NORTH DAKOTA
HEALTH INSURANCE STUDY
STATE PLANNING GRANT INITIATIVE

FINAL REPORT
INCLUDING ACTIVITIES IN THE THIRD YEAR OF FUNDING

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EXECUTIVE SUMMARY

North Dakota has historically been concerned about its citizens' access to affordable health care. A number of changes have been implemented over the past twenty-five years to address the issue of people not having health insurance. In 1981 the Comprehensive Health Association of North Dakota (CHAND) was formed as a high-risk pool for individuals denied coverage due to high risk conditions. In the early 1990s under a Robert Wood Johnson Foundation State Initiatives Project grant North Dakota examined its uninsured population and developed reform options to extend health insurance coverage. In the 1994 study an uninsured rate of 9.9% was found. The efforts of the North Dakota Health Task Force led to enactment of House Bill 1050 during the 1995 North Dakota Legislative Session. Among other components of HB 1050, the Medicaid program was expanded, insurance market reforms were put in place, and coverage for dependents was extended to age 22 or age 26 for full time students. In an effort to continue its commitment to expanding health insurance coverage, the North Dakota Department of Health was awarded the State Planning Grant (SPG) project in 2003, a project supported by the U.S. Department of Health and Human Services, Health Services and Resources Administration. The SPG provided funding to conduct state-based research on the uninsured and also technical assistance to assist North Dakota policy makers in identifying options to expand health insurance coverage. An uninsured rate of 8.2% was found in the current study.

North Dakota is a model state for enacting incremental health insurance reforms. The uninsured rate of 8.2% is a fairly constant value over the years and is almost half of the rate of the uninsured in the U.S. Yet, North Dakota strives for all of its citizens to have access to affordable health care. During the past three years, the Governor's Health Insurance Advisory Committee (Committee) deliberated about what options other states have developed to extend coverage. In addition, the Committee reviewed the state-based research conducted by the University of North Dakota School of Medicine and Health Sciences, Center for Rural Health. Research findings have assisted the Committee in identifying populations to target for health insurance coverage expansion. Having state-specific, detailed data available describing the uninsured population has been a great benefit.

An uninsured rate of 8.2% is approximately 51,920 people, or about the population of the state capital, Bismarck. Geographically the uninsured tend to be more in the very rural areas, 44% or 23,120 people, with 36% or 18,498 in the four urban areas, and 20% or 10,303 in the large rural towns. It was found that 8.1% of the children, less than 18 years old did not have coverage. Many of these children may be eligible for public programs. Efforts have been made in North Dakota to streamline the application process and to reach out to parents of these children. Over the last two years since the household survey was completed the enrollment numbers have been increasing in Medicaid and Healthy Steps, North Dakota's SCHIP program. Young adults, ages 18 – 24, have the highest percentage of being uninsured of any of the age groups at 15.9%. Previous changes to allow coverage of dependents addresses this age group, but the young, healthy, working adult is a difficult group to address with programs. It was found that 72% of the uninsured adults are employed and a majority work in firms with 10 or fewer employees. Overall, 64% of employers in the state offer health insurance coverage (single and/or family) to their employees. The larger the employer, the more likely they are to offer insurance to their employees. 94% of firms with 50 or more employees offer insurance and only 55% of firms

with 10 or fewer employees offer any kind of insurance to their employees. The most common reasons cited by employers as to why they do not offer insurance are that premiums are too high or that employees are covered elsewhere. In looking at national data it was found that North Dakota's average cost for insurance was among the lowest in the United States.

A significant finding from the North Dakota Household Survey was that almost 32% of North Dakota's Native Americans are uninsured – almost five times the percentage of White North Dakotans, at 6.9%. Because of health disparities among Native Americans, it is critical to increase the percentage of insured Native Americans. The federal government has treaty obligations to provide health care for Native Americans. The Indian Health Service is not adequately funded and it is critical that this be addressed. In North Dakota there are Native Americans who are eligible for public programs who are not enrolled. Outreach efforts are in place to improve this situation.

In the 2005 Legislative Assembly a bill was passed to meet federal requirements for tax qualifications to allow high-deductible health plans with health savings accounts to be sold in the state. Efforts are continuing to enroll those eligible for public programs and to support our safety net providers. Grassroots efforts to achieve 100% access for the uninsured are under way in North Dakota. A statewide summit of more than 120 healthcare professionals, elected officials, community champions and local community members was held in October 2005 to develop local coalitions to address access issues. A second annual conference is planned for October 2006 to provide tools and examples of successes in other parts of the country in an effort to increase community approaches for increased coverage. Ultimately, these state and local efforts are anticipated to further extend access to affordable health care for all residents of North Dakota.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

North Dakota Household Survey

The North Dakota Household Survey (NDHS) is an instrument developed to collect information about the uninsured in North Dakota. The NDHS survey was developed to determine if national estimates accurately depict the uninsured rate in North Dakota and provide specific data at the state level. The survey was adapted from the SHADAC Coordinated State Coverage Survey (CSCS) instrument. The information collected in the survey will assist the North Dakota Department of Health and the Governor's Health Insurance Advisory Committee to design policies to assist citizens in obtaining affordable health care coverage. The University of North Dakota Social Science Research Institute conducted the survey in February through April 2004. There were 3,199 respondents to the survey with a response rate of 61.9%.

For telephone interviewing, we employed a list-assisted random digit dialing (RDD) frame for general population screening. The RDD frame was comprised of a list of all potential telephone numbers in working telephone banks in North Dakota. The state was divided into three sampling regions. The three regions separated by population: urban group (cities with a population of 16,718 or greater); a large rural group (cities with a population of 5,000 to 16,717); small rural group (towns with a population less than 5,000).

Overall, 8.2% of North Dakota residents were uninsured at the time of the North Dakota Household Survey in 2004. The actual number of uninsured North Dakotans (51,920) is similar to the population of Bismarck. In comparison, a 1994 Robert Wood Johnson Foundation funded study (State Initiatives Project) found the uninsured rate in North Dakota was 9.9%. This was the last comprehensive state survey. The 2005 Behavioral Risk Factor Surveillance System (BRFSS) administered by the Centers for Disease Control and Prevention (CDC) indicated that 11.5% of North Dakotans were without health insurance. The three-year average (2003-2005) rate in the Census Bureau Current Population Survey (CPS) indicated that 11.2% of North Dakotans were without health insurance.

Geographic Location

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

Income

The NDHS data indicated that the percentage of uninsured increased as income decreased. When isolating adults between the ages of 18 and 64, more than 70% of those lacking health insurance made less than 200% of the federal poverty level. Of those that were insured, only 25.2% resided in households that reported an income of less than 200% of the federal poverty level. Nearly three-fourths of uninsured North Dakotans were self-employed or employed by someone. More than 61% of those employed worked 40 or more hours per week. Sixty-nine percent of insured North Dakotans receive health insurance through their employer. Nearly 15% of working uninsured North Dakotans had more than one job and more than 60% worked 40 or more hours a week. Eighty-four percent of the working uninsured reported that they had a

permanent job compared to ten percent indicating their position was temporary and six percent indicating seasonal. Employees working at firms with 100 or fewer employees represented ¾ of the working uninsured. Further analysis showed that nearly half of all working uninsured were employed by a firm with ten or fewer employees.

Age

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

Gender

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

Family Composition

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

Health Status

The Institute of Medicine reports that working-aged (i.e., 18-64 years) uninsured Americans report poorer health and die sooner than those who have health insurance. Children with health insurance are more likely to have negative health conditions diagnosed during wellness checkups leading to better long-term health than those without health insurance. NDHS data showed that when separating North Dakotans by insurance status, those with insurance considered their health to be excellent, very good or good 91.1% of the time; the uninsured reported excellent, very good or good health 85.7% of the time. Respondents with health insurance were 34% more likely to indicate that their health was excellent than those who did not have health insurance. NDHS data also indicated that people without health insurance were nearly 38% more likely to

describe their health as fair or poor. Uninsured Native Americans were less likely to describe their health as excellent, very good or good as compared to White respondents (73.7% versus 88.1% respectively). Uninsured Native Americans (26.3%) were more than twice as likely to describe their health as fair or poor compared to whites (11.9%). Overall, NDHS data indicated that 77.3% of insured North Dakotans made a routine visit to the doctor in the past year compared to 56.9% of uninsured North Dakotans. More than one-fifth (21.6%) of uninsured North Dakotans had not made a routine visit to the doctor in more than four years. The number of insured North Dakotans not making a routine visit in more than four years was 7% Nationally, people with health insurance are more likely to have a regular health care provider monitoring their health (Institute of Medicine, 2004). O'Connor, et al (1998) indicated that maintaining an ongoing relationship with a health care provider is a key to high quality care. In North Dakota, the percentage of uninsured with a regular doctor is 58.9% compared to 76.5% for those with health insurance. North Dakotans are more likely to have a regular doctor when residing in an urban region (79.9%) compared to those residing in large rural (76.3%) or small rural (73.4%). Uninsured North Dakotans residing in urban areas have a regular doctor 68.2% of the time compared to those residing in large rural (58.1%) or small rural (52.1%). NDHS data indicates that uninsured whites 64.5% are more likely to have a regular doctor than uninsured Native Americans (41.8%). Insured Native Americans (58.2%) are nearly one-third less likely to have a regular health care provider than insured whites (86.6%). Uninsured North Dakotans were less likely to have a regular place to obtain health care when residing in urban (30.5%) areas when compared to small rural (23.6%) and large rural (19.2%) areas.

Employment Status

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

Availability of Private Coverage

According to NDHS data, 77.3% of the working uninsured was employed by a firm that does not offer health insurance. In addition, the working uninsured, (16.9%) are nearly three times less

likely to have access to health insurance through a spouse than the working insured (49.7%). Data show that 73.7% of the working uninsured are employed by a firm with 10 persons or less. Of the uninsured eligible for health coverage through their employer, approximately 55% reported cost as the primary reason for not enrolling in the insurance. As the table below indicates, the number of hours worked (16.3%) and time employed (17.9%) also served as barriers to obtaining health insurance for the working uninsured.

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

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

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

Summary of North Dakota Household Survey findings

Overall Uninsurance Rate – 8.2% of the state's population

Demographic Factors

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

Enabling Factors

Education Level - North Dakota adults who had not earned a high school diploma were significantly more likely to be uninsured when compared to those with a college degree.
Employment Status - Self employed North Dakotans were significantly more likely to be without health insurance than those who were employed by someone, those who were not employed, or those who were unemployed.

Household Income - North Dakotans indicating they resided in a household that earned less than 200% of the federal poverty level were significantly more likely to be uninsured when compared to those residing in a household at or above 200% of the federal poverty level.

Behavioral Factors

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

Geographic Factor

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

Population Groupings Targeted for Expansion Coverage

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

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

<u>Focus Groups with North Dakota Residents</u>

Approximately 1,100 North Dakota residents were randomly invited to participate in the citizen focus groups; 47 residents participated. Groups were convened in the North Dakota communities of Valley City, Hettinger, Tioga, and Grand Forks. Participants were paid $20. In addition to participating in the focus group, each participant completed a brief demographic survey. Twenty-

five females and 22 males participated with an average age of 58 years. All but two were Caucasian. Thirty-three participants were married, 14 were single. The average income of group participants was significantly higher than the statewide household average.

Six participants of the resident focus groups reported they had no health insurance. Two participants had gone without insurance for the past 12 months, four of them had gone for three years or greater. Those without insurance indicated that cost was the primary reason they did not have coverage. Those with high deductible insurance plans were significantly affected by cost as well as evidenced by one participant who stated, "I have a $5,000 deductible. I've paid all year on the hospital bills that insurance doesn't cover…I let my insurance lapse because I can't afford it."

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

All participants talked at length about mechanisms for increasing coverage to more people. Potential solutions that were mentioned repeatedly included; adjusting rates for healthy individuals, placing a cap on malpractice/tort reform (which ND has), adding coverage for small things, education, fair pricing, greater access to group buy-ins, individual savings plans, individualized policies to fit needs better, lower prescription prices, more competition, managed medicine, nationalized healthcare, an increase in personal responsibility for health, preventive healthcare, removal of excess paperwork by insurance companies and hospitals, researching new technologies, increasing taxes, and working harder. There was a wide range of potential solutions, none of which were espoused any more or less than any others with the exception of lowering prescription prices and individual savings plans.

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

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

The concept of "basic coverage" for all participants in the resident focus groups really meant "comprehensive." Participants demonstrated a range of beliefs about health insurance. Many seemed to view it in terms of an investment versus protection. Everyone displayed some degree of confusion about their health insurance. More clearly structuring and presenting plans may help

them to better understand what "adequate" or "barebones" is and what their plans will and will not do.

Telephone Focus Groups with Uninsured

Goals

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

Methodology

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

Results

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

It was noted that the participants' primary reason for not having insurance was cost. One participant noted: "My husband and I just have never been able to afford it and we've just never been able to find a job that has offered it." Employment related reasons included employers not offering insurance or offering those that require high deductibles; employers hiring only part-time, non-benefited positions; employers excluding coverage that extends to families; and employers having mandated waiting periods for coverage. Some mentioned that the costs of participating in COBRA were too high, while some thought that inability to work due to a health condition rendered individuals unable to afford coverage. One participant believed that eligibility for IHS would meet his healthcare needs.

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

Are the uninsured getting health care? To this all participants indicated that both they and their family members had foregone some form of healthcare because of their lack of insurance. No participant had a regular medical provider. One participant expressed frustration, feeling

stigmatized by his lack of insurance. He said, "I have medical problems, and I don't go [to the doctor] because I can't afford them. I'm asked every time if I have insurance and I don't have insurance."

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

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

Take home messages

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

American Indian Focus Groups on Health Insurance Issues

According to the North Dakota SPG household survey results, American Indians within the state were approximately three times more likely than Whites to be uninsured. Thus, we designed a study to learn more about health insurance issues in North Dakota's tribal Reservations and communities. In 2006, we conducted three focus groups in the following locations: Turtle Mountain Indian Reservation (Belcourt, ND); Spirit Lake Indian Reservation (Fort Totten, ND); and United Tribes Technical College (Bismarck, ND). One additional focus group is expected to be conducted in the Fall of 2006 on the Fort Berthold Indian Reservation (New Town, ND).

All American Indian adults (ages 18 and older, non-institutionalized) residing within a 25 mile radius of each city were eligible for participation. Participants received $25 in cash for partaking in the study. There was a limit of 20 persons per group. We hired a local person to assist with

recruitment and meeting logistics at each site. The following questions were used to initiate discussion within these groups: How important is health insurance to you? Why? Do you have health insurance? If not, why? If you do, is it through an employer or purchased yourself? What are deciding factors in choosing health insurance policies for you? If you don't have health insurance, what have been the deciding factors as to why you don't have health insurance? What are some of the reasons that you, and others you may know, might not buy health insurance on your own or sign up for coverage? Do you feel like you have adequate insurance coverage? What do you think can be done to ensure that more people have health care coverage? Do you or people you know not have health insurance because you prefer to use traditional healers or alternative providers? Tell me about that. Besides the issue of cost, does it matter to you whether your health insurance is bought by your employer, or comes from Medicaid or Medical Assistance? From what you know about Medicaid or Medical Assistance, tell me how easy you think it is to get information and to enroll in these programs?

There were a number of pertinent findings that were derived from these focus groups. Clearly, across all three sites, access to health insurance is generally a problem for a substantial portion of the local populations. Significant problems exist regarding the Indian Health Service's role in meeting the health care needs of local residents. This trend varies somewhat throughout North Dakota, given there are just two IHS hospitals and no urban clinics within the state. Across all three sites, it was noted that there was a lack of understanding regarding health insurance eligibility criteria. Some uninsured participants said they had no idea of whether they were eligible for any state-sponsored health insurance programs and did not know how to obtain general information on available state programs. Other pertinent findings include the following: treaty obligations of U.S. Government with regard to American Indian health; Natives with Medicare or Medicaid being turned down for care from public health clinics and other providers and being told to seek care at IHS (racism, civil rights issues); lack of urban clinics or portability of IHS to receive services; veterans being given the wrong paperwork at discharge and then being ineligible for services because of it; difficult during transition periods such as adolescent to young adult, military to discharge, between jobs, and working to retirement; and high unemployment on and around reservations. In sum, study findings clearly indicated a need for increased state efforts for educating American Indians about health insurance policies and programs and devising methods for decreasing the number of uninsured persons residing in the state's tribal areas.

Take-Home Messages - Some of the state's American Indians:

- feel they have inadequate access to health insurance programs.
- may be eligible for existing state health insurance programs, but don't know it.
- do not know how to access information regarding health insurance program basics and eligibility requirements.
- believe that the IHS in North Dakota is not nearly enough to meet their personal and family health care needs
- experience racism when attempting to access health insurance programs and services in non-IHS facilities.
- feel that poor access to local employment opportunities limits their ability to participate in health insurance programs, thereby decreasing their access to needed health services.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Survey on Employer-Sponsored Health Insurance in North Dakota

Purpose

- Determine the number and percent of North Dakota employers that offer health insurance coverage to their employees
- Examine the most common sources of health insurance used by employers
- Identify barriers for providing health insurance to employees.

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

Employer-sponsored health insurance for employees is one of the primary sources of health insurance coverage in the United States. In 2004, approximately 159 million Americans, 62 percent of the nonelderly population, were insured through employers. This is a decline from 2000 when 67 percent of nonelders were covered by employer-sponsored health insurance. In 2005, the University of North Dakota Center for Rural Health partnered with Job Service North Dakota to survey a sample of North Dakota employers on health insurance coverage for their employees and their family members. The aim was to determine the rates and patterns of employer-sponsored health insurance coverage and explore barriers that prevent some employers from providing this benefit to their employees. About half (52%) of those surveyed responded. Most of the responding employers are in the private sector (94%); followed by local government (3%), state government (3%), and federal government (0.1%). The most common firm size is two to 10 employees (59%), followed by 11 to 50 (29%), 51 to 100 (5%), one person (4%), and more than 100 employees (3%).

Overall, about two-thirds (64%) of employers offer health insurance coverage (single and/or family) to their employees. Single coverage health insurance is offered to full-time employees by 60 percent of the employers. About twelve percent of the employers offer single coverage to part-time employees. For family health insurance coverage, 48 percent indicate full-time employees are offered this option. About ten percent indicate family health insurance coverage is offered to their part-time employees, too. Also, results indicate the larger the employer, the more likely single and family health insurance is offered to their employees.

A majority of employers contract with a commercial insurance company (e.g., Blue Cross Blue Shield) to provide employee coverage. Less frequently mentioned is 'self-funded and administered by third party payer.' That is, the employer hires an outside agency to manage the various aspects of purchasing and maintaining health insurance policies. 'Self-funded and

administered by the company,' i.e., where employers have staff members who manage the purchase and maintenance of health insurance policies, was infrequently mentioned.

The 41.6 percent (N=979) of firms that did not offer health insurance to their employees were asked why they did not. The most common responses were the following: premiums were too high (45.6%); employees were covered elsewhere (34.0%); high turnover (6.7%); too many low wage workers (5.8%); we are a new firm and insurance is not a priority (3.4%); we do not need to attract employees (1.7%); competitors do not offer health insurance (1.5%); and administrative hassle (1.2%).

For single health insurance coverage, 49 percent of employers who provide coverage pay the full annual premium, 48 percent of employers pay between 50-99 percent of the annual premium, and 3 percent pay less than half of the annual premium. For family coverage, 31 percent of employers who provide coverage pay the full annual premium, 56 percent of employers pay between 50-99 percent of the annual premium, and 13 percent of employers pay less than half of the annual premium.

To examine average health insurance costs for North Dakota, we used federal Medical Expenditure Panel Survey (MEPS) data. For employer-based single health insurance, North Dakota had an average cost of about $3,000 per employee, lower than the national average ($3,481) and among the lowest across all States in 2003.2 North Dakota employers covered four-fifths (81%) of this cost, with the employees covering the remainder. These percentage contributions were roughly equivalent to national figures.

For employer-based family health insurance coverage, insurance costs in North Dakota averaged $7,866 per employee per year; this compared to $9,249 per year for the nation, or 18 percent higher than North Dakota costs.3 Again, North Dakota's average cost for insurance was among the lowest in the United States. North Dakota employers tend to cover about three-quarters (73%) of the premium and employees paid the remaining one-quarter. This percentage breakdown is comparable to figures for the nation.

Although North Dakota's average employer-based health insurance cost is among the lowest in the nation, 36 percent of surveyed employers do not provide health insurance coverage to their employees, primarily due to perceived high premium costs. Small employers (10 or fewer employees) in North Dakota are least likely (55%) to provide any type of health insurance coverage to their workers. Conversely, 94 percent of large employers (>50 employees) provide insurance coverage to their employees. Employer-based health insurance is a cornerstone of the state's health care infrastructure. Access to affordable health insurance is and will likely continue to be a serious concern for North Dakota employers, especially small firms, who expend substantial efforts to recruit and retain good workers. In the past several years, premiums have increased beyond the rate of inflation and worker earnings. At the same time, nationally, there is a downward trend in the number of workers covered by employers. In the face of rising health care and insurance costs, it will become increasingly important for policymakers and employers to seek new ways for securing and maintaining employer-based health insurance coverage in North Dakota.

Employer Focus Groups

As part of the current State Planning Grant, several employer focus groups were conducted in the state. The purpose was to increase our understanding of the North Dakota employers' views on a variety of health insurance issues. Questions that were posed included the following: 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? How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage? What would be the likely response of employers to an economic downturn or continued increases in costs? What employer and employee groups are most susceptible to crowd out? How likely are employers who do not offer coverage to be influenced by (a) expansion/development or purchasing alliances, (b) Individual or employer subsidies, and (c) additional tax incentives? What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Findings indicated that cost was the number one consideration in determining whether or not to offer coverage to their employees. Employer size seemed to be associated with whether or not insurance was offered; larger employers appeared more likely to offer this benefit. Offering health insurance was described as important in ensuring workforce stability, minimizing turnover costs, and attracting and retaining employees. Employers who did not offer health insurance coverage indicated that cost was the number one reason they did not. All employers expressed an interest in being able to make insurance available to their employees.

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

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

The employer focus groups revealed that ND employers are struggling to maintain current levels of coverage and are increasingly frustrated with rate increases. Benefit cuts and cost sharing with employees will increase and will accelerate with any decline in the local, state or national economy. Employers are highly motivated to hold costs down and would likely be willing

participants in activities to address rising healthcare costs; at a minimum, increasing communication between insurance companies, employer organizations and the larger medical community is crucial as there as there are a large number of issues contributing to rising health insurance costs. Employers realize that many older North Dakota residents may be working solely for health insurance benefits and if left unaddressed, these issues will continue to grow, especially during difficult economic times.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

Current Health Care Delivery System

North Dakota's health care delivery system is influenced by a number of factors including being a very rural state with an increasing proportion of elderly. The population trends are forcing rural facilities to close, increasing travel time and decreasing availability of services. According to the North Dakota State Data Center North Dakota's population grew only slightly over the past decade. Data from the 2000 Census indicate that the state grew by 0.5 percent between 1990 and 2000 reaching a population base of 642,200. This is the smallest relative growth of all 50 states. Beginning in 2000, Census Bureau estimates indicate that North Dakota's population declined annually, reaching 633,051 in 2003. The July 1, 2004 population estimate of 636,308 reflected the first annual increase in North Dakota's population since Census 2000. In 2005, the population grew to 636,677, an increase of 369 people from the year before.

Decades of movement of rural residents to the larger cities have depopulated much of North Dakota. In the last decade, population growth occurred largely in the metropolitan and Native American reservation counties of the state. In fact, only six of the state's 53 counties grew between 1990 and 2000. Currently, more than half of the 53 counties in the state have a population base below 5,000 residents and over two-thirds of the counties (36 of 53) are considered frontier (having six or less people per square mile) by the federal government.

The loss of residents in their twenties and early thirties has increased markedly over the past two decades. With fewer parents of childbearing age there will be a steady decline in the number of children in a majority of counties over the next 20 years. There also is an increasing proportion of elderly (age 65 and older). In 1980, 12.3 percent of the state's population base was age 65 or older; in 2000, the proportion had increased to 14.7 percent. In addition, 27 of the state's 53 counties had more than 20 percent of their population base older than 64 in 2000. Nationally, the proportion of elderly is only 12.4 percent. North Dakota has the highest proportion in the nation of elderly 85 years and older. If current trends continue, the number of elderly in the state will grow by 58 percent over the next 20 years and represent nearly 23 percent of the state's population. The number of older seniors (i.e., 85 years of age and older) will grow by nearly two-thirds during that time frame.

In 2004 there were approximately 1,400 licensed physicians practicing in North Dakota with a rate of 2.2 physicians per 1,000 population. The national rate is 2.4/1,000. The state has 51 hospitals. 43 of the hospitals are community owned, two are Indian Health Service (IHS) hospitals, one is a state owned psychiatric hospital, one is a Veterans Administration hospital, and four are specialty hospitals. 37 hospitals are rural and 31 are Critical Access Hospitals. Safety net services are provided in North Dakota by federally funded community health centers, IHS clinics and hospitals, and through uncompensated care at other facilities. The American Hospital Association estimates that in 2000 North Dakota hospitals provided $32.5 Million in uncompensated care, or 2.4% of their total expenses. As of June 30, 2004 13 of 24 hospitals surveyed reported they lost money and eight of the 24 had financial losses at a level that if continued, puts their future viability in question. The first community health center in the state

was started in Fargo, North Dakota/Moorhead, Minnesota, which is the largest urban area in the state. It serves a diverse group including special populations of refugees, Hispanic, and urban Indians. A Migrant Health Center serves people in Grafton. Three newly formed community health centers were approved in 2002 and 2003. They serve a more rural population with a total of 8 clinics. IHS provides health care services to Native Americans living on the five tribal areas in North Dakota with a 29-bed hospital, a 16-bed hospital, outpatient health centers and health stations. Referrals to contract facilities are done as funding allows, but funds run very short every year. Native Americans comprise 4.9% of the state's population, and as a group, are much younger. About 43% of the Native Americans are under age 20.

The private insurance market in North Dakota is approximately 40% employer sponsored self-insurance plans regulated by ERISA and 60% individual, small group, and large group plans regulated by the state. Currently, 17 companies market health insurance in North Dakota including 10 that have a high deductible health plan sold in conjunction with a Health Savings Account (HSA). 7 companies market individual insurance, 9 market small group insurance (2-50 employees), and 12 market large group insurance (51+ employees). One company, Noridian/Blue Cross Blue Shield insures over 75% of the people in the state and receives over 90% of the market share of insurance premiums for state regulated plans in North Dakota.

Some aspects of managed care (e.g., the preferred provider organization - PPO model and the exclusive provider organization - EPO model) have developed systematically throughout the state in both urban and rural areas. The Health Maintenance Organization (HMO) model has not been able to develop a strong presence. There are two licensed HMO's in North Dakota serving approximately 14,500 people (2% of the population). One HMO is a small rural non-profit cooperative that started 24 years ago. Blue Cross Blue Shield of North Dakota reports that 52% of its members are covered under a group plan and receive benefits through the PPO or EPO models. In North Dakota's Public Employee retirement System (PERS) health plan, the largest group plan in the state, 17,992 lives (about 30% of the 54,944 lives covered) are covered under an EPO arrangement. EPOs tends to have the most restrictive network coverage and lowest co-payment and co-insurance options. Most other PERS members are covered by a less restrictive model, the PPO. PERS covers state employees but has been opened to allow other public employees to be served by the system. Attempts in the legislature to open the PERS program to private sector employees and others without health insurance have been defeated, but continue to be proposed.

North Dakota participates in two state administered public coverage programs, Medicaid and State Children's Health Insurance Program (SCHIP). As of June 2006 there were 54,509 individuals enrolled in the Medicaid program, including 26,667 children. The SCHIP program is known in North Dakota as Healthy Steps. In June 2006 there were 3,482 children in Healthy Steps. Healthy Steps covers children 18 years of age and younger whose net family income is greater than Medicaid levels but less than 140% of the federal poverty level (FPL). The SCHIP enhanced federal match rate for federal fiscal year 2006 has been 76.10%.

Medicaid and Healthy Steps are managed by the Department of Human Services. North Dakota provides a basic set of services to categorically eligible recipients of the program as well as medically needy groups. North Dakota also provides 34 of the possible 38 optional services

under the Medicaid State Plan. North Dakota provides the required coverage for children and pregnant women as follows: children less than 6 years of age below 133% of the federal poverty level (FPL), children between 6 and 18 years of age at or below 100% of FPL, and pregnant women at or below 133% of FPL. Households applying for coverage through children and family coverage are no longer subject to an asset test. The Department of Human Services instituted a 100-hour rule as of January 2003 to contain program costs. Adults in intact families who work more than 100 hours a month are not eligible no matter what their income. The federal government share of the costs of the Medicaid program is determined by a formula using a three-year average of per capita income in our state compared to the national average. The Federal Medical Assistance Percentage (FMAP) for federal fiscal year (FFY) 2007 starting October 1, 2006 will be 64.72%. The FMAP was at a high of 72.82% in FFY03 and has been decreasing since – FFY04 71.31%, FFY05 67.49%, FFY06 65.82%. The decreasing federal funds have made state legislative attempts to increase coverage of uninsured by raising the FPL criteria for Medicaid and SCHIP difficult.

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

Earlier Efforts to Develop and Implement Health Care Reforms

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

The 1981 North Dakota Legislative Assembly enacted legislation, which created the Comprehensive Health Association of North Dakota (CHAND). This program is essentially a high-risk pool. It offers comprehensive health insurance to people who have been denied coverage or have restricted coverage due to pre-existing conditions or high-risk status. The 1983 Legislative Assembly capped the premiums under the CHAND program at 135% of the average amount charged for standard coverage in the state. Insurance companies receive a premium tax credit equal to their losses under this program. Approximately 1,400 people are enrolled in the CHAND program.

From 1990-1995, the North Dakota Health Task Force conducted field hearings, reviewed data, and conducted statewide studies on issues related to insurance coverage. The task force had representation from health providers, associations, government officials, and state legislators. The task force recommendations were introduced in the 1995 Legislative Assembly and,

following legislative revision, a number were enacted. This Legislative Assembly produced some of the most significant health reforms on record. House Bill No. 1050, the omnibus health care reform legislation, was approved by the Legislature and signed by the Governor. Some of the key features of this legislation are provided below.

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

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

In recent years, North Dakota has initiated efforts to expand public health coverage through the state Medicaid program and the State Children's Health Insurance Program (SCHIP), referred to as Healthy Steps. In 1998, North Dakota expanded its Medicaid eligibility to include all uninsured children who are age 18 with a family income at or below 100 percent of the Federal Poverty Level (FPL). In 1999, the Legislature established the Healthy Steps program which provides coverage to children who are not eligible for Medicaid but with family incomes below 140 percent of FPL.
The North Dakota Legislature, during the 2001 session, further expanded the Medicaid eligibility by removing the asset test for family and children coverage. Children, families, and pregnant

women, who had assets such as a second car or savings accounts, may have previously been ineligible even though they fell within the income boundaries. The change was implemented on January 1, 2002.

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

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

Outreach efforts have been undertaken by North Dakota to increase awareness and enrollment of children in Medicaid and Healthy Steps. Examples of recent outreach activities include working with economic assistance programs in the state to identify children in families who may be eligible for these programs and distributing bulletins to all Medicaid providers and professional medical and health associations discussing the Healthy Steps program. A special initiative of the State Office of Rural Health grant program was used during the 2000-2001 grant cycle to conduct outreach to rural farm and ranch families on behalf of the Healthy Steps program. The state has also used financial resources from a Robert Wood Johnson Foundation Covering Kids grant to hire three full time outreach workers to assist in enrollment of children in Medicaid and Healthy Steps. This grant has placed recruitment efforts in rural counties hardest hit by the agricultural crisis and to children living on Indian reservations. In 2001, The Northland Healthcare Alliance (a rural health based network covering central and western North Dakota) received a HRSA supported Community Access Program (CAP) grant. Each of the 13 rural hospitals and two IHS partners (two separate reservations) has hired a Community Resource Coordinator (CRC) who has a primary responsibility, by working with local/area social service programs, to assist in the enrollment of eligible children and families into Medicaid and Healthy Steps. The CAP program advisory board has membership from a number of state partners including the Department of Health, the North Dakota Community Healthcare Association, the North Dakota Community Action Association, I.H.S., the Center for Rural Health of the UND School of Medicine and Health Sciences and other key partner organizations. The program is strongly supported by the local hospital boards and is evidence of the commitment of Rural North Dakotans to support access to care opportunities. Dakota Medical Foundation has now received a CAP grant for the rest of the state. They have CRCs at 16 sites and are closely coordinating with Northland Healthcare Alliance. Additional efforts have been initiated to provide outreach to Native Americans. Of the North Dakotans who receive Medicaid benefits, 17.9% are Native American even though they account for 4.9% of the state's population.

A unified application has been developed for Medicaid, Healthy Steps, and all assistance programs. This simplification has made the application process easier and along with the other outreach efforts has increased the number of children covered by programs for which they are eligible. In January 2003 there were 28,311 children enrolled in public programs (25,575 in Medicaid, 2,111 in SCHIP and 625 in the Caring Program). By September 2005 these numbers

had increased 1,860 or 6.5% to 30,171 (26,515 in Medicaid, 2,992 in SCHIP, and 664 in the Caring program).

Success and Implementation Problems of Earlier Efforts

Like many states facing the issues associated with insurance access and coverage. North Dakota has witnessed some success but has also encountered barriers. The 1995 insurance reform effort and the 1997 HIPPA refinements have ostensibly resulted in an increase in the total number of individuals covered under group contracts insured by Blue Cross Blue Shield of North Dakota (BCBSND). According to BCBSND, from 1994 to 1999, the percentage of all individuals with private health insurance covered under an "individual" non-group policy has declined from 16 percent to 10 percent. The number of persons insured under the CHAND (high risk pool) program is small, but stable (approximately 1,400 or 0.3% of the private insurance market as of January 1, 2002). Over the last five years, CHAND has had enrollments that fluctuate slightly, from 1,300 to 1,500. Although North Dakota can neither directly nor fully verify the cause of the decline in persons covered by individual private health insurance policies and the lack of any increase in the size of the high risk pool, the reasonable assumption is that the greater access to group health insurance coverage (portability, guaranteed renewal, rate bands, etc.) – combined with a substantial growth in employment – has led to more people being covered under group health insurance plans. Overall, these formal policy efforts, enacted by the North Dakota Legislature to reform insurance access, have stabilized the market and enhanced access for North Dakotans, thus contributing to a relatively low rate of uninsured citizens. The serious effort made through state policy and private provider action to develop and implement outreach activities also portend success, both in public exposure to the opportunities and actual public enrollment in programs.

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

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

The Medicaid program in North Dakota is approaching a $1 billion biennial state/federal appropriation. The governor recognized the importance of this program and its impact on the state budget. He appointed a Governor's Medicaid Working Group to specifically examine the Medicaid program for the 2005-2007 biennial budget. Of major concern for this committee were the declining FMAP and its impact on the program. Its recommendations addressed primarily management and administrative aspects of the Medicaid and do not include expansion of coverage options. Operations have been constrained by an outdated Medicaid Management Information System (MMIS), which has also made it difficult to attempt projects which might increase coverage. A new MMIS is being considered, but the costs have run higher than expected which has slowed implementation.

Healthy North Dakota is a unique statewide initiative started by the governor to build on grass roots support of healthy life styles. Personal behaviors are one of the factors that influence health more than any other factor. Several committees are working under Health North Dakota to raise awareness of health behaviors and to influence changes. Two of the committees are the Third-Party Payers Committee and the Health Disparities Committee. They have specific interests in individual's access to health insurance and health care. It is hoped that the Community Engagement Committee will become involved with the local efforts at 100% Access that have been developing across North Dakota.

SECTION 4 - OPTIONS AND PROGRESS IN EXPANDING COVERAGE

Current Political, Economic, and Social Impediments to Expansion

Even though North Dakota has been able to maintain a balanced budget, money has been very tight for any publicly funded programs. With the FMAP decreasing over the last four years a total of 7 percentage points there is a great deal of pressure on the Medicaid and SCHIP programs to maintain current enrollments. The governor has asked that any policy recommendations from the Health Insurance Advisory Committee be budget neutral. This fiscal reality makes it very difficult to propose expansion options that require state money.

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

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

North Dakota has made strides to cover its citizens with health insurance. The rate of uninsurance has dropped since the last major health care legislation in 1995. That legislation was influenced by the North Dakota Health Task Force. The state planning grant has been a good opportunity for North Dakota to gather valuable data about the uninsured and to develop policy options to incrementally address the problem with an ultimate goal of providing access to affordable health insurance for all citizens. We need to continue gathering data in areas where we don't have sufficient information, refining options that have the greatest opportunity of producing good results in our state, and working to gain collaborative partners and consensus on new options. We need to continue gathering support in the state for further changes.

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

Options Considered

1) Health Insurance Premium Subsidies:

Target Population

Low income individuals and families who are offered employer sponsored insurance but can not afford to enroll.

What are health insurance premium subsides?

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

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

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

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

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

3. ***Providing easy accessibility to benefits*:** The easier it is to obtain benefits (specifically, through the tax system rather than application to a state office) or to apply them to existing employer-based coverage rather than having to shift to a publicly sponsored program, the larger the likelihood of participation among the already insured.

Advantages

Health insurance premium subsidies have a great potential to increase enrollment in private health insurance plans.

Disadvantages

The cost of providing the subsidies can be expensive depending upon the level of subsidies and the number of people participating in the program. If small employers do not offer insurance it is difficult to apply subsidies.

Policy considerations for North Dakota

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

2) Educational Programs/ Campaigns:

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

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

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

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

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

Policy considerations for North Dakota:
The Governor's Health Insurance Advisory Committee is has been interested in exploring this solution, but nothing has been developed at this point. Based on findings from some of the focus groups, it was determined that additional education pertaining to health insurance coverage would be beneficial to consumers and employers.

3) Association Health Plans (AHPs):

Target population:
Small business employers and employers.

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

***Advantages*:** [3, 4, 5]

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

***Disadvantages*:** [3, 4, 5]

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

Policy considerations for North Dakota:

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

4) Health Savings Account with High Deductible Health Insurance Plans:

Target population:

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

What is a Health Savings Account?
The health savings account is a tax advantaged savings plan available to tax payers to cover current and future medical expenses. It allows money to be put in before tax is paid on it and then to withdraw the money tax free for qualified medical expenses. It is the new name for medical savings account (MSA) plans that were previously offered. This new plan decreased deductibles and extended the accounts to more people. The changes were made in legislation signed by George W. Bush on December 8, 2003. [6]

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

***Disadvantages*:**
May discourage individuals from seeking preventive care.

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

State legislation was needed to allow HSAs to be sold in North Dakota. HB 1208 passed the North Dakota House and Senate and was signed by the Governor on 3/15/05. This change in the law became effective August 1, 2005. "A BILL for an Act to amend and reenact subdivision d of subsection 2 of section 26.1-36-08 and paragraph 4 of subdivision f of subsection 2 of section 26.1-36-09 of the North Dakota Century Code, relating to excluding high-deductible health plans from mental health and substance abuse mandates in order to meet federal requirements for tax qualification of health savings accounts."

5) Community Coalition Approaches:

With limited possibilities for comprehensive statewide approaches to increasing health insurance coverage, we worked with Communities Joined in Action (CJA) to organize a more grassroots support for increasing coverage. It was recognized that local communities play an important role in extending access to care and expanding health insurance. Several local options are being considered as local coalitions form and move into action.

a. Three-Share Program

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

What is a Three-Share Program? [8]

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

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

Advantages:

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

***Disadvantages*:**

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

Policy considerations for North Dakota:

The Committee heard a presentation about the 3-Share Program that has been successfully implemented in Muskegon, Michigan. The Committee members liked the concept. It may be possible to develop on a local level. With the directive to the committee to consider budget neutral solutions it may not be possible to find state support for the government share component of the three-share.

Options Not Considered Feasible at This Time

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

SECTION 5. CONSENSUS BUILDING STRATEGY

The governor appointed a twelve member Health Insurance Advisory Committee for the State Planning Grant. This committee represented the farming community, the business community, advocates for low income and the uninsured, the academic community, health care, and the health insurance industry. Also on the committee as ex officio members are representatives of the state departments of health, human services, and insurance.

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

The Robert Wood Johnson Foundation State Forums Partnership Program

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

Testimony to the Interim Budget Committee on Health Care

Dr. John Baird, SPG Project Director, provided testimony to the Legislative Interim Budget Committee on Health Care pertaining to the health care system and the work of the State Planning Grant. This opportunity gave visibility to the project's progress and also provided a forum for legislators to gather more information regarding a study resolution. The committee passed a motion to recommend to the 2007 Legislative Assembly to consider providing for a comprehensive Legislative Council study of health care and health insurance during the 2007-08 interim and that a consultant be hired, as necessary, to assist with the study.

Information Dissemination

The Committee directed staff to develop a fact sheet on the findings of the Household Survey that could be distributed to legislators, state agency directors, community leaders, employers, and

other interested consumers. The fact sheet has been distributed in hard copy and also is available on the SPG Web site.

Another vehicle for information dissemination has been the development of issue briefs pertaining to policy options. Two policy option briefs, one on the 3 Share Program and one on Health Savings Accounts, have been developed for Committee members' review. These policy option briefs also have been distributed through the Web site and to policymakers.

Summit Meeting For Community Leaders

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

On October 18-19, 2005 "Community Solutions for Healthcare Coverage", North Dakota's First 100% Access Healthcare Summit was held in Bismarck, ND. This fast-paced, two-day statewide campaign brought together more than 120 healthcare professionals, elected officials, community champions and local community members. The participants looked at healthcare access issues confronting North Dakota and identified potential community-based solutions that could be built into a powerful portfolio of activities to achieve 100% healthcare access. The Summit was facilitated by CJA. The Summit was a highly interactive event with lots of work sessions and breakout sessions for the participants. The purpose of each of these sessions was to brainstorm ideas and solutions and to identify strategies to develop and implement these community-created ideas and solutions.

A 2nd Annual 100% Access Healthcare Summit, "Tools for Healthy Communities", is being organized for October 26, 2006 in Bismarck. The objectives of the statewide summit will be to provide local coalitions with examples of models from other parts of the country and tools for community engagement to address access issues.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

State-specific data was extremely important to the decision-making process. As we examined options and ways to approach access problems it was always important to define the target population. Our data was good and easy to probe for further answers. That type of in-depth analysis is not possible with national data. The qualitative research was very useful to give a face to the data. People need stories in order to understand data and to look at solutions.

The household survey was the most valuable source of information for our process. It was an expensive process, but the result was a rich set of data that we could continue to analyze as questions arose.

Originally we had proposed to repeat our household telephone survey within the Native American population to better understand the issues behind their higher uninsured rate. We encountered methodological difficulties that we could not overcome. With our normal methods of producing a representative list of telephone numbers it was impossible to get an appropriate sample of Native Americans. Many people on reservations use cellular phones and there are a number of non-tribal people living in the geographic areas of Indian reservations. After consulting with SHADAC we decided to abandon the telephone survey and instead do focus groups, which gave us good information.

The structure of health care programs are slow to change. Even with good data that describes a problem it is difficult to change the status quo.

Looking back over our grant period the employer community was not engaged early enough or broadly enough during the initial phases of the project.

In our policy planning process we did not have adequate expertise in policy modeling and did not devote enough resources to fleshing out and marketing policy options.

To do meaningful research among Native Americans it is important to have good connections with the tribes and to realize that the data belongs to the tribes and is for them to use as they see fit.

As this grant comes to a close we will continue efforts in North Dakota through local coalitions addressing access issues in their communities. Statewide coordination and support will hopefully be done through Healthy North Dakota.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

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

The federal government has treaty responsibilities to Native American tribes to provide adequate health care. The Indian Health Care Improvement Act was intended to elevate the health status of American Indians and Alaska Natives to a level equal to that of the general population. Since 1976, IHCIA has been periodically reauthorized and amended until 2000 when it expired. A bill was passed in 2000 to extend IHCIA for one year to allow Congress time to consider reauthorization legislation. Since 2001, the Congress has held hearings on the reauthorization proposals. While there have been various versions of the bill considered by the Congress since that time, the work on reauthorization of the INCIA has not been completed by the 109th Congress in 2006. It is imperative for the health of the Native American people that the Congress recognizes the great need and our treaty obligations and adequately fund IHS.

SECTION 8. OVERALL ASSESSMENTS OF SPG PROGRAM ACTIVITY

8.1 The State Planning Grant program has had an impact on North Dakota. Change comes slowly and will be incremental. Having good data has been critical to better define the problems and focus attention. In the near future changes will more than likely happen on a local level and not at an overall state level.

8.2 The most feasible expansion options will happen with local coalitions addressing access issues in their communities. These could include such options as a three-share model or coordination of volunteer services.

8.3 As we complete our 2nd Annual 100% Access Healthcare Summit on October 26 we will be better able to assess sustainability of our local approach. Healthy North Dakota is a grassroots organization which should be able to continue efforts to improve access.

8.4 No changes were initiated in our Medicaid program as a result of SPG activities. The outdated MMIS has been a major focus for Medicaid and it will be difficult to make changes until organizational activities are working more smoothly.

8.5 The uninsured rate is low enough that there is not a lot of outrage about the problem. This inhibits any major change in statewide policy.

8.6 Having a state dataset was extremely helpful for our policy discussions. The structure of the data collected and the weighting was professionally done and resulted in a dataset very representative of our state, with depth that could be probed for various questions to better define populations. We were able to stratify data by urban, rural, and semi-rural areas and look at age group differences. None of this could be done with national datasets so that we can understand who the uninsured are in North Dakota. As the data gets older it becomes less relevant and does not show changes that have occurred due to policy efforts. Our state legislature only meets every two years. Two years would be a reasonable cycle in which to collect data so it remains meaningful.

8.7 One area of data collection that we might do differently was our focus groups with the uninsured. We tried to recruit people identified as uninsured in the telephone survey to be part of an uninsured focus group. It was difficult to recruit these individuals to come together in a face to face meeting. We resorted to doing a telephone focus group which did work very well. It may be necessary to recruit uninsured individuals in a different way or to use different incentives.

8.8 In considering our steering committee it is now apparent that we did not have adequate consumer representation or have the voice of the uninsured adequately represented.

8.9 - -

8.10 - -

8.11 The AcademyHealth staff was extremely helpful for our project. They were always willing to give technical assistance. Their site visits provided a great overview of the process and policy options to consider for our SPG staff and for our steering committee.

8.12 The HRSA SPG grantee meetings were very helpful for our SPG staff. It was an opportunity to meet and visit with other states and to learn valuable information to bring back to our state.

8.13 SHADAC was very helpful for us. We used a modification of their telephone survey, which would have been extremely difficult to develop on our own. When we struggled how to survey our Native American population SHADAC assisted us with advice and by facilitating conference calls with other states looking at similar populations.

8.14 We did not participate in the Arkansas Multi-State Integrated Database System.

8.15 We used MEPS-IC as a reference for our employer data. There was not adequate sampling in North Dakota to use their data alone, so we conducted our own employer survey.

8.16 There will be long-term effects of our state's SPG program.

a) Data that was collected will continue to be useful. It is a data source with detail and depth that has not been available in the past. Our uninsured rate has not changed quickly in the past and the findings from our survey should be relevant for several more years.
b) We were not able to do adequate modeling and actuarial analysis of policy options which was a shortcoming of our SPG program.
c) Political understanding of the uninsured problem in our state has been slow to develop, but it will continue to improve in the future.
d) Collaboration has begun with local coalitions forming which should continue grassroots support of solutions for access problems due to a lack of health insurance.

APPENDIX I: BASELINE INFORMATION

Base line data for North Dakota:

Population- 633,837 (CPS, 2003)

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

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

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

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

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

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

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

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

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

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

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

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

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

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

REFERENCES

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

Literature Citations for Employer-based Coverage Survey Project

Garrett, B. (2004). Employer-sponsored health insurance coverage: Sponsorship, eligibility, and participation patterns in 2001: Kaiser Commission on Medicaid and the Uninsured.
Kaiser commission on Medicaid and the uninsured, uninsured in America, U.S. House of Representatives (2004).

(ACP-ASIM), A. C. o. P.-A. S. o. I. M. (1999). *No health insurance? It's enough to make you sick.* Washington, D.C.
(EBRI/CHEC/BCBSA), E. B. R. I. (2000). *Small employer health benefits survey*. Washington, D.C.
Buchmueller, T. C., & Lettau, M. (1997). Estimating the wage-health insurance trade-off: More data problems? *Unpublished Paper*.
Currie, J., & Madran, B. C. (Eds.). (1999). *Health, health insurance and the labor market.* (Vol. 3). New York: Elsevier.
Cutler, D. (Ed.). (1997). *Public policy for health care*. Cambridge, MA: MIT Press.
Invited testimony, expanding public programs to cover the sick and poor uninsured, Senate Finance Committee (2001).
Garrett, B. (2004). Employer-sponsored health insurance coverage: Sponsorship, eligibility, and participation patterns in 2001: Kaiser Commission on Medicaid and the Uninsured.
Hadley, J. (2001). *Sicker and poorer: The potential costs of a large uninsured population.* Washington, D.C.: Urban Institute.
Kaiser commission on Medicaid and the uninsured, uninsured in America, U.S. House of Representatives (2004).
Koopmanschap, M. A., & Rutten, F. F. (1996). The consequence of production loss or increased costs of production. *Medical Care, 34*, DS59-68.
Koopmanschap, M. A., Rutten, F. F., Van Ineveld, B. M., & Van Roijen, L. (1995). The friction cost method for measuring indirect costs of disease. *Journal of Health Economics, 14*, 171-189.
Levy, H., & Feldman, R. (2001). Does the incidence of group health insurance fall on individual workers? *U.S. Department of Labor/PWBA Conference "Why Do Employers Do What They Do?"* Washington, D.C.: April 27.
Monheit, A. C., Hagan, M. M., Berk, M. L., & Farley, P. J. (1985). The employed uninsured and the role of public policy. *Inquiry, 22*, 348-364.
Pauly, M. V. (1997). *Health benefits at work: An economic and political analysis of employment-based health insurance*. Ann Arbor: University of Michigan Press.
Peele, P. B., Lave, J. R., Black, J. T., & Evans, J. H. (2000). Employer sponsored health insurance: Are employees good agents for their employees? *Milbank Quarterly, 78*, 5-21.
Salisbury, D., & Ostuw, P. (2000). Value of benefits constant in a changing job environment: The 1999 world at work/EBRI value of benefits survey. *EBRI Notes, 21*, 5-6.
Simon, K. (2001, April 27). *Involuntary job change and employer-provided health insurance: Evidence of a wage-benefit trade off?* Paper presented at the U.S. Department of Labor/PWBA Conference "Why Do Employers Do What They Do?" Washington, D.C.
Summers, L. (1989). Some simple economics of mandated benefits. *American Economic Review, 79*, 177-183.
U.S. Congress, O. o. T. A. U. C. O. (1992). *Does health insurance make a difference?* Washington, D.C.: U.S Government Printing Office.