Iowa State Planning Grant

Final Report to the Secretary

U.S. Department of Health and Human Services

Prepared by:

Iowa Department of Public Health

October 29, 2001

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EXECUTIVE SUMMARY

Iowa's State Planning Grant, Striving to Expand Health Insurance to all Iowans

Most Iowans are able to receive quality health services when they or a member of their family need medical care. However, for the approximately 258,000 Iowans who have no health insurance, access to affordable medical care is rarely straightforward or assured. Iowa governor Thomas Vilsack, Lieutenant Governor Sally Pederson, and Iowa Department of Public Health Director Stephen Gleason, D.O. agree with the Institute of Medicine that "health insurance is one of the best known and most common means used to obtain access to health care," and that being uninsured can have serious deleterious effects on health. This is why they, and the Citizens' Alliance on Expanding Health Insurance, enthusiastically accepted the challenge of participating in the HRSA State Planning Grant effort as a means of developing the data necessary to create a feasible plan to increase access to health insurance coverage to all Iowans.

The Iowa Department of Public Health, through its State Planning Grant team, has spent the last twelve months preparing a plan to increase access to health insurance, so that all persons who wish to be covered under a policy of health insurance will be able to exercise that choice for themselves and their families. Five guiding principles defined our approach to creating a feasible plan. The first four principles were: political leadership, public stewardship provided by a public-private board (the Citizens' Alliance), expert advice provided by leading consultants, and data-driven solutions. The fifth, and most important principle, is that the completed plan must serve the interest of **all Iowans**, whether currently insured or not. Finally, the Director's expectation was that creative solutions requiring no state revenues was essential to the success of the project in times of constrained budgets.

While we do not yet have a plan ready for public debate, we have completed all the data collection activities specified in our original State Planning Grant application, and have achieved our goal of identifying feasible policies that will help uninsured Iowans obtain coverage. We have been fortunate enough to receive additional funding from HRSA to carry on with our efforts, and we will continue to work refining and implementing our data-driven plan through fiscal year 2002. Our Citizens' Alliance members have indicated that they will continue to serve

into the second year of the grant and expand their role as citizen advisors and champions of the goal to expand access.

Our Secretary's first year report provides a comprehensive description of what was accomplished in our initial SPG year, and includes a recommendation from our Citizens' Alliance, described below, on how to proceed during our second year of funding.

DATA COLLECTION AND CONSENSUS BUILDING ACTIVITIES

- Sections 1, 2, 2-A, and Appendix II

The eight SPG data collection activities completed during the first year were organized as follows:

Iowa Survey of Uninsured A survey and focus-groups were conducted by The Lewin Group to identify characteristics of the uninsured population in Iowa and the consequences of being without health insurance. Lewin completed a telephone survey in January 2001, and conducted focus-groups in February 2001. Data resulting from these tools were presented to the Citizens' Alliance and participants at regional forums.

First Round Focus-groups Conducted in March 2001 by the State Public Policy Group. (SPPG), The first round of eight focus-groups gathered responses to questions about the importance of coverage for every Iowan from the active public and stakeholders in health insurance. Participation was good in these guided, structured discussions, with 112 people participating across the state. Findings were presented to the Citizens' Alliance and other interested parties.

Business Survey Wave I Designed and conducted in March 2001 by SPPG, with support from the Selzer Company (Selzer), this survey gathered attitudinal data questions about the importance of coverage for every Iowan from Iowa businesses. The intent was to gauge businesses' perception of how expanding health insurance to all Iowans would affect the state, the business community in general, and their particular businesses. These findings were also presented to the Citizens' Alliance.

Active Public Survey Wave I Also designed by Selzer and SPPG, and administered in April and May 2001, this survey interviewed Iowans who voted in the past two general elections and who have health insurance. Its purpose was: 1) to assess the mood of the electorate about a plan to provide health insurance for all Iowans, 2) to assist in policy development, and 3) to develop a communication plan for garnering public support for a future proposed plan. The findings were presented to the Citizens' Alliance.

Regional Forums Eleven forums were held across the state during May and June, 2001, to provide the public with information regarding the issue of expanding access to health insurance. Each forum was a learning experience for participants and staff. Participants learned about expanding health insurance, and about the key findings from some of the early research. Staff learned about who was interested in the issue, how they feel about the issues, and how they reacted to facts about the issue. The forums allowed a free flow of information and ideas, and were not intended as a data-gathering opportunity. A summary report was presented to the Citizens' Alliance to help them develop policy recommendations.

Second Round Focus-Groups Conducted in June 2001 by SPPG, nine focus-groups targeted unique constituencies at each session. The scripts elicited comments and more specific questions about several possible options to increase the number of Iowans with health insurance. The targeted constituencies had clear relationships to the options and the implications of their implementation. Constituencies targeted in the second set of focus-groups were the active public, business owners, health-care providers or executive directors of health-care organizations, and state and local elected officials. Findings were presented to the Citizens' Alliance and other interested parties.

Business Survey Wave 2. Also designed and conducted by SPPG with support from Selzer, the second business survey was administered in July 2001. A sample of businesses, similar to those surveyed in March, were contacted to more thoroughly investigate findings from the first survey and to test general programmatic approaches to expanding health insurance. This survey provided data to verify the results of the first wave and asked more detailed questions regarding willingness to support policies favoring increased access to health insurance. The findings were also presented to the Citizens' Alliance.

Active Public Survey Wave 2. This survey also interviewed Iowans who voted in the past two general elections and who had health insurance. It was designed by Selzer and SPPG, and administered in July 2001. This survey provided data to verify the results of the first survey and asked more detailed questions of respondents' as to their willingness to support policies designed to increase access to health insurance. It was important to determine whether Iowans believed providing health insurance to all Iowans was in their own interest. The findings were also presented to the Citizens' Alliance.

KEY FINDINGS

- Sections 1, 2 and 2-A

Our data collection activities generated a large body of data which has been used to design Iowa-specific policy options to increase the number of persons with access to health insurance. The data has also been used to educate our Citizens' Alliance and the public-at-large regarding the complex issues that have resulted in about 9 percent of Iowans being without health insurance. In the following paragraphs we briefly describe some of our key, myth-busting findings.

Myth: Most uninsured Iowans do not work.

Reality: Access to Health Coverage is Closely Linked to Employment

Access to health insurance is Iowa is strongly connected to employment, with approximately 62 percent of the population receiving health insurance through employment. Of the 9.1 percent of Iowans who are uninsured and of working age, nearly 81 percent are employed. This means that over three-quarters of the uninsured are persons **who are working** but do not have employer-sponsored coverage. The Iowa survey of the uninsured found that of the uninsured who are employed, 43 percent work at places that do not offer coverage to any employees, 31 percent work at places where coverage is offered to some but not to them, and 26 percent decline the coverage. Uninsured focus-group participants, particularly low-wage workers, also noted the distinction between "good jobs" with good pay and good benefits and "poor jobs" with poor pay and poor or no benefits.

Myth: Being uninsured is largely a matter of free personal choice, the uninsured 'choose' to not have health insurance.

Reality: The Greatest Barrier in Iowa to Obtaining Health Insurance is Out-of-Pocket Cost.

For Iowans who decline employer-sponsored coverage, the main reason for declining is that coverage is too expensive. Twenty-six percent of employees that had health coverage available at work declined it and remained uninsured. Of this 26 percent, 61.5 percent declined coverage because it was **too expensive**. For individuals who do not obtain health coverage from their employers, the primary barrier to purchasing an individual policy is also affordability.

Iowans' health status also prevents the purchase of health insurance for some uninsured persons. Several focus-group participants reported that they were "uninsurable" or could not afford health insurance due to long-standing chronic health problems. Others were too sick or disabled to work and so had little income from which to purchase insurance. These individuals also could not meet (or assumed they could not meet) the criteria for Medicaid disability coverage. Furthermore, many of the uninsured weigh the costs and benefits to themselves and their families of purchasing health insurance, and decide that it makes more sense for them to spend money on other things. Numerous focus-group participants explained they simply did not have enough money left to purchase coverage after they finished paying for other more necessary goods and services, such as food, rent, utilities and car insurance.

Myth: Iowans do not want anything to do with the government when it comes to health insurance

Reality: Many Iowans Believe the Government Should Take a Role in Securing Coverage for the Uninsured

In general, Iowans believe the government should be involved in helping more uninsured individuals secure coverage, especially those who can be identified as "Iowans in working families."

Myth: Iowa employers see little value to insuring their employees

Reality: Employees view providing insurance to their workforce as a positive act

Iowa has very low rates of unemployment, and economic growth is hampered by the lack of skilled workers. About eighty-two percent of employers think it is very important for employee recruitment and retention that every Iowan have health insurance. Support for employer-provided health insurance cuts across partisan lines, as 77.5 percent of businesses identifying themselves as "Republican," 96.7 percent identifying themselves as "Democrats" and 84.6 percent identifying themselves as "Independents" say that every Iowan having health insurance is an important issue. Employers who do not currently provide health insurance would do so if they could afford it. Tax credits or other means of improving their "bottom lines" would encourage employers to offer coverage. 78.4 percent of businesses believe that providing health insurance to all Iowans will have a positive effect on Iowa's business climate. 75 percent of businesses say it is a good idea for the state to have a strategy for extending health insurance to all Iowans.

Myth: Business will not provide financial support for health insurance expansion

Reality: Approximately half of Iowa businesses were willing to accept a premium increase to support the concept of all Iowans having access to health insurance

Myth: The 91 percent of the public that is insured is not interested in seeing more Iowans have access to health insurance.

Reality: Eight in ten active voters, republicans, democrats and independents, believe it is a good idea for Iowa to have a strategy for extending coverage to all residents

Myth: Neither voters nor businesses believe that anything can be done at the state level to increase the number of Iowans with access to health insurance

Reality: Both business and voters support the concept of "health security" as a means to insure that no Iowan will have to go without health insurance.

POLICY OPTIONS

- Section 4

In addition to debunking numerous myths about health insurance in Iowa, we have identified 8 policy options that, working individually or in concert, could significantly increase the number of Iowans with access to health insurance. These are:

- Expanding Coverage for Children Under Medicaid/hawk-I (SCHIP);
- Expanding Medicaid Coverage for Adults;
- Subsidies to Help Individuals Purchase Private Coverage;
- Provide Short-term Insurance Coverage to the Unemployed;
- Subsidies to Help Employers Purchase Coverage for Their Workers;
- Create Low-cost Health Insurance Coverage Options;
- Pooling Small Businesses with State Employees' Health Plan; and
- A Combined Strategy, financed in part by an employee-employer contribution

IOWA STATE PLANNING GRANT GOVERNANCE

- Section 5 and Appendix II

We used a three-faceted approach to governance for this project. The first was to ask Governor Tom Vilsack to provide leadership and executive branch support. Secondly, we created a Citizens' Alliance for Health Insurance (Citizens' Alliance), composed of key Iowa stakeholders. The third facet was a public-education campaign composed of regional forums held throughout Iowa during May 2001.

The planning process was designed to provide an extensive array of data for the Citizens' Alliance, a fifteen-member group, appointed by the Governor and the Lt. Governor, whose task was asked to consider all the data and help develop policy initiatives to expand health insurance to all Iowans. Composed of people from the public and private sectors, each with varying expertise in access to health insurance, the Citizens' Alliance served as a sifting and sorting entity which was expected to reach a consensus for Iowa's policy initiative.

IOWA STATE PLANNING GRANT FIRST YEAR RECOMMENDATIONS

- Sections 4, 5, 6, and 7

At this juncture of the State Planning Grant process Iowa has not "selected" particular coverage options for implementation. We believe we are at the midpoint in our objective of expanding health insurance coverage. We have accomplished the data-gathering goals set forth in our SPG application, and we have used the results to design and evaluate policy options. The data and potential policy options have been presented to our Citizens' Alliance. The Alliance has reached consensus and directed us to focus our second year efforts on the combined strategy suggested in Section 4 of this report, and to conduct further inquiries on how to secure the funding needed to finance coverage expansions.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

The purpose of the Iowa State Planning Grant (SPG) is to identify policies that will help cover Iowa residents who currently do not have health insurance. Before developing policy options, research is needed to help policymakers and the Iowa public better understand who are the uninsured in Iowa and the reasons why individuals and families are without health coverage. Another step prior to developing policy alternatives is to learn, from the perspective of uninsured individuals themselves, what private and public sector barriers to full health coverage exist in the state. This knowledge forms a basis for designing effective strategies to expand insurance coverage in Iowa. A final step in the SPG effort is to estimate the costs and benefits of covering uninsured persons in the state. As some costs of program expansion may be borne by the uninsured themselves, it is important to understand individuals' price sensitivity and preferences for program development.

To help achieve Iowa's goal to develop a complete and "data-driven picture" of Iowa's uninsured population, The Lewin Group (Lewin) developed baseline information of the uninsured in Iowa based on national Current Population Survey (CPS) data (described below). In addition, we conducted a telephone survey of households in Iowa with at least one household member who is uninsured. In this survey, we obtained a wide range of information on the reasons why they are uninsured and the types of program/policies that would help them obtain coverage

As discussed elsewhere in this section, Lewin conducted a series of focus-group sessions with a broad range of uninsured persons throughout the state in addition to the survey of uninsured. The purpose of the focus-groups was to develop a better understanding of the reasons why individuals are without health coverage, their attitudes about health insurance, and the kinds of initiatives that could be effective in enabling these individuals to obtain coverage. We also conducted structured interviews with representatives of certain populations including immigrants and African Americans.

A. Methods and Approach

Our approach to data collection was to begin by examining all of the data currently available on the characteristics of the uninsured in Iowa. We then designed the survey of the

uninsured and the focus-group scripts to obtain information on the uninsured in the state that did not exist. The result of this is a detailed accounting of the characteristics of the uninsured, the reasons for being uninsured, the consequences of being without coverage and insights into what could be done to expand coverage in Iowa.

The telephone survey, combined with the focus-group and structured interview sessions, were designed to complement each other's strengths in defining the uninsured population in Iowa. The survey provides quantitative information concerning the demographic and economic characteristics of the uninsured population. The focus-groups provided an opportunity to explore and probe deeper into the reasons for going without coverage and the sorts of initiatives that could be considered to expand coverage. The methods used to develop these data are presented Table 1, below.

Table 1
Iowa SPG Sources of Information on the Uninsured

Source of Information	Description of Data
Current Population Survey[1]	Health insurance coverage information and demographics of the uninsured. Data were pooled for 1997 – 2000, and 258,000 weighted responses from uninsured individuals were analyzed.
Survey of the Uninsured	Information on characteristics of the uninsured (including demographic makeup, health and financial consequences of living without insurance) for a representative sample of 1,500 uninsured Iowans.
Focus-groups of Uninsured Individuals	Information on reasons for not having health coverage, barriers to purchasing health coverage, perceptions concerning public programs, consequences of no coverage, and implications for the design of strategies to increase coverage for uninsured individuals.
Structured Interviews	Information on experiences with health insurance and the U.S. health system. In person or telephone interviews were conducted with members of the Bosnian, Vietnamese and African American communities, as well as with representatives of the meatpacking industry.

1. Survey Design

The survey of uninsured persons was designed using, as a starting point, certain existing surveys with questions about insurance status. These include the Medical Expenditure

Panel Survey (1996), the yearly March supplement of the Current Population Survey, Robert Wood Johnson Family Survey, Centers for Disease Control yearly Behavioral Risk Factor Surveillance System and the Minnesota Health Insurance and Access Survey. The advantage of this approach was that many questions had been pre-tested by other researchers and their validity has been established. These questions also tended to be recognized by policy experts as those that best capture the experience of uninsurance. As the questionnaire design evolved, however, the survey developed into a tool uniquely suited for the purposes of the Iowa's SPG.

The questionnaire was designed by Lewin, in consultation with Baselice and Associates (who also conducted the telephone surveys), Iowa Department of Public Health-SPG staff (IDPH-SPG), and the University of Minnesota's State Health Access Data Assistance Center. (This Center, funded by the RWJ Foundation, was established to provide technical assistance in designing state surveys and to facilitate states' uniform data collection in support of health reform efforts.) The IDPH-SPG staff provided valuable design input and approved the questionnaire prior to its use.

Baselice & Associates pre-tested the survey instrument and conducted telephone interviews of the uninsured in January 2001. The telephone interview method was selected as the only feasible approach to capture up-to-date information on the uninsured with a sufficient sample size to allow comparisons of interest, within the project's time frame. One potential disadvantages of telephone surveys, however, is that not all of the population one might wish to interview have telephones.[2] Differential rates of telephone coverage pose a problem in telephone surveys only if the populations (those with telephones and those without phones) are different from each other. We concluded that for the purpose of this survey of the uninsured there was not a serious issue because lower-income households typically bounce in and out of having telephone service, as household income fluctuates.

In addition, in a rural state such as Iowa, it was important that all uninsured persons, even those who were geographically dispersed or linguistically isolated, had an equal probability of being reached. Survey questions were translated into Spanish; several Baselice workers in the telephone call center were Spanish-speaking and were assigned to telephone call lists on which Latino-appearing surnames appeared.

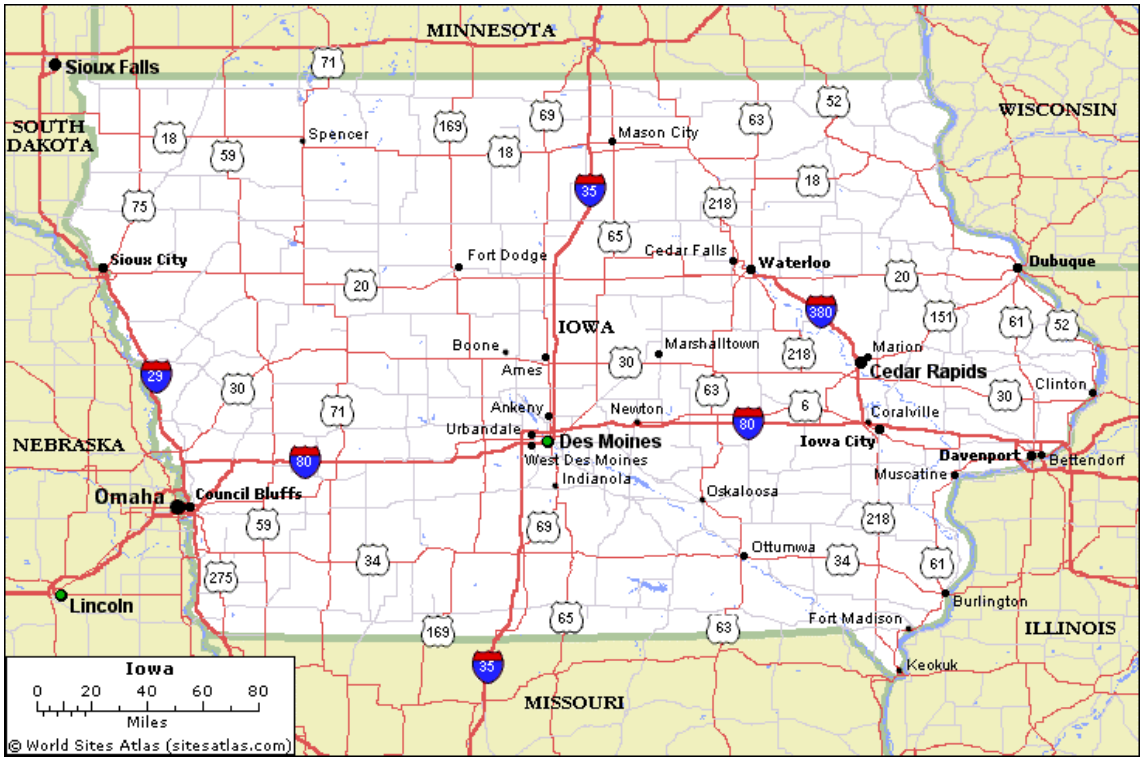
Developing a sampling frame to assure 1,500 completed interviews with a broad spectrum of Iowa uninsured residents was a challenge. This is because being uninsured in Iowa is a low-probability event and persons who are uninsured are a heterogeneous group. The representative sample in Iowa was proportionately selected based on each county's estimated total population with household incomes under $25,000. To assure an adequate representation of the diversity of uninsured persons in Iowa, areas identified as lower-income areas were over-sampled, and every Iowa county had households that were interviewed, certain conducted interviews in Spanish. Random digit dialing (RDD) of listed phone numbers, as well as generated phone numbers, allowed for all residents of the state to have a chance of being interviewed. The sample was controlled for a 46 percent male/54 percent female gender split in each of the five Congressional Districts in the state. The actual gender split of respondents, which takes into consideration incidence of not having insurance and other members in the household besides the respondent without insurance, was 42 percent male/57 percent female respondents.

To achieve a sample of 1,500, nearly 200,000 total telephone calls were made (n=198,389). Another way of describing this effort was that 132.26 telephone dials (calls) were made per completed interview.[3]

2. Focus-Group Development

Focus-groups were designed to understand the reasons why individuals are uninsured and what alternatives for health coverage may be appealing to them. Focus-groups, a qualitative research method, can provide policy researchers with a unique information tool when the policy goal is to modify behavior (e.g. secure health insurance) that depends on a complex mix of attitudes, knowledge, and past experiences. By comparing different points of view that participants exchange during the focus-group sessions, policy makers can examine the complex motivations and behavior that drive individuals' valuation of health insurance and their decisions to be uninsured. From the individual consumer's point of view, the consequences of being without health insurance can be explored and the administrative and financial barriers that impede securing health insurance can be identified. Researchers can then probe and uncover clues about how private and public programs of health insurance could be altered, and what incentives could be offered, to induce more people to secure coverage.

Figure 1
Geographic Areas for Focus-Groups of the Uninsured and Employers



Twelve focus-groups of uninsured individuals were sponsored in Iowa during February, 2001. Focus groups were held in Davenport, Cedar Rapids, Des Moines, and Northwest Iowa.[4] This distribution assured that researchers obtained a geographically broad diversity of individual views, in areas both rural and urban, about the experience of being uninsured. One focus-group was conducted entirely in Spanish; two others were conducted in English and Spanish. Based on IDPH preferences, some focus-groups were designed to capture information about particular groups of uninsured persons, such as low-income persons, those who are self-employed, older uninsured persons, and others. As many uninsured Iowans are young and healthy, and apparently see no reason to purchase coverage, researchers sought to learn about their perspectives through focus-group interaction, as well.

Two subcontractors, Personal Marketing Research, Inc. and American Public Opinion Survey & Market Research Corporation arranged recruitment of participants, obtained sites for focus-groups and handled other logistical tasks. Focus-group meetings were held primarily in the late afternoon (after work) or evening to assure high participation. Respondents were each

offered a meal and snacks and $65 (or more). In addition, all confirmed invitees were called a few days before the focus-groups to remind them of the session's time and place. Finally, in northwest Iowa, where invitees were geographically dispersed and the weather was inclement, the subcontractor arranged a van pick up to assure high participation. For nearly all focus-groups, a show rate of 8-10 persons was achieved.

A Moderator's Guide was developed in conjunction with Iowa SPG staff in preparation for the focus-groups. The Guide outlined issues to be explored and the interactive techniques to be used. The focus-groups themselves were video and audio taped and summarized subsequent to their completion.

3. Structured Interviews

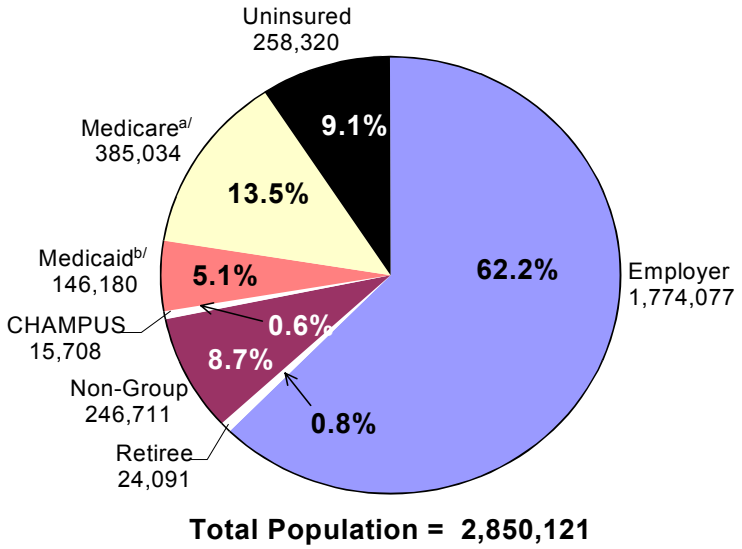
In addition to focus-groups described above, structured in-person and telephone interviews were carried out with several targeted groups including immigrant groups, African Americans, and representatives of the meatpacking industry.[5] As part of the SPG qualitative research effort, structured discussions were held with targeted groups to learn more about their experiences with health insurance and the U.S. health-care system, in general. Interviews among immigrant groups included those who had newly arrived and those with longer experiences in the United States. To reach geographically dispersed immigrants in a trusted environment and assure dependable language translation, interviews were scheduled through community health centers. Interviews with African American informants were scheduled through The Iowa Commission on the Status of African Americans. Representatives of the meatpacking industry, a large employer of Hispanics and other immigrant groups, were also interviewed.

B. Health Insurance Status of Iowans

Lewin estimated the number of uninsured persons in Iowa using the Iowa subsample of the Current Population Survey (CPS). The March supplement to the CPS is an annual survey of households conducted by the Bureau of the Census that provides information on health insurance, employment and income for the participants in the prior year (e.g., the 2000 March CPS reports insurance data for 1999). Lewin pooled March CPS data for the years 1996 through 1999 to obtain a sufficient sample size for detailed analyses of the uninsured in Iowa.

An estimated 90.9 percent of all Iowans had some form of health insurance coverage between 1996 – 1999. Among all states, Iowa ranks high in the percent of its population with health insurance because a relatively large proportion of Iowa's population has employer-sponsored coverage or Medicare. ***Figure 2*** presents the primary source of insurance coverage for the Iowa population. As in other parts of the United States, the main source of health coverage in Iowa was through employers. Approximately 62.2 percent of Iowa residents received employer-sponsored health-care coverage. Thirteen and a half percent of the population were covered by Medicare, (Iowa's population is older on average than most states) and 5.1 percent had Medicaid as their primary source of health coverage.[6] Persons who were dually eligible for Medicare and Medicaid were counted as Medicare beneficiaries. Another 8.7 percent of the Iowa population had individual non-group coverage as its primary insurance source. The remaining 9 percent of Iowa's population, or an estimated 258,320 individuals, were uninsured during the 1996-1999 period. The uninsured individuals in Iowa were a diverse group in terms of age, ethnicity, gender, marital status, income, and employment status. The remainder of this section describes the uninsured based on each of these demographic categories.

Figure 2
Distribution of Iowa Population by Primary Source of Insurance Coverage (All Ages)

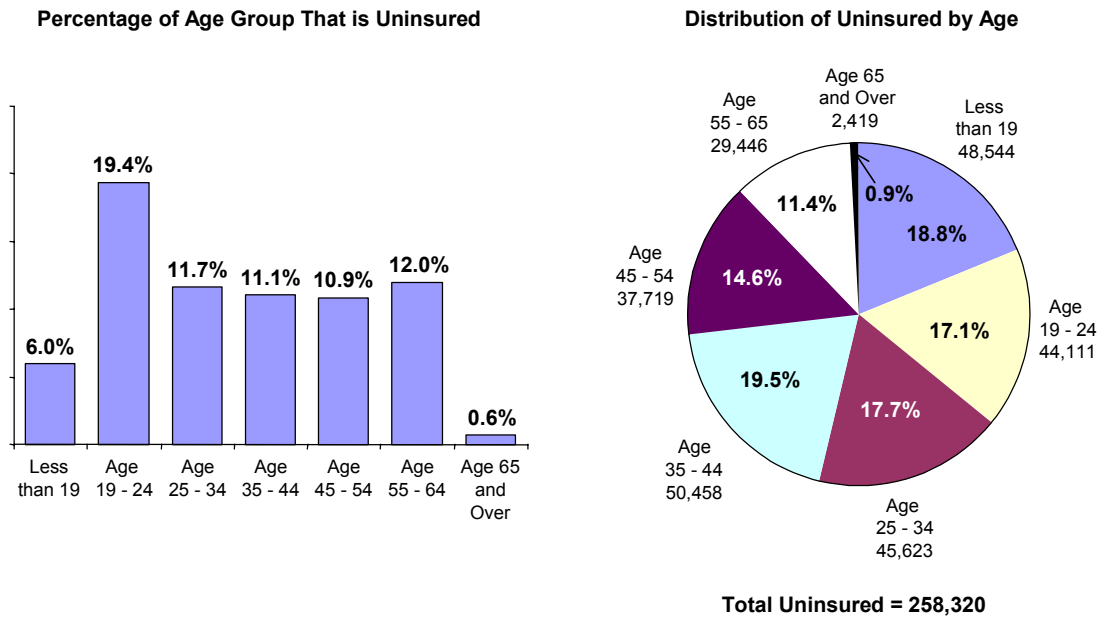


a/ Includes all Medicare beneficiaries, including persons with dual eligibility under Medicare and Medicaid.
b/ Excludes dual eligibles (i.e., persons with both Medicaid and Medicare) who are counted as having Medicare as their primary source of coverage.
Source: Lewin Group estimates based on an analysis of the Iowa sub-samples of the March Current Population *Survey* (CPS) for 1997 - 2000 (covering years 1996 - 1999).

1. Age

Lack of insurance was most common among young adults in Iowa. About 19.4 percent of persons aged 19-24 were uninsured compared with 11.7 percent of those aged 25-34, 11.1 percent of those aged 35 – 44, and 10.9 percent of persons aged 45 to 54 (***Figure 3***). In terms of the total uninsured population, those between 35 and 44 years of age made up the greatest percentage of uninsured individuals at 19.5 percent, followed by children under age 19 at 18.8 percent. Individuals between 25 and 34 years comprised 17.7 percent of the uninsured population. Individuals aged 65 years and over made up the smallest percentage of the uninsured population in Iowa (0.9%).

Figure 3
Age Characteristics of Uninsured in Iowa



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

2. Ethnicity

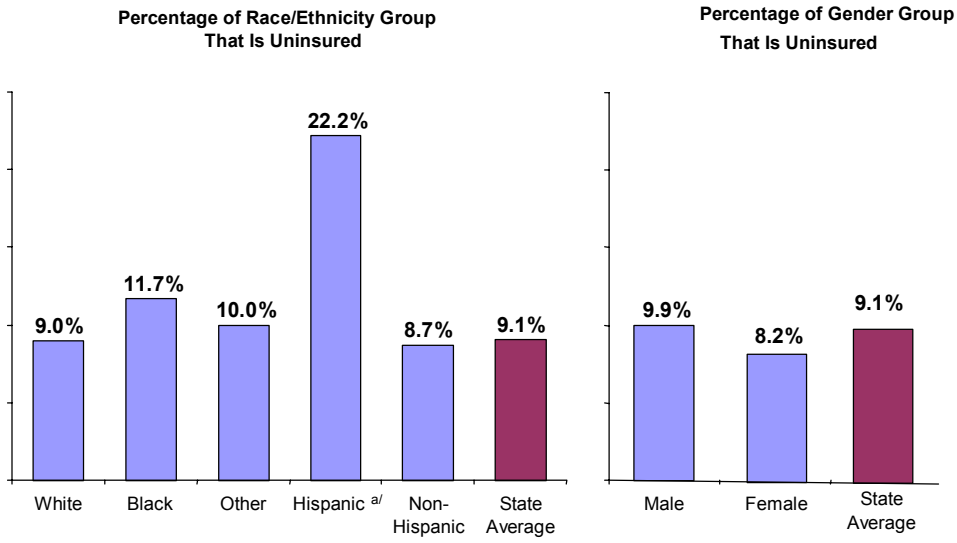
Of all the racial and ethnic groups included in the March CPS, individuals who identified themselves as Hispanic were by far the most likely to be uninsured (***Figure 4)***. Over 22 percent of the Hispanic population were uninsured, compared with about 11 percent of individuals who identified themselves as black, and 9 percent who identified themselves as

white. Hispanic individuals are twice as likely to be uninsured than other racial/ethnic groups in Iowa as in other states, because they work in jobs that often do not provide health insurance as a benefit and because of the difficulty of proving qualifying legal status for public benefits programs, such as Medicaid.

3. Gender

About 10 percent of males and 8 percent of females were uninsured (***Figure 4***). An explanation of why a slightly lower percentage of females than males are uninsured in Iowa is that Medicaid provides coverage for single parents (who are typically female) of young children and pregnant women with incomes up to 185 percent of the federal poverty level. (FPL) By comparison, single males are generally ineligible for Medicaid unless they are disabled or have incomes less than 50 percent of the FPL (50% of the FPL was $4,295 for a family of one in 2001).

Figure 4
Percentage of Iowa Demographic Groups That Are Uninsured



a/ Persons who declared themselves Hispanic could be of any race.

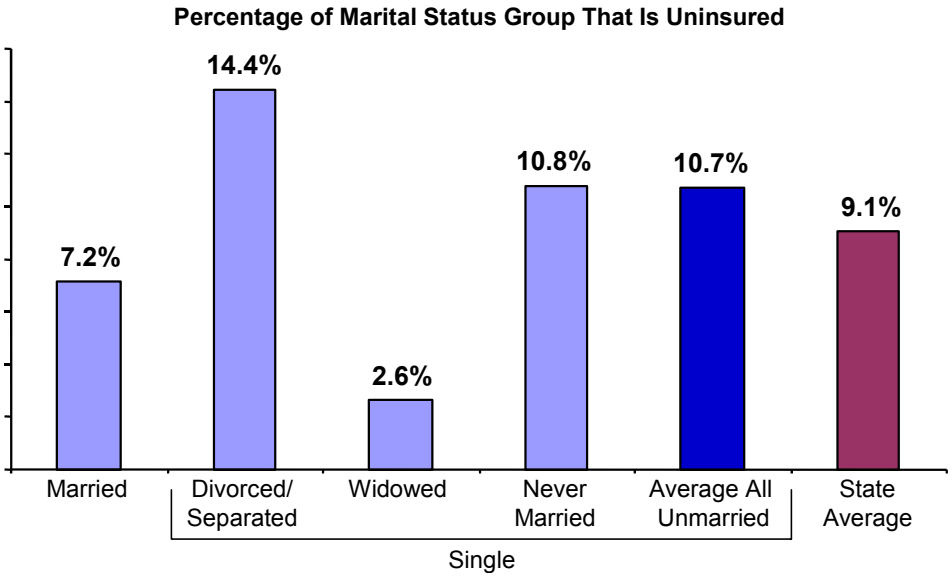
Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

4. Marital Status

In the Iowa subsample of the March CPS data, a greater percentage of unmarried persons were uninsured than married persons. About 10.7 percent of the unmarried were

uninsured, compared with 7.2 percent of married persons (***Figure 5***). When the category of unmarried persons was further divided into divorced/separated, widowed, and never married, we found that persons who were divorced or separated were far more likely to be uninsured than other unmarried groups . For example, 14.4 percent of this group was uninsured, compared to only 2.6 percent of those who were widowed

Figure 5
Uninsured in Iowa by Marital Status

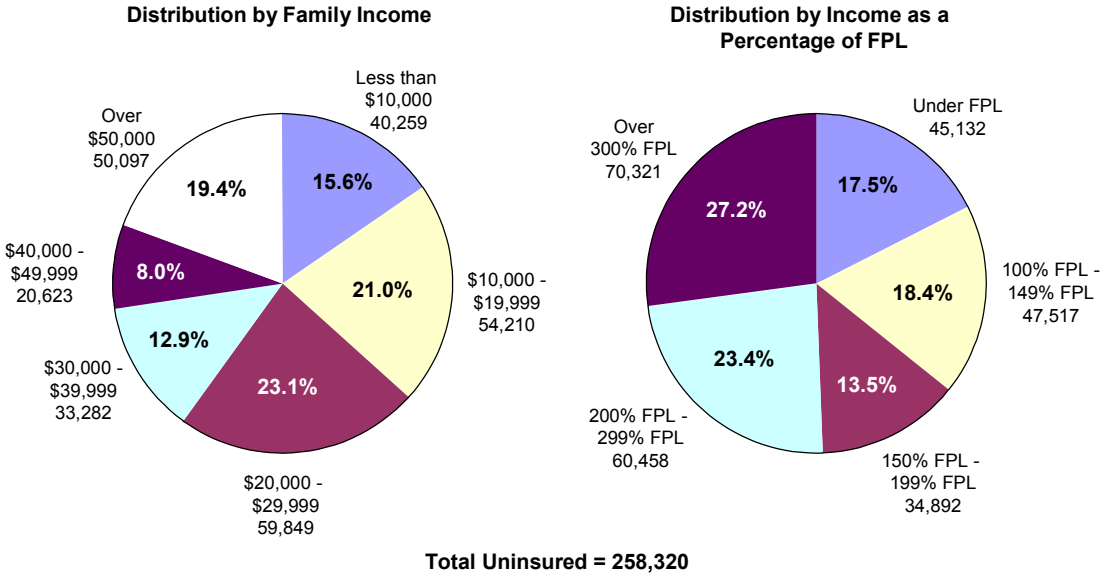


Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

5. Economic Status

The majority of uninsured individuals in Iowa lived in families with low-incomes. Nearly 37 percent of uninsured persons lived in families with incomes less than $20,000. An additional 23.1 percent had annual incomes between $20,000 and $29,999. Thus, nearly 60 percent of the uninsured have annual family incomes under $30,000 (***Figure 6***). At the same time, nearly 20 percent of Iowa's uninsured lived in families with incomes of over $50,000. Another way to consider economic status is as income adjusted for family size. About half of Iowa's uninsured had family incomes below 200 percent of the FPL (***Figure 6***).[7]

Figure 6
Distribution of Uninsured in Iowa by Family Income and Income as a Percentage of FPL [a/]



a/ The FPL is recalculated every year and is adjusted for family size. In 2001, FPL for a family of four is $17,650.
Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

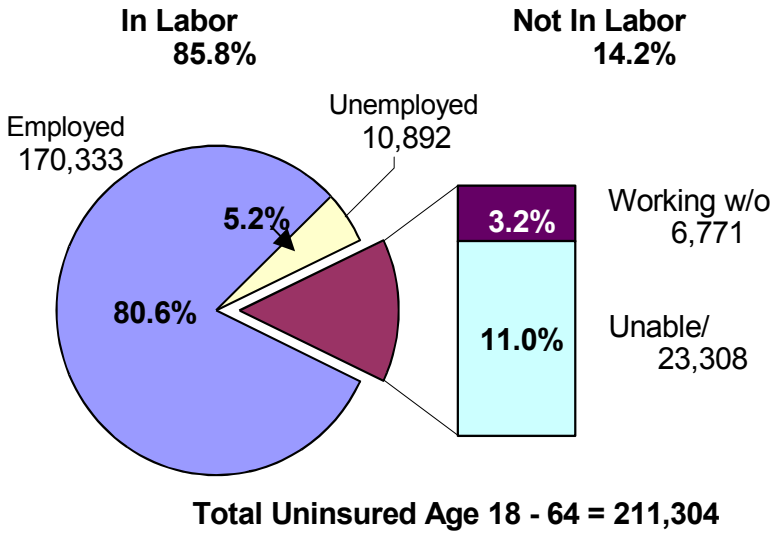
6. Employment Status

Working people constituted the vast majority of the uninsured. Of the 258,320 uninsured, over 80 percent were of working age (between 18 and 64). It may surprise readers that 80.6 percent of the working age uninsured were employed (***Figure 7***). An additional 5.2 percent were unemployed and 14.2 percent of the adult uninsured were not in the labor force. ***Figure 8*** highlights the importance of employment-based health insurance, even for those who may not be workers themselves. Of all Iowans who are uninsured, nearly two thirds are employed. In addition, 21.9 percent of the uninsured are either dependent spouses or children of uninsured workers.

Analysis of the data from the March CPS has given the IDPH-SPG staff and Lewin a foundation of understanding of who uninsured Iowans are and a framework that can be used to place Iowa in the context of other states. Reviewing existing data is merely a preliminary step towards understanding the uninsured. The CPS does not provide important information on why and how long individuals are uninsured or the consequences of living without health insurance.

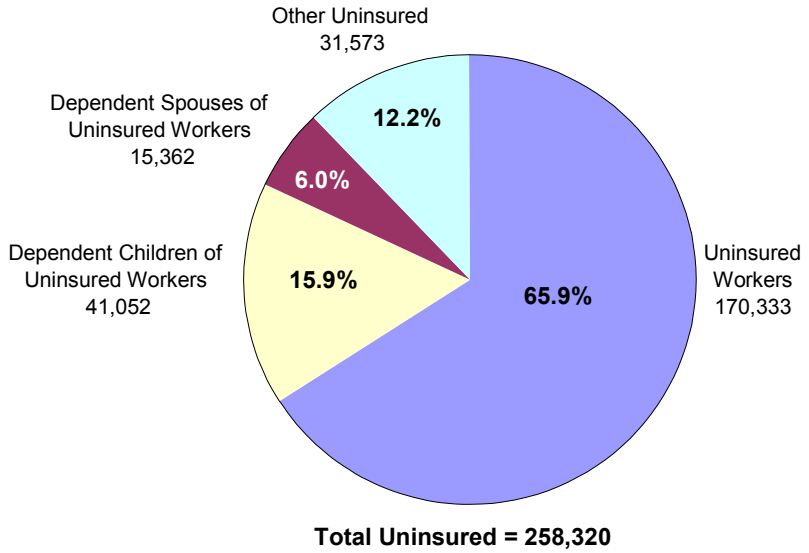
To find answers to these and other questions, Lewin conducted a statewide telephone survey of the uninsured that is described below.

Figure 7
Distribution of Iowa's Uninsured by Labor Force Status (Age 18 - 64)



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Figure 8
Distribution of Uninsured in Iowa by Connection to Workforce



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

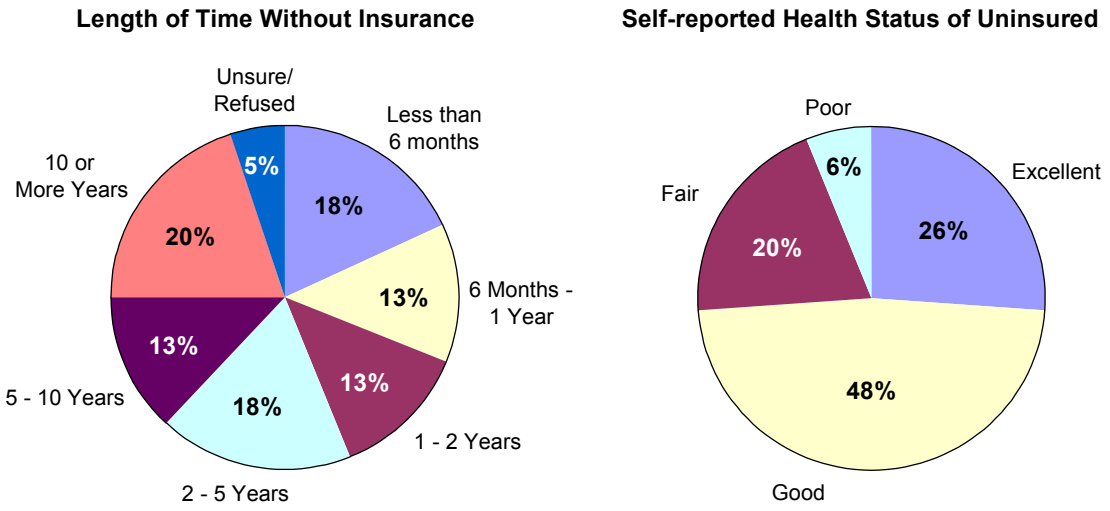
C. Iowa Survey of the Uninsured: Results

The telephone survey was undertaken by Lewin to yield a more comprehensive understanding of the uninsured. The survey examined why these individuals were uninsured and the health and financial consequences of being without coverage. The survey was conducted in January 2001 and 1,500 uninsured Iowans were interviewed.

1. Characteristics of the Uninsured

Nearly one-third of all persons surveyed reported they had been without health insurance for less than one year. At the same time, another one-third had been uninsured for extended periods of time (***Figure 9***). About 13 percent of the uninsured had been without coverage for five to ten years, with another 20 percent uninsured for ten or more years. The self-reported health status of uninsured persons in Iowa was surprising. Three-quarters of all uninsured Iowans reported their health status was either good or excellent. One-quarter reported having poor health.[8]

Figure 9
Distribution of Uninsured in Iowa by Length of Time Without Insurance and Health Status

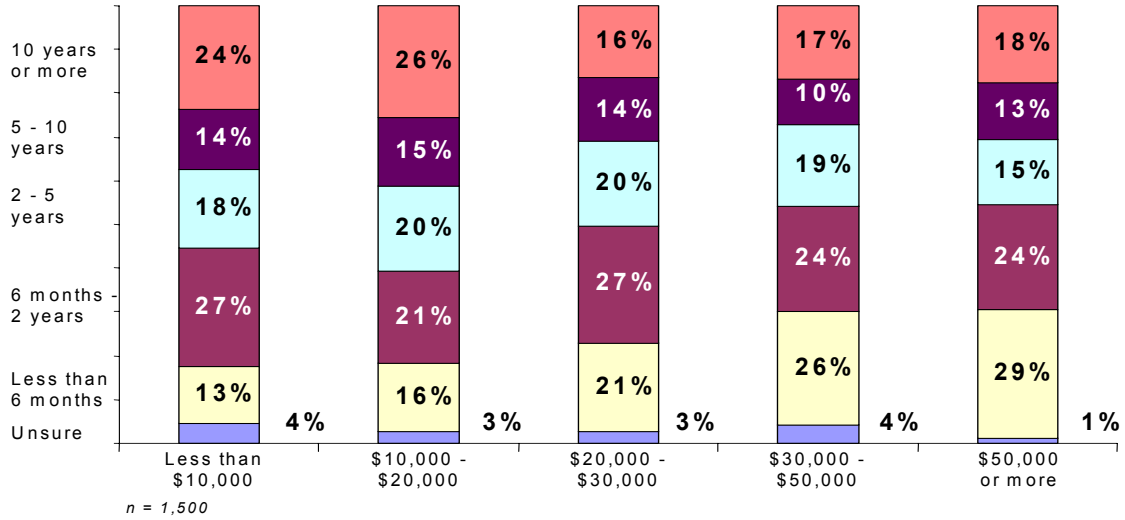


n = 1,500

Source: Lewin Group Survey of 1,500 uninsured persons in Iowa, conducted by Baselice and Associates, Inc. (Winter 2001).

Lower income uninsured persons tended to be uninsured for longer periods of time than higher income uninsured persons (***Figure 10***). For example, 26 percent of uninsured individuals earning $10,000-$20,000 reported being uninsured for 10 or more years, compared to 18 percent among individuals earning $50,000 or more annually. Among those earning $10,000-$20,000, 16 percent of respondents were uninsured for less than six months compared to 29 percent of those in the highest income group.

Figure 10
Length of Time Without Insurance by Income



Source: Lewin Group Survey of 1,500 uninsured persons in Iowa, conducted by Baselice and Associates, Inc. (Winter 2001).

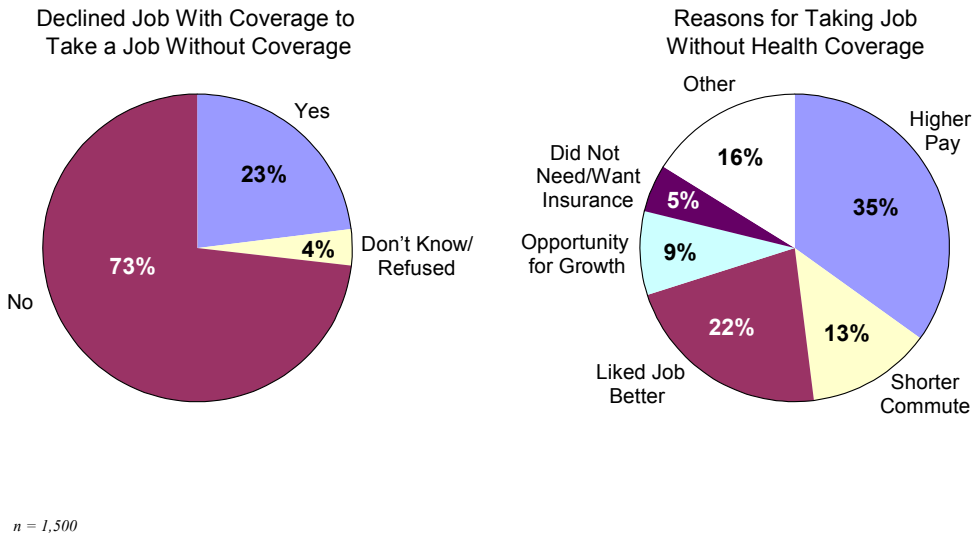
2. Coverage Opportunities and the Uninsured

As health insurance status is closely linked to employment for most Iowans (***Figure 7***), it is recognized that initiatives to expand the availability of employer coverage could have a significant impact in reducing the number of uninsured in the state. Yet, policy initiatives are often influenced by belief systems about individual behavior, particularly related to work.

Some policymakers assert that workers are often uninsured because they choose to be uninsured. This study found that nearly three quarters of workers had never declined a job with health coverage to take a job without it. ***Figure 11)*** About 23 percent of the uninsured persons interviewed indicated however, that they had turned down job offers by firms that provided health benefits to take other jobs that did not. The most common reasons given for doing so were

higher pay (35%), liked the job better (22%), shorter commute (13%), and opportunity for growth (9%). Significantly, only 5 percent indicated that they did not need or want insurance.

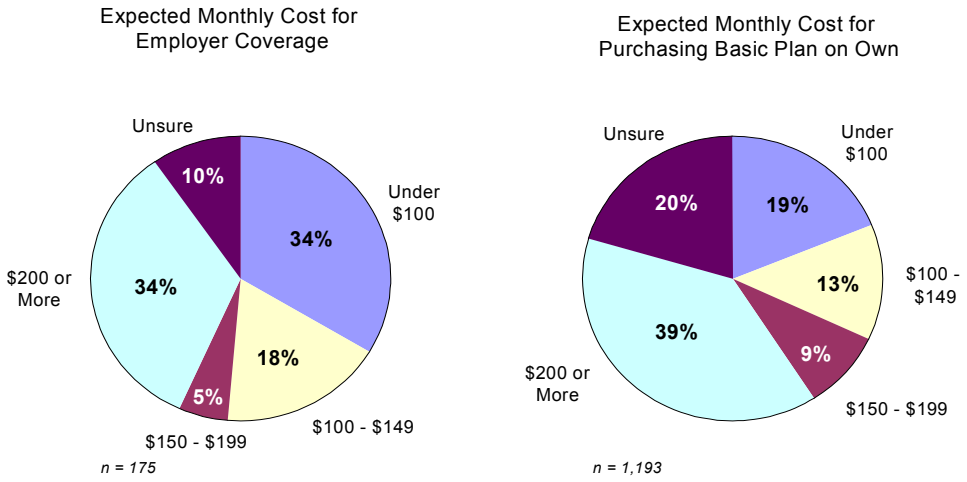
Figure 11
Uninsured Persons Declining Employment with Health Benefits in Iowa



Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001).

For those who declined coverage, 34 percent indicated they thought they would have to pay over $200 per month to participate in the plan (***Figure 12***). Another 34 percent of those who declined coverage thought that they would have to pay $100 or less per month. It is interesting that survey respondents recognized the economic value of employment based coverage to their household budgets. As ***Figure 12*** shows, Only 19 percent of respondents reported they could secure coverage in the individual market for less than $100 per month.

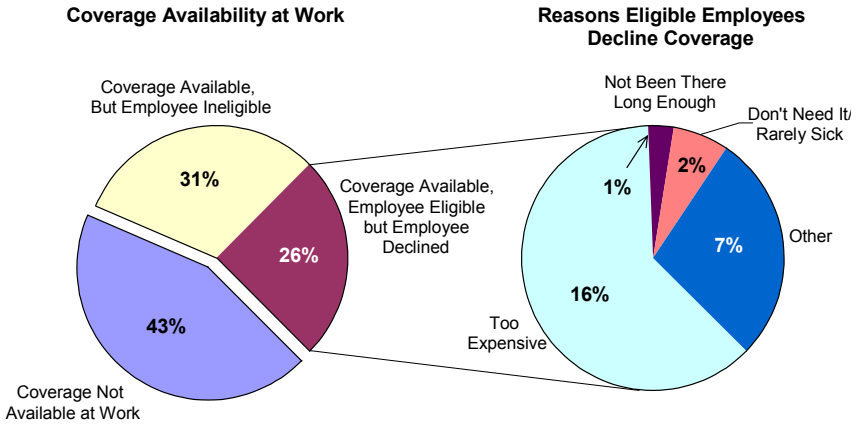
Figure 12
Perceived Personal Out-of-Pocket Cost of Coverage if Uninsured Were to Obtain Insurance



Note: Numbers may not add up to 100% due to rounding
Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

Of all the uninsured workers surveyed, the largest proportion (43%) did not have health insurance available to them through work. Another 31 percent reported that health insurance was available through their employers, but they were not eligible to receive these benefits. About 26 percent of the working uninsured in the survey were eligible for employer-sponsored health insurance, but had declined the coverage. Of these, most (63%) declined coverage because it was too expensive or because they did not believe they needed it (8%). About 27 percent cited other reasons for declining the coverage (***Figure 13***).

Figure 13
Only 26 Percent of the Employed Uninsured Who are Eligible for Health Coverage at Work Have Declined it

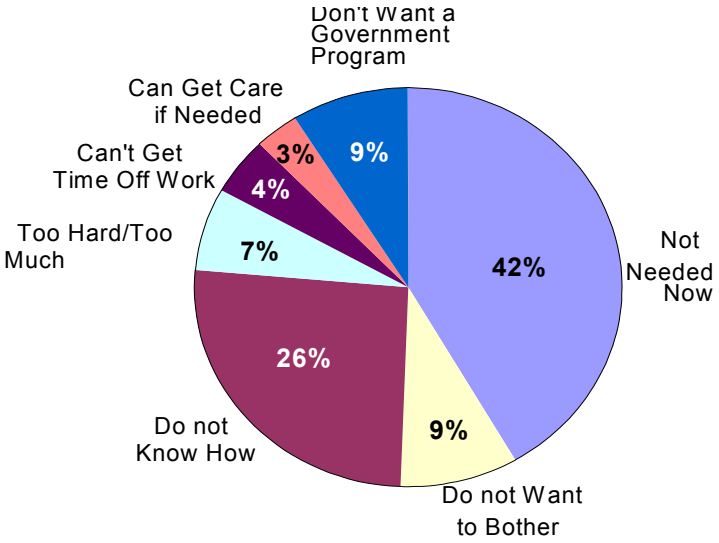


Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

3. Public Coverage Eligibility

About 19 percent of the respondents indicated they believe they would be eligible for Medicaid or hawk-i, but had not applied for coverage (***Figure 14***). We have not assessed the veracity of this claim, we suspect a far smaller percentage of respondents are in fact eligible. Of those individuals, over two-fifths (42%) had not applied because they did not think they currently needed the coverage. 26 percent did not apply because they did not know how to, 9 percent did not want to bother, and 9 percent did not want to participate in a government program. About 7 percent believed the application process was too hard or involved too much paperwork, 4 percent could not get time off to apply, and 3 percent said they could get care if they needed it without applying for programs.

Figure 14
Reasons for Not Applying for State Programs

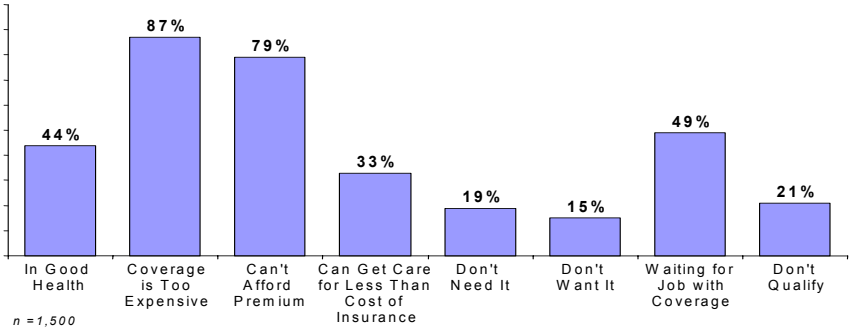


Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

The expected cost of insurance weighed heavily in the decision to purchase or not purchase health coverage (***Figure 15***). The reasons cited most often for not obtaining health coverage were that it was too expensive (87%), and the premium was too high (79%). One-third of uninsured individuals had not purchased health coverage because they said they could purchase needed care for less than the cost of insurance. Some uninsured individuals had not purchased coverage for reasons that were not related to cost. Almost half of uninsured individuals (49%) had not purchased health coverage because they were waiting to secure a job

that offered it. 19 percent had not purchased health coverage because they believed they did not need it and 15 percent had not purchased it because they did not want it.

Figure 15
Reasons for Not Purchasing/Signing Up for Insurance for Self or Family



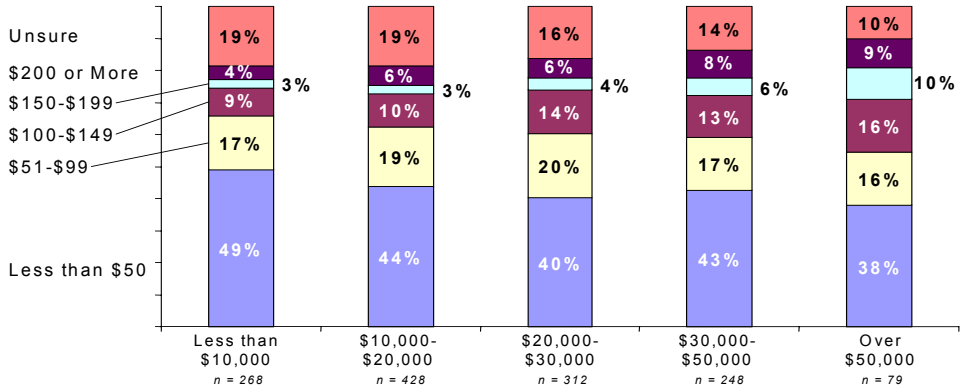
Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

Uninsured Iowans, like others without health insurance throughout the United States, are sensitive to the price of coverage. Respondents of all income ranges generally expressed a willingness to pay some monthly cost for health coverage. The amount of money respondents would be willing to pay each month varies by income. (***Figure 16***). For those with household incomes less than $10,000, nearly half (49%) would be willing to spend less than $50 per month for coverage, and 16 percent would be willing to spend between $100-$200 per month. For those with incomes over $50,000, 38 percent would be willing to spend up to $50 per month and 35 percent would spend between $100-$200 per month for a basic health plan. This suggests that even very small subsidies such as $50 per month could entice a large portion of this group to take coverage when offered.

4. Consequences of Being Without Health Insurance

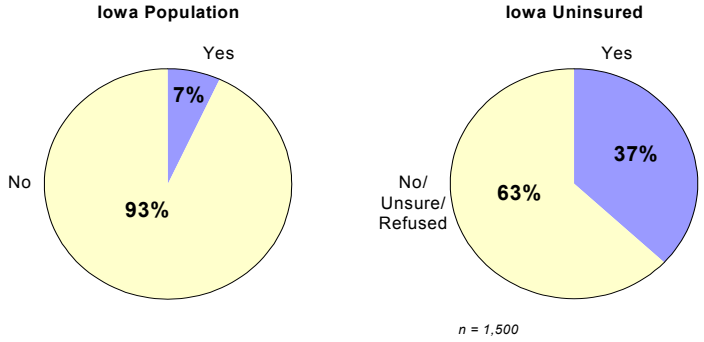
Compared to the general Iowa population, uninsured Iowans were more likely to not see a doctor when they thought they needed care (***Figure 17***). Approximately 37 percent of the uninsured reported that they needed a doctor in the past 12 months, but had not seen one due to cost. Statewide, 7 percent of all Iowans (as reported in the Behavioral Risk Factor Surveillance System[9]) reported needing a doctor in the past 12 months but not going due to cost. This suggests that Iowans without health insurance are more likely than insured Iowans to not receive needed medical care because of cost.

Figure 16
Willingness to Pay for Basic Health Plan Each Month by Income



Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

Figure 17
Needed a Doctor in Past 12 Months but Did Not Go Due to Cost

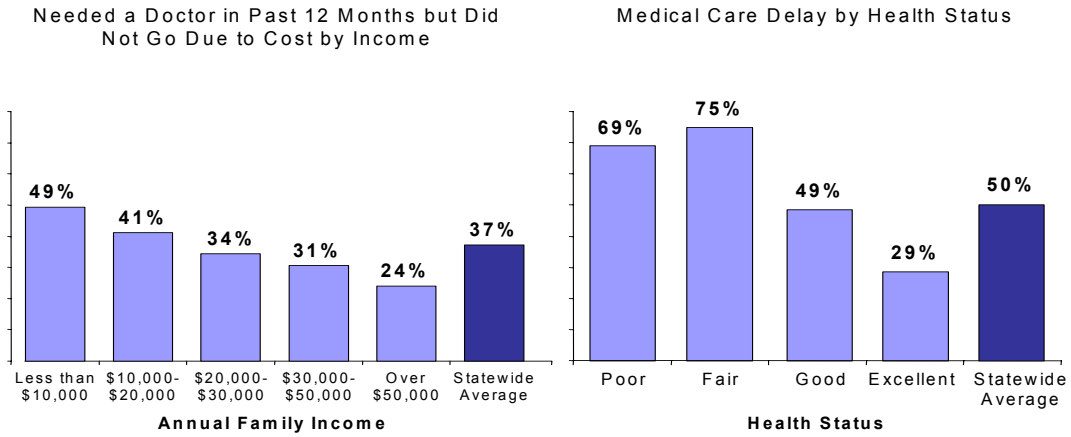


Source: Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Online Prevalence Data, 1999.
Source Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

The uninsured, especially those with lower incomes and those who were in poor health, would most likely delay seeking a doctor's care because of cost concerns (***Figure 18***). Overall, 37 percent of the uninsured reported they needed to go to the doctor in the past 12 months, but did not go due to cost. Almost half of those earning less than $10,000 per year, 41 percent of those with family incomes between $10,000 and $20,000 per year, and 31 percent of those earning between $30,000 and $50,000 per year reported delaying medical care. By comparison, only 24 percent of those with incomes over $50,000 reported such a delay.

Fifty percent of uninsured individuals reported delaying medical care in general (***Figure 18)***. Individuals in poor to fair health (self-reported) were more likely to delay medical care than those in good or excellent health. Sixty-nine percent of those in poor health, and 75 percent of those in fair health delayed medical care compared to 49 percent of those in good health and 29 percent of those in excellent health. Such delay in medical care can have serious negative implications for uninsured individuals (and society). Delayed medical care endangers the lives and health of all persons and adds unnecessary costs to the health-care system in Iowa.

Figure 18
Delayed Medical Care Because Uninsured



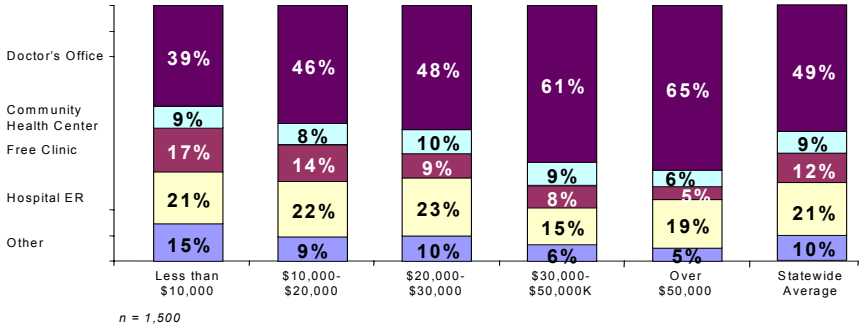
Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

5. The Uninsured and Sources of Medical Care

Uninsured persons in Iowa mostly received medical care in doctors' offices. The source of medical care used by uninsured individuals varied with income (***Figure 19***). The percentage of uninsured individuals that reported a doctor's office as their primary source of medical care increased steadily as annual family income increased, from a low of 39 percent for individuals earning less than $10,000 per year to a high of 65 percent of those earning over $50,000 per year. Use of community health centers as regular source of medical care was generally stable across all income groups (between 8 and 10%), although it was slightly lower (6%) for uninsured individuals that earned over $50,000 per year. As family income increased, the percentage of uninsured individuals who reported receiving medical care from a free clinic also steadily decreased. In general, a higher percentage of low-income earners reported using the

hospital emergency room as a source of medical care, compared to those with higher incomes, although the general trend did not continue across all income groups.

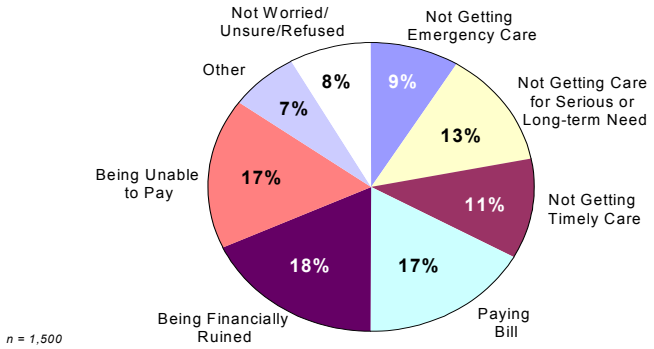
Figure 19
Source of Medical Care, If Uninsured, by Income



Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

The financial and health consequences of being without health insurance were of great concern to many of the uninsured (***Figure 20***). The main worries about not having health insurance can be divided into those worries that deal with the financial consequences of being uninsured (52%), and the worries that relate to accessing health-care (33%). For uninsured individuals the primary worries about not having health insurance were financial ruin (18%), being unable to pay for their household bills (17%), paying the medical bills (17%), not getting care for serious or long-term health-related needs (13%), and not getting timely care (11%). Eight percent of uninsured persons were either not worried about not having health insurance, unsure of their worry, or did not respond to the question. Seven percent of uninsured persons had main worries others than those presented above.

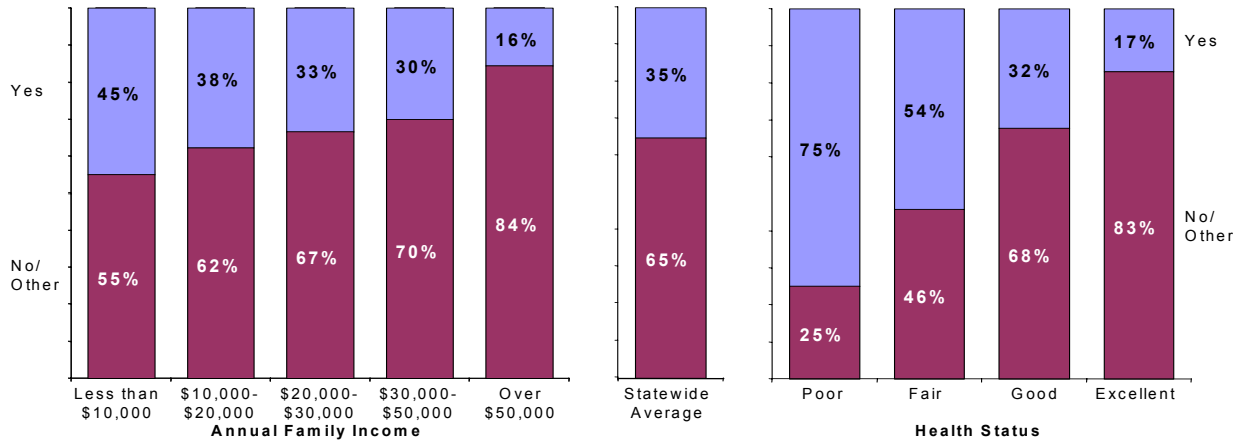
Figure 20
Main Worry About not Having Health Insurance



Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

Overall, 35 percent of the uninsured had large medical bills (***Figure 21***). The likelihood of having large medical bills was related to income and health status. In general, as income increased, the percentage of individuals with large medical bills decreased. Also, as health status improved, the likelihood of having high medical bills decreased. Forty-five percent of uninsured individuals with incomes less than $10,000 per year reported having high medical bills, compared with 38 percent of those with incomes between $10,000 and 20,000, 33 percent of those with incomes between $20,000 and $30,000, 30 percent of those with incomes between $30,000 and $50,000 and 16 percent of those with incomes over $50,000 per year. Three-quarters of uninsured individuals reporting poor health had large medical bills. In contrast, 54 percent of those with fair health status, 32 percent of those with good health status and 17 percent of those with excellent health status reported having large medical bills.

Figure 21
Have Large Medical Bills That Are Difficult to Pay Off by Income and Health Status



Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001)

D. Focus-groups of Uninsured Individuals

The survey of the uninsured was useful in presenting a detailed picture of uninsured Iowans. The survey helped the IDPH-SPG staff and Lewin develop a thorough appreciation of the barriers involved in purchasing health insurance as well as the consequences of being without coverage. In order to develop a deeper understanding of the issues that confront uninsured individuals, Lewin also conducted focus-group sessions with uninsured Iowans. Specifically, Lewin conducted focus-groups with uninsured individuals in order to understand the complex behavior and experiences that drive individuals' decisions that result in being uninsured. The

focus-group sessions revealed rich and often poignant information about health status, barriers in securing coverage, and the consequences of going without health insurance. Information gathered from the focus-groups also helped uncover clues about how private and public programs of health insurance could be altered to increase overall coverage rates, and incentives that could be offered to induce more people to secure coverage.

1. Barriers to Not Having Health Insurance

The reasons why focus-group participants were uninsured mirrored those of persons who participated in the survey of the uninsured. By far, the most common reasons for not being insured were employment related. According to the survey of the uninsured, about 74 percent of the uninsured working for someone else did not have access to employer coverage either because the coverage was not offered or they were not eligible for the coverage that was offered. However, employer-sponsored health coverage is the route through which the majority of individuals obtain health insurance. [According to Lewin analyses of the March CPS, the primary source of insurance for 62 percent of Iowans was through their employers.] When an individual is not offered health coverage through a place of employment, few other realistic options are available.

While many of the individuals in focus-groups were employed, none had health insurance. As said by one low income uninsured woman "you either have a good job with good insurance or a poor paying job with poor or no insurance." Some employed individuals who did not have insurance worked at places that did not offer insurance to any employees. These employers were often small businesses that decided not to include health coverage as a benefit, often due to high costs.

Some of the uninsured were employed where insurance was offered, but not to all employees. For example, they may have been part-time or temporary employees, and insurance was only offered to full-time or permanent employees. Some may have been working full-time, but were in fact classified as part-time and, were therefore not offered insurance. These individuals sometimes reported that although they were identified as part-time they in fact worked a full-time schedule. Some of the part-time worker focus-group participants would have

"The only way you can get insurance is through a job. It is too expensive to pay on your own."

liked to work full-time but their employers did not offer it. These workers believed that one reason they were not offered full-time schedules was because with full-time-status they would be eligible for benefits, including insurance. Other employees may have eventually become eligible for employer-sponsored coverage, but were waiting for a probation period to end. Some uninsured individuals worked at places where insurance was offered, but they could not afford to pay the employee contribution.

In the focus-groups it was discovered that for unemployed individuals, it was nearly impossible to purchase insurance on their own. Without a job, it was simply not possible to pull together enough money each month to an insurance premium. Unemployed individuals had to use their limited resources to pay for the more imperative necessities of rent, food, car payments and utilities.

Some uninsured individuals chose not to participate in employer-sponsored coverage for which they were eligible. In fact, according to our survey of the uninsured, about 23 percent of uninsured individuals selected jobs that did not offer insurance over other jobs available to them that did sponsor insurance. Focus-group participants identified several reasons why employees declined coverage for which they were eligible. First, some employees could not afford their portion of the monthly premium or they believed coverage was futile because they knew they could not meet their deductible or co-pays. Others could, in theory, afford coverage, but also chose not to participate. For these employees, the employee contribution amount was seen as too high relative to the potential benefit which they might receive from the insurance. Also, the policies that were offered were perceived as not being of good enough quality (high deductibles, not enough coverage) to merit participation. This group was most commonly made up of young adults and teenagers.

Some individuals, who felt capable of covering the cost of an insurance premium, questioned the rationale for doing so. They reported needing medical care less than once per year, and therefore found it less expensive to pay for the care out-of-pocket than to pay a monthly premium. Overall, most uninsured focus-group participants say they wanted a quality health insurance policy and that having poor-quality health insurance policy was akin to not having a policy at all.

A third reason that some individuals declined employer-sponsored coverage was that they were covered somewhere else (such as through a spouse or family member). While this group did have insurance, they may have influenced employers' decisions to not offer health insurance to their workforce. In several focus-groups with employers, many said that the reason they did not offer coverage was that all or most of their employees had coverage through their spouses or some other means (see Section 2).

The expected cost of insurance weighed heavily in the decision not to get health insurance. The reasons cited most often in the survey of the uninsured for not getting health insurance were that it was too expensive (87%) or that the premium was too high (79%). Focus-group participants substantiated the importance of affordability as a barrier to health coverage.

"Willing to pay is not the correct term. It should be what I am able *to pay."*

As one participant said "I can hardly pay my rent and utilities and car insurance, let alone get health insurance."

Uninsured individuals generally reported that they would be willing to pay between $25 to $400 per month (with most participants reporting amounts between $25 and $100 per month) for health coverage for a plan with no deductible, no co-pays and a prescription benefit.

Sporadic income also limited the ability of some uninsured to purchase health insurance. Some of the uninsured did not have a regular or steady source of income from which to purchase insurance, often due to employment in seasonal, temporary or highly variable jobs.

"I don't know how much I will be making from month to month, but the payments (for health insurance) have to be paid on time, regularly."

Health status also prevented the purchase of health insurance for some uninsured. Several focus-group participants report that they were "uninsurable" due to long-standing health problems. Others were too sick or disabled to work and so had little income from which to purchase insurance.

2. The Uninsured and Public Programs

In the telephone survey, uninsured individuals indicated they choose not to participate in Medicaid because they questioned the quality of Medicaid coverage. On the contrary, nearly all focus-group participants said they valued the Medicaid program, with its lack of deductibles and co-payments. However, for focus-group participants, a significant deterrent to Medicaid participation, was the time it took to get through the application process. Many focus-group participants had had direct experience with Medicaid, either for themselves of their children. Only a small portion of focus-group participants believed that they were currently eligible for public health insurance programs. Most persons simply did not believe they were eligible.

"Welfare reform gives people training to get a job for minimum wage and then you get everything taken away from you like subsidized housing and health insurance."

"If you make between $18,000 and $21,000 per year you are stuck between a rock and a hard place."

"Government punishes you so that once you make money, they take it [all the help they once provided you] all away...The people who don't work – they can get all the care they want for free."

Some of the currently uninsured had been on public programs in the past but lost eligibility either because they exceeded the income requirement or because of welfare reform. Many believed they earned barely more than was permitted for participation. Some currently-uninsured individuals had Medicaid as their most recent source of health insurance but then lost Medicaid coverage, often due to restrictive financial eligibility determinations.

Uninsured individuals did not voluntarily dis-enroll from public programs but dis-enrollment was still common. Individuals were often forced to leave public programs if they earned too much during a specific time period. For individuals whose income fluctuates regularly, enrollment and disenrollment from public programs was routine.

3. Consequences of No Insurance

Individuals without health insurance reported in focus-groups that they did get some medical needs met, particularly for urgent situations. For preventative or routine care, the uninsured frequented either community health centers, clinics or private physician offices and paid cash or arranged payment plans with providers. Overall, as seen in the survey of the uninsured, the most common place for uninsured individuals to receive medical care was in a doctor's office. Some focus-group participants did report frequenting county hospitals or community health centers or clinics to receive medical care.[10] They reported that it was easier to receive care from these safety net providers than to worry about the cost of a premium or a deductible. Women were particularly knowledgeable about services and programs available in the community for low or no cost health-care.

All of the uninsured focus-group participants reported delaying medical care because of concern over the expense, often until the situation became urgent. Many of the focus-group participants reported and seemed to the moderator to have serious or chronic health problems. For example, the focus-group participants included:

- A woman who said she has a heart murmur who had not been to the doctor in five years;
- A women who was deaf (she read lips in the focus-group) who had not been to an ear doctor in ten years; and
- A woman who indicated she has breast cancer

One person commented that "you are aren't allowed or able to take care of your health without health insurance," saying that he could not go in for a yearly check-up, even though he knows he should, because of the cost.

Finally, the focus-group participants reported that they have difficulties simply paying for rent, utilities and food. They indicated they had no "cushion" from which to purchase health insurance. Some said that even if they could afford the monthly premiums for health insurance, the high deductibles discouraged them from purchasing. As a result of not having insurance,

many of the participants constantly worried about the next major illness or accident that would happen and the financial implication of such an event.

4. Role of Government

Uninsured focus-group participants believed that the government needed to be involved in securing health insurance for more Iowans. While they were not interested in employer-sponsored *mandated* health insurance (they believed that such a requirement would discourage small businesses from opening and force many out of business), they would support government subsidized or sponsored insurance programs for the uninsured.

Uninsured Iowans believed that the government, through employers, should encourage the provision of health insurance through tax credits for employers offering coverage. They believed that tax credits for uninsured individuals would not be as effective. When faced with the choice between health insurance and other goods and services, health insurance seems expendable for all but the very sick. If such incentives were offered to employers, however, then it would only help the uninsured that were employed or who were connected to the workforce.

Small group risk pools could also be created with government assistance to help uninsured individuals secure coverage, especially unemployed uninsured individuals. This suggestion came out of every focus-group session conducted. Focus-group participants also believed that unemployed uninsured individuals needed governmental assistance with subsidizing premium costs, as this group generally had very limited financial resources.

E. Synthesis.

1. Access to Health Coverage is Closely Linked to Employment

The health insurance system in Iowa is strongly connected to employment, with approximately 62 percent of the population receiving health insurance through employment (***Figure 2***). Of the 9.1 percent of Iowans that are uninsured and of working age, nearly 81 percent are employed.[11] This means over three-quarters of the uninsured are persons who are working but do not have employer-sponsored coverage.

According to a report published by the Commonwealth Fund, approximately 20 percent of adults working for an employer do not have access to employer-sponsored coverage.[12] The

Lewin/IDPH-SPG survey of the uninsured found that of the uninsured who are employed, 43 percent work at places that do not offer coverage to any employees, 31 percent work at places where coverage is offered to some but not to them, and 26 percent decline the coverage. Focus-group participants also discussed this close connection between employment and health coverage. They said that simply being employed does not guarantee coverage, but note that employed individuals are more likely to have health coverage than unemployed individuals. For the unemployed, securing coverage is much more challenging, as these Iowans do not have as much expendable income from which to purchase insurance.

Furthermore, low-wage workers are less likely to have access to employer-sponsored coverage. According to a recent survey conducted by the Kaiser Commission on Medicaid and the Uninsured, 58 percent of American workers earning less than seven dollars per hour are insured.[13] Focus-group participants in Iowa, particularly low-wage workers, also noted the distinction between "good jobs" with good pay and good benefits and "poor jobs" with poor pay and poor or no benefits.

2. The Greatest Barrier to Obtaining Health Coverage is Consumer Out-of-Pocket Cost

For Iowans who decline employer-sponsored coverage, the main reason for declining is that coverage is too expensive. As discussed previously, 26 percent of employees that had health coverage available at work declined it and remained uninsured. Of this 26 percent that declined coverage, 61.5 percent declined coverage because it was too expensive. The Commonwealth Fund found that over 33 percent of adults with employer-sponsored coverage spent more than $1,000 per year on premiums, and 22 percent spent more than $1,500 per year.[14] These amounts are substantial, especially for low-income employees with dependents. The Commonwealth Fund also found that only a fraction of low-wage employees declined coverage to participate in a family member's plan, compared to a much larger percentage of those who earned higher incomes.

For individuals who do not obtain health coverage from their employers, the main barrier to purchasing a personal policy is also affordability, as found in the survey of the uninsured. Couple this with the finding from the Commonwealth Study that 42 percent of working

individuals earning less than $20,000 per year are not eligible to participate in employer-sponsored coverage or work for firms that do not offer health coverage, and we learn that those who cannot afford health coverage from their employers are the least able to purchase it on their own.[15]

Health status also prevents the purchase of health insurance for some uninsured persons. Several focus-group participants reported that they were "uninsurable" due to long-standing health problems such as diabetes, hypertension, and heart problems.[16] Others were too sick or disabled to work and so had little income from which to purchase insurance. These individuals also could not meet (or assumed they could not meet) the criteria for Medicaid disability coverage.

Furthermore, many of the uninsured weigh the costs and benefits of purchasing health insurance, and many decide that it makes more sense for them to spend money on other things. Focus-group participants discussed their decisions not to purchase health insurance and many relayed that they simply did not have enough money left to purchase it after they finished paying for other more necessary goods and services, such as food, rent, utilities and car insurance.

3. The Uninsured, Especially Low-income Earners, Delay Obtaining Medical Care

The uninsured are more likely than the insured to delay medical care. Overall, 37 percent of the uninsured in Iowa said they needed to go to the doctor in the past 12 months, but did not go due to cost. Based on the survey of the uninsured, we found that certain groups such as those with fair or poor health status or those who are low-income earners are more likely to delay care than other groups. Almost 70 percent of individuals with self-reported poor health status and 75 percent of those with fair health status report delaying medical care, compared with 29 percent of those with self-reported excellent health status. Several focus-group participants indicated they were in immediate need of medical care yet had no plans to seek it due to cost.

Uninsured individuals with lower incomes are more likely to delay care compared to those with higher incomes. As indicated above, 37 percent of the uninsured said they needed to go to the doctor in the past 12 months, but did not go due to cost. But when examined by annual family income, we found that 49 percent of those earning less than $10,000 per year and 41

percent of those earning between $10,000 and $20,000 per year report delaying medical care. By comparison, only 24 percent of those with incomes over $50,000 reported delaying care.

According to the American College of Physicians and the American Society of Internal Medicine, delays in receiving medical care can lead to greater severity of illnesses and even mortality.[17] Delayed medical care also results in increases in costs to the nation's health-care system and reduces productivity.

4. The Government Should Take a Role in Securing Coverage for the Uninsured

In general, uninsured Iowans believe the government should be involved in helping more uninsured individuals secure coverage, especially those who can be classified as "low income." Specifically, they believe the government should be involved with the financing of such coverage. They were not as keen with the government providing medical care or being involved in the provision of care. Tax credits for employers offering insurance to their employees would help uninsured and employed individuals, but would not help those who were not connected to the work force. A different set of solutions would be needed to impact this group's access to health coverage.

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[1] http://www.bls.census.gov/cps/overmain.htm

[2] While telephone coverage in Iowa exceeds 97 percent, while telephone coverage for those in poverty is estimated at below 90 percent.

[3] The screen out ratio of ineligible households was 11.31 to 1 (16,967 to 1,500). The refusal rate was 9.37 to 1 (14,050 to 1,500). The rate of mid-interview terminations was 1.90 to 1 (2,849 to 1,500).

[4] Focus groups for northwest Iowa uninsured were held in Sioux Falls, South Dakota, as this was the most convenient meeting place for persons in extreme northwest Iowa.

[5] Structured interviews were completed among several members of the American Meat Institute with slaughtering, processing or packing companies in Iowa. These interviews were completed at IDPH's request to learn more about the availability of health insurance among workers, a concern of several advisors to the SPG project.

[6] We have adjusted the data to correct for underreporting of Medicaid coverage.

[7] The FPL is recalculated each year and is adjusted for family size. The FPL was $14,630 for a family of three in 2001, and $17,650 for a family of four.

[8] According to National Center for Heath Statistics, "nearly 1 out of 10 Americans report they are in fair or poor health." The self-reported health status of uninsured Iowans is worse than that reported by the general public. www.cdc.gov/nchs/fastats/hstatus.htm

[9] National Centers for Chronic Disease Prevention & Health Promotion Centers for Disease Control & Prevention, Behavioral Risk Factor Surveillance System Online Prevalence Data, 1999.

[10] In focus groups held in Des Moines, several participants mentioned the availability of "Broadlawns insurance" an apparent reference to Polk County's county hospital, Broadlawns.

[11] *ibid.* (Working age refers to individuals that are between 18 and 64 years of age.)

[12] Duchon L, Schoen C, Simantov E, Davis K, and An C. January 2000. Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century. The Commonwealth Fund.

[13] The Kaiser Commission on Medicaid and the Uninsured, Uninsured in America: Key Facts. March 2000.

[14] Duchon L, *Ibid*.

[15] Ibid.

[16] Iowa is a guaranteed issue state.

[17] Schriver, M. November 1999. No Health Insurance? It's Enough to Make You Sick. White Paper of the American College of Physicians—American Society of Internal Medicine.

SECTION 2: EMPLOYER-BASED COVERAGE IN IOWA

The purpose of the Iowa State Planning Grant (SPG) was to identify policies that will help cover Iowa residents who currently do not have health insurance and develop strategies to achieve the goal of expanded health insurance coverage. As described in the previous chapter, research was conducted in order to identify reasons why individuals and families are without health coverage. Because employers are the cornerstone of private health coverage in the United States, it was important to gain an understanding from businesses about the health insurance they offer in Iowa. In addition, it was important to learn, from the perspective of businesses themselves, what barriers exist to providing health insurance to workers and their dependents. This knowledge forms a basis for designing policy options and effective work place strategies to expand coverage in Iowa.

The difference in coverage levels by firm size was a major impetus for surveying employers and conducting focus-groups of employers in Iowa. It is well known that small employers are less likely than large employers to offer health insurance coverage. Among firms that do offer insurance, however, lower-income workers are less likely than higher income workers to enroll in health insurance benefits because of its cost. These dynamics of the employer-sponsored health insurance market are important to consider in designing effective coverage options to expand insurance coverage.

As part of Lewin's development of a "data-driven picture" of Iowa's uninsured population, Lewin initiated three companion efforts. This research, both quantitative and qualitative, followed an approach that was similar in design to what was carried out for uninsured persons in Iowa. Lewin developed baseline information about employer-sponsored health insurance from our analysis of the Current Population Survey (described below). Second, Lewin designed and conducted a telephone survey of Iowa employers in early 2001. Finally, we conducted a series of focus-groups with employers throughout the state that either offered or didn't offer health insurance.

F. Methods and Approach

Our approach to data collection was to begin by reviewing all available secondary data concerning the employment characteristics of the uninsured in Iowa. Building on that base, we

then designed the survey of Iowa employers and focus-groups to obtain more detailed information about employers and their decisions to offer or not offer health insurance. The result of this effort is a description of the characteristics of employers, the concerns they have about health insurance, what they understand to be the consequences of their being without coverage, and insights into what could be done to expand coverage in Iowa.

As in the research conducted on the uninsured in Iowa, the telephone survey and the focus-group sessions were designed to complement each other's strengths. The survey provides quantitative information about employers in the State that both offer and do not offer health insurance to their workers. The objective of the survey was to gather information about employers' behavior with respect to their provision of health insurance, to track trends in health coverage provided by employers, and to assess selected policies designed to regulate or expand employer-based health insurance for employees and their dependents. The focus-groups provided an opportunity to explore and probe deeper into the attitudes of employers concerning their decision making about offering health insurance to their workers, the constraints that they experience in doing so, and the kinds of initiatives that they believe could be effective in enabling more employers to offer health coverage.

1. Survey of Employers

The survey of employers in Iowa was designed using, as a starting point, other surveys with questions about employment-based insurance such as the Robert Wood Johnson Survey of Employers. The advantage of this approach was that many questions had been pre-tested by other researchers and their validity has been established. These questions also tended to be recognized by policy experts as those that best capture the marketplace dynamics that influence the availability of employment-based coverage. As the survey questionnaire design process continued, the survey developed into a tool uniquely suited for the purposes of the Iowa SPG.

The questionnaire was designed by Lewin, in consultation with Baselice and Associates (who conducted the telephone surveys), and IDPH-SPG staff. IDPH-SPG staff provided valuable design input and approved the questionnaire prior to its use. Baselice & Associates pre-tested the survey instrument and conducted telephone interviews of employers in early 2001.

The sample frame was intended to be broadly representative of all private businesses in Iowa. All private businesses (non-government) in Iowa with at least one employee was included in the universe from which to draw the sample potential survey participants. The sample of employers recruited for up to 20-minute telephone interviews was derived from the American Business Directory and other database sources. (This Directory is the same source of information that the Iowa Department of Economic Development uses for its administrative purposes and it contains approximately 135,000 businesses.) Employers in Iowa were grouped into four geographic regions and from each region part of the sample was recruited. As an estimated 48.6 percent of private establishments offered health insurance in Iowa in 1996 (MEPS), it was important to assure through sampling a similar proportionality of firms that offer and don't offer health insurance was achieved.

2. Focus-Groups of Employers.

Focus-groups were designed to identify the factors that influence employers' decisions to offer or not to offer health insurance to employees and to understand, from the perspective of employers, what options may be most appealing for increasing affordable coverage in the State. By comparing different points of view that participants exchange during the focus-group sessions, one can examine the complex motivations and behavior that drive employers' valuation of health insurance and the decisions they make in the health-care marketplace

Twelve focus-groups of employers held during February, 2001 in Davenport, Cedar Rapids, Des Moines, and Northwest Iowa. This distribution assured that researchers obtained a geographically representative of employer views. Focus-groups were organized around specific employer groups (e.g., mid-size employers that offer insurance, small employers not offering insurance, and self-employed workers).

Two subcontractors, Personal Marketing Research, Inc. and American Public Opinion Survey & Market Research Corporation arranged recruitment of participants, obtained a site for focus-groups and took care of other logistical tasks. To assure high participation in the focus-groups, we conducted focus-groups primarily in the late afternoon (after work) or evening. We offered each respondent a meal and snacks and $90 (or more). In addition, all confirmed invitees

were called a few days before the focus-groups to remind them of the session's time and place. For nearly all focus-groups, a show rate of 8-10 persons was achieved.

A Moderator's Guide was developed in conjunction with IDPH-SPG staff in preparation for the focus-groups. This Moderator's Guide outlined the issues to be explored and the interactive techniques to be used. The focus-groups themselves were video and audio taped and summarized subsequent to their completion.

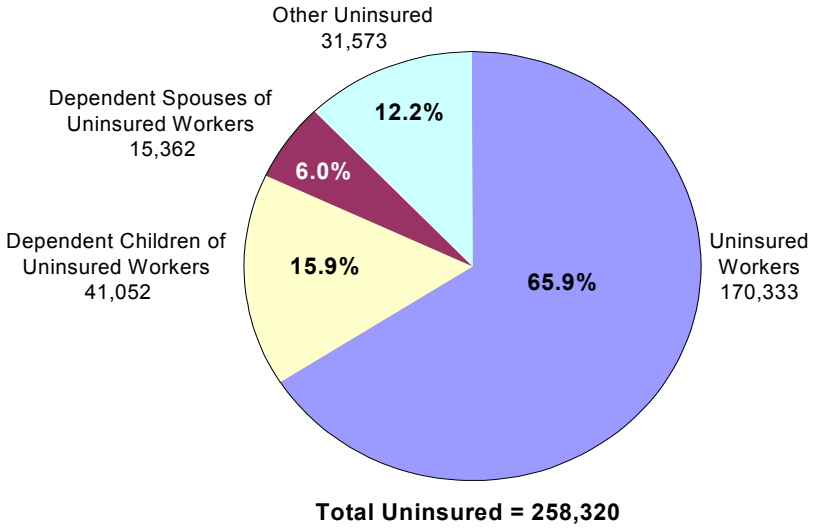
G. CPS Analysis

The March Current Population Survey (CPS) is an annual survey of households conducted by the Bureau of the Census. The CPS provides information about demographic characteristics, health insurance coverage, employment and sources of income for the prior year. Due to concern about the small sample size in less populated states such as Iowa, four years of data were pooled for purposes of the analysis. Data from CPS 1997-2000 (covering years 1996-1999), were merged to provide a sufficient sample size for detailed analysis of coverage by socio-demographic group.

The analysis reveals that most of the uninsured in Iowa (87.8%) are connected to the work force either as workers or dependents of workers. Of 258,320 surveyed uninsured individuals in Iowa, 65.9 percent (170,333 individuals) are employed and another 21.9 percent (56,414) are dependent children or spouses of uninsured workers (***Figure 22***).

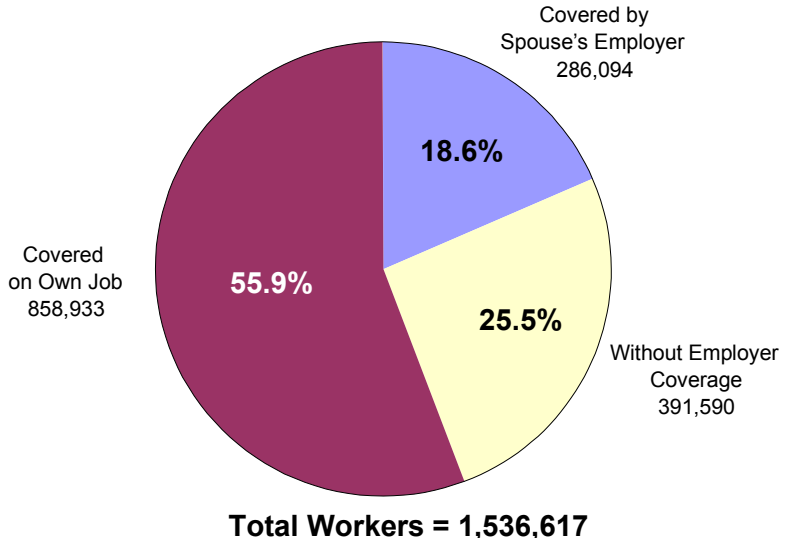
Of the approximately 1.5 million workers in Iowa, 55.9 percent (859,000) are offered and accept employer-sponsored health insurance (***Figure 23***). Another 18.6 percent (286,000) of workers are insured through their spouses' health plan. The remaining 25.5 percent of the working population in Iowa (392,000) have no access to employer-sponsored coverage either through their own job or another's. The following pages identify what the CPS reveals about the quarter of the working population in Iowa without health insurance.

Figure 22
Distribution of Uninsured by Connection to Workforce



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Figure 23
Distribution of Workers by Employer Coverage Status



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Several employment factors (such as employment sector, industry, and firm size) affect the likelihood that an employer in the U.S. will offer health insurance. In Iowa, 75 percent of

workers in government and 60 percent of workers in the private sector receive health insurance coverage through their employers whereas only 17.1 percent of self-employed workers are covered through their work places (***Table 2***).

Table 2
Employment Characteristics of Workers With Employer Coverage [a/]

	Total Number of Workers	Covered on Own Job	Percentage Covered on Own Job
All Workers			
Total Number of Workers	**1,536,617**	**858,933**	**55.9%**
Industry of Worker			
Agriculture/ Forestry/ Fishing	76,973	16,745	21.8%
Construction	84,244	39,826	47.3%
Durable Goods Manufacturing	159,906	128,174	80.2%
Non-durable Goods Manufacturing	113,314	77,886	68.7%
Transportation/ Communications	94,107	60,674	64.5%
Wholesale Trade	66,256	42,488	64.1%
Retail Trade	233,465	84,423	36.2%
Finance/ Insurance/ Real Estate	101,521	73,648	72.5%
Business and Repair Services	80,157	38,285	47.8%
Personal Services	40,414	15,893	39.3%
Entertainment/ Recreation	15,674	6,421	41.0%
Professional Services	375,842	213,779	56.9%
Public Administration	59,464	51,398	86.4%
Mining or Not Identified	35,280	9,293	26.3%
Employment Sector of Worker			
Private	1,092,598	655,381	60.0%
Government	**220,795**	**165,667**	**75.0%**
Federal	26,875	22,027	82.0%
State	86,444	65,235	75.5%
Local	107,476	78,405	73.0%
Self-employed	**190,511**	**32,493**	**17.1%**
Incorporated	49,636	15,639	31.5%
Unincorporated	140,875	16,854	12.0%
Not Specified	32,713	5,392	16.5%

[a/] Includes workers that are not covered on own job and are not covered by spouse's employer coverage.

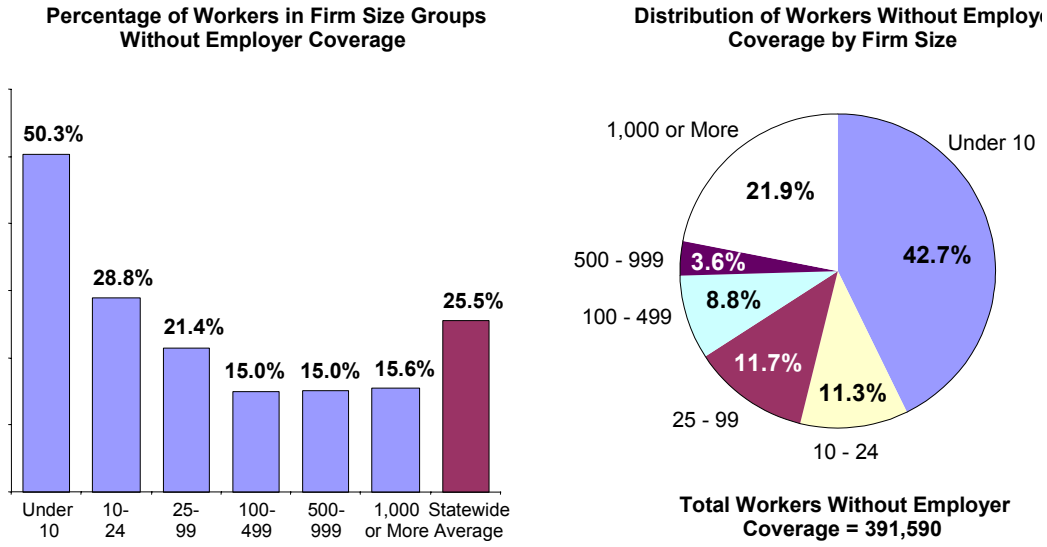
Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Table 2 also shows the percentage of workers insured by their employers by industry. Public administration, durable goods manufacturing and finance/insurance/real estate are the industries most likely to offer health insurance to employees. Comparatively, industries in which

employees are least likely to be offered health insurance through their jobs are agriculture/forestry/fishing, mining and entertainment/recreation. Among industry groups, health coverage ranges from a high of 80.2 percent in manufacturing to a low of 21.8 percent in agriculture/forestry/fishing in Iowa.

Firm size is also correlated to the likelihood that an employer will offer health insurance; the percentage of workers covered increases as firm size increases. Overall, 65.7 percent of workers without employer coverage work in firms with less than 100 employees. (As mentioned above, the statewide average percentage of workers without insurance is 25.5%) ***Figure* 24** shows that in Iowa 50.3 percent of people in firms with ten or less employees do not have employer-sponsored health insurance. This is an important finding because 42.7 percent of Iowa residents without employer coverage work in firms of under ten employees. Comparatively, about a third (34.3%) of Iowa residents without employer coverage work in firms of 100 or more workers; about 15 percent do not have access to health insurance coverage through their jobs.

Figure 24
Workers Without Employer Coverage by Firm Size [a/]

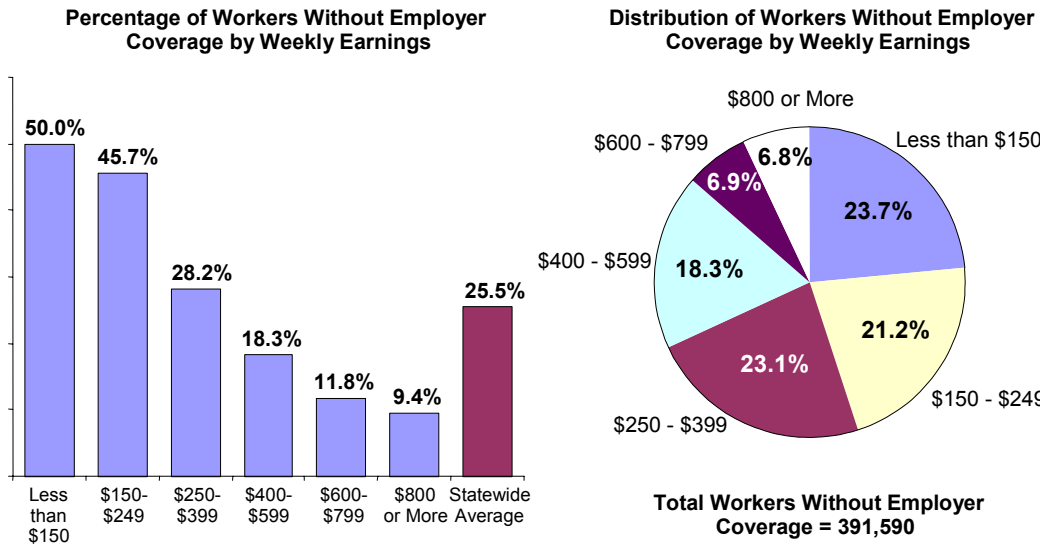


[a/] Includes workers that are not covered on own job and are not covered by spouse's employer coverage.
Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Additionally, individual characteristics of workers (such as earnings level, age, gender, and ethnicity) affect the likelihood that an employee will have access to employer-sponsored health insurance. There is a direct correlation between the weekly earnings of residents of Iowa

and the percentage of individuals without employer coverage as low-wage workers are least likely to receive employer coverage. ***Figure 25*** shows that 50.0 percent of workers earning less than $150 per week do not have employer coverage while only 9.4 percent of workers earning $800 or more per week do not have employer coverage. The percent of workers without health insurance drops significantly for those workers earning less than $400 per week. More than two-thirds of workers without insurance in Iowa earn less than $400 per week. Yet only 6.8 percent of workers without employer coverage earn, on average, $800 or more per week. Of the 391,590 total workers without employer coverage, 23.7 percent earn less than $150 weekly, 21.2 percent earn between $150 and $249, and 23.1 percent earn between $250 and $399 per week.

Figure 25
Earnings Characteristics of Workers Without Employer Coverage [a/]

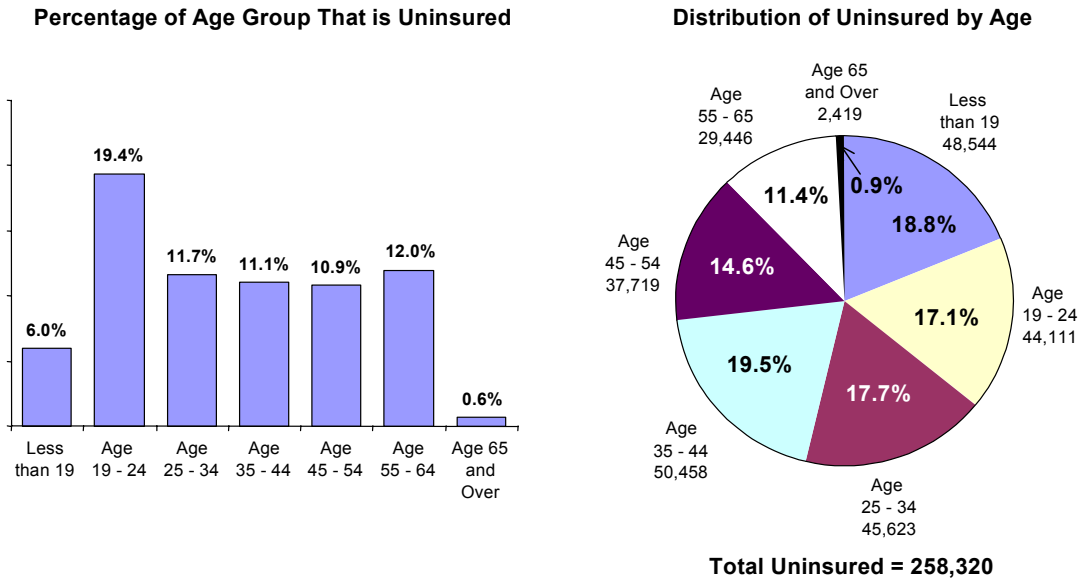


[a/] Includes workers that are not covered on own job and are not covered by spouse's employer coverage.

Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

Generally, the percentage of workers with employer coverage increases with age. Over 40 percent of workers between 19 and 24 do not have employer coverage compared to 18.2 percent of workers ages 35 to 44 (***Figure 26***). Slightly more men (52.4%) than women (47.6%) are offered health insurance through their employers. Finally, in terms of ethnic disparities in employer coverage, a disproportionate percentage of black (42.0%) and Hispanic (33.0%) workers are likely to be uninsured, compared to the statewide average 25.5 percent.

Figure 26
Age Characteristics of Uninsured in Iowa



Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

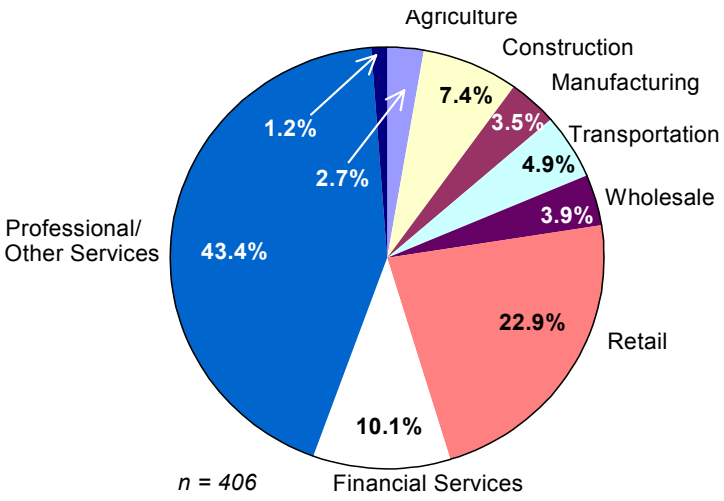
H. Survey of Employers: Results

A telephone survey of private employers in Iowa was undertaken to yield a more comprehensive understanding of employers' propensity to offer health insurance to employees and the kinds of coverage offered. Characteristics of the employers surveyed are summarized below. Due to the sample design[18] we are able to provide information on characteristics among firms offering and not offering health insurance to their employees as well as, for example, costs associated with offering the benefit, consequences to employees who do not receive the benefit, employers' views on who is responsible for offering health insurance and ways of expanding coverage.

1. Surveyed Employer Characteristics

Of all the firms surveyed in Iowa, 43.4 percent are in the professional and service industries (***Figure 27***). Retail employers comprise the second largest percentage of firms, 22.9 percent. Firms providing financial services comprise 10.1 percent of surveyed employers. The remaining 23.6 percent of employers surveyed includes those in the agriculture, construction, manufacturing, transportation, and wholesale industries.

Figure 27
Industry by Firms Included in the Survey



Source: Lewin Group estimates of employers in Iowa

Nearly one-third (31.5%) of the companies surveyed employ four to ten people. Another 24.4 percent of firms have two or three employees. Firms with 11 to 50 employees comprised 18.2 percent of the firms and self-employed firms or those with only one employee comprised 17.5 percent of the employers surveyed. Finally, large size firms with 51 or more employees comprised 7.4 percent of the firms surveyed.

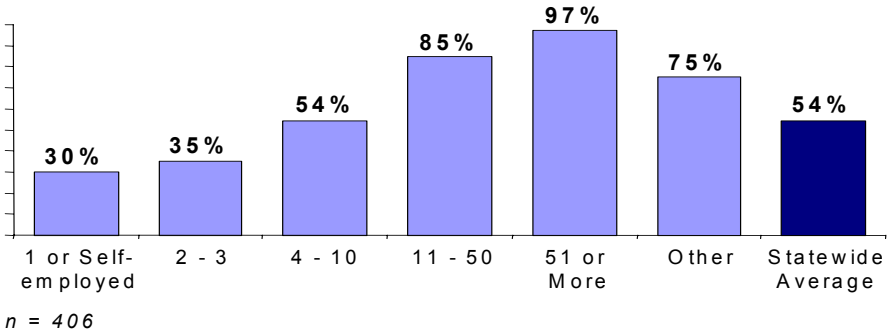
Firms with employees at different wage levels participated in the survey. One third of firms reported that the majority of their employees earned between $40,000 and $100,000 annually. Another 29.3 percent reported their employees earn between $20,000 and $40,000 per year. In 9.5 percent of firms, employees earned at a wage level of less than $10,000 and another 15.3 percent of the firms reported a wage level of $10,000 to $20,000.

2. Characteristics of Insuring and Non-Insuring Firms

The survey of employers revealed that 54 percent of employers in Iowa offer health insurance to their employees. The likelihood of firms offering health insurance did not vary significantly among different geographic regions of the State. In the East Central and West regions, 58 percent of employers offered health insurance compared to 49 percent in Des Moines area and 51 percent along the Mississippi river.

The likelihood of offering health insurance to workers varies by firm size. Only 30 percent of self-employed/one employee firms offer insurance. The number of firms offering health insurance increases to 54 percent for firms with four to 10 employees, 85 percent for firms with 11 to 50 employees, and 97 percent for firms with 51 or more employees (***Figure 28***). The statewide average of firms offering health insurance is 54 percent.

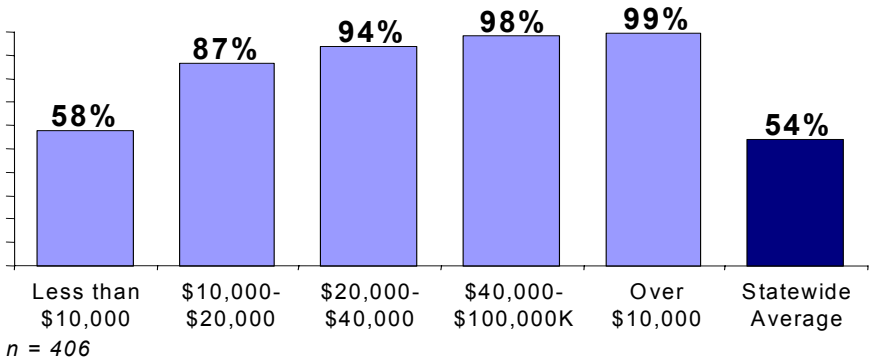
Figure 28
Coverage Level by Firm Size



Source: Lewin Group survey of employers in Iowa

As shown in ***Figure 29***, the percentage of employers offering health insurance also increases as wage levels increase. Of firms with a wage level less than $10,000, 58 percent offer health insurance. The percentage of firms that offer health insurance increases to 87 percent for the wage level category $10,000 to $20,000 and 99 percent for those with a wage level over $100,000.

Figure 29
Percent of Employers Offering Coverage by Average Wage Level

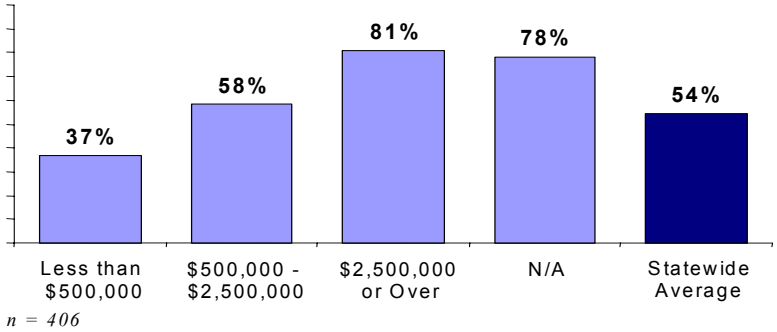


Source: Lewin Group survey of employers in Iowa

Firms with higher sales volumes are more likely to offer coverage (***Figure 30***). While 37 percent of firms with a sales volume of less than $500,000 offer health insurance, 81 percent of firms with a sales volume of $2,500,000 and over offer health insurance.

The percentage of firms offering health insurance varies by industry. It ranges from a low of 40 percent in the retail sector and 45 percent in agriculture to a high of 85 percent in the transportation sector. Slightly more than half of surveyed firms in the construction, wholesale and financial sectors reported offering health insurance and 71 percent of those in manufacturing offer coverage.

Figure 30
Percent of Employers Offering Coverage By Sales Volume

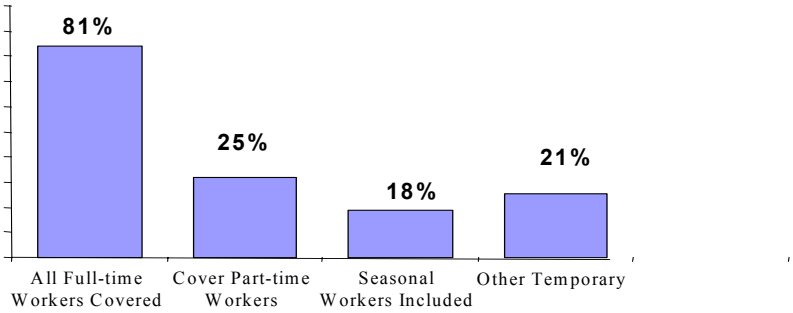


Source: Lewin Group survey of employers in Iowa

3. Employee Eligibility Requirements Among Insuring Firms

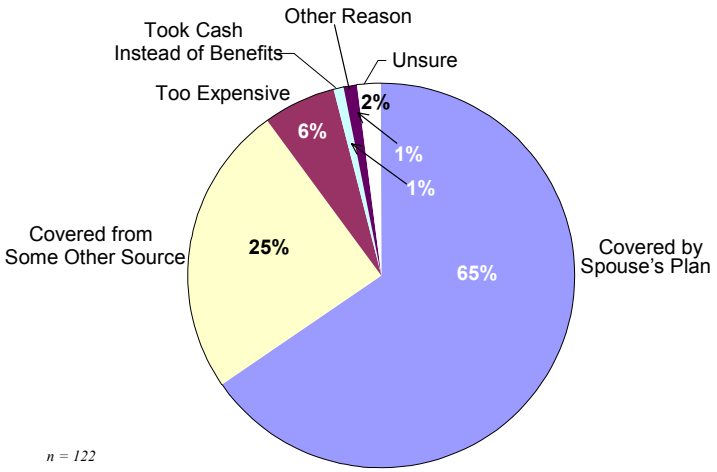
Employers who offer insurance were asked whether certain classes of workers are eligible under the plan. Eighty-one percent of employers that offer health insurance reported that all of their full-time employees are eligible for coverage (***Figure 31***).

Figure 31
Percent of Firms Offering Coverage That Also Cover Other Selected Groups



Source: Lewin Group Survey of Employers in Iowa

Figure 32
Reasons Employees Decline Coverage



Source: Lewin Group Survey of Employers in Iowa

Twenty-five percent of employers that offer health insurance also cover their part-time workers (***Figure 31***). About 18 percent of employers offering coverage include seasonal workers and 21 percent extend coverage to other types of temporary workers. There was little variation according to firm location in terms of coverage of part-time workers. In terms of industry, the agriculture sector was most likely to exclude part-time workers from benefits coverage (80%) and retail firms were least likely to exclude part-time workers from coverage (43%).

About 58 percent of surveyed employers reported that one or more of their eligible employees had declined coverage. These employers were then asked the main reason why some of their employees declined coverage ***(Figure 32***). Sixty-six percent reported that employees declined coverage because they are covered by their spouse's plan. Another 25 percent of employers reported that the employees who declined insurance were covered from some other source (not specified). An additional 6 percent said employees declined because coverage is too expensive. Taking cash instead of benefits was reported by only 1 percent of employers. Of the firms surveyed, only 12 percent offer cash as an alternative to health benefits.

Approximately 14 percent of insuring firms surveyed have health plans with pre-existing health condition limitations. Of these, approximately 16 percent have one or more employee excluded from coverage due to a health condition.

In total, 42 percent of firms have no employees who decline health insurance coverage, if they are eligible. Twenty-eight percent of firms have only one to three eligible employees who decline coverage. Only 15 percent of employers have four to ten employees who decline coverage and only 12 percent have 11 or more eligible employees declining coverage.

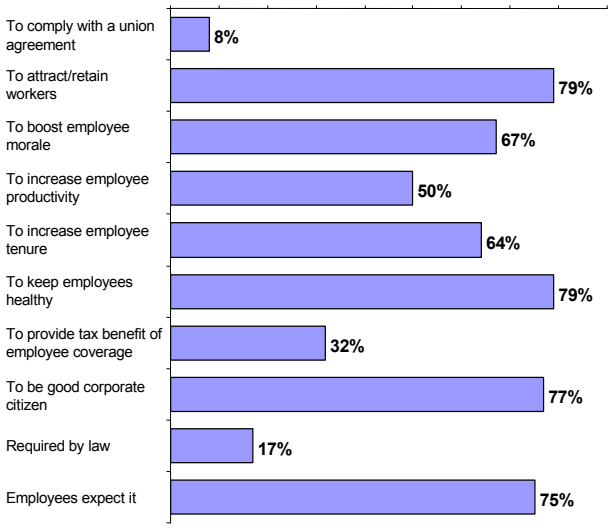
4. Cost of Health Insurance

Insuring firms in Iowa on average pay about 81 percent of the premium, with the employee paying the remainder. About 43 percent of employers pay 50 percent or less of the employees' premium, 31.9 percent pay between 51 and 80 percent, and about 25.1 percent pay the full premium for workers. Employer contributions comprise a smaller share of the family premium, on average, less than half of the family premium is paid by employers.

Although cost can be a serious deterrent to companies, many companies that provide health insurance to their workers continue to do so. Surveyed firms that offer some level of health insurance coverage to their employees (220), were asked to offer reasons about why they offer coverage. Seventy-nine percent reported they provide health insurance coverage to keep employees healthy (***Figure 33***). Seventy-nine percent also stated they offer insurance to attract or retain workers. Companies offer health insurance to be good corporate citizens (77%) and because their employees expect health insurance as a benefit (75%) as well.

The cost of offering health insurance is a major deterrent for companies in Iowa considering worker benefits. Employers were asked which of twelve reasons for not offering insurance coverage applied to their firms. The primary reasons that companies don't offer health insurance to their workers is that offering coverage was too expensive (74%), companies also reported their employees are covered elsewhere (70%) and 42 percent are concerned about future rate increases. Thirty-four percent stated that offering health insurance is not necessary to attract workers, some employers claims their employees would not want to contribute to a health plan (29%) or that employees do not want a health benefit (27%).

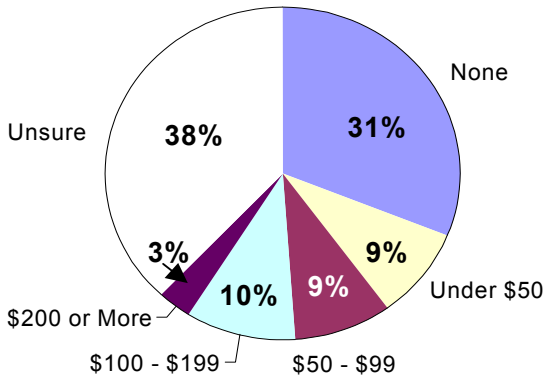
Figure 33
Reasons Employers Offer Health Insurance



Source: Lewin Group survey of employers in Iowa

Employers who do not offer insurance were asked to indicate how much they would be willing to contribute for employee health insurance. About 9 percent would be willing to spend under $50 per month for coverage (***Figure 34***) Another 9 percent would be willing to pay $50 and $99 per employee. A total of 10 percent said they would be willing to spend between $100 and $199, 3 percent would spend over $200 and the greatest percentage, 31 percent, would not be willing to contribute towards employee health insurance costs. Thirty-nine percent of respondents were unsure about the amount they would be willing to spend.

Figure 34
Distribution of Employers Not Offering Coverage by Amount They Would Be Willing to Contribute Per Month for Employee Benefits



Source: Lewin Group survey of employers in Iowa

5. Consequences of Not Providing Health Insurance

About 67 percent of Iowa non-insuring firms reported that they have no uninsured workers. These firms were asked where their employees obtain coverage. Of the employers surveyed, 71 percent said that at least one of their employees was insured through their spouses' employer plan. Employers also reported that employees purchased their own private coverage, received coverage from Medicare or received coverage from Medicaid.

The survey indicates that employers recognized the adverse effects of not providing health insurance to their employees. As ***Table 3*** shows below, 10 percent of firms report that some employees are unable to obtain needed care when firms do not offer health insurance. The consequences varied by geographic area. Near the Mississippi River, 16 percent of employers said their employees would be unable to obtain needed care; 15 percent in West Iowa reported this as well. However, only 5 percent of employers in Des Moines claimed that their employees would be unable to obtain needed care.

Twenty-three percent of employers who do not offer coverage indicate that their employees have faced large out-of-pocket medical bills. Of the four geographic areas, West Iowa had the largest percentage of employers who replied that this was the case (37%) while only 14 percent of employers surveyed from East Central Iowa had this concern.

Table 3
Consequences for Employees When Employer Does Not Offer Health Insurance

	Employee(s) Unable to Obtain Needed Care	Employee(s) Face Large Out-of-Pocket Medical Bills	Employee(s) Took New Job With Health Benefits
Overall	10%	23%	22%
Geographic Area			
West Iowa	15%	37%	24%
Des Moines	5%	19%	21%
East Central Iowa	8%	14%	14%
Mississippi River	16%	24%	29%
Industry Type			
Agriculture/Construction/ Manufacturing	17%	29%	38%
Transportation/Wholesale/ Retail/Finance	10%	24%	16%
Other	8%	19%	23%
Sales Volume			
Less than $500,000	10%	24%	18%
$500,000 - $2,500,000	10%	20%	27%
Over $2,500,000	18%	27%	36%
Wage Level of Employees [a/, b/]			
Less than $10,000	3% - 5%	6% - 23%	5% - 30%
$10,000 - $20,000	7% - 19%	13% - 38%	14% - 33%
$20,000 - $40,000	6% - 17%	13% - 30%	15% - 46%
$40,000 - $100,000	6% - 8%	19% - 23%	19% - 23%
Over $100,000	0%	50% - 63%	63% - 75%

[a/] The question asked if the particular consequence happened to "one or more employees." Thus, we give a range of estimates. The low number assumes that the particular consequence happened to only one employee at the given wage level. The higher number assumes that the particular consequence happened to all employees at the given wage level

[b/] For employees that took a new job with health insurance, assumes that the employee that left was replaced by another employee at the same wage level.

Source Lewin Group survey of employers in Iowa

Employers also recognized that failure to offer coverage has been associated with the loss of workers. For example, firms not offering insurance were asked what proportion of their employees leave their firm for jobs with health insurance benefits. Twenty-two percent of employers report their employees took a new job with health benefits. This statistic varied by industry; only 5 percent of employers in the financial services industry reported employees leave for jobs with benefits compared with 43 percent in the construction industry.

6. What is Needed to Help Firms Increase Insurance Coverage

The survey requested employers to provide information about what would be required for their firms to offer insurance coverage. The reasons given were not mutually exclusive. A lower monthly premium was the most popular answer, reported by 73 percent of employers. Another 72 percent of firms reported that stabilizing premiums was necessary. In order to cover their employees, 66 percent of employers thought a reduction in paperwork was necessary and 61 percent thought government-subsidized coverage could help, as well.

Of the 186 non-insuring firms surveyed, 49 percent reported they would participate in a subsidized insurance program for employees if offered. Another 31 percent said they would not participate, 15 percent said it depended on the subsidy and 5 percent were unsure. The reasons employers reported they might be hesitant to participate in a subsidized program were varied. Twenty-six percent of those hesitant to participate said they do not want to get involved with the government. Another 17 percent do not want to get involved with health-care.

Of the 186 non-insuring employers interviewed, 62 percent asserted state funds should be used to help lower-wage workers afford coverage. Another 52 percent thought individuals should be required to provide coverage for themselves and their families. Only 28 percent believed employers should be responsible for providing coverage for their employees. Ironically, 27 percent reported health insurance costs are high because some employers do not offer health coverage.

When asked if their employees would be willing to accept reduced pay raises to obtain health coverage, 12 percent of non-insuring employers thought they would and 68 percent of employers responded with a definite no. About 16 percent of non-insuring firms plan to change the employee benefits package to include health benefits in the next five years. The main reason some firms may start providing health coverage was that the firm is doing well (30%). Another 23 percent said their main reason for adding coverage is the increased competition for labor. About 20 percent also plan to add staff to assist in administering the plan.

7. Expected Change in Health Insurance Premiums

Insuring firms' expectations as to whether health insurance premiums will increase over the next year were fairly uniform. Over 65 percent expect either a moderate or large increase in health insurance premiums over the next year. Only 10 percent expect no change in premiums. If premiums increase, 43 percent of employers expect, to increase the employee share of premiums, another 43 percent expect a reduction in their profit. In addition, 34 percent anticipate increasing employee copayments and 33 percent expect to raise prices of their products.

8. Who is Responsible?

Of the 220 insuring employers interviewed, 86 percent of employers asserted that employers should be responsible for providing coverage for workers even if the employer contributes little or nothing toward the premium. Additionally, 70 percent of insuring firms stated that employers should be responsible for providing coverage to workers. Fifty-six percent thought that state funds should be used to help employers of lower-wage workers afford coverage while 43 percent indicated that they feel individuals should be required to provide coverage for themselves and their families. Finally, 38 percent of firms thought employers should be required by law to provide coverage for their workers.

I. Focus-groups of Employers

Focus-groups of small, medium, and large employers were held in four geographic areas of Iowa during Winter 2001. These areas included northwest Iowa, Des Moines, Cedar Rapids, and Davenport. Some focus-groups included only companies that offer health insurance, while most targeted companies that did not offer coverage to employees.

Employers uniformly agreed that the cost of health insurance was a serious impediment to providing this benefit. In addition, they agreed that there is not one single step that could be taken to solve the problem of the uninsured in Iowa. Many different steps need to be taken simultaneously to address the issue. Some employers stated they weren't sure that insurance should always be tied to employment as many individuals are left out of opportunity.

1. Reasons to Not Offer Coverage

The over-riding and primary reason employers give for not providing coverage is cost. Many employers that do not provide coverage have at some point in the past inquired about prices for policies, but were not able to buy in due to high costs. There is a belief among small business owners that insurance companies are not interested in insuring small businesses. Many of the small employers report that they would be unable to get group plans for their employees and single policy plans were very expensive.

Other factors are that employees do not need the insurance (either they are covered through some other means, or they do not want it) and that insurance is ***not necessary*** to retain and / or attract employees. This last point, however, seems to differ across size of employer. Mid sized and large companies report that a quality benefits package is needed to recruit and retain workers.

Another reason that employers choose not to provide health coverage is that they are already *required* to purchase other types of insurance (worker's compensation, liability insurance for construction companies, etc.) and this consumes any available revenue that could have been used to provide this sort of optional benefit.

A third reason that many employers, particularly small employers, say they choose not to offer insurance is that they feel it is not necessary to attract or retain employees. Some maintain that if it became harder to attract and retain employees then they would possibly reconsider their decision. Following up on this reason, some employers experience so much turnover with their work force, that it is not worth it for them to offer coverage. Many others rely on part time employees. Some also assert that most of their employees do not even ask for health coverage.

A fourth reason that employers choose not to provide insurance is that they believe that their employees do not need it. This view was expressed by a number of small businesses who have only a few employees. Often these employees have health coverage through their spouses or parents. Also many employees in small businesses work part time.

"Health insurance sucks the profit out of companies."

2. Scope of Participation

The majority of employers in focus-groups who provide insurance provide it for full time salaried and full time hourly employees. The majority of employers who offer health coverage offer it for all of their employees. Ranges for employee contribution for the premium are reported to be between 0 percent and 50 percent. A few employers also reported that they would sometimes share the cost of the deductible with the employee, as this would cause the cost of the premium to decrease. Employee contribution sometimes increases if the plan is for the whole family, as opposed to just the employee. Many employers state that they used to cover the entire cost of the premium for all employees, but cannot afford to do so currently.

These perceptions are inconsistent with those of the uninsured themselves. In the focus-groups with uninsured individuals, we found that some employees who are classified as "part-time" actually may in reality, work close to 40 hours per week; because of this classification distinction, they are not offered health insurance.

3. Effect of Economic Difficulties

In the event of an economic downturn or rapidly rising health-care costs, likely responses would include: employees sharing a greater portion of the premium, higher deductibles or co-pays, and less coverage for employees. It is unlikely that employers who once offered coverage would ever choose not to offer health insurance period—rather it seems more likely that the quality of the plan they offer would decrease.

An economic downturn may influence the decision of a company who was considering offering coverage. If profits were decreasing or became losses it is not probable that employers would make such a move. Continued increase in costs, which employers who are considering offering are probably monitoring, would also discourage them from offering.

4. Encouraging Employers to Offer Health Insurance

Employers report they would likely be influenced to offer health insurance by certain incentives, including:

- Expansion / development of purchasing alliances,
- Individual or employer subsidies, and
- Additional tax incentives.

Small business employers say that there is a big need for a small group market for insurance and that they need help getting into an insurance pool. Many of the small businesses report that when they have inquired about health insurance, the number of people they are interested in insuring is too low to qualify for a group plan. This results in higher premium prices than if they wanted to employ a larger group of employees.

Individual or employer subsidies and additional tax incentives would also likely influence employers. Many employers state that they would like to offer insurance, but simply cannot due to high costs. If the government assisted with the cost of premium or with a tax break, then this could motivate some employers to offer the insurance. Employees of small businesses, however, are skeptical that tax breaks would encourage their employers to offer coverage.

"The government doesn't care about us (employers) except to tax us."

5. Additional Alternatives.

According to some focus-group participants, the biggest step that the government could take to motivate employers to provide or contribute to coverage would be to "free up" some funds to use towards that end. This could be accomplished either through tax cuts or government subsidies. Further, the cost of the premium is the single most deciding factor in employer's decisions and if its cost could somehow decrease, then employers may have the means to contribute some to coverage. One step that the government could take in that regard would be to help control costs of insurance premiums and the rate of premium increases.

Another step that employers seemed receptive to was if the government would allow and/or assist small businesses to get together into a pool and purchase insurance as a group—which they think would lower premium costs to a more acceptable level.

There was also a belief across many of the focus-groups that tort reform is absolutely necessary to help lower the cost of health insurance and health-care in general. The belief is that when insurance companies pay for lawsuits then policy costs increase as well.

Some of the employers also said they would like a "barebones" subsidized policy from the government if there were not many "strings attached" but they did not see this as a likely occurrence.

The employers were also very vocal that one thing that the government should not do is to require employers to provide health insurance for their employees. They say such a move would cause many companies to go bankrupt. They prefer a voluntary system and are not concerned with "crowd out" (i.e., discontinuing private coverage to take public coverage). The working uninsured and their children may be the group that is most susceptible to crowd-out. However, many of the working uninsured are currently employed in businesses that do not offer employment.

Employers of all sizes express skepticism that that a new government program would solve the problem of uninsurance in the state. They all are, however, interested in other reforms, such as community rating and purchasing alliances. Further, employers say that they might be able to offer coverage if they became more profitable or if they could receive a large tax deduction or credit for providing coverage.

J. Employers in Iowa: Lessons Learned

The high cost of health insurance is a major factor influencing employers' decisions not to offer coverage to workers and is a serious concern among focus-group participants. Results of the employer study varied by size of employer. Mid-size and large companies report that a quality benefits package that includes health insurance is essential to recruiting and retaining workers. Small businesses, however, express widespread frustration because they believe that their small firm size increases plan prices since they can not pool risk. Furthermore, they must

comply with mandated insurance requirements first and they perceive that insurance companies are not interested in them.

Nevertheless, small employers reported they might offer coverage under some conditions. Namely, they would consider offering coverage if their "bottom line" improved, if employees demanded coverage or if there was less turnover. Lastly, if companies received help from the state, in the form of tax deductions or credits or premium supports, they might offer coverage. Small employers conveyed resistance to new government programs (perceived as inefficient), but are interested in other reforms such as purchasing alliances and community rating. Additionally, small employers expressed concern about the well-being of rural hospitals and clinics.

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[18] 200 firms sampled that offer health insurance and 200 firms that do not.

SECTION 2-A: IOWANS BELIEFS ON EXPANDING ACCESS TO HEALTH INSURANCE

One of the purposes of the Iowa State Planning Grant is to understand and respect the limits of the public's tolerance for policy changes needed to expand access to health insurance. The approximately 258,320 uninsured Iowans are unlikely to exert much direct influence on the political and policy agenda to expand access to health insurance. Therefore we have directed a large part of our data-gathering efforts to develop a thorough understanding of the beliefs of two groups of Iowans who are quite likely to be influential, the "active public" and the businesses, regarding expanding access to health insurance.

In previous sections, we presented research-based explanations of why certain individuals and families are without health insurance, and why some businesses and not others, choose to provide health insurance to their employees. In this section, we present findings from two separate surveys. The first is a survey of the "active public", which we define as Iowa residents who are currently listed on the secretary of state's active voter registration list. They have health insurance, and have voted in the last two Iowa general elections (1996 and 2000). The second survey is of Iowa businesses.

The surveys are complemented by observations from two rounds of focus-groups, which included sessions with members of the "active public," as well as with targeted groups, including small business owners, elected officials and health-care providers.

A. Methods and Approach

To help achieve our goal of a "**data-driven picture" of Iowans' beliefs** about expanding access to health insurance, the State Public Policy Group (SPPG), assisted by Selzer and Company (Selzer), reviewed the materials on uninsured individuals and families (Section 1), employer based coverage (Section 2) and policy options (Section 4) to increase health insurance coverage developed by Lewin and IDPH's SPG staff. The information was then used to develop two telephone-survey instruments and several focus-group scripts. The surveys and focus-group sessions were conducted in two "waves." The first wave was in Spring 2001 and the second in June and July, 2001.

As with the focus-groups and telephone survey of the uninsured, the active public and business surveys and focus-group sessions were used to complement each other's strengths in identifying Iowans attitudes towards health insurance expansion. The surveys provided quantitative information regarding Iowans' beliefs. The focus-groups provided multiple opportunities to understand and probe more deeply into beliefs about the uninsured and the potential options available to the state to increase coverage.

The information from the first wave of surveys and focus-groups was used to assist Lewin and the IDPH-SPG staff in designing policy options to fit Iowa's particular social and demographic climate. The second wave provided feedback on the public's and businesses' perceptions of proposed options.

The results of this work have been given to our Citizens' Alliance for Health Insurance (Citizens' Alliance) (See Section 5 for a full description of the Citizens' Alliance and its activities) and have been shared with the public and Iowa policy makers. We believe the findings have led to a greater understanding of the public's and the business community's support for policy changes leading to greater access to health insurance in Iowa.

B. Survey of Iowa Businesses

As part of our exploration of Iowans' attitudes, we wanted to understand businesses' beliefs on potential policies favoring expansion. We chose to survey Iowa businesses for two reasons: first, because employment is the primary conduit through which Iowans receive health insurance, (***Figures 2, 7, 8***), and secondly, because we believe that a significant reduction in the number of uninsured Iowans will come about only with business support.[19]

SPPG designed both questionnaires with support from J. Ann Selzer. IDPH-SPG staff, and Lewin representatives also assisted in the survey design. IDPH-SPG staff approved the questionnaires prior to their use. SPPG tested the survey instruments and Central Surveys, Inc. conducted both sets of telephone interviews. The telephone-interview method was selected as the best approach to capture pertinent information from the businesses. It provided a sufficient sample size to allow comparisons of interest within the State Planning Grant time frame.

Five hundred and fifty people who make the health-care purchasing decisions for their businesses were interviewed. Each sample included 450 businesses that provide insurance to their employees and 100 businesses that do not. The first wave was conducted March 7 through March 16, 2001, and a second wave was conducted July 17 through August 1. The businesses were randomly selected from the Iowa secretary of states' corporation database. As with all the research conducted as part of the Iowa SPG, we focused on achieving a broad geographic representation in the sample. (See Appendix 2 for a geographic distribution of respondents). For questions that were asked of all 550 respondents, the margin of error is roughly ± 4.2 percent.

C. Survey of Iowa Businesses: Results

The survey results offer significant encouragement from the business community, at the conceptual level, for taking action to increase access. In the most general terms, Iowa business supports expansion. In every test of the idea in wave 1, a majority endorse the concept of finding a way of covering the uninsured. An large majority, (82.5%) of all businesses think it is *very important* that every Iowan have health insurance. surveyed The support cuts across partisan lines: 77.5 percent of those who identify themselves as "Republican", 96.7 percent who identify themselves as "Democrats," and 84.6 percent of those who identify as "independents," say that every Iowan having health insurance is an important issue. A clear majority, 78.4 percent, believe providing health insurance to all Iowans will have a positive effect on Iowa's business climate. In addition, respondents agree it is a *good* idea for the state to have a strategy for extending health insurance coverage to all residents (75%).

1. First Wave

Businesses see a benefit to providing health insurance to their employees. Seventy-eight percent of businesses have either benefited *a lot* or *some* from providing insurance. About eighty-four percent of businesses believe that providing health insurance has been *very* (63%), or fairly (21.2%) important in recruiting and retaining employees. A majority of 53 percent of businesses that provide health insurance *strongly* agree that in their line of business, "health insurance is a benefit you *have* to provide employees to be competitive." Another 33 percent agree somewhat, with 12 percent disagreeing, and the rest saying they're unsure. (***Table 4***)

Table 4
Ways Iowa Business Report they Have Benefited From Providing Health insurance to Employees.

	Benefits A lot	Benefits Some
Peace of mind, it is the right thing to do.	50.5%	29.1%
Ability to hire qualified employees.	47.2	31.2
Overall reduction in absences.	16.1	29.0
Higher productivity due to fewer people coming in sick.	14.8	31.8
Fewer employees absent to take care of sick kids.	10.6	22.6

*The categories "*a little*" and "*not at all*" have been omitted.

Source: SPG Survey of Iowa Business

Support for Change: Iowa vs. the Nation. To compare the beliefs of Iowa's businesses with national businesses we modified a question that had been used in the Kaiser Family Foundation's Year 2000 Post-Election survey. The results show a clear rejection of the status quo, as 85 percent of respondents do not want to "keep things as they are." The responses provide further evidence that Iowa businesses are supportive of some change in public policies to increase access to health insurance (***Table 5***).

Table 5
Business Support for Efforts to Increase Access to Health Insurance

	Nationally	Iowa Businesses
Keep things the way they are.	7%	15%
Make a limited effort to provide health insurance for some of the uninsured which would require a tax increase.	50	60
Make a major effort to provide health insurance for nearly all uninsured Iowans / Americans.	38	22

Source: SPG Survey of Iowa Businesses

Health Security. The concept of "health security" is endorsed by a majority of businesses

As we did in the active public survey, we asked businesses for their opinions on the concept of "health security." as indicated by responses to this first wave question:

> " . . . All working Iowans and employers would pay a small additional contribution so they and all other Iowans would have health security. When any Iowan loses their health insurance coverage by maxing out their benefits or losing their job, they can get coverage under the plan and they pay a regular premium based on a sliding fee scale according to household income.

Sixty-nine percent of the respondents say this would be a *good* idea, 28 percent say this would be a *bad* idea, and 3 percent *aren't sure*. About 48 percent (48.9% agreed their company would benefit from the "health security" concept, and about 47 percent (47.3%) disagreed that their business would benefit from it. Businesses back up their endorsement of a "health security" concept with some willingness to contribute to increased access. About forty-eight percent of businesses that insure their employees expressed willingness to accept an insurance premium increase to provide insurance to those Iowans who lack it. (***Figure 35***)

Figure 35
Percent Increase in Premium to Extend Health Insurance that is Acceptable to Business

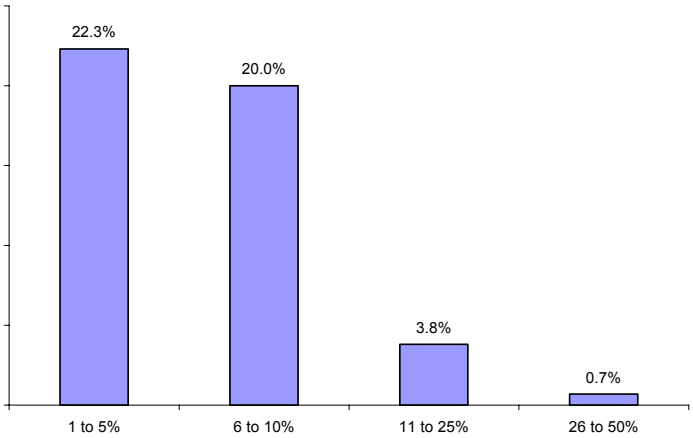
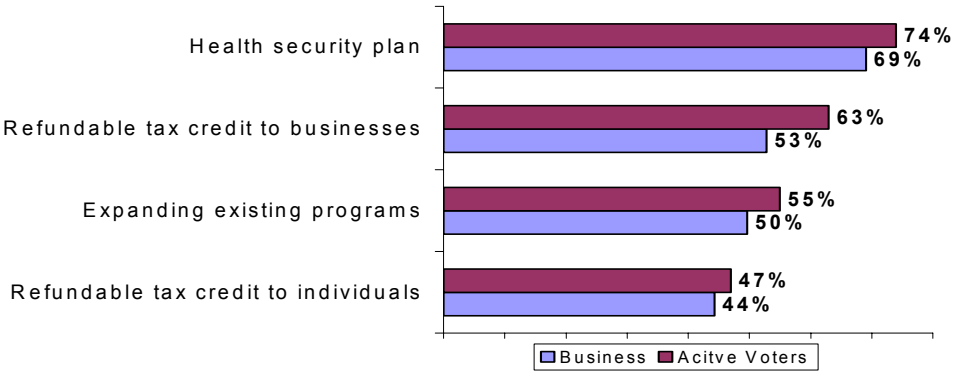


Figure 36
Business and Voters Endorsing Proposed Options



2. Second Wave

In the second wave, by a conservative estimate, 56 percent of businesses understood the health security plan as it was described to them and were willing to make at least a $10 per month contribution per employee to a "health security plan" fund. Being a benefit to business is not a prerequisite of thinking health security is a good idea. Forty-eight percent of those that disagree that their company would benefit from the health security plan think it is a good idea.

A cautionary finding is that some respondents indicated they would drop coverage if a government-sponsored "health security plan" was created. Speaking hypothetically, if the health

Source: SPG Business and Active Public Surveys, Summer 2001

security plan became a reality, 24 percent of businesses that insure their employees would strongly consider dropping their plans. However, a majority of 58 percent say they would want to keep their current plans.

Refundable Tax Credit to Business. Fifty-three percent of respondents say a refundable tax credit to businesses would be a *good* idea (***Figure 36***), 43 percent say this would be a *bad* idea, and 4 percent *aren't sure*. While this option ranks as the second choice among respondents, it is the option that most businesses that currently do not offer insurance say they would use. Almost half (48%) say they would use it, including 20 percent who would *probably* use it and 28 percent who *might* use it.

Expanding Existing Programs. Fifty percent say this would be a *good* idea (***Figure 36***), 45 percent say it would be a *bad* idea, and 5 percent *aren't sure*. Among those businesses with employees who might qualify for the program, 19 percent say *a lot* of their workers would use the program and 57 percent say *a few* workers would use it. Just 2 percent say *none* of their workers would take advantage of this program and rest aren't sure.

Refundable Tax Credit to Individuals. Forty-four percent say this would be a *good* idea (***Figure 36***), 51 percent say this would be a *bad* idea, and 5 percent *aren't sure*.

3. Business Support for Funding Change

Knowing that any access expansion would entail costs and expecting that cost would be an issue of contention, the business survey was designed to explore ways businesses might lend financial support. Earlier it was noted only 22 percent of respondents favored a major effort that would include a tax increase to provide health insurance for nearly all uninsured Iowans. (***Table 5***) Yet, nearly half (46.8%)of the insurance-providing respondents were prepared to support the concept of all Iowans having health insurance by paying higher insurance premiums, with 46.8 percent of them willing to accept a premium increase. (22.3% would accept a premium increase of 1 to 5%; 20% would accept a premium increase of 6 to 10%; the remaining businesses (4.5%), were willing to accept even larger premium increases.)

4. Conclusions – Business Survey

The business survey was useful in obtaining a detailed picture of the support and potential opposition, both in concept and financially, that Iowa business could bring to expansion of access to health insurance. The results from the first wave helped us design policy options that respect business tolerance for change. The Citizens' Alliance and the IDPH-SPG staff were especially mindful of businesses' belief that health insurance is a useful tool in recruiting and retaining workers. Since Iowa state government is trying to attract workers to Iowa, this may be an especially important finding. It may meet two important policy objectives, the desire to expand coverage to a greater number of Iowans, and to grow the state's population of workers.

D. Survey of the Active Public

Since the overarching goal of Iowa's State Planning Grant is to create a feasible plan to expand access to health insurance we had to assess potential public support and opposition to policies designed to increase access. To understand the public's opinions, we used a two-wave telephone survey to interview Iowans who voted in the past two general elections and who have health insurance (the "active public.") We chose to survey the active public to understand the attitudes and beliefs of people most likely to participate in the public debate/process necessary to adopt policy options that would expand access to health insurance. As in the business survey, we chose to conduct the survey in two waves.

The first wave of the active public survey had three purposes: 1) To assess the electorate's attitudes regarding a state plan to expand access to health insurance to all Iowans, 2) to provide insight into policy creation, and 3) To begin developing a plan for how to "sell" new access policies. The second wave provided data verifying the results of the first wave and asked more detailed questions about respondents' willingness to support and pay for expanded access.

J. Ann Selzer and SPPG designed the active public survey with the assistance of IDPH-SPG staff and Lewin representatives. IDPH-SPG staff approved the questionnaires prior to their use. SPPG pre-tested the survey instruments and Central Surveys, Inc. conducted both sets of telephone interviews. The telephone-interview method was selected to capture pertinent information form the business community with a sufficient sample size to allow comparisons of interest within the State Planning Grant time frame.

In the initial survey, 575 phone interviews were conducted from April 12 to May 4, 2001. Each interview lasted approximately 15 minutes. The sample was drawn from the master voter list compiled by Iowa's secretary of state. To qualify for the survey, respondents needed to have health insurance and to have voted in the past two Iowa general elections. The margin of error for this wave is plus or minus 4.1 percentage points.

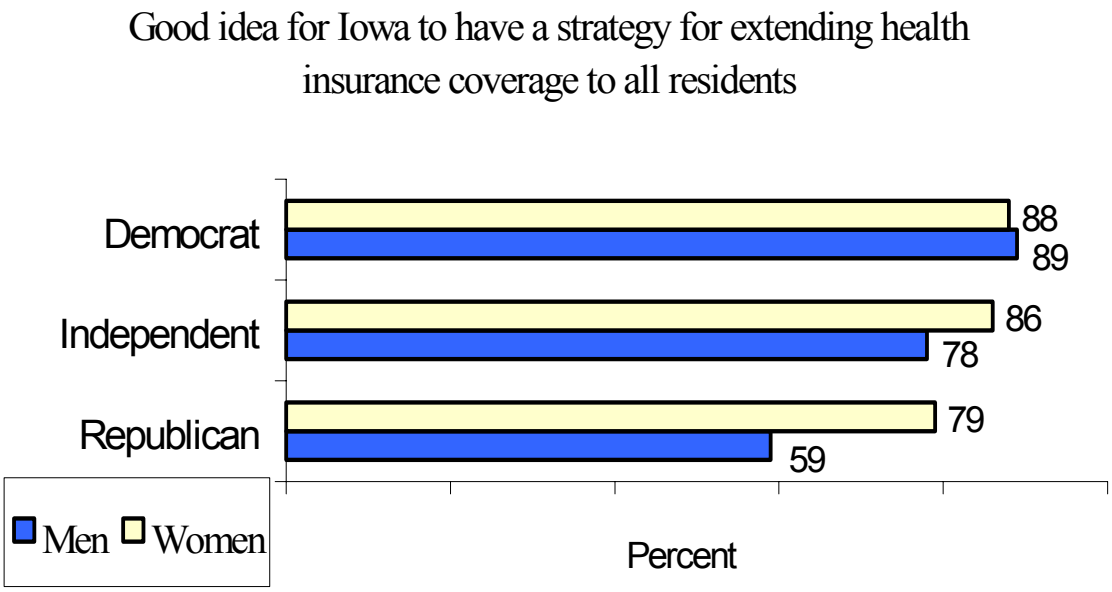
In the second wave, conducted July 16 through July 27, 2001, 550 Iowans who had voted in the past two general election and have health insurance were interviewed. Each interview lasted approximately 12 minutes. The margin of error for this wave is plus or minus 4.2 percentage points.

Quotas for age and geography for both waves were employed as interviewing controls to ensure that both final samples represented a true cross-section of active voters in Iowa.

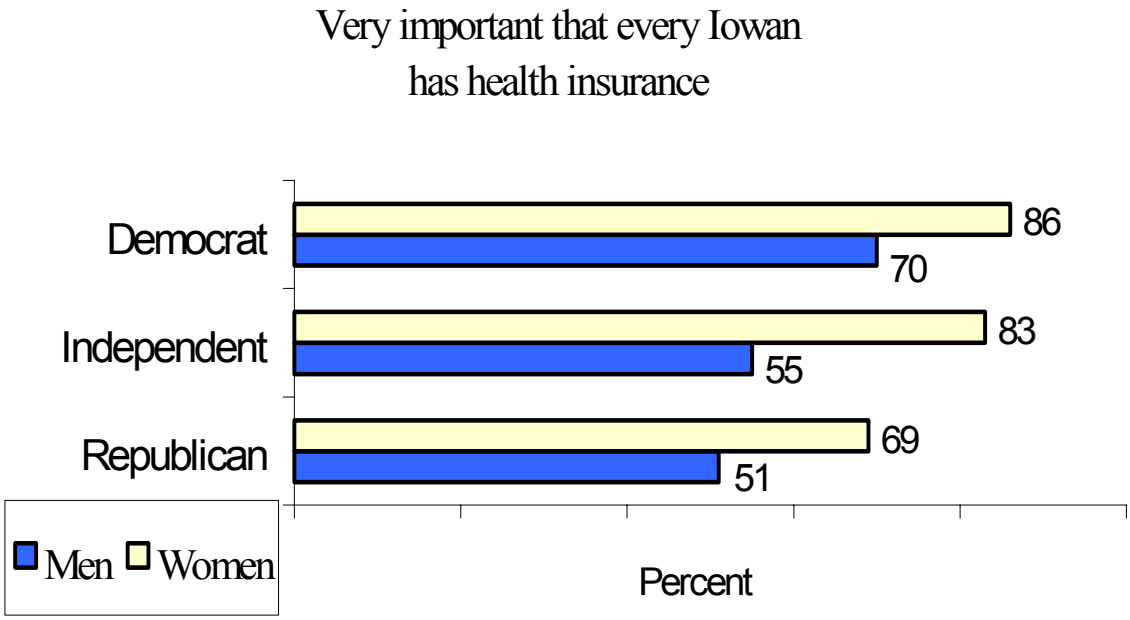
E. Active Public Survey Results

Both waves of the active public survey show strong support for extending health insurance to all Iowans. Nearly eight in ten (79%) active voters believe it is a *good idea* for Iowa to have a strategy for extending coverage to all residents, a percentage which is identical to wave 1 results. In addition, two-thirds (66%) say it is *very* important that all Iowans have health insurance, compared to 69 percent in the first wave. Overall, women and Democrats were more likely to endorse increasing access (***Figure 37***). Still, a majority of men in all parties approve of the idea.

Figure 37
Active Public Support



Source: ***Source*: SPG Active Public Survey**



Source: SPG Active Public Survey

Key opponents to expansion comes from those persons who believe access to coverage is not important for state government to solve (8% overall), and from those who identify themselves as Republicans.

1. Self-Interest: A Key to Support

Self interest is a key to why people think expanding access is a good idea. The first wave of the active public survey makes clear that the idea of extending health insurance works because it includes *all Iowans*. Possibly because there's something in it for them, a majority of 54 percent of voters agree it is *reasonable* for all working Iowans to make a contribution to a fund to provide health insurance to all Iowans, much like the current Social Security system does for financial security. Such a system would provide a safety net for Iowans who have insurance but lose their coverage. Loss of health insurance is a widespread concern, with 68 percent of respondents indicating some level of concern. **Table 6** show the breadth of the respondent's fear of losing health insurance.

Table 6
Fear of Losing Health Insurance Coverage.

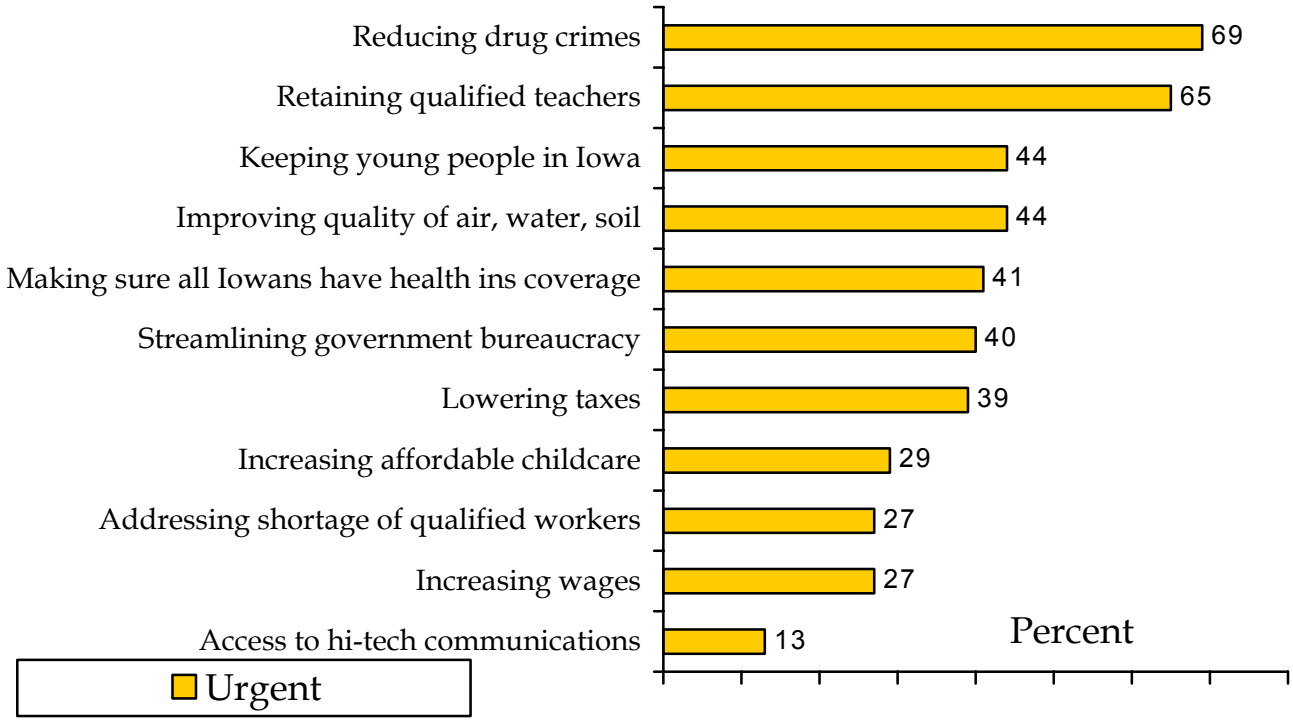
Question	Response Categories	%
"Do you think any of the following that would cause you to lose your insurance could happen to you in the future?"	Inability to get an insurance policy due to a preexisting condition.	28.3
	Trying to switch between health plans.	29.4
	Loss of job.	29.2
	Unable to afford health insurance premium.	30.1
	By retirement before age 65	30.8
	"Maxing out" your benefits due to a catastrophic illness or accident.	44.2%

Source: SPG Survey of Iowa Businesses

Despite the apparent support for expansion of health insurance coverage, the public lacks concern for the issue of uninsured persons. In the first wave, we asked the active public to indicate the urgency of selected problems state government could address. The issue "making sure all Iowans have health insurance" is a second tier issue in the minds of the active public, with only 41 percent labeling it as an *urgent* issue. There is a strong consensus among the IDPH-SPG research team and opinion survey consultants J. Ann Selzer and SPPG that the issue has to raise in urgency before the public or its elected representatives will be engaged enough to commit public and private money to increasing access. Two scenarios could raise the level of urgency. The first would be a campaign led by respected public "champions" to get the public and their representatives to commit funding and political capital to initiatives to increase

coverage levels. The second is the economic downturn that began in the summer of 2001 which could lead to so many people without health insurance that intervention at the public and private level would be needed to maintain the integrity of the state's health-care system.

Figure 38
Urgency of Selected Problems State Government Could Address



Source: SPG Active Public Survey, Spring 2001

The findings from the first wave prompted the IDPH –SPG staff, with the assistance of SPPG, Selzer, and Lewin, began to explore a concept we labeled "health security." Broadly speaking, the results of the first wave of the business and active public surveys told us that to garner public and business community support for expansion of health insurance, both the public and businesses had to perceive that they would benefit directly from any expansion efforts. But with over 90 percent of Iowans with health insurance, the promise of providing coverage to more people was not likely to be perceived as a personal benefit except by the most altruistic people. The question became, how could an expansion of access provide a direct benefit to those who were already covered? We were drawn to responses to a question posed in the first wave active public survey that attempted to gauge a respondents' fear of losing existing coverage. The responses to the question, shown in ***Table 6***, show that insured Iowans fear losing their coverage. We decided to explore further this notion that it was reasonable for all working Iowans to make a

contribution to a fund to provide health insurance to all Iowans, much like the current Social Security system does for financial security.

2. Wave 2 Results

We used the second wave to test four approaches for extending coverage to all Iowans:

- Giving individuals refundable tax credits to buy their own health plan.
- Expanding existing government programs for low-income families.
- Giving businesses refundable tax credits to pay for part of the premium if they start offering health insurance.
- The "health security plan."

Health Security. In the second wave survey instrument we defined the "health security" plan as something similar to Social Security in that all workers would pay a "small contribution" into the system in return for a guaranteed benefit. The benefit would be guaranteed access to coverage at a lower cost than they could get on the individual market for any Iowan who loses coverage by exceeding policy limits or benefits or losing their job. (See Appendix 2 for full text of the instrument) The still developing notion was, in lay terms, to insure Iowans against the fear of losing their health insurance, and to use a portion of that 'premium' to help pay for a portion of the cost of increasing access to health insurance to the uninsured.

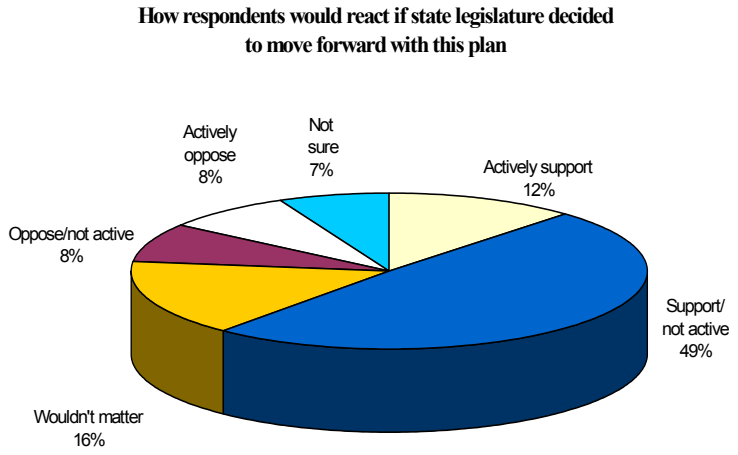
The "health security" concept garnered strong support, more than any other idea tested. Three in four (74%) respondents described the "health security plan" is a good idea. (***Table 7***) While "health security" approach seems to appeal to voting Iowans' self-interest, the issue does not arouse much activism. Nearly two-thirds (65%) agree the "health security" plan" would benefit them, leaving just 30 percent seeing no benefit and 5 percent who are unsure. However, just one in ten (12%) say they would actively support an initiative. An additional 49 percent would support it, but not actively, for a total of 61 percent who would support such legislation if the legislature introduced it and decided to move forward. In comparison, 16 percent would oppose such an effort (including 8% who would oppose actively). (***Figure 39***)

Table 7
Support for Approaches for Extending Health Insurance to All Iowans.

Approach	Good Idea (%)
"Health security plan"	74
Give companies a refundable tax credit	63
Expand existing programs	55
Give individuals a refundable tax credit to buy their own insurance.	47

Source: SPG Survey of Iowa Businesses

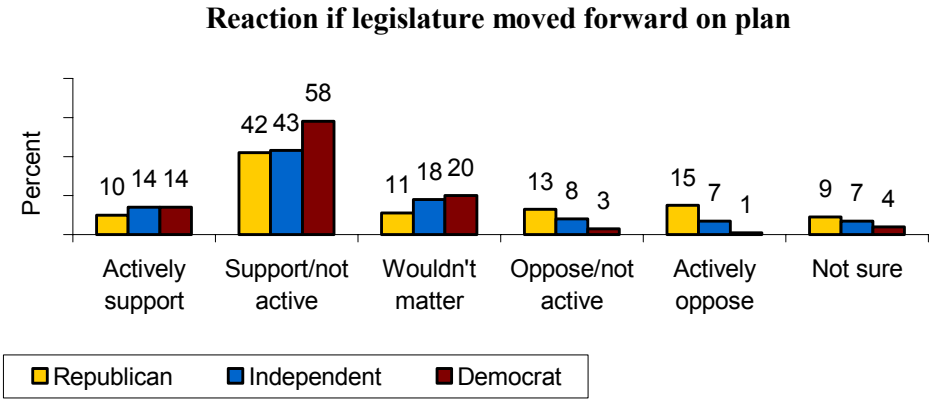
Figure 39
Reaction to Legislative Action.



Source: SPG Active Public Survey

There is some difference when looking at the respondents by party affiliation.(***Figure 40***)

Figure 40
Expressions of Support and Opposition.



Source: SPG Active Public Survey

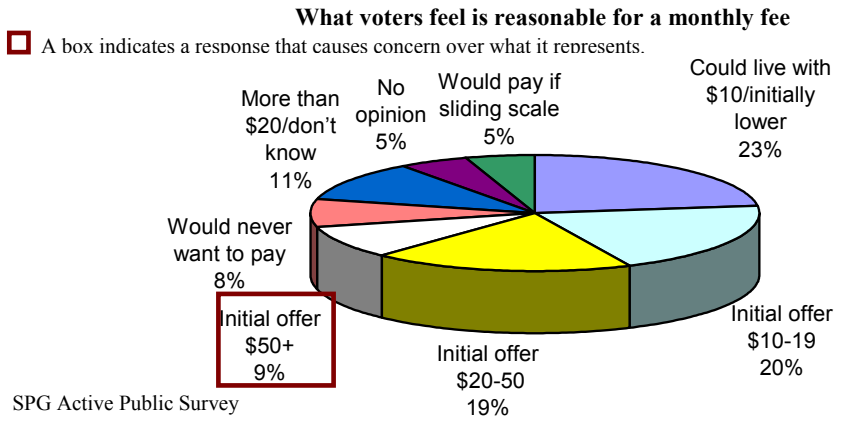
3. Funding: A Mixed Expression of Support

The wave 2 results provide some, though not complete, evidence that voters would support the idea of health security with their pocketbooks. Voters were asked in a series of questions what they thought might be a reasonable amount to pay each month for the "health security" plan. First, they were asked to volunteer a number. Respondents who weren't sure of a specific number were read a list of ranges from which to choose. If the number they volunteered or if the range they chose was less than $10, the respondent was then asked if $10 a month seemed like an amount they could live with. If they said $10 was too expensive, they were offered the idea of a sliding fee scale from $4 to $14, depending on household income.

> *Methodological note:* Some active voters initially volunteered a rather large number, a few saying $100 or $200 and one as high as $500. Because of this, we are not confident that all respondents understood what the monthly deduction was and fear some respondents were thinking the monthly deduction was the premium. The following chart accounts for those respondents whose responses we doubt. We are more confident that respondents who initially volunteered a lower number were correctly thinking about a monthly deduction to ensure access to affordable health insurance rather than the premiums themselves. Still, further research is needed to firm up this number.

Two in three voters show tolerance for a monthly fee of $10. We are fairly confident that those respondents who volunteered a number less than $50 were thinking about a monthly deduction, not the premiums themselves. We are also confident those who said they could live with $10 after naming a lower number were thinking about the monthly deduction. Together, these groups account for 62 percent who would tolerate a monthly $10 deduction to ensure access to affordable health insurance for them and all Iowans. (***Figure 41***)

Figure 41
Active Public Level of Support for $10 Deduction

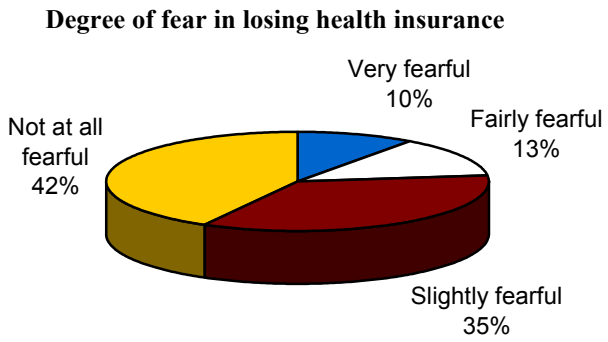


Source: SPG Active Public Survey

4. Fear of Losing Insurance.

Iowans fear losing their insurance; but that fear is not intense. A majority of 58 percent say they are fearful they could lose their health insurance in the future (compared to 69% in Wave I). Wave 2 put this fear into perspective; just 10 percent of active voters are very fearful they would lose their health insurance (***Figure 42***).

Figure 42
Iowa Voters Fear of Losing Health Insurance



Source: SPG Active Public Survey

As might be expected, those who are the most fearful are the most supportive of extending health insurance to all Iowans. Nine in ten (89%) of those who are *very fearful* think it's a good idea to extend health insurance to all Iowans, compared to the average of 79 percent overall; 85 percent of the most fearful think it is *very important*, compared to the average of 69 percent.

5. Iowans Without Health Insurance

The active public survey helps confirm the findings of the uninsured survey as well the data presented in our analysis of the CPS, also in Section 1, in that our survey confirms that Iowa's uninsured population is often young.(***Figure 3)***

Four in ten (40%) active voters in Iowa report having gone without health insurance sometime in their life. A majority of 53 percent of those who report not having health insurance at some time in their lives say it was when they were under 25. An additional 27 percent say they were between the ages of 25 and 34. This totals 80 percent who were under age 35 when they did not have health insurance.

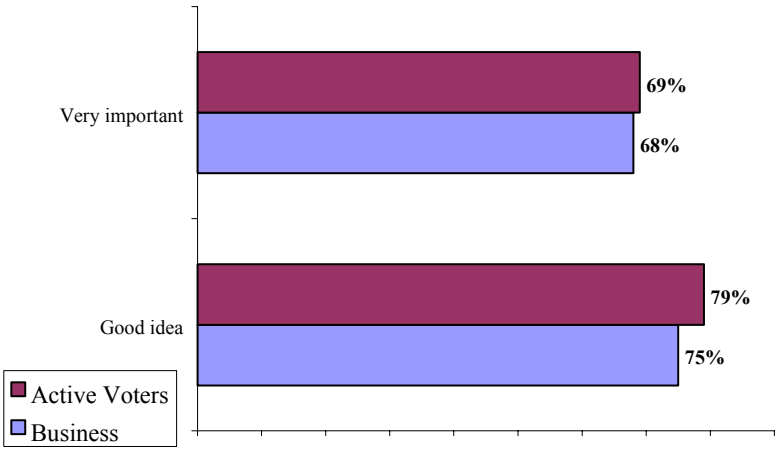
When the respondents who have been without insurance are combined with those who worry about losing current coverage, 73 percent of all active voters express fear or living without coverage. This is a strong base of support for a safety net that could protect all Iowans from losing their insurance.

6. In Summary

Voting Iowans and businesses like the idea of a health insurance safety net to give them peace of mind. We believe the active public and business survey results show there is sufficient tolerance for a monthly fee to support continued exploration of the concept of a health security plan (***Figure 43***).

While acknowledging that a good base of support exists, there is a sobering reality in the finding that among the list of problems the active public respondents say state government needs to address, increasing access to health insurance does not rank very high. It ranks behind reducing drug crimes (69% *urgent*), retaining qualified teachers (65% *urgent*), keeping young people in the state (44% *urgent*), and improving the quality of air, water, and soil (44% *urgent*).[20] (***Figure 38***)

Figure 43
Similarities in Support Between Business and Active Public for Expanding Access to Coverage



F. Active Public Focus-Groups

The surveys of the uninsured, the active public and businesses were very helpful in developing our understanding of the potential for expanding access to health insurance in Iowa. Standing alone, however, the surveys were not capable of providing enough information regarding the intricate mix of beliefs and motivations that drive public support for policy changes. For this reason, we choose to supplement the surveys with focus-group sessions with "active public" targeted groups. More specifically, we wanted to use the focus-groups to provide Iowa SPG policy researchers with unique information on how participants viewed the notion of expanding access to health insurance. By observing the ebb and flow of the verbal exchanges among participants, the SPG researchers were able to understand the factors that most directly color individual view points regarding the volatile question of who should be insured and under what circumstances. The information has given us insight into what policy interventions have the greatest chance at broad public acceptance.

The focus-groups were held in two rounds, the first in March, the second in July. The sites for both rounds assured that a geographically broad range of Iowans presented their thoughts to the researchers. Equally as important was the assurance that opinions came from people from both rural and urban areas. Opinions can vary widely in different settings and important lessons can be learned about how a plan to increase access to health insurance should be developed to ensure wide public support. We have also found that the public views research findings as more credible opinions are sought from people with a variety of perspectives. In Iowa, it is particularly important to seek input from both rural and urban interests.

1. Round 1 Active Public Focus-Groups

The purpose of the first-round of focus-groups was to gather responses from the active public on the issue of health insurance and the importance of every Iowan having coverage. More specifically we wanted to see how participants reacted and responded to a broad range of questions on health insurance access. The questions were as follows:

- Is health insurance a broad issue with many implications for Iowans?
- Is it a right to have health insurance? Is it a luxury?

- Is it a benefit of job or economic status?
- How do Iowans react to the uninsured in the state?
- What are Iowans perceptions of the problem of lack of access to health insurance?
- Should government play a role in health insurance beyond traditional federal programs?
- Is it an important issue to Iowans in general or only to those who do not have health insurance?
- Should the state accept that some Iowans will always go without insurance or is it the state's responsibility to see that every Iowan have health insurance coverage?
- Would Iowans support an effort to increase access to health insurance?
- If Iowans do support action being taken to increase the number of Iowans with access to health insurance, what alternatives do Iowans suggest?

Invitations and Selection of Participants. Eight focus-group sessions of up to 18 participants were held in Iowa during March.. The sessions were held in Waterloo, Ottumwa, Villisca, Postville, Council Bluffs, Primghar, Burlington, and Fort Dodge. This site selection assured a geographically broad distribution of views, in both rural and urban settings.

SPPG mailed invitations to people within a 30 mile radius of each community where a focus-group was to be held. One quarter of the invitations for each location were mailed to people with a record of involvement in public policy issues. For purposes of this report, we term these people "activists." The other three-quarters were "registered voters" who had voted in the last two Iowa general elections (1998 and 2000), selected randomly from the Iowa secretary of state's voter registration lists. Up to 18 reservations were accepted for each focus-group meeting. Among the 18 people who agreed to participate, we accepted no more than six "activist" registrations. As is typical in focus-group research, a financial incentive was provided to induce participation. For both rounds of focus-group sessions, participants were paid $40 and provided a light meal during the meeting. In one instance, a participant was paid an additional $20 to cover child-care costs. Each participant was asked to sign a release to allow the session to be recorded. Each of the eight sessions was recorded (audio) following the initial instruction phase.

Round 1 Focus-group Structure. The structure was consistent throughout the eight sessions. Each meeting was held in the early evening after normal working hours. These hours have been shown to produce the most consistently high participation rates. For all the sessions, a minimum show rate of 12 persons was achieved.[21]

Each facilitator worked from a script that SPPG prepared with the assistance of IDPH-SPG staff and Lewin. The script was carefully designed to elicit the desired information without leading participants' responses. It was composed of a series of three premise paragraphs, each of which were accompanied by a series of questions. This method was used to provide participants with a frame of reference within which to understand the questions. For the most part, participants were encouraged to answer questions, but were not required to do so. The facilitator worked to ensure that participation was easy and freely given, guarding closely against the tendency of the most vocal participants to dominate the session. The facilitators reported that while each of them took precautions to ensure widespread participation, very little effort was needed. It appeared to all the facilitators that the people who chose to participate in these sessions had a lot to say, and that little or no encouragement was necessary to get them to speak their mind.

Besides the audio taping, an SPPG staff member used a laptop computer to document participants' responses to the questions. Whenever possible, verbatim responses were recorded. All comments were recorded as non-attributable. The audio tape and the memorialized responses were summarized subsequent to Round 1completion.

Based on the comments elicited at the eight meetings, some common themes or perceptions emerged.

Health insurance is a quality of life issue. Participants agreed that health insurance is a quality-of-life issue, especially if people do not have it or have to pay much of their income for it. Participants also believed healthier Iowans would lead to a more productive workforce, which would help the state's economy. Participants noted that good quality, affordable health insurance helps attract people to the state and retain them. Participants also said that people, particularly the elderly, should not be forced to choose food or medicine over health insurance because of cost.

"We are greatly impacted by the health of our family. If something catastrophic happens, you are in trouble."

Health-care is a human right. Participants said **health-care** is a human right, and that most Iowans can access care if they choose to. It appeared, given the comments by significant number of participants that they were struggling with a distinction between health-care and health insurance. But many also said many Iowans cannot access health insurance unless it is provided by employers or a federal program, and that many cannot access health-care without health insurance. A majority of participants believed individual responsibility plays a part in Iowans' ability to access health insurance. The belief seems to be that Iowans should pay what they can, with the private sector or government helping to control costs. When asked to characterize health insurance as a human right, a benefit of individual economic level, a responsibility of society to provide, or a luxury, the participants were split. There was no clear agreement on any of the choices. Many viewed this as a philosophical question and noted that opinions vary.

"I guess I agree more with the line he was taking- health insurance is a benefit of one's economic level is the reality. How we get to the end of everybody being covered is the debate."

All Iowans should have health insurance. Participants expressed support for a statewide insurance pool, where all Iowans could obtain health insurance through the private sector. Participants believed such a pool would reduce health-care costs and insurance premiums for all Iowans. In fact, many said that if every Iowan had health insurance, the result would be healthier and more productive Iowans.

"Small businesses should have the same rates as the large businesses. Need to have a larger pool to get cost-effective insurance. I don't care who pays for it; everyone should have health insurance no matter who pays for it the business, the individual, the government."

There is an understanding of who are the uninsured and how they obtain care. Participants had a mental picture of who the uninsured are and how they get access to care. In general, the participants believed the uninsured went without care or turned to emergency rooms for assistance as their only recourse. Some participants characterized farmers, part-time

employees and the working poor as the "typical" uninsured Iowan. Others took a broader view and said any Iowan could find themselves uninsured due to a change in personal circumstances.

"I think it's as varied as there are people. Some by choice, some by fate. In my business I see people who don't have the money to pay for it. Others I see have the money but choose to spend on something else.

Currently, health insurance focuses to much on catastrophic care and not enough on prevention. Participants expressed the belief that coverage should focus more on prevention than on health emergencies. They believed a such focus could reduce overall health-care costs, including the cost of premiums.

"Very few medical events are actually emergencies. A lot of problems can actually be prevented, but unfortunately, in our country, we don't do a lot of preventative medicine, even if you are insured, because it's just not available, at any price."

Not all Iowans need or should receive government support when it comes to health insurance. Participants appeared to divide the population by level of need. For example, some thought all children should have health insurance. They also thought the elderly should continue to benefit from Medicare and that prescription-drug coverage should be offered within Medicare. For adults, participants saw the work place as the proper locus of coverage. There was general agreement that businesses should receive financial incentives to offer good quality health insurance to their employees. A pool should assist self-employed Iowans buy health insurance through the private sector.

There is little support for a national health insurance program. There is some increased support for a state health insurance program, but most participants did not support government programs. Participants expressed a preference for some kind of public/private partnership if government had to be involved.

"I think to some extent you have to be responsible for yourself and your family"

"I hate to say government (should be responsible), because government would screw it up."

Health-care and health insurance are individual responsibilities. Participants thought individual adults were responsible for obtaining their own health-care and insurance, but not children. Most agreed that Iowans should be required to pay what they can for health-care, and supported a sliding fee scale for insurance premiums.

"The individuals have to have some accountability. It can't just be another freebie."

There is little public demand for increasing access to health insurance. Participants agreed every Iowan should have health insurance, but they did not think there was anything but minimal public support to address the issue. They said greater public education about the uninsured is needed, however.

"The people that need it the most don't know how to demand it or recognize its value in some cases."

State involvement in increasing access to health insurance should be limited. Participants agreed that if a state program were necessary, the state should protect patient choice of physicians and other providers. Many participants said they would prefer to see funds spent at the local level rather than the state level.

"Government should provide for everyone. It is our tax dollars that go to the current and the money should go to the programs."

"I don't buy that the bureaucracy is impenetrable. If there are good people, it can be useful. This would have to be administered by state or county government."

2. Round 2 Active Public Focus-Groups

The second round of focus-groups held in June asked more specific questions than the first round. The scripts for this round were developed primarily to elicit answers to questions on the potential options developed as part of the SPG work plan. In this round, policy options were presented as possible avenues by which greater numbers of Iowans could have access to coverage.

The second round also differed from the first in another essential way. First round participants were Iowans identified as members of the public. The second round included targeted groups, such as business owners, elected officials (both members of the Iowa legislature

and municipal and county officials), and health-care providers and executive directors of health-care organizations. These groups were targeted for their ability to comment on policy options from their own knowledge coupled with their ability to reflect specific constituencies. Besides the targeted group sessions, five groups were composed of members of the "active public."

Participant and Site Selection. Nine focus-group sessions were held during June at Dubuque (business), Decorah (active public), Des Moines (health-care providers), Chariton (active public), Charles City (active public), Humboldt (1 session of elected officials and one of active public members), Grinnell (active public), and Mount Pleasant (elected officials).

Round 2 Focus-group Structure. As in the first round, the structure was consistent throughout the nine sessions. Each facilitator worked from a script designed to elicit response without leading the participant. The script had three premise paragraphs followed by several questions. At each session, responses were recorded by an SPPG staff member familiar with the State Planning Grant objectives.

Based on the comments elicited at the eight meetings, some common themes or perceptions emerged within targeted group.

Active Public Focus-Groups. Participants generally supported the concept that every Iowan should have access to health insurance. Also, as in the first round, they believed Iowans should bear some responsibility in obtaining their own coverage. If people are unable to pay the whole cost of health insurance on their own they should pay what they can, many said. Strong support was shown for a sliding scale.

> *"Most employers are currently charged a percentage of the premium. A possible option for health insurance coverage is employers charge a percentage of your pay to help cover your insurance coverage. Every employee is responsible for paying his or her share. It is a fair and acceptable plan."*

Some participants believed it was important for state government to step in to ensure that all Iowans have access to affordable health insurance. Others were firm that it is strictly up to the private sector to provide affordable coverage. Participants were unsure if state government should offer access to everyone or only to those who had no other alternative but to turn to the

government. In some sense, it appeared the public expected the insurance industry to act as a public service, rather than as individual for profit businesses.

> *"Health- care insurance should be offered to everyone. It is very important and many that do not have coverage are working in the small business sectors. They are working hard and do not have insurance."*

> *"Private sector is the first priority is my thought. This is where the coverage should start. If there are gaps then the state can step in. Government can help to alleviate some of the cost."*

As discussed in Section 4 of this report, one of the proposed policy options would be a Medicaid expansion to 200 percent of the FPL as well as expanding Iowa's SCHIP program, hawk-i, to cover parents, and perhaps adults without children. In general, this option was well received. Several participants said hawk-i should be removed from the control of the Iowa Department of Human Services to reduce the stigma associated with "government programs" and lessen the level of bureaucracy associated it

> *"If you took Medicaid and hawk-i insurance and combined them all together and called it Iowa State Insurance – that is how it should be handled. One name, one office to go to for your business. It would be their job to figure out what kind of coverage you're eligible for. No one would know except the state office."*

Participants were also asked their opinion about requiring families to show proof of health insurance prior to enrolling a child in school, much like the state does for immunizations. There was virtually no support for this idea. Participants appeared to be primarily concerned that the school system would be harmed and/or that parents would be forced into home schooling. Overall, participants said they were opposed to any mandate requiring coverage. Participants saw the school as the proper venue to educate Iowans about hawk-i, Medicaid, and other government programs.. As a general proposition, participants supported the notion that existing government health insurance programs should be expanded rather than creating new programs.

Participants most often identified children and "senior citizens" as the two groups that should have guaranteed access to coverage. At the same time, participants expressed realization

that many Iowans "fall through the cracks" and go without health insurance due to a job change or other circumstances beyond their control. Participants generally thought *something* should be done about this, including guaranteeing access to all, but disagreed on the mechanism, public or private. Specific mechanisms, such as *community rating,* received a fairly positive response from those who understood it. Other ideas, such as a *tax credit* to employers for contributions towards premiums of low income workers received a more neutral response. Additionally, there was only limited support for a *state subsidy* to help eligible Iowans pay their premiums. Participants doubted that such a subsidy could cover the high cost of health insurance and would do little to contain premium costs. Participants did however agree that businesses needed to participate engaged if any increase in access were to occur.

3. Business Focus-Group

Participants in the Dubuque business focus-group included people who owned or were employed by small businesses. In general, most represented businesses that offer health insurance to their employees. For those who did not, the decision was based on premium costs. All participants agreed every Iowan should have access to health insurance, whether or not it was offered by an employer. Participants were asked to comment on whether a tax credit offered to those businesses to help them pay premiums for low-wage workers would be beneficial to their enterprises. Most said they their would not benefit because they already had written off their premium costs, or they are in the not-for-profit sector. Others expressed skepticism that such a measure would be approved by the Legislature. Overall, they believed a tax credit could help convince more employers to offer health insurance, which might help recruitment and retention.

Participants were also asked if they supported allowing small employers to join a health insurance *purchasing pool.* Participants perceived that joining a pool would drive up premiums because employers with older and/or sicker employees would be most likely to join. The concept of *community rating* was also placed before this group.[22] In general, response was neutral because participants said they did not understand the community rating concept well enough to offer an opinion.

When asked if there were a need for health insurance reform in Iowa, respondents generally agreed the private sector should be left to determine costs and coverage schemes, but

that the Iowa insurance commissioner should do more to prevent fraud and abuse, a mixed message for government involvement in health insurance.

Several business owners indicated it was a challenge to educate their employees about the true costs of health insurance, and that employees had responsibility for maintaining their own health.

4. Health-Care Provider Focus-Group

In general, these participants believed all Iowans would benefit from having health insurance, but there was no agreement about how to offer it to all. Participants agreed all children should be covered, but did not agree that proof of coverage need be supplied prior to school enrollment. Participants agreed expansion of existing government-sponsored programs would help the health-care industry, but noted numerous flaws in Medicaid, hawk-i, and Medicare.

There was widespread agreement for the need to change the health insurance system, due primarily to a general belief that insurance companies put profits ahead of policy holders.

Participants supported providing *tax credits* to employers to assist in covering premium expenses. Participants viewed the employer-based health-care system as the best method for covering most Iowans.

5. Elected Official Focus-Groups

"Having health insurance and access to prevention makes a healthy work force. If you get regular checkups and prevent some of the crisis situations, it helps the economy overall."

Targeted focus-group sessions with elected officials (legislators and municipal and county officials) were held in Mount Pleasant and Humboldt. In general, the elected officials said Iowans should be able to choose coverage or not, as opposed to mandating coverage, They also agreed availability of health insurance is important to maintain the health of Iowans and help the state's economy. Furthermore, they generally agreed that Iowans should pay what they can for health insurance, and support sliding fees, and that options such as *community rating* and *tax credits* could be beneficial.

"If the family can pay some, then the public might have to pay the rest. This might be the only option. How far do you open the window so people do not say they can't pay when they probably can pay? People will try to meet the guidelines to get help. I think hawk-i encourages people to pay something. It is a sliding scale and this helps people."

"Since we are already paying for the care, we need to encourage people to join insurance programs. Need to have a sliding fee scale so they can contribute."

All participants believed it was up to the private sector to provide insurance, but that government should assist those who cannot buy coverage for themselves or their families. When asked about a *state subsidy*, legislators said they were concerned about how it would be paid for, given the state's poor budgetary outlook and the overall declining health of the state economy. Legislators were also asked if the political will to make changes in health insurance accessibility exists in Iowa. Overall, they agreed any reforms would need the support of businesses.

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[19] Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Surveys (CPS) for 1997-2000. (covering years 1996-1999)

[20] SPG Active Public Survey, March 2001.

[22] Community rating was described as allowing businesses, regardless of size, to pay a common premium for health insurance for their employees.

SECTION 3: HEALTH CARE MARKETPLACE

One of the SPG purposes is to provide an assessment of the state's health-care marketplace as it relates to opportunities to expand access to health insurance coverage. Section 4, where we present policy options the state could pursue to increase the number of Iowans with access to health insurance, provides some information on state's health-care marketplace. Other information on the marketplace comes from the results of the surveys and targeted focus group which are described in Sections 1, 2, and 2-A. Additionally, we obtained information from discussions with our Citizens' Alliance as well as with members of the health insurance and health-care industries and from regulators. The following paragraphs contain responses to specific questions posed in the Guidance for Preparing Final Reports.

A. Adequacy of Existing Insurance Products

As a general statement, it would appear that existing insurance products in Iowa are "adequate." While adequacy is a difficult concept to define, the fact that an estimated 90.9 percent of all Iowans had some form of health insurance coverage between 1996 and 1999, provides ample evidence that the insurance products sold in Iowa are adequate, if the focus is on the rate of coverage within the state.

In defining adequacy, however, we should not limit our inquiry to the statewide coverage rate. To do so would be to ignore significant concerns that a number of state residents' and their health-care providers have regarding the adequacy of existing health insurance products. If we look at income levels, we see that workers with modest incomes have significantly greater difficulty obtaining coverage than workers with higher incomes. In fact, the percent of workers without health insurance drops significantly for those workers earning less than $400 per week. More than two-thirds of workers without insurance in Iowa earn less than $400 per week. Of the 391,590 total workers without employer coverage, 23.7 percent earn less than $150 weekly, 21.2 percent earn between $150 and $249, and 23.1 percent earn between $250 and $399 per week. (***Figure 25***)

We do know there are a number of low-cost/low-benefit/high deductible health insurance products available in the individual market in Iowa, however, these do not appear to hold much appeal for many uninsured persons. In the focus groups sessions held with uninsured persons the

participants stated they wanted a quality health insurance policy, and that having a poor-quality health insurance policy was akin to having no policy at all. Participants equated 'quality' policies with first dollar coverage or very limited deductibles, and prescription drug coverage.

Most uninsured Iowans, with their sensitivity to the price of coverage, would have difficulty matching their purchasing abilities with the type of policy they apparently want. In our uninsured survey, respondents of all income ranges generally expressed a willingness to pay **some** monthly cost for health coverage, and the amount respondents would be willing to pay each month, varied by income. (***Figure 16***) For those with household incomes less than $10,000, nearly half (49%) would be willing to spend less than $50 per month for coverage, and 16 percent would be willing to spend between $100-$200 per month. For those with incomes greater then $50,000, 38 percent would be willing to spend up to $50 per month and 35 percent would spend between $100-$200 per month for a basic health plan. This suggests that from the standpoint of consumer choice there would appear to be a lack of adequate coverage for lower income workers who are not covered through employment.

The 385,034 Iowans covered by Medicare would almost certainly describe their coverage as inadequate to the lack of prescription drug coverage in that program. Additionally, those persons with a need for significant mental health treatment would in all probability find Iowa products inadequate as the state does not require "mental health parity."[23]

At this juncture, we have not agreed on a definition of an adequate health insurance product. We have received valuable input on this issue from our Citizens' Alliance, our survey research, and our focus group sessions. Also, when we toured the state making presentations of our research findings, we did hear from a number of residents as to how they characterize an adequate product. The most significant discussions to date have centered around the issues of mental health parity, prescription drug coverage, adequacy of provider panels in rural areas, and coverage for preventative versus tertiary care.

B. Variation in Benefits

The Iowa insurance commissioner does not keep data on variations in benefit levels among non-group, small group, large group or self-insured plans. The commissioner is aware that there is a wide range of coverage plans available in the state, from very stripped down to

extremely costly coverage. Susan Voss, the deputy insurance commissioner advised IDPH-SPG staff that the insurance division has, on occasion attempted to learn more about benefit variance, but that the information is not readily shared by the industry or those firms which are self-insured.[24] The IDPH-SPG team did not focus on benefit levels during the first year of the SPG, preferring to concentrate instead on identifying who the uninsured were and why, and on the attitudes of Iowans and businesses towards expanding access. As the state enters its second year of funding we will examine benefit levels and variances much more closely.

C. Prevalence of Self-Insured Firms

The insurance division was unable to provide information on the number of self-insured firms in the state as they do not regulate that market. Deputy Commissioner Voss estimates about 25 percent of all health care dollars spent in Iowa are spent through a self-funded plan (50% through government sponsored plans and 25% through state regulated insurance).

D. Impact of State Purchasing

Iowa has not pursued the policy goal of using its health care purchasing to impact the insurance marketplace. In part, this is because there is an existing belief that purchasing power opportunities for savings in the Iowa health-care marketplace are very small, due to the state's limited managed care penetration and minimal excess provider capacity.[25]

In Section 4 of this report, we discuss the possibility of forming purchasing pools of businesses and state employees, as one means of increasing access to coverage. The limitations on purchasing pools discussed in that section provide additional information as to why using the state's aggregate purchasing power to influence the marketplace has not been popular in Iowa.

E. Impact of Current Market Trends

Current health insurance market trends are not favorable in the context of increasing access to insurance. According to the insurance commissioner, health care costs are increasing significantly, and premium hikes of 20 percent in the coming year to 18 months are anticipated. Coupled with a softening economy, it is possible that some Iowans will become uninsured either through loss of employment, loss of coverage in the work place, or through declines in workplace coverage.[26] As ***Table 8*** shows, businesses appear to be more inclined to reduce their

workforce in the event of an economic downturn, than to reduce benefits. Absent some state-wide initiative to expand access to coverage, we anticipate that Iowa's rates of coverage will vary with the unemployment rate and the general state of the economy, and the cost of health-care itself. We anticipate that health-care cost increases that exceed the general rate of inflation will negatively impact businesses ability to offer affordable coverage to their employees, which will in turn reduce coverage obtained through employment. Iowans do not show much appetite for the non-group market, and we do not anticipate that the state's regulatory environment will be able to do much to raise Iowans' appreciation of non-group products.

Table 8.
Business Responses to an Economic Downturn

If the profitability of your company were affected in an economic downturn, which of the following would be the two most likely approaches your business would be to remain viable. (1st choice/2nd choice)		
	First Choice (%)	Second Choice (%)
Reduce workforce	37.3	11.3
Operate on a slimmer profit margin	17.3	17.8
Cut benefits	14.7	0
Cut salary	14.2	2.2
Increase marketing efforts	5.6	19.3
Use cash reserves	4.2	8.7
Use short-term debt	2.0	7.6
Increase the price of goods and services	0.9	22.9
Don't know	3.8	4.7
Volunteered Answer	-	1.1
No second choice stated	-	4.4

Source: SPG Survey of Iowa Businesses (March 2001)

At this point in time, we have not looked at the state's regulatory environment to assess the impact of "universal coverage." This may be an area that we will revisit during the upcoming year as we continue to develop the options described in Section 4.

F. "Universal Coverage" and the Financial Status of Plans and Providers

Prior to determining the potential impact of "universal coverage" on plans and providers, we would need to know how to characterize, with some precision, the rate of coverage implied by the term "universal coverage." The current political climate in Iowa does not support

coverage mandates. Accordingly, under any scenario currently contemplated to increase coverage levels there would be a residual number of uninsured persons who would choose to remain uninsured. (See Section 4)

While some policymakers have asserted that workers are often uninsured because they **choose** to go without coverage, our study of the uninsured found nearly three-quarters of workers had never declined a job with health coverage to take a job without it. (***Figure 11***) The reasons cited by workers for taking a job without coverage are instructive. **Only** 5 percent said they "did not need/not want" coverage. Other reasons cited were higher pay (35%), liked job better (22%), "other" reason (16%), shorter commute (13%), opportunity for growth (9%).

We take the position that our "universal coverage" goal, in the absence of a coverage mandate, is to make health insurance accessible to those want it. From the survey results described above, we believe that most uninsured persons would choose coverage. This would leave those who do not want insurance, and undocumented persons who could not afford anything but publicly sponsored insurance without coverage.

From this definition of "universal coverage," as something approaching 100 percent of the population, , we know that the amount of "charity" or totally uncompensated care provided would decline over time as the uninsured obtained coverage. What we do not know is the amount of pent up demand for health care existing in the newly covered population. Our survey of uninsured persons indicated that approximately one-third had been uninsured for extended periods of time (***Figure 9***), including about 13 percent who had been without coverage for five to ten years, and another 20 percent uninsured for ten or more years. This would suggest that a certain amount of pent up demand exists. On the other hand, the survey indicates the self-reported health status of uninsured persons in Iowa is surprisingly good. Three-quarters of all uninsured Iowans reported their health status was either good or excellent, and one-quarter reported having poor health.

G. Safety Net Providers

We did not specifically look at the situation of safety net providers in our planning process. We did, however, include providers who could be characterized as "safety-net" providers as members of our Citizens' Alliance.

We note that in Iowa, safety net providers are somewhat different than in more urban states. Many health-care providers function as both safety-net and non-safety-net providers due to the large rural population in the state. Our aim in this planning process has been to increase the number of persons with health insurance coverage. Since coverage mandates are not currently an option, a viable safety-net will have to remain in place to care for those who choose to remain uninsured and do not have the means to purchase care at full price.

H. Utilization and Universal Coverage

We have not specifically considered how "universal coverage" would change utilization. As mentioned above we have considered the issue of pent up demand for care for newly insured persons. We also believe that high rates of coverage, approaching 100 percent of the population, will put pressure on utilization as means of controlling costs.

I. Other States

We have not focused extensively on the experiences of other states. In Section 4, we briefly describe how we considered other states' experiences as we designed our own coverage options.

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[23] National Conference of State Legislatures, Health Policy Tracking Service, 2001.For the purposes of this report we would define "mental health Parity requires insurers to provide benefits for mental illnesses that are equal to the benefits provided for physical illnesses. These laws do not allow different benefit limits to be applied to copayments, deductibles, inpatient days, outpatient visits, or annual and lifetime limits.

[24] The bulk of the information in this section comes from two interviews, one with Iowa deputy insurance commissioner Susan Voss, and Edward Schor, MD, Medical Director, IDPH Division of Family and Community Health, conducted in September 2001.

[25] The Interstudy Competitive Edge 10.2, Part II: HMO Industry Report, October 2000. http://www.interstudypublications.com .

[26] On October 11, 2001, Gov. Tom Vilsack (D) ordered 4.3 percent cuts in state spending last week (10/11), a $200 million follow-up to $108 million reductions earlier in the year. Lawmakers expect a special session to discuss details within the month. White, J. & Nagy, J., "State Budget Snapshot Not A Pretty Picture" *Stateline.org,* Oct. 12, 2001, http://www1.stateline.org/story.do?storyId=202423.

SECTION 4: OPTIONS FOR EXPANDING COVERAGE

One of the primary objectives of the State Planning Grant was to evaluate the cost and coverage impacts of a wide range of options for expanding insurance coverage in Iowa. During the course of the project, we analyzed eight general approaches for increasing coverage. These include mechanisms for expanding coverage through both public programs and private insurance.

For each option, Lewin estimated the number of persons who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the state and costs to the federal government under policies where federal matching funds are available. Also within each of the eight general types of policy options, we examined several variants to show the sensitivity of program costs and coverage impacts to various design parameters.

In this chapter, we first introduce these policy options and present the estimates of their impacts. Then we also provide a description of the methods and approaches used to perform these analyses. The analysis is presented as follows:

- Methods and Approach;
- Expanding Coverage for Children Under Medicaid/hawk-i;
- Expanding Medicaid Coverage for Adults;
- Subsidies to Help Individuals Purchase Private Coverage;
- Provide Short-term Insurance Coverage to the Unemployed;
- Subsidies to Help Employers Purchase Coverage for Their Workers;
- Create Low-cost Health Insurance Coverage Options;
- Pooling Small Businesses with State Employees' Health Plan; and
- A Combined Strategy.

A. Methods and Approach

The estimates presented in this report were developed using The Lewin Group Health Benefits Simulation Model (HBSM), which was adapted for use in Iowa. The HBSM is a micro-simulation model of the U.S. health care system. The model is designed to simulate policies

ranging from narrowly defined Medicaid coverage expansions to broad based reforms such as changes in the tax treatment of health benefits. The model also has been used to simulate the impact of numerous universal coverage proposals such as single-payer plans and employer mandates. For this project, we adapted the model to simulate these impacts for Iowa using data available for the state.

The database used in the model includes the Iowa sub-sample of the March Current Population Survey (CPS) data for 1997 through 2000[27], and the 1996 National Medical Expenditure Panel Survey (MEPS) data.[28] The model also uses a recent survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), which provides information on employer characteristics and health plan provisions.[29] The model also uses data on health spending in the state available from various state and federal sources.

Lewin created HBSM to provide comparisons of the impact of alternative health reform models on coverage and expenditures for employers, governments and households. The key to its design is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policies for a base year, which in this study is 2001. We also "aged" these data to be representative of the population in 2001 based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of the Iowa health care system. These base case data then serve as the reference point for our simulations of alternative health reform proposals.

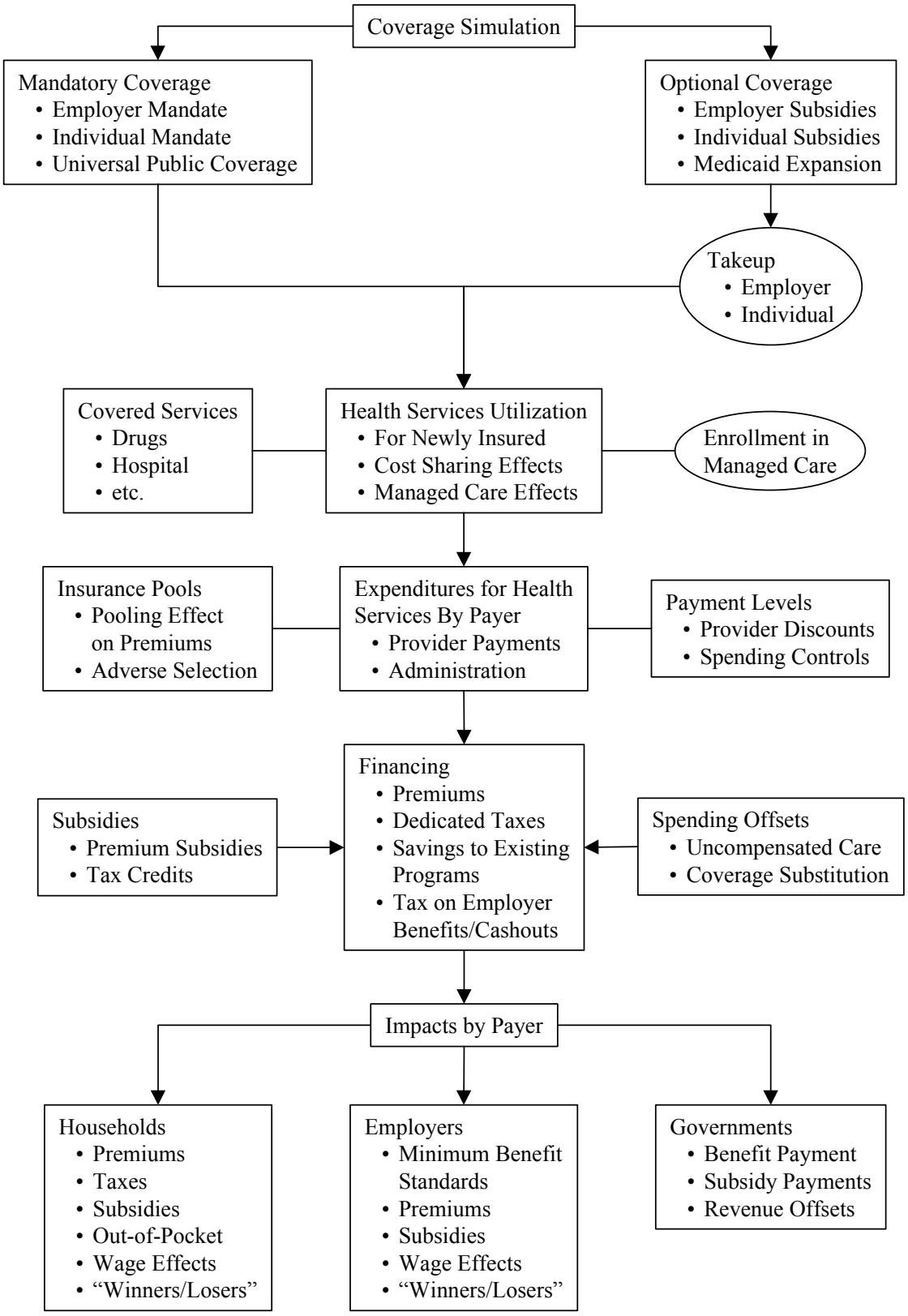
We estimate the impact of health reform initiatives using a series of methodologies that apply uniformly in all policy simulations. The model first simulates how specified state policy options would affect sources of coverage, health services utilization, and health expenditures by source of payment (***Figure 44***). Mandatory coverage programs such as employer mandates or single-payer models can be simulated based upon the detailed employment and coverage data recorded in the database. The model also simulates enrollment in voluntary programs such as tax credits for employers and employees, based upon multivariate models of how coverage for these groups varies with the cost of coverage (i.e., modeled as the premium minus the tax credit). In addition, the model simulates enrollment in Medicaid or SCHIP expansions based upon a

multivariate analysis of historical take-up rates under these programs, including a simulation of the substitution of public for private coverage under these proposals (i.e., "crowd out").

The HBSM is designed to facilitate comparisons of alternative health reform initiatives using uniform data and assumptions. For example, take-up rates for Medicaid and various tax credit/premium voucher policies are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. The model also uses a series of uniform tables for reporting the impacts of these policies on households, employers and governments. This uniform approach assures that we can develop estimates of program impacts for very different policies using consistent assumptions and reporting formats.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured persons and changes in utilization resulting from the cost sharing provisions of the plan. In general, we assume that utilization among newly insured persons will increase to the level reported by insured persons with similar characteristics.

Figure 44
Flow Diagram of the Health Benefits Simulation Model (HBSM)



The various steps included as part of the simulation modeling include:

- **Establishing a Baseline:** HBSM is based upon a representative sample of households in Iowa, which includes information on the economic and demographic characteristics of these Iowans as well as their utilization and expenditures for health care. These data were derived from the 1996 Medical Expenditures Panel Survey (MEPS) that we use together with the Iowa sub-sample of the March Current Population Survey (CPS). We also use the Kaiser/HRET survey of employers in simulations of policy scenarios involving employers. In addition, we adjust these data to show the amount of health spending in the state by type of service and source of payment as estimated by the office of the Actuary of the Health Care Financing Administration (HCFA) and various state agencies

- **Determining Eligibility:** The HBSM database provides the detailed demographic and economic data required to identify persons who would be eligible for public or private sector programs designed to expand insurance coverage. The model identifies those who meet the income or work eligibility provisions for any coverage expansion proposals we are modeling. Eligibility for Medicaid or other income-tested subsidy programs is determined on the basis of family income in each month. The model also identifies persons who are potentially affected by programs designed to expand employer coverage such as tax credits and income-tested premium subsidy programs.

- **Modeling Program Participation:** Most of the major health reform proposals developed in recent years would rely upon providing incentives for individuals to obtain coverage rather than mandating coverage. This has required the development of models that estimate the likely response of individuals to various forms of subsidized coverage. Lewin has developed models of enrollment for the Medicaid/SCHIP program that we use to simulate enrollment among persons who become eligible under proposed expansions in these programs. We have also developed multivariate models of how changes in premiums affect the decision to take-up private insurance coverage.

- **Modeling Employer Responses:** The model also simulates the impact of policies affecting the employer's decision to offer insurance and the resulting impact on employee coverage. An example of one policy option is employer tax credits designed to encourage employers to

offer coverage and tax reform proposals that change the relative tax advantages of employer provided insurance. In these simulations, the model first simulates changes in employer decisions to offer coverage at the firm level using the Kaiser/HRET data and then simulates the corresponding impact on workers who have been assigned to each of the firms in the Iowa database. As discussed above, this often involves compiling data on the workers assigned to each firm such as the average marginal tax rate for workers or the number of employees who are eligible for a particular coverage expansion program.

- **Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the coverage provisions of the proposal. For tax credit proposals and premium vouchers, program costs are equal to the amounts of the credits or vouchers for persons who participate in the program. Under proposals where benefits for eligible individuals are provided through a public program (e.g., Medicaid), costs are equal to the cost of the health services used by enrollees. These costs are estimated based upon the cost of covered services received by individuals in the household database who are simulated to enroll in the program. This includes expenditures reported in these data during the months in which the individual is simulated to participate in the program, plus an estimated increase in spending for newly insured individuals.

The model can simulate several policy options at the same time. For each option, the model estimates the impact on health expenditures in Iowa by type of service (such as hospitalization and physician visits) as well as the changes in costs for various stakeholder groups. HBSM also provides information on the financial impact of programs to expand coverage for state, federal and local governments. It provides estimates of how these policies may affect employer costs by firm size and industry, as well. Finally, it provides estimates of the impact of these reforms on household health spending by income, age and several other population groups.

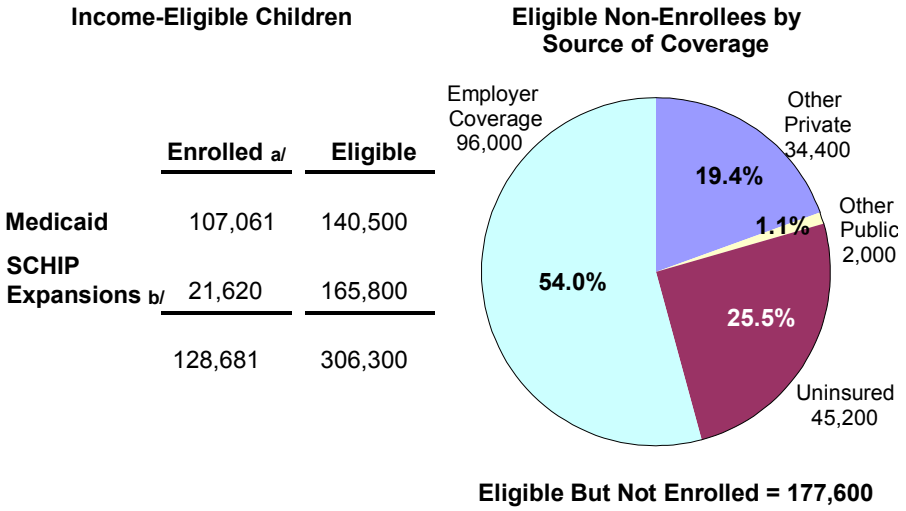
B. Expanding Coverage for Children Under Medicaid/hawk-i

Children up to 19 years of age living below 200 percent of the FPL.[30] are eligible for coverage under Iowa's Medicaid/hawk-i program. Children with incomes up to 133 percent of the FLP are enrolled in the Medicaid program. For these children, the state's Medicaid benefits

package is available at no charge to the family. Children with incomes between 134 percent and 200 percent of the FPL are covered under a separate program known as Healthy and Well Kids in Iowa, or "hawk-i," which has its own benefits package and premium contribution requirements.[31]

There are about 128,681 children enrolled in Iowa's Medicaid and hawk-i programs. This includes about 107,061 children in traditional Medicaid, and about 21,620 covered under the SCHIP Program which includes the Medicaid expansion children and hawk-i.[32] (***Figure 45***). However, many of those who are eligible do not enroll in these programs. Using the models and data described above, we estimate that there are a total of about 306,300 children who are eligible for coverage under one of these programs, of whom about 177,600 are not enrolled.

Figure 45
Children Eligible for Medicaid/ hawk-i by Coverage Status



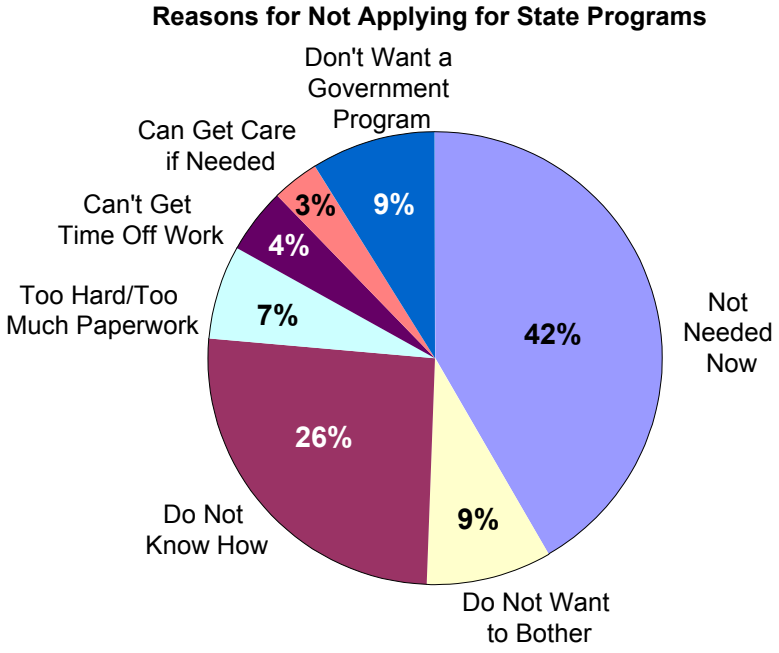
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).
a/ Enrollment as of September 2001.
b/ Includes hawk-i and Medicaid expansion for children reimbursed at the enhanced SCHIP matching rate.

Most of these eligible but not enrolled children have health coverage from some other source. About 130,400 of the 177,600 eligible but not enrolled children have coverage through a parent's employer-sponsored health plan or some other form of private coverage. Thus, only about 45,200 (25.5%) of the eligible but not enrolled group is actually uninsured. These

estimates underscore the importance of parents' job-based health insurance in assuring coverage of low-income children.

It is unclear why parents of eligible children do not enroll in the Medicaid or hawk-i programs. As discussed above, about 19 percent of persons in Lewin's survey of Iowa's uninsured population indicated that they thought that they would be eligible for coverage under the Medicaid/hawk-i program but have not enrolled. Of these, about 42 percent indicated that they did not need the coverage (***Figure 46***). Another 26 percent said they didn't know how to get coverage under Medicaid or hawk-i. About 9 percent of respondents indicated that they did not want to bother, and 3 percent said that they could get care when needed. Another 9 percent felt that they did not want to get involved in a government program.

Figure 46
About 19 Percent of the Uninsured Believe They Would Be Eligible for Medicaid or hawk-i, But Have Not Applied [a/]



a/ Includes only those persons that gave one of the reasons listed; all other responses were excluded.
Source: Lewin Group survey of 1,500 uninsured persons in Iowa, conducted by Baselice & Associates, Inc. (Winter 2001).

These data reveal some public misunderstanding of the program. For example, about 33 percent of these respondents indicated that they either did not know how to apply or felt that there was too much paperwork in the application process. Another 4 percent indicated that they

could not take time from work to apply. However, the state has already implemented changes that should streamline the enrollment process including a simplified application form (reduced to 2 pages), and a mail-in application process that should help those who feel that they can not leave work to apply. Expanded outreach could help parents better understand what is required to enroll.

The state has implemented a number of initiatives designed to increase enrollment of children (***Figure 47***). As discussed above, the state has streamlined the enrollment process by reducing the application form to two pages and permitting mail-in applications. Participants are also approved for "12 months continuous eligibility" (in hawk-i) rather than the six months allowed in some other states, which is designed to keep children in the program longer. The state also conducts a number of outreach activities through schools, child-care organizations and employers.

Figure 47
Strategies to Increase Enrollment

Current Initiatives in Iowa

- 12-month certification in hawk-i
- Participation in back-to-school "fairs"
- Through school-based nursing
- Outreach through child care
- hawk-i conference
  - Social workers
  - Community action physician
  - Physician office
- Plant layoff presentations
- Relationship with insurance brokers
- Two-page form
- Mail-in application

Potential Initiatives

- Eliminate the six-month waiting period for privately insured
- Eliminate premium ($10 per month for incomes greater than 150% of FPL)
- Streamline Medicaid/hawk-i transitions (i.e., seamless processing)
- Expand efforts in rural areas
- Increase Medicaid certification for children from the current six months to twelve months as under hawk-i

There are additional changes to hawk-i which could be made that would increase enrollment. For example, the state could eliminate the premium requirement for children living above 150 percent of the FPL. The premium for these families is equal to $10 per month up to a maximum of $20 per family. The available research indicates that participation is reduced by about one-third in cases where a premium is required, even where the premium is as low as $10 per month. Thus, eliminating the premium could result in a substantial increase in enrollment in Iowa's hawk-i program.

The federal government has relaxed its original requirements to limit "crowd out" in the Children's Health Insurance Program (hawk-i) for persons living below 200 percent of the FPL. Thus, Iowa could eliminate the six month waiting period requirement, which is designed to prevent privately insured persons from dropping their private coverage to enroll in the publicly subsidized plan. However, while this could increase enrollment, it would also increase the potential for crowd-out. Crowd-out is a concern among some policymakers who worry that lower-income families may drop their employment-based insurance for public coverage (through Medicaid or hawk-i) because of its lower cost and extensive benefits.

Because of the importance of assuring primary and preventative health services to children and reducing out-of-pocket costs for these services, many public health and children's advocates believe that all children should have health coverage. One approach to increasing coverage would be to require all parents to obtain insurance for their children as a pre-condition to enrolling in school. This would have the effect of increasing coverage among school-age children. It would also result in some increase in coverage for pre-school while addressing the requirement for their school-age children. For example, Medicaid coverage is provided to all children in eligible families and employer health plans typically include all children in the family under their family coverage policies. Such a requirement would also result in a substantial increase in enrollment in the Medicaid and hawk-i programs, as parents would enroll currently uninsured children in order for the children to enter school.

As discussed elsewhere in this report, there are about 77,000 uninsured children in Iowa, of which about 47,000 are eligible for Medicaid/hawk-i but are not enrolled. Under a children's coverage mandate, about 58,000 of the 77,000 uninsured children would become covered leaving

about 19,000 children uninsured. Remaining uninsured children would include those who are pre-school aged and have no older siblings. (***Figure 48***).

Figure 48
The Impact of Requiring All Children to Have Health Insurance as a Precondition to Enrolling in School

	Newly Covered Children	Total Costs (in thousands)	State Costs (in thousands)
Medicaid/SCHIP Eligible Children			
Medicaid Eligible			
School-age Children	8,838	$11,809	$4,408.3
Younger Siblings	1,658	$1,923	$717.9
Total	**10,496**	**$13,732**	**$5,126.2**
SCHIP Eligible			
School-age Children	26,406	$35,587	$9,298.9
Younger Siblings	2,443	$2,833	$740.3
Total	**28,849**	**$38,420**	**$10,039.2**
Total Medicaid/SCHIP Children	**39,345**	**$52,152**	**$15,165.4**
Non-Medicaid/SCHIP Eligible Children			
Non-Medicaid/SCHIP Eligible Children	**18,664**	**- -**	**- -**
TOTAL PROGRAM	**58,009**	**$52,152**	**$15,165.4**
Children Who Remain Uninsured	**18,991**		

a/ There are currently an average of about 77,000 children per month who are uninsured.
Source: Lewin Group estimates.

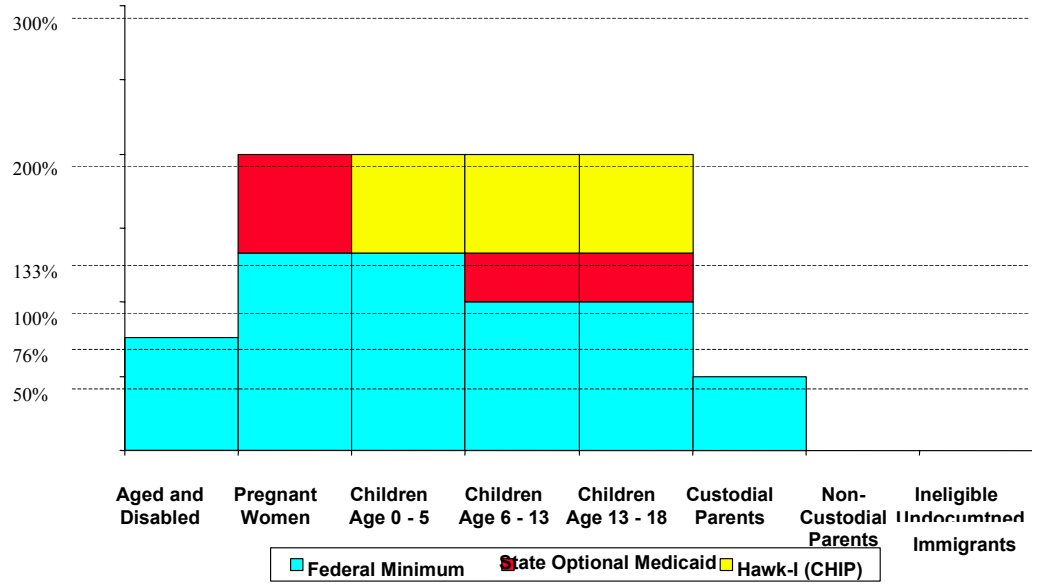
Of the 58,000 children who become covered, about 39,300 would be covered under either Medicaid or hawk-i. The total cost of this increase in coverage would be about $52.1 million, of which about $37.0 million would be paid by the federal government. The state's share of spending would be about $15.2 million.

C. Expanding Medicaid Eligibility for Adults

While the state has extended eligibility to 200 percent of the FPL for pregnant women and children, eligibility for adults has remained quite limited (***Figure 49***).[33] The income eligibility level for aged and disabled adults is 76 percent of the FPL (92% for married couples). Parents living with children are also eligible for coverage only if their income is less than about 50 percent of the FPL (i.e., TANF eligibility level).[34] Moreover, non-disabled adults who do not

live with children (i.e., non-custodial adults) are not eligible for the program regardless of their income.

Figure 49
Summary of Income Eligibility Levels as a Percentage of the Federal Poverty Level Under the Iowa Medicaid/SCHIP Program



1. Expanding Coverage for Adults

Under section 1931 (b) of the Social Security Act, states have the option to increase the Medicaid income eligibility level for parents to match the maximum income level at which children are eligible for Medicaid/hawk-i. For these newly eligible adults, Iowa would receive federal matching funds at the states standard Medicaid matching rate of about 63 percent.[35] For non-custodial adults, Iowa could also implement a program through the state's existing Medicaid program, but without federal matching funds. (federal matching funds could be made available if expansions took place through a 1115 waiver.)

In the first set of options Lewin analyzed, we estimated the impact of expanding coverage to adults to various income levels. We estimated coverage and cost impacts under the following Medicaid expansion options:

Cover custodial parents below 100 percent of the FPL;

- Cover parents below 150 percent of the FPL;

- Cover parents below 200 percent of the FPL;

Cover non-custodial adults below the medically needy level (i.e., the current eligibility level for parents, which is about 50% of the FPL);

- Cover non-custodial adults below 100 percent of the FPL;
- Cover non-custodial adults below 150 percent of the FPL;
- Cover non-custodial adults below 200 percent of the FPL.

Using the methods described above, we estimate that 342,800 adults would become eligible for coverage if eligibility were increased to 200 percent of the FPL for all adults (***Figure 50***). Based upon historical data on enrollment patterns under such public programs, we estimate that about 170,100 of these adults would enroll. In addition, in the course of screening adults for eligibility, we estimate that about 15,900 children who are currently eligible but not enrolled would become covered, including children whose parents do not pursue enrollment for their children until they are motivated to apply for themselves or as a family unit.

Overall, an estimated 186,000 people would become enrolled in Medicaid or hawk-i. Of these, 103,700 (56%) would be non-custodial adults. About 66,400 (36%) would be parents. Another 15,900 (9%) would be children who are already eligible for the program. However, of the 186,000 persons who would enroll, an estimated 107,400 (58%) would be persons who otherwise would be uninsured. The remaining 78,600 (42%) would be persons who otherwise would have been covered under a private employer health plan.

Expanding coverage for adults to 200 percent of the FPL would cost about $506.5 million ***(Figure 50)***. This is an estimated cost for this population of about $237 per member per month (PMPM). Of this the state would be responsible for $380.3 million.[36] The federal share for the parents and children would be $104.4 million. However, as discussed above, there would be no federal match for coverage of non-custodial adults, leaving the state to pay the whole cost for this particular segment of the population.

Figure 50
Coverage and Cost Impacts of Selected Expansions in the Iowa Medicaid/SCHIP Program: Medicaid Benefits Package with No Premium [a/]

Eligibility	Newly Eligible Persons (in thousands)	Newly Enrolled Persons [b/] (in thousands)	Newly Insured Enrollees (in thousands)	Benefits Costs (in millions)	State Share of Costs (in millions)
Below 50%					
Children	- -	- -	- -	- -	- -
Parents	- -	- -	- -	- -	- -
Non-custodial adults	44.7	22.6	18.5	$63.3	$63.3
Total	**44.7**	**22.6**	**18.5**	**$63.3**	**$63.3**
Below 100%					
Children [c/]	- -	3.6	3.6	$5.6	$2.1
Parents	26.4	13.3	6.9	$38.2	$14.3
Non-custodial adults	74.7	37.2	30.2	$97.0	$97.0
Total	**101.1**	**54.1**	**40.7**	**$140.8**	**$113.4**
Below 150%					
Children [c/]	- -	10.1	10.1	$14.2	$4.3
Parents	72.9	32.4	16.7	$88.2	$32.9
Non-custodial adults	135.4	69.6	50.4	$197.9	$197.9
Total	**208.3**	**112.1**	**77.2**	**$300.3**	**$235.1**
Below 200%					
Children [c/]	- -	15.9	15.9	$21.8	$6.3
Parents	140.8	66.4	25.1	$176.4	$65.7
Non-custodial adults	202.0	103.7	66.4	$308.3	$308.3
Total	**342.8**	**186.0**	**107.4**	**$506.5**	**$380.3**

a/ Assumes Medicaid benefits package with no premium requirement
b/ The number of new enrollees who otherwise would have been uninsured.
c/ Some children who are now eligible but not enrolled in Medicaid/SCHIP would become covered as parents become insured.
Source: Lewin Group estimates using the Iowa version of the Health Benefits Simulation Model (HBSM).

2. Use of an Alternative Benefits Package

The estimates presented in ***Figure 50*** assume that all enrollees would be covered under the state's Medicaid benefits package. Medicaid is considered a comprehensive benefits package that covers services not typically included in the scope of private health insurance benefits. Such Medicaid benefits may include early and periodic screening, diagnosis, and follow-up treatment for children and teens; care for the developmentally disabled, mentally retarded, and mentally ill; dental and optical services; nursing facilities; and ambulance services. In addition to a wide scope of health benefits, Medicaid generally does not require point-of-service cost sharing such as deductibles and co-payments.

An alternative approach to covering the low-income uninsured would be to provide them with a benefits package that is more typical of the types of health plans that many Iowa workers have through their employers. For illustrative purposes, we used the benefits package offered to state employees under the Blue Cross/Blue Shield Wellmark plan. We estimate that the cost of this package for the newly eligible population would be about $207 per member per month (PMPM), which represents a savings of about 13 percent from the estimated PMPM cost for this population under the usual Medicaid benefits package (i.e., $237 PMPM).

The total cost of insuring low-income Iowans would be $442.0 million under the Wellmark benefits package, which compares to a total cost of $506.5 million under the Medicaid benefits package (***Figure 51)***. The state share of program costs would drop to $332.1 million with the Wellmark benefits package from $380.3 million with the Medicaid benefits package.

The Department of Health and Human Services Secretary Tommy G. Thompson announced on August 4, 2001 a plan to allow states greater flexibility in setting benefits packages for Medicaid expansion groups. Under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, states can apply for a Section 1115 waiver in which the state would have the option of adopting less comprehensive benefits packages for optional and expansion Medicaid population groups in the state.[37] These groups could include uninsured persons not covered under the Medicaid or SCHIP State Plan. The savings from adopting less comprehensive benefits packages would then be available together with the state's unused SCHIP allotment to extend coverage to groups that are currently ineligible for Medicaid coverage, such as non-custodial adults.

Under the HIFA initiatives, states will be given flexibility for altering cost-sharing requirements for optional and expansion populations. In addition, Medicaid benefits for optional eligibility groups can be reduced to levels comparable to selected "benchmark" health plans in the area such as the state employees' health plan or the largest HMO in the area (which is similar to SCHIP rules). Optional eligibility groups include children above mandatory income levels, children covered under SCHIP, and parents above the TANF income eligibility levels. States would have even greater freedom in setting the benefits package for the expansion population

(e.g., non-custodial adults). However, states would be required to provide the Medicaid benefits package to mandatory eligible groups.[38]

While this approach would permit Iowa to use its unspent SCHIP allotment, the opportunities for savings in the current program may be small. This is because it would be difficult to restructure Medicaid service delivery and benefits in Iowa, a state with limited managed care penetration and minimal excess in its provider capacity. In addition, the Iowa Medicaid program currently covers few optional groups. Finally, reducing expensive Medicaid benefits (such as for the medically needy) to generate sufficient savings that could be applied to the uninsured is a substantial challenge for most states, including Iowa.

3. The Impact of a Premium Requirement

The coverage expansion for adults through Medicaid could be funded in part with an enrollee premium requirement. This would reduce program costs by partially offsetting benefits costs with member premium contributions. However, the premium would also discourage some individuals from enrolling, resulting in lower enrollment and an associated reduction in costs. To illustrate, we assumed that coverage is expanded to 200 percent of the FPL for all adults, with persons above 150 percent of the FPL paying a premium on a sliding scale with income up to a maximum of 5 percent of family income.

Under this premium contribution scenario, the number of persons enrolling in the program would decline from about 186,000 persons to 154,700 persons ***(Figure 51)***. This estimate is based upon numerous historical data that show how enrollment varies with the amount of the premium contribution. (Enrollment drops as premium contribution requirements rise.) However, most of the decline in enrollment would be among persons who currently have coverage from another source (i.e., the “crowd out” population). About 93,800 uninsured persons would obtain coverage under this scenario compared with 107,400 persons if no premium was required.

Figure 51
Cost of Extending Medicaid Coverage to All Persons Below 200 Percent of the FPL Under Alternative Benefits Packages and Premium Requirements

	Medicaid Benefits		PPO Benefits [b/]	
	Without Premium	With Premium [a/]	Without Premium	With Premium [c/]
Program Participants (in thousands)	186.0	154.7	186.0	155.6
Newly Covered (in thousands)	107.4	93.8	107.4	94.3
Benefits Cost (in millions)	$506.5	$422.4	$442.0	$371.0
State Share of Cost (in millions)	**$380.3**	**$308.2**	**$332.1**	**$269.4**

a/ Assumes a cost-based premium for persons above 150 percent of the FPL on a sliding scale with income up to $237 per month with the premium capped not to exceed 5 percent of income.
b/ Based upon the Wellmark benefits package offered to Iowa state employees.
c/ Assumes a cost-based premium for persons above 150 percent of the FPL on a sliding scale with income up to $207 per month with the premium capped not to exceed 5 percent of income.
Source: Lewin Group estimates using the Iowa version of the Health Benefits Simulation Model (HBSM).

Total program costs to the state would drop from $380.3 million without the premium requirement (i.e., with the Medicaid benefits package), to $308.2 million with the premium requirement. If a premium requirement were implemented under a program using the Wellmark benefits package, state costs would drop to $269.4 million.

D. Programs to Assist Families in Purchasing Private Coverage

Congress has been considering proposals that would provide assistance to individuals purchasing coverage in the non-group market. Under current law, the amount spent by employers to provide health benefits is not taxable to the employee even though this is a form of income to the worker. This is a substantial tax subsidy to those receiving coverage from their employer which equals an average of about $2,000 per worker family. However, individuals who do not have access to employer-sponsored health insurance who must purchase non-group coverage on their own receive no tax benefits. Some consider this to be a substantial inequity in the tax code. When it comes to maximizing the number of covered individuals in a state it can be argued that this subsidy, paid for with forgone tax revenues, leaves uninsured individuals not currently

eligible for public benefits, in a less subsidized position than their employer-insured, and often more highly compensated peers. In addition, those without employer provided health insurance must seek coverage in the non-group market where policies are at a premium over those in the group market.

1. Tax Credit for Purchasers of Non-Group Coverage

There are several federal proposals that would provide a tax credit to persons purchasing non-group coverage. The tax credit is designed to both encourage these individuals to purchase coverage, and to promote equitable tax policy. To illustrate the impact of such a program, we analyzed an illustrative tax credit typical of those being considered by Congress and the Administration in the summer of 2001. The tax credit would be available to persons purchasing non-group coverage and who do not have access to employer provided coverage. The credit would be limited to persons with incomes below 300 percent of the FPL.

In this illustration, the tax credit would equal specified dollar amounts, such as $1,000 for single individuals and $2,000 for families. The credit would be capped at the amount actually spent on health insurance by the taxpayer. However, the credit would be "refundable," which means the amount of the credit can exceed the amount owed in taxes during a year. This assures that persons with too little income to be required to pay income taxes could receive the full amount of the credit. In addition, we assume that the tax credit is phased out on a sliding scale with income for persons with incomes between 200 percent and 300 percent of the FPL. We analyzed three credit amount scenarios including:

- Credit amount of: $750 for individuals, and $1,500 for families;
- Credit amount of: $1,000 for individuals, and $2,000 for families;
- Credit amount of: $1,250 for individuals, and $2,500 for families.

We estimate that there would be about 363,800 persons in Iowa families that qualify for the credit (***Figure 52***). These include persons without access to employer sponsored health insurance who are living below 300 percent of the FPL. (In 2001, the FPL for a family of three was $14,630. Of these, about 145,000 persons are currently purchasing non-group coverage and about 218,800 persons are currently uninsured. In this analysis, we assume that all eligible

persons who are currently purchasing non-group coverage (145,000) would receive the credit. We also estimate that up to 79,000 of all eligible uninsured persons (219,000) would be induced to purchase coverage with the help of the credit. Thus, the impact of offering a tax credit to individuals and families would reduce the number of uninsured persons by 79,200 in Iowa.

Figure 52
Cost and Coverage Impacts of a Tax Credit for Individuals Purchasing Non-Group Coverage

	Eligible (in thousands)	Enroll (in thousands)	Newly Covered (in thousands)	Total Cost (in millions)	Cost per Enrollee	Cost per Newly Covered Person
$750/$1,500						
Currently Insured	145.0	145.0	- -	$76.3	$526	
Uninsured	218.8	49.7	49.7	$32.0	$643	
Total	**363.8**	**194.7**	**49.7**	**$108.3**	**$556**	**$2,179**
$1,000/$2,000						
Currently Insured	145.0	145.0	- -	$101.5	$700	
Uninsured	218.8	58.4	58.4	$51.0	$873	
Total	**363.8**	**203.4**	**58.4**	**$152.5**	**$750**	**$2,611**
$1,250/$2,500						
Currently Insured	145.0	145.0	- -	$126.9	$875	
Uninsured	218.8	79.2	79.2	$84.1	$1,061	
Total	**363.8**	**224.2**	**79.2**	**$211.0**	**$941**	**$2,664**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The number of uninsured persons who would become covered will vary with the amount of the credit. For example, with a credit amount of $750 for individuals and $1,500 for families, about 49,700 uninsured persons would purchase coverage. When the credit is increased to $1,250 for individuals and $2,500 for families, about 79,200 uninsured persons would become covered.

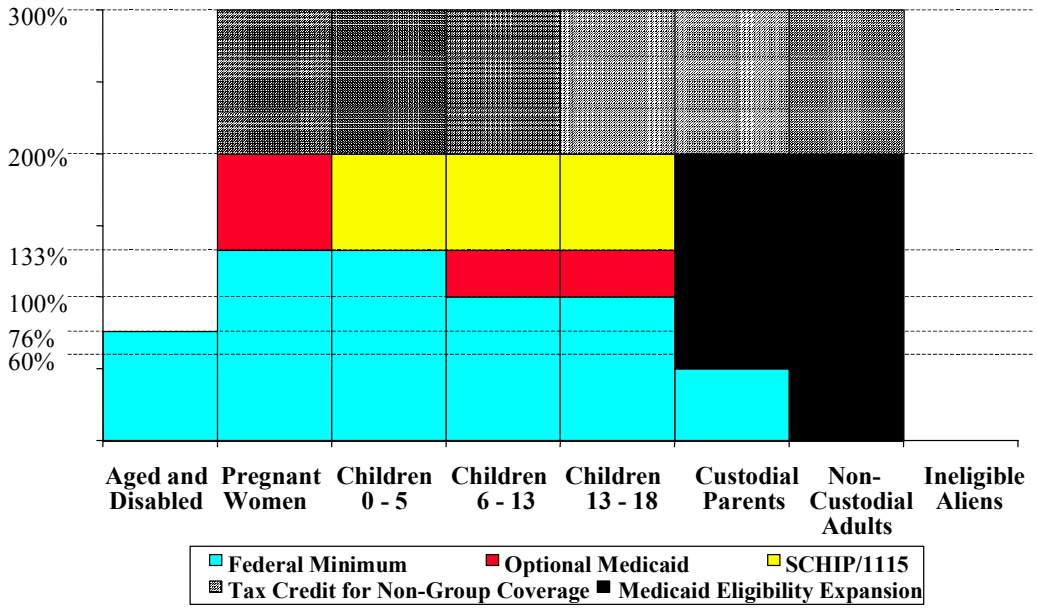
It is important to note that the increase in coverage not-withstanding, most of the tax credit dollars would go to persons who already have coverage. For example, under the $1,250/$2,500 tax credit scenario, total tax credit payments would be $211.0 million, of which, $126.9 million would go to persons who are already purchasing coverage under current tax law.

2. A Combined Medicaid/Tax Credit Program

The tax credit model could be implemented together with one of the Medicaid/hawk-i expansions discussed above. To illustrate, we analyzed a scenario where

Medicaid eligibility for both parents and non-custodial adults would be extended to 200 percent of the FPL (***Figure 53***). The expansion in eligibility would be supplemented with a tax credit for persons with incomes between 200 percent and 300 percent of the FPL. For illustrative purposes, we assume that the tax credit would be equal to $1,250 for individuals and $2,500 for families, and the credit amount phased-out on a sliding scale for income between 200 percent and 300 percent of the FPL.

Figure 53
Summary of Income Eligibility Levels with a Medicaid/SCHIP Expansion and an Illustrative Tax Credit for Non-Group Coverage



Under this combined program, about 306,000 persons would be in families that either receive the credit or become enrolled in the Medicaid/hawk-i program. This program would reduce the number of uninsured by about 136,000 persons, which would be a 53 percent reduction in the number of uninsured persons in the state (currently about 258,000 persons). The combined cost of the program would be about $573.9 million. The state cost net of any federal matching funds would be $447.7 million (***Figure 54***).

E. Provide Short-term Insurance Coverage to the Unemployed

One approach to helping working families is to provide insurance coverage to workers during periods of unemployment. To illustrate the potential impact of such a policy, we

estimated the cost of providing health insurance to claimants for unemployment insurance for the duration that they receive unemployment compensation. We assume that the benefits package would be modeled on the Wellmark benefits package available to state employees. There would be no premium payment requirement for these individuals and their families while unemployed.

Figure 54
Combined Impact of a Medicaid Expansion with a Tax Credit for Non-Group Coverage

	Medicaid Expansion Only [a/]	Tax Credit Only [b/]	Medicaid Expansion with Tax Credit
Program Participants (in thousands)	186.0	224.2	306.4
Newly Covered (in thousands)	107.4	79.2	135.9
Benefits Cost (in millions)	$506.5	$211.0	$573.9
State Share of Cost (in millions)	**$380.3**	**$211.0**	**$447.7**

a/ Assumes Medicaid eligibility is increased to 200 percent of the FPL for parents and non-custodial adults with the Medicaid benefits package without a premium contribution requirement.
b/ Assumes a refundable tax credit for non-group coverage equal to $1,250.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Iowa is a state with a low insurance rate. During 2000, the Iowa Unemployment Insurance Services program paid about $220.7 million in unemployment insurance claims to about 105,100 persons (***Figure 55***). The average period receiving benefits was 9.23 weeks (2.13 months). Under this policy scenario, (health coverage for the unemployed) these individuals would be provided with the Wellmark health insurance benefits for the duration of their unemployment period.

For illustrative purposes, we assume that the premium for this coverage would be the same as it is for this plan under the state employees health benefits program. This is a premium of about $199 per month for single coverage and $478 per month for family coverage. However,

a more detailed actuarial analysis of the unemployed population would be required to set an appropriate premium.

Based upon these assumptions, we estimate that the program would cost about $77.1 million in 2000. This would be a 35 percent increase in total costs to the unemployment insurance program, resulting in a corresponding increase in employer payments to the unemployment fund. The program would reduce the number of uninsured by about 24,000 persons. This includes the workers and their family dependents.[39]

Figure 55
Providing Health Insurance to Unemployed Workers and Their Families Through the Unemployment Insurance Program

	Iowa Program Characteristics
Current Iowa Unemployment Insurance Program	
Benefits in 2000	$220.7 million
Total Claimants in 2000	105,114 Persons
Average Period Receiving Benefits	2.13 Months (9.23 weeks)
Cost of Providing Health Insurance While Uninsured	
Monthly Premiums (Wellpoint PPO for State Employees)	$199 Single $478 Family
Reduction in Uninsured	24,000 Persons
Total Program Cost[a/]	$77.1 million

a/ Bureau of the Census data on health coverage in Iowa indicate that 48 percent of covered workers take single coverage while 52 percent take family coverage.
Source: Lewin Group estimates.

F. Subsidies to Help Employers Purchase Coverage for their Workers

Another approach to expanding coverage would be to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not currently providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the employer's expenditures for employee health benefits (e.g., 25 to 40%).[40]

To illustrate the potential impact of this approach, we estimated the coverage and cost impacts of an employer tax credit (for employee health coverage) that is targeted towards small employers with low-wage workers. Eligibility would be restricted to: (1) firms that have not provided coverage for at least 12 months; and (2) firms with an average payroll below the average for small firms in the state. These firms would receive these tax credits for a period of three to five years as long as the firm continues to meet the firm size and average payroll eligibility criteria. (The dollar amount of the credit could also be phased-out with percentage reductions each year over the three to five year period.)

In our first scenario, we assume that the credit is limited to only firms with 10 or fewer workers. The amount of the credit is assumed to be equal to 25 percent of the employer's expenditures for health benefits. We also estimated the impact of alternative scenarios of eligibility by firm size and tax credit amounts including:

- Firms with 10 or fewer workers - 25 percent credit;
- Firms with 10 or fewer workers - 40 percent credit;
- Firms with 25 or fewer workers - 25 percent credit;
- Firms with 25 or fewer workers - 40 percent credit.

We estimate that there are about 150,000 workers and dependents in firms with 10 or fewer workers in Iowa that would be eligible for the credit (***Figure 56***). These include firms with under 10 workers who have not offered insurance for 12 or more months that also have an average payroll per worker (i.e., full-time equivalent worker) that is less than the average for firms of this size. Of these 150,000 workers and dependents, about 120,400 are currently uninsured, while about 29,500 already have insurance from some other source (i.e., on-group coverage, dependent of working spouse with employer coverage, etc.).

Figure 56
Cost and Coverage Impacts of Tax Credits for Small Employers with Low-wage Workers in Iowa

	Eligible (in thousands)	Enroll (in thousands)	Newly Covered (in thousands)	Total Cost (in millions)	Cost per Enrollee	Cost per Newly Covered Person
10 Or Fewer Workers						
25% Credit						
Currently Insured	29.5	7.0	- -	$2.9	$421	
Uninsured	120.4	32.6	32.6	$14.0	$430	
Total	**149.9**	**39.6**	**32.6**	**$16.9**	**$427**	**$518**
40% Credit						
Currently Insured	29.5	10.1	- -	$6.8	$673	
Uninsured	120.4	47.2	47.2	$32.6	$690	
Total	**149.9**	**57.3**	**47.2**	**$39.4**	**$688**	**$835**
25 Or Fewer Workers						
25% Credit						
Currently Insured	41.2	9.8	- -	$3.9	$397	
Uninsured	139.7	38.0	38.0	$15.5	$407	
Total	**180.9**	**47.8**	**38.0**	**$19.4**	**$406**	**$511**
40% Credit						
Currently Insured	41.2	14.3	- -	$9.1	$635	
Uninsured	139.7	55.8	55.8	$36.3	$651	
Total	**180.9**	**70.1**	**55.8**	**$45.4**	**$648**	**$814**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Assuming the credit is equal to 25 percent of employer costs, we estimate that about 39,600 workers and dependents are in firms that would be induced to obtain coverage. Of these, 32,600 would be persons who otherwise would be uninsured. The total cost of the credit in the form of forgone revenue to the state would be $16.9 million.

The state could increase the number of firms that would potentially be induced to offer coverage by increasing the credit. For example, increasing the amount of the credit to 40 percent of the employer's health benefits costs would increase the number of uninsured persons who become covered to 47,200 persons at a total cost of about $39.4 million. In addition, extending the 40 percent tax credit to all firms with under 25 workers (i.e., and who meet the average salary requirement) would cover about 55,800 persons at a total cost to the state of $45.4 million (***Figure 56***).

G. Create Low-cost Health Insurance Coverage Options

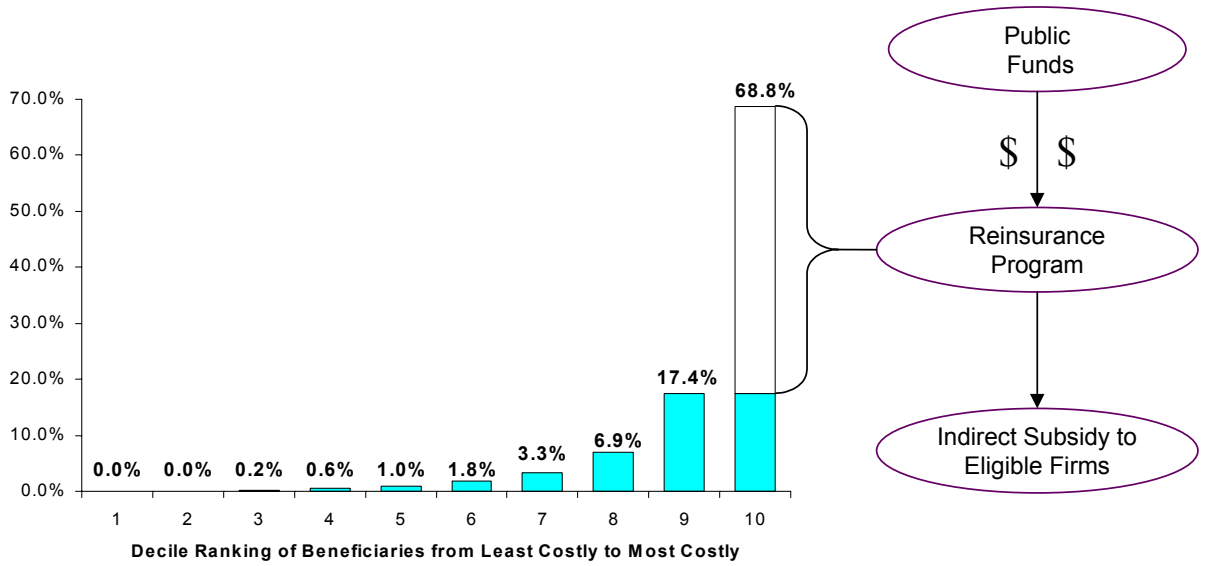
The state could also expand coverage by subsidizing the cost of a low-cost health insurance product for employers who currently do not provide coverage. In this analysis, we

examined the potential impact of creating an Iowa program modeled on the "Healthy New York" program recently implemented in New York State. This program allows lower income individuals and employers with lower-wage workers to purchase a private health plan that does not include certain state mandated benefits. In the "Healthy New York" program, the state also effectively subsidizes premiums for eligible employers and individuals in these plans through a modified reinsurance system.

The state subsidy is provided through a reinsurance mechanism that pays a substantial percentage of health benefits costs for high-cost cases among the eligible individuals and employers who purchase such a health plan. As shown in ***Figure 57***, about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. Under Healthy New York, the state financed reinsurance program pays 90 percent of costs in excess of $30,000 for each person covered under these plans up to a maximum covered amount of $100,000 per member. The subsidy cost of this reinsurance is paid through trust funds established for this purpose using New York's tobacco settlement receipts. This reinsurance mechanism will control the cost of coverage in these plans which will result in lower premiums.

Figure 57

Subsidized Insurance for Small Groups Through State-funded Reinsurance



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

It is estimated that premiums under the program will be reduced by about 15 to 20 percent. About half of this amount is attributed to the elimination of mandated benefits, with the other half attributed to the reinsurance subsidy. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program, which was implemented in New York in January 2001, currently has about 3,000 members.

In this analysis, we estimated the impact of adopting a similar program in Iowa using the eligibility criteria used in the "Healthy New York" program. Self-employed persons and other individuals would be eligible if they have been uninsured for 12 or more months and their income is less than 250 percent of the FPL. Eligibility for employers is limited to firms meeting the following criteria:

- Firms with 50 or fewer workers;
- At least half of employees enroll in the plan;
- Have not offered coverage in 12 or more months;
- Less than 30 percent of employees are earning over $30,000; and
- The employer pays half of the premium.

This program would have less of an impact on premiums in Iowa than it will in New York. This is because Iowa, unlike New York, has relatively few benefit mandates. Thus, only the reinsurance subsidy would have a significant impact on premium. For purposes of developing estimates for Iowa, we assume that the program would reduce premiums for participating firms and individuals by about 10 percent if the same reinsurance mechanism were used.

We estimate that in response to these premium reductions, about 11,000 persons would take up coverage under these subsidized health plans. This includes both individuals and persons in firms that are induced to purchase this subsidized coverage (***Figure 58***). Of these, nearly all would be persons who otherwise would have been uninsured (10,125 persons). The total cost to the state of the reinsurance program would be $2.9 million.

Figure 58
Coverage and Costs under the Low-cost Coverage Options [a/]

	Persons in Firms with Fewer than 50 Workers	Individuals Below 250 Percent of FPL	Total Program
Number Enrolled	6,915	4,089	11,004
Newly Insured	6,036	4,089	10,125
Reinsurance Program Costs (in thousands)	$1.8 million	$1.1 million	$2.9 million

a/ Estimates apply to a reinsurance program for small firms and low-income individuals, which effectively reduces the cost of insurance to individuals.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

H. Pooling Small Businesses with the State Employees Health Plan

Several states have considered forming purchasing pools composed of small businesses and state employees. Various types of pooled purchasing models are also in use in other states. The purpose of these purchasing pools is to:

- Aggregate purchasing power to negotiate lower prices with providers;
- Increase small group coverage by reducing premiums;
- Reduce administrative costs through a common administrative mechanism; and
- To provide employees with a choice of alternative health plans.

The available research indicates that purchasing pools have had little positive impact on the cost of coverage and have not effectively increased coverage overall. However, these pools have been shown to provide greater choice of health plan alternatives to workers in small firms.

1. Experience with Purchasing Pools

Experience with purchasing pools in other states indicates that aggregating purchasing power reduces costs only in areas where there is substantial competition among providers. Under these models, the purchasing pool represents a block of business that can

negotiate lower provider payments under what are called "selective contracting" agreements. Under these agreements, the pool agrees to channel their full volume of members to a given provider network in exchange for lower reimbursement rates.

For example, in large metropolitan areas with several hospitals competing for patient volume, the hospitals often will negotiate substantial price discounts to secure the volume of business represented by a sizable purchasing pool. The key to this model is the credibility of the threat of losing volume to a lower bidder. Conversely, in an area with few competing providers, each provider has a certain degree of monopoly control in the market. This substantially lessens the incentive to negotiate.

Unfortunately, the Iowa health care market is not highly competitive. Much of the state is rural, with long distances between hospitals and other providers. Most of the urbanized areas of the state are small (under 130,000 persons) and offer only limited provider competition. There is some managed care penetration in the Des Moines area and some other parts of the state. However, in Iowa, the managed care plans use relatively loose provider networks with few restrictions on access. Thus, small employer purchasing pools are likely to have little impact on premiums and coverage.

Additionally, the experience of purchasing pools in other parts of the country indicates that these pools have had little success in reducing administrative costs. This is because insurers and the pool must still deal with each small employer individually, which eliminates the potential for savings through economies of scale. A recent study of small employer health care associations showed little administrative savings to participating employers.[41]

Moreover, a study of purchasing pools across the country showed that they have had little impact on costs and coverage. For example, studies indicate that premiums within the various purchasing pools were largely the same as for comparable coverage sold outside of the purchasing pool.[42] Savings were found only in the California purchasing pool, which operates in a very competitive health care market. Enrollment was generally low in these various pools and there was no increase in the number of employers offering coverage. However, the primary effect of these purchasing pools has been to provide workers with greater choice of health coverage options.

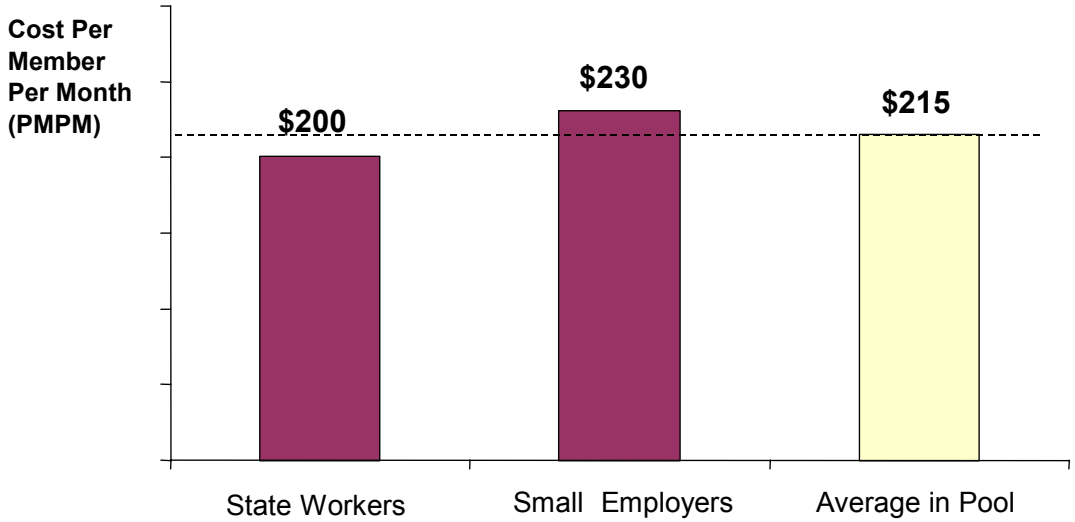
2. Rating in a Small Employer/State Worker Purchasing Pool

While purchasing pools have little overall impact on costs, the organization of a small employer/state worker purchasing pool could have significant impacts on costs for both the state government and small employers. For example, the employers who will tend to participate in the plan would be those who find that the cost of coverage under the pool is less than what they would have to pay for comparable private coverage outside of the pool. Because private insurer premiums are permitted to vary with age and experience (up to +/- 25%), the pool would tend to accumulate higher cost cases, which would increase the overall average costs per individual (i.e., PMPM). The higher cost of administering coverage for small groups would also increase PMPM costs in the pool.[43]

For example, the Wellmark PPO plan offered to state employees costs about $200 per month (PMPM) for single individuals (***Figure 59***). For illustrative purposes, assume that the average cost of coverage for small employers who opt into the pool is about $230 (i.e., it attracts higher cost cases). Assuming the number of small group participants is the same as the number of state worker participants, the overall average PMPM cost would be about $215.

If all employers (including the state) are required to pay the average premium of $215, costs for state workers would increase by about $15 PMPM ($215 - $200), resulting in about an eight percent increase in Iowa state expenditure for employee health benefits. Conversely, participating employers would save about $15 PMPM ($215 - $230). In this model, coverage for participating small businesses would in effect be cross-subsidized by the state through the increase in what the state pays to cover its own workers. This subsidy to small business would effectively reduce the cost of coverage for small groups resulting in some increase in coverage.

Figure 59
Illustration of the Impact of a Pool of State Workers and Small Employers on Premium



Source: An illustrative example prepared by The Lewin Group, Inc.

The alternative would be to "rate" (i.e., set the premium) the state workers and the small employers separately. Under this model, small businesses pay a premium equal to their costs, which in this example is $230 PMPM while the state would pay its own average cost of $200 PMPM. This would eliminate the increase in state employee costs resulting in no net change in what the state pays to cover its workers. However, without this cross-subsidy, pooling state employees with small employers will have little impact on costs and coverage. However, such a pool would give workers in small employer firms access to the range of coverage options (e.g., HMOs, PPOs etc.) that are now available to state workers.

I. A Combined Strategy

The state could adopt a combination of approaches that together extends coverage to most of the uninsured population. In this scenario we assume a combined strategy built upon several of the options discussed above. These programs would be funded with federal matched funds where available and an assessment of $10 per month on workers and an assessment on employers of $10 per worker each month. Under this combined strategy we would implement the following initiatives:

- Provide (short-term) insurance coverage to the unemployed through the unemployment insurance program. The program would be funded through increases in state unemployment insurance taxes.

- Expand income eligibility for Medicaid and SCHIP to cover all adults living below 200 percent of the FPL. This would include coverage for parents of children on Medicaid/hawk-i and non-custodial adults. We assume that the program will provide the "Wellmark-PPO" benefits package and that a small premium contribution would be required for newly eligible adults above 150 percent of the FPL.

- Provide refundable tax credits to employers of low-wage workers in small firms for the amount paid by the employer for coverage. Eligibility would be restricted to firms that have: (1) 25 or fewer workers; (2) not provided coverage for at least 12 months; and (3) an average payroll below the average for small firms in the state. For illustrative purposes, we assume that the credit amount is equal to 40 percent of the employer's share of the cost of coverage.

- Establish a health insurance purchasing pool composed of state employees and employers with 25 or fewer workers. The pool would be open to all Iowa firms with 25 or fewer workers regardless of worker income and without a waiting period. Thus, employers would be permitted to discontinue their current coverage to join the pool. We assume that small groups under the pool would be rated separately so the premium paid by small employers is equal to the average cost for small group members.

- Require that all children have health insurance as a precondition to enrolling in school. This would result in an increase in coverage though Medicaid and SCHIP, with an associated increase in costs for these programs.

Figure 60 presents our estimates of enrollment and costs for each option. Because some individuals would be eligible for more than one of these benefits, we assume that individuals would enroll in the program that represents the lowest cost alternative. Consequently, the cost of these options when implemented together will differ from our estimates of the impact of these options when implemented separately (presented above).

We estimate that if implemented together, there would be about 346,900 persons who would enroll in one of these programs. This would result in a reduction in the number of uninsured by about 206,000 persons, which would be roughly an 80 percent reduction in the state's currently uninsured population (258,000). Total program costs would be $504.2 million. The state's share of these costs after accounting for the Medicaid/hawk-i federal match would be $373.9 million.

As shown in ***Figure 60***, we estimate that the small group purchasing pool would not result in an increase in coverage. This is because the available evidence on purchasing pools indicates that they do little to lower costs, and have no impact on premiums unless they are in some way subsidized. Moreover, we have assumed that small group premiums in the pool would be set at a level sufficient to fully fund the cost of coverage for these groups. Thus, in the absence of subsidies, we estimate that pooling would result in little change in the number of insured persons. However, we do expect enrollment among employers seeking to offer workers a choice of health plans (about 8,900 persons).

Figure 60
Impact of Adopting a Combination of Policy Initiatives: With Mandatory Coverage of Children [a/]

	Public Program Participants (in thousands)	Newly Insured Persons (in thousands)	Public Program Benefits Costs [g/] (in millions)	State Share of Costs (in millions)
Coverage for the Unemployed [b/]	105.1	24.0	$77.1	$77.1
Expand Medicaid/Hawk-I Coverage to 200% of FPL [c/]	143.5	87.0	$341.0	$247.6
Employer Tax Credit for Firms With 25 or Fewer Workers (40% Credit) [d/]	52.5	41.8	$34.0	$34.0
Pool Small Businesses with State Workers [e/]	8.9	- -	- -	- -
Children's Coverage Mandate [f/]	36.9	53.5	$52.1	$15.2
Combined Total	**346.9**	**206.3**	**$504.2**	**$373.9**

a/ Individuals are assumed to enroll in the initiative that represents the lowest cost to the individual. Due to overlapping eligibility, estimates differ from the estimated impacts of these policies if implemented on their own.

b/ All uninsured persons wold be provided coverage for themselves and their families during the duration of their unemployment compensation claim without a premium contribution requirement for participants. Assumes the Wellmark PPO benefits package.

c/ Recipients would be covered under the Wellmark PPO benefits package and would be required to pay a premium not to exceed 5 percent of income.

d/ Assumes a tax credit is provided to firms with under 25 workers equal to 40 percent of the premium paid by the employer.

e/ Assumes that firms with 25 or fewer employees are permitted to purchase coverage through the State employees' health benefits program. We assume that participants would be required to pay a premium sufficient to cover the full cost of coverage for participating small employers. Because this would do little to reduce costs

for small employers, we estimate no increase in coverage. The primary effect of the program would be to provide a choice of alternative health plans to participants.
f/ Assumes that parents are required to cover children as a condition of enrolling in school.
g/ Includes the public cost of benefits less premiums received.
Source: Lewin Group estimates using the Iowa version of the Health Benefits Simulation Model (HBSM).

One of the main reasons why this combined approach has such an impact on the uninsured population is that it includes a mandate for children to have insurance. Without this mandate, the combined effect of these options would be to reduce the number of persons who become insured from 206,300 with the mandate to 152,800 without the mandate (***Figure 61***).

Figure 61
Impact of Adopting a Combination of Policy Alternatives With and Without Mandatory Coverage of Children

	With Children's Mandate	Without Children's Mandate
Public Program Participants (in thousands)	346.9	338.0
Newly Insured Persons (in thousands)	206.3	152.8
Public Program Benefits Costs (in millions)	$504.2	$452.1
State Share of Costs (in millions)	$373.9	$358.7

Source: Lewin Group estimates using the Iowa version of the Health Benefits Simulation Model (HBSM).

However, state costs under the combination scenario would be reduced by only about $15.2 million (i.e., from $373.9 million to $358.7 million). This reflects the fact that most of the children affected by this provision would be eligible for Medicaid or hawk-i where the federal match is equal to between 63 percent and 73 percent of program costs. Thus eliminating the mandate would have relatively little impact on state costs even though it would greatly reduce the number of persons who would become insured under the combine policy scenario.

As discussed above, the portion of costs under these programs that is not covered with federal matching funds would be funded with an assessment on workers and employers. The assessment would be equal to $10 per month for all workers plus and an assessment on employers of $10 per month. We estimate that revenue from these assessments would be about

$332 million per year. This would be equal to roughly 90 percent of the net state cost of implementing this combined approach as shown above in ***Figure 61***.

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[27] Sponsored by the U.S. Bureau of the Census.

[28] MEPS is sponsored by the Agency for Health Care Policy and Research. For more information about MEPS, see J. Cohen et al. , "The Medical Expenditure Panel Survey: A National Health Information Resource" (Winter 1996,1997): 373-380.

[29] L. Levitt, J. Gabel, et al. Employer Health Benefits 1999 Annual Survey. The Henry J. Kaiser Family Foundation and Health Research and Educational Trust.

[30] In 2001, 200 percent FPL was $35,300 for a family of four.

[31] The hawk-i program requires a premium of $10 per month per child up to $20 per month per family for eligible persons living above 150 percent of the FPL.

[32] The expansions in coverage under SCHIP were implemented in two steps. First, all children with incomes below 133 percent of the FPL are covered under Medicaid. Second, children between 133 percent and 200 percent of the FPL are covered under hawk-i.

[33] The program includes an earnings exclusion of 20 percent, which effectively increases eligibility to 240 percent of the FPL for children with working parents.

[34] The TANF income eligibility level is equal to the eligibility levels for adults prior to the TANF program (i.e., welfare reform).

[35] Under Medicaid, the federal government pays about 63 percent of the program costs under the traditional Medicaid program and about 73 percent of costs under the hawk-i program. Although children over age five between the FPL and 133 percent of the FPL are covered under Medicaid, costs for these children are matched at the enhanced matching rate (i.e., 73 percent).

[36] The federal matching rate is about 63 percent for Medicaid recipients and about 73 percent for persons covered under the SCHIP program. In Iowa, the enhanced matching rate also applies to children age 6 and older between 100 percent and 133 percent of the FPL.

[37] Section 1115 of the Social Security Act permits the DHHS Secretary to waive certain portions of the federal Medicaid Act for a five year demonstration project, if the demonstration is budget neutral to the federal government.

[38] Letter from Secretary Tommy Thompson to US governors, August 3, 2001.

[39] The CPS data for Iowa indicates that only 24,000 of the 258,000 uninsured persons in the state are unemployed or the dependent of an unemployed person.

[40] John F. Sheils, "Health Coverage 2000: Cost and Coverage Analysis of Eight Proposals to Expand Health Insurance Coverage" (Report to the Robert Wood Johnson Foundation (RWJF), September 2000.

[41] The Congressional Budget Office (CBO),"Increasing Small-firm Health Insurance Coverage through Association Health Plans and Healthmarts", January 2000.

[42] Long, S. & Marquis, M., "Have Small Group Health Insurance Purchasing Alliances Increased Coverage?" *Health Affairs*, Vol. 20 No. 1, 154-163, 2001.

[43] The disproportionate accumulation of higher cost members in an insurance pool is termed "adverse selection".

SECTION 5 : CONSENSUS BUILDING STRATEGIES

One of the goals of Iowa's SPG was to steer policy-makers and the public toward adoption of policies that will increase access to coverage. We used a four-faceted approach. The first was to ask Governor Tom Vilsack to provide political leadership and executive branch support. Secondly, we created a Citizens' Alliance for Health Insurance (Citizens' Alliance), composed of key Iowa stakeholders. The third facet was a public-education campaign composed of regional forums held throughout Iowa during May, and the fourth was extensive public opinion research to understand the views of key segments of the Iowa public on expansion of access. Each approach is described in detail below, with the exception of the opinion research, which is described in Section 4.

A. Governance Structure and Key Constituency Involvement

This section provides answers to the following questions:

- 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?

1. Iowa SPG Governance Structure

The planning process was designed to provide an extensive array of data for the Citizens' Alliance. This fifteen-member group, appointed by the Governor and the Lt. Governor, was asked to consider all the data and help develop a policy initiative to expand health insurance to all Iowans. Composed of people from the public and private sectors, each with varying expertise in access to health insurance, the Citizens' Alliance was a sifting and sorting entity which was expected to reach a consensus for Iowa's policy initiative.

Lt. Governor Sally Pederson was the formal chair of the Citizens' Alliance. She carried the message of the importance of the issue to Iowans and the executive branch. The day-to-day

chairmanship was shared by IDPH Director Dr. Stephen Gleason and Iowa Farm Bureau Federation Executive Director Jerry Downin. This demonstrated the necessary partnership between the public and private sectors. Downin's presence was especially important as he represented three key Iowa constituencies: citizens, business (agribusiness and farmers), and insurance providers.

Great care was taken to ensure that the makeup of the Citizens' Alliance would extend beyond government-agency staff and be representative of Iowans. Members were recruited to provide a fair balance of perspectives and expertise on health insurance and peripheral considerations, such as employment. Also, geographic, ethnic, and gender balance was recognized and addressed. The governing body included representatives of: business and the private sector; the public; insurance providers; federally qualified health centers, nurses, health systems; physicians, state agencies dealing with health and insurance; and hospitals.

The Citizens' Alliance met eight times between May and October. Members participated in other roles as well, such as being local hosts for a regional forum. A number of members met with staff to provide additional information.

As a decision-making and governance entity, the Citizens' Alliance developed into a group able to listen to one another, forthrightly discuss issues, and identify common elements for Iowa's initiative. All groups require time to evolve into an "organization" with its own identity. As the period allowed for the planning effort drew to a close, the Citizens' Alliance began to form that critical sense of itself as a group, and any future efforts would wisely continue to draw upon the growing value it provided.

The Citizens' Alliance had a great challenge. There was an abundance of data, and complex peripheral issues. Members patiently and determinedly absorbed and studied the data. They were briefed fully on the results of the CPS Analysis, the Survey of the Uninsured, the Survey of Iowa Businesses, the attitudinal surveys of Iowa businesses and the active public, and given focus-group reports. Not only was the Citizens' Alliance a decision-making entity, it provided a reality check of the data and input from around the state, and members own experiences provided a balance of perspectives on increasing access, and reflected the political realities. They developed critical tenets by which their decision-making was driven. This allowed

the Citizens' Alliance policy recommendations to the state, and ultimately, the secretary, to reflect the extensive data gathered by the Iowa SPG and to include the expertise of members.

B. Key State Agencies and Branches of Government

A number of state agencies have roles related to health or insurance, or both. Those agencies, including the Iowa insurance commissioner and the director of the State Department of Human Services, were represented on the Citizens' Alliance. State agencies also provided research, specific program information or data, and staffed the entire planning grant effort. The Iowa Department of Public Health was the lead agency; the Iowa Department of Human Services and the Insurance Division of the Iowa Department of Commerce provided both data and technical expertise.

Executive branch involvement was also extensive. The Citizens' Alliance was appointed by the Governor and the Lt. Governor. The Governor's health-policy staff helped launch and support the planning process, and participated in many meetings to identify needs and opportunities for executive branch involvement. Additionally, executive branch staff members received continuing information on the planning process and Citizens' Alliance deliberations.

Clearly, no policy change or major initiatives can occur in the state without support and involvement of the legislative branch. Legislators need to be involved and their awareness and commitment to expanding health insurance to all Iowans enhanced. The planning addressed these needs in a number of ways. Because many of the SPG activities occurred in communities where legislators resided, it was important to provide information through a personal letter to each legislator. He or she received information about the state planning grant process, opportunities to attend and participate in events and activities, and the goal of developing a policy initiative to expand coverage. During the second round of focus-groups, two sessions were targeted to policy makers to provide them an opportunity to discuss their perspectives and provide input into the decision-making process.

C. Public and Key Constituency Input into the SPG Process

This section provides answers to the following question:

- 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)?

Public and constituency input was critical to the state planning grant process. Qualitative and quantitative data was obtained through focus-groups and surveys. Regional educational forums brought key messages to interested stakeholders and the public and collected their thoughts on the issue. The process was structured to result in public awareness, public education and marketing of the issue. The following activities were undertaken to obtain input and engage various constituencies. (For a more detailed review of the following activities see Sections 1, 2 and 2-A)

Analysis of Iowa Survey of Uninsured A survey and focus-groups were conducted by Lewin to identify characteristics of the uninsured population in Iowa and the consequences of being without health insurance. Lewin completed a telephone survey in January and conducted focus-groups in February. Data resulting from these tools were presented to the Citizens' Alliance and participants at the regional forums as background to increasing access to health insurance in Iowa.

First Round Focus-groups Conducted in March by SPPG, the first round of eight focus-groups was structured to gather responses from the active public and stakeholders in health insurance and the importance of coverage for every Iowan. Participation was strong in these guided, structured discussions, with 112 people participating across the state. Findings were presented to the Citizens' Alliance and other interested parties.

Business Survey Wave I Designed and conducted in March by SPPG, with support from Selzer, this survey was designed to gather attitudinal data from Iowa businesses. The intent was to gauge businesses' perception of how expanding health insurance to all Iowans would affect the state, the business community in general, and their particular businesses. These findings were also presented to the Citizens' Alliance.

Active Public Survey Wave I Also designed by Selzer and SPPG, and administered in April and May, this survey interviewed Iowans who voted in the past two general elections and who have health insurance. Its purpose was: 1) to assess the mood of the electorate on a state plan to provide health insurance for all Iowans, 2) to provide insight into policy creation, and 3)

to develop a communication plan for selling the program. The findings were presented to the Citizens' Alliance.

Regional Forums Eleven forums were held across the state during May and June. Each was a learning experience for participants and staff. Participants learned about expanding health insurance, and about the key findings from some of the early research. Staff learned about who was interested in the issue, how they feel about the issues, and how they reacted to facts about the issue. The forums allowed a free flow of information and ideas, and were not intended as a data-gathering opportunity. A summary report and presentation was provided to the Citizens' Alliance for developing policy recommendations.

Second Round Focus-Groups Conducted in June by SPPG, the nine focus-groups in the second round aimed to target various constituencies at particular sessions. The scripts were developed to elicit comments on more specific questions on options to increase the number of Iowans with health insurance. The targeted constituencies have clear relationships to the options and the implications of their implementation. Constituencies targeted in the second set of focus-groups were the active public, business owners, health-care providers or executive directors of health-care organizations, and state and local elected officials. Findings were presented to the Citizens' Alliance and other interested parties.

Business Survey Wave 2. Also designed and conducted by SPPG with support from Selzer, the second business survey was administered in July. A sample of businesses similar to those surveyed in March were contacted to more thoroughly investigate findings from the first survey and to test general programmatic approaches to expanding health insurance. The findings were also presented to the Citizens' Alliance.

Active Public Survey Wave 2. This phone survey also interviewed Iowans who voted in the past two general elections and who have health insurance. It was designed by Selzer and SPPG, and administered in July. This survey provided data to verify the results of the first survey and to ask more detailed questions on respondents' willingness to support and pay for health insurance. It was important to determine whether Iowans believed providing health insurance to all Iowans was in their own interest. The findings were also presented to the Citizens' Alliance.

D. Building Public Awareness

This section provides answers to the following question:

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

Creating an identity for the SPG planning initiative was important to developing public awareness and ongoing interest and recognition. One method was development of a logo, letterhead, and the use of consistent messages to identify the initiative. The intent was for constituencies and the public to identify the messages and the materials within this complex initiative.

1. State Planning Grant Web Site

A web site was developed to provide information to all interested parties about the planning process and development of policy recommendations. The site is within the IDPH web site and on the Internet at <www.idph.state.ia.us / www.iowahealthonline.com>.

Media were also a key part of the outreach and awareness. General media releases were provided for the regional forums and both rounds of focus-groups to inform and promote the planning initiative. Coverage occurred in newspapers, radio, and on television across the state.

E. SPG'S Effect On the Iowa Health Policy Environment

This section provides answers to the following questions:

- How has this planning effort affected the policy environment?,
- What is the current policy environment in the state and the likelihood that the coverage expansion proposals will be undertaken in full?

At any level of government, making new health insurance access policies and changing existing policies is a struggle that requires consensus building and an intensive incremental effort. In a perfect policy environment, "the stars would line up," and Iowa would be able to provide access to health insurance to all Iowans. For those stars to line up, Iowa would need a progressive governor, willing to take substantial risk, and define himself as a leader who makes a

difference. Furthermore, Iowa would need a public confident in the ability of the state's public and private resources to accomplish such a complex initiative.

In the best of worlds, we would demonstrate the existence of an appetite for such a goal within Iowa's business community and the public at large – and perhaps even more importantly, within the voting public.

F. The Stars are Beginning to Line Up

Indeed, Iowa has a progressive governor with high approval ratings, facing little opposition, and with the intention of serving only one more term. Coming to the end of his first term, he is seeking to leave a mark on Iowa's policy landscape.

The opinion research contains a clear message that Iowa's businesses recognize the value of coverage as a means to recruit and retain workers. They see coverage as an issue of fairness, and the greater percentage is willing to contribute to their employees' coverage. At the same time, two of three of Iowa's voters are willing to contribute a minimum of $10 per month to expand health-care coverage to Iowa's 9.1 percent of uncovered residents.

Certainly, the potential for a policy shift which would lead to a significant increase in the number of Iowans with health insurance exists in this state. Given a three-to-five-year window, and an understanding of consensus building, success will come as a result of political leadership and risk taking, systematic planning, and a passionate education campaign that forms the public into a formidable advocacy constituency to drive change.

The first year of Iowa's State Planning Grant has been an important first step in a process that can lead to as close to 100 percent access to coverage as possible without requiring it. Given the time allowed, it was not feasible to move the project to completion in even the best policy environment. We did, however, move forward. The work accomplished in the last 12 months provided more than hope. It provided a data-based realization of what is possible. Reaching out to Iowa's communities helped define and understand public sentiment around this issue. The Survey of the Uninsured helps to understand how best to target public and private resources to make the most significant reductions in the number of uninsured Iowans. The opinion research painted a clear picture of the potential to move forward.

There are **barriers**. Iowa, like many other states, faces a deficit budget as a result of a slumping national and state economy. This has required the governor and state departments to re-examine resource allocation, make corrections and adjustments, and re-invent the way services are provided. Public confidence in the economy has slipped, leaving many to doubt if the resources will ever exist to expand access. These difficulties do not make the goal of expanding access to health insurance impossible; they can open the political doors to support bold policy change over a short period. The answer to the lament, "but there's no money," will require a more aggressive and publicly confident approach to advocating for change.

Some expect that implementing this policy will be easier over the next three to five years during a time of economic recovery and with a progressive, popular, lame-duck governor. But on September 11, 2001, the policy environment changed with most everything else. No doubt, these events and the ensuing state and national discussions will blur the policy environment for some time. But two truisms stand just as firm as they did before September 11; these are that "change is constant" and "all policy is local." Therefore, we can surmise that Iowans will understand and support some aspects of new national priorities, but will eventually shift their attention back home. Iowans have spoken: increasing access to health insurance is an important state issue. It is not the time to take a break from this issue and wait for better times.

Even in the best of economic times no jurisdiction in the United States has managed to create a method to insure coverage for all. Maintaining an intense level of effort – even being aggressive and boldly innovative in designing and promoting new policies – is especially timely given the complete policy environment in Iowa. This will require a plan, a constituency, time, and champions to fight for the issue. It is expected that the political will of the governor will be there. A successful advocacy effort that is powerful and sustained over time will help ensure that the political will of state legislators and the public is also present.

Now that we have completed the first year's SPG work, and obtained an extension and additional funding from the federal government, we have the financial means, independent of the state's current budget woes, to pursue to fruition the goal of expanding access to health insurance to all Iowans.

SECTION 6: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A. Importance of State-Specific Data

Iowa specific data was extremely important to our SPG process. Our entire SPG effort revolved around our ability to gather data which would take us beyond previous Iowa health-care reform efforts, none of which had used data to design policy. We were able to use the SPG funds to present, apparently for the first time, a clear picture of who the uninsured are in Iowa and why they are uninsured. This picture included information from employers regarding what coverage they offer, to whom it is available, and the nature and magnitude of barriers to expanding employer-based coverage. We supplemented that data with attitudinal surveys of the public and employers regarding their beliefs about expanding access to health insurance and the means to finance an expansion. The data that we collected is presented and analyzed in Sections 1, 2, and 2-A. The data was shared with the public in "Regional Forums" and with our Citizens' Alliance (Section 5). The entire process of gathering and sharing the data has allowed us to design the policy options presented in Section 4, and has given us a basis on which to proceed with our goal of expanding access to health insurance in the second year of our SPG funding.

The ability to develop our own state-specific surveys, as well as to conduct extensive analysis of the Current Population Survey, was especially important in light of a common misperceptions about Iowa. We often see references to Iowa as a state that, albeit small, is somehow representative of America as a whole. What we have been able to show is Iowa is not just a miniature version of America, but that it is a complex social and demographic environment, and that any successful attempt at expanding access will have to take this unique and complex environment into account.

As part of our data gathering work we conducted extensive focus group sessions throughout the state (See Section 2-A). The sessions focused on such issues as reasons for not having health coverage, barriers to purchasing health coverage, perceptions concerning public programs, consequences of no coverage, implications for the design of strategies to increase coverage for uninsured individuals, public and employer attitudes towards the uninsured, and support and opposition to various methods of coverage expansion. The information derived from

these sessions was very useful in allowing us to understand what would be the best means to expand coverage in Iowa.

B. Effectiveness of Various Data Collection Activities

No particular activity stood out with respect to efficaciousness. The surveys and focus group sessions were designed to complement each other in terms of the information developed. We believe the information derived from each method achieved that goal.

C. Data Collection Activities Contemplated But Not Carried Out

All activities proposed in our original application have been carried out.

D. Data Collection Strategies

No particular strategies were taken to increase response rates.

E. Need for Additional Data Collection Activities

At this time we are most interested in conducting actuarial studies to determine with a greater degree of exactitude the costs associated with the options presented in Section 4. Additionally, we intend in our second year of funding, to examine much more thoroughly the opportunity to create an Iowa Health Security Trust, the outline of which is described in Section 2-A. We do not know enough about how much "health security" would cost and if the state's voters, employers and legislators would approve of such a plan. The viability of the "health security" concept will have to be determined through actuarial analysis and further attitudinal surveys.

While not part of our SPG objectives, during the last year we have learned that there is a lack of data in the area of adequacy of benefit packages. There is little information available as to what are the most prevalent benefit packages available within the state. Benefit packages, and their adequacy and availability are not within the insurance commissioner's regulatory ambit, and therefore no data is available in this critical area. If this data existed, we believe it could be of tremendous help in designing affordable benefit packages that would be attractive in bringing new populations to the coverage rolls. Also, in the area of benefit design there appears to be little Iowa data available to help define what an adequate policy is in terms of

maximizing both individual and population health. If such data was available we could use it to help design benefit packages for newly covered population that would maximize the social utility of the public investment in coverage expansion.

F. Operational Lessons Learned

The most significant operational lesson we learned is that it is difficult to stimulate public discussion around the issue of the uninsured, when almost 92 percent of the population is covered under a policy of health insurance. There is a certain lack of urgency among the public when the state's coverage rate is perceived as being extremely high. When Iowans become aware that this rate is among the highest in the country there is a certain sense of satisfaction and job well done.

We also became aware that the public tends to be confused when trying to understand the distinction between health insurance and health care. Great care needs to be taken in public presentations, and in designing surveys and other materials, to make sure that the audience understands that health insurance is being used as an vehicle to expand access to care, and is not being discussed as an end in itself.

In our focus group discussions with the uninsured we learned there was a general lack of understanding surrounding the concept of risk based insurance. We often heard the question 'If a person had health insurance and did not use any medical services during the year, would premiums be refunded to the policy holder?' We know that in a society without coverage mandates, those persons not covered through employment essentially have to make a consumer decision to purchase coverage. If an individual doesn't understand how health insurance works and the potential value of an insurance product, it is unlikely they will purchase health insurance even if the policy cost is low. Thus we believe there is great potential value in conducting a public education campaign designed to broaden knowledge of risk-based health insurance. This is especially true given that some portion of the uninsured were raised in families that have never had health insurance. (See ***Figure 9***, Distribution of Uninsured in Iowa by Length of Time Uninsured, where about one third of respondents indicated they have been without health insurance for five years or more, including 20 percent who had been without it for 10 years or

more.) To be insured is not normative for these individuals and education will be vital in helping bring them into the ranks of the insured.

G. Key Lessons Learned

Many of the key lessons learned are covered in Sections 1, 2, and 2-A above, where we describe in detail what we learned about the uninsured, about employers, and about attitudes towards the uninsured and increasing access to coverage. How closely insurance status is related to employment was a key lesson reinforced rather than learned. Also, the fact that over 80 percent of the uninsured are connected to the active labor force was a revelation which both the public and policy makers found to be of great interest.

Attitudinal Surveys

- Civically minded individuals (the active public) and businesses will support coverage expansion, if they believe they will benefit directly from the expansion effort. This knowledge is vitally important as it helped us conceive the notion of "health security," where the benefit to those already covered is protection from future loss of coverage. No matter what means the state chooses to expand access, the public's need to realize a benefit form expansion will have to be taken into account if public support is to be gained.

- A large majority of businesses (82.5%), and the "active public" (66%), think is *very important* for all Iowans to have health insurance coverage.

- Businesses see a benefit to providing health insurance to their labor force. About 78 percent of businesses (78.4%) think that providing health insurance to all Iowans will have a positive affect on Iowa's business climate. Seventy-eight percent of business say they have benefited *a lot* or *some* from providing health insurance to their employees. About 84 percent of business believe that health insurance is *very important* (63%) or *fairly* important (21.2%) in recruiting and retaining employees.

- Iowans fear losing their health insurance (69% in Wave 1, 58% in Wave 2), but the fear itself is not that intense, only 10 percent are *very fearful* of losing coverage.

- Only 15 percent of Iowa business support keeping "*things the way they are*" with respect to health insurance. Sixty percent would support "*a limited effort to provide health insurance which would require a tax increase*", and 22 percent would support "*a major effort to provide health insurance for nearly all uninsured Iowans that would require a tax increase*."

- Both businesses and the "active public" select "health security" as the most favorable means to expand access (74% and 69%, respectively) over the relatively more familiar means of "refundable tax credits to business" (63% and 53%, respectively), "expanding existing programs" (55% and 50%, respectively), and "refundable tax credit to individuals" (47% and 44%, respectively).

- It is difficult to generate a public dialog on the topic of expanding access to health insurance when about 91 percent of the population is covered by some type of health insurance policy.

The Uninsured

- Forty-nine percent of the uninsured have family incomes below 200 percent of the federal poverty level.

- About 80 percent of the uninsured are currently working (80.6%), and only 14.2 percent of the adult uninsured are not in the labor force.

- The uninsured are not well informed about public programs. When asked why they have not applied for state provided coverage programs, 26 percent of the uninsured responded they did not apply because they did not know how to.

- The lower the income of an uninsured person, the more likely that person is to delay obtaining medical care even in the face of belief that medical attention is needed. This suggests that among the uninsured themselves, income influences the ability to obtain needed medical care.

Employers

- Fifty-four percent of Iowa employers offer health insurance to their employees.

- Among the firms that insure their employees, 81 percent reported that all their full-time personnel were eligible for coverage, while only 25 percent offer coverage to their part-time workforce.

- Firm size is highly correlated to the likelihood that an employer will offer health insurance. In Iowa, 50.3 percent of persons working in firms with 10 or fewer employees do not have employer-offered health insurance and 42.7 percent of employees without coverage work in firms with 10 or fewer employees.

H. Key Recommendations for States

The key recommendation that we can provide is to exercise **patience** and accept that it will take a significant commitment of time and resources (for data collection) to design a plan to increase access to health insurance coverage. Obviously, the creation of a plan to expand access to health insurance is a tremendously complicated endeavor. It is vitally important that plan design focus on economic and political feasibility, and any state that wishes to embark on an expansion of health insurance to universal or near universal coverage levels will need to understand, as a foundation, the following:

- Who the uninsured are,

- Why they are uninsured,

- Who among employers offers insurance, and why,

- Who among employers does not offer insurance, and why not,

- What tolerance for change exists among the public, employers, providers, insurers, and elected representatives

We believe that after these questions are answered, it will be much easier, all things being relative, to design specific methods by which to expand coverage, as the targeted population will be fully understood, and the public's potential support and resistance to change can be factored into coverage design.

Additionally, we recommend the use of modeling, such as the Lewin Group Health Benefits Simulation Model (HBSM), to estimate the number of persons that could be added to the coverage roles and the costs of subsidies, when designing policy options. We believe that use of modeling simulations can allow states to compare such variables as increase in coverage rates and the costs to the state of increased coverage across an array of policy options. The modeling results can effectively provide defensible information to supplement the political information already in the hands of a state's governmental and legislative establishments.

We also recommend that states devote significant resources to developing public leadership capacities, public education campaigns, and a marketing-driven approach to the need to expand access to health insurance. Advocates for children have been successful in convincing the public to support the notion that access to healthcare is necessary for children to begin school "ready-to-learn." This public understanding is no doubt in large part behind the broad base of support for the SCHIP programs.

The data we have gathered shows that the same type of support can be achieved for a broad range of policy options that will increase coverage rates. While there will be no shortage of naysayers who argue that funds are currently lacking to support making health insurance more accessible, it is important to remember that American political history teaches us that dollars follow political will, and not the converse, as events of September 11, 2001 so aptly remind us.

SECTION 7: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

One of the objectives of the State Planning Grant is to provide recommendations to the federal government as to how to devise plans at the state level to increase access to health insurance coverage. As a state planning grantee, Iowa has always tried to fulfill this dual duty of advancing the interests of the state, while also identifying those parts of this planning process that would be germane to any of the 49 other states.

While much of the information conveyed in this report reflects Iowa's particular demographics, and political and social climate, there is much information that can be useful to any state wishing to increase the number of citizens and residents with access to health insurance coverage. As such, Iowa, through its SPG team, is prepared to share the experiences gained through participation in the State Planning Grant process with all sister states and the federal government. Our offer extends beyond the materials presented in this report, especially in Sections 6 and 7, and we will, as we continue into the second year of our State Planning Grant involvement, to respond to inquiries from states, the federal government and other entities regarding what we have learned to date.

The guidance for this section of the secretary's report asks us to comment on the coverage options Iowa has selected that would require federal waiver authority or other changes in federal law prior to implementation. At this juncture of the State Planning Grant process it would be premature to say that Iowa has "selected" particular coverage options for implementation. We believe we are at the midpoint in our objective of expanding health insurance coverage. We have accomplished the data-gathering goals set forth in our SPG application, and we have used the results to design and evaluate policy options. This has allowed us to meet our goal of presenting a panoply of potential expansion options to our Citizens' Alliance. This allowed the Alliance to reach consensus and direct us to focus our ongoing efforts on the combined option strategy suggested in Section 4 of this report, and to further refine the concept of "health security" as a means to help finance coverage expansions.

The suggested combined strategy could reduce the number of uninsured Iowans by roughly 80 percent <u>with</u> the child mandate (down by 206,000 from the estimated 258,320), and

by 41 percent without the child mandate, and is based on the implementation of the following initiatives:

- Provide (short-term) insurance coverage to the unemployed through the unemployment insurance program. The program would be funded through increases in the state unemployment insurance tax. No federal waivers would be required, but there will have to be changes in the state's unemployment insurance statutes and regulations.

- Expand income eligibility for the Medicaid and hawk-i (SCHIP) programs to cover *all* adults earning up to 200 percent of the FPL. This would include coverage for parents of children on Medicaid/hawk-i and non-custodial adults. We assume that this expansion would provide what we call the "Wellmark-PPO" benefits package, and that furthermore a small premium contributions would be required from those newly eligible adults with countable earnings above 150 percent of the FPL. (see waiver discussion below)

- Provide refundable tax credits to employers of low-wage workers in small firms for the amount paid by the employer for coverage. Eligibility would be restricted to those firms that 1) have 25 or fewer workers, 2) have not provided coverage for at least 12 months, and 3) have an average payroll below the average for small firms in Iowa.

- Establish a health insurance purchasing pool composed of state employees and employers with 25 or fewer workers. The pool would be open to all Iowa firms with 25 or fewer workers regardless of worker income and without a waiting period. Thus employers would be allowed to discontinue their current coverage to join the pool. We assume that small groups under the pool would be rated separately so that the premium paid by small employers is equal to the average cost for small group members.

- Require that all children have health insurance as a precondition to enrolling in school. This would result in an increase on coverage through Medicaid and hawk-i, with an associated increase in costs to these programs.

Each of these options is discussed in great detail in Section 4 of this report. In this section we will address the specific issues presented in Section 7 of the Guidance for Preparing Final Reports, issued in the Spring of 2001.

A. Coverage Expansions and the Need for Waivers

As requested, we have examined our options from the standpoint of whether they would require federal waiver authority or other changes in federal law. (See also ***Figure 47***)

1. Expanding Coverage for Adults

Under Section 1931 (b) of the Medicaid Statutes, Iowa has the option to increase the eligibility level for *parents* to the maximum income level at which children are eligible for the Medicaid and hawk-i programs. The federal government would provide support for the costs incurred for these newly eligible *parents* through its provision of federal matching funds at the state's Medicaid matching rate. (about 63% in Iowa).[44]

In addition, the state could also implement a coverage program for non-custodial adults who are currently not eligible for any Medicaid coverage in Iowa. Unfortunately, under current law, the federal match would not be available for these newly covered, leaving the state to cover the entire expansion cost. It is possible, however, that the state could receive the federal match if the expansion took place through a Section 1115 waiver. This type of waiver could be tremendously beneficial to the state, and would essentially allow the state to bring this economically vulnerable population into the Medicaid program. (See Section 4, Expanding Medicaid Eligibility for Adults)

Another possibility for the state would be to apply for a waiver under Secretary of Health and Human Services Tommy Thompson's recently announced Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. Under HIFA, states can apply for a Section 1115 waiver, whereby Iowa could offer a limited benefits package for optional and expansion Medicaid populations (See Section 4, "Use of an Alternatives Benefits Package"). As discussed in Section 4, this approach would insure that Iowa would spend its entire SCHIP allotment, something which has been problematical for the state in the past. The idea of reducing benefits to the medically needy and other vulnerable populations as a means to generate savings which can then be used to expand coverage is not without controversy. In a state like Iowa, where the savings that can be anticipated from such an approach are probably de minimis, this approach is not likely to gain needed support.

There are also changes in the Internal Revenue statutes that could assist workers in obtaining coverage (tax credits for employees and/or employers) and that could reduce inequities in the current statutes. (See Section 4-D, Programs to Assist Families in Purchasing Private Coverage) These issues could also be addressed in the state's revenue and finance statutes.

B. Additional Federal Support

At this juncture, it does not appear that there would be much additional value to the federal government expending resources to more thoroughly identify those Iowans or residents of other states, who are uninsured. In Iowa, we chose to focus on two research strategies as we pursued our goal of devising a plan to increase access to health insurance. The first effort was devoted to developing a more thorough understanding of Iowa's uninsured population, by creating a data-driven picture of Iowa's uninsured population using both quantitative and qualitative research methods.[45] (See Section 1, above) The second effort, described more fully in Section 2-A, above, was directed to developing an understanding of Iowans beliefs on expanding access to health insurance. Our goals were to understand 1)who the uninsured are in Iowa, and why, they are uninsured, 2) the beliefs of Iowa voters and employers towards the uninsured, and 3) the degree of support and opposition among Iowans to strategies to expand access to coverage. We do not need a more complete picture of the uninsured at this time. However, we do need access to a reliable measure of how the number of uninsured persons changes over time. The CPS would appear to be adequate in that respect.

What we do need is the financial support of the federal government. Currently, Iowa is experiencing fiscal difficulties related to shortfalls in state revenues. For fiscal year 2002, the state will cut its budget 4.3 percent ($59 million) across the board.[46] While there is little public appetite in Iowa for federal involvement in the provision of medical care beyond the existing Medicare and needs-based programs such as Medicaid and hawk-I, it is difficult for small states such as Iowa to go it alone in terms of developing means to insure all state residents. Iowa's total population is a little over 2.8 million residents and 258,000 uninsured persons. The state has two dominant insurers, and relatively little provider competition. The ability to use market forces at this level to hold down costs and maximize efficiencies is lacking. The federal government, with its far larger size, is better positioned to realize to influence the market and realize savings.

As discussed in Section 4, with additional federal support, in the form of federal matching dollars, and targeted tax credits can go a long way towards assisting Iowa in increasing the number of persons with access to health insurance. We believe this analysis is pertinent for all states in the same size range as Iowa. Providing federal support in the fashion suggested above seems to match Iowans' current views on the proper role of the federal government in the healthcare market.

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[44] Under Medicaid, the federal government pays about 63percent of the program costs under the traditional Medicaid program and about 73 percent of the costs under HAWK-I program.

[45] Our "data-driven" picture also included identifying why individuals and families are without health insurance coverage as well as determining who the uninsured are.

[46] "Leaders Propose Budget Changes," Des Moines Register, 10.17.01.

APPENDIX 1

IOWA POPULATION

SUBJECT	NUMBER
TOTAL POPULATION	2,926,324

SOURCE: U.S Census Bureau, Census 2000

NUMBER AND PERCENTAGE OF UNINSURED IN IOWA

	NUMBER	PERCENT
TOTAL POPULATION	2,926,324*	
TOTAL UNINSURED	258,520**	9.1%**

* *Source*: U.S Census Bureau, Census 2000

** *Source*: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997-2000 (covering years 1996-1999)

POPULATION DISTRIBUTION BY AGE*

	NUMBER	PERCENT
TOTAL POPULATION	2,828,390	
Children 18 & Under	784,220	28
Adults 19-64	1,658,350	59
65+	385,820	14
64-74	199,640	7
75-84	144,480	5
85+	41,700	1

* *Source*: Urban Institute & Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys (CPS).

PERCENT OF POPULATION IN POVERTY 1997-1999*

	NUMBER	PERCENT
TOTAL POPULATION	2,828,390	
Under 100% FPL	309,910	11
100-199%	562,950	20
200% +	1,955,520	69

* *Source*: Urban Institute & Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys (CPS).

PRIMARY INDUSTRIES AND COVERAGE [a/]

	Total Number of Workers	Covered on Own Job	Percentage Covered on Own Job
All Workers			
Total Number of Workers	**1,536,617**	**858,933**	**55.9%**
Industry of Worker			
Agriculture/ Forestry/ Fishing	76,973	16,745	21.8%
Construction	84,244	39,826	47.3%
Durable Goods Manufacturing	159,906	128,174	80.2%
Non-durable Goods Manufacturing	113,314	77,886	68.7%
Transportation/ Communications	94,107	60,674	64.5%
Wholesale Trade	66,256	42,488	64.1%
Retail Trade	233,465	84,423	36.2%
Finance/ Insurance/ Real Estate	101,521	73,648	72.5%
Business and Repair Services	80,157	38,285	47.8%
Personal Services	40,414	15,893	39.3%
Entertainment/ Recreation	15,674	6,421	41.0%
Professional Services	375,842	213,779	56.9%
Public Administration	59,464	51,398	86.4%
Mining or Not Identified	35,280	9,293	26.3%
Employment Sector of Worker			
Private	1,092,598	655,381	60.0%
Government	**220,795**	**165,667**	**75.0%**
Federal	26,875	22,027	82.0%
State	86,444	65,235	75.5%
Local	107,476	78,405	73.0%
Self-employed	**190,511**	**32,493**	**17.1%**
Incorporated	49,636	15,639	31.5%
Unincorporated	140,875	16,854	12.0%
Not Specified	32,713	5,392	16.5%

[a/] Includes workers that are not covered on own job and are not covered by spouse's employer coverage.

Source: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997 - 2000 (covering years 1996 - 1999).

NUMBER AND PERCENT OF EMPLOYERS OFFERING COVERAGE

	NUMBER	PERCENT
TOTAL WORKERS	1,536,617*	
Covered on own Job	858,933	55.9
Covered by Spouse's Employer	286,904	18.6
Without Employer Coverage	391,590	25.5

* *Source*: Lewin Group estimates based on an analysis of the Iowa subsamples of the March Current Population Survey (CPS) for 1997-2000 (covering years 1996-1999)

MEDICAID & SCHIP (hawk-i) ELIGIBILITY AS A PERCENT OF FEDERAL POVERTY LEVEL, 2000*

COVERAGE CATEGORIES	FPL PERCENT
Medicaid Infants 0-1	200
Medicaid Children 1-5	133
Medicaid Children 6-16	133
Medicaid Children 17-19	133
Separate SCHIP Program (hawk-i)	200
Pregnant Women	200
Supplemental Security Income	74
Medically Needy - Individual	72
Medically Needy - Couple	53

* *Source*: Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures, Findings from a Fifty State Survey, The Kaiser Commission on Medicaid and the Uninsured, prepared by the Center on Budget and Policy Priorities, October 2000, Table 1, with preliminary update from the Center on Budget and Policy Priorities.

***Source*: Maternal & Child Health (MCH) update: States Have expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children, National Governor's Association, February 2001, Table 3, found on National Governor's Association website at <www.nga.org>.

USE OF WAIVERS AND OTHER STRATEGIES

TYPE	IOWA STRATEGY
Medicaid Section 1115	NO
Medicaid Section 1931[1]	**YES**
Medicaid HIPP[2]	**YES**
Medicaid TMA	NO
Separate SCHIP Program[3]	**YES**
SCHIP Employer Buy-In	NO
SCHIP Section 1115	NO
SCHIP Full-Cost Buy-In	NO
State-Only High-Risk Pool[4]	**YES**
State-Only Tax Incentives[5]	**YES**

[1] For more information, see State Coverage Matrix, Section 1931, <www.statecoverage.net/ia-1931.htm>
[2] For more information, see State Coverage Matrix, HIPP,<www.statecoverage.net/ia-hipp.htm>
[3] For more information, see State Coverage Matrix, State Government ,<www.statecoverage.net/ia-fpl.htm>
[4] For more information, see State Coverage Matrix, <www.statecoverage.net/ia-highrisk.htm>
[5] For more information, see State Coverage Matrix, <www.statecoverage.net/ia-tax.htm>

APPENDIX II

SPG Timeline January – October 2001

SPG Informational Sheet

Towns Visited By SPG

Iowa Employer Study Questionnaire

Iowa Uninsured Study

Lewin Focus Group Discussion Guide for Uninsured Individuals

Focus Group Discussion Guide for Employers that Offer and Don't Offer Health Insurance

Analysis of Iowa Survey of Uninsured & Employer Focus Group Summary

Analysis of Uninsured Population in Iowa Based on CPS Data (Draft Report)

SPG Business Survey Wave I Questionnaire (Version 1045)

IDPH Survey of Iowa Business (Report), March 2001

SPG Business Survey Wave II Questionnaire (Version A)

SPG Business Survey Wave II (Report), September 2001

SPG Focus Group Proceedings Spring 2001

IDPH Survey of Active Voters, March 2001

IDPH Survey of Active Voters, May 2001 Presentation

SPG Round Two Focus Group Proceedings, June 2001

Options to Expand Health Insurance in Iowa – Presentation Materials, July 9, 2001

Regional Forum Report

Regional Forum Press Releases & Press Packet

Citizens' Alliance Roster

Citizens' Alliance Agendas & Meeting Summaries

IDPH Citizens' Alliance: Value of Data in the Planning Process