



Nebraska
Center
for
Rural
Health
Research

Reactions to Proposed Strategies to
Increase Health Insurance Coverage in Nebraska:
Results from the Nebraska State Planning Grant Year-Two Focus Groups

August 2005
PR05-03

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The Nebraska Center for Rural Health Research, formed in 1990, is organized as a multicampus center located within the Department of Preventive and Societal Medicine, University of Nebraska Medical Center.

The broad mission of the Center is to conduct research and analysis related to improving health care delivery in rural areas. The Center focuses on special populations among rural residents, including the elderly, children, minorities, mentally ill, underinsured and uninsured, and new immigrants whose needs for assistance are unique. Members of our Center work collaboratively with the Rural Policy Research Institute (www.rupri.org).

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EXECUTIVE SUMMARY

In October 2004, the Nebraska Health and Human Services System contracted with the University of Nebraska Medical Center to conduct nine focus groups to obtain reactions to proposed public and private strategies to improve the availability, accessibility, and affordability of health care services to Nebraskans. This contract was issued as part of the U.S. Department of Health and Human Services, Health Resources and Services Administration's State Planning Grants Program to complement the household survey and focus groups completed under the first year of the program. The 28 members of the Nebraska Health Insurance Policy Coalition used the survey and initial focus group results to develop these public and private strategies.

Key Results

- Uninsured, small employer, refugee advocate, and young adult focus group participants favored the development of a safety net provider in central Nebraska to improve access to care for the uninsured in this area of the state where Hispanics are 5% to 25% of the population.¹
- Uninsured participants, refugee advocates, and small employers identified confusion, lack of information, and fear of deportation as reasons that eligible children and adults may not be enrolled in Kids Connection and Medicaid. They suggested streamlining the enrollment and reenrollment process, not asking for Social Security numbers during the application process, and making information about these programs available in churches, schools, and courthouses, and on buses.
- African American participants supported the use of a Medicaid care coordinator to facilitate disease management programs for eligible beneficiaries. To maximize trust between beneficiaries and care coordinators, coordinators should not determine eligibility for benefits, which is an activity negatively associated with case workers.
- Uninsured participants, refugee advocates, small employers, and young adults supported increasing the flexibility in public program income eligibility requirements to avoid the disincentive to work that is created when small increases in income make children and adults ineligible for coverage.
- Uninsured participants, refugee advocates, small employers, and young adults supported the use of a partnership between Medicaid, employers, and low-income employees to pay health insurance premiums and thus create a bridge between public and private coverage for low-income workers.
- Uninsured participants, refugee advocates, small employers, micro-employers, and young adults supported reinsurance programs for small employers and the self-employed to stabilize premiums and remove preexisting conditions as a barrier to coverage.
- All participants suggested that schools should take a leading role in educating young adults and newcomers about public and private health insurance options using a face-to-face targeted approach.

Next Steps

The Nebraska Health Insurance Policy Coalition will use these reactions to refine the strategies to be proposed to the legislature to improve the availability, accessibility, and affordability of health care services to Nebraskans.

BACKGROUND AND PURPOSE

In September 2003, the Nebraska Department of Health and Human Services contracted with the University of Nebraska Medical Center to examine the characteristics of the uninsured in Nebraska and to suggest strategies for providing them with access to affordable health insurance coverage. This work was supported by funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration's State Planning Grants Program. Researchers at the Nebraska Center for Rural Health Research (Center) conducted a household survey of 3,750 Nebraskans and 13 focus groups to determine the characteristics, location, and lived experiences of the uninsured in Nebraska.

Key Results of the Household Survey

- Approximately 9.9% of Nebraskans (145,000) under age 65 were uninsured.
- Approximately 79% of the uninsured lived in households with income at or below 300% of the federal poverty level (\$55,200 per year for a family of four).
- Approximately 63% of the uninsured lived in households where the head of the household was employed by a small business.
- Those Nebraskans at greatest risk of being uninsured had less than a high school education, were Hispanic, or were from 19 to 34 years of age.

Key Results of the 13 Focus Groups Conducted in June – July 2004

- Participants believed that health insurance is too expensive, is usually obtained from an employer, is necessary to fulfill obligations to provide health care for families and communities, but is of limited value if it does not pay for primary and preventive care.
- Uninsured participants decided whether to purchase health insurance after considering how likely they were to get sick and whether they could afford to pay for basic necessities such as food, clothing, housing, and transportation if they also purchased health insurance.
- Uninsured participants described cost, preexisting conditions, eligibility requirements, and documentation status as major barriers to participating in employer-sponsored insurance.
- Uninsured and underinsured participants delayed or did not seek needed health care for fear of incurring debt.
- Uninsured participants with access to the formal safety net described it as limited in scope but a source of hope and access to essential care.
- Rural participants believed that the high cost of health insurance and the prevalence of uninsurance and underinsurance are barriers to rural economic development.
- Small employer participants reported that the major barriers to offering health insurance were cost and the fact that premiums escalate by up to 30% annually.
- All focus group participants emphasized the need for our health care system to change so that costs are equitable, care is coordinated, and everyone has access to basic primary and preventive care.

The Nebraska Health Insurance Policy Coalition (Coalition)—composed of 28 members representing state agencies, the state legislature, businesses, the health insurance industry, non-profit agencies, minority populations, health organizations, and two medical schools—used the survey and initial focus group results to develop public and private strategies to improve the

availability, accessibility, and affordability of health care services to Nebraskans. These strategies are as follows:

Public Strategies

- I. Develop a plan for expanding the safety net by increasing the number of Federally Qualified Community Health Centers (FQHCs), satellites of existing centers, and FQHC look-alikes.
- II. Expand the implementation of the 340B program to all eligible organizations in order to take advantage of lower prescription drug costs.
- III. Explore the option of creating a state pharmacy organization to take full advantage of discounted drug prices.
- IV. Improve marketing and outreach efforts to enroll children and adults who are currently eligible for Medicaid and Kids Connection (the State Children's Health Insurance Program).
- V. Develop and implement disease management initiatives to reduce the costs of Medicaid and Kids Connection.
- VI. Use savings from initiatives to reduce the cost of Medicaid and Kids Connection to expand income eligibility (e.g., increase eligibility levels from 185 to 200 percent of the Federal Poverty Level for the Kids Connection program).

Private Strategies

- I. Create public-private partnerships between employers and Medicaid to leverage private funds to help stabilize the private health insurance market.
- II. Implement a state-funded reinsurance program to make insurance premiums more affordable for small employers and self-employed individuals.
- III. Provide education and training to consumers and small employers about the benefits of health insurance coverage and the advantages and disadvantages of various policies.

In October 2004, the Nebraska Health and Human Services System contracted with the University of Nebraska Medical Center to conduct nine additional focus groups to solicit reactions to the strategies proposed by the Coalition. This report summarizes the reactions obtained from the nine groups conducted in May 2005.

Results from the Household Survey and Focus Groups Conducted in 2004

Based on the 2004 State Planning Grant household telephone survey, we learned that approximately 145,000 Nebraskans, or 9.9% of the population under age 65, were uninsured. Seventy-nine percent of the uninsured earned less than 300% of the Federal Poverty Level (FPL), which is \$55,200 per year for a family of four. Among those earning less than 300% of the FPL, 17% of rural residents and 14% of urban residents were uninsured. Small employers

(those who employed 50 or fewer people) were less likely than larger employers to offer health insurance to their employees, and 63% of the uninsured worked for small employers. In addition to income, geographic location, and employment, other variables such as education, ethnicity, and age were also associated with an increased risk of being uninsured. Specifically, 36% of those with less than a high school education, 27% of Hispanics, and 16% of those aged 19 to 34 years were uninsured. The uninsured were twice as likely to have poor health status, four times more likely to not have a medical home, and four times more likely to not get needed care as were the insured.

The cost of health care was a concern to both the uninsured and the insured: 48% of the uninsured and 27% of the insured worried that insurance would not cover the cost of care. This result reflects the potential prevalence of underinsurance in Nebraska. Being underinsured is defined as having one of three characteristics: (1) medical expenses amounting to 10% or more of income, (2) medical expenses amounting to 5% or more of income for those with an income below 200% of federal poverty level, and (3) health insurance deductibles that amount to 5% or more of income.²

Coding for themes and subthemes contained in the transcripts of the 13 focus groups conducted in June and July of 2004 revealed the following:

Attitudes Toward Health Insurance

- Participants believed that health insurance provides access to health care and medications; allows people to fulfill obligations to provide care for their families, their employees, their communities and to society in general; and provides security by preventing debt and loss of assets.
- Participants believed that the employer is the usual source of health insurance.
- Participants believed that health care is too expensive, that insurance coverage is limited, that claims are often denied, and that health insurance is of limited value if it does not provide coverage for primary and preventive care.
- Participants decided whether to obtain health insurance after considering how likely they were to get sick and what other purchases they would have to forego to pay for the insurance. These phenomena reflect the economic concepts of moral hazard and opportunity cost.

Effects of Uninsurance

- Uninsured participants reported forgoing or delaying care because they were uninsured. They reported that they often substituted folk remedies, medications obtained on the black market, and medications of other family members in order to avoid incurring debt by seeking care.
- Uninsured participants reported the necessity to manipulate the system or bend the rules associated with Medicaid or Kids Connection in order to obtain necessary care for themselves or a family member.
- Uninsured participants believed that being uninsured affected the technical and interpersonal quality of the health care they received.
- Participants' responses revealed that being uninsured affected the physical, psychological, and economic quality of life.

- Rural participants believed that the high cost of obtaining health insurance for small employers and the self-employed is a significant barrier to rural economic development.

Small Employer Perceptions

- Small employers described many factors that affected their decision whether to offer health insurance: the cost and continually escalating premiums, fluctuating business income, whether an insurance benefit is necessary to compete for employees, whether they need to obtain coverage for themselves, whether they have the time or knowledge to investigate various health insurance plans, and whether offering health insurance will avoid misuse of worker's compensation benefits.
- Small employers were willing to consider a variety of policy options to decrease the cost of offering health insurance. However, they did not want these options to require tax increases. They preferred options that included tax credits or forming purchasing alliances or pools.

Barriers to Obtaining Health Insurance

- Uninsured participants described barriers to employer-sponsored insurance including cost, preexisting conditions, eligibility requirements (full-time vs. part-time, length of employment), lack of information due to illiteracy and language barriers, misinformation from the employer, and not understanding the U.S. health care system.
- Uninsured participants described barriers to public insurance including eligibility requirements, lack of information due to illiteracy and language barriers, not understanding the U.S. health care system, the application process, and case workers who functioned as gate keepers rather than advocates.
- Uninsured and underinsured participants described barriers to individual health insurance coverage, including the State High Risk Pool, that included cost, preexisting conditions, and lack of information.

Health Care Options for the Uninsured

- The formal safety net is defined as care that is publicly funded including that provided by FQHCs and the Indian Health Service. Uninsured participants with access to the formal safety net believed that these services were limited and saturated but provided them with a lifeline and a source of hope. Those without access to the formal safety net reported incurring debt and being denied access to care.
- The informal safety net is defined as care that occurs in physicians' offices, clinics, and hospitals for which the provider absorbs all or part of the cost of providing care. Use and satisfaction with the informal safety net varied among uninsured participants.
- Options for dental care for the uninsured were limited to a university-based clinic in the eastern part of the state and "Dental Days" provided by mobile university programs in the western part of the state. Many participants reported forgoing dental care until an emergency and that lack of dental care was especially problematic for uninsured children.

Desired Health Insurance Plan

- Uninsured participants were willing to pay \$150 per month for a health insurance plan. However, many pointed out that they were currently not able to pay this amount due to the need to pay for basic necessities first.
- Uninsured participants preferred to obtain health insurance through an employer but were willing to consider any source that provided an affordable alternative to being uninsured.
- Uninsured participants desired a comprehensive health insurance plan that covered preventive and primary care, specialists, dental care, vision care, mental health, hospitalization, medications, and disease management.

The Most Important Thing (Participant responses to the summary question, “What was the most important thing said?” provided overarching themes.)

- Health insurance is too expensive and provides limited value for the money.
- Health care is too expensive because as a society we expect to receive the most technologically advanced care that is available.
- Having health insurance does not ensure access to health care; uninsured and underinsured participants preferred access to health care and not health insurance.
- The health care system needs to change so that costs are equitable, care is coordinated, everyone has access to basic preventive care, malpractice costs are controlled, and the working poor have a means to transition from public to private coverage.

For further details of the results of the household survey and 2004 focus groups, see the Nebraska Center for Rural Health Research Web site (<http://www.unmc.edu/rural/SPG>).

METHODOLOGY

Nine focus groups were conducted by the Center staff in May 2005 to obtain reactions to proposed public and private strategies to improve the availability, accessibility, and affordability of health care services to Nebraskans. Open-ended questions were developed using a review of the literature and collaboration with the Coalition. This study was approved by the Institutional Review Board of the University of Nebraska Medical Center prior to recruiting participants. In the fall of 2004, follow-up thank you letters and copies of the initial results were sent to the key contacts of the first 13 focus groups in order to lay the ground-work for the recruitment of future groups. Thus, key contacts from the original focus groups were used to obtain new key contacts and/or to recruit participants for the nine groups held in May 2005. Participants were recruited from the following populations because they were likely to be representative of uninsured populations, to have knowledge of an uninsured group, or to have knowledge of the challenges small businesses face in offering affordable health insurance to employees:

- Rural Hispanics
- Urban Hispanics
- African Americans
- Employed young adults (aged 19 to 34)
- Advocates for refugees and asylees
- Self-employed/micro-employers
- Rural small business owners
- Urban small business owners

- Insurance agents and brokers

The key contacts provided ethical access to vulnerable populations and negotiated and confirmed participants. Incentives for recruitment included a monetary stipend, transportation, a light meal, and child care. The two Hispanic groups were conducted in Spanish. For all groups conducted with minority populations, a researcher co-moderated with the key contact. Group proceedings were audio-recorded and transcribed to allow coding and analysis using NVivo software. Researchers identified themes and subthemes unique and similar across all groups.

The composition of the nine focus groups is summarized in Tables 1 to 4 in the Appendix.

RESULTS

Center staff conducted a preliminary analysis using debriefing notes and presented the findings to the Coalition on June 13, 2005. Center staff continue to analyze the transcripts in order to publish a definitive report encompassing all 22 focus groups.

Public Strategy I: Develop a Plan to Expand the Safety Net

All focus groups were asked to consider which populations would most likely benefit from an expansion of the safety net and whether their community could support and benefit from an expansion of the safety net.

Who Will Benefit From Expansion of the Formal Safety Net?

Nebraska businesses employ a large number of immigrant workers, many of whom are undocumented. Approximately 27,000 Nebraskans³—40% to 49% of Nebraska’s foreign-born population—is undocumented and thus most likely to benefit from an expansion of the safety net because they are ineligible for Medicaid and employer-sponsored insurance. In addition, much of Nebraska’s immigrant workforce is Hispanic. According to the 2004 household survey, 27% of Hispanics under age 65 were uninsured, which was the highest rate of uninsurance within any racial or ethnic group in the state. Small employer, young adult, and Hispanic focus group participants from the central part of the state, where a large proportion of Hispanic workers live, expressed the need for a safety net facility such as an FQHC. On the basis of current population growth rates, the Hispanic population in Dawson, Buffalo, Hall, and Adams counties is projected to more than triple from 12,968 to 38,514 in the next decade (Bureau of Business Research, personal communication, 2005). This projection is consistent with the support expressed by these focus group participants for developing an FQHC in central Nebraska.

What we heard about the need to expand the safety net from those with access to a safety net facility:

Urban Hispanic woman: *“At OneWorld [an FQHC in Omaha] there is follow-up with phone calls. People are treated differently there.”*

Urban Hispanic woman: *“At OneWorld there is no difference between anyone.”*

Urban Hispanic man: *“At OneWorld it is heart-to-heart. There I found someone to walk with to reach goals.”*

What we heard from those without access to a safety net facility:

Rural Hispanic woman: “*There are two clinics devoted to prevention [for the uninsured in this central Nebraska community], but none for when a person gets sick.*”

Rural Hispanic woman: “*Well, [I would like] that there is help for us to be seen when we do not have insurance. We do not have help.*”

The Role of Local Context in the Expansion of the Safety Net

Participants reported several factors to consider when deciding whether a community should develop a new FQHC, including ease of travel to the community, existing community resources, the support of local stakeholders, and availability of specialty care.

What we heard about the local context in safety net expansion:

Rural small employer: “*The CEO at the hospital [Good Samaritan Health Systems in Kearney] is open to this dialogue because he’s been doing some research on his own with some community groups about health care issues.*”

Young adult: “*People in the rural areas around Kearney go to Kearney to get groceries, to get everything else . . . You seem to have this western part of the state of Nebraska that is so unserved.*”

Rural micro-employer: “*I think that is a very bad idea [an FQHC]. Maybe it would work in Omaha . . . It isn’t a rural thing.*”

Public Strategy II. Expand the Implementation of the 340B Program to All Eligible Organizations In Order To Take Advantage of Lower Prescription Drug Costs

Public Strategy III. Explore the Option of Creating a State Pharmacy Organization to Take Full Advantage Of Discounted Drug Prices

The second and third public strategies were not discussed with focus group participants because results from the town hall meetings revealed that active opposition to these strategies was minimal to nonexistent.

Public Strategy IV: Improve Marketing and Outreach Efforts to Enroll Eligible Children And Adults In Kids Connection And Medicaid

Eligible Children May Not Be Enrolled In Kids Connection

Uninsured focus group participants described confusion, lack of information, and fear of deportation as reasons that eligible children may not be enrolled in Kids Connection. Specifically, uninsured focus group participants reported that parents are unaware of or confused by income guidelines, they don’t receive adequate notification when reenrollment applications are due, and they are unsure about the information required to complete the application process. This lack of information can result in multiple absences from work to complete the application

process. Hispanic participants and immigrant advocates reported that undocumented parents are fearful that disclosing Social Security numbers on application forms for eligible children may result in deportation of themselves or other undocumented family members. African American participants explained that the application process can be intimidating and difficult and lacks adequate notification when a reenrollment application is due. Focus group participants suggested that information about Medicaid and Kids Connection should be placed “where people are,” such as churches, buses, schools, libraries, and courthouses. They also suggested that Kids Connection information be sent home by schools and included with notices about reduced school lunches.

What we heard about improving Medicaid outreach:

African American woman: *“With reenrollment you would think your information is in that computer system, but it’s not. If you’re a diabetic, you’re a diabetic, and that isn’t changing. But they keep asking you the same questions.”*

African American woman: *“There’s a lot of single mothers that I know that have jobs that have insurance . . . They assume they have to be on public assistance to qualify for Kids Connection.”*

African American woman: *“People out there with their clipboards at places where children are [for example] the child advocate from my son’s Head Start, at Open Door Mission, at the Salvation Army, places where they recruit for Head Start. Where some one can say, ‘Can I talk to you about your kid’s health care?’ ”*

Rural Hispanic woman: *“What I think is that when they give the form [for Kids Connection], they should give a list saying what [information] is necessary because [my employer] does not give us any flexibility to leave and take the papers to social services. . . . In order to only miss [work] once and not ask us to go back and forth.”*

Rural Hispanic woman: *“If the children are American citizens and the parents are not, then they are afraid of being deported—that the agency deports them or that they are connected with immigration.”*

Rural Hispanic man: *“The lack of education of lots of people that don’t know how to write or read [prevents eligible people from enrolling in Kids Connection and/or Medicaid].”*

Public Strategy V: Develop and Implement Disease Management Initiatives to Reduce the Costs of Medicaid and Kids Connection

Disease Management Functions Must Be Independent from Program Eligibility Functions

Focus group participants indicated that disease management programs can help people to coordinate care across multiple providers and settings, understand confusing prescription drug regimens, obtain needed supplies, and improve their ability to understand and use health information. African American participants considered the relationship between the patient and the individual who manages their care as very important. However, the terms *case manager* and *case worker* evoked negative associations with the gate-keeping function performed by Medicaid

case workers. Consequently, participants suggested the term *care coordinator* as an alternative to identify nurses who conduct disease management activities. African American participants explained that they valued a personal relationship with the care coordinator and suggested that this trust could not exist if the care coordinator was also accountable for determining eligibility for Medicaid benefits.

What we heard about disease management in Medicaid:

African American woman: *“You can have a chronic illness and you go to one doctor, next time you go about a month later, you have a different doctor. . . Having just one doctor is very important.”*

African American man: *“I couldn’t get a test strip and I thought that they give them to you free once they label you as diabetic. I thought there was some clinic I would be sent to to pick one up.”*

African American woman: *“Sometimes it can get confusing if there’s a lot of medicine, so that’s why I think its good if a person has just one doctor [or] just one person to go to.”*

African American woman: *“A case manager don’t do nothing but help you get a welfare check and they don’t care whether or not you getting seen at the hospital.”*

Public Strategy VI: Expand Medicaid Income Eligibility Levels

Income Eligibility Requirements for Medicaid Need to be Flexible

Uninsured focus group participants agreed that income eligibility requirements to qualify for Medicaid and Kids Connection need to be flexible and take into account the amount of money required to cover expenses for basic necessities.

What we heard about Medicaid income eligibility:

African American woman: *“Insurance is just not affordable, and the minute you have an accident or something happens to you or your kids, you are right back where you started. You’re right back in the system. It’s just a revolving door to me. And again, I find more people want to work than just don’t want to work. . . . You have got to outsmart the system and in the end it benefits you to just stay home.”*

Rural Hispanic woman: *“They only deduct 25% of your expenses from you [to determine eligibility], even if your expenses are more than what you earn . . . that is why many people do not qualify.”*

Rural Hispanic woman: *“If I want to have another job and earn more, then I have to think: ‘OK, if I earn \$100.00 more, they are going to take Kids Connection from me.’ ”*

Rural Hispanic man: *“If she earns, for example \$100.00 more a week, they are going to take it away from her kids. Well then just say we are going to leave the insurance, but out of those*

\$100.00 that you are going to receive that week, you are going to have to give us \$15.00 so your children can remain with it. That they have some flexibility, but taking some of what she earns. Because insurance for five children is not cheap.”

Rural Hispanic woman: *“You don’t have to earn more than \$100.00 for them to take it away; with only a dollar, you go over.”*

Private Strategy I: Create Public-Private Partnerships Between Employers and Medicaid

Premium Assistance Should Create a Bridge between Public and Private Coverage

Medicaid premium assistance is a public-private partnership between employers and Medicaid to provide assistance to low-income workers to pay insurance premiums. The cost of health insurance premiums can be divided between Medicaid, an employer, and an employee. For example, employers might pay 25% of a premium, employees 15%, and Medicaid the remainder. Uninsured and small employer focus group participants believed there is a significant need for a bridge between public and private coverage. Participants suggested that a premium assistance program could create this bridge by allowing low-income workers to purchase health insurance while working for employers who would not otherwise offer health insurance. However, small employers feared the administrative burden associated with partnering with public programs to offer premium assistance.

Premium Assistance May Not Benefit Rural Areas

Rural focus groups participants believed that premium assistance would not be helpful to rural workers with low incomes and assets such as land or farming equipment. These participants suggested that these assets be excluded from income when determining eligibility for premium assistance. Rural participants were also concerned that rural communities would associate a premium assistance program with the stigma of receiving public assistance. Finally, rural participants believed that a public-private partnership to offer assistance with premiums would not stimulate small business growth as much as a reinsurance program that targeted the self-employed, micro-employers, and small employers.

What we heard about public-private partnerships:

African American woman: *“I was on the Kids Connection and I let them know I was working. And the owner, he let them know that he didn’t provide no health insurance. They gave my son six months and then I needed to be able to pay it. This was very close to a minimum wage job—\$7 an hour. There was no way I could pay for health insurance; just because I was working that means no more insurance for my son.”*

African American woman: *“My neighbor started working, she made like \$5 an hour or \$6 and they [the state] cut her off just like that. But see when you get sick, you lose your job and you’re back in that system.”*

African American man: *“Everyone wants to be self-sufficient. Instead of rejecting us, this [premium assistance] sounds positive—you’re given a chance that makes it affordable to buy insurance.”*

Urban small employer: *“I tell you what, I would just close my doors when I think about that [Medicaid premium assistance] and the bookkeeping involved in something like that. Getting reimbursed from the state, keeping track of it all.”*

Rural small employer: *“Could this help a retired person before they can get Medicare? My mom’s retired and in that gap; she has little income—she is putting off surgeries and can’t afford some of her medications and is paying quite a bit for insurance.”*

Rural small employer: *“Will it include the agriculture sector, too? With rural Nebraska, how many are farmers and won’t have that employer to partner with?”*

Private Strategy II: Implement a State-Funded Reinsurance Program

Reinsurance for Small Employers Should Minimize Barriers to Offering Health Insurance and Facilitate Rural Economic Development

Reinsurance is an option many states are exploring to reduce and stabilize health insurance premiums. Reinsurance provides coverage for insurers and can be offered as a state subsidy to reduce premiums for the self-employed, micro-employers, and small businesses. Reinsurance plans reflect the fact that a small proportion of people typically account for the highest individual claims. Consequently, states that offer reinsurance pay claims above a specified threshold—such as all claims over \$30,000. Thus reinsurance should result in lower, more stable premiums for small employers who offer insurance because claims above the threshold are paid by the state and not the employer’s insurance carrier. Reinsurance is also intended to minimize adverse selection by carriers who ensure small employers. By limiting the reinsurance threshold amount to a range such as all claims between \$30,000 and \$100,000, a state can control its liability for reinsurance programs.

Focus group participants believed that providing reinsurance for small and micro-employers would minimize the barriers that these employers encounter when considering whether to offer health insurance. Focus group participants understood that reinsurance could be used to stabilize premiums, keep employees with preexisting conditions in the risk pool, and facilitate rural economic development by enabling more small employers and micro-employers to offer health insurance benefits.

Small employers, micro-employers, insurance brokers and agents urged careful consideration of eligibility restrictions and claim thresholds in reinsurance programs. Specifically, these participants suggested that reinsurance plans should be available to nonprofit organizations, small employers, and the self-employed. Small employers and micro-employers were in agreement that reinsurance not be restricted to those who had been unable to offer health insurance for a period of time. They viewed this restriction as punishing those employers who had struggled to maintain coverage despite continually escalating premiums. Participants agreed that businesses with 2 to 15 employees would benefit most from reinsurance but that all businesses with 50 or fewer employees could benefit. They suggested that claim thresholds be selected actuarially and reflect an amount that will make a significant impact, but not make premiums too high. Participants were also concerned about the effect reinsurance would have on the state’s Comprehensive Health Insurance Pool (CHIP). Finally, feedback from several groups

suggested that high-deductible insurance plans be combined with health savings accounts (HSAs) to fund preventive and primary care. Insurance brokers and agents suggested that this combination might help control health care costs since consumers use money from their HSA to pay initial costs of routine care.

What we heard about reinsurance:

Insurance broker/agent: *“Yes, yes it would encourage your small employers to offer health insurance plans because it would keep the premiums down and be less volatile. . . . It would help all sizes (of employers), but you have to design it such that you do not steer employers away from a certain size. . . . People are going to re-arrange their business so that they fit those qualifications.”*

Insurance broker/agent: *“I don’t know how it could not help. You have a lot of carriers that won’t participate in small groups because it’s so volatile and because of the HIPAA transfer of coverage, certificate of coverage. We’ve driven a lot of carriers out of the small group market.”*

Insurance broker/agent: *“It [health insurance] is going to have to be substantially less expensive for them [small employers] to even consider it. I don’t think \$25 or \$40 a month is going to make that big of a difference on the number of people that are now going to contribute to their group plan. . . . I don’t know what the magic number is, but for a guy who won’t pay \$400, he’s probably not going to pay \$350 either.”*

Insurance broker/agent: *“Well I don’t think [participation] should be limited because if the increases keep happening to [small businesses], it could literally force them out of business eventually.”*

Insurance broker/agent: *“If you only offer it to a group, you are going to adversely affect the individual market and vice-versa. So it should probably be offered to groups and individuals.”*

Insurance broker/agent: *“Plus, if my tax dollars are in some way funding that pool [for reinsurance], I would be pretty disappointed if I couldn’t participate.”*

Rural Micro-employer: *“Are you saying that this [reinsurance] will keep people in the pool of private insurance—avoid the vicious cycle of preexisting conditions?”*

Rural micro-employer: *“Are these limitations really going to punish people that are trying their best not to be uninsured?”*

Rural micro-employer: *“Crowd out? They [insurance companies] don’t want us [self-employed and micro-employers] anyway, at any price! They don’t give you a price, they will not insure you!”*

Young adult male: “If individuals could have an HSA available that would be fabulous. This money would be before tax. . . . And it will carry over to the next year so at least you have something for the deductible when you get thrown into the hospital.”

Rural small employer: “My son-in-law can’t find a teaching job. He has asthma and sent his dad to the doctor to say he had breathing problems to get his inhalers refilled this year. . . . How sad that he couldn’t set aside some pretax money to be used for that.”

Rural micro-employer: “I was mad when CHIP wouldn’t let me put \$2,500 in for an HSA.”

Rural small employer: “What makes you more competitive than your people? And if you can’t hire [good people] because you can’t afford insurance coverage, you can’t improve.”

Rural small employer: “This is a real economic development issue. Tom Osborn has really been pushing for all the small businesses.”

Private Strategy III: Provide Education About the Benefits of Health Insurance Coverage

Young adults aged 19 to 34 and newcomers discussed the need for education about health insurance coverage. The term *newcomers* describes immigrants, asylees, refugees, undocumented persons, and others who are new to the United States. Participants in the young adult and newcomer focus groups commented on how the content and format of education should be tailored to their specific needs. Finally, these groups were enthusiastic about the role schools could play in providing education about health insurance and access to health insurance.

Educating Young Adults

Young adult focus group participants agreed that they would like to be knowledgeable purchasers of health insurance and that they could benefit from education about health insurance coverage. Young adults reported that they have had few opportunities to learn about the role of health insurance or how to choose an appropriate policy. Young adult participants suggested that education be placed in the context of personal financial responsibility and should explain how the insurance industry works, frequently used insurance-related terms, their rights as policy holders, and the benefits that an adequate policy should offer. Young adults also believed that employers should share responsibility for educating employees who are new to the workforce about the value of health insurance coverage and the use of pretax dollars to purchase health insurance and health care.

Young adults also suggested that educators present health insurance information in a direct and timely manner such as immediately prior to the expiration of parental coverage. Participants preferred face-to-face education or a one-page, bulleted handout. Young adults suggested the use of information booths at college and high school career fairs to introduce young people to the concept of health insurance. Finally, young adults suggested that high schools and colleges consider integrating information about health insurance into civics, life skills, and financial planning classes.

Educating Newcomers

Newcomers believed that employers should be responsible for educating their employees about health insurance because a job is often the first contact that newcomers have with American culture and because employers have a vested interest in the health of their workers. Newcomers suggested that employers who do not offer health insurance benefits should provide employees with education about the advantages of and resources for purchasing individual insurance.

Newcomers expressed confusion about the role of health insurance in the complex American health care system. Refugee advocates explained that the concept of health insurance cannot be effectively taught until a newcomer develops an understanding of the American health care system and how to access care. Refugee advocates agreed that newcomers should understand the following about the health care system: they have the right to choose a provider; it is important to find a medical home to coordinate care; primary, preventive, specialty care, and prescription medications play different roles in health care; office visits should be used for routine care and the emergency department for true emergencies; and health insurance is necessary to gain access to care. Education about health insurance should include definitions of terms, an explanation of the rights of a policyholder, and the benefits an adequate policy should provide.

Hispanic participants and refugee advocates provided information about the format, location, and desired provider of health system and health insurance education. Face-to-face instruction was preferred over pamphlets and literature. Hispanic participants suggested Spanish radio as a method to educate Spanish-speaking audiences. They cited churches, schools, health clinics, and places of employment as practical settings for education. Refugee advocates and Hispanics indicated that educators should be knowledgeable and culturally and linguistically competent in order to be trusted. Hispanic participants explained that public information meetings are not common in Latino culture, so personal recruitment and follow-up from trusted individuals is necessary to obtain commitment to attend a group educational meeting.

Hispanic newcomers regarded schools as especially effective venues for disseminating information about health insurance and access to care. They described schools as the universal point of entry to the community because many immigrant and refugee families have school-age children. Schools were described as the initial link in the chain of information that newcomers need about community services. Hispanic participants expressed trust in the information disseminated by schools because schools typically have “a responsible adult who speaks Spanish” and bilingual and culturally competent staff are available to effectively provide information about public health clinics, nutrition programs, Medicaid/Kids Connection, and referrals.

What we heard about education:

Young adult male: *“If you have to buy it [insurance] yourself, you get nothing. You are paying out every month, and you have a \$1,500 deductible, which you will never use.”*

Young adult female: *“There’s not a chip in your brain saying, ‘you’re getting booted from your parents’ insurance next month, so you need to go get your own.’ You don’t know unless someone tells you.”*

Young adult male: *“Your expectations differ depending upon what you’ve been around. If your Dad was self-employed, health insurance was a catastrophic policy—put your arm in an auger. Where someone that grows up in a household with good insurance, you sneeze and you go to the doctor.”*

Young adult female: *“Knowledge is key, but it’s such a big picture. You can’t just pick up a piece of paper and get it.”*

Young adult female: *“There could be a booth handing out information from the state—one sheet, hot pink—there would be terms and the age you might be kicked off your parents’ plan.”*

Young adult female: *“First job you’re willing to take anything, it doesn’t matter if it has benefits or not. By the second job, your priorities change and you want insurance . . . so you don’t have to worry about going out and finding it and keeping track of it; you’ve got it.”*

Urban Hispanic female: *“Schools are the entry point to the chain of information.”*

Urban Hispanic female: *“The first place where my siblings received [health] information was school.”*

Rural Hispanic female: *“[The role of the employer] means that for all the people that come for the first time to this country . . . that they listen to the people. What are the advantages of being insured? Because they only say, ‘This is what it costs and this is what is covered’ and that’s it.”*

Rural Hispanic female: *“If our employer does not have the resources to help us, they should intervene in giving advice or in looking for other resources.”*

Rural Hispanic female: *“[The employer] has the principle role . . . his objective should be that his employees are healthy.”*

Refugee advocate: *“You can teach somebody vocabulary and they still don’t understand the concept.”*

Refugee advocate: *“One of the things we hear . . . it [the emergency department] is open 24/7. I can get help there when I can’t get it anywhere else. . . . Knowing that in the back of my mind there’s a 24/7 place open for me tends to take away from following up or showing up at the appointment.”*

Refugee advocate: *“If the provider appears to be not only close minded to that concept [culturally specific practices] there is no communication at that point because you’re not accepting me for who I am.”*

Conclusion

Being uninsured affects the physical, psychological, and economic quality of life of Nebraskans. The Coalition has proposed public and private strategies that are designed to mitigate limitations in human and social capital that increase the likelihood that Nebraskans will be uninsured.

Human capital refers to the skills and abilities people have to interact with their environment. These skills and abilities are typically developed through the educational system and employment. *Social capital* refers to the support provided to individuals through social networks such as families and communities.⁴ Thus, providing reinsurance and premium assistance can affect the human capital of the uninsured by increasing the likelihood that small employers will offer affordable, desirable insurance products. Expanding the safety net in central Nebraska, ensuring that eligible children and adults receive public coverage and improving the knowledge young adults and newcomers have about the role of health insurance in access to health care will improve the support communities can offer to those with limited education, skills, and income. The results of the household survey indicate that Nebraskans who are likely to be uninsured are those with limited human capital—limited income, limited education, aged 19 to 34, and of Hispanic ethnicity—who are self-employed or work for small employers. Consequently, enhancing human and social capital for those who work for small employers is an overarching strategy that should significantly decrease the number of uninsured Nebraskans.

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³ Office of the Secretary of State, State of Nebraska.
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Table 1. Summary of Nebraska State Planning Grant Year 2 At-Risk Focus Group Participants

Focus Group	Location	Health Planning Region	Number of Participants	Number of Female Participants (%)	Number of Uninsured Participants (%)	Number of Participants with Public Coverage (%)	Mode of Annual Household Income Range of Participants (number responding)
Rural Hispanic	Lexington	II	12	10 (83%)	8 (67%)	3 (25%)	\$12,500–\$14,999 ¹ (3)
Young Adult	Kearney	III	9	5 (56%)	0 (0%)	1 (11%)	\$35,000–39,999 ² (1)
African-American	Omaha	VI	10	7 (70%)	0 (0%)	7 (70%)	\$7,500–\$9,999 ³ (1)
Urban Hispanic	Omaha	VI	10	5 (50%)	6 (60%)	3 (30%)	Less than \$5,000 (5)
TOTALS			41	27 (66%)	14 (34%)	14 (34%)	

1. The median was used because there were two modes. Responses ranged from categories “less than \$5000” to “\$35,000 - \$39,000.”

2. The median was used because there were two modes. Responses ranged from categories “\$20,000 - \$24,999” to “\$65,000 or more.”

3. The median was used because there were two modes. Responses ranged from categories “less than \$5,000” to \$65,000 or more.”

Table 2. Summary of Nebraska State Planning Grant Year 2 Refugee Advocate Focus Group Participants

Focus Group	Number of Participants	Average Number of Years Advocate has Worked with Newcomers	Average Number of Years Organization has Worked with Newcomers	Examples of Countries	Average Newcomers who are Uninsured (%)
Refugee Advocate	9	7.5	22	Iraq, Bosnia, Sudan, Vietnam, Mexico, Nigeria, Afghanistan, Iran, Russia, South Korea, South America, El Salvador, Guatemala	52%

Table 3. Summary of Nebraska State Planning Grant Year 2 Small Employer Focus Group Participants

Focus Group	Location	Health Planning Region	Number of Businesses Represented	Average Number of Employees	Average Annual Salary Range of Employees	Number of Businesses Offering Insurance (%)	Average Range of Employee Participation in Employer Health Plan (of those offering coverage)	Participants Reporting that Coverage is “Very Important” or “Important” to Employees (%) ¹
Small Urban Employers (construction and service)	Omaha	VI	3	18	\$15,000–\$19,999	100%	Less than 25%	2 (67%)
Self-Employed/ Micro-Employers	Holdrege	III	9	5	\$15,000–\$19,000	11%	Less than 25%	7 (76%)
Small Rural Employers	Kearney	III	8	10	\$30,000–34,999	63%	75%–99%	8 (100%)
TOTALS			20	11		58%		17 (85%)

1. Categories to choose from were “Very Important,” “Important,” “Somewhat Important,” “Not at all Important,” and “Don’t Know.”

Table 4. Summary of Nebraska State Planning Grant Year 2 Agent/Broker Focus Group Participants

Focus Group	Number of Participants	Main Focus of Business	Range of Businesses Offering Health Insurance to Small Employers (50 or fewer employees)	Range of Businesses Offering Health Insurance to Self-Employed
Agent/Broker	8	Long-Term Care, Life Insurance, Employee Benefits, Property and Casualty, Multi Line Insurance	2%–80%	2%–15%