



## Roundtable Report

March 2002



# ACHI

ARKANSAS  
CENTER FOR  
HEALTH  
IMPROVEMENT

Report of the  
Arkansas Health Insurance Expansion Initiative  
Roundtable  
March 2002

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**Funded through a HRSA State Planning Grant  
Presented to the Governor, the General Assembly,  
and the Citizens of the State of Arkansas  
and the US Secretary of the Department of Health and Human Services**

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# Roundtable Report

## March 2002

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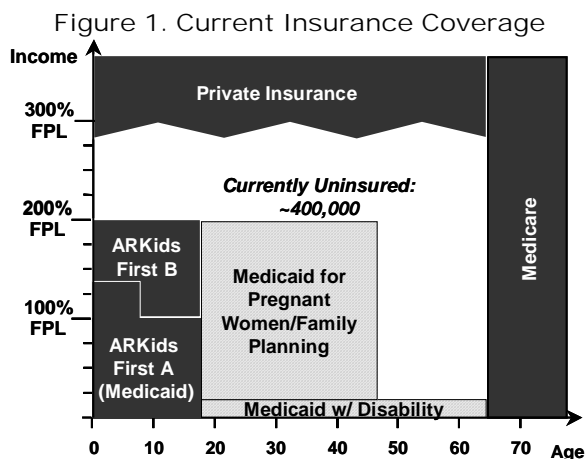
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## A CRISIS IN ARKANSAS—THE HEALTH INSURANCE PROBLEM

Arkansans are facing a threat to their health and economic security not previously experienced: Arkansans are less healthy than other people in the US, their costs of receiving health care are increasing much more rapidly than their incomes, and employers who serve as the primary source of Arkansans' health insurance are being forced to drop or modify health insurance coverage. Together, these three factors form a crisis in Arkansas as evidenced by the following.

- More than 400,000 of our 2.67 million citizens now lack health insurance.
  - Among working-aged adults (19–64 years old), 20% are uninsured.
  - In certain regions, uninsurance rates are even higher (up to 28%).
- Most households get their insurance from their employers (>80%); however, employers are struggling to maintain health care benefits due to rising costs.
  - Employers who offer health insurance coverage are experiencing cost increases of 25%–80% this year.
  - Only 1 in 3 of Arkansas's small employers (<50 employees) can offer health insurance.
- More than half of Arkansas households are concerned about their ability to maintain health insurance coverage.
  - If insured, families are increasingly “patching” insurance together from multiple sources to maintain coverage.
  - For the uninsured, families frequently must choose between seeking needed care and facing financial demise, including personal bankruptcy.

Current health insurance coverage in the state includes private insurance; federal coverage for the elderly through Medicare; and state coverage for children, pregnant women, and the disabled through Medicaid (Figure 1). More than 80% of individuals get their insurance coverage from the private sector. For those older than 65 years of age, >99% receive hospital and medical coverage through Medicare although prescription drugs are frequently not covered; for children (≤18 years), the ARKids program provides nationally recognized coverage in both outreach and delivery of services. Unfortunately, for those individuals between 19 and 64 years of age who do not have access to employer-based insurance or incomes great enough to buy into existing insurance products, little support is present. The state's Medicaid program does provide coverage for pregnancy and family planning. However, coverage for basic medical services is very restricted and requires that families have incomes <25% of the federal poverty level **and** an individual disability **and** minimal family assets. Thus, no “safety net” exists for the majority of working Arkansans who are an accident away from financial and medical catastrophe.



Arkansans' lack of health insurance has a direct and negative effect on both the health of the state's citizens and its economy. Insurance coverage is critical to seeking and receiving appropriate treatment for most conditions. Families without health insurance that delay obtaining timely health care risk higher illness and death rates because treatable illnesses become catastrophic when not treated early.<sup>1</sup> Many uninsured families are forced to turn to emergency departments when their health care needs become acute. Increased dependence on these 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

<sup>1</sup> American College of Physicians – American Society of Internal Medicine. No Health Insurance? It's Enough to Make You Sick – Scientific Research Linking the Lack of Health Coverage to Poor Health. Available at <http://www.acponline.org/uninsured/lck-exec.html>. Verified October 24, 2001.

health care costs likely provides additional reason to delay seeking health care and defer purchasing health insurance.

When individuals without health insurance do receive care, 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—which subsequently has a direct, negative impact on 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 recent closure of rural hospitals and providers.

Finding funds to cover rising health care and insurance costs in Arkansas is difficult. Arkansas's economic base is one of the poorest in the nation. The overall tax base in the state is relatively small when compared to other states largely due to the low per-capita income. 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.

To address this growing crisis in health insurance coverage, in 2000, Governor Mike Huckabee asked the Arkansas Center for Health Improvement (ACHI) to lead in an examination of health insurance issues facing the state. Through a competitive proposal submitted to the Health Resources and Services Administration (HRSA) on behalf of the state, ACHI secured a 1-year, \$1.4 million award to examine the issues and develop a strategic plan for the state. Arkansas's proposal was 1 of 11 national awards to the 50 states and the only award in the first round of the HRSA program given to a Southern state.

Previously, no systematic assessment or ongoing monitoring strategy had been employed by the state to determine insurance coverage or direct policy development. Through **Arkansas's State Planning Grant (SPG)**, the state has completed its first empirical assessment and systematic evaluation of strategies to address its uninsured citizens. Statewide data collection from households and employers was conducted to assess the availability and need of health insurance within Arkansas. With this new information, a Roundtable consisting of 21 private citizens representing employers, consumers, and health insurance/providers examined all options for stabilizing and expanding health insurance coverage in the state. Through these activities, a draft of strategic steps for local, state, and federal action has been developed. After legislative and executive review, these action steps will be submitted to the US Department of Health and Human Services in March 2002 as Arkansas's final report and strategic plan for addressing a growing health and fiscal crisis.\*

## A PROFILE OF HEALTH INSURANCE COVERAGE IN ARKANSAS

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### THE INSURED AND UNINSURED

Through systematic collection of information by the SPG team, a profile of Arkansans—both insured and uninsured—has been created. The challenges facing the uninsured are clearly visible; the success of insurance expansion to children through the ARKids program is apparent; and the challenges facing a poor, rural, Southern state are starkly self-evident.

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\* **Abbreviations used in this report:** **AACF**, Arkansas Advocates for Children and Families; **ACHI**, Arkansas Center for Health Improvement; **AHRQ**, Agency for Healthcare Research and Quality; **BRFSS**, Behavioral Risk Factor Surveillance System; **CHIP**, Comprehensive Health Insurance Program; **CMS**, Center for Medicare and Medicaid Services; **CPS**, Current Population Survey; **ERISA**, Employee Retirement Income Security Act; **FPL**, federal poverty level; **HRSA**, Health Resources and Services Administration; **MEPS**, Medical Expenditure Panel Survey; **MEPS-HC**, MEPS Household Component; **MEPS-IC**, MEPS Insurance Component; **MSA**, (Archer) Medical Savings Account; **SCHIP**, State Children's Health Insurance Program; **SPG**, State Planning Grant; **SSDI**, Social Security Disability Insurance; **UAPB**, University of Arkansas at Pine Bluff; **VA**, Veterans Administration.

## COLLECTION OF INFORMATION FROM HOUSEHOLDS AND EMPLOYERS

To create a complete profile of health insurance in Arkansas, the SPG gathered information from employers, consumers, and insurers to optimally develop and prioritize health insurance expansion options for the state. **Existing data** from previous data collection efforts and from administrative records compiled by federal, state, and proprietary sources included the following.

- Behavioral Risk Factor Surveillance System (BRFSS) data from the Arkansas Department of Health (1997–2000) provided state-level estimates of health care utilization, health status, health risk behaviors, and health insurance status.
- Hospital discharge data collected from 1997 through 1999 and provided by the Arkansas Department of Health included 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, obtained from the US Bureau of Labor Statistics and the Bureau of the Census, provided estimates of the uninsured population and provided 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.
- The Arkansas State Medicaid program fact sheets combined with program eligibility guidelines derived from the 2000 Annual Federal Poverty Level Guidelines provided information on Medicaid programs and eligibility. Medicaid eligibility is determined by income eligibility levels, household assets, age of the individual, and family size in household of residence.
- 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.
- Data collected and reported by the Arkansas Advocates for Children and Families (AACF), including *Working Families and the New Economy*,<sup>2</sup> and *Making it Day-to-Day: A New Family Income Standard for Arkansas*,<sup>3</sup> were used to gain a better understanding of economic challenges facing Arkansas households.
- Specific databases including business listings and published reports were identified for inclusion in profiles of Arkansas businesses and their employees.
- The Medical Expenditure Panel Survey Insurance Component (MEPS-IC), which is a nationwide annual survey of more than 25,000 private-sector establishments and governments in the US, provided estimates of job-related insurance both at the national and at the state level; information gleaned from the data included estimates of workers' access to job-related health insurance.

**New data** was gathered from surveys, key informant interviews, and targeted focus groups.

- The **2001 Arkansas Household Survey of Health Insurance Coverage** was a telephone survey over a 6-month period (2/27/01–8/27/01) that yielded 2,572 household interviews, collecting data regarding 6,596 individuals in Arkansas that provided new state-level and regional-level estimates of the insured and uninsured adults and children in Arkansas. Questions were also included in the survey to accurately classify households according to federally or state-supported insurance programs. Eligibility for Arkansas's Medicaid program, including ARKids First, ConnectCare, and Medicaid-eligible Medicare beneficiaries, is

**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, 200% of the FPL for pregnant women, <25% of FPL for disabled adults 19–64 years of age, and 120% for Medicaid-eligible Medicare beneficiaries over age 65 years.

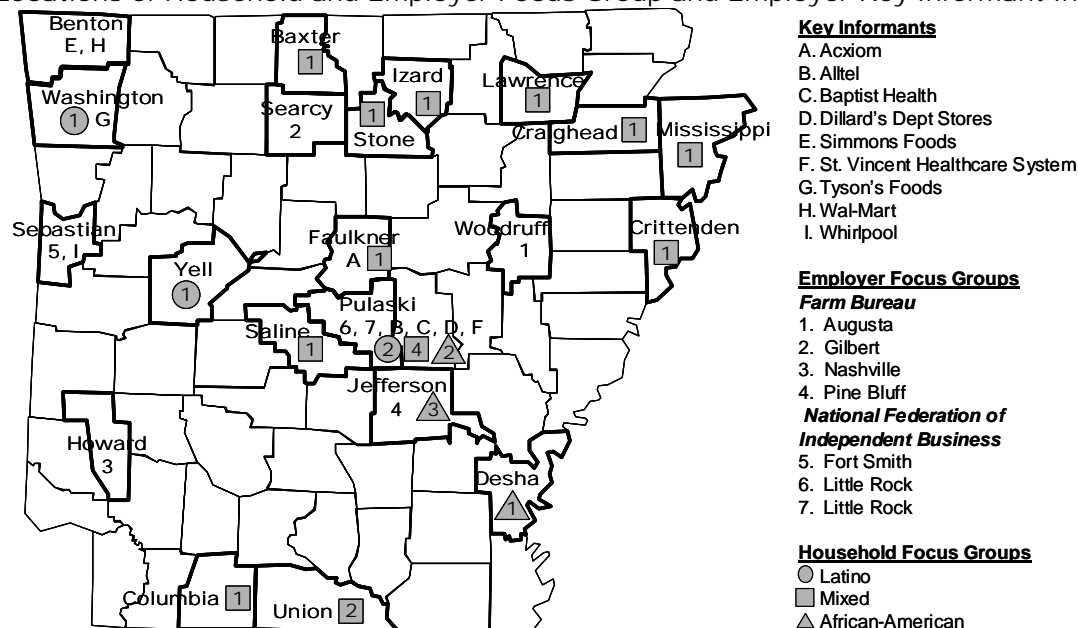
<sup>2</sup> Working Families and the New Economy. Arkansas Advocates for Children and Families. Available at <http://www.aradvocates.org/workfam/labormrktPSA10.00.asp>. Verified September 25, 2001.

<sup>3</sup> Making it Day-to-Day: A New Family Income Standard for Arkansas. Arkansas Advocates for Children and Families. Available at <http://www.aradvocates.org/workfam/workfamrpt.asp>. Verified September 25, 2001.

determined by household income and assets. Table 1 provides thresholds for 2000 annual federal poverty level (FPL) for households that are used to determine program eligibility and that vary by family size.

- The **2001 Arkansas Household Focus Groups** were conducted by AACF and consisted of 20 household focus groups in communities throughout Arkansas, 4 of these 20 were conducted entirely in Spanish with Latino household members. The University of Arkansas at Pine Bluff (UAPB) conducted an additional 6 household focus groups with African-American participants. These 26 household focus group sessions (Figure 2), each with 8–10 participants, were used to investigate the circumstances influencing adults' rationale when making decisions regarding health insurance.
- The **2001 Key Informant Interviews** were conducted with 9 of the largest employers in Arkansas (see Figure 2); 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) and investigated what influences large employers' decision-making regarding employer-sponsored health insurance.
- The **2001 Employer Focus Groups** targeted small- to moderate-sized employers (see Figure 2) to provide additional perspectives to those of the largest Arkansas-based employers; working with the Arkansas Chapter of the National Federation of Independent Business (NFIB) and the Arkansas Farm Bureau, 7 employer focus group sessions were held that included a total of 50 employers, with an average of 7 participants per session; the employer data collected investigated the decision-making process of small- to moderate-sized employers with regard to employer-sponsored health insurance.
- The **2001 Employer Survey** (MEPS-IC Arkansas Sample) is currently being collected from Arkansas employers through an expanded sample of the MEPS-IC Survey. By June 2002, the Agency for Healthcare Research and Quality (AHRQ) will conduct and analyze data from a mail survey with telephone follow-up of 1,800 employers in Arkansas via the nation-wide 2000 MEPS-IC Survey.

Figure 2. Locations of Household and Employer Focus Group and Employer Key Informant Interviews



## Insured and Uninsured Arkansas Households

While new challenges threaten Arkansans' ability to secure health insurance, the challenge of uninsurance is not a recent phenomenon. Before the ARKids First program was founded, Arkansas had one of the highest percentages of uninsured in the nation. CPS estimates of the uninsured were 24.4% in 1997 of Arkansas citizens and dropped since ARKids began to 14.7% in 1999.<sup>4</sup> Unfortunately, while the elderly remain predominantly insured by Medicare and ARKids First increasingly provides insurance options for

<sup>4</sup> US Bureau of the Census. Health Insurance Coverage: 1999. Table E. Percent of People Without Health Insurance Coverage Throughout the Year by State (3-year Average): 1997 to 1999. Available at <http://www.census.gov/hhes/hlthins/hlthin99/hi99te.html>. Verified December 17, 2001.

children, working aged adults (19–64 years) have not gained new health insurance benefits as part of the nation’s economic expansion of the last decade. During this time, a stable 18%–20% of working Arkansas adults across the state have remained uninsured with several regions reporting higher rates of uninsured. Importantly, recent reports of significant increases in private health insurance premiums threaten to increase the number of uninsured adults and children, as families can no longer afford coverage. To achieve precise projections of both the insured and uninsured and to provide accurate information on the characteristics that may be associated with the uninsured, ACHI undertook a multi-component data collection effort to portray the current profile and decisions under consideration in the state.

### New Findings—2001 Arkansas Household Survey of Health Insurance Coverage

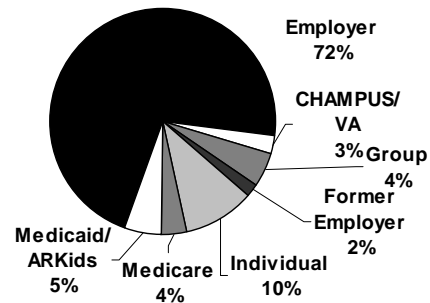
**Overall Insurance Rates.** The SPG survey found that more than 15% (~0.4 million) of all Arkansans are uninsured. Conversely, ~85% (~2.3 million) of Arkansans are insured. Examining the age and employment status of the uninsured and their household incomes provides previously unavailable Arkansas-specific information to target increased outreach for existing programs and new program development.

**Age and Insurance.** Age is an important determinant of insurance status due to program eligibility definitions. Virtually all Arkansans (99%) ≥65 years of age are covered by the federal Medicare program. In addition, 87% of children and adolescents (≤18 years) have health insurance, either private or through the state’s ARKids First program. However, 1 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 people are working.

**Employment and Insurance.** When the source of insurance is examined for those 19–64 years of age, the importance of employer-based health insurance becomes readily apparent. Among this group, more than 80% receive their benefits through current or previous employment (Figure 3). Of the remaining 20% in this bracket, half purchase health insurance in the individual health insurance market and the remaining 9% receive public support through Medicaid or Medicare. But, while individuals with insurance largely receive their benefit due to their employment status, many uninsured are working or have family members who are employed.

**Poverty and Insurance.** Arkansans from lower-income families represent a greater proportion of the state’s uninsured (Figure 4). Importantly, most uninsured individuals are in working families with household incomes of 100%–200% of the FPL (Figure 5). Of the uninsured children, ~81% live in families with incomes <200% of the FPL and, therefore, are potentially eligible for the ARKids First Medicaid/SCHIP (State Children’s

Figure 3. Insured Adults (19–64 yr) in Arkansas



CHAMPUS=Civilian Health & Medical Program of the Uniformed Services. VA=Veterans Administration.

Figure 4. Uninsured and Insured Arkansans by Federal Poverty Level

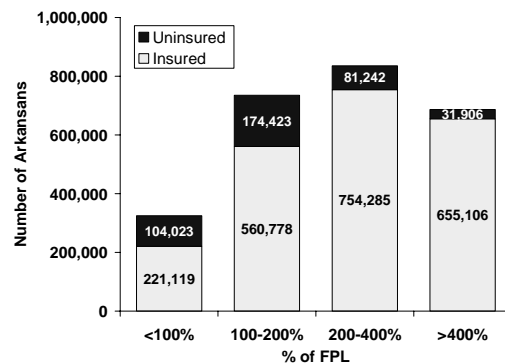
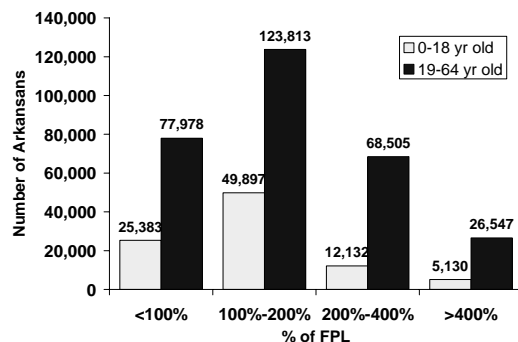


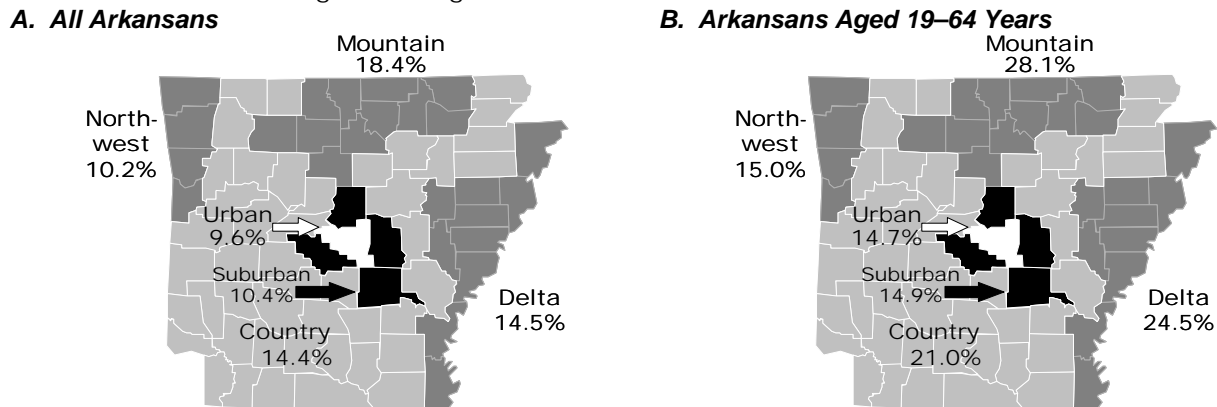
Figure 5. Uninsured Adults and Children in Arkansas by Federal Poverty Level



Health Insurance Program). These children may have never enrolled; may have been previously enrolled but failed to re-enroll; or, if their family has recently lost health insurance in the private sector, may be in the requisite waiting period prior to enrollment (currently 6 months without health insurance). Obviously, eligible children should be enrolled and maintained in the existing ARKids program, which has demonstrated success and continued political support. However, public programs offer very limited, if any, health insurance coverage for the “working poor” adults aged 19–64 years.

**Region and Insurance.** Regional variation of the proportion of uninsured Arkansans is marked (Figure 6A). Using six groups of counties, homogeneous regional groups were analyzed, including urban Pulaski County in central Arkansas, 4 central suburban counties, 4 counties in the economically prospering Northwest corner of the state, the rural areas of the state, and the economically depressed areas of the north central mountain area and the Mississippi Delta. While the overall state proportion of the uninsured is 15.2%, proportions vary from 9.6% in the Urban region to 18.4% in the Mountain region. Restricting the examination to 19–64-year-old adults, the regional variation in the uninsured becomes more dramatic (Figure 6B).

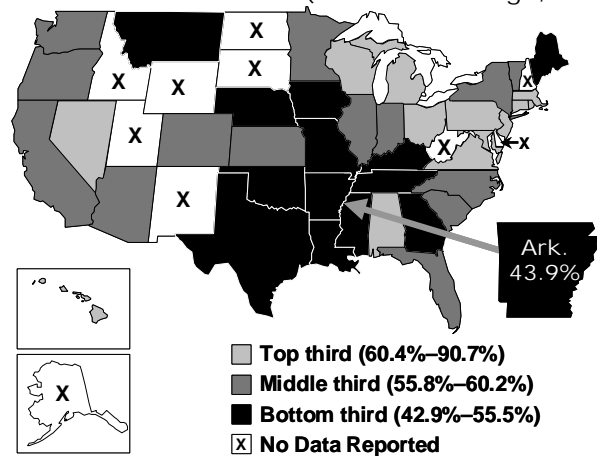
Figure 6. Regional Variations in the Uninsurance Rate



### Existing Data on Employer-Based Coverage

Results from the MEPS-IC in 1999 revealed important issues surrounding access, cost, and choice of health insurance in how Arkansas compared with its neighboring states and the nation. As noted above, job-related health insurance serves a major role in covering American workers and their families across the country. On average nationally, 58.4% of private sector establishments offered health insurance and only 3 states reported fewer than half of their establishments offering health insurance. Arkansas, at 43.9% was next to last and joined Mississippi and Montana in the group of states with the *fewest* number of establishments offering employer-based health insurance (Figure 7).

Figure 7. Percent of Private-Sector Establishments Offering Health Insurance in 1999 (National average, 58.4%)



In every state, establishments that had >50 employees were more likely to offer health insurance than small firms. Nationally, 99.1% of large firms (>1,000 employees) offer employer-sponsored health insurance. Arkansas exceeds the national average with 99.6% of its large firms offering health insurance benefits to employees (Figure 8). However, Arkansas’s businesses are comprised mostly of small employers (<50 employees). On average nationally, 47.1% of small employers offer health insurance. However, Arkansas ranked *last* in the nation with only 31.3% of its small employers offering health insurance (Figure 9).

Figure 8. Percent of Large Firms Offering Health Insurance in 1999 (National average, 99.1%)

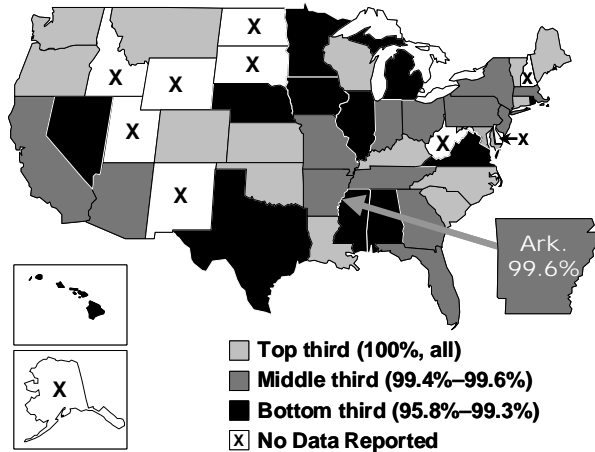
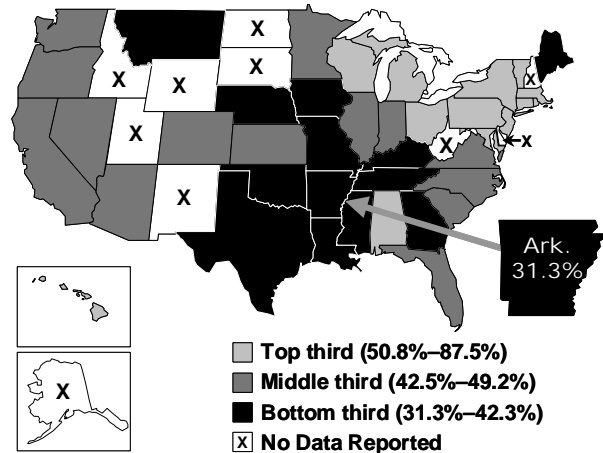


Figure 9. Percent of Small Firms Offering Health Insurance in 1999 (National average, 47.1%)



While employers may offer health insurance to eligible employees, the variation in eligibility of part-time employees (as defined by respondents) affects 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. Arkansas was in the top third of states offering health insurance to its full-time employees at 91.7%. But, it was also the state in which employers are *least likely* to offer health insurance to part-time employees. Only 13% of part-time Arkansas employees were 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 were 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 (national average was \$1,997 for annual single premium, \$4,953 for annual family premium in 1996).

## FACTORS INFLUENCING HEALTH INSURANCE COVERAGE

While profiles of households and employers help state leaders develop strategies to stabilize and expand health insurance coverage, understanding the decision processes and perspectives of households and employers is critical to successfully develop and deploy policies and programs. Through discussions with key informants and groups of individuals across the state, insight into these decision processes was obtained.

### UNDERSTANDING HOUSEHOLDS’ DECISIONS

#### Decisions and Events Affecting Insurance Coverage

**Decision-Making Process for Households.** Information from household focus groups helped portray how citizens come to be uninsured. Factors that influence these decisions, triggers that precipitate a decision, and insurance options available to the household were identified. By better understanding these issues, tactics to assist households can be optimally developed.

Households frequently make decisions about their health insurance when faced with changes in their lives. These changes can be precipitating events that lead to obtaining insurance coverage, such as gaining a new job, new responsibilities of marriage or parenthood, or increased concerns about future health issues. Precipitating events can also lead to loss of insurance coverage, such as benefit changes at work, loss of a

job, insurance premium increases beyond financial means, death of a spouse or divorce, or young adults no longer being covered by their parents' insurance. Households faced with these situations must reassess their options, evaluate alternative strategies, and make a decision regarding health insurance coverage.

**Common Precipitating Events.** Overall, data from the 26 household focus groups were consistent across racial and ethnic lines. When queried about their insurance status, participants most often related their current insurance status to their employment status. Thus, the most common precipitating event for insurance coverage was directly related to employment. Participants commonly expressed the belief that the only possible way they could become insured would be to get a job (a positive precipitating event) with a company that offered employer-sponsored health 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**

Many reported losing employment through lay-offs or retirement as leading to their uninsured status (a negative precipitating event). Many also said that their employers previously offered health insurance, either in full or part, but no longer do so. Negative precipitating events are further complicated by an individual's personal experiences, such as health status and pre-existing conditions. Many more who are currently insured; either fully or partially by their employer, predicted that because of premium increases their employers would 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. Others who are currently uninsured look forward to a positive precipitating event, reporting that with their new job, after a designated time, they will qualify for employer-sponsored health insurance.

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. 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. 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.

**“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.”**

**—Female focus group participant**

**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. Many of the participants worked in low-wage, temporary jobs that provided very low take-home pay. 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 copay or premium would have to be set very low for them to consider it affordable. 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 the elderly who did not have insurance included limited incomes that afford them little discretionary income.

A large proportion of Arkansas households living at minimal income levels have limited choice in reapportioning their expenses. Proportionately, health care expenses account for ~14% of the Family Income Standard, a minimum household income requirement to meet basic daily living needs for an Arkansas family of four defined by Arkansas Advocates for Children and Families.<sup>5</sup> Shelter, food, childcare, taxes, and personal care requirements must be met on a daily basis. However, while immediate health care

<sup>5</sup> Kennedy SR, Wacks C. Improving the Health Insurance Status of Massachusetts Residents, 1998 and 2000 Survey Results. Massachusetts Division of Health Care Finance and Policy.

needs frequently require attention, health insurance premiums (in total or as part of employer-based coverage) for future health care are beyond the means of many households. 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.<sup>6</sup> Thus for most Arkansas households with family incomes at the FPL (\$17,500), the maximum range (\$525–\$875) of affordability far exceeds current market prices estimated at \$3,000 for individual coverage and \$6,000 for family coverage.

## Common Strategies

**Strategies Used by Insured Households to Keep Coverage.** All households interviewed desired health insurance. However, currently insured households were concerned about losing coverage due to premium increases or job loss. Households reported either staying in current employment due to health benefits and/or searching for employment with perceived better benefits. Premium increases, particularly those affecting family coverage, were believed to be a major threat to continued ability to maintain their insured status. Their ability to accurately assess the value of different options included in health insurance was increasingly challenging as co-payments, tiered pharmacy plans, and restricted provider networks became more common.

**Strategies Used by Uninsured Households to Obtain Needed Care.** Uninsured households viewed new employment opportunities that included health benefits as their best opportunity for obtaining coverage. However, because of limited skills and/or available jobs, many households were unable to secure employment that offered benefits. Households had strategies to achieve care when medical conditions required treatment. However, they also reported delaying care, seeking treatment knowing they would be unable to pay for services, and using safety net providers (hospital emergency rooms and free clinics). Frequently, such actions resulted in poorer health outcomes and more costly care.

## UNDERSTANDING EMPLOYERS' DECISIONS

Because a majority of households receive their health insurance through an employer–employee relationship and because most benefit decisions are made by employers on behalf of their employees, efforts to capture the diverse perspectives of the business community were undertaken. Targeted sources of information included large employers, many of whom were self-insured, that have a unique perspective on management of health benefits, costs, and utilization for a large number of “covered lives”. Very different perspectives were captured through the focus groups with small- and moderate- sized employers. From these information sources, important understanding and suggested guidance on program development and management was gained.

### Employer Key Informant Interviews

Individual interviews were conducted with the largest Arkansas-based employers to better understand the challenges and benefit decisions surrounding health insurance coverage. Unlike most small employers in the state that do not offer health insurance, each of these larger companies did offer health insurance to their employees. Several major themes emerged from the data gathered during interviews that were related to experiences influencing health insurance benefit design, structure, or management.

**Reasons for Providing Coverage.** When examining the perspective and outlook of large Arkansas employers, every large 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 the “responsibility” of 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.

**“As an employer we have a responsibility to provide health insurance for our workers and assist with their families...but it is getting harder and harder.”**

**—Large, Arkansas-based employer**

<sup>6</sup> Ku L, Coughlin, TA. The Use of Sliding Scale Premiums in Subsidized Insurance Programs. March 1997. Urban Institute. Available at <http://www.urban.org/entitlements/premium.htm>. Verified September 27, 2001.

**Strategies to Manage Insurance Benefits.** Most large state-based employers self-insured to achieve optimal management and control costs on what was reported as the largest employee-related business cost next to salaries. Many employers aggressively pursued network development and direct contracts with participating clinicians and hospitals. Some even excluded providers/services upon which employees were dependent (e.g., local hospitals) when agreements could not be reached on use-management strategies, quality control issues, or costs. Of those companies that used a fully insured carrier in the past decade, most eliminated that option because this strategy lacked choice and/or competitive pricing when compared with self-insurance. Tax strategies also afforded financial incentives for self-insurance rather than fully insured carrier contracts.

Overall, large employers expressed a strong distrust of the health care system and governmental efforts to influence benefit design and coverage requirements. Many large employers wanted the “consumers of care” (their employees) to discuss with their physician not only the value and necessity of care being provided, but also the cost. 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 result. No employers interviewed planned to move from health benefits to direct contributions as a form of compensation at the time of the interviews.

**Scope of Benefits Offered.** All 9 employers interviewed provided 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 (e.g., a \$1-million cap on transplants).

One of the most dramatic differences among large employers was the coverage for preventive clinical services, which include mammography, cholesterol screenings, and childhood immunizations and which are predictable based on the age and gender of a person. Companies either included preventive services with 100% coverage or excluded preventive services as a covered benefit. The decision for developing plans that lack prevention coverage was frequently made based not on costs, but on the principle that health insurance should be restricted for non-predictable expenses. The amelioration of future costs and health impact through preventive services was recognized by those not offering preventive coverage, but relegated as a responsibility of the individual to save for and fund.

**Innovations.** Changing market conditions and increasing health benefit costs have led to innovations by employers. One implemented, but later abandoned because of employee dissatisfaction, a pre-tax “savings account” for employees to use for prescription drug expenses instead of providing insurance coverage, in an attempt to increase employee awareness of prescription drug costs. Another employer added a very restrictive \$25,000 cap on health care expenditures for employees or their dependents 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 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 employee eligibility. Another employer with an average hourly wage of \$8.50 per hour achieved 100% employee participation through participation requirements as a condition of employment.

**Future of Employer-Based Health Insurance.** The future expectations of the large employers interviewed included 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 expected to reduce benefits and increase cost sharing to maintain premium costs while capping their exposure to medical inflation. Pharmaceutical costs in particular were 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 that could potentially be addressed by giving stable patients access to bulk purchasing of prescription drugs needed long term.

Finally, unlike information provided by small- to moderate-size employers (see below), no large employer interviewed anticipated abandoning health insurance compensation. 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.

## Employer Focus Groups

Information from employer focus groups helped identify and enhance the understanding of influences that affect decisions regarding employer-based health insurance. Small- to moderate- sized employers are the most common size of employer in the state and Arkansas's small employers are among the least likely in the nation to offer employer-based health insurance. Factors that influence these decisions, triggers that precipitate decisions to change health benefits, and insurance options available to employers were identified. With this understanding, 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 Process for Employers.** Employers were faced with balancing business decisions to optimize revenue and manage costs. Second to wages, employee benefits, led by health insurance, were frequently the highest cost to businesses. Changes in the economic climate, job market, health insurance premium costs, or insurance eligibility criteria can affect the range of decisions afforded to employers. Challenges reported by employers centered on the desire to provide health benefits and the cost in doing so. Events precipitating decisions by employers to modify their current practice were most often steep increases in health insurance premiums. Common annual increases of 20%–35% with some exceeding 80% were reported. Alternatively, for employers requiring skilled labor, recruitment needs precipitated consideration of enhancing health insurance benefits. Employers faced with these events were forced to reassess their options, evaluate alternative strategies, and make new decisions regarding health insurance coverage in the context of their business environment.

**“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 [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*

**Common Strategies Used by Employers.** Faced most frequently with the negative precipitating event of increasing health insurance costs, employers reported a variety of methods to contain present and future health care costs. Those committed to maintaining health insurance benefits for all employees most commonly modified covered benefits by restricting covered services, increasing copayments and deductibles, and modifying utilization controls such as tiered formularies. Other employers, when faced with escalating health insurance costs far exceeding their business revenue, reported dropping insurance and marginally enhancing wage rates.

Employers forced to abandon traditional health insurance strategies adopted practices through which they contributed to the cost of health insurance but delegated responsibility entirely to the employee. Such practices, commonly known as “list-billing”, worked for healthy younger workers who could obtain affordable insurance in the individual market. However, for employees who had a pre-existing condition or a chronic illness, such insurance was not obtainable.

**“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 with 35 employees*

These business decisions were 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 small- to moderate-sized employers reported difficulty finding comparable fully insured products from which to select and suspected that because of their size they were unable to attain the discounts afforded larger employers.

## DEVELOPING SOLUTIONS: THE ARKANSAS SPG ROUNDTABLE

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The Arkansas SPG Roundtable—a 21-member group representing perspectives of purchasers, consumers, and providers/insurers—was formed to assess options and prioritize strategies for ensuring that Arkansans have basic medical coverage and to suggest recommendations for stabilizing the health insurance marketplace. The Roundtable was supported by the SPG staff and a multidisciplinary, broad-based Working Group. (see Appendix I). Members of an Observer Group (see Appendix) were also available during deliberations. Through Roundtable deliberations, general assumptions about provision of health insurance in Arkansas, employers, families, and guiding principles for health insurance expansion options were accepted.

### GENERAL ASSUMPTIONS ABOUT HEALTH INSURANCE

1. High-income Arkansans (>400% FPL) who are not insured were a low priority in the strategic plan.
2. Recommended solutions included employer-based health insurance, publicly funded programs, and strategies for the self-employed.
3. Solutions had to address both the uninsured and those whose continued insurance coverage was “at risk” or “unstable”.
4. “Basic benefits” should include outpatient and inpatient services, prescription drug benefits, and preventive care.

### GENERAL ASSUMPTIONS ABOUT EMPLOYERS

1. Most employers want to provide employer-based health insurance.
2. Some employers will not offer health insurance to their employees.
3. Above a specific cost threshold, some employers have *limited* capacity to support employer-sponsored health insurance.
4. Above a specific cost threshold, some employers have *no* capacity to support employer-sponsored health insurance.

### GENERAL ASSUMPTIONS ABOUT FAMILIES

1. Most families need health insurance coverage.
2. Some families will not participate in health insurance programs.
3. Families can afford to pay 3%–5% of their total income toward health insurance costs.
4. Below a specific income threshold (~200% of the FPL), families have *limited* capacity to contribute to health insurance premiums.
5. Below a specific income threshold (~100% of the FPL), families have *no* capacity to contribute to health insurance premiums.

### GUIDING PRINCIPLES FOR NEW SOLUTIONS

1. Stabilize current health insurance coverage levels.
2. Build on existing structures and consider new/creative solutions.
3. Maximize use of available public funds.
4. Focus on those with greatest need first.
5. Ensure saleable solutions.
6. Ensure affordable solutions.
7. Focus on joint responsibility—individual, employer, government, and provider.
8. Include prevention and wellness to avert avoidable costs.

Options developed subsequently by the Roundtable, described below, address both the stabilization of the private insurance market and strategies to address the 400,000 uninsured Arkansans.

## THE SOLUTIONS

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Timely and appropriate access to medical care is a fundamental requirement for individuals to remain healthy and productive members of society. However, data collected through the SPG project suggest that many Arkansans are forced to avoid or delay care, risk disability or death, and become more dependent upon social support systems. Not only is the health of individuals at risk, but they also place their households and communities in financial peril through assuming debt for uncompensated care, which directly results in a majority of personal bankruptcies in Arkansas and contributes to rapidly rising health care costs and destabilization of the health insurance system.

The challenge of the uninsured has existed for many years. However, recent escalations in health care costs combined with economic conditions that endanger employer-based health insurance also threaten the future availability and affordability of health insurance for all Arkansans. Many states have pursued strategies to stabilize existing health insurance coverage and expand new options for the uninsured; Arkansas has been one of these through the ARKids First program. Rapidly rising health insurance costs, increasing destabilization in the private insurance market, and documented local need and negative impact on households across the state demand action. Through the Roundtable, all options to stabilize and expand health insurance coverage have been examined and the following recommendations generated.

### ROUNDTABLE RECOMMENDATIONS FOR STATE ACTION

#### Establish Community-Based Purchasing Pools/Cooperatives

Although most adult Arkansans (>80%) who have health insurance obtain it through their employers, a large proportion of Arkansans work for small businesses (<50 employees) that cannot or do not offer insurance benefits. Aggregating small purchasers of health insurance into a large block of purchasers can theoretically enable employers to efficiently provide coverage to employees by creating better negotiating power for the group in the health insurance marketplace.

Through Act 924 of the Arkansas General Assembly of 2001, small employers can now organize into purchasing pools to achieve advantages afforded to large employers. Through community-based purchasing cooperatives, small businesses in communities that organize, monitor, and support purchasing pools for health insurance benefits can secure more affordable insurance options for their employees. Several community characteristics will support successful deployment of community-based purchasing pools. First, tight controls on enrollment at the community level can address the historical problems of adverse-risk selection in purchasing pools organized around “associations”. Second, several communities faced with the economic demise and loss of their hospital currently have local taxes supporting the care of indigent patients that could be incorporated. Finally, aggregation of small employers into purchasing pools will increase the administrative ease and efficiency of procuring health insurance in addition to bargaining clout associated with large-group insurance.

**The Roundtable recommends that communities organize, develop, and deploy community-based purchasing pools and cooperatives with support from the Arkansas Department of Insurance and insurance companies operating in the state.** In addition, federal tax credits under consideration to individuals for purchasing health insurance should include small-group purchasing pools as qualifying plans.

#### Increase ARKids Enrollment

While the ARKids First program has been largely successful in enrolling more than 70,000 of the original 90,000 targeted children, increasing insurance premiums have forced many families to drop health insurance coverage. According to data obtained from the 2001 Arkansas Household Insurance Survey, ~75,000 Arkansas children live in families earning less than 200% of the FPL and are uninsured—many of these represent newly uninsured children and adolescents.

**The Roundtable recommends aggressive outreach and enrollment building upon the new school nurse enrollment strategies implemented in the fall of 2001.** Continued surveillance and additional outreach efforts may be necessary to ensure all children who are eligible for services are enrolled. Through recommendations below (see Employer–State Partnership, p. 14) state budgetary implications of these increased needs may be minimized.

## Expand Safety-Net Medicaid Program

Arkansas's current Medicaid program **does not** offer basic benefit coverage unless an adult has a disability lasting longer than 6 months, **and** a household income below ~\$5,000 per year, **and** total household assets worth less than \$2,000 (income and assets for a family of 4). Arkansas's Medicaid program **does** provide insurance coverage for pregnancy and childbirth to women in households with incomes  $\leq 200\%$  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.

Many adult Arkansans live in households with insufficient incomes to afford health insurance. They do not have enough income to participate in employer-based health insurance (if offered) or purchase health insurance in the individual market. The Arkansas Tobacco Settlement Proceeds Act of 2000 allocated approximately \$17 million (with federal matching funds of \$68 million) for Medicaid expansion including a limited benefit package for 19–64 year olds, pregnancy coverage from 133% to 200% of the FPL, increased reimbursement to rural hospitals, and prescription drugs for the elderly. In other states, Medicaid programs have funded programs for citizens who earn less than 250% of the FPL using federal matching funds through Medicaid waiver processes.

The Roundtable defined a "safety net" insurance package for low-income individuals consisting of 6 outpatient visits/year, 2 outpatient surgeries/year, 7 inpatient hospital days/year, and 2 prescription drugs per month as a minimum benefit package to ensure access to minimal care. Through use of the appropriated Tobacco Settlement funds and additional revenues such as a medical use fee, **the Roundtable recommends the establishment of a "safety-net" insurance program to expand coverage with a minimal benefits package for currently uninsured adults (19–64 years of age) to households earning  $\leq 100\%$  of the FPL, the ceiling of which will be set by the availability of funds.**

## Create Employer–State Health Insurance Partnership

Most uninsured adults (19–64 years) in Arkansas earning below 200% of the FPL work full time (i.e., the "working poor") and lack health insurance. According to evidence from the Arkansas SPG, most employers want to offer health insurance and most households participate when offered health insurance. The cost of such care is the single largest barrier to achieving the shared goal of health insurance coverage. In addition, employers are required by insurance carriers to achieve ~80% participation of all employees to be eligible for group health insurance. Because many low-income workers frequently cannot afford the employee/family contributions, both the low-income worker and their more affluent fellow employees are thus excluded from participation. Currently, no publicly subsidized coverage exists to help the employer or low-wage employee attain coverage.

To cover these workers and families, **the Roundtable recommends extension of the "safety-net" benefits package described above through voluntary participation of employers unable to achieve health insurance in the private market.** This innovative proposal would establish a voluntary partnership between interested employers and the state Medicaid program. After federal review and approval, the state could obtain a waiver to allow employers to voluntarily pay the state match for low-income, eligible employees. Arkansas's federal matching rate (73%–82%) would apply and offer needed fiscal support for workers earning  $< 200\%$  FPL. Employers would support the insurance costs of workers who earn above 200% of the FPL or the program ceiling. Employees/employers would have options to support family coverage and attain the federal matching level needed to support low-wage workers. Copayments, deductibles, and established mechanisms for appropriate use of medical services could also be incorporated. In exchange for the significant subsidy for low-wage workers, maximum participation rates would be required of employees. Outreach and enrollment of employers could be achieved through the use of local independent insurance agents.

This innovative potential program requires significant state and federal development prior to implementation. Currently, under operating rules of the Center for Medicaid and Medicare Services (CMS) of the federal government, the "safety-net" benefits package will require approval. In addition, procedures to enable employers to "buy into" the Medicaid program for their low-wage workers will require state authorization and federal approval. This proposal is responsive to the current Bush Administration's request for innovative proposals to improve and expand health insurance coverage through Medicaid. In addition, it provides a mechanism to achieve the state matching funds (through employer participation) necessary to

use the nearly \$50-million annual State Children's Health Insurance Program (SCHIP) funds that are allocated to Arkansas but not currently accessed. If successfully implemented, this employer–state partnership would minimize the state budgetary requirements under the Medicaid expansion and newly eligible ARKids First children by providing most Arkansans with a means to achieving employer-based health insurance.

## Optimally Manage Insurance Products: Develop Small-Group Reinsurance Strategies

Because the private sector health insurance market for small groups is currently not sound, stabilization efforts will prevent 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 potential adverse-risk selection, they must offer employer-sponsored insurance to all employees (a requirement of guaranteed issue under the Health Insurance Portability and Accountability Act of 1996 [HIPAA] legislation). The insurer is also 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.

The National Association of Insurance Commissioners recommends small-group reinsurance as a strategy whereby insurance plans can individually “reinsure” their high-risk enrollees, thus pooling the risk and minimizing the variance that negatively affects the cost of insuring all employees in 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. **The Roundtable recommends establishment of the small-group reinsurance strategy with required participation of Arkansas insurance carriers.**

## Educate Employees: Wage/Benefit Compensation Summaries

Consumers of health care services frequently are not aware of the actual cost of providing health insurance coverage. **The Roundtable recommends that employers consider providing a report of annual employee compensation to their employees.** These reports could facilitate discussions between employers and employees, give credit to employers for participating in health care benefits, and help employees make employment decisions based on knowledge of their full compensation package. In addition to increasing overall awareness of health care costs and benefits, reports could serve as recruitment and retention tools.

## Include 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 use of preventive clinical services. The **Arkansas SPG Roundtable endorses the incorporation of evidence-based preventive medicine into proposed health insurance expansion activities.** Financing strategies for all health insurance programs managed and/or regulated by the state should include these basic preventive clinical services. Through appropriate use of scientifically supported and cost-effective strategies preventable illness and disease can be avoided and health care resources more effectively managed. This effort would significantly reduce the long-term burden of poor health.

## Optimize Federal Funds for Health Care Coverage

States' options for providing health insurance and health care to their citizens include new Medicaid benefits (e.g., individuals with tuberculosis), new Medicaid coverage options (e.g., Medicaid/SCHIP waivers), new safety-net support (e.g., HRSA-supported community health centers [CHCs]), new programs (e.g., Department of Justice programs for drug and alcohol abuse treatment), and programs funded exclusively by individual states. Arkansas 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. **The Roundtable recommends that options for new funding of clinical services be quickly identified and**

**expeditiously implemented to serve the citizens of the state.** Currently, no funding or identified responsibility exists to execute this policy development and implementation process. Establishment of a state policy development center should be considered.

## ROUNDTABLE RECOMMENDATIONS FOR FEDERAL ACTION

### Achieve Income Tax Neutrality for Health Insurance/Health Care Expenditures

A clear consensus emerged from the Roundtable that all parties purchasing health care insurance should be treated similarly with respect to state and federal tax policies. Currently, some parties purchasing health insurance have a significant advantage over others. With employer-sponsored health insurance, both employer and employee contributions are tax-exempt and self-employed workers also have tax deductions for health insurance available. However, for employees who lack employer-sponsored health insurance and/or cafeteria plans, no state or federal deductions are available for health care expenditures, and having to purchase individual health insurance with after-tax dollars places them at a financial disadvantage. Income tax neutrality with respect to health care insurance or use costs would be achieved if all health insurance or care expenditures were made taxable or tax-exempt. **The Roundtable recommends that the federal government pursue legislation making all methods of purchasing health insurance tax deductible.**

### Modify Medicare Program

**Incorporate Prescription Drug Benefits.** The Roundtable assumed that a basic benefit package should include prescription drugs. Although the Roundtable's proposed plans focus primarily on uninsured adults, aged 19–64 years, it acknowledges that persons older than 65 years do not have “basic benefits” under Medicare according to the general assumptions made by the Roundtable about adequate coverage (see General Assumptions about Health Insurance, p. 12). For this reason, **the Roundtable recommends the federal government take legislative action to develop an affordable prescription drug program for Medicare beneficiaries.**

**Expand Eligibility through Buy-In Options for “Near Elderly”/Disabled.** If other strategies proposed by the Roundtable are successfully implemented, these options will provide coverage to currently uninsured Arkansans aged 55–64 years through the larger expansion efforts of a public–private partnership SCHIP (see Create Employer–State Health Insurance Partnership, p. 15). Many disabled will also be covered by the limited-benefits Medicaid programs proposed for individuals below 100% FPL (see Expand Safety-Net Medicaid Program, p. 14). Thus, the Roundtable did not develop separate strategies specifically for these two populations. However, the near-elderly (55–64 years) often have difficulty continuing to access employer-based health insurance coverage due to divorce from or death of a working spouse or retirement. Similarly, the disabled frequently are unable to afford health insurance even if it is available.

Medicare is the major insurance mechanism for individuals over age 65 and for some citizens eligible for Social Security Disability Insurance (SSDI) assistance. Narrow eligibility requirements force disabled individuals to wait 24 months after initiation of SSDI disability payments before they become eligible for Medicare. Thus, **the Roundtable encourages and supports efforts at the federal level to relax eligibility requirements for the disabled and expand eligibility for the near elderly**, thereby increasing insurance options to those frequently excluded from private health insurance.

### Tie Medical Savings Accounts to Group Catastrophic Policies

Medical savings accounts (Archer MSAs) allow individuals both greater control and increased responsibility for expected health care expenditures. Having individuals bear the initial cost of health care is expected to achieve more appropriate use of health care resources, leading to cost containment in the market. Under pilot federal MSA legislation, those who are self employed or work for a business with  $\leq 50$  employees can place pre-tax money in tax-deferred accounts. Enrollees can use money from these accounts to pay for non-catastrophic, routine health care expenditures. To obtain an MSA, the enrollee must also have a high-deductible individual catastrophic health insurance policy that is portable and MSA-compatible.

A drawback of this insurance option, however, is that individual catastrophic insurance policies have higher long-term risks to participants compared with group catastrophic policies. Some individuals will prosper by remaining healthy and utilizing their MSAs as savings vehicles, but others who develop chronic and/or costly conditions will face escalating individual premiums and/or limits on catastrophic coverage options. To avoid segmenting the catastrophic insurance component and isolating those who are less healthy, **the Roundtable recommends tying MSAs to group rather than individual catastrophic policies.** This change would spread the risk associated with adverse health-related events so premium increases or policy cancellations would occur less frequently while achieving the attractive cost-containment and personal savings attributes of MSAs.

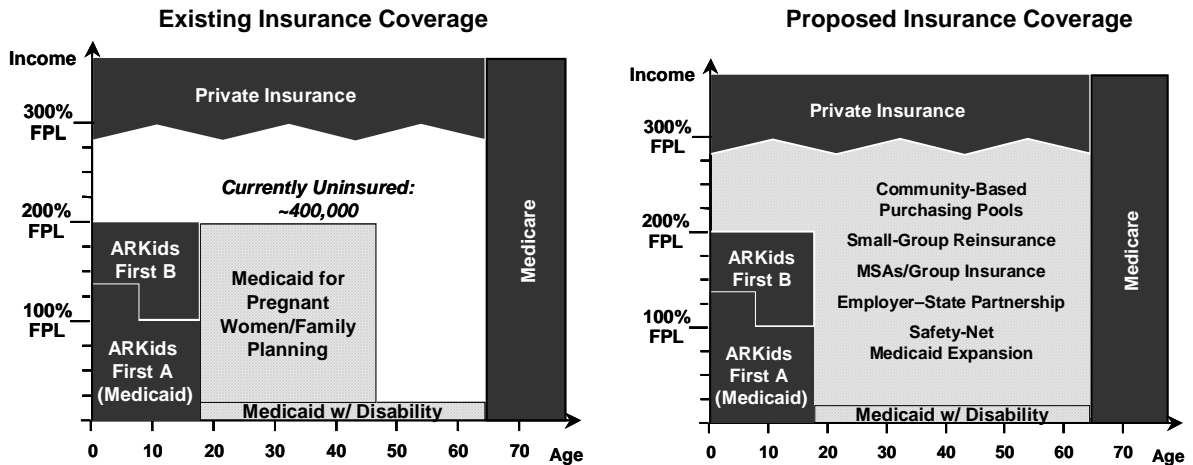
### Improve the US Health Care System through Additional Research

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. However, funding is lacking for research to better understand and empirically support policy development. Thus, **the Roundtable recommends that the federal government increase research into the delivery, appropriate utilization, costs, and quality of health care delivery systems.**

## CONCLUSION

As depicted in Figure 10, the solutions described above include stabilization efforts for the 2.3 million currently insured and new efforts to insure the 400,000 currently uninsured Arkansans. Through these solutions and recommendations, 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.

Figure 10. Summary of Roundtable Recommendations



These recommendations are a summary of the first state-wide assessment and evaluation of health insurance issues facing Arkansas. After review of all options available, the SPG Roundtable has recommended a prioritized list of strategic solutions for consideration. Serving as a 5–10-year strategic plan, each of these solutions, if aggressively pursued, will contribute to the stabilization and expansion of Arkansas's health insurance market. Early in 2002, legislative review by the Arkansas General Assembly and refinement of expansion strategies is anticipated. Recommendations to the Secretary of the US Department of Health and Human Services on behalf of the state are requested by the summer of 2002. Through national grants awarded to the Arkansas Center for Health Improvement and the new College of Public Health at the University of Arkansas for Medical Sciences, external funding to support further refinement of this strategic plan has been secured through 2004.

## APPENDIX I

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## APPENDIX II

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### CLINICAL PREVENTIVE SERVICES FOR INCLUSION IN ALL HEALTH FINANCING STRATEGIES

Due to the potential to ameliorate future illness, protect against avoidable costs, and improve the health status of Arkansans, the following list of clearly supported scientifically based clinical preventive services are highly recommended for inclusion in all Health Financing Strategies.

- Childhood immunizations (basic series)
- Childhood screening (lead & newborn screening)
- Height and weight screening (periodic)
- Blood pressure screening (periodic)
- Cholesterol screening (every five years for men 35–65 y/o; women 45–65 y/o)
- Screening for breast cancer: mammography (every other year for women 50–69 years of age)
- Screening for cervical cancer: Papanicolaou (Pap) test (every 3 years for sexually active women)
- Screening for colon cancer: sigmoidoscopy (every 5 years after age 50)
- Tetanus booster (every 10 years)
- Influenza vaccines (annual for elderly and at risk individuals)
- Pneumococcal vaccines (every 5 years for those >65 years of age)
- Prenatal care for expectant mothers (first trimester initiation)
- Smoking cessation coverage for tobacco users
- Dental health visits (periodic)

In addition to these specific services, the following counseling activities should be contained in periodic visits to assess and address health risks:

- Child safety counseling
- Injury prevention
- Sexually transmitted disease prevention
- Multivitamin with folic acid in women capable of becoming pregnant
- Counseling to prevent unintended pregnancy
- Alcohol abuse counseling/treatment
- Hormone prophylaxis in postmenopausal women

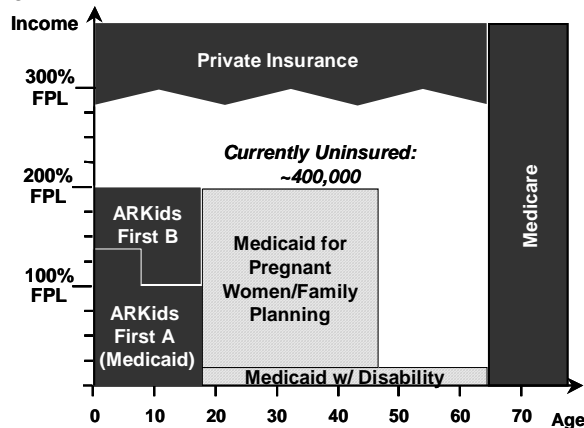
These clinical preventive services represent those health promotion strategies that have incontrovertible scientific evidence that supports their use to ameliorate future illnesses and healthcare costs. Additional services based upon family history, clinical symptoms, and/or risk determined by providers should be considered for financial coverage.

## APPENDIX III

### BASELINE INFORMATION – ARKANSAS

- 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)
  - 36 yr (US Census 2000)
  - 13% (2001 Arkansas Household Survey of Health Insurance Coverage)
- 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 HMOs remain in operation
  - 60+ plans have ceased doing business in the state over the past 3–4 years (by report of Arkansas Department of Insurance)
- 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 200% of FPL

## APPENDIX IV

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### SUMMARY OF QUESTIONS ANSWERED BY FINAL REPORT

#### 1.1 What is the overall level of uninsurance in Arkansas?

- **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 as being 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).
- 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).
- 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 Arkansas 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).

**Other target populations assessed included:**

- 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?**

- Review of available secondary data reveals that eligible persons do not participate in public programs for the following reasons:

Knowledge deficit regarding availability of programs

Perception that program is not needed because other resources are available

Ability to immediately enroll in the program if presenting with a qualifying precipitating event (e.g., acute and/or catastrophic illness)

Perceived social stigma of receiving “welfare”

Time cost associated with program enrollment (e.g., lost/uncompensated work time)

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

- Reported causes of public program dis-enrollment considered by the Arkansas SPG included failure to complete re-enrollment process prior to automatic dis-enrollment, perceived ease of reenrollment if acute and / or catastrophic care occurs, 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 3<sup>rd</sup> 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 are the features of an adequate, bare-bones benefit package?**

- The Arkansas SPG Roundtable concluded that the minimum health insurance plan benefit should ensure financial access by including the following benefits:
  - 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.
- This benefit package is based upon the assumed availability of catastrophic coverage through the Medicaid program for categorically disabled, low-income adults.

**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 determined that the present lack of prescription drug coverage under Medicare is an area of underinsurance for the elderly that can only be addressed by the Federal government.

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**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 1999).

***For those employers offering coverage, please discuss the following.***

**Cost of policies:**

- Overall premium costs of health insurance policies are increasing. Insurance brokers have reported that they are routinely writing quotes with annual premium increases of 25% to 60%.

**Level of contribution:**

- Many employers have reported that they are reducing the proportion they contribute for the purchase of employees' health insurance.

**Trend of decreasing employer contributions:**

- The downward movement in the proportion of employer contributions combined with the accompanying rapid rise in premiums 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 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decision regarding premium contributions, benefit package, and other features of the coverage**

- For fully-insured employers, state law has until recently 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. While it is premature to assess the impact of this Act, to date, no carriers in Arkansas have made such a plan available on a widespread basis. Most self-insured employers offer benefit packages that include hospital, outpatient, and prescription drug 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 Arkansas employers reported in key informant interviews conducted by the Principal Investigator 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.

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**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 January 2002, there were only 3,198 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 until 2001 there was no provision for offering benefit plans with “less than mandated coverage”, the fully insured group market in Arkansas has demonstrated 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 Arkansas? What impact does that have in the Arkansas 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 1999).
- 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 Arkansas 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— ~3,198 enrollees. (reported by Arkansas Department of Insurance – March 6, 2002)
- In the aggregate, Arkansas state government has a direct impact as a purchaser of health care coverage for ~21% of the state’s population of 2.67 million citizens.

**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 mitigated.

**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 constituent perspectives.

**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 review were put before the Roundtable. 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.)

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**4.1 Which coverage expansion options were selected by Arkansas (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 waiver expansion
- State–employer partnership through Medicaid waiver expansion
- Establish community purchasing pools for small business
- Small-group reinsurance strategies
- Modification of Federal legislation for Archer 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	Archer MSA Modification (to Require a Group Catastrophic Policy)	Medicare Expansion to Near Elderly / Disabled
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 <b>Co-payments</b> 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	Archer MSA Modification (to Require a Group Catastrophic Policy)	Medicare Expansion to Near Elderly / Disabled
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 Arkansas 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.
- Per state constitutional mandates, the state is prohibited from operating with a budgetary deficit. As the state’s economy deteriorated in 2001, state revenues fell behind initial projections. As a result, state government agencies were subject to across the board budget reductions, directly impacting many key programs. To prevent further erosion of existing public sector programs, state government officials have debated the appropriateness of reallocation of funds designated in the Act to expand Medicaid benefits to adults. At present, this issue remains unresolved.

**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 Arkansas address the eligible but unenrolled in existing programs? Describe Arkansas’ 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 ARKids 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.
- 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: The Roundtable members were surveyed after each meeting. Results of those preliminary surveys indicated that the Roundtable members 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. Results of this final survey were almost uniformly positive among all respondents across all indicators. The sole exception noted by two members was that temperature in the meeting rooms was not ideal.

**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.
- Citizens in our state were kept abreast of the project through the Arkansas Center for Health Improvement (ACHI) web site ([www.ACHI.net](http://www.ACHI.net)) and select public speaking opportunities by the Principal Investigator and Project Staff.
- An additional avenue for dissemination of SPG related information was through the periodic generation of a newsletter that was emailed to interested parties.
- Upon release of the Arkansas Health Insurance Expansion Initiative Report by the Governor to US DHHS Secretary, Tommy Thompson, the SPG project staff began distribution of the Roundtable's findings and proposal 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). Additionally, the Principal Investigator and SPG staff have begun a series of briefings with members of the Arkansas Congressional delegation.
- On December 20, 2001, the SPG staff presented the findings of the Roundtable to the Joint Insurance and Commerce Committee and the Joint Public Health, Welfare, and Labor Committee of the Arkansas General Assembly.
- The Principal Investigator participated in a televised panel discussion on the topic of uninsured in Arkansas that included representatives of the state legislature and insurance commissioner's office.

**5.4 How has this planning effort affected the policy environment? Describe the current policy environment in Arkansas 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 address 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 impediments are counterbalanced by a cadre of political and health leaders with strong personal commitments to the state and a demonstrated ability to effect change.

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**6.1 How important was Arkansas-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of Arkansas' 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 Arkansas 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 to provide detailed programmatic cost projections to state decision makers.

**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 Arkansas 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?**

- Key insurer and provider representatives served as members of the Roundtable, the Observer panel, and the Working Group. 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 Arkansas?**

- 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 Arkansas 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.

**6.9 How did Arkansas' political and economic environment change during the course of your grant?**

***Political changes***

- The Arkansas General Assembly convenes on a biennial basis; the previous session ended on May 23, 2001. During the interim period between sessions, lead staff from the SPG have consulted with and provided testimony before the Joint Public Health, Welfare and Labor Committee and the Insurance and Commerce Committee.
- The issue of the uninsured has assumed headline status in Arkansas and it is anticipated that there will be legislative initiatives made during the January 2003 session of the General Assembly to address this problem.
- By law, Arkansas's elected state constitutional officers (Governor, Lt. Governor, Secretary of State, Land Commissioner and Treasurer) and members of the bi-cameral General Assembly are term-limited. During the 2002 election cycle, approximately one-fifth of the House and one-third of the Senate will be newly elected.
- In the November 2002 election, all state constitutional officers and all but one of the members of Arkansas's congressional delegation will stand for re-election.

### **Economic changes**

- From 1990 to 2001, Arkansas saw an annual growth rate of 3.79% in goods and services production; during the same time period the United States as a whole experienced a growth of 3.07% for the same sector. However, in the biennium beginning 2001, Arkansas is projected to lag the US slightly in this area (3.10%AR v. 4.10%US). (Arkansas Department of Finance & Administration)
- Forecasts of state revenue collection originally made in early 2001 were revised in response to the changing economy. In the face of declining corporate sales tax revenues, officials called for reductions of approximately 4% in the three and half billion dollar state government budget. (For perspective, total annual revenue in Arkansas is about \$40 billion.) (*State revenue tops February forecast*. Arkansas Democrat-Gazette. March 5, 2002). This decline in sales tax revenue impacts all state agencies and programs, including provision of services to beneficiaries in so-called medically needy Medicaid programs.
- Nationally, it is reported that most states project state government budget shortfalls for FY 2002 ranging from \$6 million up to \$12 billion. (National Association of State Budget Officers *State Budget Update January 25, 2002*). Forecasts available as of March 2002 project that Arkansas will not have a budget shortfall for FY 2002. (Arkansas Department of Finance & Administration)

#### **6.10 How did your project goals change during the grant period?**

- The project goals grew to include development of recommendations intended to provide stabilization to the health insurance marketplace in addition to the original goal of expansion of health insurance coverage to the uninsured. The implementation time frame and scope of expansion options has been constrained due to the present economic uncertainty.

#### **6.11 What will be the next steps of this effort once the grant comes to a close?**

- Dissemination of the Arkansas Strategic Plan will continue with active engagement in the 2003 Arkansas General Assembly to advance initial steps already undertaken including a) expansion of Medicaid to low income adults using Tobacco Settlement funds, b) community-based purchasing pools, and c) insurance regulation.
- Arkansas has received supplementary funding from HRSA to support development of a multi-state integrated database ([www.HealthDataNow.info](http://www.HealthDataNow.info)). This database supports the efforts of other State Planning Grant states to use both nationally available data and their respective state-specific datasets to inform health policy decisions on a real time basis.
- Additionally, Arkansas was one of four states designated by the Robert Wood Johnson Foundation in 2001 to receive a State Coverage Initiative (SCI) grant. The goals of the SCI are to fund select states to develop and implement pilot programs designed to expand health insurance coverage. The Principal Investigator, Project Director and staff of the SPG are continuing these roles with the SCI.

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#### **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 the recommended expansion of Medicaid to 100% of the FPL for adults aged 19–64 years with a limited benefits package.
- The Roundtable's recommendation to create an employer–state partnership to offer employer-based limited benefits coverage for adults aged 19–64 years with income in the range 100% to 200% of the FPL would require an SCHIP waiver.
- An elimination of the current requirement that MSAs are accompanied by individual catastrophic coverage and redesign of MSAs to be tied exclusively 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:

continue to convene states and disseminate information about lessons learned from this process;

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

support over-sampling of national surveys in small states to provide state-specific information; and

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, states should be allowed 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.