Arkansas Health Insurance Expansion Initiative
2001 Roundtable Report

Funded through a HRSA State Planning Grant

Presented to
the Citizens and Governor of the State of Arkansas
and
the US Secretary of the Department of Health and Human Services

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ARKANSAS HEALTH INSURANCE EXPANSION INITIATIVE 2001 ROUNDTABLE REPORT

EXECUTIVE SUMMARY

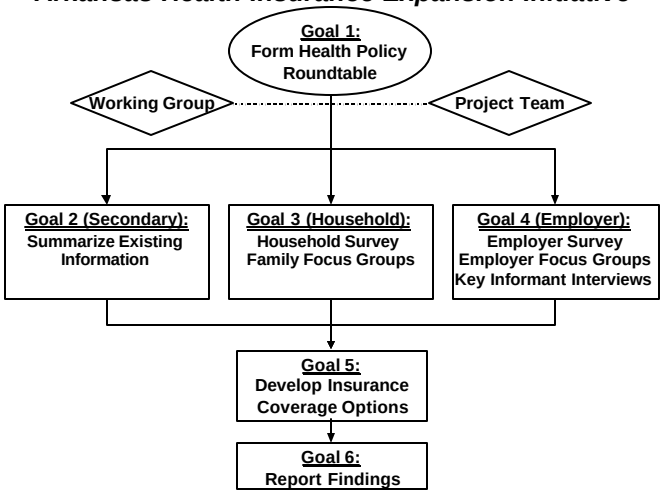
OVERVIEW OF ARKANSAS STATE PLANNING GRANT—PROJECT GOALS

Through Arkansas's State Planning Grant (SPG), the state's first empirical assessment and systematic evaluation of strategies to address the uninsured has been undertaken. Statewide data collection from households and employers was conducted to assess the availability and need of health insurance within Arkansas. The information generated is being used to directly inform the executive and legislative branches of government. Thus, empirically based policy options have been developed to address issues surrounding lack of health insurance coverage in the state. Arkansas accomplished six goals through its SPG.

1. Established the Arkansas SPG Roundtable to guide the State Planning Grant Program, which was staffed by a multidisciplinary Project Team and Working Group.
2. Examined and summarized existing secondary data on health insurance status in Arkansas.
3. Collected and analyzed primary qualitative and quantitative data obtained from focus groups with households and new state data collection efforts using modified national surveys to further inform and guide the development of viable options for expanding insurance coverage.
4. Collected and analyzed qualitative data from employers through key informant interviews with large employer and focus groups with small employers. Quantitative data collection is underway.
5. Identified, evaluated, and prioritized options for health insurance coverage under the guidance of the Roundtable.
6. Generated and submitted this interim summary report to the Arkansas Governor and General Assembly and to the US Secretary of DHHS.

The statewide planning process implemented through the Arkansas SPG was based on information obtained from multiple data sources, the review and generation of alternative options to insure Arkansans, and a commitment to implementation through the Roundtable (Figure 1). All stakeholders—employers, insurers, providers, and consumers—were represented in the process.

Figure 1. Structure and Information Flow for the Arkansas Health Insurance Expansion Initiative



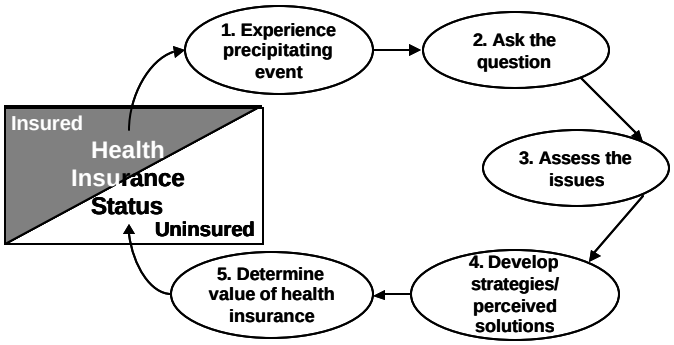
KEY FINDINGS AND RECOMMENDATIONS

Health Insurance Status of Arkansans

The SPG gathered information from employers, consumers, and insurers through three modes of data collection. Each mode was required to optimally develop and prioritize health insurance expansion options for the state and is described below.

1. **Secondary qualitative and quantitative data** was obtained from previous data collection efforts and from administrative records compiled by federal, state, and proprietary sources including the Behavioral Risk Factor Surveillance System (BRFSS); Current Population Survey (CPS); Census Population and Housing Survey; Medical Expenditure Panel Survey Household Component (MEPS-HC); MEPS Insurance Component (MEPS-IC); Arkansas BlueCross BlueShield administrative database; Arkansas Medicaid Summary Reports; the Arkansas Hospital Discharge Database; and the Advocates for Children and Families (AACF) qualitative data, summarized in *Making it Day-to-Day: A New Family Income Standard for Arkansas*.
2. **Primary qualitative data** included key informant interviews with large employers and insurers, and focus groups with Arkansas household decision-makers and small- to moderate-sized employers.
3. **Primary quantitative data** included a statewide random-digit dial phone survey of Arkansas households, and will include, in a subsequent analysis, survey data collected from employers via the 2000 MEPS-IC collected in 2001.

Figure 2. Decision-Making Model for Determining Insurance Status



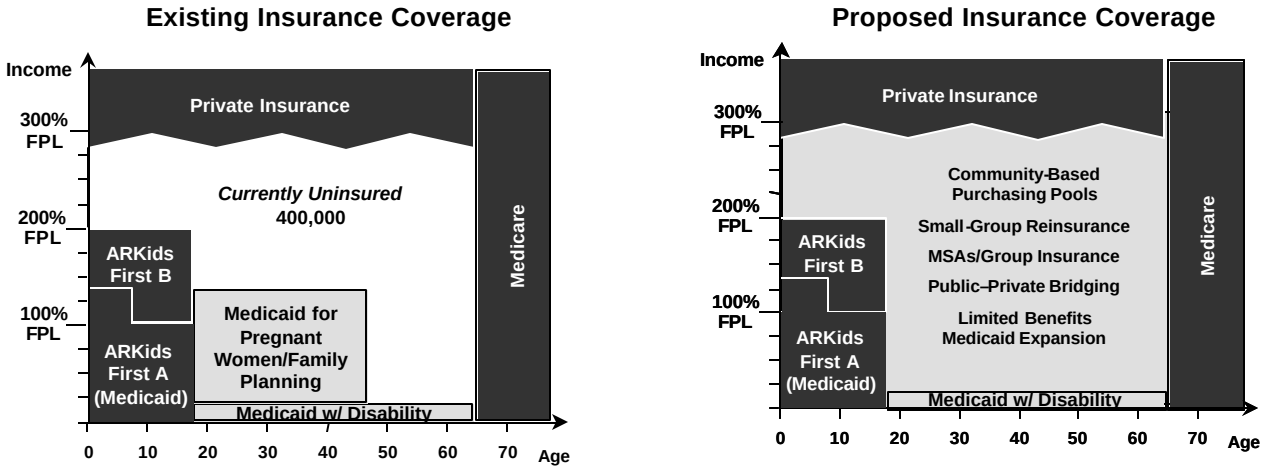
Analysis of the primary qualitative data collected from household members and employers led to the development of an analytic model (Figure 2). This model outlines the decision-making process that either a household member or employer experiences when evaluating health insurance options, and provides a structure that was useful in framing analyses and presentation of qualitative findings throughout this project. The decision-making model is described in detail in Sections 1B (p. 13) and 2B of this report (p. 21).

Policy Options Selected to Expand Health Insurance in Arkansas

The Roundtable developed and evaluated options after reviewing existing data and available information obtained through new data collection efforts. Through this report, the Roundtable proposes a multi-faceted strategy to address the health and economic impact of the uninsured. Achievable options require employer, individual, and governmental participation. As depicted in Figure 3 below, these strategies include stabilization efforts for the currently insured and new efforts to insure the 400,000 currently uninsured Arkansans. Components of this strategy include the following.

- ✍ Expand a limited benefits Medicaid program for the impoverished.
- ✍ Establish new partnership strategies that bridge state and employer sectors (public–private options) with voluntary employer participation in publicly subsidized health insurance for the working poor.
- ✍ Create community-based purchasing pools to assist small businesses in attaining access to competitive insurance options.
- ✍ Stabilize the small group market through new reinsurance mechanisms.
- ✍ Explore new insurance mechanisms through self-directed medical savings accounts tied to catastrophic group health insurance.

Figure 3. Summary of Roundtable Recommendations



Federal Action to Expand Health Insurance

In addition to the options for Arkansas, strategies that are recommended by the Arkansas SPG Roundtable on a national level include the following suggestions.

- Expand legislation for tax credits to include individuals purchasing health insurance through community purchasing pools.
- Explore and modify Federal laws related to current medical savings accounts so that the qualifying high-deductible plan becomes tied to the group market rather than individual policies.
- Conduct additional research to better understand the clinical, economic, and social factors influencing the US health care system and guide policy development and system evolution.
- Include scientifically supported preventive services as components of insurance benefits.
- Enable states to optimize available federal funds for health care coverage.
- Encourage employers to educate employees about annual wage and benefit compensation
- Ensure income tax neutrality through uniform exemptions for health insurance/health care expenditures.
- Incorporate prescription drug benefits for persons covered by Medicare.
- Expand Medicare eligibility through buy-in options for the near elderly and disabled.

In addition, efforts to increase the appropriate allocation of medical resources, expand our understanding of the effectiveness and costs of alternative treatment strategies, and explore new and innovative mechanisms to achieve needed cost containment should be supported.

Through the proposed strategy, a significant expansion of insurance coverage would be accomplished through the shared responsibilities of employers/employees, state government, and Federal government. Through these programs, the health of Arkansas's citizens and the economy of the state will be improved.

1. SUMMARY OF FINDINGS: INSURED AND UNINSURED INDIVIDUALS AND HOUSEHOLDS*

Obtaining affordable health insurance has been a challenge for Arkansas's 2.6 million citizens because of the state's large rural population, limited numbers of providers in rural areas, cultural diversity, and an economy dominated by small businesses. Most Arkansans live and work outside of the relatively few metropolitan areas,[1] reflecting its low population density, which limits efforts to foster competition in the health care field and contain costs. Previous studies have documented that insurance coverage is critical to seeking and receiving appropriate treatment for most conditions.[2] Importantly, no systematic assessment or ongoing monitoring strategy has been employed by the state to determine insurance coverage or direct policy development. Through the SPG, the first major empirical assessment of insured and uninsured individuals and households in the state was undertaken.

1A. STRATEGY FOR OBTAINING INFORMATION

Data gathered from Arkansas residents used to inform the development of options to expand health insurance coverage through the State Planning Grant (SPG) involved three modes of data collection: secondary quantitative and qualitative data obtained from previous data collection efforts and administrative records, primary quantitative data collected via a random digit dial phone survey with a state-wide representative sample of households, and primary qualitative data collected via focus groups with household decision-makers.

Secondary Quantitative Household Data—Methods

Secondary quantitative household data was gathered to inform the sampling design of the household phone survey, and to supplement the quantitative household phone survey data and the qualitative household focus group data. These data sources included the following.

- Behavioral Risk Factor Surveillance System (BRFSS) data was obtained from the past 4 years (1997–2000) from the Arkansas Department of Health. These data, collected via a random digit dial phone survey, provided state-level estimates of health care utilization, health status, health risk behaviors, and health insurance status.

*__Abbreviations used in this report:__ **AACF**, Arkansas Advocates for Children and Families; **ABCBS**, Arkansas BlueCross BlueShield; **ACHI**, Arkansas Center for Health Improvement; **AHRQ**, Agency for Healthcare Research and Quality; **AHSRHP**, Academy for Health Services Research and Health Policy **ARS**, audience response system; **ARSRAP**, Arkansas Southern Rural Access Program; **BRFSS**, Behavioral Risk Factor Surveillance System; **CATI**, computer-assisted telephone interview; **CHAMPUS**, Civilian Health & Medical Program of the Uniformed Services; **CHC**, community health center; **CHIP**, Comprehensive Health Insurance Program; **CMS**, Center for Medicare and Medicaid Services; **COBRA**, Consolidated Omnibus Budget Reduction Act; **CPS**, Current Population Survey; **CSR**, Center for Survey Research; **DFA**, (Arkansas) Department of Finance and Administration; **DHHS**, (US) Department of Health and Human Services; **DHS**, (Arkansas) Department of Human Services; **EBRI**, Employee Benefit Research Institute; **ERISA**, Employee Retirement Income Security Act; **FFS**, fee-for-service; **FIS**, Family Income Standard; **FPL**, federal poverty level; **HCFA**, Health Care Finance Administration; **HIFA**, Health Insurance Flexibility and Accountability; **HIPAA**, Health Insurance Portability and Accountability Act; **HIPG**, health insurance purchasing group; **HMO**, health maintenance organization; **HRSA**, Health Resources and Services Administration; **IRA**, individual retirement account; **IRS**, Internal Revenue Service; **MEPS**, Medical Expenditure Panel Survey; **MEPS-HC**, MEPS Household Component; **MEPS-IC**, MEPS Insurance Component; **MSA**, (Archer) Medical Savings Account; **NFIB**, National Federation of Independent Business; **PPO**, preferred provider organization; **QME**, qualifying medical event; **RDD**, random digit dial; **RHAPP**, Rural Health Access Pilot Program; **RWJF**, Robert Wood Johnson Foundation; **SCHIP**, State Children's Health Insurance Program; **SCI**, State Coverage Initiative; **SHADAC**, State Health Access Data Assistance Center; **SIS**, Survey of Insurance Status; **SPG**, State Planning Grant; **SSDI**, Social Security Disability Insurance; **TPA**, third-party administrator; **UAPB**, University of Arkansas at Pine Bluff; **VA**, Veterans Administration.

- Hospital Discharge data collected from 1997 through 1999 obtained from the Arkansas Department of Health provided information on inpatient utilization, primary sources of payment, and proportion of uncompensated care in Arkansas hospitals.
- Current Population Survey (CPS) data, collected in 1997, 1998, 1999, and 2000, was obtained from the US Bureau of Labor Statistics and the Bureau of the Census to provide estimates of the uninsured population and provide comparisons with regional and national estimates.
- US Census Bureau Population and Housing survey data collected in 1990 and 2000 provided population estimates, demographic characteristics, and family/household information.
- Medical Expenditure Panel Survey Household Component (MEPS-HC) survey data provided the most recent information available on employer/employee participation and contributions toward health insurance coverage.

Primary Quantitative Household Survey—Methods

The Center for Survey Research (CSR) at the University of Massachusetts was retained by the Arkansas SPG to conduct the 2001 Arkansas Household Survey of Health Insurance Coverage, a random digit dial (RDD) telephone survey of 2,625 households, containing approximately 6,000 individuals in Arkansas. The primary purpose of the household telephone survey was to obtain state-level and regional-level estimates of the insured and uninsured adults and children in Arkansas. To generate accurate estimates of health insurance coverage in the state's population of 2.6 million, the SPG in collaboration with the CSR used a validated instrument to collect the data, developed a stratified sampling design, and developed methods to adjust for differences in probabilities of selection and non-response to ensure accuracy in reported results. (See CSR methodological report in Appendix III.)

Instrument. The 2001 Arkansas Household Survey of Health Insurance Coverage instrument is a revised version of the instrument employed in the Survey of Insurance Status (SIS) originally developed by the CSR and the State of Massachusetts Division of Health Care Finance and Policy. The Arkansas instrument was designed and validated to produce state-level estimates of uninsured adults and children. The computer-assisted telephone interview (CATI), previously fielded in Massachusetts in two large-scale CATI studies, followed the model of the National Health Interview Survey as it collected household and person-level data from an informed adult within the household. The instrument was translated into Spanish for administration to monolingual Spanish-speakers, including both translation and back-translation to ensure integrity between the English and Spanish versions. (The survey instrument can be found in Appendix III.) The instrument took an average of 20 minutes to administer, and included the following discrete modules.

- The **Screener Module** was administered to all households to determine household eligibility, and to collect demographic data for all members of a household, including marital status, employment status, gender, age, educational level, region, household income, race, ethnicity, and current status of health insurance coverage.
- The **Insured Module** collected data about a randomly selected insured adult and a randomly selected child, including employment history, source, cost (including premiums and out-of-

pocket expenses), benefits of health insurance, insurance history over the past 12 months, health care utilization, and health status.

- The **Uninsured Module** collected data about uninsured adults and children including employment history, availability of health insurance through employment, insurance history and source of last insurance, familiarity with and attempts to enroll in government health insurance programs, health care utilization, and health status.
- The **65+ Module** collected data about randomly selected adults ?65 years of age to capture data regarding prescription medications including costs, benefits, and utilization.

Instrument Revisions. Through a series of 6 cognitive interviews and 27 pretest interviews, the original SIS instrument was revised for the 2001 Arkansas Household Survey of Health Insurance Coverage to:

- add items to obtain the source of health insurance for all insured household members;
- revise question wording to target Arkansas-specific public and private health care systems, health insurance programs, and safety net services;
- revise income items to identify current program eligibility and to capture 2000 federal poverty level (FPL) data;
- revise selection procedures to randomly select a child for insured and uninsured modules rather than select the youngest child;
- add items to capture data regarding interruption in telephone service during the past 12 months to adjust for errors in estimates resulting from households currently without telephones; and
- add items to collect the name of employer(s) for each employed adult.

Sample Design. To obtain both state and regional estimates of the insured and uninsured, the 2001 Arkansas Household Survey of Health Insurance Coverage telephone survey employed a stratified statewide RDD sampling design. Based on secondary data analysis of county-level variables, including availability of health insurance, uptake of existing options for health insurance, and income, the 75 counties in Arkansas were stratified into 3 non-overlapping strata, i.e., "Delta" (N=10 counties), "Mountain" (N=11 counties), and "Other Counties" (N=54 counties). To obtain reliable regional estimates, sample sizes were increased in the less populous Delta and Mountain strata.

Weighting. The weighting of data in the household telephone survey is relatively complicated due to the modular construction of the instrument, the stratified sampling design, the random selection of individuals within specific modules, and the random selection of health insurance plans when there was more than one plan in a household. The CSR sampling statistician and the CSR survey methodologist along with the Arkansas SPG worked closely together to develop eight separate weights to adjust for differences of probabilities of selection across the three regions, household non-response, multiple residential telephone numbers, and random selection of the participants and health insurance plan.

Field Period. Data collected over a 6-month period (2/27/01–8/27/01), yielded 2,572 household interviews, collecting data regarding 6,596 individuals, with an overall screener response rate of 61.7%. Of contacted individuals, the response rate for the long interview ranged from 93% of

uninsured households to 98% of insured households. Survey response rates were calculated using the rigorous formula designed and endorsed by the American Association for Public Opinion Research. Extraordinary efforts were made by CSR to screen and complete interviews with households, often requiring interviewers to contact households numerous times, and in some cases requiring interviewers to call up to 50 times just to determine household eligibility. As expected of RDD telephone surveys, the largest component of household non-response was refusals. For each of the 1,039 households that ultimately refused to participate in the survey, a specially trained refusal converter interviewer attempted to contact the household three times in an attempt to convey the importance of participating in the survey. An additional 41% of initial household refusals were converted into completed interviews by the refusal converter interviewers.

There was little variation in screener response rates across the 3 regions, from 65.2% in the Mountain stratum, 61.7% in the Delta stratum, and 61.1% in Other Counties stratum. There was also little variation in long interview response rates across the 3 regions for each of the modules, with 99.5% completing the insured module in the Mountain stratum, 99.7% in the Delta stratum, and 98.6% in Other Counties stratum, and for the uninsured module 96.3% in the Mountain stratum, 93.6% in the Delta stratum, and 92.7% in Other Counties stratum. This exceptional rate of response was due in large part to the care in design and execution of the data collection effort. For analytic purposes, the Other Counties stratum was subdivided into four regions—Urban, Suburban, Northwest, and Country—in addition to the Mountain and Delta regions, resulting in 6 regions for subsequent analyses.

Eligibility Determination. Questions were included in the survey to accurately classify respondent households according to program eligibility. Eligibility for Arkansas's Medicaid program, including ARKids First, ConnectCare, and Medicaid-eligible Medicare beneficiaries, is determined by household income and assets. Table 1 represents the variations in incomes and assets by household size used to determine program eligibility.

Table 1. 2000 Annual Federal Poverty Level Guidelines

Family Size	100% Poverty	200% Poverty
1	$8,350	$16,700
2	$11,250	$22,500
3	$14,150	$28,300
4	$17,050	$34,100
5	$19,950	$39,900
6	$22,850	$45,700
7	$25,750	$51,500
8	$28,650	$57,300

Note: Arkansas's current Medicaid/SCHIP eligibility is 200% FPL for children and adolescents 0–18 years of age, 133% of the FPL for pregnant women, <25% of FPL for disabled adults 19–64 years of age, and 100%–120% for Medicaid-eligible Medicare beneficiaries over age 65 years.

Secondary Qualitative Household Data—Methods

To supplement and enrich the primary household quantitative and qualitative data collected by the Arkansas SPG, additional secondary qualitative household data collected by Arkansas Advocates for Children and Families (AACF) in previous data collection efforts were utilized. These secondary data, including *Working Families and the New Economy*,[3] and *Making it Day-to-Day: A New Family Income Standard for Arkansas*,[4] were particularly useful in gaining a better understanding of economic challenges facing Arkansas households.

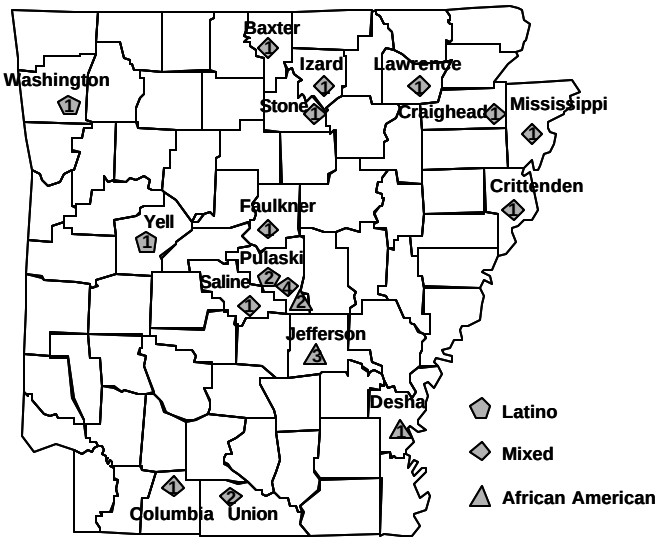
Primary Qualitative Household Focus Groups—Methods

The Arkansas SPG retained AACF to conduct 20 household focus groups in communities throughout Arkansas. In addition to the 20 household focus groups conducted by AACF, the University of Arkansas at Pine Bluff (UAPB) was retained to conduct 6 household focus groups with African–American participants. The primary purpose of the 26 household focus group sessions, each with 8–10 participants, was to investigate the circumstances influencing adults' rationale when making decisions regarding health insurance.

Household focus group participants were stratified by current health insurance status; income; region; and, in some cases, by race and ethnicity (Figure 4). Ten focus groups were conducted with uninsured participants with incomes below 200% of the FPL, 10 were conducted with insured participants with incomes between 200% and 400% of the FPL. Of these 20, 4 of the household focus group sessions were conducted with Latino household members and were facilitated entirely in Spanish. The additional 6 household focus group sessions with African Americans were also stratified by income and insurance status, and were facilitated by African Americans.

The 26 household focus groups were conducted over a 10-week period (4/01–6/01), and were taped (video or audio) and subsequently reviewed. The focus group sessions were on average 90 minutes in length, including introduction, consent process, dialogue, and wrap up. In most cases, the sessions were conducted in local hospital community rooms or other public facilities. Participants received a $40 cash incentive, refreshments, and in some cases transportation to and from the session.

Figure 4. Qualitative Household Focus Group Locations



Latino and mixed-race focus groups conducted by AACF; African–American focus groups conducted by UAPB. Numbers designate number of focus groups conducted at each location.

In collaboration with AACF, UAPB, and an external qualitative research consultant, the SPG developed the focus group question guide, the participant recruitment protocol, and the analytic process. (See Appendix III for the Household Focus Group Question Guide, and AACF and UAPB Final Reports on Household Focus Group Findings.)

1B. INSURED AND UNINSURED IN ARKANSAS

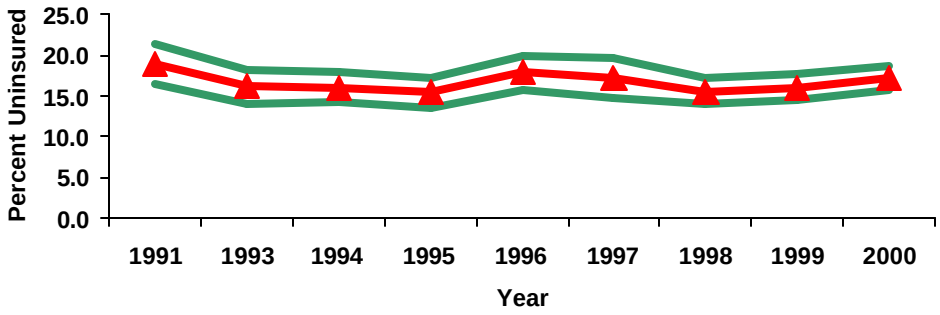
Through systematic collection of information from data sources identified above, a profile of Arkansans—both insured and uninsured—emerged. The challenges facing the uninsured became starkly visible; the success of insurance expansion to children through the ARKids program became apparent; and the challenges facing a poor, rural, Southern state became self-evident.

Through Arkansas's SPG process and based upon the available household information, a strategic plan for expanding health insurance coverage in the state has been developed.

Secondary and Primary Quantitative Household Data—Results

Existing Data on the Uninsured. From the BRFSS, which annually surveys a randomly selected set of Arkansas households, a stable estimate of the proportion of uninsured adults is evident over the past 10 years. As depicted in Figure 5, the proportion of uninsured adults ?18 years of age has consistently been 18%–20% over the past 10 years.

Figure 5. Percentage of Uninsured Adults in Arkansas (?18 years)

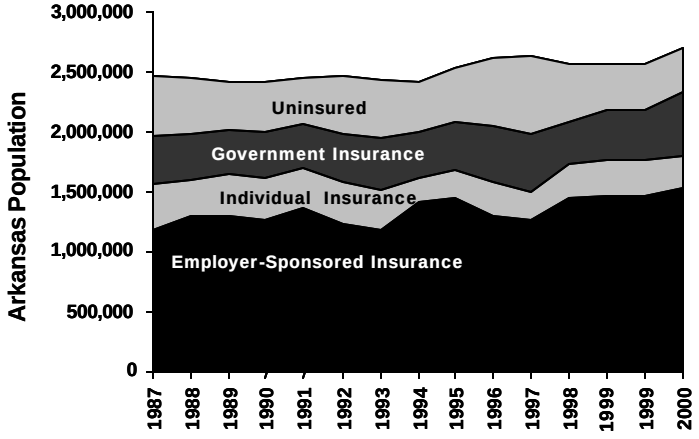


Annual percentage point estimates are shown with 95% confidence intervals. Source: BRFSS.

Importantly, the BRFSS only assesses the insurance status of adults; therefore it does not allow states to evaluate the expansion strategies that have targeted children and adolescents over the past decade.

From the March Supplement of the CPS, a reduction in the number of uninsured Arkansans has been reported over the past several years (Figure 6). From 1997 to 2000, a reduction from 24% to 13.7% in the total number of uninsured has been reported. To minimize the error associated with estimates generated from small survey samples, a 3-year estimate (1998–2000) projects Arkansas's uninsured rate to be 15.3%.[5] These estimates include children as well as adults and likely reflect the expansion of the Medicaid program through ARKids First since its inception in 1997. This nationally recognized program currently has ~75,000 enrollees (12% of Arkansas's children). Sample size limitations prevent accurate

Figure 6. Arkansas Estimates for Insurance Source



Data reflects modifications of US Census methodology. Source: Annual March CPS <www.census.gov/hhes/hlthins/historic/hihistt4.thml>.

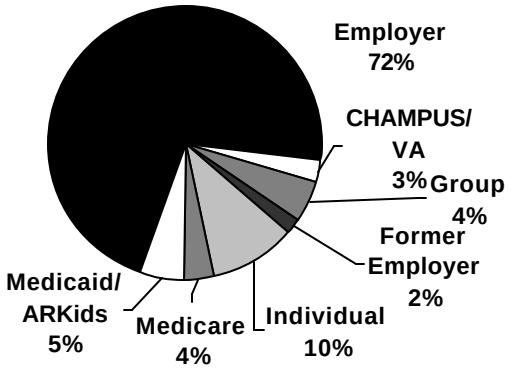
projections to be made of regional estimates or characteristics associated with the uninsured, which led to the requirement of an Arkansas-specific household telephone survey supported by the Arkansas SPG.

To provide a more complete profile of the uninsured in the state and to facilitate deliberations and decisions of the Roundtable, the Arkansas SPG undertook the 2001 Arkansas Household Survey of Health Insurance Coverage. As described above, detailed data on both insured and uninsured Arkansans were collected. The operational design and implementation of proposed expansion initiatives will be based on these data. Information generated for decision support of the Roundtable in conceptual and programmatic design is reflected below.

New Arkansas-Specific Data on the Uninsured. According to the 2001 Arkansas Household Survey of Health Insurance Coverage, approximately 15.2% (~400,000) of Arkansans are uninsured. Conversely, ~85% (2,275,000) of Arkansans are insured. When insurance status is examined, age becomes an important determinant due to program eligibility definitions. Virtually all Arkansans (99%) ?65 years of age are covered by Medicare. In addition 87% of children and adolescents ?18 years of age are covered by health insurance, while only 80% of adults aged 19–64 years are covered by health insurance. When the source of insurance is examined for those 19–64 years of age who are insured, the important contribution of the employer base of health insurance becomes apparent.

Of the insured adults between 19 and 64 years of age, more than 80% receive their benefits because of their current or previous employment status (Figure 7). Almost 3 of 4 (72%) of the insured working-aged adults receive their insurance through employer-based health insurance. Another 9% receive health insurance due to current or past employment—3% through the Civilian Health & Medical Program of the Uniformed Services (CHAMPUS) and Veterans Administration (VA); 4% through group policies, largely the Arkansas State and Public School Employee Health and Life Insurance Program; and 2% through former employers, either through COBRA (Consolidated Omnibus Budget Reduction Act) or early retirement options. Another 10% purchase health insurance through the individual market and less than 10% receive services through a public program such as Medicare or Medicaid. Thus, only 20% of working-aged adults receive health insurance coverage through a source unrelated to their employer.

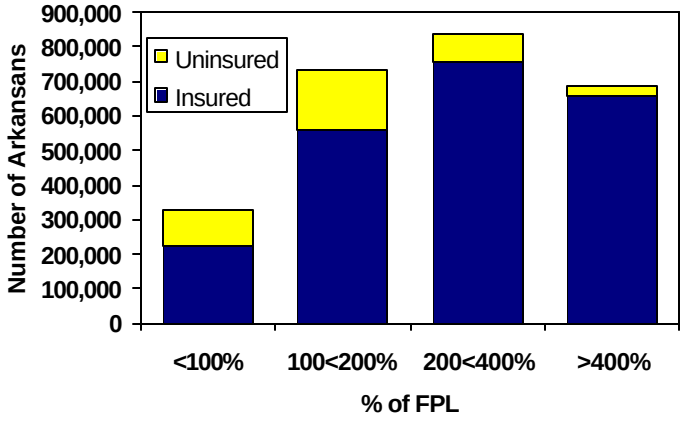
Figure 7. Insured Adults in Arkansas (19–64 years)



While individuals with insurance largely receive their benefit due to their employment status, many uninsured are working or have family members who are employed. The distribution of Arkansans by FPL and insurance status is depicted in Figure 8.

Consistent with previously published national findings, individuals from lower income families in Arkansas represent a greater proportion of the uninsured. Importantly, the largest number of uninsured individuals are in families with household incomes of 100%–200% of the FPL, representing working families.

Figure 8. Uninsured and Insured Arkansans by Federal Poverty Level

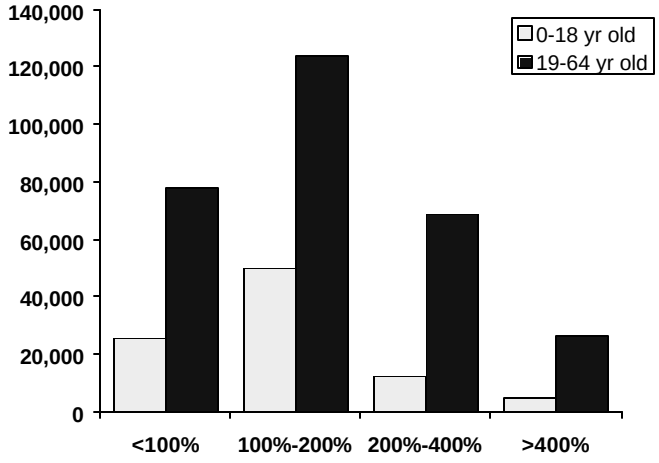


One in 5 adults aged 19–64 years lacks health insurance, and almost 1 in 4 young adults aged 19–44 years lacks health insurance—most of these adults currently are in the workforce. Examining the age of the uninsured and their household incomes provides previously unavailable Arkansas-specific information to target increased outreach for existing programs and new program development.

Of the uninsured children, approximately 81% live in families with incomes below 200% of the FPL and, therefore, are potentially eligible for the ARKids First Medicaid/SCHIP (State Children's Health Insurance Program). These children may have never enrolled; may have been previously enrolled but failed to re-enroll; or, if their family is above federal requirements for automatic coverage, may be in the waiting period (currently 6 months without health insurance).

Uninsured adults are also present in families with diverse family incomes. Approximately 78,000 uninsured adults are in households making <100% of the FPL, while approximately 124,000 are in households making between 100% and 200% of the FPL. Approximately 95,000 uninsured adults are in families with incomes above 200% of the FPL, while the number of uninsured children in these families is relatively small (Figure 9).

Figure 9. Uninsured Adults and Children in Arkansas by Federal Poverty Level

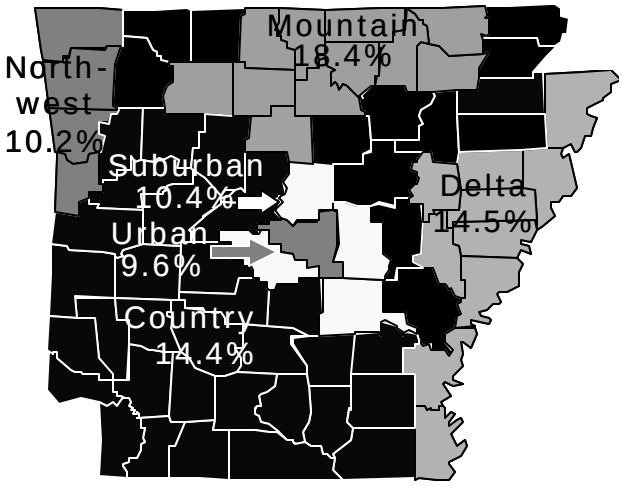


Obviously children eligible for the existing ARKids program should be enrolled and maintained in a program that has demonstrated success and continued political support. However, public programs offer very limited, if any, support for health insurance coverage in the working population aged 19–64 years.

Regional variation of the proportion of uninsured Arkansans is marked. From the three sampling strata described earlier, six regional county groups were formed representing homogeneous groups. These included Pulaski County in central Arkansas (Urban), suburban counties

(Suburban), 4 counties in the economically prospering Northwest corner of the state (Northwest), the rural areas of the state (Country), and the economically depressed areas of the north central mountain area (Mountain) and the Mississippi Delta (Delta). While the overall state proportion of the uninsured is 15.2%, regions vary from 9.6% in the Urban region to 18.4% in the Mountain region, as depicted in Figure 10.

Figure 10. Regional Variation in Uninsured



Secondary Qualitative Household Research—Results

Qualitative data previously collected by AACF for their report, *Making it Day-to-Day: A New Family Income Standard for Arkansas*,[4] sought to determine if the current FPL is a realistic measure of the income an individual and/or family in Arkansas requires to meet basic daily living needs (shelter, food, child care, health care, transportation, taxes, and miscellaneous items such as clothing and personal care). Results from these secondary data informed the Roundtable on the economic issues facing Arkansas families and framed the competing demands for limited household income; other existing studies were used to address questions regarding the amount an individual/family would be willing and/or able to pay for health insurance coverage.

AACF determined that to meet basic daily living needs, a family of four (two adults and two children) would require an income of $28,541, almost 200% of the FPL in 1998. To highlight these findings, AACF developed the Family Income Standard (FIS), which illustrates that the income threshold required to meet basic needs is substantially more than the established FPL threshold. In fact, in a 2001 report by the US Census Bureau[6], the Arkansas median family income was estimated to be $32,714, which is below the 200% FPL level of $35,300 for a family of four. The low median Arkansas income is in stark contrast to the rest of the United States at $41,343, placing Arkansas 48th of 50 states when comparing household income. [7]

Using the AACF FIS, it is clear that the large proportion of Arkansas households living at minimal income levels have limited choice in reapportioning their expenses; by definition, no basic needs are truly optional and few are readily deferrable. Proportionately, health care expenses account for ~14% of the FIS for an Arkansas family of four. Shelter, food, child care, taxes, and personal care requirements must be met on a daily basis. However, while immediate health care needs are frequently addressed, affording health insurance premiums (in total or as part of employer-based coverage) proves to be beyond the ability of many households. Immediate needs compete with the ability of families to allocate fiscal resources to ameliorate future financial risks due to potential health problems. Even when health conditions require immediate attention, the purchase of health insurance to pay for future risks is beyond many families' ability to pay.

Families without health insurance that delay obtaining timely health care risk higher morbidity and mortality rates due to early and treatable illnesses becoming catastrophic.[8] Additionally, many uninsured families are forced to turn to emergency departments when their health care needs become acute. Increased dependence on these more expensive methods of receiving care combined with a lack of reimbursement places further strain on the limited resources of the health care system. Dissatisfaction with health care costs likely provides additional support to delay seeking health care and defer purchasing health insurance. In the Health Confidence Survey[9] released in 2000 by the Employee Benefit Research Institute (EBRI), 40% of the respondents stated they were dissatisfied with the costs of their health care and ~45% thought their health insurance coverage of costs was insufficient.

The amount individuals and families are willing to pay for health insurance has been reported by the Urban Institute to be 3%–5% of family income.[10] As premiums increase beyond 5% of income, the authors of this study found that fewer than 18% of households were willing to purchase health insurance. The EBRI Health Confidence Survey discussed above also examined willingness to pay for health insurance among currently insured and uninsured individuals. Over half of the respondents who had employment-based insurance were willing to spend $150–$190 a month for health insurance premiums. The amount uninsured respondents were willing to pay was determined by the EBRI study to be significantly less; only 16% were willing to pay $100–$149 for monthly premiums and only 7% would pay $150–$199. Not dissimilar results were described by the State of Massachusetts, which found that a significant majority (56.4%) of uninsured adults aged 18–64 years were only willing to pay $100 or less per month for individual health insurance.[7]

Primary Qualitative Household Focus Groups—Analyses and Results

The primary purpose of the household qualitative data collection component was to understand household members' decision-making processes related to health insurance. Analysis of the qualitative data, collected through 26 SPG-supported household focus groups, allowed the SPG to develop an analytic model of these decision-making processes. The model provides an analytic framework to better understand the steps in the households' decision-making processes, identify factors that influence the outcome of the decision making process, and isolate potential steps at which interventions may be more targeted and potentially successful. The result is the ability, through policy changes, to positively influence an individual's (or employer's) ability to adopt and/or maintain health insurance or and avoid the discontinuation of health insurance, which in turn leads to increased numbers of the uninsured.

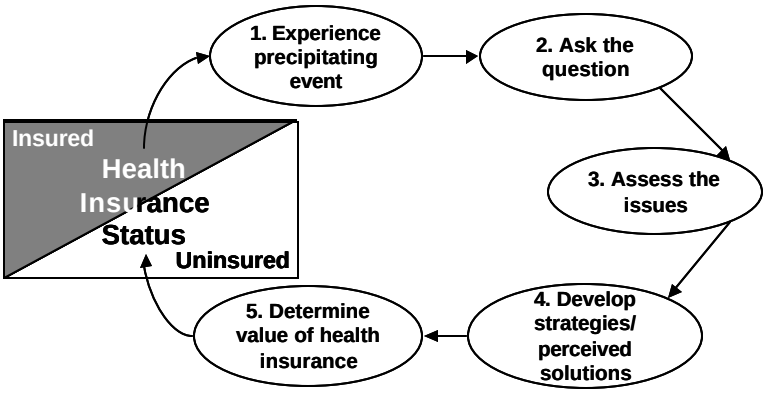
Decision-Making Model (Household Application). The model is designed to contain components facing household members when making decisions about health insurance.. The cycle of decision-making may be frequent (e.g., a family with multiple changes in family or job status) or it may be infrequent (e.g., an uninsured individual working in an industry that does not traditionally offer health insurance). For most insured individuals, the decision process occurs on an annual basis at re-enrollment.

Two types of "external factors" were observed as influencing the decision-making process—environmental factors and personal experiences. Environmental factors are broad, more global factors. Examples include employment status and history, type of occupation, industry, region, age, and many others. Personal experience factors are events in people's lives that appear to

impact their outlook toward obtaining or keeping health insurance. Examples include an individual's general health status, previous experiences with health care, and family and individual histories of health insurance experience(s).

Step 1. The actual decision-making process starts with a **precipitating event** (Figure 11). This is a category of events that causes people to reassess their health insurance status, and are either negative or positive events, depending upon the final decision. Examples of precipitating events are wide-ranging—loss of or a new job; open enrollment periods; meeting with an insurance salesperson; change in health status, premium costs, or residence; or life events including birth, death, and divorce. A positive precipitating event is a new-found possibility of attaining insurance, while a negative precipitating event is a situation that may ultimately force a person to discontinue health insurance for themselves and/or other family members.

Figure 11. Decision-Making Model for Determining Insurance Status



Step 2. Once a precipitating event occurs, the individual is jarred into **asking a question**. If the person is uninsured, the question becomes, "-Can I adopt health insurance or must I remain uninsured?" If the person is insured, then the question becomes, "Can I maintain my health insurance, or must I drop my health insurance, or modify it in some way?"

Step 3. Once the question is asked, an **assessment of issues** (real and perceived) takes place. This initial assessment is essentially a balancing act between competing issues, somewhat similar to a cost–benefit analysis. On one hand, the individual assesses the **costs** and on the other, the individual assesses the **benefits** of having health insurance. The **costs** include not only the *financial cost of the premium* but also the *time costs* associated with obtaining and managing health insurance policies. Several household focus group participants reported an extraordinary burden associated with having to obtain and manage multiple plans for individuals within the same family. The **benefits** of health insurance include an individual's assessment of needs, desires, and the quality of the product. The difference between *needs* and *desires* can be illustrated by noting that a person may need health insurance and not desire it or vice versa. Additionally, while a person may both need and desire health insurance, the final decision is often further impacted by the individual's perception of the quality of the particular plan. Finally the cost–benefit analysis is often impacted by an individual's **sense of responsibility**. This is a perceived moral obligation to provide health insurance to themselves and/or their family.

Step 4. After the assessment of issues is complete, the individual now develops **strategies and/or perceived solutions** in an effort to reconcile competing issues (the ultimate goal being to remain insured, or if currently uninsured, to become insured). Strategies and solutions are essentially the same, with the difference being that strategies are actually implemented, while perceived solutions are strategies that the individual was unable to implement. Household focus

group participants described numerous strategies and perceived solutions used to reconcile competing issues. A commonly reported strategy used by the insured in an attempt to reduce health insurance costs was to either modify the health insurance benefits (often by increasing deductibles and reducing benefits) or discontinue health insurance coverage for some, but not all, of the family members. A commonly reported perceived solution was to consider a change of jobs, moving from an employer who did not offer health insurance to an employer who did, but due to a lack of employers offering health insurance in a particular region or in a particular industry, this solution is frequently not an option.

> "It is difficult to convey the level of hopelessness expressed and to describe thoroughly the disheartening experiences related by many of the focus group participants as they talked about their decisions regarding health insurance."
> —*Focus Group Facilitator*

Step 5. The final step in this process is the decision (**outcome**) at which the individual arrives. A formula may be used to help clarify the final step an individual goes through to determine the value of health insurance and can be illustrated by **value**?**benefit/cost**. Once the value of health insurance is determined, the insured individual decides whether to maintain, modify, or discontinue health insurance. The uninsured individual, based on the determined value of the health insurance, either remains uninsured or adopts health insurance. While this formula is useful to clarify the final step in the decision making process, it is critical to convey the actual complexity and difficulty of this decision making process as reported by the majority of the focus group participants. In fact it is difficult to convey the level of hopelessness expressed and to describe the disheartening experiences related by many of the participants as they talked about their decisions regarding health insurance.

Household Focus Group Findings. Although all household members have, at some point in time, entered into the decision-making process that led to their current health insurance status, it is important to highlight analysis of data collected from those currently uninsured, particularly those whose household income fell below 200% of the FPL. These data revealed that many of the uninsured, due to external factors (defined as "personal experiences" and "environmental characteristics" in the analytic model) were unable to re-enter the process that would allow them to change their current health insurance status from uninsured to insured. In other words, the lack of a "positive" precipitating event leaves these individuals virtually outside the decision-making loop, forcing them to remain uninsured. Thus, strategies to expand health insurance to those currently uninsured should focus on mechanisms that will lead to a "positive" precipitating event. By altering circumstances that lead to a "positive" precipitating event, the uninsured will more frequently enter the decision-making process, ultimately leading to the adoption of health insurance.

Overall, data from the 26 household focus groups were consistent across racial and ethnic lines. When queried about their insurance status, household focus group participants most often related their current insurance status to their employment status. Thus, the *precipitating event* for most adults appeared to be directly related to their employment. Unemployed, uninsured participants commonly expressed the belief that the only possible way they could adopt health insurance would be to get a job (a positive precipitating event) with a company that offered employer-sponsored health insurance. Many reported the negative precipitating event of losing employment through lay-offs or retirement as leading to uninsured status. Many participants

reported that while their employers previously offered health insurance, either in full or part, the employers no longer do so (a negative precipitating event). Many more currently insured, either fully or partially by their employer, predicted that, due to increases in premiums, their employers were likely to reduce or discontinue employer-sponsored health insurance in the near future. Some participants reported that getting a job actually caused them to lose health insurance—e.g., individuals on Medicaid easily exceed the income and/or asset limits when they become employed, regardless of availability of employer-based health insurance.

Due to a negative precipitating event, such as an employer reducing or discontinuing employer-sponsored health insurance, an individual is forced into the decision making process which, in many cases, leads to the negative outcome of discontinuing health insurance. Negative precipitating events such as these are further complicated by an individual's personal experiences, such as health status and pre-existing conditions. A female focus group participant explained, "My employer is having to drop coverage but will provide us with a monthly stipend to go toward a policy we get individually. Unfortunately I have been denied an individual policy due to a prescription medication I was given two years ago." Others who are currently uninsured look forward to a positive precipitating event, reporting that with their new job, after a designated amount, they will qualify for employer-sponsored health insurance. A female participant described the loss of her job, a negative precipitating event, in the following way, "I worked as a temp [temporary employment is an example of an environmental characteristic] for about a year before they made my position permanent. Then I had to wait another 3 months to qualify for insurance coverage. It was just about 3 months after that they had a lay off and I lost my job and my [ability to adopt] insurance."

> "My employer is having to drop coverage but will provide us with a monthly stipend to go toward a policy we get individually. Unfortunately I have been denied an individual policy due to a prescription medication I was given two years ago."
> —*Employed female in Little Rock*

Some women and young adults reported precipitating events that were unrelated to employment. For example, some women with low incomes reported that they had government-sponsored health insurance when they were pregnant but lost it after childbirth. Others described events, such as becoming married, and thus becoming eligible to join a spouse's plan, or losing insurance when they divorced or were widowed. A female participant explained, "I had good insurance until my husband divorced me and canceled my policy and dropped the children too." One man said, "My wife was pregnant when my employer switched plans and the family rate increased so much I couldn't afford it. I had to switch her coverage to her employer in the middle of the pregnancy. It has been a nightmare to get the policies straight and to get payment for her medical services." Young adults reported age as their precipitating event, explaining that they used to be covered under their parent's policy but now they have aged out of that option.

> "I have outstanding bills at the local hospital and I am paying a small monthly amount. My greatest fear is that one of my children will get sick and will be turned away at the hospital because I owe them money."
> —*A Young Mother*

Several more participants reported moving to Arkansas as a negative precipitating event, in some cases because they were no longer able to obtain coverage via public insurance programs, and in some cases because the same insurance that was affordable in another state had higher premiums

in Arkansas. A woman said, "I moved here to let my daughter help me and now my social security check puts me over the income to get Medicaid. I was able to get coverage in the state I moved from."

> "I cook at the senior center just so I can pay for my medicines and my insurance. I don't know what I'll do if I can't work anymore."
> *—60-year-old female*

Assessment of Issues. Without exception, the low-income uninsured report the cost of health insurance as the single most important factor in not having insurance. While employment offered some the hope for gaining access to health care, these same individuals would explain that their employer would have to cover the full cost or they could not pay for it. It was also clear that the definition of a reasonable co-pay or premium would have to be set very low for them to consider it affordable. It is important to realize that many of the participants worked in low-wage, temporary jobs and that the take-home checks were extremely low. Individuals who were parents seemed to have the most vivid accounts of how costly insurance was and how little money they had available to pay for it. Other compelling cost reasons for not having insurance were given by those individuals who were aging. Living on limited incomes due to early retirement, or forced retirement, left little for them to pay when examining individual insurance plans. Several women over 60 years of age reported that the only reason they were working was to pay for insurance: "I cook at the senior center just so I can pay for my medicines and my insurance. I don't know what I'll do if I can't work anymore."

1C. RELATIONSHIP OF FINDINGS TO COVERAGE OPTIONS

Findings from these data sources directly informed and facilitated deliberations within the Roundtable and development of strategies for consideration. Section 4 fully describes the coverage options recommended by the Roundtable (p. 36). Strategies to engage the individual, family, and employer with low-wage employees are necessary to address the uninsured in these target populations. As indicated, most uninsured children live in families below 200% of the FPL and thus are potentially eligible for an existing program. Targeted strategies to increase outreach, awareness, and enrollment of eligible children and adolescents must be combined with strategies to increase retention and decrease inappropriate dis-enrollment from this nationally recognized program. For those over the age of 65, the primary gap in health insurance is a benefit issue related to the lack of prescription drug coverage in Medicare, not in program eligibility, which has achieved near-universal participation rates.

For working-aged adults, however, strategies necessary to address the uninsured require more in-depth assessment and creative development. The private employer-based system is obviously achieving health insurance coverage for most Arkansans; however, ~20% of adults aged 19–64 years lack health insurance. Clearly the limits on public sector programs (Medicaid eligibility <25% of the FPL), and the limited availability and affordability of private sector programs have left ~300,000 Arkansas adults without financial access to the health care system. These financial barriers result in missed opportunities for prevention and health promotion strategies, failed opportunities to address clinical conditions in a timely manner, and less-effective and more costly care in later stages of disease progression.

Efforts to bridge the available funding and delivery strategies in the public sector with the demonstrated interest and efficiencies of the private sector are needed to address the uninsured.

The Roundtable employed these information sources in their efforts to develop options that would both expand coverage to the uninsured and stabilize the private sector currently serving a large majority of Arkansans.

2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

2A. STRATEGY FOR OBTAINING INFORMATION

Background on Arkansas's Economy

Although many states have experienced significant population shifts to cities, Arkansas remains a largely rural state, with the majority of its population living outside the relatively few urban and suburban areas. Although the state possesses a diversified manufacturing base and is seeing increased growth in the high tech sector, much of the economy is still either directly or indirectly related to agrarian business interests.

The state's economic, racial and geographic diversity is reflected in the breadth of Arkansas's economic indicators, e.g. Benton County in the northwest corner of the state recently reported an unemployment rate of 1.6% whereas Desha County reported a rate of 10.0% for the same period.[11] Racial diversity is present with some Mississippi Delta counties having a high proportion of African-American citizens while some of the largest Hispanic growth in the nation has been experienced in the northwest sector. Overall, the state reported an unemployment rate of 4.9% in September 2001, a notable increase of a full percent over the same period in 2000.

Some Arkansans are employed in "large businesses" (>1000 employees), and there are number of national and international corporations operating in the state (85 Fortune 500 companies), but only 4 have headquarters in Arkansas.[12] However, the majority of businesses in the state are classed as "small" (<50 employees) and utilize a labor force that is largely non-organized. Arkansas is by law a "Right to Work" state and has not experienced significant penetration over the years by organized labor.[13]

As have other states, Arkansas has experienced a slow down in the overall economic boom that began nationwide in the 1990s. This downturn in the business sector has resulted in a decrease in state revenue collections; September 2001 general revenue collections were down 4.2% over the same period in 2000 and were almost 8% less than had been originally forecast.[14] These general revenue funds are primarily collected from a combination of sales/use taxes (5.125%) and individual income taxes (averaging 4.2% per person, although low income households are exempt).

The overall tax base in the state is relatively small when compared to other states largely due to the low per-capita income. Arkansas's median household income is $32,714 (national median household income $41,343).[6] Arkansas's per capita income is $16,713 (national per capita income is $21,684).[15] Because of these low incomes, Arkansas has a limited tax base resulting in low revenue generation: Arkansas ranks 47th in the nation in per capita state and local taxes and 48th in the nation in per capita property tax collection.[15] The weakening economy and subsequent decrease in state revenue is especially significant in our state due to the Arkansas Revenue Stabilization Act, which mandates a balanced budget and prohibits deficit spending by state

government. This decrease has resulted in government planners calling for across the board cuts by state agencies affecting both insurance and safety-net provider programs.

Data Gathering Activities

Data gathered from Arkansan employers used to inform the development of options to expand health insurance coverage through the SPG involved three modes of data collection—secondary quantitative and qualitative data obtained from previous data collection efforts and administrative records, primary qualitative data collected via key informant interviews with large-sized employers, and focus group sessions with small- and moderate-sized employers. The 2000 Medical Expenditure Panel Survey–Insurance Component (MEPS-IC), a quantitative data collection effort currently being fielded via a SPG subcontract with the Agency for Healthcare Research and Quality (AHRQ) will provide additional information during coming months.

Secondary Quantitative Employer Data—Methods

Existing Federal and state data sources related to employer-based health insurance coverage were identified and incorporated into the analyses as appropriate. In addition, specific databases including business listings and published reports were identified for inclusion in profiles of Arkansas businesses and their employees. Importantly, due to the complexities of decisions surrounding employer-based health insurance—small and large businesses with multiple sites, variations in insurance participation and contribution by type of industry, and variation in employee uptake if offered—a systematic assessment of employer-sponsored health insurance required a sampling frame drawn from a complete and objective source with access to confidential employer data.

The Arkansas SPG chose the MEPS IC, which is a nationwide annual survey of more than 25,000 responding private-sector establishments and governments in the US. It provides estimates of job-related insurance both at the national and at the state level in select years. The most recent year for which Arkansas-specific data was available is the 1996 survey of employers that included estimates of workers' access to job-related health insurance. Information was available both for particular workplaces or "establishments" and the corporate entity or "firm". Such information was critical to evaluate benefit decisions that are made at the firm level, but that affect employees at each establishment. In addition to published and available data analyzed by the Arkansas SPG, select analyses were performed by AHRQ and US Census Bureau staff to assist in data applications specific to the Arkansas SPG.

Primary Quantitative MEPS-IC Survey—Methods

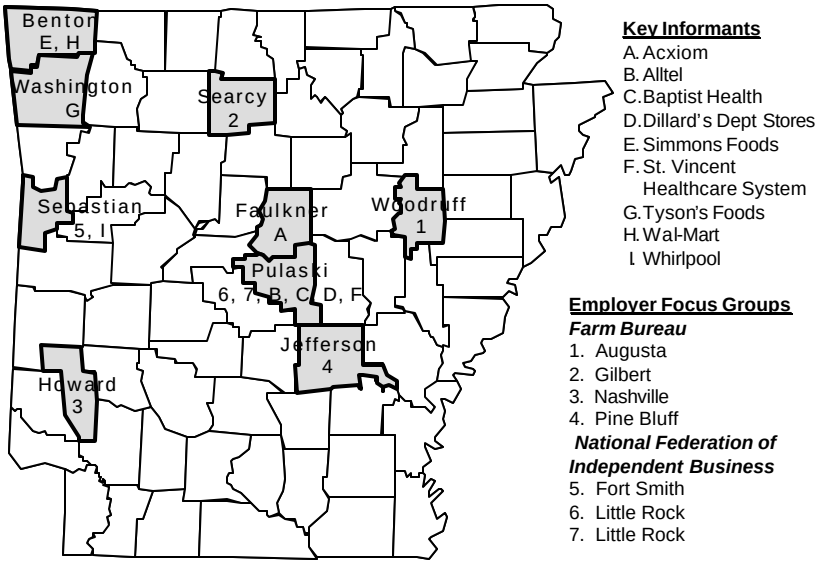
In addition to using the 1996 MEPS data, AHRQ was subcontracted by the SPG to conduct a mail survey with telephone follow up of 1,800 employers in Arkansas via the nation-wide 2000 MEPS-IC survey. On behalf of the Arkansas SPG, AHRQ agreed to adjust the rotation schedule of states for the 2000 MEPS-IC to allow for the 800 cases originally to be fielded statewide in Arkansas in a subsequent year (sometime after 2001) to be fielded during the 2000 MEPS-IC survey. To further increase sample size, the Arkansas SPG provided support to AHRQ to field an additional 1,000 cases statewide in Arkansas in the 2000 MEPS-IC survey, increasing the total number of fielded cases in Arkansas to 1,800.

AHRQ will field the 1,800 2000 MEPS-IC surveys in Arkansas from July 2001 through December 2001. These surveys will be collected using the MEPS-IC sampling design of statewide establishments based on sampling frames developed from Internal Revenue Service (IRS) records, and will use the 2000 MEPS-IC Health Insurance Cost Study Establishment Questionnaire, the 2000 MEPS-IC Health Insurance Cost Study Plan Information Questionnaire, and will follow all established MEPS-IC data collection protocols, including face-to-face recruitment of specified large employers, and telephone and face-to-face follow-up with non-responders. Final delivery of analyzed and weighted Arkansas-specific data collected during the 2001 MEPS-IC survey will be received by the SPG no later than June 1, 2002.

Primary Qualitative Data from Key Informant Interviews—Methods

In addition to statewide surveys of employers, nine of the largest employers in Arkansas participated in face-to-face key informant interviews conducted by the SPG (Figure 12). Key informant interviews were conducted in the corporate offices, usually with the CEO/president of the company and the principal individual responsible for health insurance and/or employee benefits (e.g., human resources director).

Figure 12. Location of Key Informant Interviews and Employer Focus Groups



The primary purpose of these key informant interviews was to investigate what influences large employers' decision-making regarding employer-sponsored health insurance. Key informant interviews provided data to assess the developmental history of an organizations' participation in employer-sponsored health insurance, described the decision process regarding options for employees' benefits, and identified key issues threatening current participation in the employer-sponsored health insurance. Evidence of employee productivity and turnover rates, future employee benefit options under consideration, and suggestions for increasing the proportion of employer participants in health insurance were collected. Key informants from the insurance industry were asked to relay their experiences in the small, moderate, large, and self-insured insurance markets; describe failed efforts to expand market share and the suspected reasons for such failures; and identify attractive options for insurance expansion. Suggestions for insurance reform that would stabilize and expand the individual and small group insurance markets were also solicited.

Key informant interviews were conducted over a 2-month period, and were audiotaped and transcribed for analytic purposes. The key informant interviews were on average 60–75 minutes, including consent process, dialogue, and wrap up. The SPG staff worked with a qualitative research consultant to develop the questions used to guide the open-ended key informant interviews. (See Appendix III for Key Informant Question Guide.)

Primary Qualitative Data from Employer Focus Groups—Methods

In addition to qualitative information from large employers through the key informants, the SPG targeted small- to moderate-sized employers for additional perspectives. Working with the Arkansas Chapter of the National Federation of Independent Business (NFIB) and the Arkansas Farm Bureau, the SPG recruited and conducted 7 focus group sessions with small- to moderate-sized employers and health insurers in the state. The employer focus groups, facilitated by the SPG, included a total of 50 employers, with an average of 7 participants per session. The primary purpose of the employer qualitative data collection was to investigate the decision-making process of small- to moderate-sized employers with regard to employer-sponsored health insurance. Information was solicited on past and current participation, current deliberations about future participation in employer-sponsored insurance programs, and factors perceived to influence decisions regarding health insurance.

Employers were recruited from a variety of industries, including farming, logging, retail shops, cosmetology, real estate, accounting, architecture, and community services. One of the employer focus groups was comprised entirely of African–American farmers, and one was comprised entirely of health insurance representatives from the state. The focus group sessions were conducted in 6 areas of the state (see Figure 12), including Pulaski, Sebastian, Faulkner, Jefferson, Searcy, Woodruff, Howard, Benton, and Washington Counties.

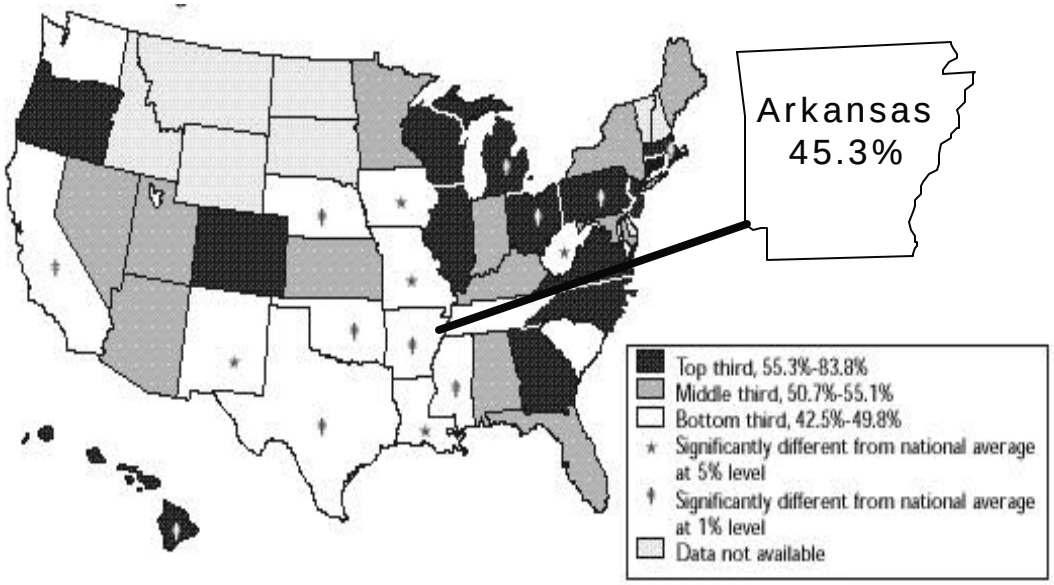
Employer focus groups were conducted over a 2-month period, and were audiotaped and transcribed for analytic purposes. The sessions were on average 120 minutes, including introduction, consent process, dialogue, and wrap up. The employer focus groups were conducted in private rooms of restaurants around the state. The SPG staff worked with a qualitative research consultant to develop the questions used to guide the open-ended employer focus group sessions. (See Appendix III for Employer Focus Group Question Guide.)

2B. EMPLOYER-BASED COVERAGE IN ARKANSAS

Secondary Quantitative Employer Research—Results

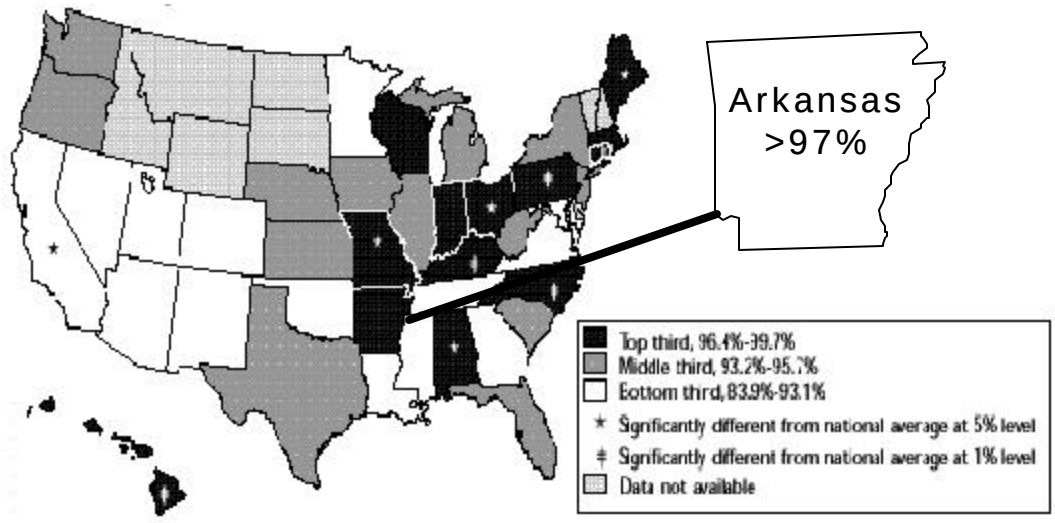
Results from the MEPS-IC in 1996 revealed important issues surrounding the access, cost, and choice of health insurance in Arkansas compared with its neighboring states and the nation. Job-related health insurance serves a major role in covering American workers and their families across the country. While the national average was 53.2% of private sector establishments offering health insurance, only 14 states had fewer than half of its establishments offering health insurance. As depicted in Figure 13, Arkansas (45.3%) joins Mississippi (42.5%) and Oklahoma (45.7%) in being the group of states with the fewest number of establishments offering employer-based health insurance. The highest rate of employer-sponsored health insurance occurred in Hawaii (83.8%), where employers are mandated by Hawaii State law to offer coverage to most workers.

Figure 13. Percent of Private-Sector Establishments Offering Health Insurance (1996; National average = 53.2%)



In every state, establishments that have >50 employees (large firms) were more likely to offer health insurance than small firms. Nationally, an average of 93.8% of large firms offer employer-sponsored health insurance. Arkansas surpassed most other states with >97% of its large firms offering health insurance benefits to employees (Figure 14). This is in stark contrast to most of its neighbors including Oklahoma (93.3%), Mississippi (92.0%), Louisiana (91.1%), and Tennessee (91.5%).

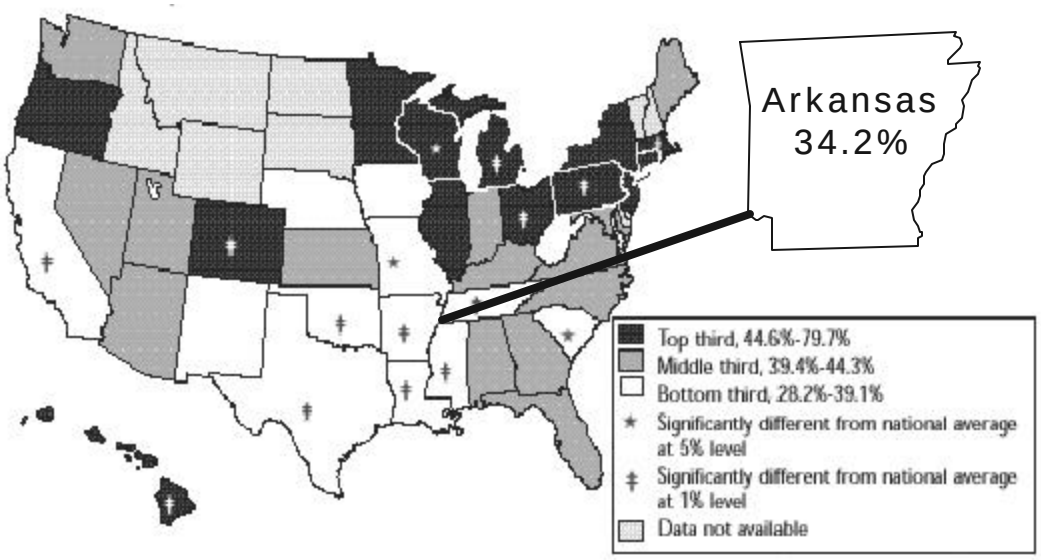
Figure 14. Percent of Large Firms Offering Health Insurance (1996; National average = 93.8%)



While Arkansas's largest employers are leading the nation in employer-sponsored insurance, unfortunately, Arkansas's businesses are comprised mostly of small employers (<50 employees). On average nationally, 42.1% of small employers offer health insurance; by this measure,

Arkansas and all of its neighboring states were in the bottom third of the states and significantly lower than most. Only 34.2% of establishments in Arkansas with <50 employees offer employer-based health insurance (Figure 15). One challenge clearly identified by the Roundtable was the low participation rate of small employers.

Figure 15. Percent of Small Firms Offering Health Insurance (1996; National average = 42.1%)



While employers may offer health insurance to eligible employees, the variation in eligibility of part-time employees (as defined by respondents) may affect coverage dramatically. The eligibility for full- as opposed to part-time employees was significantly different in every state. Nationally, 89.8% of full-time workers and 33.7% of part-time workers are eligible for employer-sponsored health insurance. However, the difference between full- and part-time workers was greatest in Arkansas where both positive and negative findings are present. Arkansas is in the top third of states offering health insurance to its full-time employees at 91.7%. But, Arkansas is also the state in which employers are least likely among all states to offer health insurance to part-time employees. Only 13% of part-time Arkansas employees are offered employer-based health insurance. These findings have important consequences in determining options available to uninsured Arkansans.

Being offered health insurance by an employer does not ensure uptake by the employee. When examining whether employees enroll in health insurance if offered, Arkansas and other Southern states in general are in the top third of states nationally in eligible employee uptake. Arkansas had more than 87.2% of its eligible employees participating in 1996. Importantly during that year's assessment, the average total health insurance premium in Arkansas for both single ($1,763) and family coverage ($4,157) was among the lowest in the nation ($1,997 annual single premium, $4,953 annual family premium in 1996).

From recently released MEPS-IC data collected from employers in 1999,[16] Arkansas remains one of the states with the lowest proportion of employers which offer health insurance (43.9% of all employers). Of Arkansas's 57,329 employers, 45,580 (79%) have fewer than 50 employees and 35,942 (63%) have fewer than 10 employees. Arkansas continues to have one of the lowest

proportion of participating employers across all other categories with only 31.3% of employers with fewer than 50 employees offering health insurance and only 22.9% of employers with less than 10 employees. Most of Arkansas's largest employers (99.6%), those with over 1000 employees, continue to offer employer-sponsored insurance to their employees. Ongoing analyses are underway to identify interim changes including costs and benefit modifications in employer-sponsored health that could influence expansion initiatives currently under consideration.

From results based upon the MEPS-IC data, the Roundtable clearly identified the small employer and their employees as targets for development of programs to address the problems of the uninsured. To optimally describe the small-employer market, an Arkansas business listing was obtained that included the size of employer, geographic location, and type of industry. As depicted below, the small business community in Arkansas represents a unique set of employers with substantial numbers of Arkansas employees (Table 2).

Table 2. Small Businesses in Arkansas

Business Descriptions	# Businesses	# Employees
Churches	3,608	10,220
Restaurants	3,234	51,748
Beauty salons	2,676	6,056
Insurance Agents	2,014	10,497
Automobile dealers-used cars	1,850	3,450
Attorneys	1,634	6,810
Physicians & surgeons	1,314	12,709
Schools	1,291	63,586
Automobile repairing & service	1,202	2,766
Real estate	1,189	6,230
Convenience stores	1,125	7,008
Grocers-retail	1,114	20,060
Banks	964	13,900
Apartments	892	2,285
Dentists	876	4,076
Service stations-gasoline & oil	768	3,536
General contractors	740	6,672
Hotels & motels	716	10,731
Automobile body-repairing & painting	704	2,145
Child care service	702	5,931
Farms	675	2,590
Accountants	634	2,656
Government offices-county	622	4,858
Post offices	598	5,070
Plumbing contractors	596	1,744
Air conditioning contractors & systems	565	2,369
Florists-retail	549	2,037
Automobile parts & supplies-retail-new	543	5,813
Electric contractors	534	3,483
Gift shops	533	1,717
Pharmacies	524	3,867
Clinics	516	6,726
Barbers	468	818
Antiques-dealers	447	717
Liquors-retail	439	1,463
Government offices-city, village & townships	434	4,167

While several large companies exist in the state, most of these are located in the central or northwestern areas of the state. Large areas within the state contain only small employers and have been largely abandoned by most insurance carriers. Those that remain are reluctant to become the sole carrier for a region due to the potential for adverse risk selection, particularly in the small group market. Thus, the market for small group health insurance and the competition for those companies desiring coverage both contribute to an increasingly unattractive future for the private health insurance market.

Primary Quantitative MEPS-IC Survey—Results

As discussed in the methods section above (p. 19), AHRQ will conduct a mail survey with telephone follow-up of 1,800 employers in Arkansas through the nationwide 2000 MEPS-IC survey. Via a contract with the US Census Bureau, AHRQ will field the 1,800 surveys using the 2000 MEPS-IC in Arkansas from July 2001 through December 2001. Final delivery of analyzed and weighted Arkansas-specific data collected during the survey will be received by the Arkansas SPG no later than June 2002. Findings will be incorporated into the state's health insurance expansion recommendations at that time.

Primary Qualitative Data from Key Informant Interviews—Results

Several major themes were extracted from the data gathered during key informant interviews and specific examples of experiences influencing health insurance benefit design, structure, or management are detailed below. All key informant interviews were conducted with employers who offered health insurance to their employees.

A majority of large state-based employers self insure to attain optimal management and cost-control on what is reported as the largest employee-related business cost next to salaries. These self-insured companies either manage claims and health benefits directly through internal personnel or contract with external third-party administrators (TPAs) for claims and utilization management services. Many employers aggressively pursue network development and direct contracts with participating clinicians and hospitals. Some have temporarily excluded providers even when employees are dependent upon services (e.g., local hospitals) when desired utilization management strategies, quality control issues, or costs have been perceived to be inappropriate.

Of those companies that utilized a fully-insured carrier in the past decade, most have eliminated that option from their employee benefits due to the perception that this strategy provides few choices and lacks competitive pricing structures that are available to them through self-insurance. Tax strategies also afford financial incentives to bring benefits into company management of employees rather than externally contract for services.

When examining the perspective and outlook of large Arkansas employers, every employer interviewed expressed a sense of obligation to provide options on health insurance benefits to their employees. Descriptions varied from "paternalism" as a social obligation to "responsibility" as being able to "strike the best deal" on behalf of employees. The business case for expending company resources in pursuit of these goals consistently included the ability to attract and retain employees and the need to exercise business practices of bulk purchasing power to optimize benefits for employees.

Overall, there was a strong distrust of the health care system and governmental efforts to influence benefit design and coverage requirements. Many large employers expressed a strong desire to insert the "cost discussion" into the employee–physician relationship. This desire was based upon the need for consumers of care, their employees, to accurately assess the value and necessity of care being provided. A strong belief that there are few financial incentives in place for clinicians to avoid unnecessary and ineffective treatments due to the current insurance system was present in some employers. Several expressed a long-term desire for a complete overhaul of the financing mechanism of health benefits, but would not recommend that goal due to the short-term instability and destabilization in employee–employer relations that would be required. No employers interviewed planned to move from health benefits to direct contributions as a form of compensation at the time of the interviews.

When the benefit composition was examined across these 9 employers, all employers included major components of inpatient, outpatient, and prescription drug coverage. Employer contributions ranged from 66% to 90% of the health insurance premiums for individuals and their families. Deductibles ranged from $100 to $1,000 per year. Out-of-pocket maximum expenditures for individuals ranged from $1,000 to $2,500 per year; family expenditures ranged from $2,500 to no limit in each year. Lifetime maximum eligibility for covered expenses also ranged from one company that had no lifetime cap to a $1-million lifetime cap. Some companies pursued limited caps, for example, a $1-million cap on transplants.

One of the most dramatic differences among large employers targeted preventive clinical services, which include mammography, cholesterol screenings, and childhood immunizations—use of these services is predictable based on the age and gender of a person. Dichotomous findings were present on the inclusion of preventive clinical services: companies either included preventive services with 100% coverage or excluded preventive services as a covered benefit. From discussions, the decision for developing plans that lack prevention coverage frequently was made based not upon costs, but on the principle of health insurance being restricted for non-predictable expenses. The amelioration of future costs and health impact through preventive services was recognized in those plans not offering preventive coverage, but relegated to the responsibility of the individual employee and their family to save for and fund.

Several employers had contributed to employee wellness programs either through direct contribution to health insurance premiums or through increased premium payments for employees with select habits (e.g., tobacco use). Concern and discomfort was expressed by employers not wanting to assume police functions required to monitor and adjust premium payments based upon personal health habits. However, the link between current health habits and future health care costs was present in the discussions of several large employers.

Several innovations as a result of changing market conditions and increasing health benefit costs were reported by employers. One employer had implemented a type of pre-tax savings account for employees to use in expenditures on pharmaceutical costs, rather than providing standard insurance benefits, in an attempt to increase employee awareness of prescription drug costs. Even though a substantial employer contribution was made to the employees' accounts, the program was discontinued within a year of establishment due to employee dissatisfaction. Future efforts to educate the workforce prior to implementation were cited as a needed component.

One employer that in previous years did not cap health care expenditures for employees or their dependents reported adding a very restrictive $25,000 cap during the first year of service. The reported cause was the explicit information that an individual with more than $100,000 of pharmaceutical expenses was advised by a pharmaceutical representative to have a family member gain employment with this company and thus become eligible under the Health Insurance Portability and Accountability Act for covered benefits. The perceived "gaming" of federal legislation at the expense of this employer resulted in a limiting restriction placed on first-year employees eligibility.

Finally, an employer in the agricultural food production industry with an average hourly wage of $8.50 per hour achieved 100% employee participation through participation requirements as a condition of employment. Employees at this company are required, regardless of insurance availability or coverage through other mechanisms, to pay premiums and participate in the company's health insurance program. Despite a 30% Latino workforce (who traditionally have very low rates of insurance coverage), low-wage jobs, and a decentralized operation, this company has achieved 100% coverage for its employees.

The future expectations of the large employers interviewed include multiple approaches to cost-containment efforts. They each reported double-digit increases in medical inflation, some in the 20% range over the past 12–18 months. They expect to reduce benefits and increase cost sharing to maintain premium costs while capping their exposure to medical inflation. Pharmaceutical costs in particular are targeted for tiered formularies and various pharmacy management strategies. The management of chronic pharmacy needs and the current practice of limiting refills to monthly amounts were identified as specific issues potentially addressed through allowing long-term stable patients access to bulk purchasing of needed prescription drugs.

Finally, unlike information provided by small- to moderate-size employers, no large employer interviewed anticipates abandoning health insurance as a major compensation provided to their employees at this time. Each employer freely expressed interest in pursuing a joint resolution to the funding and cost issues facing the nation. However, strong reservations were expressed about unintended consequences of federal legislation that would shift costs differentially to them through modification and potential erosion of the Employee Retirement Income Security Act (ERISA) under which they operate their health plans.

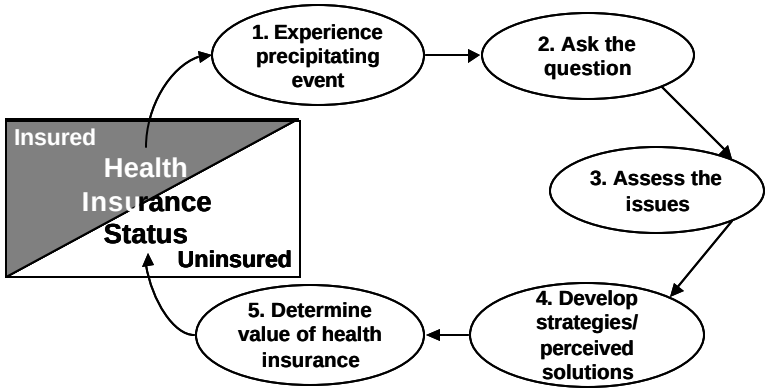
Primary Qualitative Data from Employer Focus Groups—Results

The primary purpose of the employer qualitative data collection components, including the 7 employer focus groups and the 9 key informant interviews, was to understand employers' decision-making process related to employer-sponsored health insurance, as well as to identify the circumstances that influence the process. Analysis of the qualitative data obtained via employer focus group sessions and key informant interviews allowed the SPG to develop an analytic model. The model outlines the decision-making process an employer experiences when conducting an assessment and selection of health insurance options, as well as identifies the circumstances that appear to determine the outcome of the process. Thus, the model is used to provide the analytic framework to report significant findings and essential steps of the process. Through the use of the model, factors determining the outcome of the decision-making process can be identified and efforts to expand health insurance coverage or decrease the loss of employer-based coverage can be better targeted.

Decision-Making Model (Employer Application). Similar to the model for individual decision-making regarding health insurance, the model for employers is self-contained (Figure 16), and influenced by employer size, type of industry, including seasonal business, average wage, region, and employee demographics, as well as the personal experiences in employer's lives that appear to impact their outlook toward employer-sponsored health insurance.

All employers have at some time entered into the decision-making process that led to their current policy regarding employer-sponsored health insurance. However, it is important to recognize, that there appear to be external factors such as industry type and employer size that essentially leave some "types" of employers outside of the decision-making loop, forcing them to remain stuck with their current policy not to offer health insurance to their employees.

Figure 16. Decision-Making Model for Determining Insurance Status



Step 1. The actual process starts with a **precipitating event**. This is a category of events that forces employers to re-assess their policy regarding employer-sponsored health insurance, and can be either "negative" or "positive" events depending upon the final decision. Examples of precipitating events are wide-ranging. They include a change in the economic climate, premium costs, job market, group insurance eligibility criteria, and many others. A positive precipitating event is a new-found possibility of offering health insurance to their employees, while a negative precipitating event is a situation that forces an employer to reduce or discontinue employer-sponsored health insurance. An executive of an architectural firm with ~17 employees described a common negative precipitating event in the following way: "We offer health insurance to all of our employees. We paid 100% [of the employee's premiums] up to about 4 years ago when we started seeing these monumental increases. [At that point we reduced our portion of the premium costs] to 90%, then 80%, now it is at 75%. We are having to put those part of the costs onto our employees, which we don't like, but just can't afford it…." An insurance business employer with ~35 employees, explains a similar precipitating event: "In our office we explored the possibility of stopping [employer-sponsored health insurance], which sounds really bad for an insurance agency. But you can't stop it. You've always got someone that's uninsurable, or nearly uninsurable. So how do you in clear conscious say we promised you this, but we're taking it away?"

"In our office we explored the possibility of stopping [employer-sponsored health insurance], which sounds really bad for an insurance agency. But you can't stop it. You've always got someone that's uninsurable, or nearly uninsurable. So how do you in clear conscious say we promised you this, but we're taking it away?"
— Insurance Agency Employer with 35 employees

Step 2. Once a precipitating event occurs, the employer is jarred into **asking a question**. If the employer does not currently provide employer-sponsored health insurance, the question becomes " Can I offer health insurance to my employees or must I retain the current policy and continue to not offer employer sponsored health insurance?" If the employer currently offers employer sponsored health insurance, then the question becomes, "Can I continue to offer health insurance, or must I modify the offer, or stop offering health insurance to my employees?"

> "What they [employees] look at is what they're going to lose, say $40 per month and they'd have a $1000 deductible. To them they're never going to meet that $1000 deductible, so you're just taking that $40 away from them."
> —*Small-farm employer*

Step 3. Once the question is asked, an **assessment of issues** (real and perceived) takes place. This initial assessment is essentially a balancing act between competing issues, somewhat similar to a cost–benefit analysis. On one hand, the employer assesses **costs** and on the other the employer assesses the **benefits** of offering health insurance. The **costs** include not only the *cost of the premium* but also the cost associated with *administering health insurance policies*. Because adopting and administering health insurance is often time consuming, the *time burden* is also included in cost assessments. A small farmer predicts that, because the farm is too small to qualify for group insurance, it would require another full-time person just to manage all of the paperwork associated with individual policies to insure the farm's employees. The **benefits** of health insurance include an employer's perception of his or her employees' needs and desires for health insurance, as well as perception about the necessity to attract and retain employees by offering health insurance, and an assessment of the quality of the product. This balancing act was described by a small farmer: "For us it's been expensive [employer-sponsored health insurance] and the fact that I don't think they'd [i.e., the employees] take it. What they [as perceived by the employer] look at is what they're going to lose, say $40 per month and they'd have a $1,000 deductible. To them they're never going to meet that $1,000 deductible, so you're just taking that $40 away from them." Whether this employer's perceptions are valid is not the point, as it is clear that real or perceived assessments of an employees' needs and/or desires impacts the employer's decision to offer employer-sponsored health insurance. Finally the cost–benefit analysis described above is impacted by an employer's **sense of responsibility**. Many employers perceived a moral obligation to provide health insurance to their employees. It was common for employers to report that they feel a "responsibility" to their employees to offer health insurance. Many smaller employers, particularly those that did not provide employer-sponsored health insurance, described other "benefits" they did provide, including paying for an employee's doctor's bills, gas, transportation, housing, and food.

Step 4. After the assessment of issues is complete, the employer then develops **strategies and/or perceived solutions** in an effort to reconcile competing issues. A typical example of a strategy used to address cost issues is to lower the cost of the premium either by modifying the health insurance plan itself or by off-loading costs to the employee. The annual increases reported by employers are forcing an assessment of alternative strategies to manage the rising costs. While many perceived solutions may exist, only those that are realistic alternatives, e.g., strategies, are available to the decision-maker.

Step 5. The final part in this process is the decision-making step at which the employer arrives. An assessment of alternative strategies is applied by the employer to determine the value of

health insurance and can be approximated by the following formula: **value ? benefit/cost**. Once the value of health insurance is assessed, the employer decides whether to maintain, modify, or discontinue health insurance for the employees. The employers who do not currently offer insurance to their employees, based on their perceived value of the health insurance, either remain uninsured or adopt health insurance. For those employers who have been offering insurance, strategies to contain rising costs will likely be used or the costs associated with providing insurance may exceed the "value" resulting in a discontinuation of health insurance benefits.

2C. RELATIONSHIP OF FINDINGS TO COVERAGE OPTIONS

Review of information available on employers in Arkansas and their experience in participating in employer-sponsored health insurance identified several key challenges to the goals of the Arkansas SPG. Section 4 fully describes the coverage options recommended by the Roundtable (p. 36). First, the low number of small employers participating in small group insurance combined with the high uptake of employees when offered suggested that small employers will be a required target of any strategy considered. Second, from qualitative data collected from both small and large employers, a sense of responsibility exists in employers to assist their employees in attaining health insurance. Third, because of the predominance of small employers in the rural areas including the Mississippi Delta, Mountain, and Country areas, strategies are needed to help communities that lack major employers offering health insurance benefits. Fourth, while 1996 data suggests that Arkansas's health insurance premiums were lower than the national average, a review of current Arkansas insurance costs through the SPG process suggest that Arkansas's premiums have joined the national experience and recent anecdotal reports of annual premium increases of 20%–35% in the small group market may reverse the high rate of employee uptake in the state if a majority of those costs are transferred to the employee. Finally, without exception, the rising premium costs appear to be the single most important factor influencing decisions surrounding employer-sponsored health insurance.

3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

3A. STRATEGY FOR OBTAINING INFORMATION

The SPG sought to paint a detailed picture of the health insurance marketplace in Arkansas through a variety of means. Analysis of **existing administrative data and studies** (peer-reviewed literature, studies conducted by policy research organizations, and examination of state and Federal government resources) were employed. In addition, involvement of Roundtable members (see Section 5, p. 49) participating in the market and supplementation of SPG resources with additional expertise through the Academy of Health Services and Health Policy optimized information available to deliberations. "Homework" assignments included Roundtable members "shopping" for a standardized small business insurance need through local agents.

Key informant interviews were conducted with very large Arkansas-based employers offering health insurance benefits to their employees. Information-seeking discussions were also conducted with health insurance organizations and their staff. Finally, and most importantly, the staff drew upon the expertise and guidance of the **Working Group** members (see Section 5, p.

49) in conducting analyses, collating existing information, and seeking access to data and other resources essential to the work of the SPG. The multidisciplinary Working Group proved to be an innovative and essential mechanism for framing the materials and issues put before the Roundtable for their consideration.

The experiences of other states were carefully considered by the Roundtable as they crafted their recommendations for stabilizing the health care marketplace and expanding health insurance to uninsured Arkansans. Early in the process, Roundtable members expressed a clear desire "not to re-invent the wheel," and looked beyond the borders of Arkansas for lessons learned by others. Other states' attempts to expand public coverage were examined, including alternative strategies to obtain 1115 Medicaid waivers and expansions of SCHIP programs. They also reviewed efforts by other states to forge public–private sector partnerships, such as programs that allowed employer buy-in to public health insurance coverage, premium subsidies by the state to employers and employees, strategies to utilize purchasing pools, and state and local tax programs designed to provide incentives to employers to offer health insurance coverage to their employees.

3B. HEALTH CARE MARKETPLACE

There is an overall need for expansion of the health insurance products currently offered in the Arkansas marketplace. The lack of sufficient affordable coverage is clearly indicated by the long-standing double-digit rates of uninsurance seen in the state. While many people at all income levels lack health insurance coverage, those of lower income (<200% of FPL) are disproportionately affected.

As with the rest of the United States, Arkansas is experiencing a softening economy and a fairly bleak short-term economic forecast. A number of employers have announced recently that they are curtailing operations within the state and/or are withdrawing entirely. In light of increasing premiums and other costs of doing business, many of the remaining employers are faced with the difficult decision to either reduce premium costs by offering a lessened benefit or eliminate health insurance entirely as a benefit. In the public sector, state government revenues have trended downward during recent quarterly reports and forecasting officials have predicted this downward spiral will likely increase in magnitude in coming months. A number of state agencies have experienced across-the board budget reductions; more of these are likely forthcoming if this trend continues.

Geographically, the provider market was historically concentrated in central Arkansas with referral patterns directed to major tertiary providers in and around the capitol city, Little Rock. However, growth in other areas of the state has occurred in recent years, notably in northwest Arkansas, which has experienced a robust economy and lower than average unemployment. There have been significant increases in the number of primary care and specialty providers establishing practices outside of Little Rock, further decentralizing the health care marketplace in Arkansas.

While the provider economy in northwest Arkansas has grown, other areas of the state have not been as fortunate. Arkansas remains a largely rural state with numerous medically underserved areas. Over half the state has been designated as a medically underserved area.

Disproportionately large segments of the population in these areas are uninsured and unemployed and few industries choose to relocate operations in this region.

Many health care providers in these rural areas are in the midst of an acute financial crisis due to decreased revenue streams and increased amounts of un-reimbursed care. A number of hospitals and health care facilities in these regions have ceased operation in recent years, many of those remaining report significant financial problems. As a result, recruitment and retention of physicians and other health care workers to these regions has been very difficult.

Private Health Insurance in Arkansas

While ~25% of Arkansans receive their health care through some type of managed care arrangement between their provider and insurer, the predominant mode of insurance in Arkansas is through preferred provider organizations (PPOs) that have discounted fee-for-service (FFS) reimbursement contracts with physicians and hospitals.[17] Although long predicted, the significant penetration of tightly managed care and other financing and risk control mechanisms designed to restrict utilization and costs (e.g., highly structured gatekeeper health plan models and capitated reimbursement) seen in other areas of the US has not occurred in Arkansas.

The private insurance market in Arkansas has only three entities maintaining significantly active health maintenance organizations (HMOs)—Arkansas BlueCross BlueShield (ABCBS), in partnership with Baptist Health Systems; QualChoice QCA, which has provider agreements with St. Vincent's Hospital System and the University of Arkansas for Medical Sciences; and United HealthCare of Arkansas. Of the three, ABCBS covers by far the most lives and is the largest insurer in the market. While other regional and national companies have product lines in the state (e.g., CIGNA and Aetna) and present significant competition for the PPO and individual market, more than 50 of the approximately 500 companies eligible to underwrite health insurance in the state have elected to leave the Arkansas health insurance market within the past 2 years, presumably because of increased cost pressures and inadequate profitability. Among those companies that remain, products are being pared if they represent high-risk and/or unprofitable product lines. Similar to the national experience, Medicare managed care has also seen the two remaining providers of Medicare managed care in Arkansas (ABCBS and United) withdrawing from the state market after December 31, 2001.

Like many states, Arkansas has recently witnessed pronounced annual increases in health insurance premiums.[18] These increases are attributable to several factors: the generally poor health status of our citizens, rapidly rising service costs and increasing use of pharmaceutical and other new technologies, the difficulty in health care coordination in rural areas, and limited employer participation in the health insurance market. While previous studies have suggested low per-member per-month costs,[19] recent assessments show that premiums for the Arkansas market are at or above the national average.[20] While more than 10% of the eligible carriers have exited the market,[21] the remaining carriers are building all risks into the premium costs of health insurance contributing to rapidly rising costs.

About one-fourth of Arkansas's private-sector employers offer health insurance benefits through a self-insurance mechanism. This percentage is only slightly below the national average of 26.5%.[22] Consistent with national experience, larger Arkansas firms self-insure to a far greater degree than their smaller counterparts; 64.7% of firms with >500 employees self-insure while

<10% of firms with <50 employees self-insure. This affects the Arkansas health insurance market in several ways. First, under Federal ERISA statutes, self-insured firms' benefit plans are not subject to the oversight of state agency regulation. Second, by self-insuring their employees, these employers effectively reduce the number of potential enrollees for health insurance companies and limit the attractiveness of the market for fully insured carriers.

Health insurance plans in the state are subject to regulation by the Arkansas Department of Insurance. Carriers have historically been required to offer at a minimum, a statutorily mandated scope of benefits. This list of mandates has increased in number since its inception, now including such services as *in vitro* fertilization. The requirement that health plans offer this complete slate of benefits was pared back by the Health Insurance Choice Act, passed in the Arkansas General Assembly of 2001 primarily to help contain escalating insurance costs. This Act allows consumers to select insurance policies that offer less than this full scope of mandated benefits. However, to date, no carriers have made any such policies available.

Other recent significant changes in the state's regulatory environment include the Health Insurance Purchasing Group Act of 2001, which allows small employers to pool purchasing power as non-profit purchasing pools and the Rural Health Access Pilot Program, which is a demonstration program allowing communities to organize and purchase insurance as a large group to achieve cost and administrative efficiencies, increase access to care, and stabilize local healthcare systems. It is premature to measure the impact of these statutes.

Public Health Care Assistance in Arkansas

Historically, Arkansas provided public support through Medicaid at the minimum level of Federal requirements. However, in the past decade, efforts to increase the availability of health insurance in the state, although limited by the lack of state-specific data to guide empirically based expansion, have resulted in increased coverage particularly for children and adolescents. The Soft Drink Tax of 1992 provides for a significant portion of the state's Medicaid program, including care of children and pregnant women, in addition to other Medicaid services including those for the disabled and elderly. Medicaid coverage for medical services was selectively expanded based upon the recommendations of the 1993 Governor's Task Force for Health Care Reform.

In 1996, Governor Mike Huckabee established the ARKids First Program as a Section 1115 Medicaid waiver to the Federal Social Security Act. This program provides health insurance to children from families with annual incomes ?200% of the FPL. Since its inception in March 1997, an expansion covering ~75,000 children of the targeted 90,000 uninsured children at the time of initiation has been achieved. ARKids First offers participants a benefits package that is similar to the Arkansas State and Public School Employee Health and Life Insurance Program, and while there is no deductible, a small co-payment is required for prescription drugs and office visits. Through the 1115 waiver, a majority of the coverage is through the Medicaid program while a small component of the program—coverage to 16–18 year olds above 100% of the FPL—is through Arkansas's State Child Health Insurance Program (SCHIP) allotment.

Recently, the state has folded its traditional Medicaid program into ARKids so that two coverage options are available to enrollees. ARKids A (formerly Arkansas Medicaid) offers complete benefits coverage to children in households through age 6 with less than 133% of the FPL and

aged 6–18 years in those with household income < 100% FPL. There are no co-pays or premiums required in the ARKids A. ARKids B provides coverage for children in households with incomes between the ARKids A eligibility level and 200% of the FPL and with a co-pay/deductible structure that resembles a traditional health insurance plan. Children from households with incomes <100% of the FPL are also eligible for ARKids B and may choose to enroll their children in this program, despite the lower benefits and increased cost as compared to part A. Ongoing studies to better understand the issues surrounding this event and efforts to appropriately enroll children are underway including a single enrollment form, increased education, and continued parental assessment of program desirability.

The ARKids First program has received national recognition. Much of its success is due to the use of innovative marketing and enrollment mechanisms. Intense media coverage, especially through television and radio spots and newspaper advertisement was solicited at the inception of the program. Governor Huckabee has served as a vocal advocate and spokesperson. Outreach campaigns were conducted with the assistance of advocacy groups such as AACF and most recently by a program underway to utilize school nurses to identify and enroll eligible children. Enrollment procedures have been streamlined with widespread and ready availability of applications. Many providers maintain staff to identify eligible children and assist their parents with enrollment; the requisite 6-month waiting period following private sector insurance is waived if a precipitating medical event is involved.

Unlike many states that have had difficulty establishing an adequate provider network, Arkansas physicians and hospitals have been eager participants in the Medicaid program. Although the amount reimbursed by Medicaid is usually less than that from commercial payers, the ability to submit all claims electronically to Medicaid (through an affiliation with Electronic Data Systems) with an average 3-day payment processing has resulted in attractive cash flow for providers and ensured programmatic participation by providers.

For adults aged 19–64 years, the available public health insurance programs are very limited. Currently, the Medicaid program is not available to individuals in this age group who do not meet categorical qualifications (i.e., blind, disabled, or medically needy). Also, asset limits of $2,000 prevent eligibility for many impoverished, medically needy individuals who own their own form of transportation or have other disqualifying assets. Finally, these individuals only qualify for Medicaid if they have an income <25% of the FPL. Efforts are underway at the state level to consider increases in income eligibility for Medicaid and to assess the impact of the asset limitation on enrollment. However, inadequate support of policy development and lack of accurate projections of the costs and budgetary impact associated with expanded eligibility have led to governmental inaction.

Arkansans with pre-existing conditions who can no longer afford traditional health insurance have only one option—Arkansas's Comprehensive Health Insurance Pool (CHIP). Arkansas's high-risk insurance pool was created by legislation in 1995 and became effective in July 1996. This minimum coverage guaranteed-access major medical policy is funded through a combination of mandatory assessments to insurance carriers and premiums paid by policyholders. These premiums are capped by statute at 150% of individual new market rates.[23] As of May 2001, there were 2,447 enrollees in the Arkansas high-risk pool. Many individuals report that despite the rate cap, the premiums charged for new market rates for individuals with chronic or costly conditions are prohibitive. Thus, the high-risk insurance pool reportedly serves

predominantly the more affluent, who are unable to achieve insurance in the open market but can afford the state-subsidized, albeit still high-cost, option.

Uninsured Arkansans also are able to obtain assistance with health care through a variety of private non-governmental entities such as churches, philanthropic groups, and the Arkansas Medical Society, which has established a voluntary referral network through which participating physicians will treat qualifying medically indigent persons without charge.

3C. RELATIONSHIP BETWEEN FINDINGS AND POLICY DELIBERATIONS

The secondary and primary data available to the Roundtable (see Sections 1, p. 8; 2, p. 21; and 5, p. 49) guided the development of recommended mechanisms for stabilizing the state's health insurance market and expanding coverage to uninsured Arkansans.. Priority was given to the proportionately high number of low-income (<200% FPL) uninsured Arkansans. The diverse demographic mixture of the state required that the plan include both employer-based health insurance and publicly funded programs to reach the target populations. To address the acute and chronic health needs of Arkansans, the Roundtable strongly supported the position that a plan should consist of a basic benefits package that included inpatient and outpatient services, prescription drugs, and preventive care.

From the available information, approximately 400,000 of the 2.6 million Arkansans lack health insurance. Most of the uninsured are in households that make <200% of the FPL. The profile of uninsured Arkansans include children and adults in families that have full-time working adults, but that lack a mechanism to obtain health insurance. Fortunately, despite the fact that the median Arkansas household income is below 200% of the FPL, ~80% of adults are covered through private health insurance mechanisms.

Findings from the information on the health insurance marketplace informed the Roundtable in their deliberations surrounding what type of expansion coverage to recommend. Two specific needs were identified—first, a minimum benefits package that protects individual **access** to the healthcare system; and second, a more traditional insurance strategy that protects individuals and their **assets** from catastrophic losses due to unforeseen events.

A program that addresses **access protection** helps to ensure the ability of lower income individuals to attain needed preventive, acute, and chronic care. From household information obtained (Section 1), many individuals are not adequately treated for conditions that could be prevented or ameliorated but present later in the stage of their disease for more costly and less effective care.[8] Predominantly a "safety-net" insurance strategy, access protection is needed to ensure minimal health needs are met for all citizens of the state.

A program that is designed for **asset protection** provides coverage for expensive and ongoing medical care and to protect the economic security of individuals who may have possibly catastrophic or chronic medical care needs. Asset protection was identified as a desire for individuals who are risk averse and/or who have attained minimal access protection and also desire further insurance against unpredictable health events.

The Roundtable supported a combined strategy based on these assumptions. First, strategies targeting the uninsured low-income Arkansans would achieve access protection by expanding the Medicaid program and subsidizing employers with low-income uninsured workers. Second,

strategies to stabilize and expand both access and asset protection would be achieved through the private health insurance system that can enable insured Arkansans to have continued health and financial security. As described in Section 4, such a multi-pronged strategy is necessary to ensure basic services and meet the diverse demands of Arkansans.

4. OPTIONS FOR EXPANDING COVERAGE

4A. INTRODUCTION

Obtaining affordable health insurance has been a challenge for Arkansas's 2.6 million citizens because of the state's large rural population, limited numbers of providers in rural areas, cultural diversity, and an economy dominated by small businesses. Most Arkansans live and work outside of the relatively few metropolitan areas,[1] reflecting its low population density, which limits efforts to foster competition in the health care field and contain costs. Previous studies have documented that insurance coverage is critical to seeking and receiving appropriate treatment for most conditions.[2]

The lack of health insurance for Arkansans has a direct and negative effect on both the health of the state's citizens and its economy. Lack of health insurance is a contributing factor to Arkansas's poor health status, with an age-adjusted death rate ~20% higher than the national average. Arkansas's economic base is one of the poorest in the nation. With a household median income of $32,714 it ranks as the 48th lowest when compared with other states and the national median income of $41,343 per year.[6] Thus, over half of all households in the state make <200% of the FPL ($35,300 per year for a family of 4).[5] The average per capita income is $16,713, compared to a national average of $21,684.[1] This is largely because of an economy based upon agricultural, transportation, and small- to moderate-sized manufacturing businesses. Employee benefits, including health insurance, have historically been less frequently available in lower-wage jobs. Even when offered, the employee component of the health insurance, particularly for family coverage, may exceed their ability to pay.

The economic effect of those without health insurance on Arkansas is substantial. Individuals without health insurance are receiving care in emergency rooms, hospitals, and clinicians' offices across the state; however, they frequently have no means to pay for these services. Efforts to secure payment results in many households declaring personal bankruptcy—the #1 cause of bankruptcy in Arkansas is unpaid medical bills—and has a subsequent direct negative impact on the communities across the state. Because many of the uninsured are in the medically underserved areas of our state, the health care system is not easily able to absorb the costs of uncompensated care and is forced to pass these costs on to those with insurance, or the system ceases to exist, as evidenced by the many rural hospitals and rural providers that have closed.

Roundtable Strategies and Assumptions

The charge to the Roundtable of the Arkansas Health Insurance Expansion Initiative (Arkansas's SPG) was to assess options and prioritize strategies to ensure that Arkansans have basic medical coverage—hospital and physician services, and prescription drug benefits—and to suggest recommendations for stabilizing the health insurance marketplace. The 21-member group

represented perspectives of purchasers, consumers, and providers/insurers. The Roundtable was supported by the SPG staff and a multidisciplinary, broad-based Working Group. Members of an Observer Group were also available during deliberations. See Section 5 for full details on governance and process (p. 49).

The SPG members realize that no simple or single approach to expanding health insurance coverage in Arkansas exists. Through Roundtable deliberations the following assumptions about provision of health insurance in Arkansas were accepted.

General Assumptions

- High-income Arkansans (>400% FPL) who are not insured were a lower priority in this strategic plan.
- Recommended solutions included employer-based health insurance, publicly funded programs, and strategies for the self-employed.
- Solutions must address both the uninsured and those whose continued insurance coverage is "at risk" or "unstable".
- "Basic benefits" that should be covered include outpatient and inpatient services, prescription drug benefits, and preventive care.

Assumptions about Families

- Most families need health insurance coverage.
- Some families will not participate in health insurance programs.
- Families can afford to pay 3%–5% of their total income toward health insurance costs.
- An income threshold exists below which families have limited capacity to contribute to health insurance premiums (~200% of the FPL).
- An income threshold exists below which families have no capacity to contribute to health insurance premiums (~100% of the FPL).

Assumptions about Employers

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

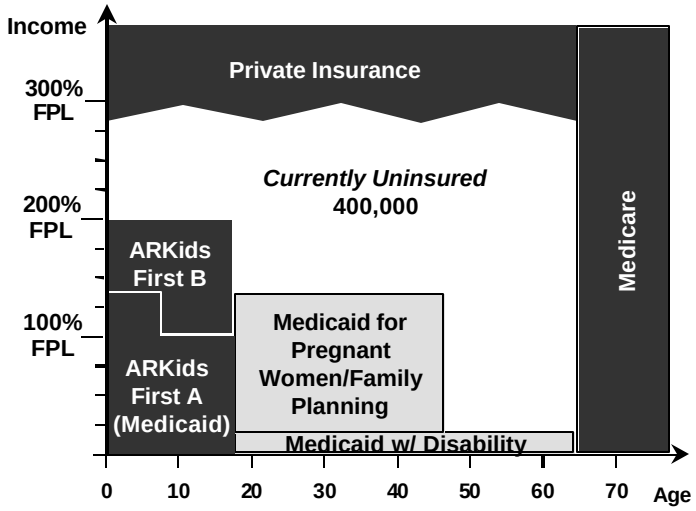
The Roundtable evaluated all available options for health insurance stabilization and expansion in Arkansas. Each strategy was thoroughly evaluated based upon the principles that options selected should accomplish the following.

- Stabilize current health insurance coverage levels
- Build on existing structures and consider new/creative solutions
- Maximize use of available public funds
- Focus on those with greatest need first
- Ensure saleable solutions
- Ensure affordable solutions

- Focus on joint responsibility—individual, employer, government, and provider
- Include prevention and wellness to avert avoidable costs

The options summarized on the following pages represent a multifaceted approach to stabilize and expand health insurance coverage in Arkansas. Figure 17 shows current program eligibility including Medicaid/ARKids for children and adolescents 0–18 years of age, Medicaid for adults between 19 and 64 years of age who are both disabled (>6 months) and impoverished (<25% of the FPL), Medicaid coverage for pregnancy-related care, Medicare for seniors over 65 years of age, and private sector health insurance for those in more affluent households. Subsequent options described address both the stabilization of the private insurance market and strategies to address the 400,000 uninsured Arkansans.

Figure 17. Existing Insurance Programs in Arkansas



4B. INSURANCE EXPANSION OPTIONS

Expansion of Limited Benefits Medicaid Program

Statement of Need: Approximately 78,000 adult Arkansans live in households with annual incomes below 100% of the FPL and lack health insurance. These individuals do not have the financial income either to participate in employer-based health insurance (if offered) or to purchase health insurance in the individual market.

Target Population: Uninsured adults aged 19–64 years who earn ?100% of the FPL could be eligible for a Medicaid program that offers limited benefits.

Mechanism of Coverage: Expansion of a limited benefits package to individuals could be achieved through a Medicaid 1115 statewide waiver.

Existing/Historical Activity: Arkansas's current Medicaid program does **not** offer basic benefit coverage unless the adult individual has a disability lasting greater than 6 months, **and** has a household income below ~$5,000 per year, **and** has total household assets worth less than $2,000 (income and assets depicted for a family of 4). Arkansas's Medicaid program does provide insurance coverage for pregnancy and childbirth to women in households earning below 133% of the FPL. Through ARKids (A and B), children are now eligible if they have not been insured in the previous 6 months and if they reside in households with incomes below 200% of the FPL.

Other states have funded Medicaid programs for citizens who earn less than 250% of the FPL and these states have attained federal matching funds through Medicaid waiver processes. Requirements for approval from the Center for Medicare and Medicaid Services (CMS, formerly

the Health Care Finance Administration [HCFA]) include generation of the state match from a tax base, categorical eligibility determination (e.g., uninsured and poor), and cost-neutrality (e.g., the program must cost no more than estimated expenses if traditional Medicaid expansion were pursued).

The Arkansas Tobacco Settlement Proceeds Act of 2000 allocated approximately $17 million for Medicaid expansion: $7.5 million for expansion of a limited benefit package to 19–64 year olds, $3.5 million to extend pregnancy coverage from 133% to 200% of the FPL, $2 million for increased reimbursement to rural hospitals, and $4 million for prescription drugs for the elderly. Of these funds, the $7.5 million available for state match will generate at total of $30 million for clinical services by drawing down federal matching funds. Current plans are to expand Medicaid through automatic eligibility to approximately 30,000 eligible food-stamp recipients. Food-stamp recipients were selected as the target population due to ease of administration and limited requirements for new eligibility determination.

Roundtable discussions of current plans for expansion have identified the lack of hospital benefits as a major deficiency in this expansion proposal. The addition of several days of hospital service (e.g., 7 days per year) would provide needed coverage and avoid continued cost shifting of uncompensated hospital care to those with health insurance.

Cost: Cost estimates are dependent upon administrative costs, uptake rates, and benefit design. For the purposes of this strategic plan, a 5% administrative cost is assumed based on current Arkansas Department of Human Services (DHS) experience, a 100% uptake rate (maximum assumption; DHS experience 50%–60% uptake), and the benefit options outlined in Table 3.

Table 3. Program-Specific Characteristics for Limited Benefits Medicaid Program

Benefits	6 clinic visits/year 2 outpatient surgeries/year 2 prescriptions/month 7 days' inpatient coverage
Cost per insured*	$1,500/year
Number of covered lives	78,000
Total annual costs	$117,000,000
State match	$31,590,000
Administrative Costs	$5,850,000
Total state costs ‡	$34,515,000

*Assume pregnancy costs are not included due to existing Medicaid coverage.

‡Total state costs determined from clinical services (27% state match) and administrative costs (50% state match).

With the $7.5 million available from the Tobacco Settlement Proceeds Act of 2000, additional annual state funds required would be ~$27 million. (Selection of benefit options for Medicaid expansion under 100% of the FPL will likely have an impact on options for expansion to 100%–200% FPL, described below, p. 40.)

Not addressed in this plan is the elimination of cross-subsidization for care to the uninsured, which would be significantly reduced by expanding the safety net insurance program. This option would also reduce the necessity to cross-subsidize for hospital care in addition to outpatient services.

Funding Source: A majority of the program costs would be provided by federal matching funds through the Medicaid program. Arkansas would be responsible for $0.27 of each program dollar and $0.50 of each administrative dollar, with the remainder supported by the federal Medicaid program. Potential sources of state funds have been suggested.

1. "Sin tax(es)"—tobacco, beer, wine, or alcohol taxes to generate necessary state funds
2. Special medical services tax—levied on payers for clinical services including privately insured, ERISA plans, and individuals above 100% FPL
3. State general tax—sales tax or alternative source
4. Employer payroll tax—levied on employers not providing employer-sponsored health insurance

Specific strategies to generate the required state match through taxation will require modeling from the Arkansas Department of Finance and Administration (DFA) and political consultation prior to selection.

Anticipated Impact: Establishing a "safety-net" health insurance program through Medicaid will capture available federal support and cover up to an additional ~78,000 Arkansans with health insurance. Uptake will be determined by individual need and ease of enrollment and will likely range from 50% to 80% of the 78,000 Arkansans eligible. Through increased coverage, uncompensated care will decrease and upward cost pressure on existing health insurance contracts will be minimized.

Strategic Recommendation: Basic Medicaid benefits health insurance should be expanded to uninsured individuals up to 100% of the FPL. A strong recommendation for this option is the inclusion of hospital coverage benefits. Funds from the Tobacco Settlement Proceeds Act of 2000 should be considered for use in this type of expansion effort.

Establish Public–Private Sector Partnership Program through SCHIP Waiver

Statement of Need: Approximately 335,000 adults in Arkansas have household income of between 100% and 200% of the FPL. Among these persons, ~37% or ~124,000 lack health insurance. A majority are working full time in jobs with wages that are inadequate to enable employee and/or family participation in either employer-based health insurance (if offered) or the individual insurance market. Some of the uninsured are married with spouses who are covered through employer-based health insurance, but these families still lack sufficient household income to pay the employee portion for "family coverage." As a result, these health insurance costs without subsidization are forcing many of the working poor and their employers out of the employer-based health insurance market.

Target Population: Uninsured adults (19–64 years) and families with household incomes of 100%–200% of the FPL who work for participating employers could be covered through a partnership between the public and private sectors.

Mechanism of Coverage: A limited benefits health insurance package could be expanded to employed individuals and their spouses through a voluntary partnership program between employers and the state via a Federal SCHIP waiver.

Existing/Historical Experience: Congressional concern to address the problems of the 42.6 million Americans without health insurance has led to Federal support of increased state flexibility in designing SCHIP programs, which were originally developed to provide health insurance coverage for children only. Most states (39, including Arkansas and the District of Columbia) now provide coverage to children in families who have incomes of ?200% of the FPL. The largest portion of uninsured adults in Arkansas falls between 100% and 200% of the FPL, commonly known as the "working poor". No publicly subsidized coverage exists, yet these

families do not earn enough to afford employer-based coverage, if offered. States have recently been allowed by the federal government to utilize SCHIP funds to expand health insurance to parents of eligible children and a number of states' requests to include non-parent adults are under consideration.

At present, Arkansas has **not** exercised its option to draw the maximum federal funds allotted to the state under the SCHIP program (~$54 million for federal fiscal year 2000). The ARKids First program covers children aged 0–18 years up to 200% of the FPL whose parents/guardians do not have access to employer-based health insurance. The ARKids program utilizes a small portion of the SCHIP funding with a majority of the funds coming from the Medicaid program at the traditional $0.27 state share matched with $0.73 federal funds for each dollar of clinical care. Recent reports from the Bush Administration of greater state flexibility in their use of Medicaid and SCHIP funds combined with implementation of the Medicaid expansion discussed above (p. 38) position Arkansas to propose a new and innovative mechanism to offer health insurance coverage to adults.

A few states have received approval to use Medicaid funds to provide coverage to employed adults. Requirements for waiver approval have usually included 1) employer contributions of more than 50%–60% of cost for the employee, 2) maintenance of existing effort, and 3) guarantees surrounding minimum benefit packages and co-payments that are determined by a sliding scale. At present, the likelihood of approval for a program providing coverage to the working poor was diminished due to the very low eligibility threshold for adults in Arkansas; however, successful implementation of the expansion described above (p. 36) would establish a substantive safety net insurance program. Subject to CMS approval, Arkansas is now poised to pursue a Federal waiver to provide coverage to the working poor by matching state funds with federal SCHIP funds at a $0.19 state to $0.81 federal match ratio. Just as in the Medicaid program, CMS would require the state match to be generated from a tax base. However, unlike the Medicaid program, SCHIP programs have more flexibility to utilize co-pays and premium contributions to off-set costs of the program.

Employer participation has been a key requirement for successful waiver approval in other states. From information collected through the Arkansas SPG, less than 30% of small businesses (<50 employees) offer health insurance coverage. In addition, privately insured groups are usually required by contract to attain participation rates at or above 80% of eligible employees. Finally, one of the largest employers in Arkansas, and one with a significant portion of low-wage employees has achieved 100% employee health insurance coverage through mandatory participation of employees.

Efforts to attain CMS approval and achieve an 81% subsidy through federal matching funds for health insurance costs will be enhanced by 1) employer and employee participation, 2) mandatory participation of all employees in each participating employer groups, and 3) optimal extension of benefits to dependent members in the family. Maintenance of current efforts and benefits will be required for children and adolescents (through the ARKids program) and for pregnant women (through the current Arkansas Medicaid program).

Cost: As with the proposed Medicaid expansion, cost estimates are dependent upon many factors. For the purposes of establishing fiscally conservative projections, we assume a 100% participation rate by employers, 100% mandatory employee participation for each employer, and

a 100% participation rate for family dependents. Although highly unlikely, these assumptions allow maximal assessment of cost-projections (Table 4).

The benefit package modeled below represents the Roundtable's preferred limited benefits package for Medicaid expansion, including hospital care, for persons living at less than 100% FPL. It is highly unlikely that federal approval could be achieved for a richer benefit package for the 100%–200% FPL, if a leaner package is selected for those at <100% of the FPL.

Table 4. Program-Specific Characteristics for Medicaid/SCHIP Expansion

Benefits	6 clinic visits/year 2 outpatient surgeries/year 2 prescriptions/month 7 days' inpatient coverage
Cost per insured*	$1,500/year
Number of covered lives	124,000
Total annual costs	$186,000,000
State match (19%)	$35,340,000
Administrative costs (5%)†	$9,300,000
Total costs ‡	$39,990,000

*Assume pregnancy costs are not included due to existing Medicaid coverage.
† Administrative cost estimates are 5% of total program costs.
‡Total employer costs determined from clinical services (19% state match) and administrative costs (50% state match).

Funding Source: The Roundtable proposes a public–private partnership program through which employers, employees, and government bear financial costs in establishing a health insurance program for the working poor. Participating employers may voluntarily pay a state tax if they desire to participate in subsidized health insurance coverage. This tax would serve as the source for the state match and draw a corresponding federal match through an SCHIP waiver. The majority of the program costs would be borne through federal matching funds in the SCHIP program. The State of Arkansas, via an employer tax, would be responsible for $0.19 of each clinical program dollar and $0.50 of each administrative dollar; these funds would be collected through a voluntary "employer tax" on participating employers to achieve the total state costs associated with this program (i.e., the $0.19 state match for clinical services plus the $0.50 match for administrative costs). Employers and employees would be responsible for the state match for employee and family coverage, respectively. Open enrollment would occur on an annual basis and participation would incorporate co-pays and deductibles for utilization management. This program would allow employers who are not currently offering health insurance coverage to provide coverage at a substantially reduced rate and would maximize utilization of public funds. The ultimate goal of the program is for all employers and their employees to participate in at least a basic health insurance benefit plan.

Administration of this program could be accomplished through one of three different mechanisms available to the Arkansas DHS. First, health insurance premium payments for eligible workers and their families could be provided to employers for them to identify, pursue, and purchase health insurance in the private market. Second, DHS could manage the program similarly to the ARKids First expansion with centralized claims processing. Finally, DHS could enroll participating groups into an organized pool of participating group insurance carriers similar to the Arkansas State and Public School Employee Health and Life Insurance Program. The Roundtable has identified the high time and administration costs to the employer of managing the program and the efficiencies achieved by DHS in outreach and delivery as reasons to support one of the latter two options. These DHS efficiencies include high medical-loss ratios, low administrative costs, and timely electronic provider payments.

In assumptions made based upon information available to the Roundtable, there is an acknowledgement that a threshold exists that limits the ability of both the family and the employer to contribute toward health insurance coverage. In addition, the desire to avoid adverse behavior of individuals or employers including the abandonment of private health insurance for those in the upper income/revenue (e.g., near 200% of FPL) to enroll in the program, and reduction in wages to become eligible for the no-cost Medicaid program (below 100% of the FPL) will require the establishment of a "sliding-scale" for households to determine eligibility. For households, the established use of the FPL could be employed.

Anticipated Impact: This program has the potential to enable employers to receive subsidies for providing health insurance coverage to more than 124,000 Arkansans. The ultimate success of the program will be determined by the level of interest of employers in participation, the ability of DHS to establish an efficient mechanism for program administration, and successful outreach to encourage participation. Through the reduction in numbers of uninsured Arkansans and the incorporation of desired benefits into employer compensation packages, indirect results of this program would include reduction in cost-shifting of uncompensated care to currently insured individuals, stabilization of the healthcare system, and enhancement of workforce stability for participating employers.

The minimum benefits package designed to ensure access, but be significantly different from available private insurance options, combined with a waiting period (e.g., 6–12 months) will minimize erosion of private sector health insurance coverage.

Strategic Recommendation: A bridging public–private sector health insurance program should be established with employer/employee/government participation using an SCHIP waiver process. Subject to CMS approval, employer participation would be voluntary but would require 100% employee coverage. Family coverage would be incorporated and supported by the employee with governmental subsidies. Sliding scales would minimize crowd-out and equity issues. An anticipated start date would necessarily follow legislative action for authorization. Employees who earn below 100% of the FPL and work for participating employers would be included in this strategy.

4C. STABILIZING OPTIONS FOR THE HEALTH INSURANCE MARKET

Establish Community-Based Purchasing Pools/Cooperatives

Background: Most adult Arkansans (>80%) who have health insurance obtain it through their employers. However, a large proportion of Arkansans work for small businesses (<50 employees) that are unable to allocate personnel to develop employee benefits and/or obtain the type of competitive health insurance contracts afforded to large employers. Aggregating small purchasers of health insurance into a large block of purchasers can, theoretically, increase efficiencies associated with providing coverage to employees and can increase the strength of the block's negotiating power in the health insurance marketplace.

Statement of Need: Fewer than 30% of Arkansas's small employers offer health insurance (the 2nd lowest rate among this group of employers in the nation). These employers need assistance to both increase their administrative efficiency and marketplace negotiating power. Organizing small employers into larger purchasing pools would address these issues.

Target Population: Uninsured employees and/or currently insured employees who are at risk of losing coverage and who work for small businesses in communities that will organize, monitor, and support a purchasing pool for health insurance benefits can be covered through community-based purchasing cooperatives.

Mechanism of Coverage: Through Act 924 of the Arkansas General Assembly of 2001, purchasing pools were authorized to form and enroll individuals to achieve aggregate purchasing power. Minimal guidelines or restrictions are placed on these purchasing pools, the exception being the requirement to have 1,000 covered lives within one year of initiation. Small groups may organize into a pool, agree on a defined benefit package, and solicit bids from existing insurance carriers. Negotiated price and service requirements can be managed by a purchasing pool administrator under the direction of a board or other appropriate oversight authority.

Existing/Historical Activity: Historically, purchasing pools organized around "associations" or types of business have universally failed due to an inability to control for adverse risk selection. This lack of selection control created a non-viable actuarial path of enrolling businesses who employ persons with undisclosed but existing medical conditions and who then generated an immediate requirement for service payments.

Association or industry-type purchasing pools have also been undermined by their interest in serving their members and by the relatively lax enrollment criteria frequently incorporated. Open enrollment, no waiting period, no pre-existing condition limitation, and minimal monitoring were frequently valued by potential enrollees, but eroded the actuarial base necessary to support the purchasing pools over time.

To prevent these problems from occurring in newly established community-based purchasing pools, tight controls on enrollment can address the adverse risk selection, but at a cost to enrollment growth. Incorporating a specified 2-week annual "open" enrollment (e.g., like large employers sometimes offer), waiting periods for coverage of select conditions, coverage restrictions for pre-existing conditions, and local management and monitoring can decrease the inappropriate enrollment of "sick" individuals only after progression of their illness.

Currently, three Arkansas communities are developing local community networks to address access issues as part of the Robert Wood Johnson Foundation (RWJF)-funded Arkansas Southern Rural Access Program. In addition, many communities have hospitals, community health centers, or other safety net providers that can serve as a nucleus for administering a purchasing pool. Nationally, several communities are implementing purchasing pool strategies that incorporate components of the methodology noted; however, their experience is too premature to judge their success. Finally, with the Arkansas Department of Health's Hometown Health Initiative's asset mapping, community-based purchasing pools may give those communities that identify insurance coverage as a top priority a local mechanism to expand health insurance coverage to currently uninsured individuals.

Cost: A marginal administrative cost would be required of the organizing entity. For employers currently purchasing insurance in the group market, a reduction in costs of ~10% could be achieved; for employers/employees not participating in the health insurance marketplace, purchasing pools would provide an efficient and less costly route to attain private sector health insurance that what is currently available through small group policies or individual coverage.

Funding Source: Minimal additional funding would be required to initiate these pools. However, organizational and start-up administrative costs would be required of an "interested" party. To ensure long-term viability and avoid the accumulation of adverse risk, innovative and, ideally, subsidized funding strategies will be required. For those counties or hospitals that have a tax base to support indigent care/hospital costs, federal matching Medicaid funds could potentially be used to subsidize purchasing pool enrollees' premiums. The self-employed or individually insured could be allowed to participate, but under the enrollment and coverage restrictions suggested above and with appropriate actuarial projections.

Anticipated Impact: Communities that organize and pursue purchasing pools with aggressive outreach and ongoing monitoring may reduce the number of uninsured and stabilize their health care systems. Insurance carriers would be attracted to the potential for stable pools of enrollees.

Drawbacks of this coverage option include the threat that individual insurance agents may feel caused by the consolidation of potential clients into pools. Also, based on historical experience, pools based around associations are predicted to fail.

Strategic Recommendation: The Roundtable recommends support of community-based purchasing pools with strong recommendations for management strategies that avoid adverse risk selection and consideration given to obtaining Medicaid subsidies using existing tax bases in select communities. Pre-implementation support will be required to meet the 1,000-member requirement and state technical assistance should also be provided.

Develop Small-Group Reinsurance Strategies

Statement of Need: The private sector health insurance market for small groups is currently unstable; thus, stabilization is needed to avoid increases in the number of uninsured individuals. Rapidly rising insurance costs (annual increases of 20%–35% have been reported) for small businesses in Arkansas threaten to exceed participating small employers' ability to pay for group insurance. Because insurance companies assume greater risk in small group markets due to the potential for adverse risk selection, they are required to offer employer-sponsored insurance to all employees (a guaranteed issue under the Health Insurance Portability and Accountability Act of 1996 [HIPAA] legislation), and the insurer is less able to spread the risk of individuals with specific conditions over a large enrollee base. Thus, small businesses incur a disproportionately higher price for health insurance.

Small-group reinsurance is a recommended strategy from the National Association of Insurance Commissioners to allow insurance plans to "reinsure" their high-risk enrollees, thus pooling the risk and minimizing the variance that negatively affects the cost of insuring all employees within a group. State legislation could be developed that would require insurance companies to reinsure individuals in the small-group market. Through industry-determined selection criteria, "high-risk individuals" would be enrolled with a reinsurance company. Standard cost sharing would be established and companies would be charged per enrolled individual. The Arkansas Department of Insurance would retain oversight responsibility for monitoring participation.

Currently, 22 states operate small-group reinsurance pools with a varied impact on small group markets. Typical management strategies include the identification of a "high-risk" individual from previous years' claims, enrollment with a state-selected reinsurance carrier, establishment of actuarial costs, and management of risk. The typical payment mechanism makes the primary

insurance carrier responsible for the first $5,000 in services and 20% of the next $45,000, with 100% of costs exceeding $50,000 being a reinsured risk in the purchasing pool. Management fees are allocated; however, charges are based upon utilization costs without substantial built-in profit margins.

Strategic Recommendations: A mechanism should be explored by the Arkansas Department of Insurance to develop a small-group reinsurance strategy with mandatory participation of all insurance companies in the state.

Explore Medical Savings Accounts Tied to Group Catastrophic Policies

Statement of Need: One of the Roundtable's key operating principles is that consumers should take an informed and active role in the decision processes surrounding their health care expenditures. When citizens are insulated from this process, they are less likely to appropriately value health care received or demand fiscal accountability by insurers and/or health care providers. Medical savings accounts (Archer MSAs) are a potential vehicle to give individuals more responsibility in pursuing appropriate clinical care and managing expenses associated with their own health care.

An MSA pilot project was authorized by HIPAA in 1996 and by section 213 of the IRS Tax Code and remains in effect. Under this legislation, self-employed persons and employees of business with 50 or fewer employees are eligible to place pre-tax money in tax-deferred accounts. Money from these accounts can then be used by the enrollee to pay for non-catastrophic, routine, health care expenditures (so called qualified medical expenses [QMEs]). To obtain an MSA, the enrollee must also have a portable MSA-compatible, high-deductible, catastrophic health insurance policy.

MSA accounts are primarily funded through pre-tax contributions by the individual, up to allowable limits, which range from $1,600 to $2,400 for individuals and $3,200 to $4,800 for families. The maximum amount that can be put into the pre-tax MSA account is 75% (family) or 65% (individual) of the deductible amount of the accompanying catastrophic policy, which has to be in place **with** the MSA. Either the employer or the employee can make the contribution into the MSA (with the described limits), but only one **or** the other can do so in a calendar year. Additionally, the employer is allowed to pay the catastrophic policy **premium**, but if the employer does not pay the premium, the employee must pay it.

Having individual catastrophic insurance policies instead of group catastrophic policies incurs a long-term risk for participants due to the potential for an individual to develop chronic or costly conditions. While some will benefit by remaining healthy and utilizing their MSA as a savings vehicle, others who develop chronic and/or costly conditions will face escalating individual premiums and/or limits on catastrophic coverage options.

To avoid segmentation of the catastrophic insurance component and isolation of those who are less healthy, the Roundtable strongly recommends tying MSAs to group catastrophic policies rather than individual catastrophic policies. Group catastrophic policies are less expensive to administer, maintain pooling mechanisms for risk, and insulate against risk segmentation rampant in the individual catastrophic health insurance market.

MSAs offer a mechanism to increase individual control and responsibility for expected health care expenditures when individuals are able to systematically utilize tax-deferred investment mechanisms (e.g., individual participation in individual retirement accounts [IRAs]) and are able to project future healthcare costs (e.g., individual participation in cafeteria plans for health expenses). When individuals have to bear the initial costs of health care, it is expected that more appropriate use of health care resources will be achieved, leading to cost containment in the market.

Strategic Recommendation: MSAs are currently structured as individual-level accounts and policies. The Roundtable recommends that the concept of MSAs should be further explored, and that the requisite catastrophic coverage be available primarily through a group policy, not as an individual policy. Clarification in the definition of qualifying medical expenses is also required.

4D. GENERAL RECOMMENDATIONS

General recommendations include ideas for both states and the federal government. These include the following.

- **Additional research needed to improve the US health care system:** With double digit premium increases facing most private health insurance consumers, questions arise regarding the influence of direct marketing by pharmaceutical companies, the cost-effectiveness of new versus existing medications and technologies, and alternative mechanisms to finance and manage health care expenditures. However, funding for research to better understand and empirically support policy development is lacking. Thus, the Roundtable recommends that additional research be conducted to attain a better understanding of the clinical, economic, and social factors influencing the US health care system in order to guide policy development and health care system evolution.

- **Inclusion of scientifically supported preventive services:** The poor health status of Arkansans and high costs of providing care are directly related to lack of support for and low usage of preventive clinical services. Select clinical services have strong scientific evidence and cost-effectiveness studies that support their inclusion in all long-term health maintenance strategies. These services include childhood immunizations (e.g., *Haemophilus influenzae* vaccines which prevent childhood meningitis), mammography for women over age 50 (for early detection of breast cancer), and cholesterol and hypertension screening (for early detection of risk factors associated with coronary artery disease and stroke).

  These high-priority preventive services with strong scientific evidence should be covered by health insurance plans and mechanisms to ensure their uptake should be explored. Prior studies (RAND Health Insurance Experiment [HIE])[24], have indicated that first-dollar coverage by individuals through co-payments or benefit limitations result in markedly reduced utilization. Reduced utilization results in increased frequency and severity of avoidable health conditions, increased medical care utilization, and increases in medical costs. Based upon these findings, the Roundtable strongly recommends that effective prevention strategies be included in <u>all</u> health financing mechanisms and that optimal strategies to ensure appropriate utilization are included. Insurance options should include coverage for and, where possible, incentives to increase appropriate use of services with scientifically proven clinical benefits. Importantly, this list of required services is limited to

those with strong scientific evidence (see Appendix IV); many other services that are frequently described as preventive do not currently have sufficient evidence to support their inclusion in required coverage (e.g., screening chest X-rays) and should be relegated to services available at consumer expense. (See also Section 6B, p. 62, and Section 7A, p. 64.)

- **Optimize federal funds for health care coverage:** New opportunities to fund health insurance and health care are continually appearing. These include new Medicaid benefits (e.g., individuals with tuberculosis), new Medicaid coverage options (e.g., Medicaid/SCHIP waivers), new safety net support (e.g., Health Resources and Services Administration [HRSA]-supported community health centers), and new programs (e.g., Department of Justice programs for drug and alcohol abuse treatment). Arkansas and other states should actively and aggressively identify and pursue these strategies to address critical state needs. (See also Section 6B, p. 62.)
- **Employee wage and benefit annual compensation summary:** Consumers of health care services frequently are not aware of the actual costs of providing health insurance coverage. Through education and with employer support, a uniform wage and benefit annual compensation summary would increase health care consumers' fundamental knowledge of costs and mechanisms of health insurance coverage. (See also Section 6B, p. 62.)
- **Income tax neutrality through uniform exemptions for health insurance/health care expenditures:** About 80% of private health insurance in Arkansas is employer sponsored and both the employer and employee contributions are tax exempt; the remaining 20% of insurance coverage is purchased through the individual market with post-tax dollars. Federal and state tax treatment of insurance costs should be equivalent, regardless of mechanism of purchase. (See also Section 7A, p. 64).
- **Incorporation of prescription drug benefit for persons covered by Medicare:** The Roundtable's general assumptions about adequate health insurance coverage include the requirement for prescription drug coverage as a basic benefit. Federal incorporation of prescription drug benefits into Medicare is required to satisfy basic coverage needs of individuals over the age of 65. (See also Section 7A, p. 64.)
- **Expanded Medicare eligibility through buy-in options for the near elderly and disabled:** Medicare is the major insurance mechanism for individuals over age 65 and some citizens eligible for Social Security Disability Insurance (SSDI) assistance. Hospital insurance (Medicare Part A) is automatic at age 65, with physician services (Medicare Part B) purchased by individuals or Medicaid programs on behalf of the impoverished. Narrow eligibility requirements tied to Social Security Disability allow disabled individuals to become eligible for Medicare 24 months after initiation of SSDI disability payments. Relaxing these eligibility requirements for the disabled and expanding eligibility for the "near elderly" (55–64 years) will increase insurance options to those frequently excluded from private health insurance. (See also Section 7A, p. 65.)

5. CONSENSUS-BUILDING STRATEGY

5A. GOVERNANCE STRUCTURE

The **Arkansas SPG Roundtable** was established in March of 2001 and selected to represent the geographic and cultural interests of the state. Staffed by a multidisciplinary Project Team with oversight of the Principal Investigator, the Roundtable served as the decision-making body for the SPG and ensured involvement of multiple stakeholders (purchasers, consumers, providers, risk managers, and government). This group has guided the development of solutions that provide access to affordable health insurance to all Arkansans and suggested recommendations for stabilizing the health insurance marketplace. To create broad engagement and support, the Arkansas Roundtable consisted of key members representing three perspectives (Table 5).

- **Purchasers**—entities responsible for self-insurance or the purchasing of group health insurance, including large employers, moderate-size employers, small businesses (identified through the National Federation of Independent Business), and public purchasers
- **Providers/Insurers**—entities responsible for direct patient care, and those entities responsible for managing health care risks including both private and public insurers
- **Consumers**—individuals and representatives of consumers who receive care and on whom insurance (or the lack thereof) has a direct economic impact, including individual citizens, families, organized labor, and minority representatives

Table 5. Roundtable Membership

Bill B. Lefler, DDS, FACP Major General, USA (Ret.) Roundtable Chair	**Joseph W. Thompson, MD Roundtable Vice Chair (SPG PI)**	
Consumer Representative	*Provider/Insurer Representative*	*Purchaser Representative*
Yolanda Fields Community Development Coord.	**Larry Braden, MD** Family Practitioner	**Charles Cunningham** Central AR Development Council
Leslie Haber AFL CIO	**Steve Carter, JD** Claims Management, Inc. (Wal-Mart)	**Martha Dixon** Dixon Manufacturer
Don Hollingsworth, JD AR Bar Association	**Kay Durnett** AR State Employees Assn	**Charles Mazander** Mazander Engineered Equip.
Calvin King, PhD AR Land & Farm Development Corp.	**Kila Hau** United HealthCare of AR	**Joseph Meyer** Alltel Co.
Rev. Margaret McGhee New Horizon Church & Ministries	**Robert "Bob" Herzfeld** Herzfeld Life & Health Care	**Lee Pittman** International Paper Co.
Charlotte Schexnayder Retired Publisher/Former State Rep.	**Steve Madigan** Rebsamen Insurance	**Jerry Standridge** Citizens Bank
Ken Tillman Arkansas Farm Bureau	**George K. Mitchell, MD** AR BlueCross BlueShield	**Sandy Stroope** Boat World, Inc.

Roundtable Responsibilities and Activities

Responsibilities of the Roundtable included (1) assuring accurate assessments of current health insurance statistics; (2) fully exploring potential solutions to increase health insurance coverage to Arkansans; (3) reviewing information gained from primary and secondary data analyses; (4) developing and prioritizing solutions for expanding affordable health insurance to currently uninsured citizens and for stabilizing the health insurance marketplace; and (5) reviewing and

overseeing the report to the Secretary of the US Department of Health and Human Services (DHHS).

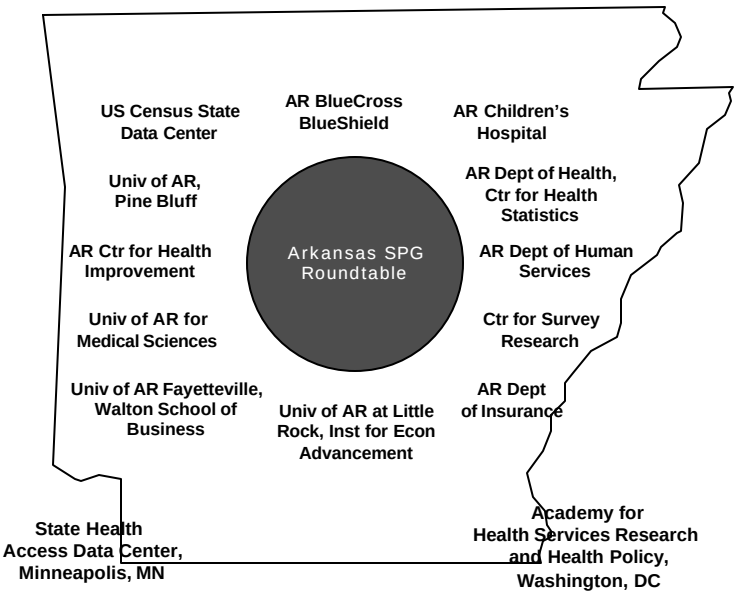
The Roundtable engaged in a process of strategic innovation. The process was not a traditional top-down, strategic-planning exercise. It was a learning process. The group's goal was to not only create a plan but also to create a strategy by focusing on teamwork and communication. This broad-based, iterative process drew from resources around the state in such a way as to create new voices, new conversations, new perspectives, new passions, and a tolerance for experimentation.

The Roundtable met six times between March and October 2001. These 1- to 1½-day meetings were held at a conference center in Little Rock. Attendance at the Roundtable exceeded 85% of all members at the meetings. The agendas for each meeting are available in Appendix III. Additionally, a 2-day educational session was held with the Academy of Health Services Research and Health Policy during the March meeting to facilitate optimal understanding and communication by establishing a common set of terms for use among participants and to update the Roundtable on other state's experiences with insurance reform and expansion.

In advance of the Roundtable meetings, the members were mailed agendas and instructional information. The Chairman guided the process and assured that the members stayed on task and focused on the agenda. During the Roundtable meetings, multiple strategies were used to gain consensus. In additional to traditional methods of didactic presentations and group interaction, the knowledge, opinions and preferences of the members were assessed using an Audience Response System (ARS). Use of this audience polling system maximized group participation by promoting discussion, measuring group comprehension, and allowing for unbiased preference selection. Group consensus was achieved by evaluating aggregate responses. Individual polled response data was kept confidential

On a regular basis during the planning period, the Arkansas SPG received expert technical assistance and consultation from the Working Group (Figure 18 and Table 6). This group vetted all the materials and presentations prior to each Roundtable meeting. In addition, an Observer Group representing the Arkansas Department of Health; the Department of Human Services; the State Health Insurance Commissioner; the Governor's Office; the Arkansas Hospital Association; the Arkansas Medical Society; the Community Health Centers for Arkansas; and the Public

Figure 18. Organizations Represented in the Arkansas SPG Working Group



Health, Welfare, and Labor Committee and the Insurance and Commerce Committees of the Arkansas General Assembly was invited to inform the Roundtable during their meetings.

Table 6. Working Group Membership

Sarah Breshears University of AR at Little Rock	**Creshelle Nash, MD** AR Center for Health Improvement	**Doug Murray** Center for Health Statistics, AR Department of Health
Joe M. "Jody" Crawford Crawford Group Inc.	**Dana M. Perry** AR Center for Health Improvement	**Ron Sheffield, JD** Attorney & Counselor at Law
Mark Evans AR BlueCrossBlueShield	**Beth Anne Petlak** AR Children's Hospital	**John Shelnutt, PhD** University of AR at Little Rock
John Fortney, PhD Univ. of AR for Medical Sciences	**Mike Pickens, JD** AR Insurance Department	**John Shields** AR Insurance Department
Gary Ferrier, PhD University of AR Fayetteville	**Carol Roddy, JD** AR Center for Health Improvement	**Kate Stewart, MD** AR Center for Health Improvement
Gregory L. Hamilton, PhD University of AR at Little Rock	**Amy Rossi** AR Advocates for Children & Families	**Tom Swearingen, JD** AR BlueCrossBlueShield
Ray Hanley AR Dept. Humans Services	**Kevin W. Ryan, JD** AR Center for Health Improvement	**Phil Taylor, PhD** University of AR at Fayetteville
John Hartnedy AR Insurance Department	**Ray Scott** AR Center for Health Improvement & Ray Scott & Associates	**Ebo Tei, PhD** University of AR Pine Bluff
David Higginson Information Systems Consultant	**John Senner, PhD** Center for Health Statistics, AR Department of Health	**Joseph W. Thompson, MD** AR Center for Health Improvement
Drew Kumpuris, MD Private Medical Practice		**John "Mick" Tilford, PhD** Univ. of AR for Medical Sciences
Suzanne McCarthy AR Center for Health Improvement		**Ruth Whitney, JD** AR Dept. Human Services

Characteristics for review of options included the background, statement of need, target population, mechanism of coverage, existing/historical activity, cost, funding source, political viability, anticipated impact, and strategic recommendation.

As a result of this deliberative process, the Roundtable served as an effective decision-making vehicle. Guided by a core set of assumptions, the Roundtable members explored all the options for expanding health insurance coverage and they modeled the impact of proposed solutions using vetting criteria reflecting the intent of the Roundtable principles. Based on this work, the Roundtable is proposing a set of recommendations for health insurance expansion to the Governor of Arkansas and US Secretary of DHHS through this report.

A final survey of the Roundtable was conducted to evaluate:

- membership recruitment
- issue orientation
- logistics
- leadership
- role of observers
- roundtable interaction
- use of audience response system
- materials
- facilities
- reimbursement fees

A review of Roundtable survey results indicated that most members felt their experience on the Roundtable was excellent when compared with other groups on which they had served. Members of the Roundtable believed they provided an important stakeholder or grassroots perspective to the plan and individually contributed to the process. Over half indicated that their

attitude/opinion toward the uninsured had changed during their service on the Roundtable. When asked the most important piece of information they learned from the SPG, many indicated that they had no idea prior to the SPG of the magnitude of the problem of the uninsured in Arkansas. Some noted that they learned that significant Federal resources had not been utilized to date to address the uninsured because of the lack of state matching funds and the low threshold required to access public insurance programs. Finally, several commented that they appreciated the fact that a very diverse group could work together to reach consensus and craft a solution to a major problem for Arkansas.

The Roundtable was committed to assuring prompt implementation of top-priority solutions and, currently, the Roundtable, as a health insurance policy group, is expected to continue functioning beyond the project period as the public forum for health issues in the state, supported in part through the RWJF State Coverage Initiative (SCI). Awarded November 1, 2001, this implementation grant through the SCI will support further design and implementation of strategic recommendations emanating from the Roundtable. Most of the active members have expressed interest in continuing to serve in their advisory capacity.

5B. BUILDING PUBLIC AWARENESS AND SUPPORT

Broad distribution of the Roundtable's findings and recommendations are now necessary to inform Arkansans and facilitate implementation of the strategic plan. The PI and core staff of the SPG deliberately chose not to engage in a broad communication plan during the first year of the planning process because of the time frame for the SPG and the scope of work. External distractions and public exposure of Roundtable members were intentionally minimized.

However, the public was kept abreast of the project through the Arkansas Center for Health Improvement (ACHI) web site and select public speaking opportunities. It is anticipated that after the release of the *Arkansas Health Insurance Expansion Initiative Report* by the Governor to US DHHS Secretary, Tommy Thompson, the Arkansas SPG will distribute the Roundtable's plan through multiple outlets. These will consist of printing and mailing reports to key stakeholders, including each member of the Arkansas General Assembly; US Congressional representatives; state and local Chambers of Commerce; identified business associations and consumer advocates; and members of the print, radio, and television media. In addition to distributing the printed reports, members of the Roundtable may be asked to participate in print, radio and television interviews. Coordination of these distribution events will be managed by the SPG and supported by funds from the RWJF SCI. In addition, SPG staff will present the findings to the State Insurance and Commerce Committees and the Joint Public Health, Welfare, and Labor Committee of the Arkansas General Assembly. Commentary and questions surrounding the proposed expansion will be catalogued and summarized.

5C. CHANGES IN ARKANSAS'S POLICY ENVIRONMENT

Arkansas's General Assembly convenes on a biennial basis, with the last session ending on May 23, 2001. The recommendations advanced by the Roundtable and the resulting policy implications will likely impact the 2003 session.

During the 2001 General Assembly, significant legislation was enacted that provides a platform of future health insurance expansion initiatives as outlined in the SPG. Specifically, funding was

appropriated from Arkansas's Tobacco Settlement Funds for Medicaid expansion and legislation was passed to facilitate reform in the private health insurance market.

Existing public sector programs were modified in the last General Assembly to simplify the application process for the ARKids First program by eliminating family asset requirements for children and will likely increase family participation in the program. After the successful passage of the Arkansas Tobacco Settlement Proceeds Act of 2000 by the citizens of the state, which allocated the second largest portion of the state's tobacco settlement funds toward Medicaid expansion, the General Assembly passed the necessary appropriation bills authorizing initiation of these programs in the upcoming biennium. The three distinct expansions related to insurance coverage include:

- extension of insurance coverage for pregnant women from 133% of FPL to 200% of FPL (an estimated additional 3,000 pregnancies covered annually, bringing the statewide coverage to >50% of Arkansas births)
- initiation of coverage for 19–64-year-olds at <33% of the FPL for basic health insurance through Medicaid (estimated additional 30,000 lives covered through automatic enrollment, bringing the statewide total to ~90,000)[25], and
- initiation of prescription drug coverage for Medicaid-eligible non-institutionalized elderly (estimated 10,000 lives covered for those ?65 years of age).

Three distinct legislative initiatives to stabilize existing private sector coverage and offer expansion opportunities to businesses and communities across the state were passed in the 2001 General Assembly. They included the:

- Health Insurance Consumer Choice Act of 2001 (Act 924), which allows consumers to select insurance policies without state mandated coverage options;
- Health Insurance Purchasing Group Act of 2001 (Act 925), which allows small employers to pool purchasing power as non-profit Health Insurance Purchasing Groups (HIPGs); and
- Rural Health Access Pilot Program (RHAPP) of 2001 (Act 549), which is a demonstration program allowing communities to organize and "self-insure" to increase access to care and stabilize local health care systems.

With strong support from the Arkansas Insurance Department, these three pieces of legislation were passed. In addition, the RHAPP is a direct reflection of the fiscal barriers and insurance needs of local community networks.

Arising from previous efforts through the RWJF-supported Arkansas Southern Rural Access Program (ARSRAP) in conjunction with several local communities that have developed provider networks to increase access to care, options for community self-insurance strategies using local taxation and existing financial capital through county- or city-owned hospitals are under consideration.

Building upon this work, Arkansas is working with funding from the HRSA *Community Access Program* to use existing models of service integration as a base for developing community-wide systems that will provide efficient and seamless delivery of care, encourage private sector involvement, and ultimately improve access for the uninsured and underinsured.

However, outside issues involving major revenue needs may overshadow the plight of the uninsured. National needs to respond to the tragedy of September 11, 2001 may affect available funds from the Federal budget. Local state reductions in sales tax revenue will make increased revenue allocation to support the Medicaid expansion portion of the plan more difficult. Additional financial challenges facing the state include a legal challenge to the state funding formula for local school districts. Arkansas's Constitution requires "adequate funding" for public school education. The pending legal determination of "adequate funding" has broad reaching economic potential to pit the legislative priorities of education and health care coverage against each other in the 2003 General Assembly.

Future dissemination and marketing efforts to rally support for components of the strategic insurance expansion plan will also require an effective education strategy to gain support from the 80% of Arkansans who already have insurance for an initiative to provide insurance to those who do not have it.

The likelihood that the expansion proposal will be undertaken is a function of how well Arkansas can counterbalance some of the impediments that currently exist. Limited state general revenue, term limits affecting institutional knowledge in the General Assembly and limited resources to develop state health policy are counterbalanced by a cadre of political and health leaders with strong personal commitments to the state and a demonstrated ability to effect change, and the promised Federal flexibility and new state responsibilities.

This 5–10-year plan for health insurance expansion advanced by the Arkansas Roundtable has provided a vital blueprint for the state. Briefings with the state's political leaders are underway and presentations to the appropriate legislative committees in anticipation of necessary legislation for implementation in the 2003 General Assembly are planned. Public forums and broad dissemination will be funded through the SPG Supplement and RWJF SCI activities.

6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6A. LESSONS LEARNED

Use of State-Specific Data in the Decision-Making Process

Prior to the SPG, Arkansas had undertaken limited empirical assessment of the causes or magnitude of its uninsured population. Available information was limited to state-specific estimates from national data collection efforts (e.g., the March Current Population Survey), or state data-collection efforts employed for other purposes (e.g., the Behavioral Risk Factor Surveillance System) that are limited by their small sample sizes. No detailed assessment or ongoing monitoring of the number and characteristics of the uninsured were underway.

Historically, state agencies and leaders have been unable to fund empirical assessment and strategic planning with state revenues. The overwhelming need for beneficiary services and health insurance coverage have been prioritized by legislative decisions at the expense of long-term strategic planning.

The SPG enabled critically important data collection, information generation, and strategic planning to occur. Without this funding, Arkansas's policies would remain subject to extrapolated findings that are generalized from other states. These data sources from other states lack specific information necessary to accurately assess the uninsured and develop politically and actuarially viable solutions to the problems of the uninsured in Arkansas.

Because of limited state-specific information from secondary sources, new data collection efforts targeting households and employers were designed to optimize available information for policy decisions. These data included household-specific information about the insured and uninsured and their economic, geographic, and racial and ethnic characteristics. Employer information gathered included the size of business and type of industry. By creating accurate descriptions of both the insured, including their mechanism of insurance, and the uninsured, including their efforts to attain insurance, a complete and accurate picture of the challenges facing Arkansas emerged. These quantitative data on both households and employers provided accurate numbers with which to assess strategies and project coverage potential and program costs. Through stratified survey techniques, variations in regions and characteristics of the uninsured were determined.

However, knowing only where uninsured individuals were and what characteristics they shared did not provide sufficient information to inform strategies that would engage the uninsured. Qualitative information was required to gain insight into the decisions facing both households and employers. Thus, focus groups were conducted with insured and uninsured families across a spectrum of household incomes to ascertain what factors led to their current status. Key informant interviews with the largest state-based employers and focus groups with small- and moderate-size businesses enhanced the Roundtable's understanding of decisions affecting employer participation in health insurance and non-traditional strategies currently incorporated by businesses to support employees' health care needs.

Transformation of data into policy relevant information for use by the Roundtable required the development and use of new technologies to facilitate discussion. Available quantitative data from both secondary and primary sources were incorporated into an "integrated database." Using new technologies, queries were answered during the policy discussions with near instantaneous display of information relevant to the discussion. In addition, the use of ARS technology allowed the SPG to immediately assess the Roundtable's understanding and facilitated decision-making in a supportive environment.

Through each of these data collection and information management strategies, previously unavailable information was introduced into the process. Individual anecdote was replaced by empirically based profiles of the uninsured. Political rhetoric was replaced by supported solutions.

Most Effective Use of Resources for Data Collection

The success of the Arkansas SPG relied on each of the data collection activities for successful deployment. Secondary sources of information assisted in framing initial discussions; qualitative information from both households and employers provided key insights into the decisions facing Arkansans. However, of all the strategies employed, the 2001 Arkansas Household Survey of

Health Insurance Coverage has been the most useful in providing a profile of households across the state.

Components of this survey included statewide and regional estimates of the number of uninsured, assessments of current sources of insurance for adults and children, and evaluation of prior insurance history and current options available to those who are not insured. Finally, for households in which an individual over age 65 resided, the need for prescription drugs and the impact of health insurance availability was assessed.

These household survey data provided the first quantitative information on the uninsured in Arkansas and these data will continue to drive and shape decision-making in the future. As noted above, without the SPG resources, all data collection efforts would not have been possible.

Data Collection Activities Not Conducted

Originally, Arkansas proposed an independent survey of Arkansas employers. However, due to the complexity associated with sampling businesses with multiple locations, interstate businesses, and governmental entities functioning as independent purchasing units for health insurance, the Arkansas SPG chose to utilize the existing AHRQ-sponsored MEPS-IC. This strategy addressed the concerns above and allowed optimal regional information and information on small businesses.

Arkansas is currently conducting its employer survey through the AHRQ-sponsored MEPS. The employer survey (MEPS-IC), administered by the US Census Bureau, receives a systematic sample of businesses from the IRS. Fielded in all states on a rolling basis, Arkansas was scheduled to have ~800 employers surveyed in 2002. In collaboration with AHRQ staff, the Arkansas data collection activities were moved to the 2001 data-collection cycle and are currently underway. To achieve stable estimates of characteristics of employers offering health insurance and to provide regional estimates across the state, the Arkansas SPG purchased an oversample of an additional 1,000 employers (total N=1,800) and worked with AHRQ to modify the sample frame to increase representation of target employers. These modifications will result in employer data being available in 2002, which will provide statewide and regional information on employer-sponsored health insurance and characteristics associated with those employers that do not offer insurance.

In addition, the Arkansas SPG proposed to conduct key interviews with five major insurance providers in the state (Aetna, Arkansas BlueCross BlueShield, Cigna, United HealthCare, and QualChoice QCA). Rather than conduct individual interviews, insurance representatives were asked to participate in the Working Group that evaluated available information and helped develop expansion and stabilization strategies. In addition, representatives from two of these major insurers served on the Roundtable, ensuring information concerning large insurers was incorporated into the decision process.

Strategies Used to Improve Data Collection

Due to the project's broad scope and narrow time frame, strategies to optimize the availability and reliability of data collected were of paramount importance. These strategies were incorporated across all phases of data collection and required the dedication of qualified full-time staff and links to external resources and expertise to ensure programmatic success.

Secondary data was collected from available sources. Expertise from the Arkansas Department of Health's Center for Health Statistics, the University of Arkansas at Little Rock (UALR) Institute for Economic Advancement (US Census State Data Center), the State Health Access Data Assistance Center (SHADAC), and AHRQ proved invaluable in the rapid acquisition and incorporation of available data into the decision process in Arkansas.

For our household quantitative survey, the CSR at the University of Massachusetts was selected because of their prior experience in surveying the uninsured and their dedication to quality control efforts in data collection activities. The 2001 Arkansas Household Survey of Health Insurance Coverage was a RDD telephone survey of 2,625 households requiring ~20 minutes to complete. Through repeated call-back attempts and standard survey recruitment methods, a response rate of 62% of all households was achieved, with >90% of screened households completing the survey.

As described above, the Arkansas SPG quantitative survey of employer data is currently underway. Due to the sampling complexity of employers that have multiple sites associated with the same business, the "buy in" to the MEPS-IC survey will achieve optimal information on employer participation in health insurance benefits.

For the key informant interviews of large state-based businesses, the Governor of Arkansas asked, via a letter, the CEO and/or the responsible decision-maker on health benefits to participate in the SPG project. All project requests for a 1–2-hour interview with these large employers were honored.

For qualitative data collection, existing organizations with community ties were employed to assist in the recruitment and implementation of focus groups. For households, the AACF and UAPB were employed to conduct and assess the availability of health insurance and the reported decisions facing households. Importantly, these focus groups were conducted with individuals from across the state and included groups containing only African-American and Latino individuals to ensure adequate understanding of the racial and ethnic differences surrounding the social construct of insurance and risk. Stipends were provided to enhance participation; however, often the opportunity to discuss health insurance issues faced by these families appeared to be an adequate stimulus for participation.

For employer focus groups, the Working Group partnered with existing organizations including the Arkansas Farm Bureau, and the National Federation of Independent Business. With their assistance, participants were recruited that represented the farms, small- and moderate-sized businesses in the state. Statewide focus groups were employed with meals provided at local restaurants.

Additional Data Needed and Questions Unanswered

Additional Data Needed. Due to the lack of information on uncompensated care within the state, little empirical evidence is available to quantify the amount of care provided by the health care system and "absorbed" without a mechanism for reimbursement. Thus, impact projections of increased insurance coverage on such uncompensated care are difficult to generate. Anecdotal evidence from the Arkansas Medical Society, which tracks services provided by clinicians for the uninsured, and the Community Health Centers (CHCs), which serve as Arkansas's primary outpatient safety net, suggests that high levels of uncompensated care are being provided.

The Arkansas Hospital Discharge Database was the only database used to estimate state-specific uncompensated care but was limited because a) it represents inpatient care only; and b) information contained represents "charges" generated by the hospitals, not true "costs" or "final payments". Only the national MEPS data provides estimates of uncompensated care; however, the small sample size does not allow for generation of state-specific estimates. No state or federal information is available to accurately capture the amount of uncompensated care provided in the state or to project the contribution to rising insurance costs that could be ameliorated if health insurance expansion efforts are successful.

Significant Policy-Relevant Questions Unanswered. The magnitude of uncompensated care and the impact these services have on health insurance costs through providers in Arkansas is largely unknown. According to both quantitative and qualitative data collected, the uninsured are accessing health care services but frequently are unable to pay the costs associated with such care. These un-reimbursed costs are absorbed into the system and represent a cost to clinical providers that is either being absorbed by the provider and/or is being transmitted to their "paying" patients. No quantification of these transactions is available and the impact that future insurance expansion will have on reducing this "cost-shifting" is unknown.

Safety net providers including CHCs, county hospitals, and the University Hospital are critical providers of uncompensated care. However, their adequacy and the impact on future health insurance expansion options remain understudied. Systematic assessment of their contribution, the costs associated with providing that care, and the potential impact of converting uncompensated care to insured care remain unknown. While no one questions the continued need for these providers, the integration of their services and strengthening of the safety net requires further evaluation.

Another area of significant policy relevance not addressed in the study is the perceived vulnerability of the individual insurance market in our state. Ten percent of those with insurance have it through the individual insurance market. Limited information is available to determine what incentives exist in our state to attract and retain carriers in the individual market. Likewise, current practices of participating carriers in the individual market are not well characterized. Insurance carriers group individual policies into pools or "books" of business. Such pools tend to develop actuarially into what is called a "death spiral" as the healthier participants seek lower premiums through new books of business offered by the carrier or its competitors, thus leaving only the less healthy in the older "individual pool". Specialized niche carriers are reported to operate in the state, and recruit low-risk participants from deteriorating pools into new, lower-premium books of business. This reduction in the spreading of risk only serves to inflate the premiums of the remaining participants from the original book further, forcing many enrollees to give up health care coverage.

Although the state's high-risk pool (CHIP) is intended to be the logical solution for individuals who can no longer afford individual health insurance policies because of health conditions, due to the high premium costs, the number of current enrollees is only ~2,800,[26] well below the number one might expect. Other studies conducted in the recent past have indicated that thousands of Arkansans are forced out of the individual market annually. Focus group information obtained during this study indicates that many of this group, those forced out of individual insurance coverage and who lack access through employment, are now forced into an "underground" payment system that pays the provider a monthly installment of $10, $20, or $50,

virtually in perpetuity. It was only until recently that this strategy kept providers from turning these accounts over to collection agencies. However, according to anecdotal evidence from providers, now many of these well-meaning payers are being forced to take bankruptcy to clear this debt.

Plans to Conduct Further Research. With the completion of the Arkansas SPG interim report to DHHS in October 2001 and through the supplemental funds provided to the SPG by HRSA, Arkansas plans to conduct a readiness assessment that will include additional business focus groups, town hall meetings, and a voter survey. These activities will further inform the Roundtable and the political leadership of the state, establish a timeline for implementation of the strategic plan, and guide these activities.

As plan components are further specified, actuarial modeling of each strategy and impact assessments must be performed to accurately project the number of insured and optimally design implementation strategies. Of importance, projected health care inflation and economic vitality for both the state and the nation will be required to inform the political leadership prior to implementation of new expansion efforts.

Ongoing analyses of the household and employer data collected through the first phase of the SPG process will continue to inform questions identified by the Roundtable. In addition, new information gleaned from this project will be made available to other states through appropriate venues to optimize information that may be of use across the nation.

Organization and Operations

For states that lack ongoing monitoring activities of health insurance coverage, a 13-month period to assess and collect information and develop a meaningful strategic plan required mobilization of resources and stretched the state's institutional capacities. Ongoing analyses of information collected will further inform policy development and better delineate options available to the state. In future efforts, states should be allowed more time to fully analyze the data collected and further develop expansion strategies. Arkansas's March SPG Supplemental Report will include these critically important components.

Through the Roundtable deliberations, the Arkansas SPG team learned that, given the opportunity, citizens with diverse backgrounds will participate in a deliberative process to determine issues that impact their lives. Although many Roundtable members were extremely busy people, they actively participated by attending meetings and completing "homework" assignments between meetings to quickly learn the breadth of the project and analyze proposed solutions for the state. Membership on the group was geographically balanced and racially diverse with both extremes of the political spectrum represented.

The SPG team also learned that attitudes can be modified by using state-specific data in the decision-making process. During the deliberations of the Roundtable, members openly identified self-admitted, drastic changes in their original perceptions about the uninsured. These changes were driven by the empirical data presented that dispelled the myths surrounding the subject and enabled a more objective and productive assessment of alternative solutions. This was confirmed in a brief exit survey conducted of Roundtable members during their October 2001 meeting.

Using available resources within the state, the Working Group helped organize and develop materials for the decision-making body in a manner that best utilized Roundtable members' time and matched their level of comprehension. The two-level process that Arkansas used to analyze information and package it for presentation to the Roundtable is described in Section 5 (p. 49). This process was found to be very effective and efficient.

As described earlier in this section (Strategies to Improve Data Collection, p. 56), access to immediate integrated information sources helped verify the level of need and confirm targeted subgroups for potential expansion options. Arkansas developed an analytical tool that permitted members of both the Working Group and the Roundtable to obtain answers to their questions during the deliberations concerning the potential solutions. This helped keep the group targeted to those with greatest need, a goal of the project, and avoided diverting resources to design solutions for subgroups that would achieve minimal impact. For example, several Roundtable members originally believed that the uninsured were only transiently without coverage and largely were lacking coverage in periods of job transition. Analyses of existing data revealed that, in contrast, many of the uninsured adults were working full-time jobs and had been without insurance for extended periods of time—more than one-third of previously insured individuals have been without coverage for 5 or more years. This finding led the Roundtable to focus on employer-based solutions, not transitional issues facing those individuals between jobs.

Insurance Market and Employers

With regard to the insurance market, the Roundtable undertook substantive discussions examining the definition of a competitive market, and regulatory and economic issues affecting coverage outcomes. An example of issues discussed was the observation that increasing the number of insurance carriers in the state does not necessarily equate with a stabilized or more competitive market. In fact, reducing the number of marginal carriers that write only a very small percentage of the total business in the state can have a positive effect on the market through increased efficiencies and lower costs. Another example were statements of the insurance/provider representatives during the Roundtable deliberations that large insurers will support regulatory changes as long as the changes "level the playing field" for carriers doing business in the state. The Roundtable also learned that large insurers will support public programs for coverage expansion as long as the programs contain strategies that will address the burden of un-reimbursed care currently being shifted on to the private market. Finally, the potential for independent insurance agents, comprising the fourth largest number of small businesses in state, either to assist in public program enrollment as currently occurs in the ARKids First program or to oppose new policies perceived to threaten the private insurance market were recognized.

Through the secondary quantitative data and key informant interviews, the Arkansas SPG team learned that most of the largest employers in the state are self-insured. All employers interviewed expressed a growing concern for the rapidly rising cost of pharmacy and are devising strategies to implement caps to control their costs in this area. These large employers interviewed believe they should take care of their employees and provide health insurance coverage regardless of the employees' perceived need for coverage. In fact, one large employer requires 100% participation in their self-insurance health insurance plan. Small employers that participated in the interviews have taken a more personalized approach to the issue and they may substitute direct payments to providers if they are unable to access affordable coverage. The complexity of annually

evaluating alternative coverage options combined with increasing insurance costs was described as approaching the limits on small employers' ability to participate on behalf of their employees.

The process utilized to bring the providers, consumers, and employers together in the Roundtable setting to review empirical data and develop solutions was helpful in dispelling many of the myths associated with the uninsured. The equality of representation forced the employer community to listen and participate in the solution design. However, it was also learned from key informant interviews and employer focus groups that employers' decision-making in this area is often based on real personal experiences. Although data can and should drive decision-making, it is often superceded by anecdotal information. For example, one large employer learned that a pharmaceutical representative had advised a patient, who had extremely large monthly prescription drug costs, to have a family member gain employment with the self-insured employer because the employer did not have a cap on prescription drug coverage. After hearing this information, that employer is now planning to implement a cap on prescription drug coverage under its plan. This consequence was directly attributed to HIPPA legislation enacted in 1996 and although unintended in scope, resulted in real benefit reductions for future employees.

6B. KEY RECOMMENDATIONS TO ARKANSAS AND OTHER STATES

Process for Decision Making

On an issue as complex as health insurance expansion, a multi-level process is needed to draw upon experts with the technical ability needed to assemble and present information (Working Group) to those that will be impacted by the proposed options (Roundtable). The decision-making group, such as the Arkansas Roundtable, should be comprised of persons who will have to make decisions about policies during the upcoming year. By having real decision-makers, not representatives of professional associations or state officials, at the table, meaningful discourse can be focused on data and policy options developed. Observers and special-interest groups should be allowed to respond to the discussion; however, no particular special interest group should be allowed to drive the agenda during the deliberations.

Use of National Technical Assistance

National experts should be relied upon to provide an overview of other states' work and some analysis on the applicability of these programs for a particular state. The exchange of information with other states during the policy-development process will prevent states from reinventing solutions with each step of the process. This can be facilitated using the Internet and new communication mechanisms. Other grantee states assisted with requests when members of the Arkansas Working Group asked for specific information. In addition, resources available through the Academy for Health Services Research and Health Policy (AHSRHP) and SHADAC proved invaluable in assisting with procurement and interpretation of national findings.

Provide Immediate Access to Empirical Data for Decision-Makers

The development of the integrated database and analysis tool was helpful in deliberations and decision-making. Using new technologies, Arkansas applied available software technology and developed database architecture to manage both national and state-specific data through an

integrated database that allowed staff and Roundtable members to generate questions, query available data, and attain information within the timeframe of the discussion (5–10 minutes) on specific issues or target populations for the plan. The availability and use of empirical data during deliberations often dispelled anecdotal information and supported empirically based decision-making.

Use Governor to Solicit Participation

To achieve high levels of participation by key informants in major Arkansas-based companies, the Governor sent letters of request to the CEO of each business. Personal calls a week or so later from Arkansas's SPG staff to schedule the time for the interview were quite successful. In each instance, the company was given the option of designating someone other than the CEO to be interviewed. Only one company refused to participate, and they did so because they were not corporately based in the state. The letterhead and signature of the Governor helped ensure high-level participation and represented the level of importance placed on the activity by the leadership of the state.

Inclusion of Scientifically Supported Preventive Services

The Arkansas Roundtable endorsed the incorporation of evidence-based preventive medicine into proposed health insurance expansion activities. Specific strategies have been evaluated for efficiency and effectiveness and have been advanced in the *"Guide to Clinical Preventive Services*, 2nd edition, Report of the US Preventive Services Task Force". These strategies with strong scientific support and accepted clinical practice should be integrated into policy decisions. Financing strategies including all health insurance programs managed and/or regulated by the state should include basic clinical preventive services (see Appendix IV). Through the appropriate use of scientifically supported and cost-effective strategies preventable illness and disease will be avoided and health care resources will be more effectively managed. This proactive recommendation will significantly reduce the long-term burden of poor health in many states. See also Section 7, below (p. 64).

Optimize Federal Funds for Health Care Coverage

States have several options to provide health insurance and health care to their citizens, including traditional Medicaid programs, exclusively state-funded programs, expansion initiatives under Medicaid and SCHIP initiatives, and traditional safety-net programs such as the CHCs. In addition, Medicaid offers targeted strategies to reach specific populations, for example, by extending coverage for individuals with tuberculosis or pregnancy. Arkansas and other states should support the provision of health insurance and clinical services by actively surveying potential new coverage options through external funding, establishing funding mechanisms in an expeditious process, and optimizing the fiscal resources flowing into the states.

Employee Wage and Benefit Annual Compensation Summary

The Roundtable recommended that employers consider providing a report of annual employee compensation to their employees. Consumers of health care services frequently are not aware of the actual costs of providing health insurance coverage. This tool is intended to facilitate discussion between employers and employees, give credit to employers for participating in health care benefits, and help the employees make employment decisions based on knowledge of

their full compensation package. Additionally, it would serve as a recruitment and retention strategy and increase overall awareness of health care costs and benefits. Due to the voluntary aspect of employer participation in provision of health care insurance benefits, a uniform wage and benefit annual compensation summary would increase health care consumers' fundamental knowledge of costs and mechanisms of health insurance coverage.

7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7A. OPTIONS REQUIRING FEDERAL WAIVERS OR OTHER CHANGES IN FEDERAL LAW

Additional Research Needed to Improve the US Health Care System

To guide policy development and health care system evolution, the Federal government should **support additional research to attain a better understanding of the clinical, economic, and social factors influencing the US health care system today.** With double digit premium increases facing most private health insurance consumers, questions arise regarding the influence of direct marketing by pharmaceutical companies, the cost-effectiveness of new versus existing medications and technologies, and alternative mechanisms to finance and manage health care expenditures. Each of these questions has both political and economic implications for the future of the US health care system. Current funding for research to better understand and empirically support policy development is lacking. Specific funding through AHRQ and the National Institutes of Health for new research should be established to address these knowledge gaps and ensure that health care advances are incorporated and appropriately utilized.

Public–Private Partnership

Arkansas is proposing a comprehensive strategy to offer coverage to adults that would **utilize both Medicaid and SCHIP waivers to cover individuals up to 200% of the FPL**. This proposal requires consideration of a limited benefits package more restrictive than that suggested by the Health Insurance Flexibility and Accountability (HIFA) operating rule. Importantly, , under the proposed plan, no benefits would be diminished for currently covered populations, and children enrolled in the program would have the same benefits as provided under current programs up to 200% FPL. Strategies to engage employers and low-wage workers include utilizing employer participation for outreach, enrollment, and funding mechanisms.

Tax Credit for Community Purchasing Pools

The strategy behind purchasing pools is to achieve administrative efficiencies and bargaining clout like that associated with large-employer group plans. As noted below, legislation is pending on tax credits to individuals and families purchasing health insurance in the individual market. **The Roundtable recommends that Congress expand the legislation to include individuals purchasing health insurance through community purchasing pools**, which would provide additional incentives for creation of these pools. However, Congress should be cautious in placing mandates on these purchasing pools, such as requiring community rating, pre-existing conditions, or guaranteed benefits, because such requirements will limit flexibility and experimentation required for local success.

Medical Savings Accounts

The Roundtable recommends **exploration and modifications of the Federal laws related to current MSAs so that the "qualifying high deductible plan" becomes tied to the group market rather than individual policies**. Arkansas's proposal is to **modify the current MSA design** to limit segmentation and subsequent isolation of the less healthy. By tying MSAs to group coverage rather than individual coverage, MSA participants would become part of a *group* catastrophic policy, rather than buying individual policies. This change would spread the risk associated with an adverse health-related events so premium increases or cancellation of the policy would occur less frequently while achieving the attractive cost-containment and personal savings attributes of MSAs.

Inclusion of Scientifically Supported Preventive Services

Through Medicare and the Federal Employee Health Benefits Plan, the Federal government has incrementally advanced and **the Roundtable supports the inclusion of scientifically supported clinical preventive services** (e.g., influenza vaccines for the elderly, cholesterol screening for at-risk individuals, and mammography for women over age 50). Continued advances through research at the National Institutes for Health and AHRQ will continue to advance our knowledge on how to prevent illness and disease and better manage known health risks. Renewed support for evaluating the scientific evidence, cost-effectiveness of alternative services and new research into alternative mechanisms to efficiently deliver high-quality care under constrained budgets are required to continue the strengths of the US health care system. **The Federal government should increase research into the delivery, appropriate utilization, costs, and quality of health care delivery systems.**

Income Tax Neutrality through Uniform Exemptions for Health Insurance/Health Care Expenditures

A clear consensus has emerged from the Roundtable that all parties involved in the purchase of health care insurance should be on an even playing field with respect to state and Federal tax policy. Currently, some participants purchasing health insurance enjoy a significant advantage over others. Employees that obtain their health insurance through their employer can pay the premiums with pre-tax dollars. Employees who participate in a cafeteria plan can use pre-tax income for other health care costs. Employers who offer group plans can deduct costs associated with the provision of health insurance. Workers who are self-employed have certain tax deductions available for the purchase of health insurance.

However, no state or Federal deductions are available for health care expenditures by those employees who do not have employer-based health insurance. Thus, if these individuals purchase individual health insurance, they must do so with after-tax dollars, which places them at a financial disadvantage. In addition, low-wage workers are, historically, less likely to optimize the pre-tax mechanism offered through cafeteria plans and so spend their after-tax dollars for health care.

Income tax neutrality with respect to health care insurance or use costs can be achieved if:

1. all monies associated with health insurance and health care are made taxable, or
2. all such monies are made tax-exempt.

Currently, various reform legislation pieces are pending before Congress that would provide tax credits to individuals and families purchasing health insurance in the individual market. **The Roundtable recommends that the Federal government make all health insurance and health benefits costs tax exempt**, thus making all methods of purchasing health insurance tax deductible.

Incorporation of Prescription Drug Benefit for Persons Covered by Medicare

The Roundtable assumed that basic benefits should include prescription drug benefits. Although the Roundtable's proposed plans focused primarily on the uninsured aged 19–64 years, it acknowledged that persons over the age of 65 years do not have "basic benefits" under Medicare according to this definition. For this reason, **the Roundtable urges the Federal government to take legislative action to develop an affordable prescription drug program for Medicare beneficiaries.**

Expanded Medicare Eligibility through Buy-In Options for the SSI Disabled and/or Near Elderly Populations

Because of the strategies used in the Roundtable proposal, options will provide a source of coverage for 80% of uninsured Arkansans aged 55–64 years through the larger expansion efforts of a public–private partnership SCHIP. In addition, many disabled will be covered by the limited-benefits Medicaid programs proposed for individuals below 100% FPL. The Roundtable did not develop a separate set of strategies specifically for these populations. However, these "near-elderly" often have difficulty continuing to access employer-related health insurance coverage due to retirement or divorce from a working spouse and the disabled frequently are unable to afford health insurance even if available. For these reasons, **the Roundtable encourages and supports efforts at the Federal level to provide a Medicare "buy-in" option for the near-elderly population and to expand eligibility for disabled individuals.** Further analyses of the data collected through the SPG will inform the future development of this recommendation.

7B. OPTIONS NOT SELECTED THAT REQUIRE FEDERAL CHANGES

The Arkansas Roundtable did consider, but did not select, mandated employer coverage or publicly funded universal coverage as viable options for expanding health insurance. Both of these options would require changes in ERISA and possibly other Federal legislation. Current Federal laws are a barrier to state flexibility in these areas. To implement pilot programs using these options, the Federal government would have to grant states waivers under ERISA.

Although prescription drug costs surfaced as one of the primary reasons for increasing insurance costs, the limited time frame of this study prevented any in-depth analysis of this issue. Thus, the Roundtable did not propose changes to Federal laws limiting direct marketing by pharmaceutical companies to consumers or regulating detailing efforts on prescribing physicians. Strategies to increase the appropriate use of the most cost-effective strategy for all health care, particularly pharmaceutical use, must be pursued. MSAs as described above are one strategy to engage the consumer in discussions surrounding the costs and effectiveness of alternative treatment strategies.

7C. ADDITIONAL FEDERAL SUPPORT NEEDED

Determine Viability and Measure Success of Options

To determine the viability of their proposed options and monitor implementation success, states should receive support from the Federal government. Funding should also be provided for the design and maintenance of a tracking system to monitor coverage progress (see below).

The Federal government should also maintain a partnership with the SPG states and develop a working relationship with other states to set negotiated, mutual coverage goals, modify funding mechanisms; and measure progress annually toward these established goals. The Federal government provides the best venue for convening and encouraging states to share their information and for allowing states to learn from each other. The SPG Grantee meetings provided a useful forum for information exchange by the participating states and future efforts to optimize knowledge gained in state experimentation should be optimized.

Support Data Collection and Sharing

As decisions are increasingly delegated to the states, empirical information is required to facilitate informed and effective policy development at the state and regional levels. Unfortunately, many of the data-collection efforts funded and performed at the Federal level fail to provide stable estimates of state-specific information due to small sample size, infrequent assessment, and/or concerns about respondent confidentiality. All future data collection efforts undertaken at the federal level should have an advisory committee consisting of a majority of state representatives to ensure appropriate state input and maximum utility for state policy development efforts.

The Federal government should support the sharing of data collected during a study process such as the SPG through a web-based database. Future programs that include data collection by states should require data sharing among states and with the Federal government. If current Federal restrictions on data collection make such voluntary data sharing less likely to occur, these restrictions should be re-examined in light of the benefit derived by states and the Federal government by having accurate data available to support policy decisions.

Regional solutions should also be supported by the Federal government. Unfortunately, the current Federal regions do not reflect the demographic, geographic, and economic similarities that truly exist. Therefore, the Federal designations should be re-evaluated and potentially modified to facilitate solution development among states with common issues. For example states in the lower Mississippi Delta region (Arkansas, Tennessee, Mississippi, and Louisiana) share many similar challenges but are divided geographically into two separate DHS regions by the Mississippi River. Currently, states seeking to create joint solutions encounter bureaucratic resistance when they cross Federal regional lines (e.g., negotiation with different DHHS regional offices).

Other activities such as those supported through the SPG require Federal government support. The opportunity to dialogue with other states and the technical expertise convened for the SPG process facilitated policy development that otherwise would not have occurred. Additionally, the current process should be expanded to additional states that were not part of the original program. The Federal government should also disseminate a document that describes exemplary

programs demonstrated in the SPG process to all states for their consideration. Future issues of national importance should be addressed through similar mechanisms to those employed through the SPG.

In addition to the Federal support required for plan implementation and the recommendations listed above, the Federal government should systematically reassess strategies designed to support the health needs of US citizens. Current strategies to address economic differences between regions and states (e.g., Federal Medicaid match rate), assessment of underserved areas (designation of medically underserved areas), strategies to ensure clinician availability (Graduate Medical Education Funding), and allocation of research funding based upon investigator-initiated research instead of population health needs should be periodically evaluated and modified to support the nation's Healthy People 2010 goals.

7D. ADDITIONAL RESEARCH NEEDED TO IDENTIFY THE UNINSURED AND DEVELOP COVERAGE EXPANSION PROGRAMS

In addition to the suggestions outlined above, the Federal government could support new research programs modeled after the SPG to encourage state developmental initiative and experimentation, to support a spirit of partnership between the Federal agencies and the states, and to ensure state input in Federal programmatic design. Systematic assessment of funding for public and private health insurance coverage and safety-net providers should be undertaken to ensure that funds are being used effectively and efficiently.

CONCLUSION

Challenges in Arkansas. Obtaining affordable health insurance is a challenge for a large portion of Arkansas's 2.6 million citizens for a number of reasons including the state's large rural population, limited numbers of providers in rural areas, cultural diversity, and an economy dominated by small businesses. Most Arkansans live and work outside of the relatively few metropolitan areas, [15] reflecting its low population density, which limits efforts to foster competition in the health care field and contain costs. Previous studies have documented that insurance coverage is critical to seeking and receiving appropriate treatment for most conditions,[2] however 20% of Arkansans between 19 and 64 years of age are uninsured. The lack of health insurance for Arkansans has a direct and negative effect on both the health of the state's citizens and its economy. Lack of health insurance is a contributing factor to Arkansas's poor health status, with an age-adjusted death rate ~20% higher than the national average.[27]

Employers and Health Insurance. Arkansas's economic base is one of the poorest in the nation. With a household median income of $32,714 it ranks as the 48th lowest when compared with other states and the national median income of $41,343 per year.[6] Thus, over half of all households in the state make less than 200% of the FPL ($35,300 per year for a family of 4).[5] The average per capita income is $16,713, compared to a national average of $21,684.[28] This sobering economic picture is largely because of a state economy based upon agricultural, service-sector, and small- to moderate- sized manufacturing businesses. While the majority of Arkansas's few large employers do offer health insurance, the state's small employers are among the least likely in the nation to offer employer-sponsored health insurance.

The Insured and Uninsured in Arkansas. When offered employer-sponsored health insurance, Arkansas households have one of the highest nationwide rates of uptake. Conversely, the economic effect on those households without health insurance is substantial. Individuals without health insurance are less likely to utilize preventive care, delay treatment for acute conditions, and have poorer health status compared to insured households. These uninsured individuals do require care through emergency rooms, in hospitals, and in clinicians' offices across the state; however, they frequently have no means to pay for these services. Efforts to secure payment results in many households declaring personal bankruptcy—the #1 cause of bankruptcy in Arkansas is unpaid medical bills—and has a subsequent direct and negative impact on the communities across the state. Because many of the uninsured are in the medically underserved areas of Arkansas, the health care system is not easily able to absorb the costs of uncompensated care and is forced to pass these costs on to those with insurance, alternatively the system ceases to exist, as evidenced by the many rural hospitals and rural providers that have closed in recent years.

Development of Options. Through the HRSA-supported SPG, the Roundtable members examined a spectrum of potential health insurance expansion options that fell into three categories—public sector expansion programs, private sector expansion programs, and programs that bridged the public–private sectors. The Roundtable felt strongly that expansion of health insurance coverage to the uninsured should include and build upon the existing relationship between employers and employees. Over 80% of insured individuals 19–64 years of age obtain insurance through a relationship with an employer. A consistent thread through both key informant interviews with large employers and focus groups with smaller employers was the concept that employers felt a duty to "take care" of their employees and wanted to provide benefits such as health insurance. While an employer's decision to offer a health insurance benefit is influenced by the custom and practice of the respective industry, the almost universal reason that employers gave as the most important factor in deciding whether or not to provide health insurance was premium costs. As health insurance costs rise, at best eroding profit margins and at worst endangering their ability to remain in operation, many employers are faced with the choice of restricting benefits or elimination of health insurance as a benefit to employees.

Household information suggested that while the employer desire to offer health insurance may be present, many households with full-time employees lack access to employer-sponsored care. The combination of low household incomes, a lack of employer-sponsored care, and the expense of the individual insurance market serve to essentially isolate many households from the private health insurance market. As with employers, the often prohibitive cost of health insurance is a significant barrier to obtaining insurance coverage. The Roundtable based recommendations on the assumptions that households with incomes <200% of the FPL have a marginal capability to contribute to the cost of obtaining health insurance and those <100% of the FPL can make only a nominal contributions. The lack of a public-sector program to assist able-bodied working adults has led to sub-optimal strategies for households to manage financial obligations associated with necessary medical care. These include long-term debt payment schedules and, for many Arkansas households, declaration of personal bankruptcy and the associated negative economic and social implications.

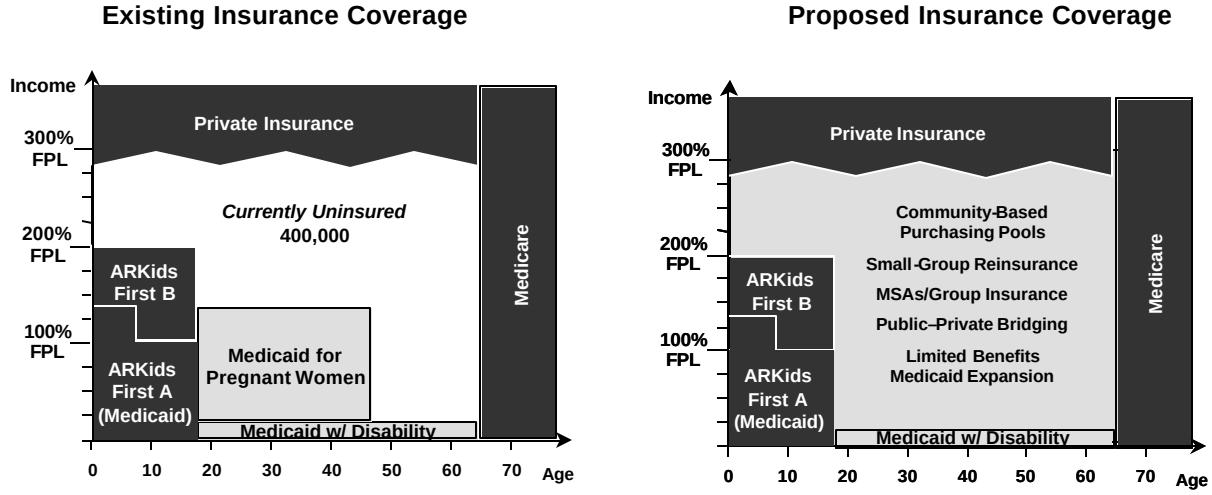
Findings from the marketplace also helped the Roundtable in deciding what type of expansion coverage to recommend—either an insurance benefit package that ensures individual **access** to

the healthcare system or a more substantive benefit package that achieves access but also protects individual **assets.** Importantly, the restrictive Medicaid eligibility for adults (~25% FPL for adults AND disability requirements AND household asset limits) provide essentially no public sector insurance safety net for most working-aged adults. The Roundtable identified critical needs for basic benefits to assure access—hospital, outpatient, pharmaceutical coverage and preventive services—in the low-income working adult populations as a top priority.

Recommendations. The Roundtable explicitly chose strategies to address health insurance needs across the state (Figure 19). First, strategies targeting the uninsured low-income Arkansans will achieve access protection by expanding the Medicaid program and subsidizing employers with low-income uninsured workers. Second, strategies to stabilize and expand both access and asset protection through the private health insurance system will enable insured Arkansans to have continued health and financial security. Finally, changes at the federal level and new operating strategies in the state will ensure continued advances and optimal allocation of limited resources to improve the health status of Arkansans. Specific recommendations include:

- Extend limited Medicaid coverage for low-income adults aged 19-64 years of age.
- Establish new employer / state partnerships with voluntary employer participation in publicly subsidized health insurance for the working poor.
- Create community-based purchasing pools to assist small businesses in attaining access to competitive insurance options.
- Stabilize the small group market through new reinsurance mechanisms.
- Explore new insurance mechanisms through self-directed medical savings accounts tied to catastrophic group health insurance.

Figure 19. Summary of Roundtable Recommendations



Future Implementation of Insurance Expansion Strategies. Through these strategies combined with additional recommendations incorporated in this report, a strategic plan to stabilize existing coverage and expand health insurance to the uninsured in Arkansas emerges. Additional analyses, further refinement of coverage strategies, and a readiness assessment for implementation are underway. Through continued empirically based discussions, policies will be developed and implemented that will directly help all citizens of Arkansas.

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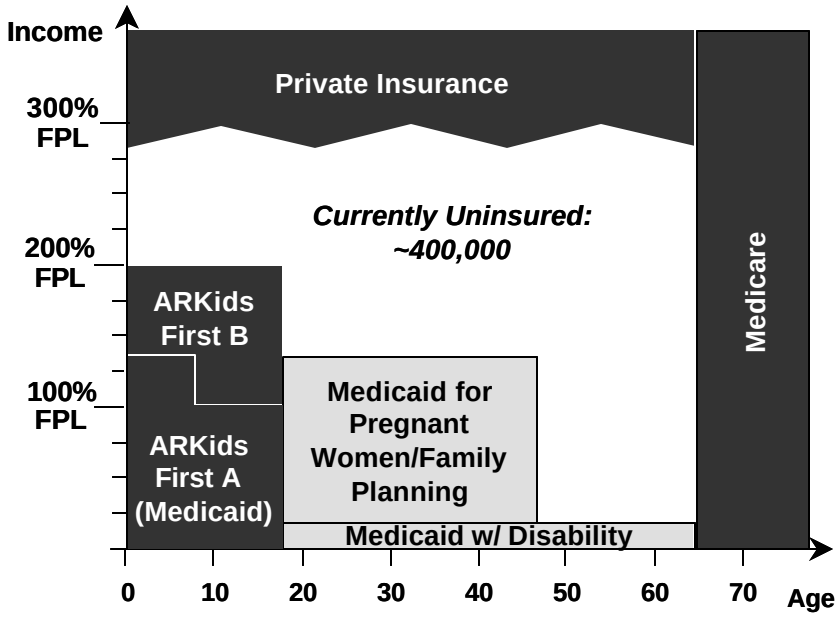
APPENDIX I: BASELINE INFORMATION

Population:	?	2,673,400 (US Census 2000)
Number and percentage of uninsured (current and trend):	?	15.2%. (2001 Arkansas Household Survey of Health Insurance Coverage)
	?	15.3% (3 year average) (2000 US Census Bureau, Current Population Survey Reports)
	?	~20% (1999 Behavioral Risk Factor Surveillance Survey. 2001 report)
Median age of population:	?	36 yr (US Census 2000)
Percent of population living in poverty (<100% FPL):	?	13% (2001 Arkansas Household Survey of Health Insurance Coverage)
Primary industries:	?	Retail trade/services, manufacturing, agriculture/farming/forestry
Percent of employers offering coverage:	?	44% total (MEPS–IC 1999)
Percent of self-insured firms:	?	25% total (6.6% of firms with <50 emp., 65% of firms with >500 emp.) (MEPS – IC 1999)
Payer mix:	?	Mostly fee for service (FFS), very little capitated contracting
	?	~25% managed care (ABCBS estimate)
	?	3 active HMO's remain in operation
	?	50+ plans have ceased doing business in the state over the past 3-4 years
Provider competition:	?	Moderate competition in urban areas and between primary care providers; slight competition in rural/suburban areas and between specialists/subspecialists
Insurance market reforms:	?	Health Insurance Consumer Choice Act of 2001 (Act 924), which allows consumers to select insurance policies without state mandated coverage options
	?	Health Insurance Purchasing Group Act of 2001 (Act 925), which allows small employers to pool purchasing power as non-profit Health Insurance Purchasing Groups (HIPGs)
	?	Rural Health Access Pilot Program (RHAPP) of 2001 (Act 549), which is a demonstration program allowing communities to organize and "self-insure" to increase access to care and stabilize local health care systems

Eligibility for existing coverage programs (Medicaid/ SCHIP/other):



Use of Federal waivers:

? 1115b – ARKids First

? Family Planning – expanding Medicaid coverage for pregnant women to 133% of FPL

APPENDIX II: SUMMARY OF QUESTIONS ANSWERED BY FINAL REPORT

1.1 What is the overall level of uninsurance in your State?

- **15.2%** (~400,000 individuals) of total Arkansas population (adults and children) **excluding** those without working telephones, the institutionalized, persons living in group quarters, and the homeless (2001 Arkansas Household Survey of Health Insurance Coverage).
- **15.3%** (3-year average) (2000 US Census Bureau, Current Population Survey Reports).
- ~**20%** (1999 Behavioral Risk Factor Surveillance Survey, 2001 report by CDC).

1.2 What are the characteristics of the uninsured?

- Income: 27% of the uninsured live at <100% FPL; 45%, 100%–200% FPL; 21%, 200%–400% FPL, and 8%, ?400% FPL (2001 Arkansas Household Survey of Health Insurance Coverage).
- Age: 24% are aged 0–18 years; 51%, 19–44 years; 25%, 45–64 years; 1%, ?65 years (2001 Arkansas Household Survey of Health Insurance Coverage).
- Gender: 48% of uninsured Arkansans are male, 52% are female (2001 Arkansas Household Survey of Health Insurance Coverage).
- Family composition: 49% live with a spouse or partner and children, 19% live with children and/or grandchildren and no spouse or partner, 17% live with a spouse or partner and no children [NOTE: above categories include non-primary relatives and other non-relatives], and 15% live alone or with other non-relatives (2001 Arkansas Household Survey of Health Insurance Coverage).
- Health status: Most uninsured Arkansans rate their health equivalent to their insured counterparts; however, a slightly larger proportion of the uninsured, particularly in the 45–64-year age range, are in fair health instead of very good health (2001 Arkansas Household Survey of Health Insurance Coverage).
- Employment status (including seasonal and part-time employment and multiple employers): 34% of uninsured adults (19–64 years) are currently unemployed. Of the 66% uninsured adults who are employed, 51% work ?35 hours per week, including 30% employed full time with one employer (?35 hours per average week), 14% self-employed working full time, and 5% employed full time with one employer, and work for more than one employer; the remaining 15% are employed part time (<35 hours per week) (2001 Arkansas Household Survey of Health Insurance Coverage).
- Availability of private coverage (including offered but not accepted): Analysis of 2001 Arkansas Household Survey of Health Insurance Coverage data is underway, and results regarding availability of private coverage will be reported through the Arkansas SPG Supplemental Grant Report.
- Availability of public coverage: Analysis of 2001 Arkansas Household Survey of Health Insurance Coverage data is underway, and results regarding availability of public coverage will be reported through the Arkansas SPG Supplemental Grant Report.
- Race/ethnicity: 78% Caucasian, 17% African American, and 5% Other Races including Native American, Asian, Pacific Islander, Multiracial, and Other (2000 Behavioral Risk Factor Surveillance Survey).
- Immigration status: Analysis of SPG household focus group qualitative data is underway, and will be reported through the Arkansas SPG Supplemental Grant Report.
- Geographic location: Uninsured rates for Arkansans varied across regions: Mountain, 18.5%; Delta, 14.5%; Other Rural, 14.5%; Central Suburban, 10.3%; Northwest, 10.2%; and Urban (Pulaski County) (2001 Arkansas Household Survey of Health Insurance Coverage).
- Duration of uninsurance for children: Of all children 0–18 years of age who are currently uninsured, 20% have not had insurance since sometime earlier in 2001, 22% have not had insurance since 2000, 13% since 1999, 2% since 1998, 4% since 1997, 3% since 1995, 3% since 1994, 2% since 1992, and 4% since prior to 1990. Over one-fourth (28%) of all children who are currently

uninsured have **never** had health insurance (2001 Arkansas Household Survey of Health Insurance Coverage).

- Duration of uninsurance for adults: Of all adults 19–64 years of age who are currently uninsured, 11% have not had insurance since sometime earlier in 2001, 15% since 2000, 9% since 1999, 6% since 1998, 4% since 1997, 4% since 1996, 3% since 1995, 2% since 1994, 3% since 1993, 2% since 1992, 1% since 1991, and 10% since prior to 1990. Almost one-third (31%) of adults who are currently uninsured have **never** had health insurance (2001 Arkansas Household Survey of Health Insurance Coverage).

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Primary populations assessed included:

- Adults (19–64 yr) with incomes <100% of FPL (non employer-based options) who comprised 26% of the uninsured adults (~78,000).
- Adults (19–64 yr) with incomes 100%–200% of FPL (employer-based options)—42% of the uninsured adults (~124,000).
- Children (0–18 yr) with family incomes <100% of FPL—27% of uninsured children (~25,000).
- Children (0–18 yr) with family incomes 100%–200% of FPL—54% of uninsured children (~50,000).

(2001 Arkansas Household Survey of Health Insurance Coverage)

Among other target populations assessed were:

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

(2001 Arkansas Household Survey of Health Insurance Coverage)

1.4 What is affordable coverage? How much are the uninsured willing to pay?

- Generally other studies have indicated that individuals and families are willing to pay between 3% and 5% of family income for health insurance (Urban Institute).
- While the Arkansas SPG did not specifically assess these two issues for Arkansans, the Roundtable was comfortable in factoring the above finding into its assumptions.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

- It is anticipated that the analysis (currently in progress) of the 2001 Arkansas Household Survey of Health Insurance Coverage will allow the Arkansas SPG to make assessments that address these issues.

1.6 Why do uninsured individuals and families dis-enroll from public programs?

- It is anticipated that analysis of the 2001 Arkansas Household Survey of Health Insurance Coverage will yield information on these issues.
- Reported causes of public program dis-enrollment considered by the Arkansas SPG included ease of re-enrollment into ARKidsFirst, which lessens risk of dis-enrollment, and the perception by some persons that there is little risk related to dis-enrollment as there are health care facilities available that will provide care regardless of insurance status.

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

- The overwhelming majority of Arkansans offered health insurance by their employers chose to accept the coverage (Arkansas has the 3rd highest uptake rate among all states) (1996 Medical Expenditure Survey).
- Of persons who are offered coverage and decline, the overarching reason given is that the **cost** of health insurance is prohibitive.

? Additional reasons given by employees for declining employer-offered health insurance include perceived lack of risk to being uninsured, inconvenience related to enrollment and filing claims, and the perception by some persons that health insurance has a limited value if the enrollee and/or provider is a member of a minority racial group.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

? Data from Arkansas SPG Household Focus Group encounters revealed that most employees prefer that their health insurance be employer based.

1.9 How likely are individuals to be influenced by:
Availability of subsidies?

? Individuals of all income levels, and especially those of more moderate means (i.e., <200% FPL), are likely to be influenced by subsidies.

Tax credits or other incentives?

? Tax credits are more likely to influence individuals in higher income levels (>200% FPL) as an incentive to purchase health insurance.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

? While affordability of health insurance is the overwhelming reason given as the reason not to purchase coverage, other barriers identified included those discussed in Questions 1.5 and 1.7 above.

1.11 How are the uninsured getting their medical needs met?

? Delaying care—Many of the uninsured report that they do **not** get their medical needs met in a timely manner, but instead delay obtaining health care as long as possible.

? Safety-net providers—Many uninsured Arkansans obtain care from providers that include Community Health Centers, emergency departments, charitable mission providers, ADH County Health Units, and the Arkansas Medical Society indigent care referral network.

? Alternative payment mechanisms—Some uninsured Arkansans reported that they obtain care from traditional (non safety-net) providers incurring long-term debt that is eventually retired or on which they make nominal monthly payments under the assumption that providers will not turn over their accounts for collection.

? Bankruptcy—Medical debt has been reported to be the primary factor listed by Arkansas households for filing bankruptcy. Many Arkansans are unable to retire their debts and/or have incurred obligations to providers unwilling to accept nominal payments in lieu of instituting formal collection procedures.

1.12 What is a minimum benefit?

? The Arkansas SPG Roundtable concluded that the minimum health insurance plan benefit should include the following:

- 6 clinic visits/year
- 2 outpatient surgeries/year
- 2 prescriptions/month
- 7 days' inpatient coverage/year

? In addition, the Roundtable concluded that appropriate preventive care services should be included in health insurance benefits.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

? An in-depth examination of the "underinsured" was beyond the scope of this study; it is an appropriate topic for future research.

? The Roundtable did discuss the lack of prescription drug coverage for elderly Medicare recipients as an area of underinsurance that should be assessed.

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

? Reports indicate that firms that do not offer health insurance as a benefit tend to be smaller in size and are likely to be comprised of blue-collar employee groups when compared to firms that do offer this benefit (MEPS–IC).

For those employers offering coverage, please discuss the following:

? Cost of policies: Overall premium costs health insurance policies are increasing.

? Level of contribution: Many employers have reported that they are reducing the proportion they contribute for the purchase of employees' health insurance. This trend of decreasing contributions has been a factor in the erosion of family coverage.

? Percentage of employees offered coverage who participate: As the expense of premiums (and employees' proportionate share) increase, the portion of employees choosing to participate decreases.

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

? **Cost of purchasing coverage** is the almost universal reason employers give for electing not to provide health insurance as a benefit to their employees.

? Other influences listed by employers as affecting their decision to offer or not offer coverage include the custom and practice of their industry and a sense of duty some employers feel toward their employees.

2.3 What criteria do offering employers use to define benefit and premium participation levels?

? For fully-insured employers, state law has mandated a standard complete benefit package including traditional prevention components (e.g., childhood immunizations), mandating minimum stay requirements (e.g., 2 hospital days for newborn care), and specified benefits (e.g., *in vitro* fertilization). The 2001 Arkansas General Assembly passed Act 924 (the Health Consumer Choice Act) that allows employers offering a mandated benefits plan the option to also offer a "less than" mandated benefits plan with covered services to be determined by the employer/health insurance plan. It is premature to assess the impact of this Act. Most self-insured employers offer benefit packages that include both hospital, outpatient, and prescription services at levels equivalent to fully insured plans. These ERISA-protected plans primarily achieve cost containment through negotiated discounts with clinical providers and utilization management strategies (e.g., co-payments).

? Variable levels of employer contribution exist within Arkansas's employer base from minimal levels of contribution to 100% employee premium contributions. Employer support for family coverage varies from no support to some fraction of total premium dollars, with the employee required to contribute the unsupported fraction of the health insurance premium.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

? Large employers reported in key informant interviews that they continuously assess the cost of providing health insurance as an expense of doing business. While no large employer reported an intent to eliminate health insurance as a benefit, several reported that they plan on reducing benefit packages and/or increasing employees' cost share.

? Conversely, several small- to moderate-size employers reported an intention to eliminate health insurance as a benefit in response to increased premium costs and the current economic downturn.

2.5 What employer and employee groups are most susceptible to crowd-out?

? In industries and/or businesses with a very low profit margin (e.g., retail grocers, small family farms), even a slight cost savings in a component of their operating budget (perhaps attained by buying into a subsidized minimum benefit health care plan) can determine whether or not their business is profitable. Employer/employee groups in higher profit businesses and/or in sectors

where health insurance coverage is the normal expectation would likely be less susceptible to crowd-out.

2.6 How likely are employers who do not offer coverage to be influenced by:
Expansion/development of purchasing alliances?:
Individual or employer subsidies?:
Additional tax incentives?:

? These issues are among those targeted for study and development through the Arkansas SPG Supplemental Grant.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

? Considered but not selected by the Roundtable at this time was required participation in employer-sponsored health insurance. Such strategies have promise to achieve high levels of employer participation in either private or publicly supported methods of funding health insurance. However, the lack of prior experience in "bridging" between the public and private sector strategies and the political support required to implement a mandatory strategy caused this idea to be tabled pending implementation of current proposals.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

? In Arkansas, those with pre-existing conditions who can no longer afford traditional health insurance coverage have only one option, the state's high-risk grouping (CHIP). This minimal coverage is funded by a combination of mandatory assessments to insurance carriers and premiums paid by policy holders, which by statute are capped at 150% of the individual market rates. As of May 2001, there were only 2,447 enrollees in the program. Individuals have reported that despite the premium cap, the rates are outside of their ability to pay.

3.2 What is the variation in benefits among non-group, small-group, large-group and self-insured plans?

? Because of mandated coverage requirements, the fully insured group market in Arkansas has less potential for variation in benefits than is seen among self-insured firms.

? Often larger groups offer richer benefit packages. However, this is affected by the custom and practice of the respective sector of industry. White-collar employees, for example, generally expect a greater level of benefit than some of their lesser paid counterparts.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

? In Arkansas, ~25% of private sector firms are self insured for at least one health plan they offer as a benefit to their employees (MEPS-IC).

? By either creating their own network or purchasing access to an existing network, self-insured firms influence the market by removing large groups of employees from the enrolled ranks of health insurance companies.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

? Medicaid (children)—236,052 children (ACES report August 2001).

? Medicaid (adults)—216,610 adults (ACES report August 2001).

? State employees/state teachers—31,000/45,000 (reported enrollees – 2000).

? Arkansas Comprehensive Health Insurance Pool— ~2500 enrollees.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

While the Arkansas SPG did not specifically address issues surrounding attainment of universal coverage, the following assumptions can be made.

- Current market trends: A number of factors would impact any attempt to mandate universal coverage in Arkansas: the softening overall economy causing many employers to reduce or eliminate health insurance benefits, the marked reduction in the number of insurance carriers in the state with an accompanying rapid increase in annual premiums, hospital stability and difficulty in recruiting providers to underserved areas of the state, and the overall diverse socioeconomic and geographic nature of Arkansas that prevents crafting a single solution to the problem of the uninsured.
- Current regulatory environment: The Arkansas Department of Insurance (DOI) has reported that it only has direct regulatory oversight of ~25% of the insurance sold in the state. DOI has actively worked with the Arkansas General Assembly to craft legislation to strengthen the marketplace. Some recent bills passed by the Arkansas General Assembly include:
  - Health Insurance Consumer Choice Act (Act 924), which will allow consumers to select insurance policies without state mandated coverage options
  - Health Insurance Purchasing Group Act of 2001 (Act 925), which will allow small employers to pool purchasing power as non-profit Health Insurance Purchasing Groups (HIPGs)
  - Rural Health Access Pilot Program (RHAPP) (Act 549), which is a demonstration program allowing communities to organize and "self-insure" to increase access to care and stabilize local healthcare systems.
- Changes to be made in current regulations to approach universal coverage: Implementation of universal coverage in Arkansas would require a wholesale reshaping of the regulatory landscape including initiation of mandates to buy health insurance with a government-defined benefits package, initiation of guaranteed issue coverage and guaranteed renewability with limits of pre-existing conditions, implementation of mandatory employer/employee payroll premium taxes, mandatory state-set price controls and global budgets, creation and support of government-controlled health care purchasing cooperatives, and creation and support of community rating and low income subsidies.

3.6 How would universal coverage affect the financial status of health plans and providers?

- Any significant health insurance expansion that reduces the number of uninsured Arkansans would likely enhance the financial stability of health care providers and health plans as the deleterious effects of cost shifting are militated.

3.7 How did the planning process take safety net providers into account?

- Representatives from the Community Health Centers, Department of Health, Arkansas Medical Society, and Arkansas Hospital Society were invited to attend meetings of the SPG Roundtable and Working Group and asked to provide comment reflecting their relative constituent perspectives.
- Analysis of results from the 2001 Arkansas Household Survey of Health Insurance Coverage related to safety-net provider issues is currently in progress.

3.8 How would utilization change with universal coverage?

Although the issue of universal coverage was not specifically addressed by the Arkansas SPG, the following assumptions can be made.

- Expansion of health insurance coverage to presently uninsured Arkansans will almost certainly result in increased utilization of health care services.
- While it is likely that this increased utilization may be more cost effective (resulting from the potential shift of the uninsured currently using emergency departments as medical homes to having access to primary care providers), programs expanding health insurance will require stringent oversight and thoughtful management to ensure that the care they deliver is done so with maximum efficiency.

3.9 Did you consider the experience of other States with regard to:

Expansions of public coverage?

? Options considered included alternative strategies taken by states through their 1115 Medicaid waivers during the 1990s, SCHIP expansions over the past 3–4 years, and recent HIFA guidance on future options likely to gain federal support.

Public/private partnerships?

? Options examined included employer buy-in and premium subsidies through the Medicaid program, and local tax incentives for employer participation.

? The Roundtable also reviewed other states' experiences with community purchasing pools and concluded that this purchasing association is not effective in the long term as a result of the problems with adverse risk selection.

Incentives for employers to offer coverage?

? Incentives offered by other states considered by the Arkansas SPG included government-subsidized employer premiums, allowing employer buy-in to existing Medicaid programs, state tax vouchers, and other tax incentive programs.

Regulation of the marketplace?

? Regulatory mechanisms employed by other states were reviewed with special attention to strategies that increased oversight of the small group and individual plans resulting in overall strengthening and stabilization of the health insurance market. The Arkansas SPG considered the alternative effects of highly regulated and loosely regulated marketplaces.

(An extensive and exhaustive review of the literature and other available resources was conducted by the SPG staff and Working Group. The results of this work was put before the Roundtable for their review. The Roundtable members carefully considered the entire spectrum of public/private expansion options, incentives, and regulatory innovations implemented by other states in crafting their proposal for expansion of health insurance coverage in Arkansas.)

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The SPG evaluated all options available to the state and nation and selected the following coverage expansion options:

? Expansion of limited benefits Medicaid 1115 waiver expansion

? State–employer partnership through SCHIP waiver expansion

? Establish community purchasing pools for small business

? Small-group reinsurance strategies

? Modification of Federal legislation for MSAs

? Medicare modifications

For each option identified, questions 4.2 through 4.15 (when relevant to Arkansas's planning process) are answered in the table below.

4.2 What is the target eligibility group under the expansion?
4.3 How will the program be administered?
4.4 How will outreach and enrollment be conducted?
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?
4.6 What will the benefits structure be (including co-payments and other cost-sharing)?
4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)
4.8 How will the program be financed?
4.9 What strategies to contain costs will be used?
4.10 How will services be delivered under the expansion?
4.11 What methods for ensuring quality will be used?
4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?
4.13 How will crowd-out will be avoided and monitored?
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?
4.15 How (and how often) will the program will be evaluated?

4.1 Proposed Programs	Expanded Medicaid	State/Employer Partnership	Community Purchasing Pools	Small-Group Reinsurance	MSA Modification	Medicare Expansion
4.2 Target Eligibility Group	Adults 19–64 up to 100% of FPL	Adults 19–64 from 100% to 200% of FPL	Community-based employers	Insurance carriers offering small-group policies	Higher wage non-insured workers	Near elderly (55–65 yr) and disabled
4.3 Administration	AR DHS	AR DHS with option for outsourcing	Community/local boards	Insurance carriers with oversight by DOI	IRS monitoring	CMS over-sight
4.4 Outreach and Enrollment	DHS County Operations	Private insurance agents under contract to DHS	Local outreach initiatives	DOI regulations and procedures	Insurance agent marketing	CMS outreach
4.5 Enrollee / Employer Premium Sharing	No premium/ nominal co-payment	Employer/employee premiums; sliding scale co-payments	Full cost unless supplemented by local tax base	Insurance carriers bear cost	Full cost on enrollee/employer	Federal tax base
4.6 Benefits Structure and/or Co-payments	6 clinic visits/year 2 outpatient surgeries/year 2 prescriptions/month 7 inpatient hospital days/year **Co-payments** Nominal | Sliding Scale		Standardized benefit determined by pool	Standardized rules for operation and oversight determined by DOI	MSAs tied to group catastrophic policy	Medicare "buy-in" for 55–65 year olds; increased eligibility for disabled
4.7 Estimated Cost of Coverage	$117 M total; $34.5 M State	$186 M total; $40 M State	Nominal	Nominal	Nominal	Significant Federal costs
4.8 Financing Mechanism	1115 State Medicaid Waiver	1115 Medicaid/SCHIP State Waiver	Health Insurance Purchasing Group Act of 2001	DOI regulation	IRS Modification	Title XVIII of Social Security Act
4.9 Cost-containment strategies	Primary care case management	Co-payments and utilization management	Community risk management	Standardized regulations and enforcement	First-dollar cost to beneficiary	Co-payments and/or utilization management
4.10 Service delivery mechanism	DHS Medicaid program	DHS Medicaid/ employer partnership	Determined by community	N/A	Provider of choice	Medicare providers
4.11 Method of quality assurance	Annual quality assessments	Annual quality assessments	Determined by community	DOI oversight	DOI oversight	Medicare Quality Review Organizations

4.1 Proposed Programs	Expanded Medicaid	State/Employer Partnership	Community Purchasing Pools	Small-Group Reinsurance	MSA Modification	Medicare Expansion
4.12 Interaction with existing programs	Integrated with Medicaid/ ARKids First	Integrated with Medicaid/SCHIP/ ARKids First	Integrated with public and private sector programs	Reinsurance managed by participating carriers	May decrease full coverage options in private sector	Integrated with Medicare eligibility
4.13 Potential for crowd-out	Unknown, believed to be low due to basic benefit package and 6–12 month waiting period		Moderate replacement of individual/small group policies with aggregate moderate or large group pooled policy	N/A	N/A	Minimal because most non-working near-elderly or disabled are not currently insured
4.14 Enrollment data expected	Monthly	Monthly	Annual, must have 500 by 12 months (Act 925)	DOI monitoring	IRS monitoring	CMS monitoring
4.15 Program Evaluation	Biennial Legislature review	Biennial Legislature review	Annual DOI review	Periodic (quarterly?) DOI review	Annual IRS review	Review by CMS, period to be determined

FPL=Federal Poverty Level; AR = Arkansas; DHS= Department of Human Services; DOI= Department of Insurance; IRS=Internal Revenue Service; CMS=Center for Medicare and Medicaid Services

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

? Based upon assumptions of the Roundtable, opportunities to maximize fiscal resources to achieve coverage goals were driving forces. The high rates of uninsurance among low income employees working full time and the higher levels of insurance available through private health insurance required bridging strategies that met the needs of low-income Arkansans while avoiding crowd-out issues and further destabilization of the private health insurance sector.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

? During the 2001 General Assembly, significant legislation was enacted that provides a platform of future health insurance expansion initiatives as outlined in the SPG including

- Health Insurance Consumer Choice Act (Act 924), which allows consumers to select insurance policies without state mandated coverage options
- Health Insurance Purchasing Group Act of 2001 (Act 925), which allows small employers to pool purchasing power as non-profit Health Insurance Purchasing Groups (HIPGs)
- Rural Health Access Pilot Program (RHAPP) (Act 549), which is a demonstration program allowing communities to organize and "self-insure" to increase access to care and stabilize local health care systems

? ARKids First is a nationally recognized Medicaid/SCHIP expansion program (initiated in 1996) that has enrolled more than 75,000 of the originally targeted 90,000 uninsured children in the state.

? The Tobacco Settlement Proceeds Act of 2000 included expansion of limited Medicaid benefits to low income adults.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

? Mandatory employer participation was not selected due to the political feasibility of achieving support and the potential economic implications of abruptly requiring all employers to participate. Similarly, increasing fragmentation and development of individual insurance policy options were felt to be destabilizing to the goals of health insurance and actively leading to increased levels of uninsured, particularly for those with chronic and/or costly health conditions.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

? The DHS has established a simplified enrollment process through which parents are evaluated for eligibility for ARKids First A (Medicaid) or ARKids First B (Expansion). Appropriate assignment and optimal benefit eligibility is achieved while maintaining parental choice in program participation.

? The DHS has engaged school nurses across the state to ensure optimal new enrollment and maintenance of coverage in the AR Kids program. Some school districts exceed 70% eligibility for ARKids First in student membership.

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

- Governance: The Arkansas SPG was governed by a Roundtable comprised of three key stakeholder groups: 1) health insurance purchasers representing small and large groups, public purchasers, and self-insured corporations; 2) healthcare providers/health insurers representing entities responsible for direct patient care and private/public companies responsible for managing health care risks; and 3) consumers representing individual citizens, families, organized labor, and minority groups. The Roundtable was staffed by a multidisciplinary team led by the Principal Investigator. Members of the Roundtable were approved by the State Health Officer and Governor prior to being invited to serve.
- Role and responsibilities of Roundtable Members: Five tasks were assigned to the Roundtable: 1) assure accurate assessments of current health insurance statistics, 2) fully explore potential solutions to increase health insurance coverage to Arkansans, 3) review information gained from primary and secondary data analyses, 4) develop and prioritize solutions for expanding affordable health insurance to currently uninsured citizens and for stabilizing the health insurance marketplace, and 5) review and oversee the report to the Secretary of DHHS.
- Roundtable meeting schedule and content areas: The Roundtable met six times between March and October 2001. Additionally, a 2-day educational session was held with the Academy of Health Services Research and Health Policy to facilitate optimal understanding and communication. Finally, a series of conversational briefings was held with smaller groups of Roundtable members to discuss the proposed plan in the latter stages of completion.
- Roundtable group process and consensus strategies: Members were mailed agendas and instructional information. The Chairman guided the process used to gain consensus. In addition to traditional methods of didactic presentations and group interaction, the knowledge, opinions, and preferences of the members were monitored using an Audience Response System, which maximized group participation by promoting discussion, measuring group comprehension, and allowed for unbiased preference selection. Group consensus was achieved by evaluating aggregate responses. Individual polled response data was kept confidential.
- Roundtable General Assumptions and Guiding Principles: General assumptions and principles upon which options were based are discussed in detail in the full report (see p. 36).
- Role of the Working and Observer Groups: The Working Group provided expert technical assistance and consultation by vetting all the materials and presentations for the Roundtable. An Observer Group representing the governor's office, legislative staff, government agencies and health care organizations was invited to inform the Roundtable during their meetings. These two consultative committees provided valuable input to the Roundtable and afforded a mechanism of representation for key state agencies.
- Vetting criteria for proposal workup: Characteristics for review included the background, statement of need, target population, mechanism of coverage, existing/historical activity, cost, funding source, political viability, anticipated impact, and strategic recommendation. Guided by a core set of assumptions, the Roundtable members explored all the options for expanding health insurance coverage and they modeled the impact of proposed solutions using vetting criteria reflecting the intent of the Roundtable principles.
- Membership survey: Early survey results show that the Roundtable felt that they were well informed about the issues and were given appropriate strategies to evaluate all options. They acknowledged that the balanced representation of membership and the ARS system substantially increased the consensus-building capacity of the group. A final survey of the Roundtable was conducted to evaluate issues including 1) membership recruitment, 2) issue orientation, 3) logistics,

4) leadership, 5) role of observers, 6) Roundtable interaction, 7) use of audio-visual materials, 8) instructive documentation, 9) facilities, and 10) reimbursement fees.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)? Describe data collection procedures.

? **Secondary qualitative and quantitative data** were obtained from previous data collection efforts and from administrative records compiled by federal, state, and proprietary sources including the Behavioral Risk Factor Surveillance System (BRFSS); Current Population Survey (CPS); Census Population and Housing Survey; Medical Expenditure Panel Survey Household Component (MEPS-HC); MEPS Insurance Component (MEPS-IC); Arkansas BlueCross BlueShield administrative database; Arkansas Medicaid Summary Reports; the Arkansas Hospital Discharge Database; and the Advocates for Children and Families (AACF) qualitative data, summarized in *Making it Day-to-Day: A New Family Income Standard for Arkansas*.

? **Primary qualitative data** included key informant interviews with large employers and insurers, and focus groups with Arkansas household decision-makers and small- to moderate-sized employers.

? **Primary quantitative data** included a statewide random-digit dial phone survey of Arkansas households, and will include, in a subsequent analysis, survey data collected from employers via the 2000 MEPS-IC collected in 2001.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

? The Roundtable has served as an effective advocacy vehicle and successfully advanced a set of recommendations for health insurance expansion to Governor Huckabee in October 2001. As part of their commitment, they expect to continue functioning beyond the SPG project period as the public forum for health issues in the state, supported in part through the RWJF State Coverage Initiative (SCI).

? The PI and project staff of the SPG deliberately chose not to engage in a broad communication plan during the first year of the planning process because of the time frame for the SPG, the scope of work and to minimize external distractions and public exposure of Roundtable members.

? The public was kept abreast of the project through the Arkansas Center for Health Improvement (ACHI) web site and select public speaking opportunities by Project Staff and the PI.

? An additional avenue for dissemination of SPG related information was through the periodic generation of a newsletter that was emailed to interested parties.

? After the release of the Arkansas Health Insurance Expansion Initiative Report by the Governor to US DHHS Secretary, Tommy Thompson, the SPG project staff will distribute the Roundtable's plan through multiple outlets (printing and mailing reports to key stakeholders, including each member of the Arkansas General Assembly; US Congressional representatives; state and local Chambers of Commerce; identified business associations and consumer advocates; and members of the print, radio, and television media).

? SPG staff will present the findings to the Joint Insurance and Commerce Committee and the Joint Public Health, Welfare, and Labor Committee of the Arkansas General Assembly.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

? Arkansas's General Assembly convenes on a biennial basis, with the last session ending in May 23, 2001. The recommendations advanced by the Roundtable and the resulting policy implications will most likely impact the 2003 session.

? The likelihood that the expansion proposal will be undertaken in full is a function of how well Arkansas can counterbalance some of the impediments that currently exist such as limited state general revenue, term limits affecting institutional knowledge in the General Assembly, limited

resources to develop state health policy, and potential for inaction at the Federal government level. These are counterbalanced by a cadre of political and health leaders with strong personal commitments to the state and a demonstrated ability to effect change.

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

- ✍ The SPG allowed Arkansas to conduct an empirical assessment of the causes and magnitude of its uninsured population. Through this process, accurate quantitative information was gathered on both households and employers. Using this information, variations in regions and characteristics of the uninsured were determined. This stratification formed the basis of priorities for expansion options. Also, qualitative research through focus groups and key informant interviews informed the decision-making process of the Roundtable.
- ✍ These activities were essential in evaluating options for expanding health insurance in the state and for assessing the need to stabilize the existing insurance market. The integration of quantitative data from secondary and primary sources into an "integrated database", in conjunction with qualitative research efforts, allowed the Roundtable to ask and receive answers in real-time during discussions, which lead to the development of data-driven solutions.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

- ? The most effective use of resources for data collection was to enable the fielding of the 2001 Arkansas Household Survey of Health Insurance Coverage, which provided the first comprehensive examination of the uninsured in Arkansas. The state had not previously conducted such a survey and this data collection effort will continue to drive and shape decision making in the future because analyses are ongoing. This effort would not have been possible without support through the SPG.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

- ? Originally, Arkansas proposed an independent survey of employers. Because of the complexity associated with this methodology, the state instead chose to purchase an oversampling of the MEPS-IC data from AHRQ to be provided in 2002. In light of the lack of quantitative employer information (other than that available from secondary sources), the qualitative information collected during the SPG was relied upon heavily in developing options. In addition, Arkansas had proposed to conduct key interviews with five major insurance providers in the state. However, due to the number of large employers that are self insured and the shrinking insurance market, only three major insurers now operate in Arkansas. Because representatives from insurance companies participated fully in both the Working Group and Roundtable, interviews were not necessary.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

- ? Assistance from UALR-IEA, ADH, SHADAC, and AHRQ were invaluable in rapidly acquiring and incorporating available data into the decision process.
- ? For quantitative data collection, the repeated call-back and recruitment methods of CSR helped achieve a high response rate for the household survey. An invitation from the Governor to large employers requesting participation in the key informant interviews was also believed to help achieve a response rate of 100%. Focus groups conducted by AACF and UAPB were also successful due to these organizations' skills and community links, and to the provision of meals to enhance participation. Existing organizations, Farm Bureau and NFIB, also assisted in successful recruitment of participants for employer focus groups.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

- Additional data needed in Arkansas relates to uncompensated or unreimbursed care. Existing state and federal information does not accurately capture these dollar figures or project the contribution that unreimbursed care plays to rising insurance costs.
- Several policy-relevant questions remain unanswered.
  - What is the magnitude of unreimbursed care?
  - What is the impact of insurance coverage on safety net providers?
  - How can the state stabilize the individual insurance market?
  - What will be the impact of a declining economy on insurance take-up rates?
- Arkansas plans to conduct a readiness assessment that will include additional business focus groups, town hall meetings, and a voter survey using supplement funds from HRSA's SPG program. Actuarial modeling of each proposed option will also be conducted.

6.6 What organizational or operational lessons were learned during the course of the grant?

- States require adequate time to fully analyze data collected and develop expansion strategies.
- Outside issues involving major revenue needs may overshadow the success of the plan implementation.
- Educational strategies are needed to effectively disseminate and market expansion efforts.
- If asked, ordinary citizens will engage in a deliberative process to improve health insurance coverage.
- Empirical state-specific data can result in significant attitude change.
- Use a working group of experts to analyze and process information to be presented to the decision-making body can reduce the time commitment for decision makers on the project.
- Real-time access to integrated data improves deliberations and policy decisions.

Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

- See responses to Section 4 questions.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort?

- Increasing the number of insurance carriers in the state does not necessarily reflect an improved market.
- Large insurers will support legislative changes that level the playing field for all carriers. They will also support public programs to expand coverage if the programs reduce the amount of uncompensated care being shifted to the private market.
- The large number of independent agents in the state drives the market and can impact the implementation of expansion and stabilization strategies.
- Most large employers are self-insured.
- Employers are concerned about the rapidly rising costs of pharmacy. They are devising strategies to implement to cap their costs in this area.
- Many employers have a strong sense of responsibility to provide employees health insurance.

How have the health plans responded to the proposed expansion mechanisms?

- At present, both large insurers and the provider community recognize that it is in their best interest to work with the grantee to attempt to reduce the level of unreimbursed care through some insurance coverage expansion strategy. Thus, they are supporting the work completed in Arkansas's SPG.

What were your key lessons in how to work most effectively with the employer community in your State?

? By providing equal seating at the table for providers and consumers, the employer community was able to listen and participate in the solution design. Empirical data can be persuasive in changing attitudes towards the uninsured. However, many decisions in the business community are driven more from personal experiences or anecdotal information.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

? States should adopt an apolitical decision-making process that relies on objective data analysis. Arkansas did this using a Working Group that fed information to the Roundtable (decision-makers). Politicizing the process was avoided by inviting representatives from the political sector to "observe" and "comment" on the Roundtable deliberations rather than lead deliberations.

? National technical assistance should be used to fully explore the work of other states.

? By providing immediate access to empirical data, decision makers' deliberations can be informed and not based on myths and other disbeliefs.

? High-profile political figures can successfully solicit participation by large employers and insurance companies doing business in the state.

? Evidence-based preventive medicine policies should be incorporated into proposed health insurance expansion activities.

? States should optimize federal funds available for health care coverage.

? Employers should use annual employee compensation summaries to educate employees, credit employers who participate in health care benefits, and help employees make decisions based on knowledge of a full compensation package.

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

? A Medicaid waiver is required for expansion of Medicaid up to 100% of the FPL for adults aged 19–64 years with a limited benefits package.

? A public–private partnership to offer employer-based limited benefits coverage for adults aged 19–64 years from 100% to 200% of the FPL would require an SCHIP waiver.

? An elimination of the current practice of MSAs associated with individual catastrophic coverage and redesign of MSAs to be tied to group catastrophic coverage would require changes in federal law and regulations.

? Providing tax neutrality by adding income tax exemptions for the purchase of individual health insurance plans would require modifications in the Internal Revenue Code.

? Providing a similar income tax exemption for individuals participating in a community purchasing pool would require changes in the Internal Revenue Code.

? The federal Medicare program should add some form of prescription drug coverage. This would require authorizing legislation, a revenue source through an appropriation and regulations for implementation. Current Medicare coverage fails to meet the definition of basic benefits adopted by the Arkansas Roundtable.

? The federal Medicare program should be expanded to provide buy-in access for persons 55–64 years of age.

? The federal Medicare program should be expanded to allow disabled persons access to health care coverage.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

? ERISA would have to be changed to allow states to mandate employer coverage or develop a publicly funded universal coverage program. The federal law should be changed to allow states to pilot innovations for further study in this area.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

? To sustain the momentum from the planning grant process, the federal government should authorize HRSA to enter performance partnership agreements to provide funding to SPG states to develop data collection systems to monitor implementation and coverage expansion. Each state and HRSA should set annual goals for progress in the coverage initiative with additional funding each year to support attainment of additional goals. The Federal government should also:

- o continue to convene states and disseminate information about lessons learned from this process;
- o should support the development of an integrated data system that would allow states to collect, analyze, and share comparable data in a more informative, meaningful way
- o support over-sampling of national surveys in small states to provide state-specific information; and
- o support creative formation of regional solutions.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

? In addition to those suggestions listed in 7.3, the Federal government should support creation of additional new research programs that encourage a partnership in design between the Federal agency and states to allow innovation and experimentation. Rather than determining the one-size-fits-all solution at the Federal level, allow states to design and implement programs customized to meet their needs. This will result in a more efficient and better program for the people to be served.

APPENDIX III: RESEARCH FINDINGS AND METHODOLOGIES

1. ***Center for Survey Research, UMASS, 2001 Arkansas Household Survey of Health Insurance Coverage, Methodological Report***
2. ***2001 Arkansas Household Survey of Health Insurance Coverage Survey Instrument***
3. ***Household Focus Group Question Guide***
4. ***Arkansas Advocates for Children and Families (AACF), Household Focus Group Final Report***
5. ***University of Arkansas at Pine Bluff (UAPB), Household Focus Group Final Report***
6. ***Employer Key Informant Question Guide***
7. ***Employer Focus Group Question Guide***
8. ***Roundtable Meeting Agendas***

APPENDIX IV: CLINICAL PREVENTIVE SERVICES FOR INCLUSION IN ALL HEALTH FINANCING STRATEGIES

Preventive services listing from* Guide to Clinical Preventive Services, *2nd edition, Report of the US Preventive Services Task Force