64	15.7%
65+	3.0%

Source: OPS 2000

Gender

Gender	% Uninsured
Female	10.3%
Male	14.4%

Source: OPS 2000

Family Composition

Family Type	% Uninsured
Single	15.1%
Single Parents	20.1%
Couples	12.0%
Families	9.6%

Source: OPS 2000

Health Status

Status	% of Uninsured	% of Insured
Excellent	19.2%	25.2%
Very Good	37.2%	29.0%
Good	19.2%	32.2%
Fair	23.1%	9.4%
Poor	1.3%	4.3%
Total	100%	100%

Source: Household Survey

Employment Status of Uninsured

Employment Status (Age 18-64)	% of Uninsured
Working/ Employer Coverage Available	23.5%
Working/ Employer Coverage Not Available	50.5%
Not Working	26.0%
Total	100.0%

Source: *Pooled 1996/1998/2000 OPS data*

Availability of Private Coverage

Firm Size	% Employees Eligible for Offered Coverage
1-9	84.1%
10-24	78.9%
25-99	70.3%
100-999	77.1%
1000+	85.4%

Source: *1998 MEPS, Oregon only*

Availability of Public Coverage

Family Income as a % of the Federal Poverty Level	% of Adults age 18-64 Enrolled in Public Coverage
≤100%	33.6%
101%-200%	13.0%
201%-300%	3.2%
+300%	1.5%
Totals	7.0%

Source: *Pooled 1996/1998/2000 OPS data.*

Race/Ethnicity

Race/Ethnicity	% Uninsured
African-American	11.5%
Asian	9.7%
Native American	10.9%
White	11.8%
Other	21.6%
Missing	23.3%

Source: *OPS 2000*

Immigration Status

Oregon's Report did not provide information on immigration status.

Geographic Location

Region	% Uninsured
Central Oregon	11.3%
Eastern Oregon	15.0%
Gorge	16.3%
Metro	11.5%
Mid-Valley	9.3%
North Coast	10.5%
South Valley	12.8%
Southern/Central	14.3%
Southwest	16.0%

Source: *OPS 2000*

Duration of Uninsurance

Number of Months Uninsured in Last 12 Months	% of Uninsured
6 Months or less	41.3%
7-11 Months	11.4%
12 Months	47.3%

Source: *OPS 2000*

What Population Groupings Were Particularly Important for Oregon in Developing Targeted Coverage Expansion Options?

Oregon's research of coverage expansion strategies led to the focus of the following groups:

- Low-income children eligible but not enrolled in SCHIP
- Adults, 100–200 percent of the Federal Poverty Level
- Low-income working adults who are offered coverage but find it too expensive
- Parents of SCHIP eligible children
- Low-income adults with no kids in household
- Oregonians who temporarily lose coverage
- Low- to moderate-income families who cannot or will not enroll for publicly offered health insurance and seek care through the safety net
- Ethnic minorities, especially Hispanic/Latino populations

Vermont Uninsured

Summary of Vermont's Strategies Used to Obtain Information on Uninsured Individuals and Families

Vermont's primary source of information on uninsured individuals and families within the state is the 2000 Vermont Family Health Insurance survey managed by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). A total of 8,623 households with 22,258 individuals were interviewed using the random digit-dial telephone survey. The response rate for the survey was 68 percent.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall level of Uninsurance

Data from the 2000 Vermont Family Health Insurance indicate that 8.4 percent, approximately 51,390, of the state's population were uninsured in 2000.

Income

Family Income as a % of the Federal Poverty Level	% Uninsured
<100%	14.0%
100-149%	13.2%
150-199%	10.5%
200-249%	11.0%
250-299%	6.1%
300%+	5.1%

Source: 2000 Vermont Family Health Insurance Survey

Age

Age	% Uninsured
0-17	4.2%
18-29	20.0%
30-44	10.4%
45-64	7.2%
65+	1.9%

Source: 2000 Vermont Family Health Insurance Survey

Gender

Gender	% Uninsured
Male	9.89%
Female	7.05%

Source: *2000 Vermont Family Health Insurance Survey*

Family Composition

Vermont's report did not provide information on family composition.

Health Status

Status	Uninsured %	Insured %
Excellent	42.5%	56.7%
Good	44.9%	36.9%
Fair	10.1%	5.3%
Poor	1.6%	0.9%

Source: *2000 Vermont Family Health Insurance Survey*

Employment Status of Uninsured (Age 18+)

Employment Status	% Uninsured
Full-time (30+ hours)	10.5%
Part-time (<30 hours)	11.8%
Not working for pay	7.7%

Source: *2000 Vermont Family Health Insurance Survey*

Availability of Private Coverage

Vermont's report did not provide information on the availability of private coverage.

Availability of Public Coverage

Availability of Public Coverage	Percent
Public Coverage, eligible but not enrolled	39.0%

Source: *Vermont State Planning Grant Report*

Race/Ethnicity

Race/Ethnicity	% Uninsured
Asian, African, American Indian or Mixed race including those whose ethnicity is Hispanic	12.9%

Note: According to Vermont's report, separate uninsured rates were not available by race or ethnicity.
Source: *2000 Vermont Family Health Insurance Survey*

Immigration Status

Vermont's report did not provide information on immigration status.

Geographic Location

Region	% Uninsured
Chittenden County	6.8%
Lamoille County	13.9%

Note: Vermont's report only contained rates for the above counties. The report stated that no county had a rate of uninsurance significantly different from the state average.
Source: Vermont State Planning Grant Report

Duration of Uninsurance

Uninsured's Length of Time Without Insurance	% of Uninsured
< 3 months	9.3%
3-6 months	5.0%
6-11 months	14.2%
≥ 12 months	69.0%
Don't Know/ Refused	2.4%
Total	99.9%

Note: Vermont's report does not specify why the total percentage of uninsured does not equal 100%.
Source: *2000 Vermont Family Health Insurance Survey*

What Population Groupings Were Particularly Important for Vermont in Developing Targeted Coverage Expansion Options?

Vermont's SPG Steering Committee looked at the options listed below. (Note: The committee discarded subsidies, low-cost insurance coverage, and single payer.)

- Increase Participation Among VHAP-Eligible People
- Expand Medicaid Eligibility for Adults
- Medicaid Buy-In to Employer Coverage for Children
- Buy-In to VHAP for Employers and Individuals
- Programs to Assist Families in Purchasing Coverage
- Subsidies to Help Employers Purchase Coverage for Their Workers
- Create Low-cost Health Insurance Coverage Options
- A Single-Payer Model for Vermont

Wisconsin Uninsured

Summary of Wisconsin's Strategies Used to Obtain Information on Uninsured Individuals and Families[9]

The Wisconsin Family Health Survey (FHS) is a random sample telephone survey of Wisconsin households. The sampling frame consists of all Wisconsin households with a working telephone. The sample design includes five geographic strata and one over-sample stratum that is expected to produce at least 20 percent black respondents. Data set weights adjust the final results to account for disproportionate sampling rates and response rates across the six strata.

The adult in each household who knows the most about the health of all household members is selected to answer all survey questions during the telephone interview. This person answers survey questions for him/herself as well as for all other household members. The final FHS sample for 2000 consisted of 2,664 household interviews, representing a total of 6,894 Wisconsin household residents. The overall response rate was 66 percent.

The Wisconsin Department of Health and Family Services (DHFS) has conducted the Wisconsin Family Health Survey on a continuous basis since 1989. Annual reports of survey results are available. For more complete information about survey design and methods, please see the most recent reports on the DHFS Web site (www.dhfs.state.wi.us).

The State Planning Grant did not have any direct effect on the design or conduct of the 2000 Wisconsin Family Health Survey. However, Wisconsin SPG funds supported the revision and purchase of an additional sample on the 2001 Family Health Survey.

In June 2001, the Department of Health and Family Services in cooperation with the Family Health Center of Marshfield, Inc. (FHC) conducted a brief survey of 18 to 24 year-olds who use the FHC sliding scale program. Questions were asked about employment, student status, availability of insurance (other than Family Health Center membership), and barriers to obtaining health insurance. While the survey is not representative of 18 to 24 year-olds in the State, it provides additional information about an age group often considered vulnerable with respect to access to insurance. A 40 percent response rate was achieved, with 72 of the 179 mailed surveys being returned.

In July 2001, the Department of Health and Family Services conducted a survey in cooperation with the Family Health Center of Marshfield, Inc. The survey was

[9] Although Wisconsin does have some point-in-time data from its Wisconsin Family Health Survey (FHS), almost all tabulated data was annual prevalence data for any consecutive twelve-month period from May 1999 end ending December 2000.

mailed to 68 farmers who participate in the FHC sliding scale program. 34 farmers or 50 percent of the sample returned the survey. Questions were asked about availability of insurance and preferences for insurance coverage.

Finally, in September 2000, although not funded by the State Planning Grant, the Barron County Health Department conducted a survey of dairy producers in Barron County. Surveys were mailed to 809 dairy farmers identified through the Farm Service Agency. The survey achieved a 28 percent response rate with 228 surveys returned. The respondents were not asked about farm size. The respondents were asked to report on their own insurance coverage and that of their families where applicable.

Overall Uninsurance Rates and Characteristics of the Uninsured

Overall level of Uninsurance

Based on estimates from the 2000 Wisconsin Family Health Survey (FHS), there were 209,000 state residents who were uninsured for a continuous period of 12 months or more. This was just 4 percent of the State's household residents. A point-in-time measure of the insured and uninsured from the FHS shows that just 6 percent (310,000) of Wisconsin household residents were uninsured at a given point in time during 2000. About 4.8 million residents (94 percent) had some type of private or public health insurance coverage.

Income

Household Income Reported in 1999	% Uninsured
Less than $25,000	10%
$25,000 - $49,000	4%
$50,000 - $74,000	1%
More than $75,000	1%
Not ascertained	4%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Age

Age	% Uninsured
Under 18	2%
18 - 24	9%
25 - 34	6%
35 - 44	4%
45 - 64	5%
Above 65	1%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Gender

Gender	% Uninsured
Male	5%
Female	3%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Family Composition

Family Composition	% Uninsured
Lives in household with >= 1 child.	4%
Lives in household with no children present	5%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Health Status

Status	% Uninsured
Excellent	3%
Very Good	4%
Good	6%
Fair or Poor	6%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Employment Status of Uninsured

Employment Status People 18 - 64	% Uninsured
Employed full time	4%
Employed part time	10%
Farm residents	10%
Not employed	8%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Availability of Private Coverage

Availability of Employment-Based Coverage	Percent
Insurance not offered	17%
Insurance offered and taken	64%
Insurance offered and not taken	18%
Not ascertained	1%

Source: *Wisconsin Family Health Survey, interviews conducted January – June 2001.*

Availability of Public Coverage

Category	Description	% Eligible
AFDC	AFDC-related Medicaid	2.7%
BadgerCare	BadgerCare Eligibles	1.7%
Healthy Start	Pregnant women, children under 6 and OBRA '90 children	2.2%
Presumptive Eligibility	Pregnant women presumed to be eligible by qualified providers	.006%
SSI	Receiving or deemed to be receiving an SSI payment	1.8%
SSI-Related	Meet SSI requirements, not receiving SSI	.3%
Institutionalized	Residing in a nursing home or other long term care institution	.5%
Waiver	Eligible under a community waiver program	.2%
TB-related	Has TB and is eligible for TB-related services	.002%
Medicare Beneficiaries	Medicare pays only for Medicare premiums, etc.	.09%
Foster Care		.2%
Subsidized Adoption	Medicaid is part of adoption contract	.17%
Miscellaneous		.0016%

Source: *Medicaid Management Information System, September Eligibility Reports*.

Race/Ethnicity

Race/Ethnicity	% Uninsured
White, non-Hispanic	3%
Black, non-Hispanic	7%
American Indian, non-Hispanic	11%
Hispanic	12%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Immigration Status

Wisconsin's report did not provide any information on immigration status.

Geographic Location

Region	% Uninsured
Milwaukee County	5%
All other metropolitan counties	3%
Non-metropolitan counties	4%

Source: *Wisconsin Family Health Survey, May 1999 – December 2000.*

Duration of Uninsurance

Wisconsin's report did not provide any information on duration of uninsurance.

What Population Groupings Were Particularly Important for Wisconsin in Developing Targeted Coverage Expansion Options?

The following groups are important to the research goals of the Wisconsin SPG, however they were not necessarily selected to develop "targeted coverage expansion options". Rather, they reflect the remaining large groups of uninsured in a state with low uninsurance.

According to the Wisconsin report, among the 209,000 Wisconsin residents who were uninsured for the 12 months prior to the survey, the numerically largest groups were:

- Individuals with income below 200 percent FPL (117,000 individuals);
- White, non-Hispanic residents (157,000 individuals);
- Uninsured adults without dependent children (108,000 individuals-50,000 of whom are below 200 percent FPL); and
- Uninsured individuals connected to full time employment (187,000 total individuals- 124,000 employed adults and 63,000 who live in a household with an employed adult).

Certain groups in Wisconsin are disproportionately more likely to be uninsured; that is, their uninsured rate is higher than the statewide population rate of 4 percent who were uninsured for 12 months. Those more likely to be uninsured include:

- Young adults ages 18-24 (9 percent uninsured);
- Individuals with income below 200 percent FPL (9 percent uninsured);
- Adults who were employed part-time (10 percent uninsured);
- Adults who were not employed (8 percent uninsured);
- Members of some minority race and ethnicity groups (7 percent to 12 percent uninsured); and
- Farm residents (10 percent uninsured)

Appendix D: State-by-State Profiles of Employer-based Coverage

The following information is provided for each of the 11 FY2000 HRSA SPG-funded states:

- Summary of the state's strategies used to obtain information on employer-based coverage;
- Overall offer rates and characteristics of firms that **do not** offer coverage, as opposed to those that do;
- Characteristics of firms that **do** offer coverage; and
- Summary of characteristics of firms that do and do not offer coverage.

Arkansas Employer-based Coverage

Summary of Arkansas' Strategies Used to Obtain Information on Employer-based Coverage

Arkansas is planning to use the 2001 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) in studying employer-provided health insurance in the state. The MEPS-IC is a survey fielded by the Agency for Healthcare Research and Quality (AHRQ). Arkansas used State Planning Grant funds to increase the standard MEPS-IC sample for Arkansas from 800 to 1800. Much of the data not included below is expected to be available by June 2003.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Based on 1996 Medical Expenditure Panel Survey Data (MEPS-IC) 45.3 percent of Arkansas establishments offer employer-based health insurance.

Employer Size

Firm Size	% of Employers Offering
50 or fewer employees	34.2%
More than 50 employees	97%

Source: *1996 Medical Expenditure Panel Survey – Insurance Component*

Industry Sector

Arkansas' report did not include information regarding industry sector.

Employee Income Brackets

Arkansas' report did not contain information regarding employee income brackets.

Percentage of Part-time Workers

Status	% Employees Eligible for Coverage
Full-Time	91.7%
Part-Time	13.1%

Source: *1996 Medical Expenditure Panel Survey – Insurance Component*

Geographic Location

Arkansas' report did not contain information regarding geographic location.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Arkansas' report did not include information regarding the cost of coverage.

Level of Employer Contribution

Arkansas' report did not include information regarding the level of employer contribution.

Percentage of Employees Offered Coverage Who Participate

Status	% Employees Eligible for Coverage
Enrolled	87.2%
Declined	12.8%

Source: ***1996 Medical Expenditure Panel Survey – Insurance Component***

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

According to 1996 MEPS-IC data, the overall rate of businesses in Arkansas that offer health insurance was 43.5 percent. Over 97percent of firms with more than 50 employees offer health insurance to their employees. Approximately 92 percent of Arkansas' full-time employees are offered coverage, while only 13 percent of the part-time employees in the state are offered health insurance by their employers.

Delaware Employer-based Coverage

Delaware's Strategies Used to Obtain Information on Employer-based Coverage

A large proportion of the uninsured in the state of Delaware are employed in companies with less than 50 employees. These companies represent the largest growing segment of Delaware's economy. Efforts were concentrated on employees of small and medium size businesses. The 2000 Small Employer benefits survey by Blue Cross Blue Shield, Employee Benefits Research Institute and Consumer Health Education Council was used as a basis for the design of a survey instrument administered to employers of these individuals. The survey was developed to find out the reasons why small employers in Delaware with less than 50 employees do not offer health insurance.

The survey instrument consisted of two separate questionnaires: One to be filled out by businesses that offer health insurance to their employees and the other by businesses that do not offer any health plans to their employees.

The questions in the questionnaire were divided into three distinctive groups:

- Attitudes towards offering health plans to employees
- Information about the business (such as number of employees, full time/part time status, annual earnings)
- General knowledge of the health insurance market

The sample size of the Small Employer Health Insurance survey was 1,598 providing appropriate representation by county. The surveys were sent out in 4 separate mailings over a period of 2 months. The response rate for the survey was nearly 50 percent. The data gathered was weighted to appropriately represent the population of small businesses in the state of Delaware.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Employer Size

Firm Size (Number of Employees)	% Uninsured (1998 – 2000)
< 25	29%
25 - 99	19.8%
100 - 499	14.8%
500 - 999	12%
> 1000	11.8%

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.

Industry Sector

Industry Sector	% Uninsured (1998 – 2000)
Construction	25.8%
Manufacturing	9.5%
Trade	19.3%
Finance, insurance and real estate	11.7%
Service	12.3%

Source: Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.

Employee Income Brackets

Annual Job Earnings	% Uninsured (1998 – 2000)
<= $10,000	29.3%
$10,000 - $20,000	20.2%
$20,000 - $30,000	15.9%
$30,000 - $50,000	11.2%
> $50,000	8.2%

Source: *Center for Applied Demography and Survey Research, University of Delaware, US Bureau of Census, Current Population Survey, March 1994 – 2000.*

Percentage of Part-time and Seasonal Workers

Delaware's report did not provide information regarding uninsurance by percentage of part-time and seasonal workers.

Geographic Location

Delaware's report did not provide information regarding the geographic location of the percent of employers that offer health insurance as compared to those that don't.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Delaware's report did not provide information regarding the cost of health care policies.

Percentage of Employees Offered Coverage Who Participate

Percent of Small Delaware Firms[10]	% Of Employees who Participate in Health Plan
33%	100%
25%	75 – 99%

Source: *Delaware Health Care Commission, "Health Resources and Services Administration State Planning Grant – Final Report," (10/29/2001).*

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

More than half (62 percent) of Delaware's small businesses not offering health insurance have 1 to 5 employees, 32 percent of small businesses have 6-15 employees, 4 percent have 16-25 employees and 2 percent have 35 to 50 employees. Small businesses offering health plans tend to have more employees, 32 percent of them have 1-5 employees, 45 percent have 6-15 employees.

In terms of gross revenue 75 percent of small businesses not offering health plans have gross revenues less than $500,000 (this is where the median is), 15 percent had gross revenues between $500,000 to $1million. Among small businesses offering health plans the median gross revenue is between $500,000 to $1 million.

Other information includes:

- The typical full time salaried employee's median income for the companies not offering health insurance is $25,000, and the median wage for hourly employees is $9. For firms offering health plan the median income for salaried employees is $30,000 and the median hourly wage is $10.
- Only around 6 percent of businesses surveyed are extremely likely or very likely to start a health plan for their employees.

[10] Small firms (businesses) in Delaware are those with 50 or fewer employees.

- One quarter (24 percent) of businesses not offering health plans are family owned businesses compared to sixty percent of firms offering health plans.
- Three quarters of small businesses not offering health plans have owners, who are covered by a health plan, compared to ninety percent for businesses offering health plans.
- The average turnover rate for a business not offering health plans is 24 percent compared to 13 percent for businesses offering health plans.
- The median part time employment is about 33 percent for firm's not offering health insurance contrasted with 10 percent for businesses offering health plans.
- Small businesses without insurance are 3 years younger than businesses with insurance (median age of 10 compared to median age of 13).
- Ninety percent of the businesses not offering health plans indicated that their employees do not belong to a union compared to 97 percent for business with health plans.
- In terms of the gender of employees, the medium business not offering health plans have an even distribution of males versus females while businesses offering health plans have 40 percent females and 60 percent males.
- The medium business not offering health plans has about 20 percent employees under the age of 30 compared with 17 percent for those with health insurance.

Illinois Employer-based Coverage

Illinois' Strategies Used to Obtain Information on Employer-based Coverage

Illinois' planning grant process did not include any significant quantitative research on employers. The data reported in the following tables is based on findings from the UIC survey.

Overall Offer Rates and Characteristics of Firms that **Do Not** Offer Coverage, as Compared to Firms That Do

Overall Offer Rates

Illinois' report did not provide information regarding overall offer rates.

Employer Size

Firm Size (Number of Employees)	% of the Uninsured
< 50	60.9%
≥ 50	39.1%
Total	100%

Source: *2001 UIC Survey*

Employee Income Brackets

Illinois' report did not provide information regarding employee income brackets.

Industry Sector

Industry Sector	% of the Uninsured
Agriculture	.6%
Construction	2.7%
Manufacturing	6.6%
Trade	19.0%
Services	62.4%
Other	8.8%
Total	100%

Source: *2001 UIC Survey*

Percentage of Part-Time and Seasonal Workers

Illinois' report did not provide information regarding percentage of part-time and seasonal workers.

Geographic Location

Illinois' report did not provide information regarding geographic location.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies (Individual Coverage)

Illinois' report did not provide information on the cost of policies (individual coverage).

Cost of Policies (Family Coverage)

Illinois' report did not provide information on the cost of policies (family coverage).

Level of Employer Contribution

Illinois' report did not provide information on the level of employer contribution.

Percentage of Employees Offered Coverage Who Participate

Illinois' report did not provide information on the percentage of employees offered coverage who participate.

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

Uninsured workers are more likely to be employed by small firms (less than 50 employees) than by larger firms (approximately 61percent vs. 39 percent, respectively). Newly insured workers (almost 54 percent) are more likely to be employed by larger firms (over 50 employees) than smaller firms (46 percent).

UIC random digit dial data showed among working adults, there were fewer industry differences versus occupation differences between newly insured and uninsured adults. Both the newly insured and uninsured were most likely to work in the service sectors than in any other sector. About twice as many newly insured adults (34.9 percent) were employed as managers, professionals, and technicians than uninsured (17.4 percent). More uninsured adults were employed in service occupations (26.4 percent) compared to newly insured (20.3 percent).

Iowa Employer-based Coverage

Iowa's Strategies Used to Obtain Information on Employer-based Coverage

Iowa used two strategies to collect information about employer-based coverage: 1) CPS analysis; and 2) two surveys of employers. In the first employer survey, the Lewin Group pooled March CPS data for the years 1996 through 1999 to obtain a sufficient sample size for detailed analyses of the employment characteristics of the uninsured.

Baselice & Associates conducted the survey of employers in early 2001 using a questionnaire designed by The Lewin Group. Participants were surveyed through a 20-minute telephone interview. Employers in Iowa were grouped into four geographic regions and from each region part of the sample was recruited. The survey provided quantitative information about employers in the State that both offer and do not offer health insurance to their workers.

The second survey, designed to test businesses' beliefs on potential policies of insurance coverage expansion, was done at two separate points in time (March 7-16, 2002 and July 17- Aug. 1) SPPG conducted the survey using a questionnaire designed by the Selzer Co. Five hundred and fifty people who make the health-care purchasing decisions for their businesses were interviewed by telephone. Each sample included 450 businesses that provide insurance to their employees and 100 businesses that do not. The businesses were randomly selected from the Iowa secretary of states' corporation database. For questions that were asked of all 550 respondents, the margin of error is roughly ± 4.2 percent.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Overall Offer Rates

54 percent of Iowa employers offer health insurance coverage to their employees.

Employer Size

Firm Size (Number of Employees)	Percent Offering Health Insurance
1 or self-employed	30%
2-3	35%
4-10	54%
11-50	85%
51 or more	97%
Other	75%

Source: *Iowa Survey of Employers*

Percentage of Workers in Firm Size Groups Without Employer Coverage	
Firm Size	Percent
Under 10	50.3%
10-24	28.8%
25-99	21.4%
100-499	15.0%
500-999	15.0%
1,000 or more	15.6%

Source: *CPS data*

Employee Income Brackets

Percent of Employers Offering Coverage by Average Wage Level	
Average Wage Level	Percent
Less than $10,000	58%
$10,000-$20,000	87%
$20,000-$40,000	94%
$40,000-$100,000	98%
Over $100,000	99%

Source: *Iowa Survey of Employers*

Percentage of Workers in Firm Size Groups Without Employer Coverage By Weekly Earnings	
Weekly Earnings	Percent
Less than $150	50.0%
$150-$249	45.7%
$250-$399	28.2%
$400-$599	18.3%
$600-$799	11.8%
$800 or more	9.4%

Source: *CPS data*

Industry Sector

Employment Characteristics of Workers With Employer Coverage	
Industry of Worker	Percent Covered on Own Job
Agriculture/Forestry/Fishing	21.8%
Construction	47.3%
Durable Goods Manufacturing	80.2%
Non-durable Goods Manufacturing	68.7%
Transportation/Communications	64.5%
Wholesale Trade	64.1%
Retail Trade	36.2%
Finance/Insurance/Real Estate	72.5%
Business and Repair Services	47.8%
Personal Services	39.3%
Entertainment/Recreation	41.0%
Professional Services	56.9%
Public Administration	86.4%
Mining or Not Identified	26.3%

Source: *CPS data*

Percentage of Part-Time and Seasonal Workers

Percent of Firms Offering Coverage That Also Cover Other Selected Groups	
Group	Percent of Firms
All Full-time Workers Covered	81%
Cover Part-time Workers	25%
Seasonal Workers Included	18%
Other Temporary	21%

Source: *Iowa Survey of Employers*

Geographic Location

The likelihood of firms offering health insurance did not vary significantly among different geographic regions of the state. In the East, Central, and West regions, 58 percent of employers offered health insurance compared to 49 percent in Des Moines area and 51 percent along the Mississippi river.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Iowa's report did not provide information regarding cost of policies.

Level of Contribution

On average insuring firms in Iowa pay about 81 percent of the employee's premium.

Level of Contribution for employee's premium.	Percent of Firms
50% or less	43.0%
51%-80%	31.9%
100%	25.1%

Source: *Iowa Survey of Employers*

Percentage of Employees Offered Coverage Who Participate

Iowa's report did not provide information regarding percentage of employees offered coverage who participate.

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

In Iowa, 54 percent of employers offer health insurance to their employees. Seventy-five percent of workers in government and 60 percent of workers in the private sector receive health insurance coverage through their employers whereas only 17.1 percent of self-employed workers are covered through their work places. Public administration, durable goods manufacturing and finance/insurance/real estate are the industries most likely to offer health insurance to employees. Comparatively, industries in which employees are least likely to be offered health insurance through their jobs are mining, entertainment and recreation, and agriculture/forestry/fishing.

Firm size was correlated to the likelihood that an employer would offer health insurance; the percentage of workers covered increases as firm size increases. Overall, 65.7 percent of workers without employer coverage work in firms with less than 100 employees. The percentage of employers offering health insurance also increased as wage levels increased. Of firms with a wage level less than $10,000, 58 percent offered health insurance. The percentage of firms that offer health insurance increases to 87 percent for the wage level category $10,000 to $20,000 and 99 percent for those with a wage level over $100,000.

Insuring firms in Iowa on average pay about 81 percent of the employee's premium, with the employee paying the remainder. Employer contributions comprise a smaller share of the family premium, on average, less than half of the family premium is paid by employers. The primary reasons that companies don't offer health insurance to their workers is that offering coverage was too expensive (74 percent) and 42 percent are concerned about future rate increases.

Kansas Employer-based Coverage

Kansas' Strategies Used to Obtain Information on Employer-based Coverage

Kansas collected data on employer-based coverage in the state through the Kansas Health Insurance Survey. The Kansas Health Insurance Survey is described previously in the Uninsured Individuals and Families Section.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Employer Size

Percent of Employed Kansans Offered Employment-Based Health Insurance by Their Employer's Firm Size*	
Firm Size (Number of Employees)	Percent
1-4	17.4%
5-9	44.7%
10-24	68.3%
25-49	76.5%
50-99	82.4%
100-249	88.3%
250-499	90.3%
500-999	91.9%
1000 or more	91.6%

*Age 18-64
Source: *Kansas Health Insurance Survey.*

Employee Income Brackets

Percent of Employed Kansans Who's Employer Offers Health Insurance to at Least Some of Their Employees, by Job Earnings. *	
Annual Job Earnings	Percent
Less than $5,000	48.8%
$5,000-9,999	53.1%
$10,000-14,999	65.3%
$15,000-19,999	77.7%
$20,000-24,999	81.1%
$25,000-34,999	86.4%
$35,000-44,999	89.9%
$45,000-54,999	88.6%
$55,000-64,999	90.6%
$65,000-74,999	89.1%
$75,000-84,999	89.8%
$85,000-94,999	82.2%
$95,000 or more	75.3%

*Age 18-64
Source: *Kansas Health Insurance Survey*.

Industry Sector

Percent of Employed Kansans Offered Employment-Based Health Insurance by Their Employer's Industry*	
Industry Sector	Percent
Agricultural Forestry Fishing	44.7%
Utilities or Communication	73.3%
Mining	66.3%
Construction	87.8%
Manufacturing	91.4%
Transport Electric Gas Sanitary	81.5%
Wholesale Trade	82.2%
Retail Trade	61.6%
Financial Insurance Real Estate	75.1%
Business Repair Services	74.7%
Personal Services	35.8%
Entertainment Recreation Services	58.8%
Health Services	79.9%
Education Services	82.2%
Social Services	69.8%
Other Professional Services	76.3%
Public Administration	93.7%

*Age 18-64
Source: *Kansas Health Insurance Survey*.

Percentage of Part-Time and Seasonal Workers

Percent of Employed Kansans Offered Health Insurance by Their Employer by Employment Status *	
Status	Offered
Permanent Vs. Seasonal	
Seasonal Employee	50.5%
Permanent Employee	77.6%
Full-time Vs. Part-time	
Full-time	88.1%
Part -time	44.1%

*Age 18-64
Source*: Kansas Health Insurance Survey*.

Geographic Location

Percent of Employed Kansans Who Report the Their Employer Offers Health Insurance Coverage, Statewide and by Region*	
Region	Percent
1	81.6%
2	85.1%
3	83.5%
4	79.2%
5	77.5%
6	83.9%
7	80.5%
8	78.0%
9	68.1%
10	72.5%

*Age 18-64
Source*: Kansas Health Insurance Survey*.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Kansas' report did not provide information regarding cost of coverage.

Level of Contribution

Monthly Employee Share of Premiums for Employment-Based Health Insurance Coverage	
Type	Share
Self-only Coverage	
25th Percentile	$32
Median	$61
75th Percentile	$108
Mean	$173
Family Coverage	
25th Percentile	$87
Median	$152
75th Percentile	$260
Mean	$225

Source*: Kansas Health Insurance Survey*.

Percentage of Employees Offered Coverage Who Participate

Enrollment of Employed Kansans Who Are Eligible for Employment-Based Insurance	
Status	Percent
Enrolled	82.0%
Declined	18.0%

Source: *Kansas Health Insurance Survey*.

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

In Kansas, employees of larger employers were more likely to be offered health insurance. Statewide, 91.6 percent of individuals who work for firms with 1,000 or more employees reported their employer offer health insurance, but only 17.4 percent of those in firms with four or fewer employees reported that their employer offers health insurance. The percentage of Employed Kansans reporting that their employer offers health insurance varied by region from a low of 68.1percent to a high of 85.1percent.

Insurance offerings varied by industry. The highest rates of coverage were reported in public administration, manufacturing and construction. The lowest rates of coverage were reported in agriculture, entertainment and recreation services, and retail trade.
Workers with higher job earnings were more likely to report that their employers offer health insurance. Approximately 49 percent of those earning under $5,000 annually reported that their employers offer health insurance. By contrast, over 80 percent of employees with annual earnings over $20,000 said that their employers offered health insurance coverage.

Permanent employees were more likely to report being offered health insurance by their employer (77.6 percent) than were seasonal workers (50.5 percent). Full-time workers were twice as likely to report their employer or union offered health insurance than part-time workers.

Of employees eligible for employment based insurance 82 percent enroll. The median employee share of employee-only health insurance premiums was $61 dollars per month. The median employee share for family coverage was $152 per month.

Massachusetts Employer-based Coverage

Massachusetts' Strategies Used to Obtain Information on Employer-based Coverage

The Division of Health Care Finance and Policy (DHCFP) developed the 2001 Employer Health Insurance Survey to better determine the status of employer-based health insurance coverage in the state. A total of 800 employers were surveyed at the time of the report, and an additional 200-300 interviews to be conducted. The survey excludes all federal and state government agencies and town government offices and direct functional agencies such as police and fire. Schools are included in the survey and are classified as educational, not governmental. The survey is telephone-based. For purposes of the report, only preliminary data is provided.

For additional information, Massachusetts also included private-sector employer data from the Agency for Healthcare Research and Quality's 1996-1999 Medical Expenditure Panel Survey (MEPS).

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Overall Offer Rates

According to preliminary data from the 2001 Employer Health Insurance Survey, 65.7 percent of employers offer health insurance coverage to their employees.

Characteristics of Firms That **Do** Offer Coverage

Employer Size

Firm Size	% of Employers Offering
2-9 employees	55.5%
10-50	83.9%
51-249	92.6%
250 or more	99.4%
All Employers	65.7%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Industry Sector

Industry Sector	% of Employers Offering
Construction	54.9%
Retail Trade	60.5%
Services	61.6%
Transportation and Public Utilities	63.5%
Finance, Insurance and Real Estate	77.1%
Manufacturing	83.6%
Wholesale Trade	90.0%
Mining	100.0%
Public Administration	100.0%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Employee Income Brackets

Employee Income	% of Employers Offering
>50% employees earning less than $20,000 annually	54.0%
>50% employees earning between $20,000-$40,000 annually	70.9%
>50% employees earning more than $40,000 annually	86.4%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Percentage of Part-Time and Seasonal Workers

Employee Type	% of Employers Offering	% of Employers Not Offering
Part-time	30.3%	43.8%
Temporary	3.7%	34.1%
Seasonal	2.9%	20.1%
Hourly	62.4%	11.3%
Union	74.3%	7.1%

Note: The Massachusetts ' 2001 employer survey did not differentiate between part-time and full-time employees, the two were combined.
Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Geographic Location

Region	% of Employers Offering
Metropolitan Boston	70.2%
Northeast Massachusetts	72.3%
Southeast Massachusetts	49.8%
Western Massachusetts	65.0%
Central Massachusetts	66.2%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Cost of Policies

Average Annual Cost (total premium)	
Type	Cost
Single Coverage	$3,376
Family Coverage	$7,605

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Level of Contribution

Monthly Employee Share of Premiums for Employment-Based Health Insurance Coverage	
Type	Share of total premium
Single Coverage	17.7%
Family Coverage	27.5%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Percentage of Employees Offered Coverage Who Participate

Status	Percent
Eligible Employees Enrolled	78.3%

Source: *Preliminary data from 2001 Employer Health Insurance Survey*

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

Preliminary data from the 2001 Employer Health Insurance Survey indicates that 65.7 percent of the employers in the state (primarily private-sector firms) offer health insurance coverage to their employees. There are a number of factors related to whether an employee has access to employer-based coverage, some of these factors include employer size, type of industry, employees wage, number of hours worked and geographic location. In addition to these factors, the survey found that the cost of policies for single and family coverage increased with in the last 12 months by 13.9 percent and 21.2 percent respectively. Employees participating in family coverage plans also experienced a 22 percent to 27.5 percent increase in employee share within the last 12 months. Whereas the employees participating in a single coverage plan only experienced a minimal increase. Finally, the 2001 Employer Health Insurance Survey found that 78.3 percent of the employees who are eligible for employer-based coverage actually enroll.

Minnesota Employer-based Coverage

Minnesota's Strategies Used to Obtain Information on Employer-based Coverage

Minnesota is conducting a survey of 2,400 employers in the state under the State Planning Grant. This survey is not yet complete, and so the information presented in this section of the report is based on Minnesota data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Overall Offer Rates

About half (51percent) of Minnesota establishments offer health insurance coverage.

Employer Size

Firm Size (Number of Employees)	Percent Offering	Percent Not Offering
< 10	44.1%	77.0%
10-49	29.8%	17.0%
50-199	11.6%	2.4%
200 +	14.4%	3.6%
Total	100%	100%

Source: *1997 RWJF Employer Health Insurance Survey*

Industry Sector

Minnesota's report did not provide information on offer rates by industry sector.

Employee Income Brackets

Annual Job Earnings	Percent Offering	Percent Not Offering
< $10,000	2.8%	15.9%
$10,000-$20,000	33.6%	52.8%
$20,000 +	63.8%	31.4%
Total	100%	100%

Source: *1997 RWJF Employer Health Insurance Survey*

Percentage of Part-time and Seasonal Employees

Minnesota's report did not provide information on offer rates by the percentage of part-time and seasonal employees.

Geographic Location

Location	Percent Offering	Percent Not Offering
Twin Cities	68.8%	53.2%
Greater Minnesota	31.2%	46.8%
Total	100%	100%

Source: *1997 RWJF Employer Health Insurance Survey*

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Type	Average Cost Per Month
Single Coverage	$157
Family Coverage	$410

Source: *1997 RWJF Employer Health Insurance Survey*

Level of Employer Contribution

Average Monthly Employer Share of Premiums for Employment-Based Health Insurance Coverage	
Type	Share
Single Coverage	82%
Family Coverage	70%

Source: *1997 RWJF Employer Health Insurance Survey*

Level of Employer Contribution

Average Monthly Employer Share of Premiums for Employment-Based Single Coverage by Firm Size	
Size	Share
< 10	91%
10-49	85%
50-199	83%
200 +	80%

Source: *1997 RWJF Employer Health Insurance Survey*

Level of Employer Contribution

Average Monthly Employer Share of Premiums for Employment-Based Family Coverage by Firm Size	
Size	Share
< 10	81%
10-49	68%
50-199	66%
200 +	70%

Source: *1997 RWJF Employer Health Insurance Survey*

Percentage of employees offered coverage who participate

Status	Percent
Employees Eligible	83%
Take-up Rate	88%

Source: *1997 RWJF Employer Health Insurance Survey*

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

In general, establishments that are part of larger firms and higher-wage firms are more likely to offer health insurance coverage than establishments that belong to smaller, lower-wage firms. Establishments that offer coverage also have a higher percentage of their workforce employed full-time than establishments that do not offer coverage. Establishments in the Twin Cities metropolitan area are more likely to offer coverage than establishments in Greater Minnesota. The methodology employed in the 1997 RWJF survey and the 2001 survey does not allow for industry-specific estimates of offer rates of health insurance.

In 1997, the average premium for single coverage was $157 per month, and the premium for family coverage was about $410. However, other data available to the state indicate that premiums have been rising rapidly with increases at or near double digits annually since 1998. The increases in premiums may also have affected employer contributions and employee take-up rates. Data from the

2001 Minnesota Employer Health Insurance Survey being conducted under the SPG will allow for an analysis of how the rapid premium increases of the last 4 years have affected the market for employer-based health insurance coverage.

On average, Minnesota employers contribute about 82 percent of the premium for single coverage and 70 percent for family coverage. Employer contributions vary by firm size. Among very small firms that offer health insurance coverage, the average share of the premium contributed by the employer was higher than for larger firms.

Lastly, a high percentage of employees who are eligible for coverage enroll. However, take-up rates vary across establishments, particularly for lower-wage vs. higher-wage establishments. For example, in establishments where the majority of permanent workers earned less than $7 per hour in 1997, only 74 percent of eligible employees accept an offer of employer-based health insurance. In comparison, about 89 percent of eligible employees in higher-wage firms enroll in coverage.

New Hampshire Employer-based Coverage

New Hampshire's Strategies Used to Obtain Information on Employer-based Coverage

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

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Overall Offer Rates

71.2 percent of New Hampshire employers offer health insurance coverage to their employees.

Characteristics of Firms That **Do** Offer Coverage

Employer Size

Firm Size (Number of Employees)	% of Employers Offering	% of Employers Not Offering
1	88.8%	11.2%
2-10	56.8%	43.2%
11-50	89.3%	10.7%
51-99	100%	0.0%
100 +	100%	0.0%

Source: *2001 Survey of New Hampshire Employers*

Industry Sector

Industry Sector	% of Employers Offering	% of Employers Not Offering
Agriculture	76.4%	23.6%
Construction	69.4%	30.6%
Manufacturing	78.2%	21.8%
Transportation	64.3%	35.7%
Wholesale	74.5%	25.5%
Retail Trade	60.8%	39.2%
Fin. Services	85.3%	14.7%
Bus. Services	73.8%	26.2%
Prof. Services	80.5%	19.5%
Healthcare	82.8%	17.2%
Childcare	100.0%	0.0%

Source: *2001 Survey of New Hampshire Employers*

Employee Income Brackets

Firm Type	% of Employees Earning = $17,180/year
Among firms offering coverage	78.7%
Among firms **not** offering coverage	21.3%
Total	100.0%

Note: 200% FPL in 2001 is $17,180/year
Source: *2001 Survey of New Hampshire Employers*

Percentage of Part-time and Seasonal Workers

Employee Type	Percent Offering	Percent Not Offering
Part-time	86.0%	14.0%
Seasonal	80.8%	19.2%

Source: *2001 Survey of New Hampshire Employers*

Geographic Location

Location	Percent Offering	Percent Not Offering
Urban counties	74.8%	25.2%
Rural counties	66.3%	33.7%

Source: *2001 Survey of New Hampshire Employers*

Cost of Policies (Individual Coverage)

Average Cost Per Month	% of Employers
$110-$184	24.5%
$185-$224	24.1%
$225-$289	24.8%
$290-$485	26.7%
Total	100.0%

Source: *2001 Survey of New Hampshire Employers*

Cost of Policies (Family Coverage)

Average Cost Per Month	% of Employers
$215-$399	21.3%
$400-$559	25.7%
$560-$734	24.4%
$735-$1300	28.7%
Total	100.0%

Source: *2001 Survey of New Hampshire Employers*

Level of Employer Contribution

Average Monthly Employer Share of Premiums for Employment-Based Health Insurance Coverage	
Contribution	% of Employers
0-64	25.1%
65-84	17.7%
85-100	57.2%
Total	100.0%

Source: *2001 Survey of New Hampshire Employers*

Percentage of Employees Offered Coverage Who Participate

Status	% of Employees
Employees Eligible	76.8%
Take-up Rate	86.0%

Source: *2001 Survey of New Hampshire Employers*

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

The overall rate of firms in New Hampshire that do offer health insurance in 2001 is 71.2 percent. From the sample of employers surveyed, approximately 94.3 percent of employees work in companies that offer health insurance. This represents 13,264 out of a total of 14,057 employees. Whether firms offer or do not offer health insurance depends on employer size, industry sector, employee income brackets, percentage of part-time and seasonal workers, geographic location, cost of policies, level of contribution, and the percentage of employees offered coverage who participate in an employer insurance program.

Oregon Employer-based Coverage

Oregon's Strategies Used to Obtain Information on Employer-based Coverage

Oregon relied on existing data sources to obtain information on employer sponsored health coverage. These sources include the Medical Expenditure Panel Survey (MEPS), and the Kaiser Family Foundation Employer Health Benefits 2001 Annual Survey (referred to as Kaiser/HRET).

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage as Compared to Firms That Do

Overall Offer Rates

According to 1998 MEPS, Oregon specific data, 50.4 percent of private employer firms offer health insurance coverage to their employees.

Employer Size

Firm Size (Number of Employees)	% of Firms that Offer	% of Employees in Firms that Offer
1-9	31.5%	40.8%
10-24	71.9%	74.1%
25-99	79.4%	77.3%
100-999	91.5%	99.0%
1000+	98.7%	99.1%

Source: *1998 MEPS, Oregon only*

Industry Sector

% of All Small Firms (3-199 workers) Offered Health Insurance, by Industry	
Industry Sector	Percent
State/Local Government	91%
Transportation/Communication/ Utility	83%
Manufacturing	76%
Health Care	73%
Mining/Construction/Wholesale	69%
Service	64%
Finance	59%
Retail	58%

Source: Kaiser/HRET Survey of Employer –Sponsored Health Benefits: 2000-2001

Employee Income Bracket

Type of Firm	% of Employers Offering
>35% employees making less than $20,000 annually	52%
All other firms	85%

Source: Kaiser/HRET Survey of Employer –Sponsored Health Benefits: 2000-2001

Percentage of Part-Time and Seasonal Workers

% of Employees Working in Firms that Offer Health Insurance		
Firm Size	Part-Time	Full-Time
<10 Employees	20.7%	49.5%
10-24	64.9%	76.5%
25-99	67.6%	81.4%
100-999	97.4%	99.4%
1000+	91.0%	99.5%

Source: *1998 MEPS (Oregon only, Private sector only)*

Geographic Location

Oregon's report did not provide information on geographic location.

Characteristics of Firms that **Do** Offer Coverage

Cost of Policies

Average Total Premium per Enrolled Employee		
Firm Size	Single Coverage	Family Coverage
≤ 50 Employees	$2,097	$5,373
> 50 Employees	$2,259	$5,641
Totals-Oregon	$2,211	$5,599

Source: *MEPS 1998*

Percentage of employees offered coverage who participate

Firm Size	% of Eligible Employees enrolled	Take Up Rates (Enrolled/ Eligible)
1-9	68.7%	81.7%
10-24	64.0%	81.1%
25-99	56.9%	80.9%
100-999	67.9%	88.1%
1000+	78.6%	92.0%

Source: *1998 MEPS, Oregon Only*

Level of Contribution

Employer Contribution Towards Coverage		
Firm Size	Single	Family
≤ 50 Employees	91%	66.0%
≥ 51 Employees	90%	78.0%
Total	90%	75.0%

Source: *MEPS 1998*

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

1998 MEPS, Oregon specific data, indicates that 50.4 percent of private-sector firms offer health insurance coverage to their employees. The data also suggest that employees of larger firms are more likely to be offered health insurance coverage from their employer. In addition, low-income workers are less likely to be offered health insurance than higher-wage workers. Other factors influencing an employee's access to employer-sponsored health insurance include employee wage and part-time status.

In terms of the cost of policies, Oregon determined from the 1998 MEPS data that the differences between small firms and large firms were not statistically significant. The premium costs are similar across firm size, which is consistent with national data indicating that small employers pay approximately the same as large employers, however receive less coverage. Employer contribution is less (66 percent) for employees in small firms participating in family coverage than employees employed in larger firms (78 percent). The employer share for single coverage across firm size remains constant.

Finally, Oregon states that although take-up rates for employees are high (87.9 percent overall), there are approximately 110,000 workers who decline coverage in which they are eligible.

Vermont Employer-based Coverage

Vermont's Strategies Used to Obtain Information on Employer-based Coverage

The 2000 Vermont Family Health Insurance Survey is also the primary source for information regarding the status of employer-based coverage within the state.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms that Do

Overall Offer Rates

Vermont's report did not provide an overall offer rate of health insurance coverage to employees.

Employer Size (Age 18+)

Firm Size	Percent of Workers Offered Health Insurance
≤ 4 employees	26.6%
5-9	57.0%
10-24	69.7%
35-49	86.4%
50-99	93.7%
100-199	94.2%
200-499	97.7%
500-999	95.9%
1,000 or More	97.3%
Don't Know	81.8%

Source: *2000 Vermont Family Health Insurance Survey*

Industry Sector

Vermont's report did not provide information on Industry Sector

Geographic Location

Vermont's report did not provide information on geographic location on employers.

Employee Income Brackets

Vermont's report did not provide information on employee income brackets

Percentage of Part-time and Seasonal Employees at Firms That Offer Coverage

Vermont's report did not provide information on the percentage of part-time and seasonal employees that are offered coverage.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies

Coverage Type	Cost
Single	$2,419
Family	$6,357

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Level of Employer Contribution

Vermont's report did not provide information on the level of employer contribution.

Percentage of Employees Offered Coverage Who Participate

Vermont's report did not provide information on the percentage of employees who participate in employer-sponsored coverage.

Summary of Characteristics of Firms that Do and Do Not Offer Coverage

According to the 2000 Vermont Family Health Insurance Survey, the majority of uninsured employees (32.7 percent) aged 18 and older work for firms with 4 or fewer employees. This percentage significantly decreases with firms who have 5-9 employees, and minimally fluctuates as firm size increases. The percentage of employees offered health insurance coverage through their employers increases with the size of the firm. According to findings from the 2000 Vermont Family Health Insurance Survey, 26.6 employees working in firms with fewer than 5 employees are offered coverage, versus over 90 percent of employees offered coverage in firms with over 50 employees.

Wisconsin Employer-based Coverage

Wisconsin's Strategies Used to Obtain Information on Employer-based Coverage

Wisconsin State Planning Grant (SPG) activities provided detailed information on the characteristics of Wisconsin employers that offer health care coverage to their employees and those who do not. Employers were compared based on their size, industry sector and employee wage levels. The ability to access health coverage through an employer was also studied from the point of view of the employees. Employees were compared based on their income, geographic location in the state, and full-time status.

Using State Planning Grant (SPG) funds, a set of new questions were added to the 2001 Family Health Survey (FHS) and the sample size was doubled for interviews conducted between January and June 2001. With the questions added to the 2001 FHS, the data was analyzed to tie characteristics of a job to the likelihood that the employee would be covered through group insurance. The new survey questions focused on job characteristics (tenure, hours per week), employer characteristics (type of employer, small business status), employer offer of insurance, employee acceptance or refusal of insurance, and dependent coverage under employer insurance. In addition, employer characteristics were compiled from the new FHS dataset and 1998 Medical Expenditure Panel Survey (MEPS) data for Wisconsin. The data used under the SPG was derived from the MEPS Insurance Component, which is a survey of employers. The sample size for Wisconsin is 800 employers. Much of the data is based on the survey that was conducted in 1999 with questions for the 1998 calendar year. Special tabulations for 1998 were released in 2001.

Overall Offer Rates and Characteristics of Firms That **Do Not** Offer Coverage, as Compared to Firms That Do

Employer Size

Firm size (Number of employees)	% Offering	*% Not* Offering
<= 50	46%	54%
>50	98%	2%

Source: *U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998*.

Industry Sector

Industry Sector	% of Workers Offered Health Coverage
Retail trade	50.6%
Agriculture, Personal Services, Wholesale Trade	57.8%
Manufacturing	88.8%
Transportation, Construction	70.1%
Business Services, Finance	78.8%
Other Services	64.3%

Source: *Institute for Health Policy Solutions analysis of Data from the 1998 MEPS Survey of Private-Sector Business Establishments.*

Employee Income Brackets

Employee Hourly Earnings	% Offered Coverage by Employer
Less than $7.50 per hour	51%
More than $20.00 per hour	93%

Source: *Institute for Health Policy Solutions analysis of Data from the 1998 MEPS Survey of Private-Sector Business Establishments.*

Percentage of Part-time and Seasonal Workers

Status	Percentage
Offered health insurance coverage by employer	35%
Eligible for employer-sponsored health insurance coverage	47%
Had coverage through their employer	8%
Policyholder of health coverage	13%

Source*: Institute for Health Policy Solutions analysis of Data from the 1998 MEPS Survey of Private-Sector Business Establishments; Wisconsin Family Health Survey, January – June 2001.*

Geographic Location

Residential Location of Wisconsin Employee	Employer Offer Rate
Metropolitan counties	84%
Non-metropolitan counties	81%

Source: *Wisconsin Family Health Survey, January – June 2001*.

Characteristics of Firms That **Do** Offer Coverage

Cost of Policies (Individual Coverage)

Range of Monthly Employee Contributions for Employee-Only Coverage under Lowest-Cost Plan Available to Eligible Employees through their Employer	
Firm Size (number of employees)	Mean Cost
<= 50	$35
> 50	$32

Source: *1998 MEPS*

Cost of Policies (Family Coverage)

Range of Monthly Employee Contributions for Full-Family Coverage under Lowest-Cost Plan Available to Eligible Employees through Their Employer	
Firm Size (number of employees)	Mean Cost
<= 50	$134
> 50	$111

Source*: 1998 MEPS*

Level of Employer Contribution

Firm Size (number of employees)	Average Single Coverage Contribution	Average Family Coverage Contribution
<= 50	**$2375**	**$5726**
> 50	**$2121**	**$5474**

Source*: 1998 MEPS*

Percentage of Employees Offered Coverage Who Participate

Firm Size (Number of employees)	Percent Eligible for Employer-Offered Insurance	Percent Declining Employer Offer	Percent Accepting Employer Offer
<= 50	51%	15%	36%
>50	79%	9%	70%

Source: *U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component, 1998.*

Summary of Characteristics of Firms That Do and Do Not Offer Coverage

When offered insurance by their employer, the vast majority (78 percent) of Wisconsin employees will take that coverage. Among the remaining employed adults not insured by their own employer, many are insured by a spouse's employer, public coverage, or privately-purchased insurance. Employees of large employers (those with more than 50 employees) are more likely than employees of small employers (those with 50 or fewer employees) to have insurance through their own employer. This is likely due to differences in offer rates, eligibility rates and decline rates between the two employer groups.

Employees of small employers are less likely to be offered coverage and are less likely to be eligible for offered coverage than their large employer counterparts. Nearly 79 percent of employees who work for large employers are eligible for the insurance offered by their employer, but only 51percent of employees who work for small businesses are eligible. Employees of small employers are also more likely to decline offered coverage. On average, 15 percent of employees of small employers decline coverage as compared to 9 percent of large business employees. This may be due, in

part, to differences in contribution rates and premium costs between small and large employers. While small employers and large employers contribute the same amount, on average, toward single coverage for their employees, small employers contribute less on average than large employers for family coverage. This lower employer contribution toward family coverage coupled with higher overall premium costs would result in higher out-of-pocket costs for employees of small employers.

Preliminary data from the 2001 Wisconsin Family Health Survey (FHS) suggests that low-income employees are also much less likely to be offered insurance by their employers. Low-income FHS respondents were twice as likely (34 percent, compared to 17 percent) to report that their employer did not offer health care coverage to them. Decline rates were also higher for low-income employees, 28 percent of low-income employees reported declining the coverage as compared to 22 percent of all employees. Similar to employees of small business, low-income employees may be declining coverage at higher rates because they are faced with higher out-of-pocket costs than employees, in general. In fact, 1998 MEPS data illustrates a correlation between wages and health benefit levels among Wisconsin employers. The data indicate that employees in establishments that pay relatively lower wages have to contribute significantly more toward their coverage than employees in establishments that pay higher wages.

APPENDIX E HRSA STATE PLANNING GRANTS

FINAL REPORT TO THE SECRETARY: OVERVIEW

Each HRSA grantee State will complete a final report to the Secretary due thirty days after the grant end date. These reports will reflect the State's experience in examining the uninsured population and developing proposals to expand health insurance coverage. HRSA will use the final State reports to develop a consolidated report to the Secretary on the State Planning Grant program.

The final State reports are to include the following major components:

Executive Summary
A summary of the activities conducted under the HRSA grant -- including the State's data collection activities and the policy options selected to increase health insurance coverage in the State -- and recommendations for Federal and State actions to support State efforts to provide health insurance for the remaining uninsured.

Section 1. Uninsured Individuals and Families
This section will include baseline information about health insurance in the State, including who the uninsured are; how the State approached the issue of studying the uninsured; and how the State used these findings in developing its plan for coverage expansion.

Section 2. Employer-based Coverage
This section includes an assessment of employer-based coverage in the State, employers' views on providing health insurance to their employees, and how this information informed the State's decisions on how to expand health insurance coverage.

Section 3. Health Care Marketplace
An assessment of the State's health care marketplace, including a description of how this information was obtained and how the findings affected policy deliberations.

Section 4. Options for Expanding Coverage
In this section, the State discusses the policy options selected for expanding coverage and the decision-making process used to reach those decisions. Includes a discussion of the State-level changes that would accompany such a plan.

Section 5. Consensus Building Strategies
The State discusses the process it used to achieve consensus on the policy options selected.

Section 6. Lessons Learned and Recommendations to States
The State discusses what it learned in designing its plan that could assist other States in seeking to expand coverage to all citizens. The State should also include any recommendations to other States regarding the policy planning process itself.

Section 7. Recommendations to the Federal Government
This section will include recommendations for Federal actions that could support State efforts.

GUIDANCE FOR PREPARING FINAL REPORTS

Note to States: The questions included in the final report format were derived from the State grant proposals. While many of the questions included will be pertinent to your State's activities under the grant, many will not. Please use all questions below that are relevant to your grant work to guide the preparation of your report. Also include a discussion of grant work conducted in other relevant areas that are not included in the questions below.

To assist in the process of compiling the consolidated report to the Secretary, states are asked to use to the following formatting guidelines: one-inch margins (top/bottom/both sides); Times New Roman font, size 12; and inclusion of endnotes rather than footnotes where applicable. We also request that states submit both an electronic and paper copy of the final report.

EXECUTIVE SUMMARY

The purpose of the executive summary is to provide an overview of the project work conducted under the HRSA grant, including a description of the insurance situation in the State as revealed by the data collection activities (survey work, focus groups, key informant interviews, etc.), and the policy options selected to increase health care coverage in the State. The executive summary should also briefly describe recommendations for Federal action to support State efforts to provide health insurance for the uninsured. The summary should be no more than 2-3 pages in length.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

More detailed survey findings (reports, spreadsheets, etc.), as well as survey instruments and other descriptions of the research methodology, should be referenced in Appendix II.

Questions 1.1 through 1.3 focus on the ***quantitative*** *research work conducted by the State. If possible, please use the Current Population Survey definitions and data breaks, even if alternate data sources are used. This will allow comparisons across all states in the summary report.*

1.1 What is the overall level of uninsurance in your State?

1.2 What are the characteristics of the uninsured?

Income:

Age:

Gender:

Family composition:

Health status:

Employment status (including seasonal and part-time employment and multiple employers):

Availability of private coverage (including offered but not accepted):

Availability of public coverage:

Race/ethnicity:

Immigration status:

Geographic location (as defined by State -- urban/suburban/rural, county-level, etc.):

Duration of uninsurance:

Other(s):

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

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?

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

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

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

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

1.9 How likely are individuals to be influenced by:

Availability of subsidies?:

Tax credits or other incentives?:

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

1.11 How are the uninsured getting their medical needs met?

1.12 What is a minimum benefit?

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

*Questions within 2.1 focus on the **quantitative** research work conducted by the State:*

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

Employer size (including self-employed):

Industry sector:

Employee income brackets:

Percentage of part-time and seasonal workers:

Geographic location:

Other(s):

For those employers offering coverage, please discuss the following:

Cost of policies:

Level of contribution:

Percentage of employees offered coverage who participate:

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

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

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

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

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

Expansion/development of purchasing alliances?:

Individual or employer subsidies?:

Additional tax incentives?:

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

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

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

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

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

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

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

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

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

3.8 How would utilization change with universal coverage?

3.9 Did you consider the experience of other States with regard to:

Expansions of public coverage?:

Public/private partnerships?:

Incentives for employers to offer coverage?:

Regulation of the marketplace?:

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. Those states that have not reached a consensus on a coverage expansion strategy may answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

For each option identified, complete questions 4.2 through 4.15 (if relevant to your State's planning process):

4.2 What is the target eligibility group under the expansion?

4.3 How will the program be administered?

4.4 How will outreach and enrollment be conducted?

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)

4.8 How will the program be financed?

4.9 What strategies to contain costs will be used?

4.10 How will services be delivered under the expansion?

4.11 What methods for ensuring quality will be used?

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

4.13 How will crowd-out will be avoided and monitored?

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

4.15 How (and how often) will the program be evaluated?

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

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

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

SECTION 5. CONSENSUS BUILDING STRATEGY

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

How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

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

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

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

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

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

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

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

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

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

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

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

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

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

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

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

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

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

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population:
Number and percentage of uninsured (current and trend):
Average age of population:
Percent of population living in poverty (<100% FPL):
Primary industries:
Number and percent of employers offering coverage:
Number and percent of self-insured firms:
Payer mix:
Provider competition:
Insurance market reforms:
Eligibility for existing coverage programs (Medicaid/SCHIP/other):
Use of Federal waivers:

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Indicate the Web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.