Health Insurance Coverage in South Dakota

Final Report of the State Planning Grant Program

Report to:

U.S. Department of Health and Human Services
Secretary Tommy G. Thompson

Prepared by:

South Dakota Department of Health
The Lewin Group

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EXECUTIVE SUMMARY

South Dakota was one of nine states in 2001 to be awarded one-year Health Resources and Services Administration (HRSA) grants to develop plans for expanding access to affordable health coverage to all state residents. Under the HRSA State Planning Grant (SPG) program, states were provided resources to conduct surveys and studies of their uninsured population and to design effective approaches for providing all citizens of the state with high-quality, affordable health coverage.

The State Planning Grant Program in South Dakota was launched early in the Summer of 2001, although state staff had been preparing for the grant during the previous year. The Department of Health, the lead administrative agency for the SPG, convened an Interagency Work Group of state officials who were charged with monitoring progress of the project and providing technical input to all major decisions concerning the grant. Members of the Work Group included staff from the South Dakota Department of Health, the Department of Social Services, the Department of Human Services, and the Department of Commerce and Regulation.

The State contracted with The Lewin Group of Falls Church, Virginia, to (1) collect and analyze information about the uninsured and underinsured in South Dakota; (2) survey employers in the state about health insurance benefits they offer to employees and dependents, and analyze resulting data; (3) develop options to increase health insurance for uninsured persons in South Dakota and estimate resulting program costs; and (4) draft a final report to HRSA.

A telephone survey was designed and completed of 1,502 households in South Dakota with at least one member who was uninsured in the Fall of 2001. The survey was designed to develop a broad understanding of uninsured persons' demographic and employment characteristics; to identify the reasons uninsured persons do not have coverage; and revealed the consequences of no health insurance. The survey was also intended to capture information (via an abbreviated questionnaire) about an additional 18,805 individuals who *do have* health insurance. This information was used for state program purposes (e.g. determine extent of prescription drug coverage among the insured population), and to derive more precise estimates of the number of persons who are uninsured.

The household survey provided detailed information that was analyzed in several steps. First, data (from insured and uninsured individuals) were used to refine Bureau of the Census' Current Population Survey (CPS) estimates for South Dakota and produce county-level estimates of the rate of uninsurance. These improved estimates are different from other published CPS estimates for South Dakota, which are often unadjusted and based on small sample sizes. As a result of careful refinements to the CPS, the estimated percent of uninsured South Dakotans dropped from 11.8 percent to 8.1 percent. Another key finding is that over 84 percent of the uninsured in the state are working men and women or their dependent children and spouses. The age groups most likely to be without insurance are young adults and those between 55-64 years of age.

Key highlights of the survey of the uninsured include:

- More than one-quarter of uninsured persons in South Dakota had no health insurance for one year or less. About 42 percent of the uninsured, however, were without coverage for five years or more.
- The primary reason the uninsured have no health coverage is because they cannot afford the monthly premiums; 80 percent of those surveyed report high premium costs as a major impediment to securing coverage.
- For over half of the uninsured in the state, health coverage is not available to them through their employment.
- One-quarter of the uninsured report they are either in fair or poor health, a rate nearly double that for South Dakotans as a whole.
- Nearly one-third of the uninsured in South Dakota report that they needed to see a doctor in the past 12 months, but didn't go because of cost concerns.
- Almost two-thirds of uninsured South Dakotans in poor health report having difficulty getting medical care when they need it, compared to nine percent of the uninsured in excellent health.
- The estimated rates of uninsurance vary by geographic region. The lowest rates of uninsurance were in the southeast region of South Dakota; the highest rates were in the south central and northwest regions of the state.

Results of the survey appear in Section I of this report.

A survey of employers was designed and carried out, also in the Fall of 2001, to identify the reasons that some employers offer coverage, while others do not, and the challenges that employers face in doing so.

Major findings of the employer survey include:

- About 55 percent of private employers in South Dakota offer health insurance to their employees.
- The major reason employers say they offer health insurance is to attract or retain workers.
- On average, 81 percent of the worker's insurance premium, and 39 percent of his/her dependent premium, is paid by employers in South Dakota.
- About 21 percent of surveyed employers in the state are self-insured, translating into approximately 62 percent of the workforce.
- The major reasons employers in the state report they do not offer health insurance is that coverage is too expensive for the company to afford and that their employees are covered elsewhere.
- There is geographic variation that employers recognize in the adverse effects of not providing health insurance to their workers. About 20 percent of non-insuring employers in the Pierre/Mobridge/Rapid City region report their uninsured employees are unable to obtain medical care, compared to seven percent in the Sioux Falls area.

? Nearly 60 percent of non-insuring firms in South Dakota say they would be interested in participating in a health insurance program that was subsidized by the state or federal governments.

Results of the employer survey are presented in Section II.

A series of eight focus group sessions were organized and sponsored in South Dakota during September and October 2001. Focus groups captured information about specific groups of uninsured and underinsured persons including those who are low-income, the self-employed, those who work for or own small businesses, Native Americans (living on and off-reservation), older and elderly persons, and farmers and ranchers. The purpose of the focus groups was to develop an 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. A summary of South Dakota's focus group findings appears in ***Appendix D***.

Key themes that emerge from the focus groups include:

? Focus group members' personal stories provided compelling evidence of the serious problems many South Dakotans face in trying to secure affordable and adequate health insurance. These problems seemed most widespread among lower income individuals, those with catastrophic or chronic medical conditions, and for individuals 50-64 years of age.

? Those who were farmers and ranchers, self-employed, or employed by small firms that don't offer job-based benefits reported extensive frustrations in their attempts to secure adequate and affordable coverage. Their low wages, modest monthly incomes relative to high premium costs and other household expenses, and/or the cyclical nature of their household incomes also undermined their ability to secure ongoing health coverage.

? The high cost of health insurance is the major factor influencing individuals and small employers' decisions not to purchase coverage for themselves, families, or workers. The high cost of health insurance is also the major reason that many individuals chose health policies with extremely high deductibles ($5,000) or limited benefits. Many focus group members perceive that insurance companies are "ripping them off" as evidenced by the extensive reporting of significant premium price increases for 2002; having their coverage dropped for reasons that seem beyond their control; and experiencing unexpected limits in benefits or payment amounts when medical claims are processed.

? In light of the difficulties individuals and families experience paying monthly premiums, there was a widespread belief expressed in many of the focus groups that health insurance isn't "worth it" if you don't use it (that is, seek medical care). At the same time, some focus group participants feared they could "lose everything" should medical catastrophe strike.

? Some focus group members wondered whether having health insurance would actually make life any easier for them to secure needed medical care, given health care shortages in many areas of the state.

? The Children's Health Insurance Program was almost universally hailed as a "good" and valuable state program by focus group members.

In addition to focus groups, structured in-person and telephone interviews were carried out with several health care provider and insurance groups and other key stakeholders in the state (such as consumers and businesses). From these interviews, project staff learned more about different organizational perspectives about the problem of health insurance in South Dakota and possible strategies for addressing it.

Each of these approaches was designed to elicit different kinds of information and to complement the other approaches. By triangulating information from the various sources, the scope and context of uninsurance in South Dakota was defined. Once data were tabulated, analyzed, and interpreted, the development of coverage options uniquely suited to South Dakota was initiated. Preliminary policy options to increase affordable health insurance coverage were developed by The Lewin Group, then discussed and evaluated by the Interagency Work Group. Based on the Work Group's assessment of several issues, including the feasibility of proposed approaches, policy options were refined and revised. For each option, Lewin estimated the number of persons who would become insured and the cost of adopting each option. The six policy options that were analyzed include:

? Expand income eligibility levels for adults under Medicaid and the State Children's Health Insurance Program (SCHIP);

? Create a Medicaid buy-in program for small employers and low-income persons;

? Create a private health insurance premium subsidy program for low-income persons;

? Create a private health insurance premium voucher program for small employers;

? Create a low-cost coverage option for small employers; and

? Expand direct services for uninsured older adults.

These options are presented in detail in Section IV of this report.

As the State of South Dakota considers options to expand affordable health insurance coverage, the Interagency Work Group recognizes the importance of federal action to support state efforts to provide coverage for the uninsured. Federal action is recommended in at least four areas:

1. The federal government should offer federal tax credits for purchasing health insurance coverage. This action is particularly important for South Dakota where there is no state individual or corporate tax.

2. State health care access initiatives often raise ERISA pre-emption concerns. The federal pre-emption for self-funded health plans should be removed to facilitate effective reform in the health insurance market and incorporate all players in state reform efforts.

3. There are nearly 63,000 American Indians living in South Dakota (8.3 percent of the state's population), according to the U.S. Census Bureau. The federal government should dramatically increase funding for the Indian Health Service, ease and revise IHS

requirements for contract health services, and use federal funds to facilitate Medicaid or alternative private coverage among American Indians. From a consumers' perspective, the burden that American Indians face in attempting to secure needed health coverage and medical services (both on- and off-reservation) undermines public efforts to improve the health status of *all* South Dakotans in measurable ways.

4. The federal government should address the deteriorating situation of health care access in frontier areas of the United States. It should identify effective frontier practice models and partner with states and tribal organizations to address the diminished availability of a wide range of health services in many areas.

As the South Dakota planning process continues even after this SPG phase is completed, there is much to be accomplished in the state. Many of the coverage expansions that have been considered would require action on the part of the State Legislature and developing a consensus around these issues will take some time. In addition, the State's fiscal situation will need time to improve sufficiently so that possible additional coverage programs can be considered.

SECTION I: THE UNINSURED IN SOUTH DAKOTA

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

To achieve South Dakota's objective of developing a better understanding of the state's uninsured population, a number of activities were undertaken. The project's consultant, The Lewin Group, developed baseline information from several years of national Current Population Survey (CPS) data. The data were then adjusted to yield more precise estimates of the number of uninsured. The effect of these adjustments was to reduce the estimated percent of uninsured persons from 11.8 percent (the figure often published) to 8.1 percent in South Dakota. Additionally, two-thirds of all uninsured persons in the state are working men and women. Over 50 percent of the uninsured have family incomes less than 200 percent of the federal poverty level ($14,630 for a family of three in 2001[1]). The results of Lewin's CPS analysis appear in ***Appendix A***.

Next, a telephone survey was completed of over 20,000 households in South Dakota to obtain a sample size of 1,500+ households having at least one member who is uninsured. New and detailed information was generated from this survey. Abbreviated interviews were also conducted with insured persons ("screen-outs"[2]), in order to provide the state with useful information about the coverage of the insured and their satisfaction with it. A series of focus group sessions was also conducted with a broad range of uninsured persons throughout the state. This multi-fold data collection effort led to a comprehensive understanding of the uninsured population in South Dakota in 2001.

A. Survey of the Uninsured

While the CPS data provides some quantitative demographic information, it does not answer questions pertaining to many characteristics of the uninsured such as, why and how long individuals are uninsured, or the health and financial consequences of living without insurance. To help answer these and other questions, a statewide telephone survey was conducted near the end of 2001. The survey was designed by The Lewin Group and the South Dakota Interagency Work Group. It was carried out by Baselice & Associates, Inc. of Austin, Texas. The sampling

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[1] *Federal Register,* Vol. 66, No. 33, February 15, 2001, ppd. 10695-10697.

[2] Persons who weren't eligible for the full survey because they had health insurance.

frame was designed to achieve broad representation of all areas of the state, particularly rural regions with small populations. The survey included complete responses from 1,502 uninsured individuals and data from a mini-survey of 18,805 insured individuals in South Dakota. The methods and approach used for the survey and focus groups can be found in ***Appendix B***. ***Appendix C*** includes all survey questions.

Highlights of the South Dakota Survey of the Uninsured are featured below.

1. Comparison of Uninsured to Insure Respondents

The uninsured and the insured groups differed from each other in a number of ways. ***Figure 1*** highlights these fundamental differences. As would be expected, persons who were uninsured were younger than those who were insured and fewer of them were married. The mean age of the uninsured was 42 while the mean age of the insured group was 51 years. Additionally, 44.3 percent of the uninsured group and 66.6 percent of the insured group was married. Approximately 25 percent of uninsured respondents were between 18 and 29 compared to 11.6 percent of the insured. Nearly half of the insured group was 50 years of age or more.[3]

Figure 1
Demographic Characteristics of Respondents

	Uninsured	Insured
Mean Age	42	51
Median Age	42	48
Age 18-29 years	25.0%	11.6%
Age 50+years	30.5%	47.8%
Married	44.3%	66.6%
Mean Number of Children in Household [a/]	1.32	1.66
% Anglo/White	91.1%	94.3%
	n=1,502	*n=18,805*

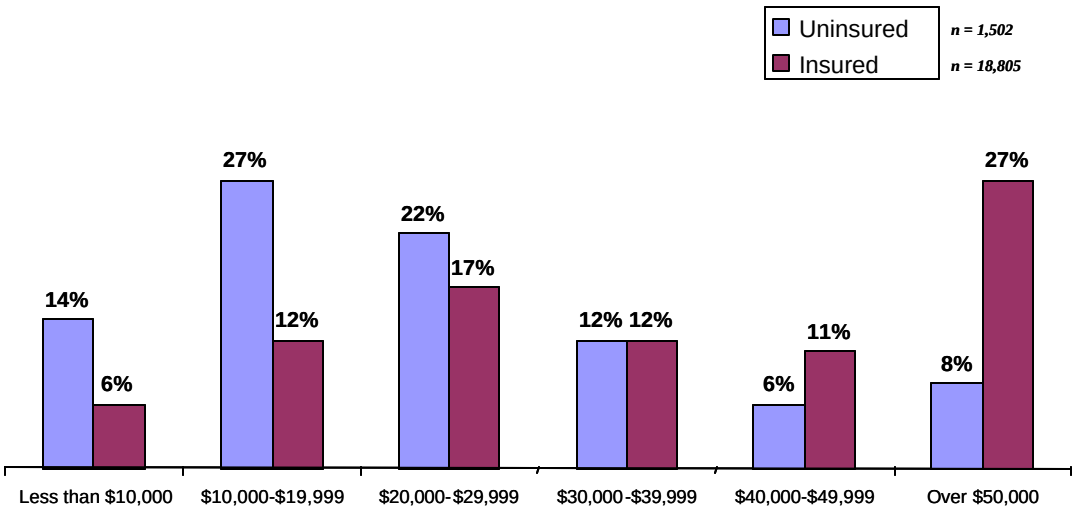
a/ Includes only households where children are present.

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The telephone survey confirmed a hypothesized difference between the uninsured and insured groups in household income and insurance status. As seen in ***Figure 2,*** the percent of uninsured surpassed the insured group in the lower income categories (under $30,000). For example, 27 percent of the uninsured respondents had annual household incomes between $10,000 and $19,999 while only 12 percent of the insured were in that category. Similarly, eight percent of the uninsured had incomes over $50,000 compared to 27 percent of the insured. The majority of the uninsured (63 percent), had household incomes of less than $30,000 per year. Alternatively, 50 percent of the insured had household incomes of $30,000 or greater per year.

[3] It is likely that the high proportion of older insured respondents influenced the numeric values of the insured group presented in Figures 1-4.

Figure 2
Distribution of Uninsured and Insured Respondents by Household Income



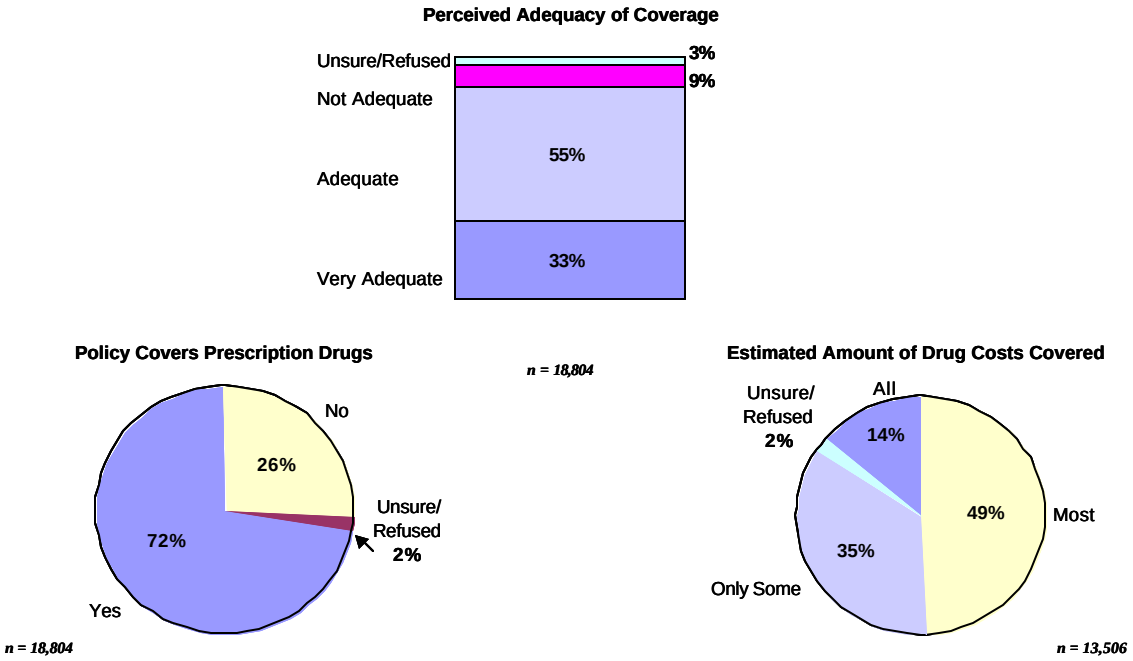
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The South Dakota SPG project differs from other planning grant states in that Interagency Work Group staff used this unique survey opportunity to interview those *who do have* coverage in order to learn more about the insured population in the state.

Eighty-eight percent of insured persons described their health care coverage as "adequate" or "very adequate" while nine percent found it to be "not adequate." (Three percent refused or were unsure.) Nearly three-quarters of insured respondents (72 percent) reported they had a health plan that covered prescription drugs. Of those with prescription drug coverage, 14 percent reported that all of their drug costs were covered; 49 percent reported that most of the cost of drugs was covered; and 35 percent reported only some of the cost was covered. These findings appear in ***Figure 3.***

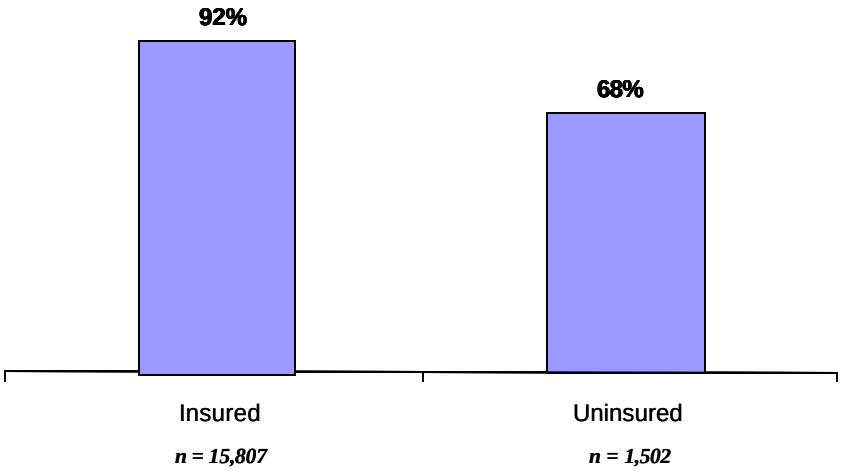
All insured and uninsured respondents were asked about how important having insurance coverage was to them. While 90 percent of the insured reported that having health coverage was very important to them, less than 70 percent of uninsured individuals reported feeling the same way. There remains much to learn about the behavior and insurance choices of the uninsured in this regard ***(Figure 4).***

Figure 3
Health Coverage for Insured Respondents



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Figure 4
Percent Reporting that Having Insurance Coverage is Very Important



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

2. Characteristics of the Uninsured

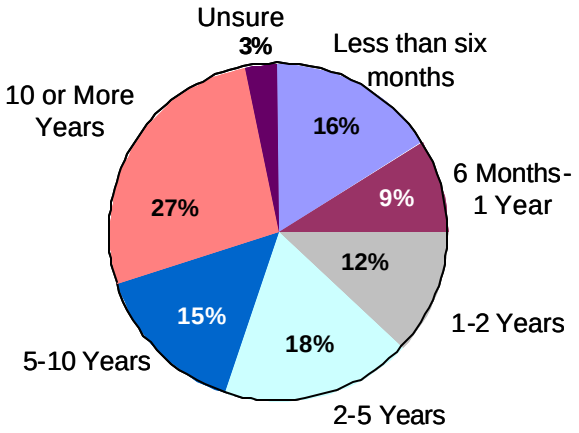
The telephone survey identified households in which there was at least one uninsured person. Nearly 80 percent of respondents were themselves uninsured. The remaining 21 percent reported on behalf of an uninsured spouse or other dependent in the household. The majority of respondents were female (56 percent). Respondents were primarily married (44 percent) or single (26 percent); the remainder were either divorced /widowed or living with a partner. Forty percent of respondents had children less than 18 years of age living in the household.

The survey revealed that forty-six percent of the uninsured had annual household incomes of under $20,000. Among uninsured households with wage earners, 45 percent reported that two or three wage earners lived in the household. Fourteen percent of primary wage earners in surveyed households were farmers or ranchers.

There was great variation in the length of time individuals reported they were without health coverage (***Figure 5)***. One quarter of the uninsured lacked coverage for one year or less. In contrast, 42 percent of the uninsured had no health insurance for five years or longer. Individuals uninsured for long periods of time are usually of greatest concern to policymakers.

Although many of the uninsured report that they are in good health ***(Figure 6)***, compared to the general population they are in worse health. Three-quarters of the uninsured assert they are in either excellent (29 percent) or good (46 percent) health. However, one-quarter are in either fair or poor health, a rate nearly double that for South Dakotans as a whole. The Centers for Disease Control's Behavioral Risk Factor Surveillance System (BRFSS) data indicated that 12.1 percent of South Dakotans viewed their general health as fair to poor in 2000.[4]

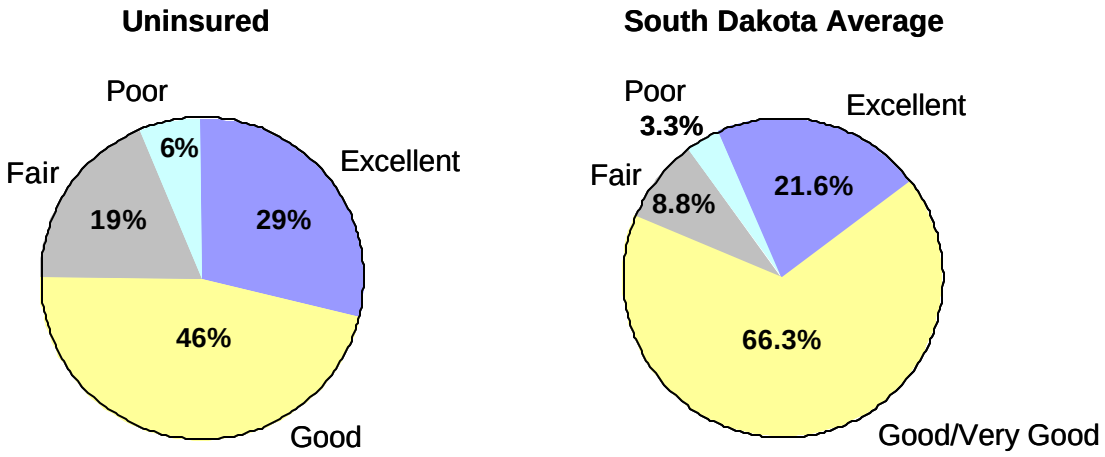
Figure 5
Length of Time Without Insurance



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

[4] Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data.* Atlanta, Georgia: U.S/ Department of Health and Human Services, Centers for Disease Control and Prevention, 2000.

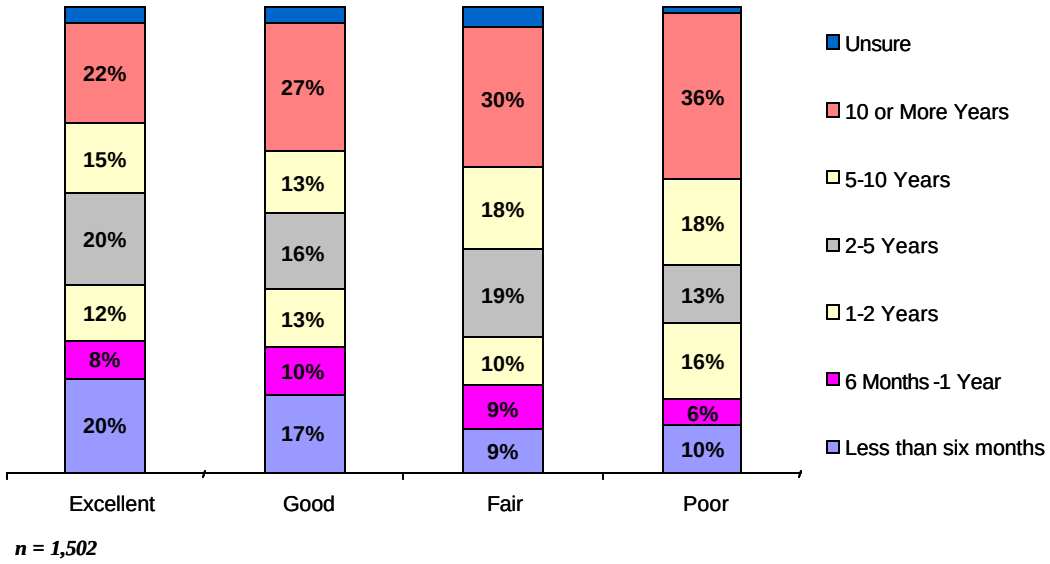
Figure 6
Self-reported Health Status of Uninsured and General Population



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001) and CDC's BRFSS data.

There is a relationship between the length of time South Dakotans are without insurance and their health status. Of those who report their health status is poor, 36 percent of them have been uninsured for ten or more years, while 16 percent have been uninsured for less than one year. Of those reporting their health to be excellent, 22 percent have been uninsured for at least ten years and 28 percent were uninsured for less than one year ***(Figure 7).*** These data indicate that lower health status is associated with longer periods of uninsurance.

Figure 7
Distribution of Length of Time Without Insurance and Self Reported Health Status

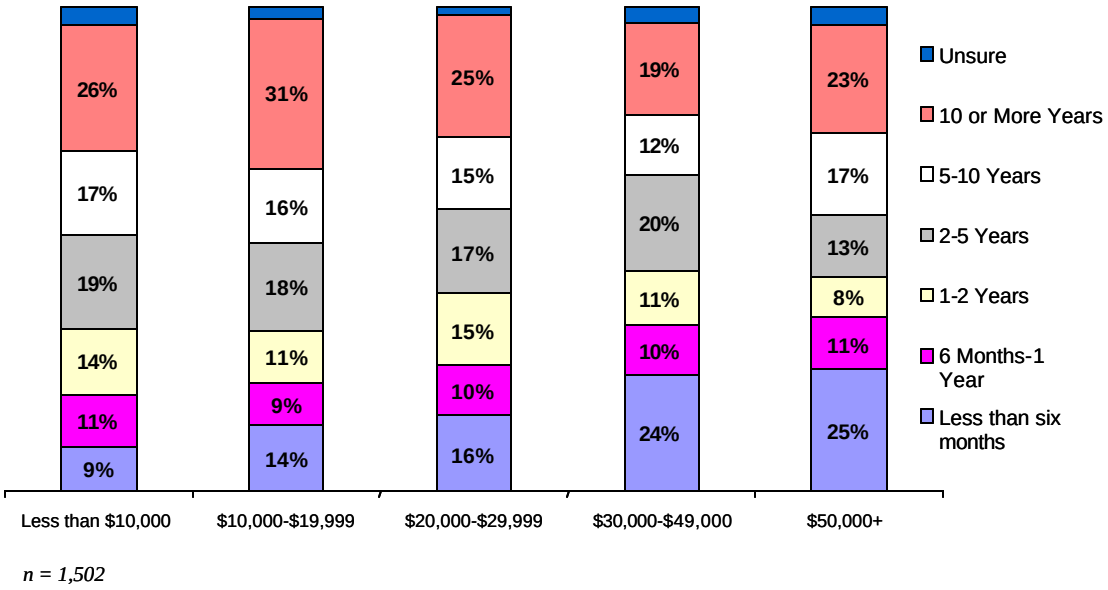


n = 1,502

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

An association between length of time without insurance and yearly income is evident. As seen in ***Figure 8***, 20 percent of those who earn less than $10,000 a year have been uninsured for one year or less, while 36 percent of those earning at least $50,000 have been uninsured for one year or less. These data indicate that for the uninsured, as household income increases, the probability of being uninsured for one year or less also increases.

Figure 8
Distribution by Length of Time Without Insurance and Household Income



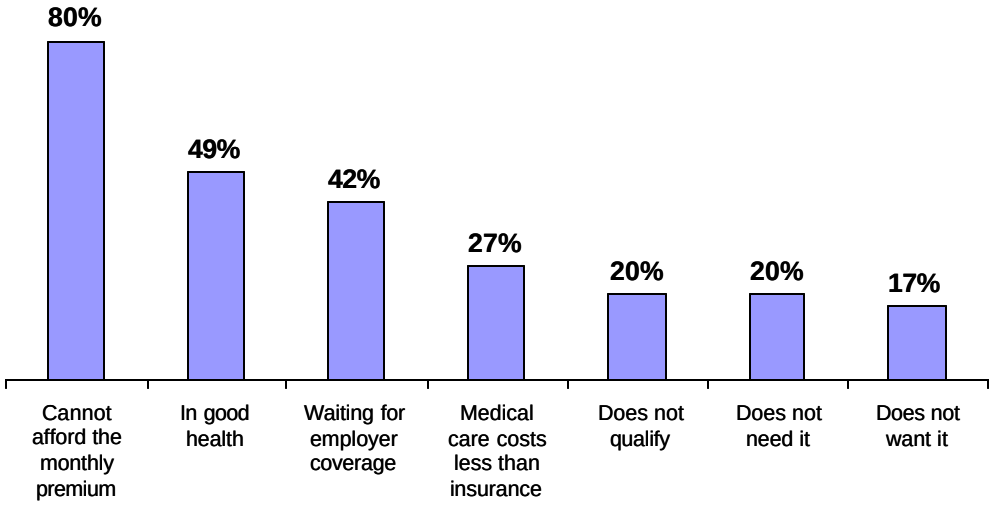
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

3. Reasons for Being Uninsured

The South Dakota survey provided a unique opportunity to ask uninsured persons the reasons they go without health coverage. The major reason the uninsured reported they have no coverage is that they cannot afford the monthly premium; 80 percent stated this was a key reason for not having health insurance ***(Figure 9)***. Forty-nine percent of the uninsured asserted they did not have coverage because they were in good health and 42 percent were waiting for employer coverage. Another major reason the uninsured said they do not have health insurance was that the medical care they needed costs less than health insurance.

Having health insurance in South Dakota is closely linked to employment, as elsewhere in the United States. Employment, however does not automatically guarantee the opportunity for health coverage. As seen in ***Figure 10,*** nearly half (48 percent) of the uninsured are employed by others and 27 percent are self-employed. Only one quarter of the uninsured in this survey are unemployed or not currently working for pay.

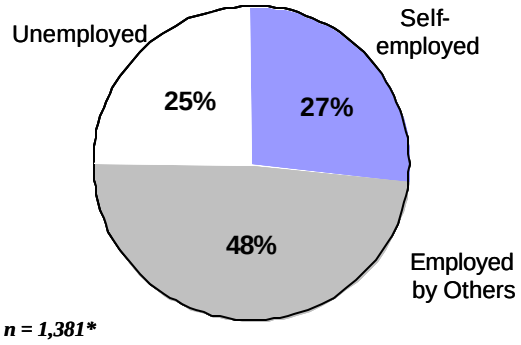
Figure 9
Primary Reasons for Not Having Health Insurance



n = 1,502

Source: Lewin Group survey of 1,502 uninsured persons in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001)

Figure 10
Uninsured by Employment Status



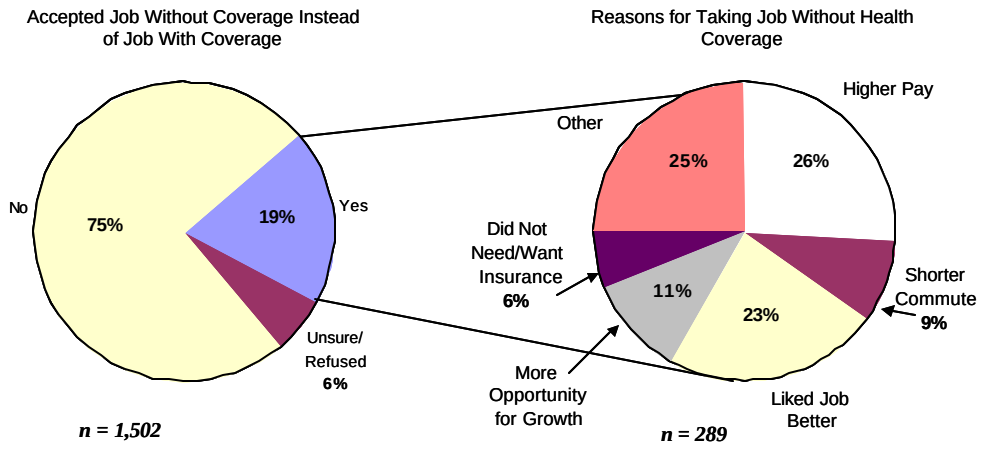
n = 1,381*

****This question was not asked of 121 respondents, as the uninsured person in the household was either a minor or an adult not in the workforce (e.g. parent)***

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Three-quarters of the uninsured have never accepted a job without health coverage instead of a job with coverage ***(Figure 11).*** Nineteen percent of respondents reported accepting a job without coverage instead of a job with coverage. The primary reasons they did so was higher pay (26 percent) and the fact that they liked the job better, despite it not offering health insurance coverage (23 percent).

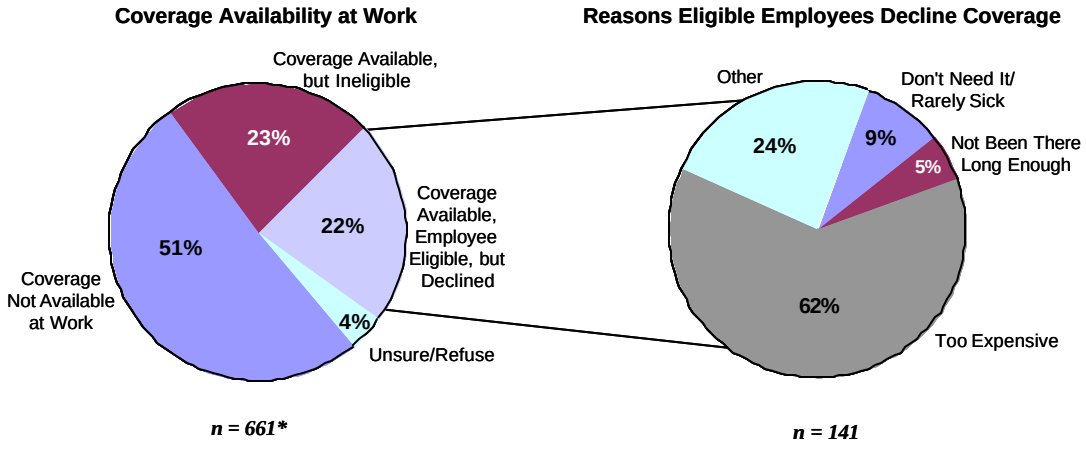
Figure 11
Accepting Employment Without Health Benefits



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The survey revealed that for over half of the uninsured in South Dakota, health coverage is not available to them through their employment. Another 23 percent are ineligible for the job-based coverage that is available to them. Not all individuals who are offered employer-based coverage accept this benefit ***(Figure 12).*** About 22 percent of the state's uninsured report they have coverage available to them through employment, but they do not accept this benefit. Most (62 percent) of them decline this coverage because it is too expensive.

Figure 12
Eligible at Work but Declined Coverage

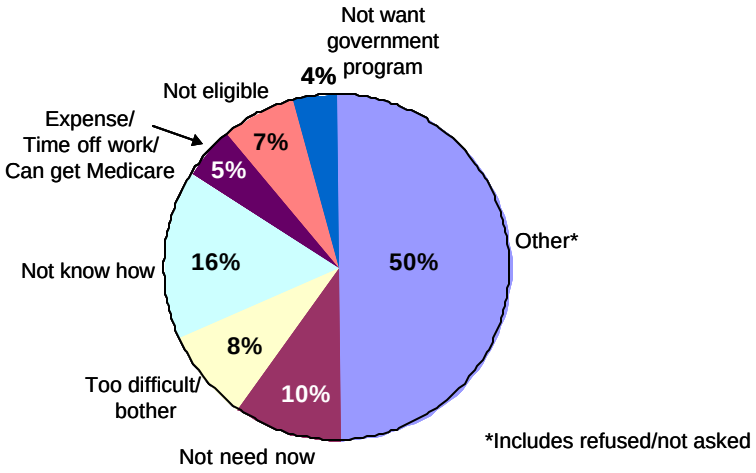


Only respondents who work for someone else were asked this question.

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Because of the relatively low income of many of the uninsured, it was hypothesized that a large percentage of them may be eligible for state health insurance programs, such as Medicaid or the Children's Health Insurance Program (SCHIP). Fifty-seven percent of the uninsured did not think that they, or others in their families, would be eligible for such assistance. Another 26 percent were unsure. However, 16 percent of the uninsured believed that they (or another family member) might be eligible for Medicaid or SCHIP but they had not applied for assistance. They did not apply for this assistance for many reasons ***(Figure 13).***

Figure 13
Reasons for Not Applying for State Programs Among Those Who Think They Are Eligible

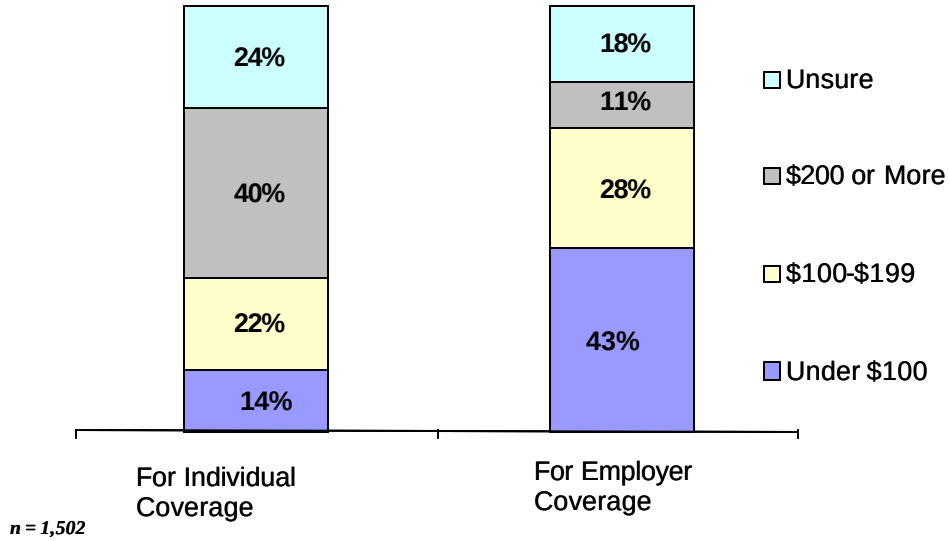


Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Respondents in households either with children or who were not covered by Medicaid or SCHIP were asked whether they had ever applied for program. Forty-two percent of these respondents (*n*=595) reported they had applied at one time or another for Medicaid or SCHIP. Of these cases, one-third of them had one or more children currently enrolled in Medicaid or SCHIP

Although research continues to confirm that high cost is the primary deterrent to attaining health insurance, many uninsured respondents did not know how much health coverage might cost. For example, 24 percent of the uninsured were unsure what the out-of-pocket cost of coverage would be for individually purchased coverage ***(Figure 14).*** Forty percent believed *individual* coverage would cost $200 or more per month. Similarly, 18 percent of uninsured respondents were unsure how much *employer* coverage would cost them. Respondents recognized, however, that employer coverage would be significantly less expensive: 43 percent of the uninsured thought employer coverage would cost under $100 compared to 14 percent if purchased as an individual policy. This finding, in combination with the survey result that over 75 percent of workers in South Dakota have never accepted a job without coverage, indicates that most workers want their employers to continue playing a role in providing health insurance.

Figure 14
Perceived Monthly Out-of-Pocket Cost of Employer and Individual Coverage



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

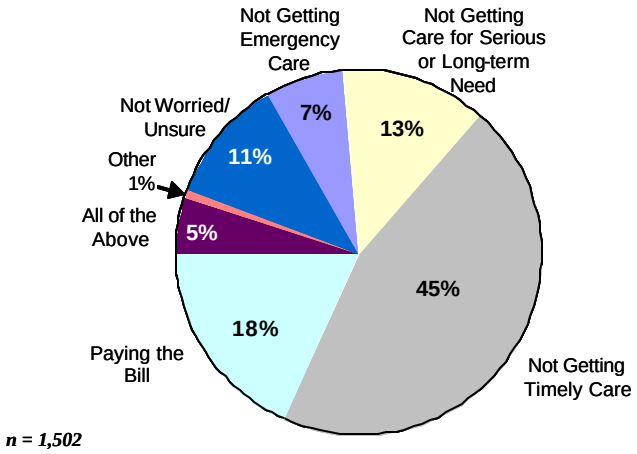
4. Consequences of Being Uninsured

The telephone survey offered the opportunity to investigate the consequences individuals experience as a result of not having health coverage and the related issues that primarily trouble them. The main worries of the uninsured population in South Dakota concern the health and financial consequences of being without health insurance ***(Figure 15)***. The *major* worry of uninsured South Dakotans is access to timely medical care (45 percent). Another 13 percent worry about getting care for serious or long-term medical needs, and seven percent primarily worry about not getting emergency care when needed. In combination, 65 percent of the uninsured in South Dakota primarily worry about access to various kinds of medical care as a result of not having coverage. Less than 20 percent (18 percent) of the uninsured report their biggest worry is the inability to pay a medical bill after receiving care.

The health and financial consequences of not having health coverage can be significant. Nearly one-third (32 percent) of the uninsured in South Dakota needed a doctor in the past 12 months but did not go due to cost. The percent of uninsured who delay seeking medical care is much higher than for the general state population, as a whole. BRFSS data for South Dakota indicates that only 7.2 percent of the population delayed seeing a doctor because of cost in 1999.[5]

[5] Centers for Disease Control and Prevention, *op.cit.*

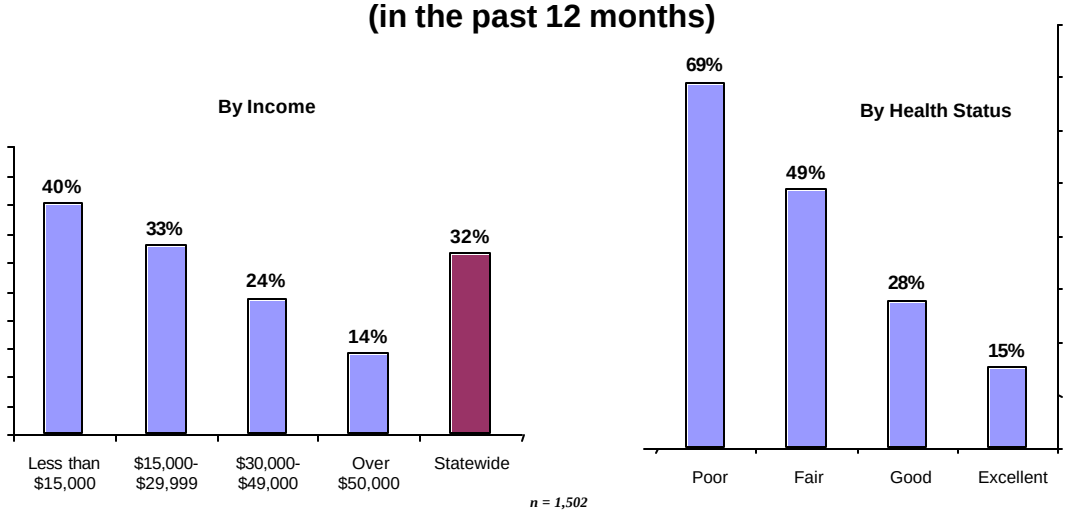
Figure 15
Main Worry About Being Uninsured



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Looking at South Dakota's uninsured population by income and health status further reveals the implications for those without insurance. Forty percent of the uninsured earning less than $15,000 per year reported needing a doctor in the past 12 months but not going due to cost. For those earning over $50,000, only 14 percent of the uninsured experienced such a situation. This finding suggests that uninsured individuals with higher incomes have access to care when they need it ***(Figure 16).*** For those in poor health, however, uninsurance is a serious deterrent to prompt medical care. Sixty-nine percent of those who reported being in poor health did not see a doctor when needed. This percentage dropped as reported health status improves. This suggests that uninsured persons with ongoing medical care needs frequently are unable to get care because of cost concerns.

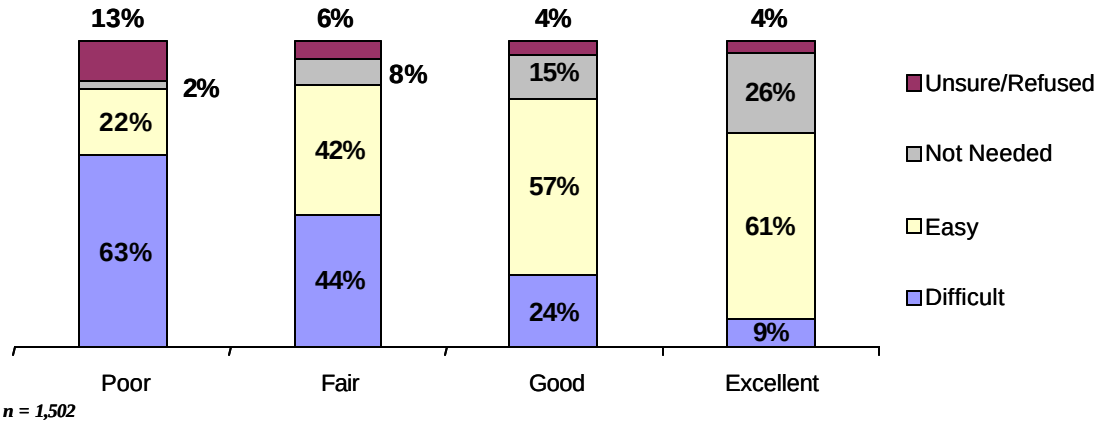
Figure 16
Needed a Doctor But Did Not Go Due To Cost
(in the past 12 months)



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The ease with which the uninsured in South Dakota secure needed medical care varies widely by self-reported health status ***(Figure 17).*** Nearly two-thirds (63 percent) of uninsured persons in poor health report having difficulty getting medical care when they need it, compared to nine percent of those in excellent health. Alternatively, 22 percent of uninsured Dakotans in poor health find it easy to get medical care, compared to 61 percent of those in excellent health. In combination with the previous findings, one can conclude that the uninsured, particularly those in poor health, have a difficult time obtaining medical care and often delay getting treatment in South Dakota.

Figure 17
Difficulty in Getting Medical Care by Health Status

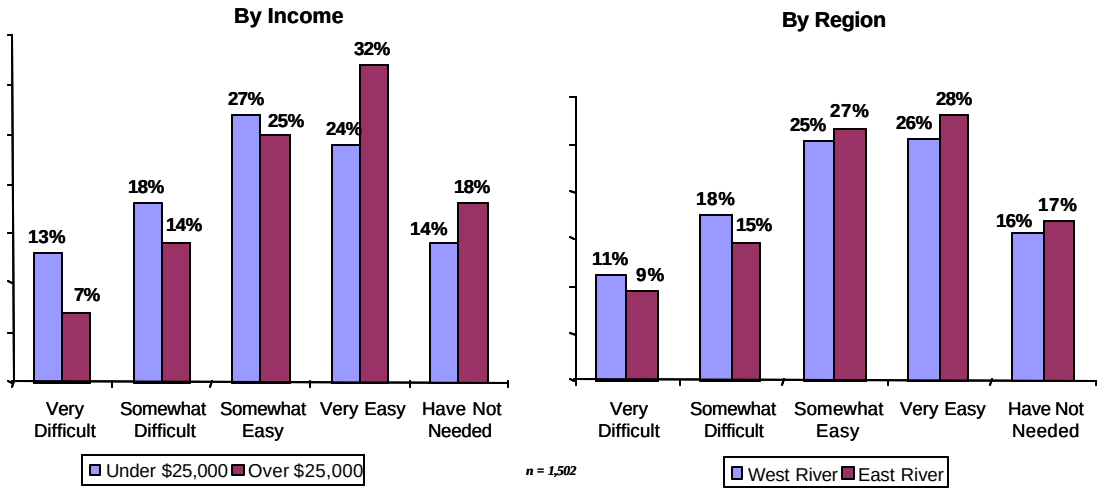


Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Exploring the difficulty in obtaining medical care by annual income and by geographic region offers further insight into the experience of the uninsured in ways similar to those who have not seen a doctor because of cost ***(Figure 18).*** Fewer lower income uninsured persons have not needed medical care since they were uninsured, as compared to those with higher incomes. While thirteen percent of those earning less than $25,000 per year find it very difficult, only seven percent of those earning over $50,000 find it very difficult to get needed medical care. Likewise, 24 percent of those with incomes less than $25,000 and 32 percent of those with incomes above $25,000 per year report that it is very easy to get medical care. Some regional differences are also apparent. The survey indicates that it is somewhat harder for the uninsured to get needed medical care in the western half than the eastern half of the state ***(Figure 18).***

As such a large percent of uninsured individuals assert that it is both hard to get care and that they delay getting care due to the cost, it is important to understand where they go for medical care. Over two-thirds (69 percent) of the uninsured in South Dakota go to the doctor's office for needed medical care. Twenty percent go to the hospital emergency room, and eight percent use the Indian Health Service or other health care providers such as community health centers.

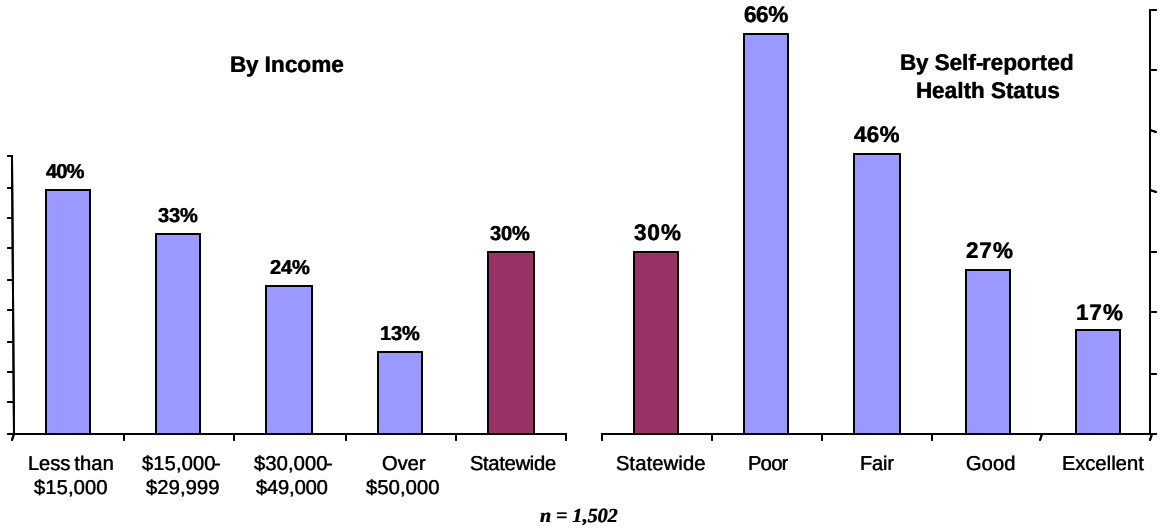
Figure 18
Difficulty in Getting Medical Care



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The financial repercussions of being without coverage can be harsh, even though nearly thirty percent of the uninsured claim that medical care is less expensive than medical coverage (see page 8). Thirty percent of the uninsured report they have large bills that are difficult to pay ***(Figure 19).*** Uninsured persons with the lowest annual incomes and the poorest self-reported health status have the greatest difficulty paying large medical bills. Forty percent of the uninsured with yearly incomes of less than $15,000 have large medical bills and 66 percent of those with no coverage in poor health experience this financial distress.

Figure 19
Large Medical Bills That Are Difficult to Pay



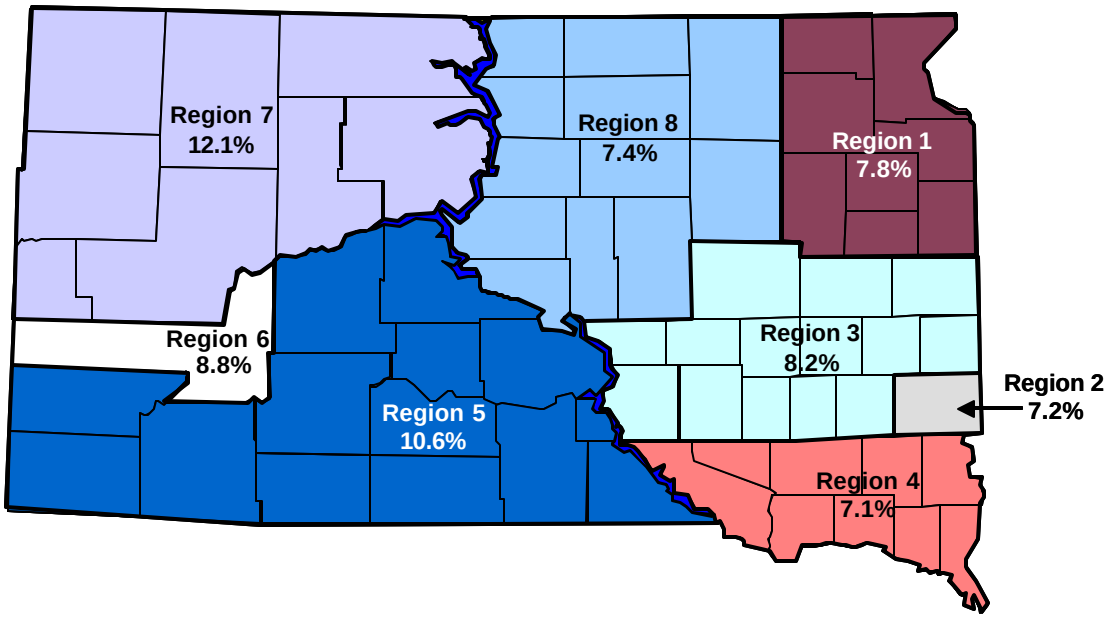
Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

5. Geographic Variation in Uninsurance Rates

As described in ***Appendix A***, some household survey data were applied to Current Population Survey (CPS) estimates of the number of uninsured persons in South Dakota. These adjustments reduced to 8.1 percent the total estimated percent of uninsured South Dakotans.

The number of telephone calls was based on a representative sample of the state's population; total population estimates for each county (based on the 2000 Census) were grouped into eight geographic regions. The distribution of survey responses and adjustments (as described above) yielded regional variations in the rate of uninsurance across South Dakota. The lowest rates of uninsurance were in the southeast corner of the state. The highest rates were in the south central and northwest regions of South Dakota ***(Figure 20).***

Figure 20
Geographic Variation in Rates of Uninsured



Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

6. Survey Summary

The findings described throughout this report yield new information about those with no health insurance in South Dakota, including their demographics, their worries, and the consequences they experience as a result of not having health coverage. The survey documented that the overwhelming majority of uninsured South Dakotans are workers who are either employed by others or self-employed. It demonstrated that uninsured persons in poor health or with limited incomes have particular difficulties accessing needed health care. These findings suggested which particular population groups are particularly important for South Dakota to consider in

developing targeted expansion options. They include uninsured workers and older adults (age 55-64) who are uninsured. Thus, it can be concluded that state surveys, such as described above, are important tools for policymakers as they develop options for making health insurance more available and affordable in their states. The survey also revealed important differences between the insured and the uninsured in their attitudes toward coverage.

B. Focus Groups of Uninsured Individuals

The South Dakota Survey of the Uninsured provided quantitative data on the scope of the uninsured problem in the state. The survey helped the SPG project team develop a deeper understanding of the barriers involved in the purchase of coverage as well as the consequences of being without coverage. In order to develop an even more meaningful understanding of the issues that confront uninsured individuals, The Lewin Group conducted focus group sessions with uninsured South Dakota residents. Compared to surveys, focus groups provide a deeper understanding of the scope and environmental context of the uninsured and underinsured population by probing individual attitudes, values, knowledge, and past experiences with respect to health insurance and health care. This consumers' point of view is important as it offers clues about how private and public programs could be modified to facilitate coverage and the incentives that could be designed to induce more individuals to secure health insurance. Such qualitative information must be considered prior to designing and assessing policy options to increase affordable health coverage to residents of the state.

Eight focus groups of 87 uninsured or underinsured individuals were sponsored in seven towns throughout South Dakota in September and October 2001. This distribution assured that researchers obtained a geographically representative sample of individual views, in both rural and urban areas, about the experience and consequences of being uninsured. Based on SPG Interagency Work Group staff preferences, some focus groups were designed to capture information about particular groups of uninsured persons, such as low-income or self-employed individuals, farmers, ranchers, Native Americans, and the elderly ***(Figure 21).*** The approach used to recruit focus group participants is described in ***Appendix B***.

Figure 21
Focus Group Location and Target Group

Date	Location	Participant Grouping
9/26/01	Sioux Falls	Lower Income Individuals
9/26/01	Sioux Falls	Small Business Employers
9/27/01	Yankton	Farmers/Ranchers
9/28/01	Winner	Farmers/Ranchers
9/29/01	Rapid City	Native Americans
10/1/01	Eagle Butte	Native Americans
10/2/01	Pierre	Older Americans
10/2/01	Aberdeen	Small Business Employers

Key findings that emerged from the focus groups expanded on the findings of the Survey of the Uninsured. While certain demographic groups were confirmed to comprise the bulk of the uninsured population, focus groups revealed that the uninsured range in age, socioeconomic wellbeing, and health status. Although focus group participants were varied in personal characteristics, most were in agreement regarding their fear and frustration over health insurance. Participants were generally uneasy if they were either uninsured or "under-insured". They reported widespread fear of being dropped by insurance carriers for reasons beyond their control. They also reported frustrations about the limited choices they had available to them with respect to insurance companies or plans that met their particular needs. Problems in securing affordable coverage were most severe among individuals in poorer health or lower economic status. The experiences that focus group members described were not new issues for them for being un- or under-insured was often a chronic situation.

In examining their personal stories, intricate problems surfaced that South Dakotans encounter when trying to secure affordable and adequate health insurance. Low wages and the cyclical nature of household income accentuated the challenge of securing affordable health coverage. The high cost of insurance was a primary deterrent to having health coverage. Many individuals conveyed their beliefs that the high cost of health insurance, often catastrophic in nature, is not worth the investment. These individuals, often younger and healthier, were willing to assume the risk of ill health and debt rather than invest in coverage. Focus groups throughout the state revealed a deeply rooted ethic of self-reliance, as well as great resourcefulness, in forging solutions to the problems that individuals experience in attempting to access needed medical care and prescription drugs. While many participants rejected the use of government aid, most agreed that the government should help monitor and control the cost of health insurance and make it possible for lower income individuals and families to afford health coverage. A full report of focus group findings is in ***Appendix D.***

C. Synthesis

All analyses conducted during the SPG project confirm that the greatest obstacle to acquiring health coverage in South Dakota is high cost. The cost of health insurance is perceived by both un- and under-insured as especially high given the relatively low wages in much of the state and the high proportion of small employers and individuals who are self employed. Whether workers and their families are unable to purchase employer-based coverage or an individual policy, high cost is consistently the main deterrent especially given their often modest or unpredictable incomes. Additionally, health insurance is often viewed as not being "worth it," considering how little some individuals use health care or how affordable essential medical care is perceived to be. In South Dakota, a largely frontier state, the issue of self-sufficiency arose frequently, especially given the difficulty of geographic access to medical care.

Both the survey and the focus groups revealed that the uninsured, especially low-wage earners, delay obtaining needed medical care. Survey respondents and focus group members consistently reported they defer meeting their medical needs due to the high cost of medical care. Of concern to public health officials, uninsured persons in poor health do not seem to be able to get the care they need in a timely fashion.

Differing perceptions among survey respondents and focus group members of "affordable" and "adequate" coverage are discussed in depth in Section Three of this report. Targeted market research would need to be conducted to learn more precisely about the uninsured's willingness to pay for coverage or their interest in securing a bare-bones benefit package. The survey and focus groups conducted for the SPG project provide limited indications of the amount of money that individuals would be willing to pay for basic coverage. Results of the survey indicate that 45 percent of the uninsured would be willing to pay up to $99/month for a plan that provides basic coverage for doctors visits, hospitalization, and prescription drugs. Another 27 percent were unsure of the amount, if any, that they would pay. Focus group members were also quite sensitive to price, depending on their family status, income level, and health care needs.

Findings from the survey and focus groups affirmed that many South Dakotans believe that government should be involved in helping uninsured individuals secure coverage, especially those considered "low income." Specifically, those queried think that government should be involved in the financing of this coverage for the uninsured or controlling the rapidly escalating cost of health coverage and medical care. This research suggests that uninsured individuals may be influenced by the availability of public subsidies, administrative simplification in the Medicaid program, insurance market reforms, or other approaches that would facilitate access to affordable coverage. While typically self-sufficient, many South Dakota residents firmly believe the health insurance situation is such that government's intervention is needed to help those who consistently find themselves unable to access affordable health coverage and medical care.

SECTION II: EMPLOYER-BASED COVERAGE IN SOUTH DAKOTA

The purpose of the South Dakota State Planning Grant (SPG) was to identify policy options that could help cover South Dakota residents and their families who do not currently have health insurance. Developing strategies to expand health coverage requires a multi-faceted approach to fully address the complexities of why people go uninsured. As employers provide the foundation of private health coverage in South Dakota and throughout the United States, an understanding of the health insurance benefits from their viewpoint is essential.

More than four-fifths of non-elderly uninsured Americans are in families with at least one adult worker[6]. With the erosion of employer-based coverage in some sectors, researchers are increasingly studying why and how working individuals go without coverage. At a time when unemployment is at a seven year low,[7] but with still many uninsured, Congress has been addressing employer-based coverage issues for the past few months as they debate economic stimulus measures and how to cover those who recently lost their jobs.

This national debate leads to the imminent need to understand, from the perspective of businesses themselves, the coverage employers are currently providing throughout South Dakota. It is important to learn what barriers prevent companies from providing health insurance to workers and their dependents; what companies report about why workers decline employer-based coverage; and what policy mechanisms might induce companies to provide health coverage in the future. This knowledge plays a key role in designing policy options and effective workplace strategies to expand health coverage in South Dakota.

As in the research conducted on uninsured persons in South Dakota, the telephone survey of private employers, focus group sessions, and structured interviews were all designed to provide a comprehensive picture and to complement each other in terms of the type of information generated. The survey provided quantitative information about employers in the state who 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 coverage for employees and their dependents. The focus groups and structured interviews provided qualitative data with an opportunity to explore and probe deeper into the attitudes of employers concerning their decision-making about offering health insurance. Furthermore, the focus group revealed the constraints that employers experience in doing so and the kinds of policy initiatives that employers believe would effectively enable more of them to offer health coverage.

The purpose of this section is to present quantitative and qualitative data on the status of employer-based coverage in South Dakota. A description of the survey's methods and approach is in ***Appendix E.*** Survey questions are listed in ***Appendix F.***

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[6] Jeanne M. Lambrew, *Health Insurance: A Family Affair*, New York: The Commonwealth Fund, May 2001.
[7] Bureau of Labor Statistics, U.S. Department of labor, January 2002.

A. Survey of Private Employers in South Dakota

As a second step in the SPG data collection process, a telephone survey of private employers in South Dakota was fielded in order to obtain some understanding of their decision to offer health insurance to employees and the kinds of coverage that are offered. Due to the breadth of the sample design, information on characteristics among firms offering and not offering health insurance to their employees can be compared. Researchers identified employers' perspectives about the reasons employees decline benefits, consequences to employees who do not receive the benefit, and potential ways of expanding coverage. Characteristics of the employers surveyed are summarized on the following pages.

The telephone survey was designed by The Lewin Group, in consultation with Baselice and Associates Inc., of Austin, Texas (who conducted the 20 minute telephone survey in September 2001) and the South Dakota Interagency Work Group staff. All private businesses in the state with two or more employees were included in the universe from which the sample was selected. The sample frame was intended to be broadly representative of all private businesses in South Dakota. Telephone surveys were completed in September 2001. A total of 401 usable surveys were generated. Of this total, 222 employers (55 percent) offered health insurance to their workers and 179 employers did not.

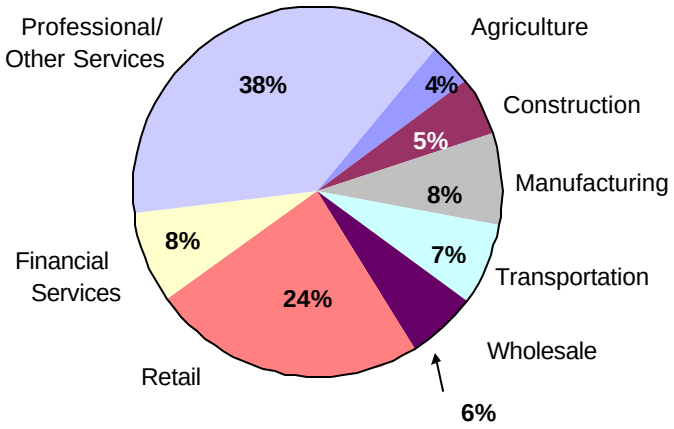
1. Characteristics of Responding Employers

Of the 401 firms surveyed, 38 percent were defined as professional and other services, the largest industry category ***(Figure 1)***. Retail employers comprised the second largest percentage of firms (24 percent). Firms providing financial services were eight percent of surveyed employers. The remaining 30 percent of employers surveyed included those in agriculture, construction, manufacturing, transportation, and wholesale industries.

Businesses in South Dakota are generally small. The average number of people employed by surveyed companies was thirty-one, while the median number of employees was five. An estimated 28 percent of businesses surveyed had two or three employees. Another 42 percent of the companies employed four to ten people. Only eight percent of firms were companies with over 50 employees ***(Figure 2).***

Businesses with employees at different wage levels participated in the survey. Forty-three percent of responding firms had at least one employee earning less than $10,000 per year and 62 percent of responding firms had at least one employee earning between $10,000 and $20,000. Ten percent of firms had at least one employee earning over $100,000 per year ***(Figure 3)***.

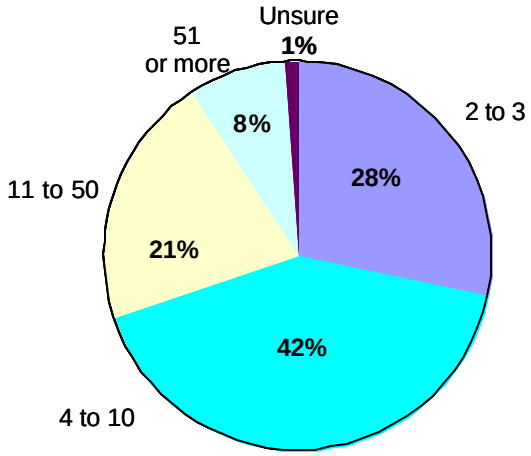
Figure 1
Employer Sample By Type of Industry



n = 401

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Figure 2
Surveyed Employer Characteristics by Firm Size



n = 401

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

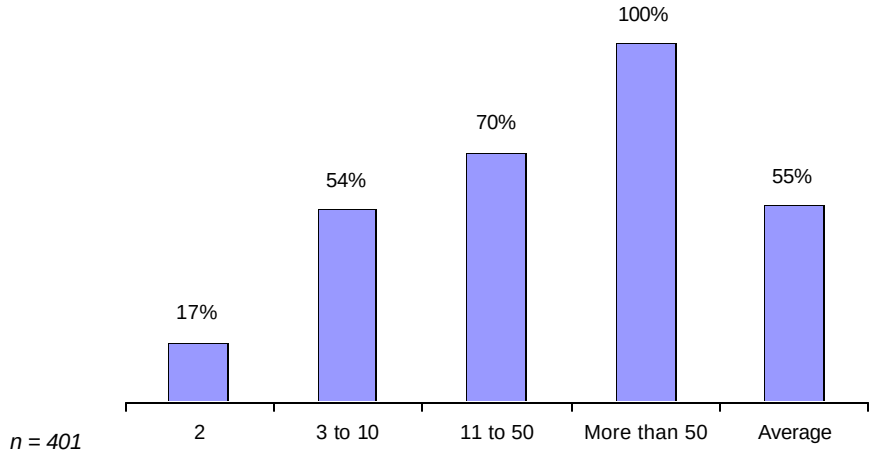
Figure 3
Wage Level of Surveyed Employers

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

2. Characteristics of Insuring Firms

Survey results indicate that 55 percent of private employers in South Dakota offer health insurance to their employees. Six percent of surveyed firms offer insurance to company retirees. The percentage of firms offering health insurance, however, varies according to firm size and geographic location. While all (100 percent) firms with over 50 employees offer insurance to their full-time employees, about half of the firms (54 percent) with three to ten employees report offering health insurance and only 17 percent of firms with two employees offer insurance. As in other parts of the United States, the likelihood of offering health insurance in South Dakota varies greatly by firm size.

Figure 4
Percent of South Dakota Employers that Offer Health Insurance by Size of Firm

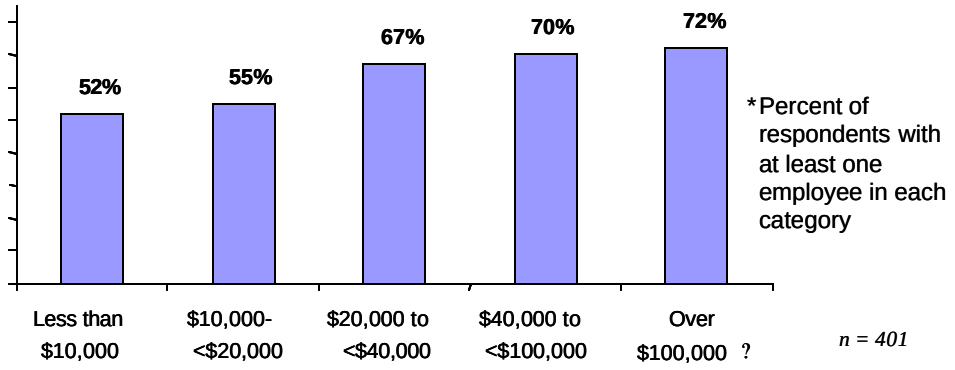


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Among different geographic regions of the state, the percent of firms offering insurance varied by nearly 20 percentage points. In the Pierre/Mobridge/Rapid City region, 44 percent of employers offered insurance while 63 percent of firms offered it in the Sioux Falls area. In the Watertown/Mitchell/Aberdeen region, 57 percent of firms offer health insurance. This spread indicates that rural location, and the type and size of businesses that serve the geographic region, diminishes the likelihood that health insurance will be offered to employees. The size of firms (in terms of employees) offering health coverage varied by geographic region as well. The average size of firms in Watertown/Mitchell/Aberdeen is 27 employers; in Sioux Falls, it is 42; and in Pierre/Mobridge/Rapid City, it is 107 employees.

As shown in ***Figure 5***, the percent of employers offering health insurance also increases as wage levels increase. Slightly more than half of South Dakota firms with employees in lower wage categories (less than $20,000 annual income) offer health insurance to their employees while 72 percent of firms with at least one employee earning over $100,000 offer health coverage.

Figure 5
Percent of South Dakota Employers that Offer Health Insurance By Wage Level*



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Coverage also varies with sales volume. The percentage of companies in South Dakota offering health benefits increases significantly as sales volume increases.

- ? Less than $500,000 (30 percent of employers)
- ? $500,000 to $2.5 million (63 percent of employers)
- ? $2.5 million or over (89 percent of employers)

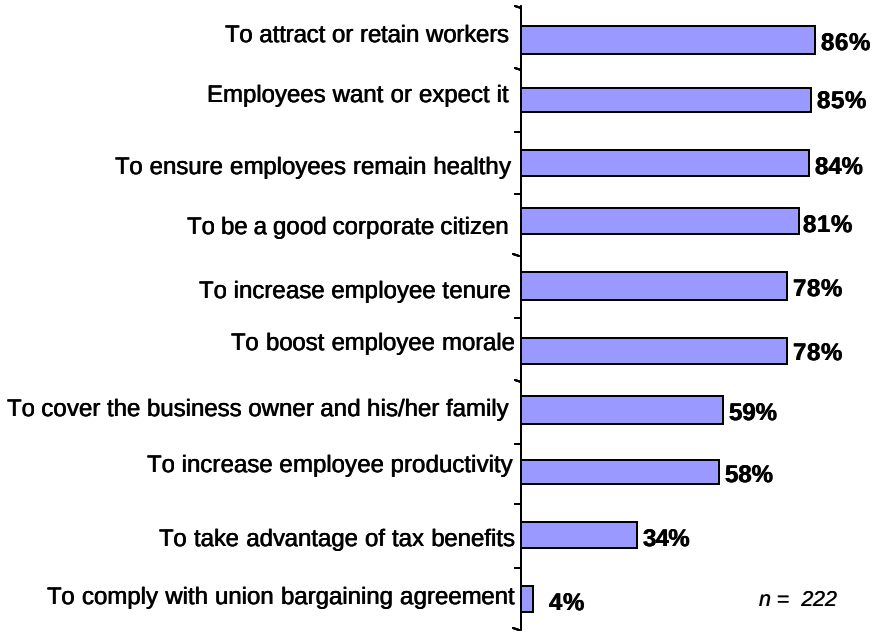
When the majority of employees are college graduates or skilled laborers, 62 percent of private employers in South Dakota offer health benefits. The percentage of employers offering health benefits drops to 52 percent for those with primarily manual laborers and 45 percent for those with primarily clerical or service workers.

The probability of offering health insurance also varies by industry type. Employers classified as agricultural (73 percent), manufacturing (70 percent), wholesale (71 percent), and transportation (69 percent) have the highest likelihood of offering health benefits to their workers. Among the types of firms less likely to offer health insurance are construction firms, of which only 33

percent offer health benefits, and retail firms, of which 45 percent offer health benefits to their employees.

Employers in South Dakota offer health insurance for many reasons ***(Figure 6).*** According to 38 percent of employers, the *most important* reason they offer insurance is to attract or retain workers. Another 21 percent assert the *most important* reason they offer insurance is to ensure that employees remain healthy. Respondents highlighted many reasons they offer health insurance to their employees. The four most prevalent reasons employers report they offer health insurance to their employees include: to attract or retain workers (86 percent); employees want or expect it (85 percent); to ensure employees remain healthy (84 percent); and to be a good corporate citizen (81 percent).

Figure 6
Reasons Employers Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

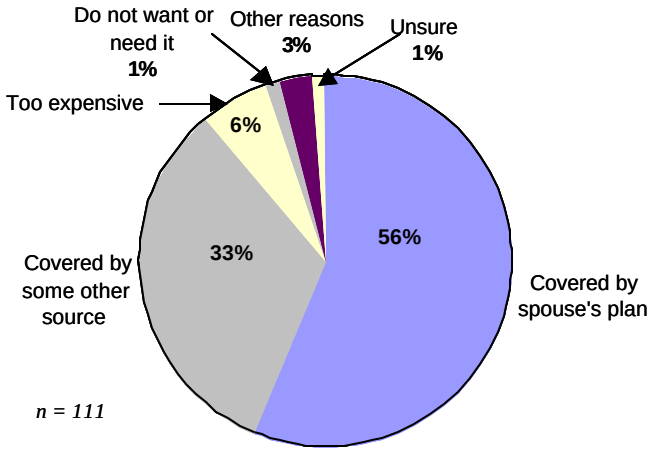
3. Variation in Coverage Offered by Employers

Among firms in South Dakota that offer health insurance, 92 percent of full-time employees are eligible for health benefits, on average. About 61 percent of insuring employers exclude part-time workers from receiving health benefits and 41 percent exclude seasonal workers. There are many reasons why employers exclude such workers. Fifty-nine percent of firms report they do not cover part-time or seasonal workers because the company isn't required to do so. In addition, coverage of part-time and seasonal workers is considered too expensive by most employers (56 percent) and nearly half of them (48 percent) say coverage isn't needed to attract or retain workers. Of most significance is the employer perception that their part-time and seasonal workers are covered elsewhere (50 percent).

The percent of the worker's insurance premium that is paid by employers varies among firms. While 21 percent of employers report they pay up to 50 percent of the premium, 50 percent of firms report they pay the entire worker premium. On average, 81 percent of the worker's insurance premium is paid by private employers in South Dakota, according to survey results. Employer payment of dependents' insurance premium also significantly varies. Forty-three percent of private employers that offer health insurance in South Dakota do not contribute anything towards the cost of the dependents' insurance premiums. Eighteen percent report they pay all of the dependent's premium. On average, 39 percent of the insurance premium for employees' dependent coverage is paid by employers in South Dakota.

Fifty-five percent of employers in South Dakota that offer health insurance report that at least one of their employees declines the health coverage offered to them through work (Figure 7). According to the employers, the major reasons their employees decline coverage include: worker is covered by a spouse's plan (56 percent) and worker is covered by some other source (33 percent). The high cost of health coverage was cited by only 6 percent of employers as a reason their employees decline coverage.

Figure 7
Reasons Employees Decline Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Of the employers that offer health insurance in South Dakota, nine percent offer cash or additional pay in lieu of health benefits. The majority of employees offered cash alternatives to health benefits accept this additional pay instead of health coverage.

Seventy-five percent of employers offering health insurance in South Dakota are fully insured by a carrier, while 21 percent of employers are either fully self-insured or partially self-insured (with stop loss).[8] (The 21 percent figure translates into approximately 62 percent of employees working for private employers in the state.) Eighty-five percent of insuring firms offer only one health plan to their employees.

[8] Four percent of employers were unsure how their companies were insured.

? 16 percent offer an HMO plan

? 37 percent offer a PPO plan

? 21 percent offer a traditional fee-for-service or indemnity plan

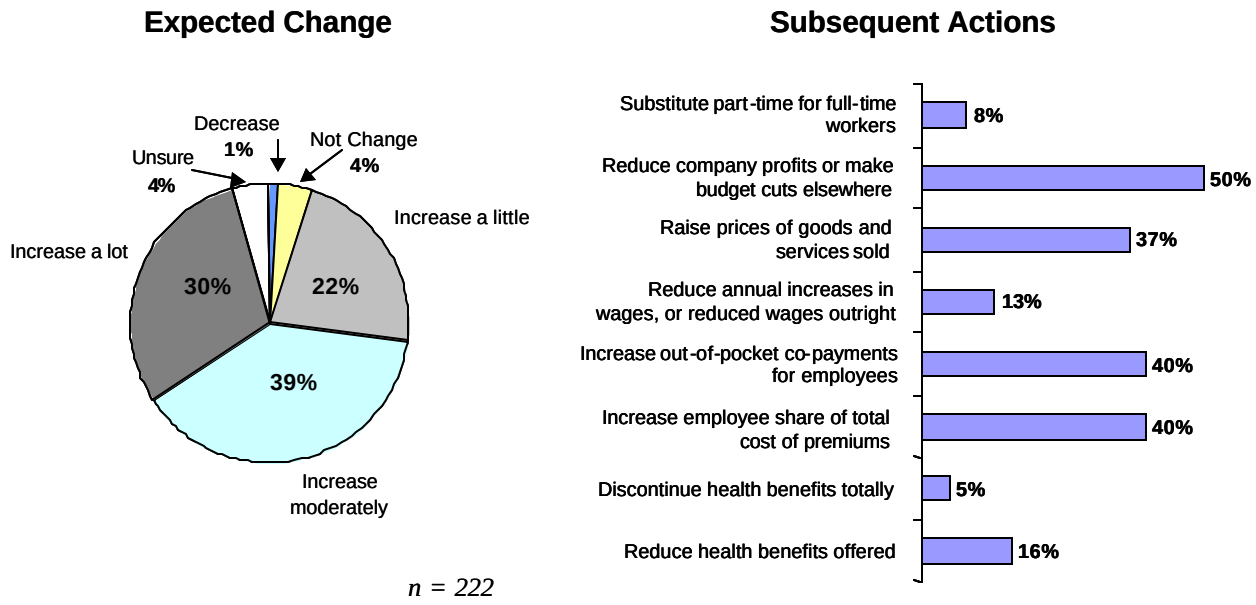
Prescription drug benefits are offered by 86 percent of insuring employers as either part of their health plans or as a separate benefit, according to survey respondents.

About three percent of employers report that some of their employees are excluded from health coverage because of particular health problems or pre-existing conditions.

4. Cost of Health Insurance

Employers who offer health insurance to workers overwhelmingly asserted that premiums they pay will increase in the coming year (91 percent of insuring employers). Thirty percent of insuring firms expect health insurance premiums to "increase a lot." As a result of these price increases, five percent of firms expect to discontinue offering health benefits. Most (50 percent of insuring employers) expect to reduce company profits or make budget cuts elsewhere. Companies also expect to transfer some of the premium cost increases to employees through increased co-payments (40 percent) and increased share of total premium costs (40 percent) ***(Figure 8)***. Thus, the increasing cost of health care is borne by employers and employees alike.

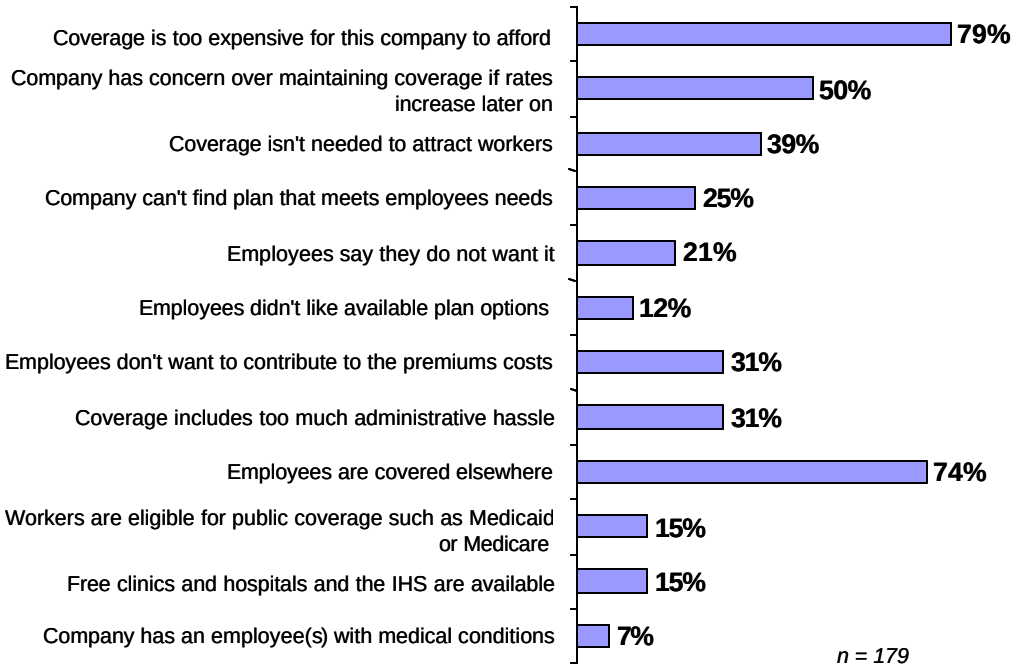
Figure 8
Expected Change in Future Health Premiums



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

The high cost of health insurance is the major deterrent to South Dakota firms offering health benefits to their employees. Among non-offering firms, over 46 percent stated the *major reason* they do not offer coverage is high cost. When firms were asked about the *many reasons* they do not offer coverage, 79 percent reported that coverage for employees was too expensive for the company to afford ***(Figure 9)***. Three quarters of South Dakota employers also reported that another major reason they didn't offer health coverage is that employees are covered elsewhere.

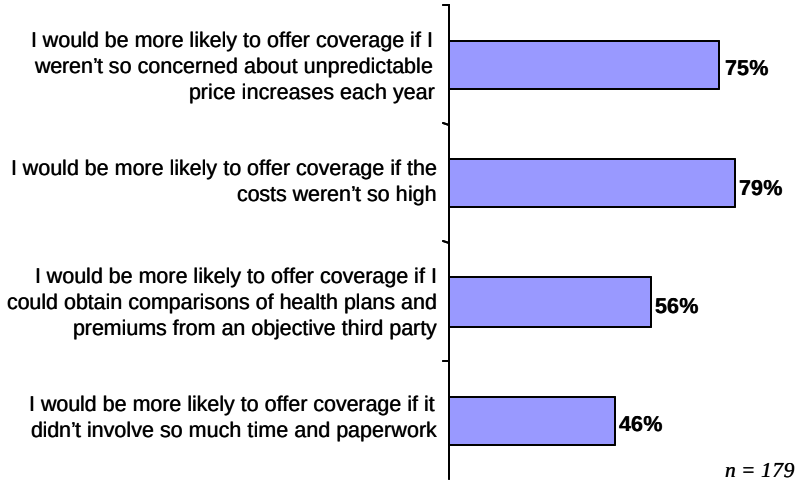
Figure 9
Stated Reasons Employers Do Not Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Among non-insuring firms in South Dakota, seven percent dropped health insurance as a benefit in the past five years. Of those who dropped the benefit, nearly 70 percent did so because the premiums were too high. About half of all non-insuring firms considered offering health insurance to workers. The major reason they did not was because premiums were too high, according to survey results. Non-insuring employers reported they would be more willing to offer health coverage if premium costs weren't so high and year-to-year price increases weren't so unpredictable ***(Figure 10).***

Figure 10
Reasons Employers Would be More Likely to Offer Coverage



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

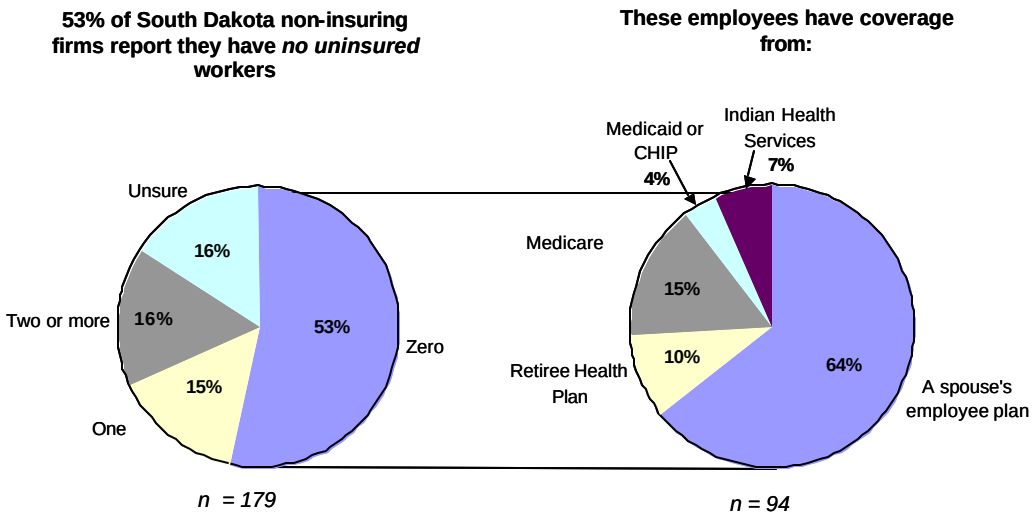
Instead of health insurance, employers may provide health benefits in other ways. Among non-insuring firms in South Dakota, 11 percent reported they contribute to the cost of coverage when an employee is covered by a spouse. Companies may also pay employees' medical bills directly (four percent of firms) or employ a nurse or doctor who provides care on-site (five percent).

5. Consequences of Not Providing Health Insurance

Despite the fact that 45 percent of South Dakota private employers do not offer health insurance, about 53 percent of South Dakota non-insuring firms reported that they have no uninsured workers. These firms were asked about where their employees obtain coverage. Sixty-four percent of non-insuring firms report that their employees are insured through their spouses' employment-based plan. Another 25 percent thought their employees were covered by either Medicare or a retiree health plan ***(Figure 11)***.

Results of the South Dakota Employer Survey indicate that employers recognize the possible adverse effects of not providing health insurance to their employees. As Figure 12 shows, 15 percent of firms report an awareness that some employees are unable to obtain needed care and 22 percent of firms have employees with large-out-of-pocket medical bills as a result of their not providing employer-based coverage. The consequences vary greatly by geographic area; 20 percent in the Pierre/Mobridge/Rapid City region report their employees are unable to obtain needed care and only seven percent in the Sioux Falls area. This variation may be attributed to greater access in Sioux Falls to medical facilities or community health centers.

Figure 11
Other Sources of Coverage for Workers at Non-insuring Firms



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

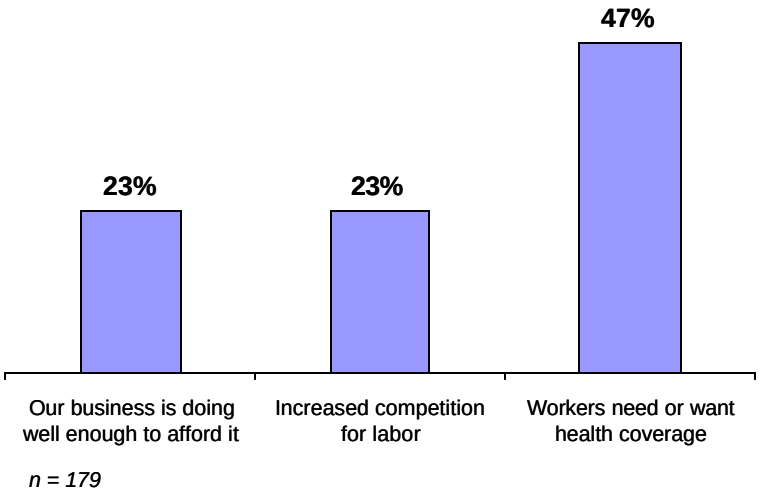
Figure 12
Consequences When Firm Does Not Offer Health Insurance

	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	15%	22%	25%
Geographic Area			
Sioux Falls	7%	18%	27%
Watertown/Mitchell/Aberdeen	16%	19%	26%
Pierre/Mobridge/Rapid City	20%	27%	21%

Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Employers also recognized that by failing to offer insurance, employees took new jobs that offered health benefits (25 percent of non-insuring firms reported this as happening in their company). In Sioux Falls where the job market is relatively competitive, employers reported a 27 percent rate of occurrence while in Pierre/Mobridge/Rapid City the rate is 21 percent. Indeed, the importance of health benefits to employees is a major reason why 17 percent of non-insuring firms plan to change their employee benefits package to include health coverage in the next five years ***(Figure 13).***

Figure 13
Reasons Why 17 Percent of Non-Insuring Firms May Add Health Coverage in the Future

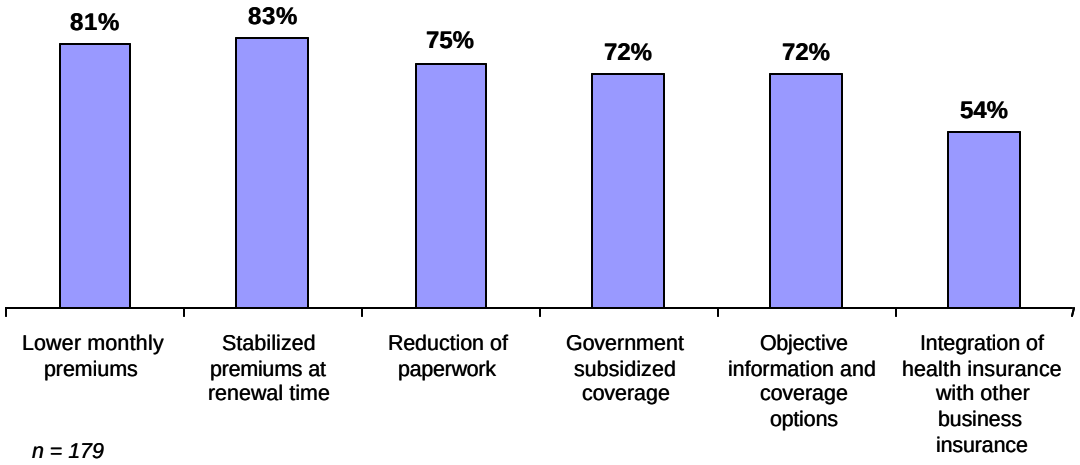


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

7. What is Needed to Help Firms Increase Coverage

Three-quarters of non-insuring firms report they would be more likely to offer coverage to employees if health insurance costs weren't so high or if premium price increases weren't so unpredictable from year to year. According to firms that do not offer health insurance to their employees, there are many things that could be done to help firms offer coverage. Chief among them are lowered monthly premiums and stabilized premiums at renewal time ***(Figure 14).***

Figure 14
What is Needed to Help Firms Increase Coverage to Employees

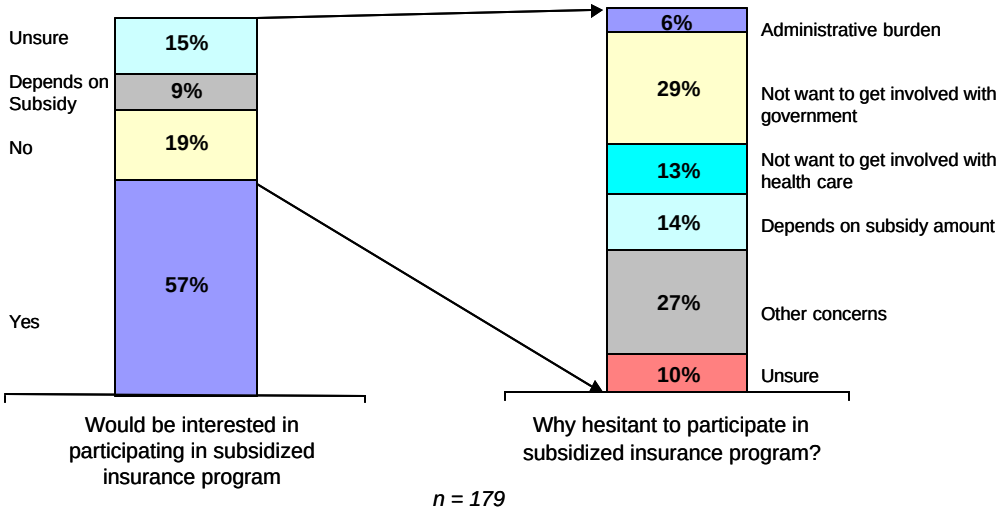


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

Non-insuring firms were asked how much they might be willing to contribute each month towards the cost of coverage per employee. The majority of non-insuring firms (55 percent) were uncertain about whether they would pay any amount towards employee coverage. Over 18 percent were unwilling to contribute any amount. Over 15 percent reported they would consider up to $99 per employee per month. About 10 percent would consider between $100 - $200 or more per employee per month.

Because high premium costs often act as a deterrent for employers to offer health benefits to their employees, the survey asked non-insuring firms whether they would be interested in participating in an insurance program that was subsidized by the state or federal governments. Nearly 60 percent of non-insuring firms in South Dakota reported they would be interested in such a program. Among the 43 percent of respondents who were hesitant about participating in such a program or who did not want to, 29 percent reported they did not want to get involved with the government or the stigma of getting involved ***(Figure 15)***.

Figure 15
Willingness to Participate in Subsidized Insurance Program
(Percent of Non-insuring Firms)

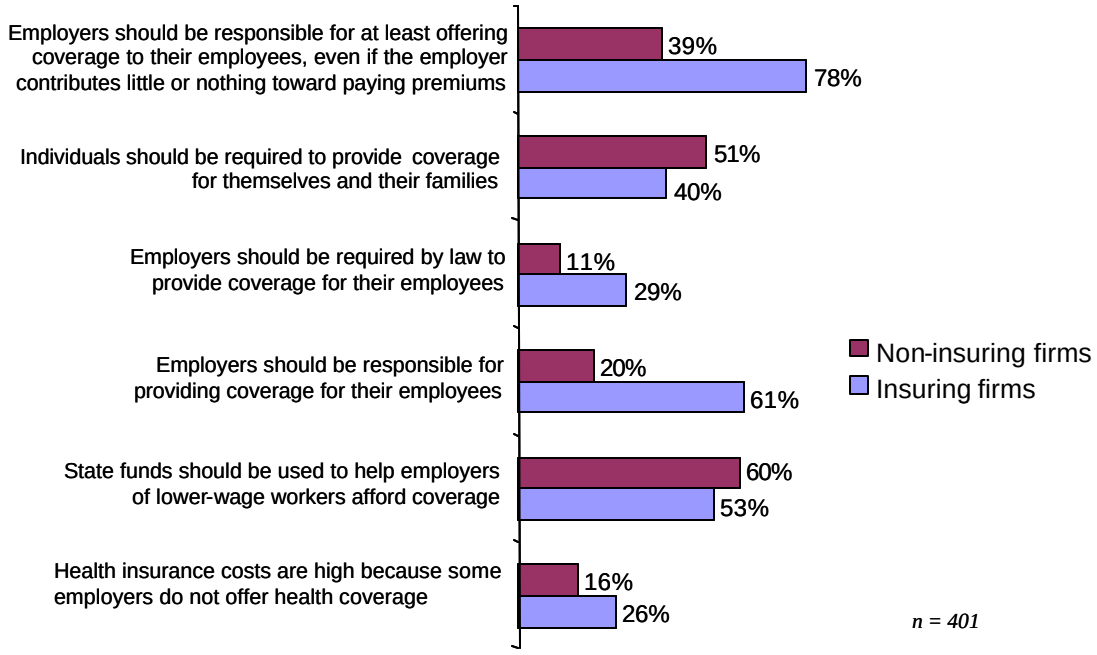


Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

8. Company Values About Employment-based Coverage

All surveyed employers were asked the same questions about corporate values concerning responsibility for providing health insurance to employees. As evidenced in ***Figure 16***, there are often great differences in perspectives among firms that offer health insurance to employees and those that do not.

Figure 16
Who Is Responsible?



Source: Lewin Group Survey of Employers in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

By far, the greatest value difference between insuring and non-insuring firms was related to the responsibility of providing coverage. Sixty-one percent of insuring firms believed that employers should be responsible for providing coverage to their employees; only 20 percent of non-insuring firms agreed with that statement. The two groups were somewhat similar in the belief that state funds should be used to help employers of lower-wage workers afford coverage, with 60 percent of insuring and 53 percent of non-insuring firms agreeing. Among both insuring and non-insuring firms, the value of individual responsibility for providing coverage for themselves and their families was expressed with more frequency than the value of corporate responsibility for health coverage.

Further complicating this subject is the difficult question of who ultimately bears the burden of, and responsibility for, health insurance costs. While many thought that employers, thus company profitability, shoulder the weight of paying for health insurable costs, employees may actually pay for their own increased benefits through reduced wages.[9] Sixty percent of non-insuring employers thought that their employees were unwilling to accept reduced pay rates to obtain health coverage. Private businesses are challenged between resistant employees on one side and the reality of high health premiums and limited alternatives for the company on the other.

[9] Mark V. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance*. Ann Arbor: University of Michigan Press, 1997.

B. Focus Groups of Small Employers

Focus groups that included entrepreneurs and small employers were asked questions designed to identify the factors that influence their decision to offer or not offer health insurance to workers. Perspective was also gained as to what options may be most appealing in order to increase affordable coverage in the state. Focus groups were conducted in September and October 2001.

Employers uniformly concluded that the cost of health insurance is a serious impediment to providing this benefit to workers. In addition, they thought there is not one single action that could be taken to solve the problem of the uninsured in South Dakota. They suggested that many different steps need to be taken simultaneously to address the issue. Some employers stated that they were not sure that insurance should always be tied to employment, as this practice exiles many individuals from coverage opportunity. Businesses with only a few employees expressed a particular frustration with the health insurance market in South Dakota. Farmers and ranchers, entrepreneurs, the self-employed, and those employed by small firms reported extensive frustrations in their attempts to find adequate and affordable coverage.

There was a belief expressed among small business owners that insurance companies are simply not interested in providing health coverage to small businesses. Most of the small employers reported that they were unable to find group plans for their employees and individual policies were prohibitively expensive. Some small employers have so much turnover and/or rely on part-time workers that they believe "it is not worth it" to offer health coverage. Others thought that the burden of "finding the best deal" and handling the administrative work associated with insurance plans is enough to deter any small employer from offering health insurance. Several employers noted how disadvantageous the American health insurance system is to entrepreneurs who attempt to start their own business.

Employers reported they would be influenced by certain incentives including: expansion/development of purchasing alliances or individual or employer subsidies. Small business employers asserted there is a significant need for a modified small group health insurance market and that they would value assistance in "getting into" an adequate insurance pool. Many of the small businesses, including small farming operations, reported that when they have inquired about health insurance, the number of people they want to insure is too low to qualify for an affordable small group plan. Subsequently, their only choice is to pay extraordinarily high premiums or have deductibles so high that the policy becomes a "catastrophic" plan only to be used in cases of extremely expensive emergencies.

The most persistent complaint from small employers in the focus groups involved the dramatic price increases in the health insurance plans they currently have. Many employers reported an increase of over 10 to 20 percent for 2002. Many small employers expressed a desire for the government to institute regulations over how much health insurance costs could increase from year to year.

C. Structured Interviews

Interviews with business leaders and many stakeholders in the health care system yielded information that was often similar to the perspectives offered by survey respondents and focus

group participants. From an employer's point of view, continually rising health premium costs is a major factor affecting the provision of health insurance. As premium costs rise, young workers (and their families) will often forgo insurance and take the risk of medical adversity. Said one interviewee, "The higher the rates go, the more people go uninsured." In addition, many "mom and pop" businesses with a few employees don't qualify as a group, especially when potentially eligible workers decline to participate in the business' health plan. Older workers, often with pre-existing conditions, have difficulty getting coverage if they work for small firms because of their high medical risk.

In attempting to hold down premium costs for their workers, businesses are confronting what seems to be a growing problem. What small businesses can offer workers for health benefits is becoming increasingly catastrophic in nature. Employers who provide coverage for their workers are finding that they can't offer the same level of health care as in the past. Workers facing monthly premiums that seem high in relation to their wages (wages that are "lower than anywhere else in the country," according to one interviewee) also resist being required to pay $2,000 - $5,000 deductibles. As a result workers, especially young and healthy ones, will often decline employment-based coverage.

Another area of difficulty for employers is the aging and declining population of much of South Dakota businesses. Said one interviewee, "we want to hang on to each employee, including older ones, but it is getting so expensive." In addition, if business people retire at 55 years and sell the business, "keeping their insurance becomes a major issue." Employers also struggle in providing health coverage for their workers because of other economic forces:

- Large areas of the state (mostly western and center) have much seasonal employment due to the tourism and agricultural sectors;
- limited industry and manufacturing and "not much economic vitality;"
- high rates of disability in the state, "perhaps due to the nature of work here;"
- farmers and ranchers have their "hands tied in terms of raising prices. They go without health care because it's so expensive for single plans;"
- "low wages are the biggest barrier to enacting health coverage expansions in South Dakota," asserted one business leader.

Several interviewees highlighted the problem from a business point of view of recruiting and retaining health professionals, especially because cities in adjacent states can hire them "at twice the salary and give them better working conditions."

D. Conclusion

Throughout this research, the project team learned that the experience of South Dakota employers is similar to that of employers throughout the United States in terms of factors that affect the availability of job-based benefits and employers' concern about the high cost of offering health insurance. The high cost of health insurance is a major factor influencing

employers' decisions not to offer coverage to workers. Employer-based coverage is a complicated issue fraught with subtle complexities. While large employers offer insurance in order to attract employees, small businesses face different constraints as they pay high premium rates attributed to their small risk pools. What makes employment-based coverage in South Dakota unique compared to many other areas of the United States is the small percentage of employers that are self-insured and the small percentage of employers that offer HMO and PPO plans. The implication of this difference is that South Dakota employers may have less leverage than elsewhere to assure value-oriented purchasing of health coverage for their workers.

The South Dakota Survey of Employers was designed to increase policymakers' understanding of the issues and challenges employers face in offering health insurance to their workers. This telephone survey, combined with focus group findings (described elsewhere), and stakeholder interviews, yielded both quantitative and qualitative information that can help guide the development of approaches to make employment-based coverage more feasible in the South Dakota workplace. A number of options are available that would make employer-based coverage more feasible and appealing to employers in South Dakota. Namely, by the government offering tax incentives, clear unbiased information about the insurance market, pooling small business owners, and regulating health insurance rates and increases, the picture of employer-based coverage could improve dramatically in the state.

SECTION III: SOUTH DAKOTA'S HEALTH CARE MARKETPLACE

As part of the SPG project, the Interagency Work Group and Lewin conducted a review of the South Dakota health care system and marketplace. We began by identifying the unique population, and geographic and health sector characteristics of the state. The team also assessed the adequacy of health coverage in the state, examined competition in the health care and insurance sectors, we reviewed available data on providers in the state to indicate whether there is sufficient provider capacity to meet any increase in demand for health services that could occur among newly insured people if coverage expansion options were enacted. Next, we reviewed South Dakota's health spending by type of service.[10]

The remainder of this chapter is devoted to answering questions posed in HRSA's guidance for preparing final reports.

A. Population Characteristics and Availability of Health Care Resources

One almost needs to visit South Dakota to appreciate how its vast geography and low population influence how policy makers view health care and coverage issues. The state's land area is 75,885 square miles, much larger than the combined area of all of New England. The state has three main groupings of population: urban, rural, and frontier. About one-third of the land area in South Dakota is dedicated to nine Native American reservations.

The 2000 Census revealed that South Dakota's population grew to 754,844 persons, averaging 9.9 persons per square mile (compared to U.S. average of 79.6).[11] Most of the population growth occurred along the state's Interstate highway system. Of the 22 counties bordering either I-29 (which runs north/south along the state's far eastern side) or I-90 (which runs east/west) the population grew by 54,659, or 13.3 percent. Interestingly, the population of the remaining counties also grew slightly, owing primarily to population increases on Indian reservations.

South Dakotans have relatively low average incomes compared to the U.S. population as a whole. Strict interpretations of financial information can be misleading, however. The state's median household income is lower than that of the U.S. in 2000 ($35,205 and $41,349 respectively[12]); yet, if one takes into account taxation levels and lower consumer costs the state ranks 28th in "purchasing power." The state also exhibits many contrasts. Two counties in the state, Shannon and Todd, are among the poorest in the country and also have the shortest life expectancies.

In 1999, South Dakota had an estimated 534 full-time equivalent (FTE) primary care physicians, and 292 FTE mid-level health care providers. The availability of nurses is a particular issue for

[10] These assessments were conducted using published data sources on health services utilization and expenditures in the state as well as interviews with state officials and outside stakeholders. State data on health expenditures was provided by the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary. Data on provide capacity and insurance regulation was provided by the South Dakota Department of Health and Division of Insurance.

[11] http://quickfacts.census.gov.qfd

[12] http://factfinder.census.gov/home. Estimates based on twelve monthly samples during 2000.

the state. About 10,000 RNs are currently licensed; but over 500 RN vacancies exist currently in health care organizations and more than one-third of South Dakota RNs will be eligible to retire in the next 10 years. The projected annual need for new RNs is about 400, yet only about 320 RNs are newly licensed to practice each year. The state has recruitment programs for all three professions, primary care physicians, mid-levels and nurses.

In addition, as of March 1, 2002, the state had 22 federally qualified health centers, 57 rural health clinics, 50 community health services offices, and 12 Health Alliance counties. Finally, in South Dakota, there are 51 general community hospitals, of which 27 are critical access hospitals, as well as five Indian Health Service hospitals and three Veterans Administration hospitals. (A map of these hospital providers appears in ***Appendix G.***) Long-term resources include: 116 nursing homes, 111 assisted living centers, 62 residential living centers, 72 home health providers, and 27 hospices.[13] The Critical Access Hospital (CAH) Program, in particular, has been important for South Dakota. Early on, state officials saw the need for a program that lessens certain restrictions on small hospitals and provides enhanced reimbursement in order to reduce the fragility of the local health care system. South Dakota was a pioneer of the CAH program, having participated in a seven-state demonstration program prior to the program being implemented nationwide.

There are three major hospital systems in the state: the Sioux Valley Health System, the Avera Health System and the Rapid City Regional Hospital Health System. These facilities all have tertiary care hospitals which are responsible for the majority of admissions in the state. Each operates an extensive system of hospitals, health care centers/clinics, long-term care facilities, and other entities.

The adequacy of the health workforce in South Dakota is mixed.

- With 165 physicians per 100,000 population, the state falls below the national ratio of 198 physicians per 100,000 population and ranks 38th among states in physicians per capita.[14]
- The rate of primary care physicians per 100,000 population in South Dakota (84.7) is lower than the national rate of 91.7.[15] In South Dakota, over 28 percent of the population have no access to primary care, compared to 17 percent for the nation as a whole.
- There are 27 physicians assistants per 100,000 in the state, nearly three times the national average.[16]
- The state ranks 45th among states in both psychiatrists and psychologists per capita.[17]

According to HRSA data for 1999, South Dakota has shortages in many areas that are considered to be medically underserved. ***Figure 1*** compares the adequacy and availability of medical services between South Dakota and the United States along many dimensions.

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[13] SD Department of Health. *South Dakota Health Check-Up,* January 1999, updated by DOH staff.
[14] ftp://ftp.hrsa.gov/bhpr/workforceprofiles/southdakota.pdf
[15] http://stateprofiles.hrsa.gov/StateProfielsIndex.html
[16] ftp://ftp.hrsa.gov/bhpr/workforceprofiles/southdakota.pdf
[17] *ibid*

Figure 1
Indicators of Areas of Unmet Need[18]

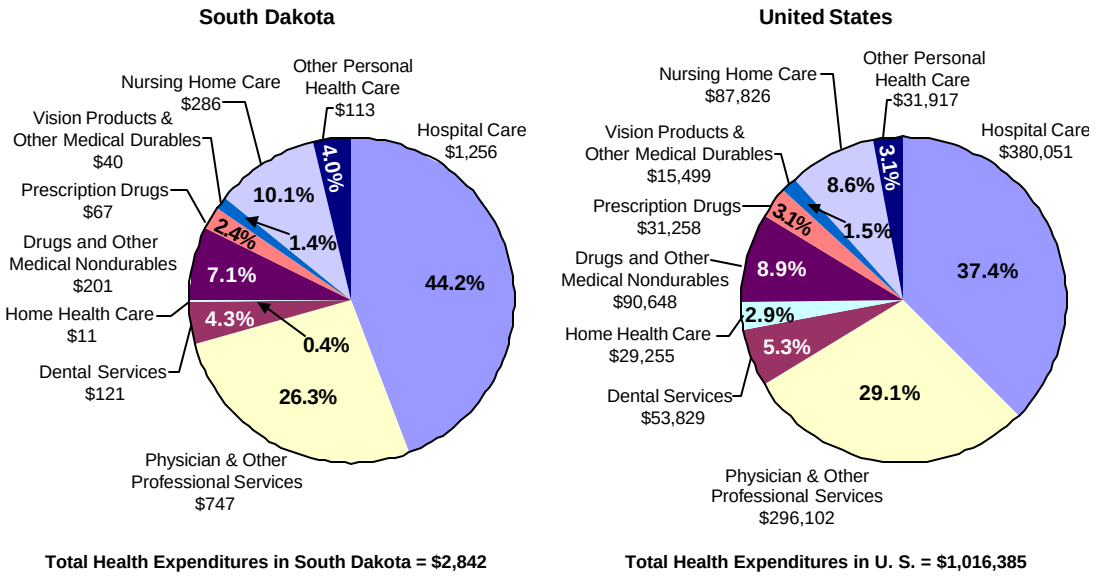
	South Dakota	United States
Percent Counties, Health Professional Shortage Areas (HPSA)	94.0%	82.2%
Percent Counties, Primary Care (HPSA)	76.1%	64.6%
Percent Counties, Dental (HPSA)	19.4%	26.9%
Percent Counties, Mental Health HPSA	62.7%	53.2%
Percent, Medically Underserved Areas (MUA)	83.6%	80.5%

B. Health Spending in South Dakota

This section examines health care spending in South Dakota. The review presented is based upon the national Centers for Medicare and Medicaid Services (CMS) State Health Expenditure (SHE) Accounts, Office of the Actuary. These accounts are the most reliable and credible source of all health spending data by state. The data capture health care expenditures by establishment and place of service (e.g., hospital, physician's office, nursing home, home health agency, etc.).

Health spending is reported by location of provider, not residence of the beneficiary. ***Figure 2*** shows the 1998 health expenditure data from all payment sources for South Dakota compared to the United States.

Figure 2
Health Expenditures in South Dakota and the United States, by Place of Service, 1998 (in $millions)



[18] http://stateprofiles.hrsa.gov/stateprofilesindex.html

Total health spending in South Dakota in 1998 was approximately $2.84 billion dollars, or about .27 percent of the national total of roughly $1.02 trillion. Hospital care comprised the largest portion of health spending in South Dakota, accounting for $1.256 billion (44.2 percent). The next largest categories of health spending were physician services (26.3 percent), nursing home care (10.1 percent), and drugs and other medical non-durables (7.1 percent). Although the hospital portion of health expenditures in South Dakota is greater than for the United States as a whole, the distribution of expenditures across services in South Dakota is similar to the U.S.

C. Adequacy of Existing Insurance Coverage

Data collection during the South Dakota SPG program yielded some indications about the adequacy of individuals' health coverage and how perceptions are different depending on the population group considered. Adequacy of health coverage was considered by survey respondents, focus group participants, and participants in structured interviews. Based on this information, the Interagency Work Group has become aware of the potential problems of *underinsurance* among some population groups in the state.

Adequacy of health coverage has been defined in the public health literature in a variety of different ways. The definition usually includes some minimum standards for insurance, such as the particular health benefits that are covered; the amount of required out-of-pocket expenses for individuals; and some measure of consumer access to medical care providers. Survey respondents and focus group participants in the SPG project considered various dimensions of the term "adequacy." It is apparent there is wide variation among consumers, employers, states, and federal agencies about how adequacy of health coverage should be considered.

1. Adequacy as Considered by Insured Consumers

While conducting the survey of the uninsured, an abbreviated questionnaire was completed for individuals who were "screened-out" because they were insured (described in Section I of this report). All insured respondents were queried about the adequacy of their health coverage. Eighty-eight percent of insured South Dakotans surveyed consider their existing health insurance coverage as either "adequate" or "very adequate."

One health benefit that is increasingly important in assessing the adequacy of health coverage is coverage for prescription drugs. As described in Section I, nearly three-quarters of the insured respondents indicated that their health insurance plan does cover prescription drugs.

2. Adequacy as Considered by Employers

The SPG project surveyed over 400 private employers in South Dakota (as described in Section II of this report). One consideration among employers of the adequacy of health insurance they offer is the out-of-pocket expenses incurred by employees in the form of cost-sharing. Employers were questioned as to the proportion of the total premiums that they paid; this provides a proxy measure of insurance adequacy. Of the firms that offer health insurance to their employees in South Dakota (*n=222*):

- 50 percent reported that they paid all of the insurance premium for worker coverage;
- Three percent paid 81 to 90 percent of the workers' premiums;
- 21 percent paid 51 to 80 percent of the premium;
- 21 percent paid up to 50 percent of the premium;
- One percent paid none of the premium; and
- Four percent were unsure of how much of the insurance premium they paid.

The majority (86 percent) of private employers surveyed that offer health coverage include prescription drug benefits either as part of their company's health plan or as a separate benefit, suggesting another possible (proxy) indicator of coverage adequacy.

3. Adequacy as Considered by Focus Groups

The focus groups conducted as part of the SPG project provided a consumer's perspective of the factors that determine adequacy of coverage for both individuals and small business employers. (A full report of the focus groups appears in ***Appendix D***.)

The majority of individuals in focus groups who *did* have health insurance reported they were either *underinsured* (that is, they had high deductibles or catastrophic plans) or *uneasily insured* in that they had deep fears about premium increases or of being dropped from the company that provided them health insurance. Lower income individuals, those with chronic medical conditions, and adults between 50 to 64 years of age expressed particular difficulties in securing affordable and adequate health insurance.

Focus group participants who were farmers or ranchers, or self-employed, or employed by small firms that didn't offer health benefits reported the most extensive frustrations in their attempts to find adequate and affordable health coverage. Individuals who were seeking non-group policies and businesses with only a few employees (either working in the business or workers who wanted health insurance) reported health policies with high out-of-pocket expenses and significant premium price increases for 2002. These individuals expressed dissatisfaction with the adequacy of their coverage for the following reasons:

- They were being dropped by insurance carriers for reasons that seemed beyond the individual's control even though they had loyally paid monthly premiums for years;
- They experienced unexpected limits in benefits, usually at the time a serious medical crisis confronted either themselves or a member of their family; and
- They were faced with unexpectedly low payment amounts to providers by plans when medical claims were processed.

4. Perceived Differences of Adequacy Between Insured Respondents and Focus Group Participants

Although 88 percent of *insured* respondents ("screen-outs") indicated that they thought their health care coverage was adequate, focus group members were dissatisfied with the adequacy of their health care coverage. This is because they were either uninsured or they had individual coverage which was limited in benefit scope and had high co-pay requirements; insured respondents primarily had employment-based coverage which is typically more comprehensive.

Other factors may also account for differences in perception of coverage adequacy.

? **Differences in household income.**

Insured respondents' household incomes were higher, on average, than uninsured survey respondents (see Section I). Focus group populations tended to be poorer than the general population in the state (as indicated by their reported livelihoods). For them, having health coverage was regarded as a trade-off with other important household expenses. Because the focus group participants tended to be lower income, they often reported problems with the *affordability* of health coverage, which contributed to their perceptions that their health plans were not *adequate* in terms of financial protection. It is likely that the scope of health benefits that is affordable to low-income persons is more limited than a health plan affordable to a person with a higher income.

? **Differences in health status.**

The insured may be healthier, in general, than focus group participants. Focus group participants often initiated discussions about their personal health problems and numerous encounters with the health care system. Such discussion was expected given the fact that many of the groups chosen (e.g., near elderly and lower-income individuals) are not as healthy, on average, as the typical South Dakotan. As a result, it is likely that focus group participants had more experiences with many providers in the medical care system and were more likely to have confronted frustrations with, or inadequacies of, their insurance coverage than individuals who were adequately insured.

5. Adequacy as Considered by Structured Interviews

The SPG project team completed interviews with knowledgeable spokespersons of provider and insurance groups and other key consumer and business stakeholders in the state. These structured interviews provided qualitative information on the factors affecting health coverage in the state. Many of those interviewed confirmed the perspectives of focus group participants and gave additional examples of inadequate health coverage, including underinsurance.

? One advocate indicated that lack of affordability of health coverage limits the adequacy of health care that is available. Because the economy in South Dakota is depressed and largely agricultural in its base, the average income of residents remains low; thus, people can't afford to obtain adequate health coverage.

? Another respondent highlighted the problem of the lack of prescription drug coverage in many plans, especially among the elderly.

- A business leader reported that there are large numbers of people in the state who are underinsured. He observed that many health insurance plans do not cover needed health benefits, even though policy premiums are high. While catastrophic medical disasters are often covered, many other essential health services often require large out-of-pocket expenses and deter timely access to care.
- Another respondent estimated that about one-third of business owners in the state offer catastrophic coverage with a "huge deductible."
- An insurance company representative indicated that the high cost of health insurance may force many participants of small group plans into the individual market. To make matters worse, many carriers are pulling out of the individual market and leaving the state. Business leaders interviewed seemed to agree that there is a shortage of non-group policies available in the state, which contributed to the lack of adequate coverage offered. As more insurance companies exit the market, there is less competition among remaining carriers, which puts the state's population at risk for higher premium costs.
- One human services advocate highlighted the difficulty that individuals with either physical disabilities or mental illness face in securing health coverage. There is a "sizeable disabled population in South Dakota." Persons with disabilities may secure Social Security Disability Insurance (SSDI) but must wait 24 months to quality. The disabled may receive Medicare benefits; Medicaid can be available to persons with very low income and limited assets. For individuals with mental illnesses, high bills for prescription drugs, as well as large co-pays and deductibles is a problem, as private insurance for persons with mental illnesses is often limited in scope. As a result, many individuals with mental illness also have to rely on Medicaid.

6. Accessibility of Medical Care

The independent and direct effect of health insurance coverage on access to health services is well established, according to a recent Institute of Medicine report.[19] Generous benefits and low co-payments may make health coverage seem adequate; however, if needed medical care cannot be accessed – for whatever reason – then value of coverage is diminished. For example, in many areas of the United States, persons insured through managed care plans may be frustrated when providers of choice are not included in their plan's panel of preferred providers.

In South Dakota, medical care may be inaccessible to individuals for other reasons. Care may be inaccessible to those who need it regardless of their income, health status, or insurance coverage, according to state officials, focus group participants, and stakeholder interviews. This is because as a rural and frontier state, many medical provider specialties may be located hundreds of miles from citizens who need care. In addition, there is a shortage of many types of medical providers in the state (as described earlier in this section). Most counties in the state have been federally

[19] Institute of Medicine, Committee on Consequences of Uninsurance. *Coverage Matters: Insurance and Health Care.* Washington, DC: National Academy Press, 2001, p. 28.

designated as medically under-served areas.[20] Finally, recruitment and retention of medical providers, especially nurses, remains a serious problem in many areas.

D. Variation in Benefits

One of the questions posed by HRSA was the extent of variation in benefits among non-group, small group, large group, and self-insured plans. The SPG project in South Dakota did not explicitly investigate variation in benefit design among different sized groups.

E. Prevalence of Self-insured Firms

Self-insured firms are far less prevalent in South Dakota than elsewhere in the United States. As a firm decreases in size there is a higher potential risk in self-insuring against employees' medical expenses, a relationship noted by several of the individuals who participated in the structured interviews. In South Dakota, approximately 70 percent of the private employers who participated in the SPG Survey of Employers had from two to ten employees. Because firm size tends to be small in South Dakota, few self-insure in the state. According to the employer survey, 21 percent of employers that offer health benefits to their workers are either fully or partially self-insured. (This 21 percent of firms employs 62 percent of workers included in the survey.)

The proportionately small number of self-insured firms in South Dakota has an impact on the state's health insurance marketplace. The specific impact may be inferred from national studies and court decisions over the years. As interpreted by numerous court decisions, the Employee Retirement Income and Security Act (ERISA) of 1974 precludes self-insured plans from state regulations such as reserve standards, mandated benefits, premium taxes, and consumer protection requirements. Insurance companies throughout the nation have claimed that state regulations of premiums can lead to increases in premium prices and health care spending for employees. Because self-insured firms may be better able to tailor health benefits to what employees want and can afford, many employers have asserted that self-insurance has the potential to expand health care coverage among workers and their dependents.

State policy makers throughout the United States would generally agree that ERISA's broad preemption clause (that supercedes state laws) has prevented states from requiring all employers to offer workplace coverage or from directly regulating private employer-sponsored health plan benefits or solvency.[21] States cannot require employer-sponsored health plans to participate in purchasing pools or to coordinate with public health care coverage programs. The fact that most private businesses in South Dakota, as well as all of state government, are not affected by ERISA provisions suggests that the State's Department of Commerce and Regulation has the potential to establish health insurance guidelines and insurance market reforms that have broad applicability across insurers and carriers in the state.

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[20] Approximately 180,000 South Dakotans reside in MUAs.

[21] See Patricia A. Butler: *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles*. New York: The Commonwealth Fund, October 2000.

F. State as a Purchaser of Health Care

There are many important roles that state governments play in the health care field. They include: protecting public health and safety; providing health care directly; purchasing health care; developing and training health care professionals; establishing rules governing health care provider entry into the market; and establishing rules governing health care marketplace activities.[22]

South Dakota state agencies, particularly the Department of Health, focus their policy attention or many specific health areas other than health care purchasing. Protecting the public's health and safety is a priority.[23] The State supports numerous child health promotions and chronic disease prevention programs. The State surveys and licenses health facilities to assure patient quality and safety. The state directly delivers professional nursing and nutrition services and coordinates health-related services to individuals, families, and communities across South Dakota. These services are delivered at State Health Department offices. In a few Public Health Alliance sites, services are delivered through contracts with county governments and private health care providers.

The State's Division of Insurance, within the Department of Commerce and Regulation, provides important oversight of the health insurance market in the state. The Division investigates consumer complaints and takes legal action against insurers who violate state laws. It reviews rate increase requests from insurers, monitors compliance with solvency and other business requirements, and protects consumers against insurance fraud.[24] The Department also oversees health professional licensing boards and commissions in the state.

The State of South Dakota's role as a purchaser of health care is less of a priority than other roles, as described above. The State can influence the purchase of health care through its Medicaid program and the administration of health benefits to State employees. There is a limit to how aggressively the State can use its purchasing power, however, to change the health care delivery system. This is because South Dakota's geography and chronic shortages of health providers in many areas impede the development of State purchasing strategies that have been implemented in many other areas of the United States. Another reason for limits in the State's role as purchaser is that public spending on health care in South Dakota is comparatively small.

Public expenditures for health care in South Dakota are proportionately lower than those in other states compared to private sector spending. Medicare and Medicaid payments for personal health care in South Dakota comprised 30 percent of all payments for personal health care (including private insurance and individual out-of-pocket payments), compared to 36 percent for

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[22] Alpha Center classification developed for AHRQ User Liaison Program Workshops; based on Altman and Morgan's "The Role of State and Local Government in Health," *Health Affairs*, Winter 1983.

[23] For example, Governor Janklow initiated a multi-phased effort enhancing the state's terrorism and bioterrorism preparedness in 2001. Because of ongoing and oftentimes severe provider shortages in South Dakota, the State has sponsored ongoing programs to train, recruit, and retain health professionals. During the 2002 Legislative Session, for example, new funds ($1.1 million) were appropriated to expand nurses training at two public universities.

[24] http://www.state.sd.us/dcr/insurance/index.htm

the nation as a whole.[25] South Dakota government expenditures for health programs and hospitals were estimated at $61.721 million and $44.67 million, respectively, in 1999.[26] Total Medicaid program expenditures (including all services and administration) were $368.5 million in SFY 1998. The State's share of this total was 31.7 percent in 2001. State spending for its employee health premiums totaled $47.2 million in FY 2001.[27]

G. Current Market and Regulatory Environment

Current market trends and the regulatory environment in South Dakota is characterized by a high proportion of small group and individual health plans, but the level of competition among companies offering these plans varies by specific market area. As reported in the SPG focus groups, many small group and individual insurance carriers are leaving South Dakota's market. From 1998 to 2002, the number of small group carriers dropped from 29 to fifteen.[28] The number of major medical carriers issuing new business in the individual market has dropped to eleven. One individual market carrier with significant market share submitted notification that it would cease marketing as of 2001 due to coverage mandates, inability to obtain an additional exemption from guaranteed issue, and the application of rating bands to previously issued products.[29] [30] Another way to view the state's health insurance market is to estimate the market share of the largest carriers in South Dakota. The three largest carriers for each insurance group dominate much of the market:

- Individual Market – 89 percent of total covered lives
- Small group – 53 percent of total covered lives
- Large group – 77 percent of total covered lives[31].

The implications of these estimates is that the health insurance market is highly concentrated in South Dakota, as in all states, particularly in the individual and large group markets. As most insurers have little market share, the largest insurers enjoy monopoly power and have some

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[25] http://www.hcfa.gov/stats/nhe-oact/stateestimates

[26] US Census Bureau, South Dakota State Government Finances: 1999. Available: http://www.census.gov/govs/state/99st42sd.html. Expenditures for health programs and hospitals include both direct and intergovernmental expenditures (such as expenditures to local governments). Health program expenditures include those for services and improvement of public health, other than hospital care and those services financed by other governments' health programs. Health program expenditures excludes vendor payments for medical appliances, supplies, or services under Medicaid. Expenditures for hospitals include the expenditures for the provision of care in public or private hospitals, including construction of hospitals. Because all expenditures of public hospitals are captured in the hospital category, a proportion of Medicaid expenditures may be captured in the hospital category, as well.

[27] http://www.state.sd.us/bfm/budget

[28] http://www.state.sd.us/dcr/insurance/LHRatesForms/IndMedCarriers.htm

[29] SD Division of Insurance, *Report on the Impact of Legislated Reform Measures on South Dakota: Individual and Small Employer Health Insurance Markets*. January 2001.

[30] It appears that the state's policy on providing coverage to those determined to be "uninsurable" because of previous or current medical conditions may have contributed to the carrier's exit. Under current law, companies offering individual policies must devote 2 percent of their premium volume to guaranteed issue.

[31] SD Division of Insurance, *Annual Average Premium Survey*, 2001.

discretion about pricing the policies they sell.[32] One member of the Interagency Work Group concluded, "The South Dakota insurance market is barely competitive. If the state continues to lose carriers, it will become less competitive." There are now 13 large group major medical carriers in the state. As of January 2001, there were four licensed HMOs in South Dakota and 9.7 percent of the state's population was enrolled in an HMO.[33]

As the SPG Interagency Work Group considers policy options to expand affordable coverage in the state, it is important that the fragile individual and small group insurance environment is stabilized in the process. At this time, it is unknown what, if any, regulatory changes could be made to accommodate policy option development.

H. Universal Coverage, Health Care Use and Providers

One of the most important issues for South Dakota to consider is whether providers in the state would have the capacity to meet consumer demand when and if health coverage is expanded to all residents of the state. This is because utilization of health care services would be expected to increase as the uninsured become covered. ***Figure 3*** presents estimates of the percentage increase in aggregate statewide utilization of health care services (including utilization for both the insured and newly insured) if the uninsured in South Dakota became covered. These data indicate that the most significant increase would be for physician and dental services.

Figure 3
Percent Increase in Aggregate State-wide Use of Health Care Services if Uninsured Become Covered

Type of Service	Percentage Increase in Utilization
Physician Visits	3.7%
Dental Visits	4.3%
Hospital Stays	0.7%
Outpatient Visits	2.6%
Emergency Room Visits	(0.9%)

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

Because South Dakota is a sparsely populated state with a shortage of health care providers in many areas, it is expected that access to health care services could become an even more challenging issue as more persons in the state become insured. To the extent hospitals, physicians, and other health providers currently have capacity that exceeds patient demand, however, expanded coverage could increase the volume of services they deliver and thus,

[32] Chollet, D., Kirk, A., and Simon, K, *The Impact of Access Regulation on Health Insurance Market Structure*, submitted to the Office of the Assistant Secretary for Planning & Evaluation, US Department of Health and Human Services, October 2000.

[33] Lauer et al. *The Interstudy Competitive Edge, Part II: HMO Industry Report*. St. Paul, MN, October 2001.

improve their financial well-being. Estimating the specific impact on plans could not be fully assessed at this moment, given the information that is available and the time limitations of the HRSA SPG grant period.

I. Planning Process and Safety Net Providers

The SPG planning process in South Dakota did not specifically take safety net providers into account. During meetings and teleconferences with the Interagency Work Group, the importance of safety net providers in providing access to care was highlighted.

J. Experiences of Other States

Prior to drafting the policy alternatives to expand affordable health coverage, both the Interagency Work Group and The Lewin Group collected and evaluated information about programs in other state jurisdictions to assess their potential application in South Dakota. Lewin also applied its project team's policy and operational experience to assess the feasibility of public and private interventions proposed in the SPG planning process.

SECTION IV: OPTIONS FOR EXPANDING COVERAGE IN SOUTH DAKOTA

One of the primary objectives of the State Planning Grant (SPG) program in South Dakota was to evaluate the cost and coverage impacts of a wide range of options for expanding health coverage in the state. The Lewin Group analyzed six policy options, including changes to both public programs and private insurance. For each option, Lewin estimated the number of persons who would become insured and the cost of adopting each option. The analyses included estimating the number of persons *eligible* for each expansion, the number of eligible persons *who would accept* the coverage, and program costs. The six options evaluated include:

- Expanding Income Eligibility Levels for Adults under Medicaid and SCHIP
- Creating a Medicaid Buy-in Program for Small Employers and Low-Income Persons
- Creating a Private Health Insurance Premium Subsidy Program for Low-Income Persons
- Creating a Private Health Insurance Premium Voucher Program for Small Employers
- Creating a Low-Cost Option for Small Employers
- Expanding Direct Health Services

The estimates presented were developed using The Lewin Group's Health Benefits Simulation Model (HBSM) In brief, the HBSM is a microsimulation model of the U.S. health care system that has been applied in the analyses of thousands of legislative and regulatory proposals at the national and state levels for over 15 years. Lewin adapted this model for application in South Dakota by integrating state level data that are available through national and state sources. The (HBSM) model predicts the impact of health policy proposals by estimating the number of individuals who may be eligible for the proposed program, the number of individuals who are expected to enroll in it, and the cost of adopting the proposal (including the total costs and the distribution of costs among payers). The HBSM makes these comparisons among different policy options by using uniform data and assumptions; this approach yields a consistent platform for evaluation of multiple possibilities. A full description of the HBSM and its estimation methodology can be found in ***Appendix H.***

The options identified below were formulated from staff discussions within the Interagency Work Group and were based on policy options that have been considered or enacted in other states. The options were generated with the intent of exploring a range of potentially feasible approaches for expanding the availability of affordable health coverage in South Dakota. However, none of the approaches have progressed to the point where they are recommended for State implementation in 2002.

A. Option One: Expanding Income Eligibility Levels for Adults under Medicaid and SCHIP

This analysis examines the cost and coverage impacts of expanding Medicaid/SCHIP coverage to adults of various income levels in the state. Currently, South Dakota covers parents of Medicaid-eligible children up to 65 percent of the Federal Poverty Level (FPL).[34] Under Section 1931(b) of the Social Security Act, the state has the option to increase Medicaid income eligibility levels for parents to the same income level as children under the state's current State Children's Health Insurance Program (SCHIP), which is 200 percent of the FPL. The FPL for a family of three was $14,630 in 2001.[35] The federal government match for these newly eligible parents would be the current Medicaid match rate (68.31 percent in 2001)[36]. Some state dollars will be needed in addition to the available federal matching funds.

Under current law, no other non-disabled adults in South Dakota are eligible for Medicaid. However, the state could implement a coverage expansion for these adults without federal matching funds. In this analysis, we assume that these expansions are funded using only state funds. The Medicaid expansions for adults analyzed under Option 1 include:

- Covering all persons under 65 percent of FPL
- Covering all persons under 133 percent of FPL
- Covering parents and children below 200 percent of FPL and all other adults below 133 percent of FPL

Figure 2 shows The Lewin Group estimates for these Medicaid program expansions. Since children and parents are already covered if their incomes are less than 65 percent of FPL, the expansion to cover all such persons would add only adults to the Medicaid program. Nearly 33,000 adults would be eligible for coverage under this alternative. Of these, an estimated 17,000 would enroll in the Medicaid program. However, more than 5,000 of these new enrollees already have insurance coverage from some other source. Thus, about 12,000 uninsured persons would become insured with this expansion. This expansion would cost an estimated $35.2 million dollars, all comprised of state funds.

An expansion to all persons with incomes under 133 percent would expand eligibility to more than 58,000 persons. We estimate that about 32,300 would actually enroll in the program, including about 800 children (who become covered when their parents sign up), 5,500 parents, and 26,000 other adults. About 10,500 of the new enrollees would drop their current coverage to enroll in the public program, resulting in a net decrease of about 22,000 uninsured persons. This expansion proposal would cost nearly $78 million, of which South Dakota's share would be about $67 million.

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[34] Broaddus, M., Blaney, S., Dude, A., et. al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Washington, DC: Center on Budget and Policy Priorities, February 2002.

[35] http://aspe.dhhs.gov/poverty/01proverty.htm

[36] http://aspe.dhhs.gov/health/fmap01.htm. In FFY 2002 the FMAP dropped to 65.93 percent in South Dakota.

Finally, the Medicaid expansion to parents and children below 200 percent of the FPL and all other adults below 133 percent of FPL would reduce the state's uninsured population by about 26,500 persons and would cost about $95 million. South Dakota's share of these expenses would be about $73 million.

Figure 2
Coverage and Cost Estimates of Selected Expansions in the South Dakota Medicaid/SCHIP Program (assumes no premium requirement) [a]

Eligibility Group	Avg. Monthly Number Eligible (thousands)	Avg. Monthly Number Enrolled (thousands)	Change in the Number of Uninsured (thousands) [b]	Total Costs (millions)	State Costs (millions)
All Below 65% of Poverty					
Children	--	--	--	--	--
Parents	--	--	--	--	--
All Other Adults	32.8	17.3	12.0	$35.2	$35.2
Total	**32.8**	**17.3**	**12.0**	**$35.2**	**$35.2**
All Below 133% of Poverty					
Children [c]	--	0.8	0.8	$0.7	$0.2
Parents	9.3	5.5	3.9	$15.6	$5.3
All Other Adults	49.1	26.0	17.1	$61.4	$61.4
Total	**58.4**	**32.3**	**21.8**	**$77.7**	**$67.0**
Parents and Children Below 200% of Poverty, Non-Custodial Adults Below 133% of Poverty					
Children [c]	--	2.6	2.6	$2.7	$0.7
Parents	19.6	10.5	6.8	$31.3	$10.7
All Other Adults	49.1	26.0	17.1	$61.4	$61.4
Total	**68.7**	**39.1**	**26.5**	**$95.4**	**$72.8**

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 their parents become insured.

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

Not all of the persons eligible to enroll in these Medicaid expansions currently lack health coverage. Some persons would drop their current source of health coverage to join the less expensive public program. This "crowd-out" phenomenon is believed by state officials to primarily affect those who currently have individual non-group coverage. However, national level studies indicate that this will occur among persons with employer coverage as well.

B. Option 2: Creating a Medicaid Buy-in Program for Small Employers and Low-Income Persons

Since many of the uninsured work in small businesses or have modest incomes, a program that would allow them to buy into the Medicaid program should reduce the number of uninsured persons in South Dakota. This option could be less costly than offering private insurance because provider payment rates and administrative costs under Medicaid should be less than that for private insurance in South Dakota.

Medicaid provider payment rates are lower than those of private insurance plans. According to the Medicare Payment Advisory Commission (MedPAC), Medicaid payment rates for hospital services are about 67 percent of private payment rates in South Dakota hospitals.[37] Medicaid payment rates for physician services are about 90 percent of Medicare payment rates in the state, which are also lower than private payment rates.[38] In addition, the Medicaid program gets a rebate of about 17 percent for prescription drugs compared to an average of about 8 percent under private health plans.[39]

The Medicaid program also has lower administrative costs than do private health plans. Medicaid program administrative costs in South Dakota equal about 3.4 percent of benefits costs, compared to administrative costs (including broker/agent commissions) for small groups, which can be as high as 30 percent of benefits costs.

The analyzed Medicaid buy-in option would allow persons in families with incomes below 200 percent of FPL to purchase coverage through the state's Medicaid program. The expansion would be geared for low-income workers (and their dependents) whose employers do not offer insurance coverage, and low-income persons in families lacking an employed adult.

Small employers also would be able to purchase coverage through the state's Medicaid program if they met the following criteria:

- They employed 50 or fewer workers;
- The average wages/salaries for their employees were below the state-wide average for small employers (i.e., less than $25,000 per year);
- At least three-quarters of their employees enroll;
- The employer has not offered insurance in the past 12 months; and
- Employers agree to pay at least half of the monthly premium.

No assumptions were made that were unique to this option about potential adverse selection. The premiums would be equal to the actuarial cost of the program and the cost of this program expansion would be fully funded through premium contributions on the part of small businesses or individuals. Thus, this approach would result in *no new costs* to the state.

Figure 3 displays the cost and coverage impacts of the Medicaid buy-in program for small employers and low-income persons. About 3,900 persons who work for small employers meet the criteria listed above. Of these, an estimated 3,700 would enroll in the program; about 2,800 of these enrollees would be previously uninsured.

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[37] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2001.

[38] Allen Dobson, et al, "Comparing Physician Fees Among Medicaid Programs," Falls Church: The Lewin Group, June 2001.

[39] Department of Health and Human Services, "Prescription Drug Coverage, Spending, Utilization, and Prices," April 2000.

Figure 3
Coverage and Cost Estimates of A Medicaid Buy-in Program For Small Employers and Low-Income Persons in South Dakota [a/]

	Number of Persons Eligible (thousands)	Number Who Enroll (thousands)	Newly Insured Persons [b/] (thousands)
Medicaid Buy-in Offered to Small Employers [c/]			
Currently Insured	8.7	0.9	--
Currently Uninsured	25.3	2.8	2.8
Total	**34.0**	**3.7**	**2.8**
Medicaid Buy-in Offered to Low-income Persons Without Access to Employer Coverage			
Currently Insured	22.7	5.9	--
Currently Uninsured	49.2	7.7	7.7
Total	**71.9**	**13.6**	**7.7**
Medicaid Buy-in Offered to Small Employers and Low-income Persons			
Currently Insured	27.6	6.7	--
Currently Uninsured	61.1	10.2	10.2
Total	**88.7**	**16.9**	**10.2**

a/ Low-income persons below 200% of poverty and small employers (50 or fewer workers) meeting the specified eligibility criteria would be eligible to buy into the Medicaid program.
b/ The number of new enrollees who otherwise would have been uninsured.
c/ About 34,000 workers and their dependents are in firms that would qualify for the program. However, it is estimated that only a portion of employers would be induced to purchase coverage for their employees.

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

Of the 72,000 low-income persons (whose employer does not offer coverage or who is part of a non-working family) eligible for the Medicaid buy-in program, an estimated 13,600 would enroll. This includes about 7,700 workers and dependents whose employers do not currently offer health insurance and approximately 5,300 persons in non-working families. Out of the total 88,700 persons eligible for the buy-in program (including employees of small employers and persons with low incomes), an estimated 16,900 individuals would enroll. About 10,200 of these enrollees would have been uninsured. Some crowd-out occurs with this policy, as well.

This approach has the advantage that it can expand health coverage to nearly 11,000 individuals in South Dakota at no cost to the state. Premium contributions on the part of individuals and small businesses would fully fund this coverage expansion. Given the reported reluctance of providers to accept more Medicaid patients, however, the realized increase in medical access may be limited.

C. Option 3: Creating a Private Health Insurance Premium Subsidy Program for Low-Income Persons

Another option examined as part of the SPG project involves a premium subsidy for low-income persons who do not have access to employer-sponsored coverage. This policy would give a full premium subsidy to qualifying persons below 200 percent of the FPL. The subsidy would phase

out for persons between 200 percent and 300 percent of FPL. The subsidy, available to uninsured persons and those who purchase individual policies, would not apply to MediGap supplemental coverage for Medicare beneficiaries.

For illustrative purposes, we analyzed the cost and coverage impacts under the following three fixed-dollar subsidy amounts:

- Subsidy of $750 for individuals and $1,500 for families ($750/$1,500)
- Subsidy of $1,000 for individuals and $2,000 for families ($1,000/$2,000)
- Subsidy of $1,250 for individuals and $2,500 for families ($1,250/$2,500)

An estimated 99,300 persons would be eligible for a private insurance premium subsidy ***(Figure 4)***. About 47,200 persons would purchase insurance with the $750/$1,500 subsidy. The total cost of this option would be $26.7 million, approximately $567 per enrollee. About 11,300 persons who purchase insurance with the subsidy would have been uninsured. The subsidy cost for each newly insured person is an estimated $2,371. As the premium subsidy increases, more people would be induced to purchase insurance with it. Nearly 51,000 individuals would take advantage of the $1,000/$2,000 subsidy and about 54,000 individuals would use the $1,250/$2,500 subsidy. The per-enrollee cost of these subsidies is $765 and $963 respectively.

There are many approaches states have adopted to provide premium subsidies to low-income persons. They include tax credits; use of SCHIP funds to subsidize employer-offered health insurance; county/state contributions for employer-sponsored insurance among individuals working for small businesses; and others. Emerging research indicates however, that premium subsidies for individuals would have to be large (and costly) to have a noticeable impact on the number of uninsured in a state.[40]

D. Option 4: Creating a Private Health Insurance Premium Voucher Program for Small Employers

Another approach to expanding coverage in South Dakota entails directly subsidizing small employers to assist them in providing coverage to their workers. The state could accomplish this by offering vouchers to employers for a certain percentage of health insurance premiums for their workers. As envisioned in the design of this option, eligible employers would meet the following criteria:

- Their average per-worker payroll is below the statewide average for small firms; and
- They have not offered health insurance coverage to their workers in the past 12 months.

[40] Res Chovsky, J. and Hadley, J. "Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly," *Issue Brief #46,* Washington, DC: Center for Studying Health System Change, December, 2001.

Figure 4
Coverage and Cost Estimates of A Private Insurance Premium Subsidy For Low-Income Persons in South Dakota [a/]

	Number Eligible for the Subsidy (thousands)	Number Who Purchase Insurance (thousands)	Newly Covered Persons [/b] (thousands)	Total Subsidy Cost (millions)	Subsidy Cost Per Enrollee	Subsidy Cost Per Newly Covered Person
Subsidy of $750 / $1,500						
Currently Insured	35.9	35.9	--	$19.2	$535	
Currently Uninsured	63.4	11.3	11.3	$7.5	$668	
Total	**99.3**	**47.2**	**11.3**	**$26.7**	**$567**	**$2,371**
Subsidy of $1,000 / $2,000						
Currently Insured	35.9	35.9	--	$25.6	$712	
Currently Uninsured	63.4	14.9	14.9	$13.3	$890	
Total	**99.3**	**50.8**	**14.9**	**$38.9**	**$765**	**$2,600**
Subsidy of $1,250 / $2,500						
Currently Insured	35.9	35.9	--	$32.0	$892	
Currently Uninsured	63.4	18.1	18.1	$20.0	$1,104	
Total	**99.3**	**54.0**	**18.1**	**$52.0**	**$963**	**$2,872**

a/ Premium subsidies would be available to all persons below 300 percent of poverty who do not have access to employer-sponsored coverage. The full subsidy would be available to qualifying persons below 200 percent of poverty and is phased out for those between 200 and 300 percent of poverty.

b/ The number of new enrollees who otherwise would have been uninsured.

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

For illustrative purposes, we analyzed the cost and coverage impacts of this option under four different scenarios:

- Vouchers are limited to firms with 10 or fewer employees;
  - Amount of the voucher is equal to 25 percent of the premium cost
  - Amount of the voucher is equal to 40 percent of the premium cost
- Vouchers are limited to firms with 25 or fewer employees;
  - Amount of the voucher is equal to 25 percent of the premium cost
  - Amount of the voucher is equal to 40 percent of the premium cost

The number of workers (including their dependents) in firms with 10 or fewer employees is about 24,900. The number increases to about 32,200 persons if the estimation includes firms with up to 25 workers. Depending on the generosity of the voucher program, the number of workers and dependents in firms that take the voucher varies from 1,500 to 3,300. Approximately 1,400 to 3,200 persons would accept the new coverage from their employers. The total subsidy cost of the program ranges from $600,000 to $2.3 million per year.

Figure 5
Coverage and Cost Estimates of A Private Insurance Premium Voucher Program For Small Employers in South Dakota [a/]

	Number of Workers and Dependents in Eligible Firms (thousands)	Workers and Dependents in Firms Induced to Offer Coverage (thousands)	Workers and Dependents Who Take Employer Coverage (thousands)	Newly Covered Persons (thousands)	Total Subsidy Cost (millions)
10 or Fewer Workers					
25 Percent Voucher					
Currently Insured	4.9	0.3	0.3	--	$0.1
Currently Uninsured	20.0	1.1	1.1	1.1	$0.5
Total	**24.9**	**1.5**	**1.4**	**1.1**	**$0.6**
40 Percent Voucher					
Currently Insured	4.9	0.4	0.4	--	$0.3
Currently Uninsured	20.0	1.9	1.8	1.8	$1.3
Total	**24.9**	**2.3**	**2.2**	**1.8**	**$1.6**
25 or Fewer Workers					
25 Percent Voucher					
Currently Insured	7.8	0.5	0.5	--	$0.2
Currently Uninsured	24.4	1.7	1.6	1.6	$0.8
Total	**32.2**	**2.2**	**2.1**	**1.6**	**$1.0**
40 Percent Voucher					
Currently Insured	7.8	0.8	0.8	--	$0.6
Currently Uninsured	24.4	2.5	2.4	2.4	$1.7
Total	**32.2**	**3.3**	**3.2**	**2.4**	**$2.3**

a/ Qualifying employers must have an average per-worker payroll below the statewide average for small firms.

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

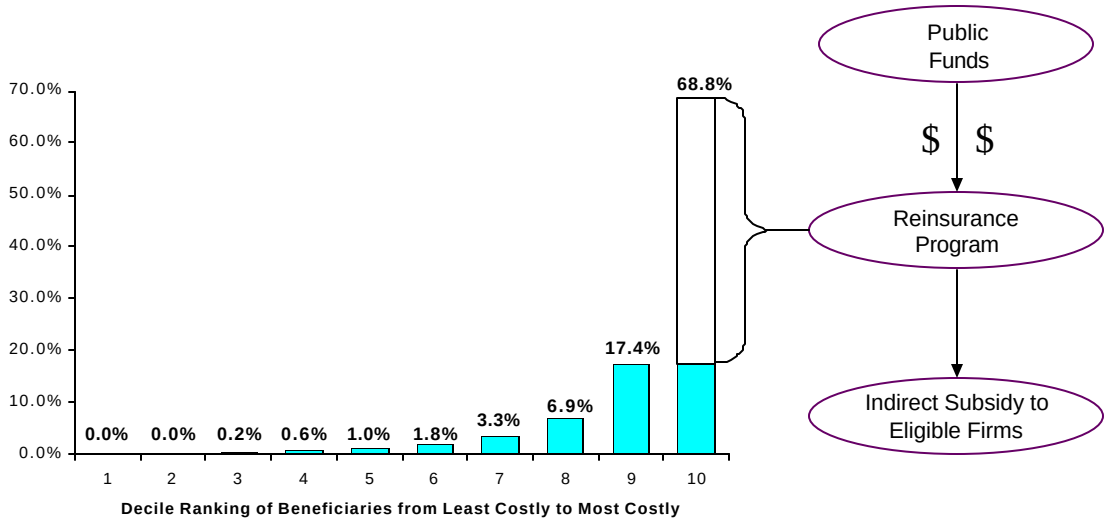
E. Option 5: Create Low-cost Health Insurance Coverage Options

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, Lewin examined the potential impact of creating a program in South Dakota modeled on the "Healthy New York" program enacted in New York State in 2001. This program permits lower income individuals and employers with lower-wage workers to purchase a private health plan that does not include mandated benefits. 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 policy. As shown in ***Figure 6***, about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. This program subsidizes the cost of coverage for many of these high-cost cases, resulting in lower premiums. Under the Healthy New York program, the state 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 cost of this reinsurance is paid through trust funds established for this purpose using New York tobacco settlement receipts.[41]

Figure 6
Subsidized Insurance for Small Groups Through State-funded Reinsurance



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

In New York, premiums under the program will be reduced by an estimated 15 to 20 percent. The elimination of mandated benefits accounts for half of this decrease while the reinsurance subsidy causes the other half. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program currently has about 3,000 members. Enrollment is expected to grow as small employers and low-income individuals learn of their eligibility.

In this analysis, Lewin estimated the impact of adopting a similar program in South Dakota using the eligibility criteria established in the Healthy New York program. Self-employed people and the 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. Eligible employers would meet the following criteria:

- Firms with 50 or fewer workers;
- 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.

[41] Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers*, New York: The Commonwealth Fund, November 2001.

This program would have less of an impact on premiums in South Dakota than it does in New York because South Dakota has fewer mandated benefits. Thus, the reinsurance subsidy would have the most significant impact on premiums in South Dakota. For purposes of developing estimates for South Dakota, Lewin assumed that the program would reduce premiums for enrolled firms and individuals by about 12 percent.

Lewin estimated that in response to these premium reductions, about 6,400 people would take coverage under these health plans. This includes both individuals and people in firms that purchase this subsidized coverage ***(Figure 8).*** Of these, nearly all would have been uninsured. The total cost to the state of the reinsurance program would be $1.7 million.

Figure 8
Developing a Low-cost Benefits Package for South Dakota a/

Eligibility	Number Enrolled (in thousands)	Newly Insured (in thousands)	State Cost (in thousands)
Non-insuring firms with 25 or Fewer Workers Only	3.6	3.0	$1.0
Uninsured Individuals Below 250 percent of FPL	2.9	2.9	$0.8
Both Non-insuring Small Firms and Uninsured Individuals	6.4	5.7	$1.7

a/ Numbers do not add to totals due to overlapping eligibility.

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

F. Option Six: Expanding Direct Health Services

The final option models an expansion of direct services through physician offices, hospital outpatient departments, and community health centers as a means of improving access to health services in the state. The option would increase the availability of free or subsidized health care for one population group about whom South Dakota policymakers are especially concerned: uninsured adults 55 to 64 years of age. Although only 8.3 percent[42] of South Dakota's population is in the 55 to 64 year-old category, the probability of this age group being uninsured is higher than for other adult age groups. Across the United States, adults aged 55 to 64 are the fastest growing group of uninsured persons.[43]

For this late middle-aged group, health insurance is a particularly pressing issue for many reasons. First, those who have been laid off or taken early retirement have few viable insurance options since they remain ineligible for Medicare and face difficulty in securing affordable individual coverage. Second, this age group tends to have a higher prevalence of chronic conditions that often result in denials and limitations in coverage available through the individual market. In addition, researchers have found this age group more likely to experience a major

[42] US Bureau of the Census, Census 2000 Summary File.
[43] P.F Short, D.G. Shea, and M.P. Powell, A *Workable Solution for the Pre-Medicare Population*, The Commonwealth Fund, December 2000.

decline in overall health when they have no health insurance. All of these considerations necessitate an expansion of affordable coverage and care for 55 to 64 year olds.

As a result, the late middle-aged group tends to purchase individual private insurance more often than other age groups. Individual insurance, however, is typically very costly. Insurers can charge higher premiums to older Americans because they file more claims. Since administrative costs can not be spread over a group of policyholders, insurers assert that only individuals at high risk of needing health care will purchase policies.[44] As a result, 71 percent of adults age 55 to 64 find it very difficult or impossible to buy affordable coverage on the individual market.[45]

The older subset of the uninsured population face significant health concerns. In general, medical expenditures for 55 to 64 year-olds are more than twice the average for the 35 to 44 age group. Additionally, the incidence of work-related disabilities increases with age.[46] Uninsured adults are less likely to obtain necessary preventive health care services, resulting in poorer health outcomes compared to insured persons. Approximately 40 percent of uninsured adults skipped a recommended medical test or treatment according to a recent Kaiser Commission on Medicaid and the Uninsured.[47] The Commission also found that uninsured adults were 30 percent less likely than insured adults to have had a check-up in the past year.[48] The majority of uninsured adults lack a regular source of care, which has been shown to be a crucial factor associated with the receipt of preventive services. Finally, continually uninsured adults in their late middle ages experienced a sharper overall decline in health between 1992 and 1996 compared to continuously insured persons. Furthermore, they are more likely to develop difficulties walking or climbing stairs when compared with continuously insured adults.

Even though the proportion of uninsured 55-64 year olds is 10.7 percent and lower than other age groups in South Dakota, the consequences of uninsurance among older adults and the findings from South Dakota focus groups provide a compelling argument for expanding either affordable coverage or direct health services for the late middle-aged population. Pursuing this option would allow for greater health care service use, improved health awareness and outcomes, and would ease the financial burden that the uninsured experience. For uninsured older adults, it would encourage them to seek timely care for treatable problems, thus preventing costly and catastrophic circumstances in the future. Ultimately, expanding affordable health care potentially reduces the burden of illness, increases productivity, and promotes the overall wellbeing of the older adult population.

The direct care model should provide uninsured people with basic services. This service delivery approach of community-based care builds on the local commitment of specific health care organizations, their physicians, and the community, to assure access to health services to

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[44] M.V.Pauly, and A.M.Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health and Politics, Policy & Law* 25, February 2000.

[45] L. Duchon, and C. Schoen. "Experiences of Working-Age Adults in the Individual Insurance Market," *Issue Brief* New York: The Commonwealth Fund, December 2001.

[46] Short, Shea, and Powell.

[47] Henry J. Kaiser Family Foundation, "The Uninsured and Their Access to Healthcare," *Fact Sheet,* January 2001.

[48] *Ibid.*

everyone. The direct care model is best exemplified in the "free clinics," and Federally Qualified Health Centers (FQHCs), that provide care on a sliding fee scale.

The model emphasizes primary and preventive care and provides assistance for accessing to additional care such as specialty care or pharmacy services. In some examples of this approach, patients are integrated into on-going primary care and treatment systems. In other cases, the free clinic sites provide services. At FQHCs, comprehensive primary care is provided on a sliding fee scale basis to those without insurance.

This is not a formal "insurance" program, but providers agree to see patients based on local criteria and in free clinics, and have the right to refuse to provide services. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The "direct care model" does not replace existing insurance programs.

The purpose of this program is to expand the availability of free or subsidized health care for needy individuals who continue to be uninsured. Uninsured older adults who present themselves at hospitals would be permitted to obtain services from participating physicians during regular business hours in the physician's office. Participants would be required to pay for a portion of the services on a sliding scale with income for people below 300 percent of the FPL.

There would be a need to communicate to the older uninsured population the availability of a Direct Care Program. There could be an office that the uninsured could call or visit to apply for the program. Other suggestions included application by telephone or mail. These other "entry points" into the program may be necessary if hospital staff do not have the time to properly screen individuals, process applications, and distribute information on the program.

There is also a question of whether it is feasible to assume that doctors would participate in such a plan given the shortage of medical professionals in most South Dakota counties. The state must consider how the doctors would get paid for their services, what the reimbursement rates would be, and how doctors could afford to treat people if they were not being fully paid for their services.

At this point, no costs have been estimated for this program. Unlike program entitlement expansion alternatives, a direct service expansion option would be implemented within specified resource constraints without respect to service needs. As South Dakota continues to build upon the work begun through the SPG initiative, one important task will be to inventory safety net providers throughout the state in order to pro-actively develop more and improved health care access points. President Bush's FY 2003 budget proposals to expand community health center sites and to strengthen the National Health Service Corps facilitate important access to care initiatives that could develop in South Dakota in the years ahead.

SECTION V: CONSENSUS BUILDING STRATEGIES

At the onset of the South Dakota SPG project, the Secretary of Health contacted the Governor's Office and the Secretaries for the Departments of Social Services, Commerce and Regulation, and Human Services to discuss the grant announcement. Through this exploration, the decision to apply for the HRSA grant was made, more than two years ago. State officials believed that the grant would provide important resources for studying the uninsured in the state and South Dakota's health insurance market. (The last survey of the state's uninsured population was conducted in 1991.) As the outlook for federal funding approval appeared favorable, the commitment of state resources necessary for preparing the HRSA application was approved.

To obtain broad support for the SPG project, State agency staff developed an overview and description of the project and distributed it to a wide range of stakeholders. Stakeholders were identified by senior State officials who recognized the importance of specific organizations as constituents and the value of diversity in representing the perspectives of South Dakotans. Through this outreach effort, the state received letters of support from the following organizations and individuals:

- South Dakota Retailers Association
- South Dakota Farmers Union
- South Dakota Farm Bureau
- South Dakota Association of Healthcare Organizations
- Aberdeen Area Tribal Chairmen's Health Board
- Aberdeen Area Indian Health Services
- South Dakota Legislative Research Council
- South Dakota Association of County Commissioners
- South Dakota State Medical Association
- South Dakota Council of Mental Health Centers
- The state's largest insurance carrier
- Two large HMOs in the state
- The State's Legislative Senate House Chairs for their respective Health and Human Service Committees.

The governance structure that was established to lead the South Dakota SPG effort was an Interagency Work Group comprised of staff from the following state agencies: Department of Health, Department of Social Services, Department of Commerce and Regulation, and Department of Human Services. State agencies were selected based on their ongoing regulatory and programmatic responsibilities for health care delivery, insurance market oversight, and Medicaid coverage in the state. While the Governor appointed the Department of Health as the lead agency for the SPG project, each agency made valuable contributions to the HRSA grant application and to the entire project.

The Interagency Work Group collaborated with each other, monitoring the SPG project's progress in completing designated tasks, and providing technical input to all major decisions concerning the grant. Each Work Group member was responsible for keeping the Secretaries of the various State agencies informed of SPG project developments and for apprising other Work Group members of issues that State agency leaders were concerned about. Work Group members were also designated as public liaisons to address questions and information requests from stakeholders and the general public. Legislative requests from stakeholders about the SPG project were responded to by Department Secretaries and the Governor's Office staff.

Based on a written agreement, The Lewin Group was charged with completing the data collection, data analysis, analysis of policy options, and drafting the final report to HRSA. The Interagency Work Group had the responsibility of guiding and monitoring Lewin's progress and approving deliverables. The Work Group provided ongoing technical guidance to Lewin during the SPG project. The Work Group and Lewin realized this goal primarily through weekly and detailed conference calls. As a decision making and governance entity, the Interagency Work Group effectively listened to one another and discussed and resolved issues. Work Group members had long-standing professional relationships with each other.

Public input was essential to the SPG process in South Dakota. Quantitative data were obtained through reaching out to employers and uninsured individuals via telephone surveys. Indeed, with South Dakota's small population, the project team recognized as the sampling framework was designed that the theoretical possibility existed for all household telephone numbers in the state to be dialed before the project was over. Many residents and employers of South Dakota directly called elected or appointed State officials to ascertain the legitimacy of the surveys and seek more information about the project. Qualitative data were obtained through focus groups and structured interviews.

In addition to the above, the South Dakota Department of Health submitted a statewide press release to the newspapers, radio stations, and television stations throughout the state after receiving the SPG Award Notice from HRSA. Additionally, during the data collection phase of the project, the DOH listed all the activities of the South Dakota SPG project on their web site. This was to insure respondents of the phone surveys, focus group interviewees, and stakeholder interviewees that the data collection activities occurred under State auspices. On both the press release and web site posting, contact information for DOH staff was also listed.

The SPG planning process has raised public awareness of health insurance in general and the uninsured in particular. Due to the short time frames involved, the project is expected to have a greater impact on South Dakota's policy environment during its second year. In two respects, the SPG planning process has advanced the potential for expanding affordable health coverage for state residents. The first year of the SPG grant resulted in new and up-to-date information about the characteristics of the uninsured in South Dakota. This information challenged existing assumptions about the composition of the uninsured population in the state. Survey data revealed the uninsured's attachment to the workforce and the consequences they experience as a result of having no health coverage. In addition, at the time the SPG grant application was made, no formal policy options had either been designed or considered to address the problem of the uninsured in the state. The SPG grant has facilitated the development of policy options that may be refined and possibly considered in the future.

No policy change can occur in South Dakota without support and involvement of key members of the Legislature. The timing of the 2002 Legislative Session (January-March) precluded State agency staff from providing information and building an awareness of alternatives to expand affordable health coverage in the state during this phase of the SPG project. It is anticipated that data and reports generated from the surveys and focus groups conducted in 2001 will be made available to Legislative members and staff in the months ahead.

In the second year of the SPG program, the Governor has indicated he will issue an Executive Order establishing a committee made up of principal stakeholders to discuss findings, review the presented options and determine what corrective actions are within the scope and ability of the state to respond. This committee is expected to meet periodically beginning in May, 2002 and will issue preliminary findings by fall. At a minimum, committee membership includes health providers, representatives of the health insurance industry, consumer advocates, employers and key policymakers.

In 2002, South Dakota, like many other states, faces a budget deficit as a result of a slumping national and state economy. Leaders of the State are currently addressing budget shortfall issues and examining the way services are provided. It is doubtful whether the State resources will ever exist to expand access to health insurance for all residents. Should the economy recover, it is possible that some policy alternatives could be enacted over the next three to five years. The feasibility of enacting some coverage programs in South Dakota would be enhanced if the federal government increased its share of funding in support of health coverage expansions.

SECTION VI: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A. Importance of State-Specific Data

State-specific data was essential to the SPG project's decision-making process and formulation of policy alternatives in South Dakota. Due to the expense of collecting state-specific data, past access efforts in South Dakota had been conducted without the benefit of extensive new data gathering and analysis. SPG funds were used to identify the characteristics of the uninsured in the state and the consequences individuals experience as a result of being uninsured. SPG funds enabled staff to generate detailed qualitative information on the experiences and perceptions of the un- and under-insured in South Dakota. Finally, SPG funds provided information, apparently for the first time, about employers in the state, the coverage that they offer, and the nature of the barriers to expanding employer-based coverage.

The opportunity to develop state surveys in South Dakota was important, given the state's unique characteristics and small population base. This process revealed geographic differences on many important dimensions. The lower rates of employer-based health benefits in the western half of the state, which is largely frontier and contains relatively large Indian reservations, led to the consideration of the development of private insurance subsidies as a policy option and to recommend federal funding improvements in the Indian Health Service. Since the vast majority of the state's population is either white or Native American (89.9 percent and 8.3 percent of the population, respectively), project staff determined that measurements on health disparities among ethnic subgroups would prove unreliable. Yet, the state-specific survey of the uninsured did provide a relatively low-cost opportunity to understand the extent of coverage among the *insured* population of South Dakota through the use of an abbreviated questionnaire. The information generated from the "screen-outs" will be used to address many health policy questions this year.

The qualitative research that the project team conducted included focus groups and structured interviews (described elsewhere in this report). The team captured and quoted the views of the focus group participants, giving a personal voice to individuals often overlooked as important health system stakeholders. Summaries of focus group member perspectives and experiences are valuable as future educational material for elected officials and advocacy groups who will be asked to engage in future policy development regarding the uninsured. Focus group findings have been particularly useful this year as an "early warning" mechanism, alerting Interagency Work Group members to the significant distress experienced by many state residents as a result of an escalation of health insurance firms exiting from the state's individual market.

B. Effectiveness of Data Collection Activities

Not enough time has passed to conclusively determine which data collection activities have been most valuable to the state. No particular data collection activity stands out as the most effective research strategy at this time. The surveys and focus groups were designed to complement each other in terms of the information developed, while building upon other areas of research. We believe that the research approach undertaken as part of South Dakota's SPG grant achieved state policymaking objectives and provided a firm foundation for moving forward with policy options.

C. Data Collection Proposed but Not Carried Out

Unlike the experiences of some other grantees, South Dakota staff conducted and completed all data collection activities within the specified and tight timeframe of the SPG project as originally proposed.

D. Strategies to Improve Data Collection

Many different strategies were adopted to improve both quantitative and qualitative data collection. For the state's telephone survey of the uninsured, a sampling frame was designed that assured an increase in the probability of rural and Native American respondents compared to strict population-based sampling (e.g. select every n^{th} household in county). Although Baselice and Associates Inc. (the firm that conducted the telephone survey) prepared to conduct the telephone survey in Spanish to capture immigrant respondents, this strategy proved unnecessary in South Dakota, given the state's population demographics. To reach the widest array of households in the telephone survey of the uninsured, Baselice generated telephone numbers from published sources and random digit dialing (RDD).

The project team adopted creative strategies to maximize a high show rate for the focus groups. In some unpopulated areas, American Public Opinion (the firm that managed the logistical details of focus group recruitment) hired a van to pick up recruited individuals and transport them to the focus group location. The project team was flexible regarding the time focus group sessions were held, varying sessions according to the perceived time constraints unique to each group. For example, one of the sessions was held in the morning so it would not interfere with the farmers' work day and scheduled high school Homecoming activities. Focus groups among Native Americans took place in locations that were well-known and comfortable for participants. Indeed, our efforts to help make focus group participants feel comfortable led one tribal leader to observe how open individuals seemed to be in expressing themselves to outsiders. A final strategy adopted to maximize focus group participation was a modest cash payment for each member.

Collecting data on the refugee population was originally a goal of the focus groups. However, the project team discovered early in the project that this group primarily lives in one area (Sioux Falls) and that the refugees are difficult to contact. To obtain information about this population, Lewin conducted a stakeholder interview with an organization that provides refugee advocacy services, Lutheran Social Services.

E. Need for Additional Data Activities

One outcome of the SPG project in South Dakota was the generation of additional policy questions that would call for new research in some areas. Research and data would be especially useful in the following areas:

- Analysis of attitudes of adults who are uninsured for long periods of time to understand why they do not avail themselves of current private and public coverage options.

- A study of uninsured or under-insured older adults (55-64 years) to determine the health status effects of this condition, treatment patterns for chronic conditions, and finally, preventable health system costs.

- A study of companies in the state that provide health insurance to those in the individual and small group markets to ascertain their compliance with state underwriting and coverage regulations.

- Market research to test consumer willingness to pay for a *specified set* of health benefits.

- The development of practical measures of "underinsurance" that can be used by policymakers and advocates to assess the well-being of state residents, as related to their health coverage.

- An analysis of the unique health care delivery system in the state (e.g. rural, under-served combined with vast Indian reservations) to understand residents' patterns of health care, geographic access, and opportunities to facilitate overall quality improvements.

During the past seven months the project team has become aware of a lack of information concerning adequacy of health benefit packages. What seemed to be a surprisingly high number of focus group participants reported that although a family member might be insured, his/her coverage was catastrophic, often with a $5,000 deductible. There is little information available as to the most common health benefit packages available within the state and carrier policies being written in the individual market. Such data could help the design of affordable benefit packages that would be attractive to South Dakotans.

F. Organizational Lessons Learned

Many operational lessons were learned during the course of the South Dakota SPG program. The first operational lesson was the value of establishing an interagency group of experienced state officials with a professional interest in the subject of the uninsured. The commitment exhibited during the SPG project, as well as the technical expertise shared by Work Group members, resulted in quality products that may be used by several agencies in the months ahead. Interagency staff collaboration improved the utility of data collection efforts and the interpretation of research results. This staff collaboration helps to assure that information and perspectives gained from the SPG project will provide a state policy foundation from which improved programs can be constructed in the future, even after some elected officials (such as Governor Janklow) leave office at the end of the year.

Another operational lesson was the importance of partnerning with contractors who have experience in designing and conducting surveys, leading focus groups and analyzing policy options. The use of modeling simulations can allow states to compare magnitudes of effects, such as increases in coverage rates and costs to the state of increased coverage, across an array of policy options. Modeling techniques can provide defensible information to supplement political information available to public and private policymakers. The project also appreciated the value of partnering with consultants who were flexible in their approach, as the state's policy environment evolved.

The most significant operational lesson learned is that it is surprisingly difficult to foster comprehensive state reforms that can expand affordable health coverage to all citizens. These reforms are difficult to enact in the absence of supportive federal policy and during times of severe fiscal constraints. When such a high percent of the state's population already had health insurance, it is difficult to mobilize elected leaders to initiate changes in the status quo. Finally, as in other states, there exist ideological barriers to addressing the problems of uninsurance. Despite information generated by this project, many South Dakotans have strong views on the value of self-sufficiency, skepticism about government intervention, and a reluctance for the state to assume financial responsibility for improving access to affordable coverage among Native Americans given federal treaty commitments.

Given the short time frame of the SPG project, it is too early to tell whether changes in the structure of health care programs will be proposed, along with methods for their coordination, as a result of the HRSA planning effort.

G. Key Lessons Learned About Insurance and the Employer Community

It is still too early to determine what lessons were learned about how to effectively work with the employer community to expand affordable health coverage. During its first year, the project emphasized data collection, limiting direct contact primarily to the Employer Survey, certain focus groups and stakeholder interviews. During the second year of the project, the employer community will be represented on the Governor's committee. This phase will provide more feedback since it involves consensus building and the formulation of an implementation strategy.

One of the large insurers in the state has expressed interest in receiving information from the surveys about characteristics of the uninsured. The insurer is considering developing a catastrophic health insurance product for the uninsured and recognizes the importance of assessing the potential demand for such an option.

H. Key Recommendations for States

The key recommendation South Dakota offers to other states considering a planning effort, such as the SPG program, is to recognize the long time that passes between data collection and potential implementation of policy options to expand health coverage. Furthermore, collecting data and designing a plan to expand health coverage are only a few of the many steps that state officials must undertake in the policy process. Implementation of any expansion effort requires a careful assessment of the economic and political feasibility of specific alternatives as well as ongoing leadership in this effort. Also required is an understanding of trade offs: if "new" state money is not allocated to health insurance expansions then from what agency's budget are necessary funds allocated?

There are several steps that states might consider in their policy planning process to "speed-up" their activities, given HRSA's compressed time frames for the SPG projects. They include:

- Schedule data collection (such as surveys and focus groups) in parallel to the identification and analysis of policy options. State-specific information about the

uninsured is most useful to the policy analysis process after considering a framework that identifies a realistic span of options.

? Reduce time spent on "gearing-up" early in the SPG project. If possible, consider including consultants while writing the SPG grant application (to eliminate the need for bidding); and develop state Requests for Proposals before receiving the federal grant award.

? Establish clear project work plans and monthly progress reports.

Finally, states need to be prepared to devote significant resources to educating elected leaders, health system stakeholders, and the general public about the dimensions of the uninsured problem and realistic alternatives for addressing it.

I. Changing State Policy Environment

Since the time South Dakota submitted its HRSA grant proposal, several significant changes occurred in the State's policy environment. First, there is a state budget crunch. State tax revenues have grown more slowly than expected as a result of the U.S. and South Dakota economic recessions. State sales tax revenues grew by only 1.66 percent over the latest 12 month period, compared to a six fiscal year historical average of 5.9 percent.[49] The budget shortfall of $18.1 million in the current year is projected to grow to $36.3 million in FY 2003.[50] Part of the deficit results from a projected increase of $19.4 million to fund the State's Medicaid program in FY 2003. To balance the state's budget in FY2002, transfers are being made from the Reserve Fund and Property Tax Reduction Fund. To balance the FY2003 budget, transfers will be made only from the Property Tax Reduction Fund. The State Legislature was extremely reluctant to consider new or expanded programs during this 2002 session. The Legislature did, however, keep most existing programs in place by allocating reserve funds rather than by cutting vital programs or increasing taxes.

Second, as a result of the unforeseen events of September 11th, Governor Janklow significantly increased efforts to upgrade the state's terrorism and bioterrorism preparedness. Many State officials were redeployed to address priority issues of airport and aircraft security, community infrastructure security, mail handling, chemical security, and bioterrorism.

Third, with new and unexpected budget constraints, State officials are understandably wary about looking to the federal government as a partner in the efforts to increase affordable health coverage in the state.

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[49] South Dakota Bureau of Finance and Management, *Economic Forecast and Revenue Report*, February 2002.
[50] *ibid*

J. Change in Project Goals

The State of South Dakota initiated no change in the SPG project goals during the grant period.

K. Next Steps in Efforts to Expand Health Coverage

Due to the necessity of having to produce a final report at the end of the first twelve-month period, it was always believed that staff would emphasize data collection and analysis for the first year. A possible second year would be devoted to a more detailed analysis of policy options coupled with consensus building.

This now appears to be the case since the state has applied for and received federal authority to extend the SPG program for 12 additional months and Governor Janklow has indicated his intention to issue an Executive Order establishing a committee. This blue ribbon committee will be made up of a number of stakeholders, including representatives of the health insurance industry, consumer advocates, employers, health providers, and policymakers.

There have been no discussions concerning longer-range activities and much of this will depend upon the new Governor taking office in 2003. At this point, there is some desire to at least minimally maintain a point of contact for the SPG program and to apply the data which have been collected through this effort.

SECTION VII: RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

One of the objectives of the SPG program is to provide recommendations to the federal government about what it can do to help increase access to health insurance coverage throughout the United States. The federal and state policy environments have changed dramatically this year due to the September 11 tragedy and a national economic recession. If the federal government expects to maintain recent coverage expansions (such as SCHIP), it must do more than offer regulatory flexibility this budget year and provide real financial assistance to states, particularly with respect to their Medicaid budget shortfalls. Altered federal priorities, a drop in the federal budget surplus, and steep drops in state tax revenue have made states wary of embarking upon new coverage expansions for the uninsured when circumstances threaten existing programs.

HRSA's guidance for Section Seven of this HRSA report calls for South Dakota's conclusions about what, if any, coverage options selected by South Dakota would require federal waiver authority or other changes in federal law. None of the options described in Section Four of this report *require* federal waivers to enact. At this point, the State of South Dakota has not selected any particular coverage option for implementation. The policy option review and selection process should continue for the remainder of this calendar year (2002) among State officials. It is possible that once policy options are fine-tuned, the need for federal waiver authority may be considered.

It should be noted that Medicaid waiver authority, such as the Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration proposal adopted in 2001, might have a limited impact in a state such as South Dakota. This is because there is little "fat" to cut out of the Medicaid supported delivery system that could be re-allocated to coverage expansions in order to achieve federal budget neutrality specifications. In states with virtually no managed care penetration (approximately six percent HMO penetration rate in South Dakota) or excess provider capacity (nearly 70 percent of counties in South Dakota are medically underserved areas), it is difficult to imagine how Medicaid service delivery and benefits could be restructured in ways to generate sufficient savings that could be applied to new program expansions.

The South Dakota SPG project recognizes the importance of federal action in one particular area to support the State's efforts to provide coverage for the uninsured. In addition to the reforms the state is considering, the federal government should offer (federal) tax credits for purchasing health insurance coverage. The proposals currently before Congress[51] vary in the dollar amount of tax credits that could be available, the income levels specified to qualify, and the mechanism that could trigger eligibility (for example, employment in firms that offer health insurance, limit to small firms only, purchase coverage in individual insurance market, etc.). Regardless of the approach taken, federal action could be particularly appealing for South Dakota residents, a state

[51] Such as the Relief, Equity, Access and Coverage for Health (REACH) proposal (S. 590) that would offer income-based tax credits of $1,000 for individuals and $2,500 for families without access to employer coverage and tax credits of up to $400 for individuals and $1,000 for families eligible for employer coverage.

with no individual or corporate income tax and a median household income that is nearly 20 percent lower than the U.S. as a whole.[52]

In addition to possible waiver authority, the federal government can provide resources and support in many areas to facilitate efforts to identify those with inadequate coverage in states, such as South Dakota. These include:

? Noticeable progress has been made at the federal level to improve estimates of the uninsured. For example, recent CPS expansions nearly doubled the number of South Dakota households in the CPS March Supplement (to 1,640) and are expected to decrease the standard errors of the estimates by 27 percent.[53] It is important that federal efforts to increase state sample sizes in the Current Population Survey March Supplement and Medical Expenditure Panel Survey and to assess the reliability of survey questions continue even as federal budgets are curtailed. Such efforts will help to improve the stability of year-to-year estimates and increase the utility of the CPS for state monitoring purposes over time.

? State-level information on the uninsured, employment and income, and health care utilization should be available to state officials on a timely basis and in formats that can be used to meet particular state analytic needs.

In addition to surveys of the uninsured, there exist many other areas of research that the federal government could undertake to assist states in meeting the coverage needs of their residents.

? During the course of the SPG project, many South Dakota state officials have become increasingly concerned about state residents who are reportedly *underinsured*. Although individuals may have health insurance, their coverage is often limited. Many focus group participants reported they had policies that only covered work-related accidents or have plan deductibles of $5,000 or more. The Interagency Work Group recommends that the federal government initiate research efforts to define the meaning of "underinsurance," measure the affordability of health insurance, identify the prevalence of underinsurance by economic sector, and capture consumer perspectives in this effort. As we believe the experience of *underinsurance* varies by geographical location, the federal government should engage state officials in research collaboration on this topic.

? The difficulty of inducing uninsured individuals to enroll in available private or public coverage has frustrated many state officials in South Dakota and elsewhere. The federal government should sponsor research to understand why individuals do not sign up for available private or public coverage. While limited income and welfare stigma play a role, focus groups on the uninsured demonstrated that other important reasons cause this consumer behavior, as well.

? Access to quality health care in frontier areas (less than seven people/square mile) is a growing concern among uninsured and insured residents of the state. Health insurance is of

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[52] U.S. Census Bureau. American Fact Finder, Profile of Selected Economic Characteristics, 2000 (QT-03).

[53] State Health Access Data Assistance Center (SHADAC). "Impact of Changes to the Current Population Survey (CPS) on State Health Insurance Coverage Estimation," *Issue Brief,* March 2001.

limited value in facilitating timely access to health services when needed medical care is simply unavailable within a 100 mile radius, for example. The federal government should study frontier health care practice models and identify new and creative solutions to the difficult issue of diminished availability of services and access to care.

? The federal government should adequately fund the Indian Health Service (IHS) to the extent that this health system meets federal treaty commitments and provides quality health and medical services to Native Americans within coverage areas. This recommendation is important to both tribal and State officials who recognize the severe and unmet health care needs of a rapidly growing and highly impoverished sector of the state's population. (Native Americans made up 8.3 percent of the state's population in 2000.) The infant mortality rate of Native Americans in South Dakota rivals that of many developing countries (exceeding 17 percent for much of the 1990s, dropping to 11.3 percent in 2000).[54] The years of potential life lost among the Aberdeen tribes (many of whom are located in South Dakota) was nearly 2.5 times the U.S. rate nearly a decade ago.[55] Coverage and service problems identified through the SPG project's focus groups and interviews include:

  ? cumbersome and oftentimes long federal process to establish individual's eligibility for Indian Health Services;

  ? provider shortages and limited facilities and service capabilities in many areas;

  ? consumer dissatisfaction with IHS health service quality and scope in many areas;

  ? consumer and provider dissatisfaction with IHS contract health services requirements, typically necessitating long travel and waiting/access delays;

  ? federal resources that are grossly insufficient to meet populations health care needs;

  ? cumbersome intersection among IHS, Medicare, and other payers' policies and regulations that inhibit timely delivery of care and payment for care received.

With the state's low population (754,844 persons in 2000) and vast land area (9.9 persons/square mile in 2000[56]), it is likely (according to several diverse stakeholders interviewed) that federal leadership in this area could facilitate health care and coverage improvements for South Dakota residents, as a whole, and not just the Native American population, and still conserve public funds.

One final recommendation that the SPG project offers is that federal Employee Retirement Income Security Act of 1974 (ERISA) guidelines should be amended, particularly those related to federal preemption of state laws for self-funded plans. This would enable state governments to evenly and effectively modify their health insurance markets and incorporate all payers in any reform measures.

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[54] SD Department of Health, Data, Statistics, and Vital Records Unit. *South Dakota Vital Statistics and Health Status: 2000*, January 2002.

[55] U.S. Indian Health Services. *Regional Differences in Indian Health, 1998 – 1999.* http://www.ihs.gov/publicinfo/publications

[56] Compared to 79.6 persons/square mile for the U.S. as a whole, according to the Bureau of the Census.

The State Planning Grant process revealed the importance of continued *federal* leadership in solving the problem of the uninsured throughout the United States. In South Dakota, with nearly 92 percent of its residents having some degree of coverage, it is unrealistic to believe that this state (or any state) can induce the remaining uninsured population to enroll in private or public health coverage programs. Subsidy levels would have to be extremely generous and it is unlikely that the majority of insured residents would support allocating state funds to support such a subsidy program.

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Appendix A:

Lewin Analysis of Current Population Survey (CPS) Data for South Dakota

Appendix A:

Lewin Analysis of Current Population Survey (CPS) Data For South Dakota

The Lewin Group estimated the number of uninsured persons in South Dakota using the South Dakota subsample of the Current Population Survey (CPS), March Supplement. This is an annual survey of households conducted by the Bureau of the Census that provides information on individuals' health insurance, employment, and income for the prior year. The Lewin Group pooled four years of CPS data 1998 – 2000)[57] to obtain sufficient sample size for detailed analyses of subgroups of the uninsured population in South Dakota.

It was recognized early on by state officials involved in the SPG project that the CPS estimates of the uninsured in South Dakota tended to be suspect for many reasons. The unreliability of small sample sizes was a special concern, given the state's small population. Within the past decade, yearly CPS estimates of the percent of South Dakota's population that is uninsured have ranged by more than one-third (1991 = 15.1 percent, 1994 = 9.3 percent). In addition, Medicaid participation tends to be under-reported in all states. To address these concerns, The Lewin Group initiated two important adjustments to CPS data for South Dakota: 1) the data were adjusted to account for under-reporting of Medicaid coverage in the CPS; and 2) some data elements within the CPS were benchmarked to demographic and coverage data compiled from South Dakota's 2001 Survey of the Uninsured. The effect of these adjustments was to reduce the estimated percent of uninsured persons from 11.8 percent to 8.1 percent in 2000.

Approximately 91.9 percent of South Dakotans had some form of health insurance in 2000. As is true nationwide, the main source of health coverage in South Dakota is through employers. Approximately 58 percent of South Dakota residents had employer-based health care coverage. In addition, 15.1 percent of the population was covered by Medicare; another 10.5 percent had individual non-group coverage as their primary insurance source; and over six percent had Medicaid as their primary source of health coverage. Persons who were dually eligible for Medicare and Medicaid were counted as Medicare beneficiaries. The remaining 8.1 percent of the South Dakota population, an estimated 61,139 individuals, were uninsured during 2000. ***Figure 1*** presents the primary source of insurance coverage for the South Dakota resident population.

The uninsured vary by age, ethnicity, gender, marital status, income, and employment status. The following pages describe many of their characteristics.

As in other parts of the United States, the lack of insurance among South Dakotans is most common among young adults. Over 20 percent of persons aged 19-24 were uninsured ***(Figure 2).*** The likelihood of being uninsured diminishes with increasing age up until age 55-64 where nearly 11 percent are uninsured. In terms of the uninsured population itself, the highest proportion of them were persons aged 19-24 (21.6 percent), and individuals between 35 and 44 years (19.8 percent). Individuals aged 65 and over, who are almost all covered by Medicare, made up the smallest percentage of the uninsured population (0.8 percent).

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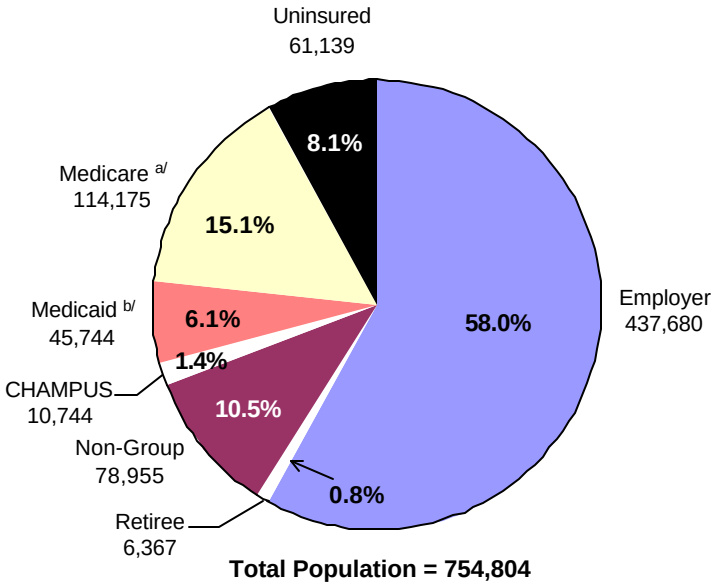
[57] Provides information on individuals for the previous year (1997-2000),

Figure 1
Distribution of South Dakota Population by Primary Source of Insurance Coverage

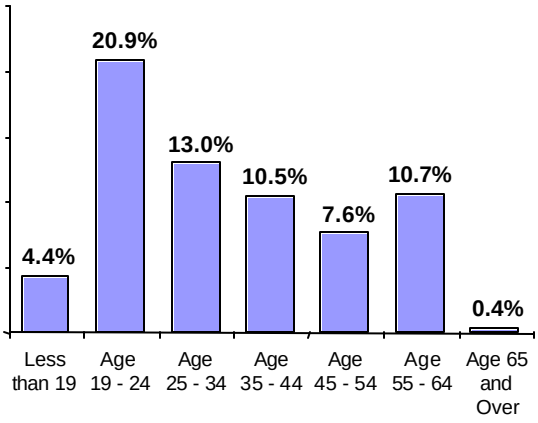


a/ Includes all Medicare beneficiaries, including persons with dual eligibility under Medicare and Medicaid.
b/ Average monthly enrollees in Medicaid were 75,395 in 2000, some of whom have coverage from some other source. Excludes dual eligibles (i.e. persons with both Medicaid and Medicare) who are counted as having Medicare as their primary source of coverage. Also excludes persons reporting private coverage, which is assumed to be the primary source of coverage for these persons

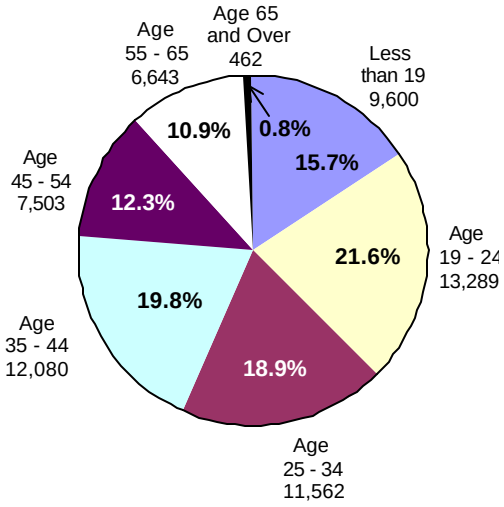
Source: Lewin Group estimates of South Dakota subsample of March Supplement, CPS for 1997-2000, adjusted.

Figure 2
Age Characteristics of Uninsured in South Dakota

Percentage of Age Group That is Uninsured



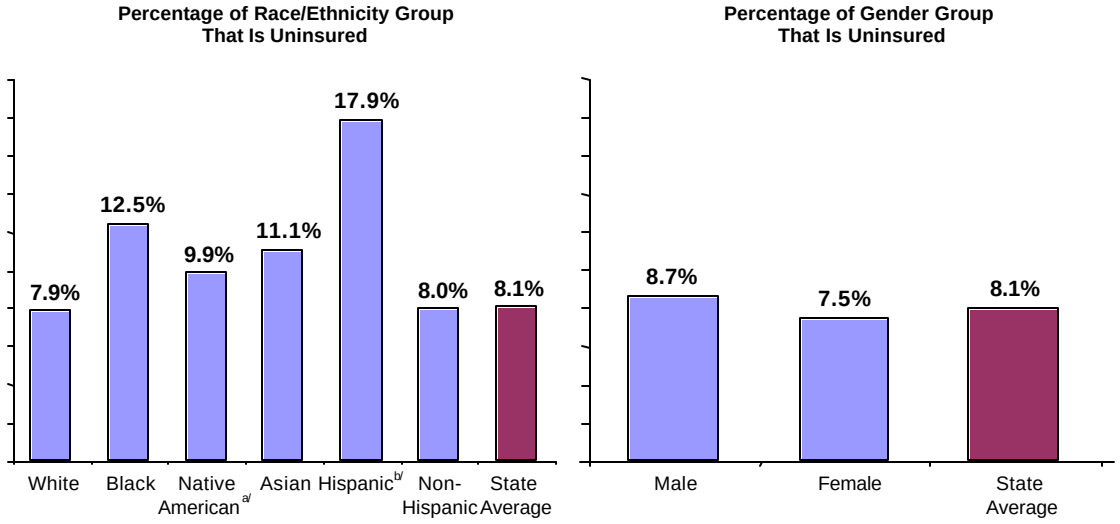
Distribution of Uninsured by Age



Source: Lewin Group estimates of South Dakota subsample of March Supplement, CPS for 1997-2000, adjusted.

The population of South Dakota is overwhelmingly white. Of all the ethnic groups identified in Bureau of the Census data, individuals who identified themselves as Hispanic had the greatest chance of being uninsured ***(Figure 3)***. Slightly more males (8.7 percent) than females (7.5 percent) were uninsured***(Figure 3).***

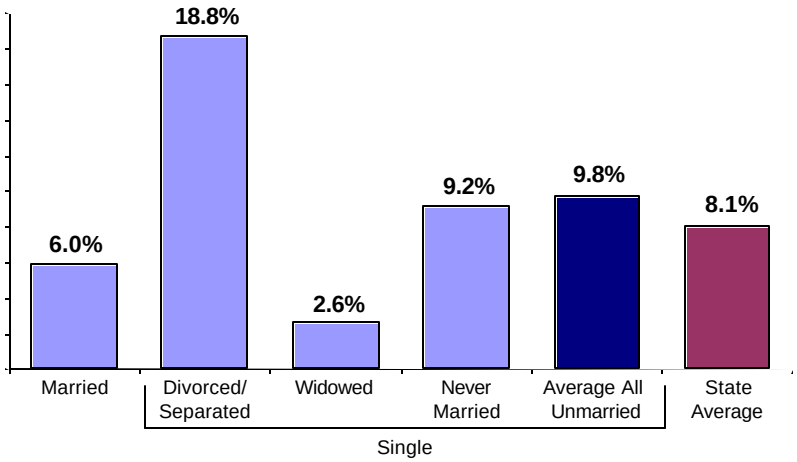
Figure 3
Percentage of Various Demographic Groups that Are Uninsured



a/ Excludes Native Americans covered by India Health Services
b/ Persons who declared themselves Hispanic could be of any race
Source: Lewin Group estimates of South Dakota subsample of March Supplement, CPS for 1997-2000, adjusted.

Marital status was closely linked to the probability of being uninsured. Persons who were divorced or separated had a rate of uninsurance that was triple that for married persons (6 percent) in the state ***(Figure 4)***.

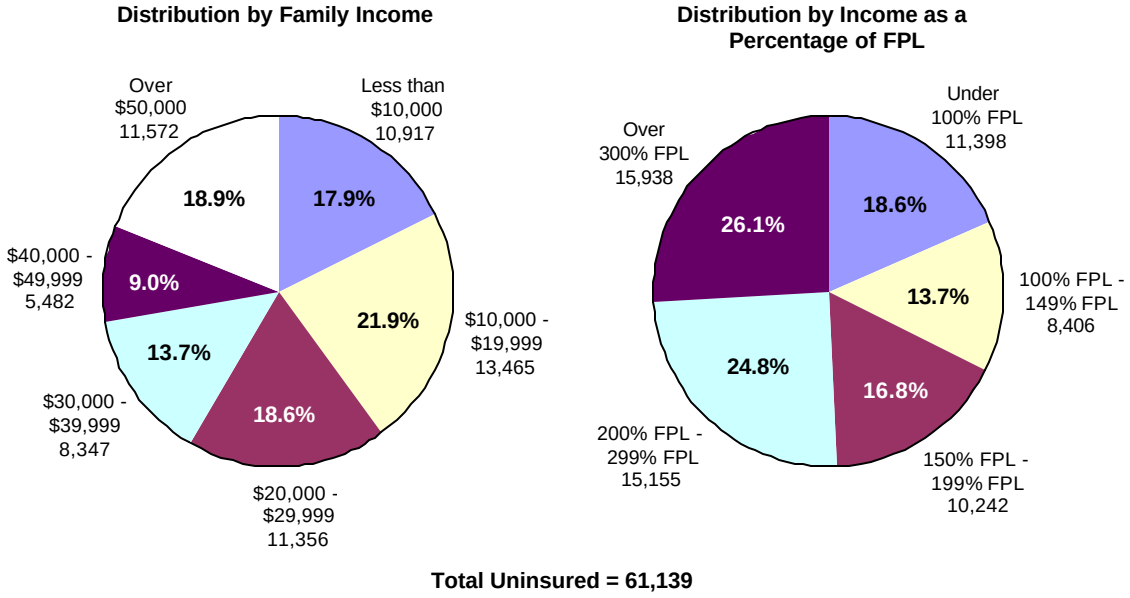
Figure 4
Uninsured by Marital Status



Source: Lewin Group estimates of South Dakota subsample of March Supplement, CPS for 1997-2000, adjusted.

The majority of uninsured individuals in South Dakota are low-income earners. Nearly 60 percent of the uninsured reported annual family incomes under $30,000 ***(Figure 5)*** and about half reported incomes below 200 percent of the federal poverty level (FPL). At the same time, nearly 20 percent of uninsured persons have family incomes above $50,000 per year and 26 percent have family incomes over 300 percent of the FPL.

Figure 5
Distribution of Uninsured by Family Income and Income as a Percentage of FPL

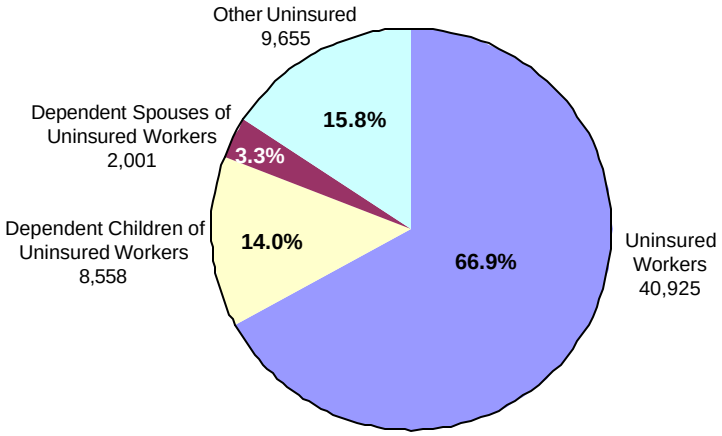


Source: Lewin Group estimates of South Dakota subsample of March Supplement, CPS for 1997-2000, adjusted.

Workers constitute the vast majority of the uninsured. More than two-thirds of all uninsured individuals in South Dakota are working men and women and another 17.3 percent are either dependent spouses or children of uninsured workers. Combining workers and their dependents, 84 percent of uninsured persons in South Dakota are somehow connected to the work force ***(Figure 6***). An estimated 78.6 percent of the uninsured adults are employed; 5.2 percent are unemployed; and 16.2 percent are not in the labor force ***(Figure 7).***

Nearly 55 percent of workers have employer coverage through their own jobs. The percentage of workers with health insurance through their own jobs varies by type of employment. In South Dakota, 75 percent of workers in government and 58 percent of workers in the private sector receive health coverage through their employment and less than 20 percent of self-employed workers are covered through their workplaces ***(Figure 8)***.

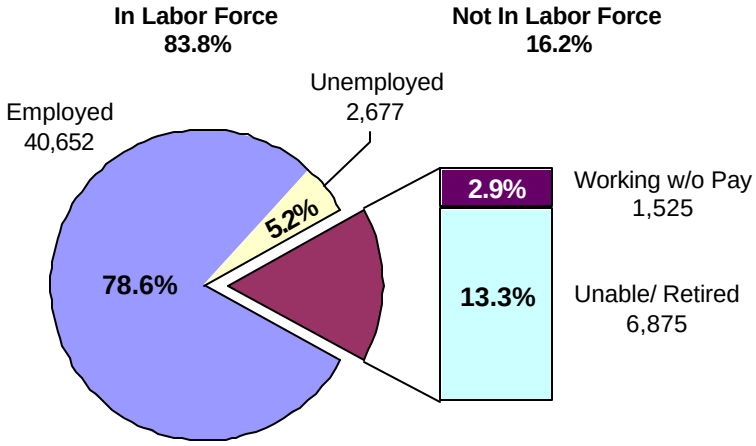
Figure 6
Distribution of Uninsured by Labor Force Status



Total Uninsured = 61,139

Source: Lewin Group estimates of South Dakota subsample of March CPS for 1997-2000, adjusted.

Figure 7
Distribution of Uninsured by Labor Force Status (Ages 18-64)



Total Uninsured Age 18 - 64 Years = 51,729

Source: Lewin Group estimates of South Dakota subsample of March Supplement CPS for 1997-2000, adjusted.

Figure 8
Type of Employment for Workers with Employer Coverage

	Total Number of Workers	Covered on Own Job	Percentage Covered on Own Job
All Workers			
Total Number of Workers	**398,664**	**218,039**	**54.7%**
Class of Worker			
Private	256,105	148,674	58.1%
Government	**73,203**	**54,935**	**75.0%**
Federal	17,021	14,519	85.3%
State	21,420	15,566	72.7%
Local	34,762	24,850	71.5%
Self-employed	**62,708**	**12,486**	**19.9%**
Incorporated	9,811	3,708	37.8%
Unincorporated	52,897	8,778	16.6%
Not Specified	6,648	1,944	29.2%

Appendix B:

Methods and Approach for Survey of the Uninsured and Focus Groups

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Survey Design and Sampling Frame

As a first step to designing the Survey of the Uninsured, all data currently available on the characteristics of the uninsured in South Dakota were examined. Other surveys with questions about insurance status were reviewed. These included the Medical Expenditure Panel Survey, Current Population Survey, Robert Wood Johnson Family Survey, Behavioral Risk Factor Surveillance System, and the Iowa Survey of the Uninsured (completed as part of another SPG program). The advantage of this approach was that many questions had been pre-tested by other researchers and their validity established. These questions also tend to be recognized by policy experts as those that best capture the experience of the uninsured. As the questionnaire evolved, the survey developed into a tool uniquely suited for the purposes of South Dakota's Interagency Work Group.

The questionnaire was designed by The Lewin Group, in consultation with Baselice and Associates, Inc. of Austin, Texas (who conducted the telephone interviews), and the South Dakota Interagency Work Group. Baselice & Associates pre-tested the survey instrument and conducted telephone interviews of the uninsured in August-October 2001. Telephone interviews were the only feasible approach to capture up-to-date information on the uninsured with a sufficient sample size to allow comparisons of interest and within the project's timeframe. In addition, in a rural/frontier state such as South Dakota, it was important that all uninsured persons, even those who were geographically dispersed or linguistically isolated, had a high probability of being reached.

Developing a sampling frame to assure 1,500 completed interviews with a broad spectrum of South Dakota uninsured residents was a challenge. This was because being uninsured in South Dakota is a low probability event and persons who are uninsured are a heterogeneous group. The representative sample designed was based on an average of the total population estimates for each county in South Dakota grouped into eight geographic regions.

To assure an adequate representation of the diversity of uninsured persons in South Dakota, the project team over-sampled in rural areas and made sure that every South Dakota county had at least one uninsured household that was interviewed. 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 South Dakota SPG team decided to use the telephone survey of the uninsured as an opportunity to learn more about the population in South Dakota that *does* have coverage. This was accomplished by interviewing the "screen outs," that is, persons in households where there was no one who was uninsured. While 1,502 uninsured persons completed telephone interviews, 18,805 insured "screen outs" were also interviewed -- yielding an unusually comprehensive picture of health insurance coverage in South Dakota. The distribution of completed interviews by geographic local is show in ***Figure 1***.

Figure 1
Geographic Distribution of Insured and Uninsured

Region	2000 Population	% of Total	Number of Insured Interviews	% of Total	Number of Uninsured Interviews	% of Total
North East - 1	68,784	9.1%	1,984	10.6%	152	10.1%
Minnehaha – 2	148,281	19.6%	3,985	21.2%	279	18.6%
East Central – 3	114,949	15.2%	3,247	17.3%	265	17.6%
South East - 4	108,896	14.4%	2,869	15.3%	195	13.0%
South Central - 5	66,109	8.8%	954	5.1%	105	7.0%
Pennington – 6	88,565	11.7%	1,662	8.8%	146	9.7%
North West – 7	72,537	9.6%	1,120	6.0%	145	9.7%
North Central – 8	86,723	11.5%	2,984	15.9%	215	14.3%
Total	**754,844**	**100.0%**	**18,805**	**100.0%**	**1,502**	**100.0%**

Source: Lewin Group Survey of the Uninsured in South Dakota, conducted by Baselice & Associates, Inc. (Fall 2001).

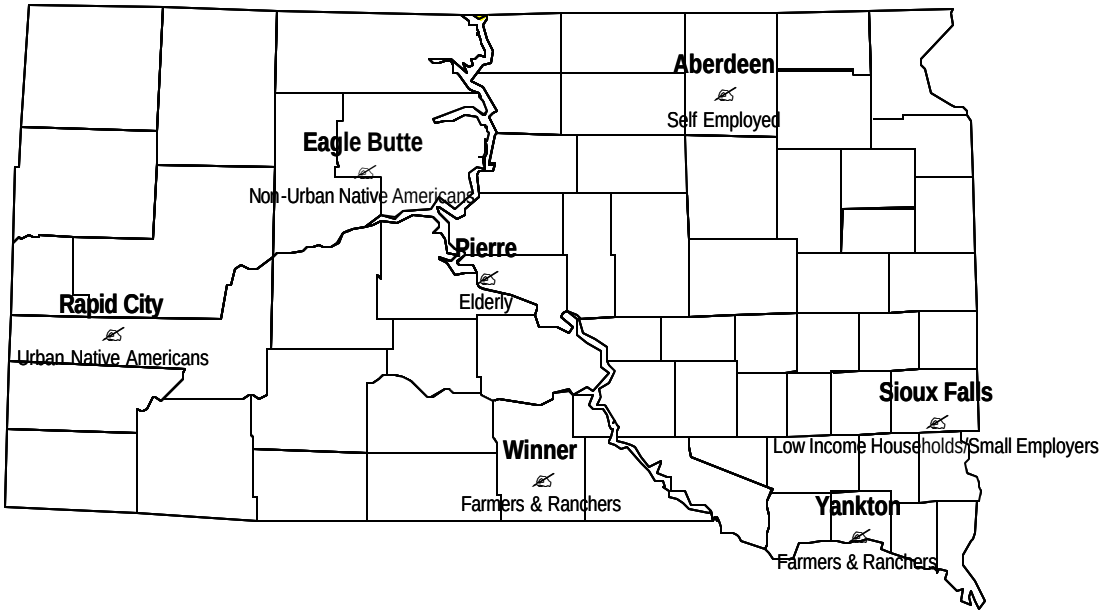
To generate 1,502 completed interviews, 231,789 telephone dials were made (154.4 dials/completed interviews). The refusal-to-complete interview rate was 7.84 to 1. The screen-out ratio was 13.63 screen outs per completed interview.

Focus Groups of Uninsured Individuals

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, one can examine the complex motivations and behavior that drive individuals' valuation of health insurance and their decisions to be uninsured. From the 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.

Eight focus groups of 87 uninsured or underinsured individuals were sponsored in seven towns throughout South Dakota in September and October 2001 (Figure 2). This distribution assured that researchers obtained a geographically representative sample of individual views, in rural and urban areas, about the experience and consequences of being uninsured. Based on SPG staff preferences, some focus groups were designed to capture information about particular groups of uninsured persons, such as low-income, self-employed, farmers, ranchers, Native Americans, and the elderly. As many uninsured individuals are young and healthy, and apparently see no reason to purchase coverage, we sought to learn about their perspective through focus group interaction, as well.

Figure 2
Focus Group Sites and Participants



American Public Opinion Survey & Market Research Corporation of Sioux Falls, South Dakota, arranged recruitment of participants using targeted and "snowball" sampling techniques. It also obtained sites for focus groups and managed other logistical tasks. To assure high participation in the focus groups, sessions were conducted primarily in the late afternoon or evening and a financial incentive was offered to each respondent. All confirmed invitees were called a few days before the focus groups to remind them of the session's time and place. Where invitees were geographically dispersed or if they had no transportation, American Public Opinion arranged a van pick up. The focus groups themselves were all video- and audio-taped.

A Moderator's Guide was developed in conjunction with South Dakota 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 were summarized subsequent to their completion.

Appendix C:

South Dakota Survey of the Uninsured - Questionnaire

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South Dakota Survey of the Uninsured - Questionnaire

1. To make sure we have a representative sample of people in South Dakota, what is your age, please?

2. For us to better understand the types of people we interview, please tell me if you are currently single, married, living with a partner, divorced or separated, or widowed?

   ? Single
   ? Married
   ? Living with a partner
   ? Divorced or separated
   ? Widowed
   ? Unsure
   ? Refused

3. Including yourself, how many people currently live in your household?

   ? One
   ? Two
   ? Three
   ? Four
   ? Five
   ? Six
   ? Seven
   ? Eight or more
   ? Unsure
   ? Refused

4. And how many children under the age of 19 live in your household?

   ? One
   ? Two
   ? Three
   ? Four
   ? Five
   ? Six
   ? Seven
   ? Eight or more
   ? Zero / None
   ? Unsure
   ? Refused
   ? Not asked

5. Please tell me if you have any of the following types of health insurance coverage.

   ? Coverage through your employer
   ? Coverage through an employer of someone else in the household
   ? Coverage you pay for on your own
   ? Coverage someone else pays for you
   ? Coverage through the State Medicaid, Title 19 or Children's Health Insurance program
   ? Coverage through the military or the Veterans Administration
   ? Coverage through Medicare
   ? Coverage through the Indian Health Service
   ? Coverage from some other source

7J. And to confirm, do you yourself currently have ANY health insurance coverage, such as coverage you get through a job, the government, that you purchase on your own, or any of the other types of health coverage we just mentioned?

   ? Yes
   ? No
   ? Unsure
   ? Refused

7K. Would you rate the health insurance coverage you have as....

? Very adequate
? Adequate
? Not adequate enough
? Unsure
? Refused

7L. Does your health insurance cover medicines prescribed by a doctor?

? Yes
? No
? Unsure
? Refused

7M. And does it cover all, most, or only some of the cost of medicines prescribed by a doctor?

? All
? Most
? Only some
? Unsure
? Refused

6. Please tell me if your spouse has any of the following types of health insurance coverage.

? Coverage through your employer
? Coverage through his / her employer
? Coverage he / she pays for on his / her own
? Coverage someone else pays for him / her
? Coverage through the State Medicaid, Title 19 or Children's Health Insurance program
? Coverage through the military or the Veterans Administration
? Coverage through Medicare
? Coverage through the Indian Health Service
? Coverage from some other source

8J. And to confirm, does your spouse currently have ANY health insurance coverage, such as coverage through a job, the government, that is purchased, or any of the other types of health coverage we just mentioned?

? Yes
? No
? Unsure
? Refused

8L. Does your spouse's health insurance plan cover medicines prescribed by a doctor?

? Yes
? No
? Unsure
? Refused

8M. And does it cover all, most, or only some of the cost of medicines prescribed by a doctor?

? All
? Most
? Only some
? Unsure
? Refused

7. Please tell me if (the other person / any of the other people) in the household (has / have) any of the following types of health insurance coverage.

- ? Coverage through your employer
- ? Coverage through an employer of someone else in the household
- ? Coverage you or they pay for them
- ? Coverage someone else pays for them
- ? Coverage through the State Medicaid, Title 19 or Children's Health Insurance program
- ? Coverage through the military or the Veterans Administration
- ? Coverage through Medicare
- ? Coverage through the Indian Health Service
- ? Coverage from some other source

9J. And to confirm, does the other person (do any of the other people) in the household currently have ANY health insurance coverage, such as coverage through a job, the government, that is purchased, or any of the other types of health coverage we just mentioned?

- ? Yes
- ? No
- ? Unsure
- ? Refused

9L. Does the other person's (other people's) health insurance plan cover medicines prescribed by a doctor?

- ? Yes
- ? No
- ? Unsure
- ? Refused

9M. And does it cover all, most, or only some of the cost of medicines prescribed by a doctor?

- ? All
- ? Most
- ? Only some
- ? Unsure
- ? Refused

D7s. We want to classify people into broad income groups only. Was your total household income last year before taxes... ?

- ? Under $5,000
- ? $5,000 but less than $10,000
- ? $10,000 but less than $15,000
- ? $15,000 but less than $20,000
- ? $20,000 but less than $25,000
- ? $25,000 but less than $30,000
- ? $30,000 but less than $40,000
- ? $40,000 but less than $50,000
- ? $50,000 or over
- ? Unsure
- ? Refused

8. How is the other person in the household who is without health coverage related to you?

? Husband
? Wife
? Fiancée
? Boyfriend
? Girlfriend
? Just a friend/roommate/my partner
? Mother
? Mother-in-law
? Father
? Father-in-law
? Son
? Stepson
? Daughter
? Stepdaughter
? My child (include foster/adopted child)
? My stepchild
? Uncle
? Aunt
? Nephew
? Niece
? Live-in housekeeper/Maid/Sitter/ Au pair
? Cousin
? Other person (specify)
? Unsure / refused

9. How is another person in the household who you know the most about and who is without health coverage related to you?

? Husband
? Wife
? Fiancée
? Boyfriend
? Girlfriend
? Just a friend/roommate/my partner
? Mother
? Mother-in-law
? Father
? Father-in-law
? Son
? Stepson
? Daughter
? Stepdaughter
? My child (include foster/adopted child)
? My stepchild
? Uncle
? Aunt
? Nephew
? Niece
? Live-in housekeeper/Maid/Sitter/ Au pair
? Cousin
? Other person (specify)
? Unsure / refused

10. In your own words, please tell me the main reason you are / your spouse / your _____ is without health insurance coverage?

11. About how long has it been since you / your spouse / your _____ last had some type of health insurance coverage?

? Less than six months
? At least six months but less than one year
? At least one year but less than two years
? At least two years but less than five years
? At least five years but less than ten years
? Ten years or longer
? Unsure
? Refused

12. Is it possible for you / your spouse / your _____ to get health insurance coverage through some other adults' employer?

? Yes
? No
? Unsure
? Refused

14X And from whose employer would you / your spouse / your _____ get health insurance coverage?

13. I am now going to read a list of reasons some people have given for <u>not</u> having, not buying, and not signing up for health insurance coverage for themselves or their families. For each reason I read, please tell me if this is a reason you do / your spouse does / your _____ does not have health insurance coverage.

? You are / your spouse is / your _____ is in good health.
? You / your spouse gets / your _____ gets the necessary care through Indian Health Services.
? You / your spouse / your _____ can get the medical care needed for less than what you / he/she would have to pay for insurance.
? You do / your spouse does / your _____ does not think you need / he/she needs it.
? You do / your spouse does / your _____ does not think you want / he/she wants it.
? You / your spouse / your _____ can not afford to pay the monthly cost for insurance premiums.
? You are / your spouse is / your _____ is waiting until you have an employer who offers health coverage.
? You do / your spouse does / your _____ does not qualify for health insurance coverage.

14. Was there a time during the last twelve months when you / your spouse / your _____ needed to see a doctor, but could not go because of the cost?

? Yes (maybe)
? No
? Unsure
? Refused

15. If you / your spouse / your _____ were to get sick or needed medical care, where would be the <u>most</u> likely place you / your spouse / your _____ would go for medical care?

? A doctor's office or medical clinic
? A hospital emergency room
? An Indian Health Services Clinic
? Other
? Unsure
? Refused

16. In general, would you say your / your spouse's / your _____ overall health is excellent, good, fair, or poor?

? Excellent
? Good
? Fair
? Poor
? Unsure
? Refused

17. Would you say your / your spouse / your _____ health is better, is worse, or is about the same as it was twelve months ago?

? Better
? Worse
? About the same
? Unsure
? Refused

18. Have you / has your spouse / has your _____ had an injury, serious illness, or chronic condition that has required medical attention in the last twelve months?

? Yes
? No
? Unsure
? Refused

20X. And did you / your spouse / your _____ receive medical care for this?

? Yes
? No
? Unsure
? Refused

19. Since you have / your spouse has / your _____ has been uninsured, has it been very difficult, somewhat difficult, somewhat easy, or very easy for you / your spouse / your _____ to get medical care when needed?

? Very difficult
? Somewhat difficult
? Somewhat easy
? Very easy
? Have not needed it
? Unsure
? Refused

20. Have you / has your spouse / has your _____ delayed getting care because you do not have health insurance coverage?

? Yes
? No
? Unsure
? Refused

21. Which of the following worries you / your spouse / your _____ most about not having health insurance coverage?

? Not getting medical care in an emergency or after having an accident
? Not getting medical care for a serious or long term illness like cancer
? Not getting the proper health care at the time it is needed
? Having to pay the hospital or doctor bill
? Being wiped out of money or financially ruined to pay for health care
? Being unable to pay for health care
? Other (Specify)
? No worries
? Unsure
? Refused

22. Have you ever decided to take a job that did not offer health care coverage rather than a job that did offer it?

? Yes
? No
? Unsure
? Refused

24X. Which of the following best describes why you did not take the job that offered health insurance?

? The job I took offered more money
? Shorter commute -- easier to get to work
? Liked the other job better
? More opportunity for growth
? Did not need or want the insurance
? I retired - did not go to work
? Other
? Unsure
? Refused

23. Are you / your spouse / or _____ currently self-employed, employed by someone else, or unemployed?

? Self-employed (have own business)
? Employed by someone else
? An unpaid worker for family business or home
? Unemployed
? Unsure
? Refused

24. Does your / your spouse's employer offer any type of health insurance coverage for its employees?

? Yes
? No
? Unsure
? Refused

25. Are you / your spouse eligible for that insurance coverage <u>now</u>?

? Yes, eligible
? No, not eligible
? Unsure
? Refused

26. Why do you / does your spouse NOT have the insurance offered by the employer?

? Do not need or want any health insurance
? Rarely sick
? Too much hassle / paperwork
? Could not afford / too expensive
? Rejected because of health condition
? Do not work enough hours in a week
? Have not worked there long enough
? Benefits package offered did not meet needs / not good enough
? Other **(specify)**_____
? Unsure
? Refused

27. Now how much, if anything, do you think you / your spouse / your _____ would have to pay each month for you / him/her / him/her as well as other uninsured persons in the household, to be covered on your / your spouse's / your _____ employer's plan?

29X. And how much do you think you / your spouse / your _____ would be willing to pay each month for you / him/her / him/her as well as other uninsured persons in the household, to be covered on an employer's plan?

28. Have you / your spouse / your _____ ever tried to purchase health insurance coverage for yourself through someone or some organization other than an employer?

? Yes ? Unsure
? No ? Refused

29. Did you / your spouse / your _____ actually purchase health coverage?

? Yes ? Unsure
? No ? Refused

30. Why don't you / doesn't your spouse / doesn't your _____ still have this health coverage?

? Still has/have it
? Monthly premiums too high / too expensive
? Did not cover others in my family
? Got insured through an employer
? Did not want / need / use it
? Life change -- moved / divorce / new job
? Other **(specify)**_____
? Don't know
? Refused

31. What is the main reason you have not purchased health insurance coverage / your spouse has not purchased health insurance coverage / your _____ has not purchased health insurance coverage?

? Do not need or want any health insurance
? Rarely sick
? Too much hassle / paperwork
? Could not afford / too expensive
? Rejected because of health condition
? Do not like what was offered
? Not gotten around to it - too busy
? Still looking into it / shopping around
? Waiting to be covered by employer / after getting a job
? Do not know if coverage is available
? Do not know if qualify
? Have / has a pre-existing condition
? Do not know how to go about getting it / applying
? Other **(specify)** _____

? Unsure
? Refused

32. How much do you think it would cost each month to purchase a basic health insurance plan for yourself / your spouse / your _____ ?

33X. Now how much, if anything, would you / your spouse / your _____ be willing to pay each month out of your / his/her / his/her own pocket for a health insurance plan that provides basic coverage for doctor visits, hospitalization, and prescription drugs?

35Y. Now how much, if anything, would you be willing to pay each month out of your own pocket for a health insurance plan that provides basic coverage for doctor visits, hospitalization, and prescription drugs for yourself / your spouse / your _____ ?

34X. Have you / has your spouse / has your _____ ever tried to get health insurance and been turned down because of a medical condition?

? Yes ? Unsure
? No ? Refused

36Y. Have you ever tried to get health insurance and been turned down because of a medical condition?

? Yes ? Unsure
? No ? Refused

MEDICAID

35. Do you think you / your spouse / your _____ or others in your family might currently be eligible for a state health insurance program such as Medicaid, Title 19, or the Children's Health Insurance program?

? Yes ? Unsure
? No ? Refused

36. Have you / has your spouse / has your _____ applied for a program like Medicaid, Title 19, or the Children's Health Insurance program for yourself / himself/herself / himself/herself or any children in the household?

? Yes ? Unsure
? No ? Refused

38X. Are there any children in your household currently enrolled in Medicaid, Title 19, or the Children's Health Insurance program?

? Yes ? Unsure
? No ? Refused

37. Have you / has your spouse / has your _____ applied for Medicaid, Title 19, or the Children's Health Insurance program for yourself / himself/herself / himself/herself?

? Yes
? No
? Unsure
? Refused

38. Why have you / has your spouse / your _____ not applied for Medicaid, Title 19, or Children's Health Insurance coverage?

? Do not need it right now
? Do not want to bother
? Do not know who to call / how to apply
? Application is too hard / too much paper work
? Can not take time from work
? Can get medical care if need to
? Do not want to be in a government program
? Not eligible / not qualified
? Not old enough
? Don't know enough about it
? Don't need - employer or some other covers
? Cost / expense of it
? Other **(specify)** _____
? Unsure
? Refused

39. Why do you think you / your spouse / your _____ might NOT be eligible for Medicaid, Title 19, or Children's Health Insurance?

40. Do you have any large medical bills that have been difficult to pay off?

? Yes
? No
? Unsure
? Refused

DEMOGRAPHIC

D2. How many wage earners are there in your household?

? No main wage earner
? Unsure
? Refused

D3. In what industry or type work is the main wage earner employed?

? Farming / Ranching
? Mining
? Construction
? Manufacturing (ie. Factory worker, food processing)
? Food Stores
? Finance / Insurance / Real Estate
? Lodging and Recreational Services
? Personal and Business Services
? Health Services

- ? Transportation/Communication / Utilities
- ? Wholesale Trade
- ? Eating and Drinking Places
- ? General Merchandise / Apparel Stores
- ? Government (Federal, State, Local including education)
- ? Other (**Specify**) _____
- ? Unsure
- ? Refused

D5. And is your race White, African-American, Asian or Pacific Islander, American Indian, or some other race?

- ? Anglo / White
- ? American Indian
- ? African-American / Black
- ? Asian / Pacific Islander
- ? Hispanic
- ? Other
- ? Unsure
- ? Refused

D7. We want to classify people into broad income groups only. Was your total household income last year before taxes... ?

- ? Under $5,000
- ? $5,000 but less than $10,000
- ? $10,000 but less than $15,000
- ? $15,000 but less than $20,000
- ? $20,000 but less than $25,000
- ? $25,000 but less than $30,000
- ? $30,000 but less than $40,000
- ? $40,000 but less than $50,000
- ? $50,000 or over
- ? Unsure
- ? 11 - Refused

Appendix D:
Summary of Focus Group Findings

How South Dakotans View Being Uninsured: Summary of Focus Group Findings

Focus Group Moderator: ***JoAnn Lamphere, DrPH***
Research Assistant: ***Kate Kochendorfer***
Project Director: ***John Sheils***

December 17, 2001

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Attachments

5. EXECUTIVE SUMMARY

The Lewin Group, in partnership with the South Dakota Department of Health, convened structured discussions with residents across the State to hear why individuals are without adequate health insurance and to learn about the problems small employers face as they struggle to offer health coverage for their workers. This research was initiated as part of the State Planning Grant (SPG) program, with funds awarded to the Department of Health by the U.S. Health Resources and Services Administration.

Eight focus groups of 87 uninsured or underinsured individuals were sponsored in seven towns throughout South Dakota in September and October 2001. This distribution assured that researchers obtained a geographically representative sample of individual views, in areas both rural and urban, about the experience and consequences of being uninsured. Focus group settings by date, location, and demographic characteristics of participants follow:

Date	Location	Participant Grouping
9/26/01	Sioux Falls	Lower Income Individuals
9/26/01	Sioux Falls	Small Business Employers
9/27/01	Yankton	Farmers/Ranchers
9/28/01	Winner	Farmers/Ranchers
9/29/01	Rapid City	Native Americans
10/1/01	Eagle Butte	Native Americans
10/2/01	Pierre	Older Americans
10/2/01	Aberdeen	Small Business Employers

American Public Opinion Survey & Market Research Corporation, of Sioux Falls, South Dakota, arranged recruitment of participants using targeted and "snowball" sampling techniques. It also obtained sites for focus groups and managed other logistical tasks. To assure high participation in the focus groups, sessions were conducted primarily in the late afternoon or evening and a financial incentive was offered to each respondent. All confirmed invitees were called a few days before the focus groups to remind them of the session's time and place. Where invitees were geographically dispersed or if they had no transportation, American Public Opinion arranged a van pick up. The focus groups themselves were all video- and audio-taped.

Focus groups were designed to complement the statewide telephone surveys of the uninsured and employers (also sponsored by the SPG program) that were conducted in Fall of 2001. Compared to surveys, focus groups provided a deeper understanding of the scope and context of the uninsured and underinsured population in South Dakota by eliciting individuals' attitudes, values, knowledge, and past experiences with respect to health insurance and health care. The focus groups supplied researchers with important insights about how participants assessed the value of health insurance, perceived the consequences of being without health insurance, and how they came to make their decisions to be uninsured. This consumer's point of view is important as it offers clues about how private and public programs could be altered, and what incentives could be designed, to induce more individuals to secure coverage. Such qualitative information should be considered prior to designing and assessing policy options to increase affordable health coverage to residents of the state.

Experienced Lewin Group staff moderated each 1 ½ hour focus group session. A Moderator's Guide (Attachment 1), designed in collaboration with South Dakota's Interagency Workgroup staff, provided a consistent framework to guide participants' discussions.

Individuals who participated in focus groups were either uninsured themselves or spoke on behalf of their uninsured spouse, were underinsured (they had high deductibles or catastrophic policies), or were uneasily insured (they expressed deep fear about premium increases or of being dropped by the company that provided them health insurance). Key themes that emerged from these focus groups and structured interviews include:

? Participants were a diverse group of individuals, ranging in age, socioeconomic wellbeing, and health status. Their personal stories provided compelling evidence of the serious problems many South Dakotans experience in trying to secure affordable and adequate health insurance. These problems seemed to be most widespread among lower income individuals, those with catastrophic or chronic medical conditions, and for persons 50-65 years of age.

? From an employment perspective, participants who were farmers and ranchers, self-employed, or employed by small firms that don't offer job-based benefits reported the most extensive frustrations in their attempts to find adequate and affordable coverage. Individuals' low wages, their modest monthly income relative to high premium costs and other household expenses, and/or the cyclical nature of their household income also undermined their ability to secure ongoing health coverage.

? The high cost of health insurance is the major factor influencing individuals and small employers' decisions not to purchase coverage for themselves, families, or workers. The high cost of health insurance is also the major reason that was expressed for many individuals choosing health policies with extremely high deductibles ($5,000) or limited benefits.

? Persons seeking individual policies (non-group) and businesses with only a few employees expressed a common frustration and concern about the health insurance market in their state. They perceive that insurance companies are "ripping them off" as evidenced by the extensive reporting of significant premium price increases for 2002. Many individuals reported they felt "let down" by their health insurance companies for multiple reasons. Reasons include getting their coverage dropped for reasons that seems beyond individuals' control and experiencing unexpected limits in benefits or payment amounts when medical claims are processed. Finally, they think insurance companies don't value them as consumers, because they have learned from the companies that insure them that many companies are leaving the state. They wish that they had more choice in companies from which to select coverage in the insurance market.

? In light of the difficulties many individuals and families confront paying monthly health insurance premiums, there was a widespread belief expressed in many of the focus groups that health insurance isn't "worth it" if you don't use it (that is, seek medical care). This viewpoint was expressed more among younger or healthier participants. At

the same time, some focus group participants recognized they could "lose everything" should medical catastrophe strike.

? Given the challenge of accessing medical services in South Dakota due to vast geographic distances and the shortage of many types of providers in the state, some participants wondered whether having health insurance would make life any easier for them to secure needed medical care.

? Often living without health insurance is not the result of any specific decision on the part of household members. Other priorities exist in their lives and they simply "wake up" one day and realize that it's been years since they've visited a doctor or had coverage.

? The majority of focus group participants reported that they and their family members do not routinely seek medical or dental care. Many reported that even when they did need medical care, they would not seek it because of cost concerns. Several conveyed an attitude of self-reliance and expressed great resourcefulness in their pursuit of affordable medical interventions and alternative medicine.

? The relationship between the mainstream medical system in South Dakota and the Indian Health Service (IHS) was a topic explored in at least three focus groups. Participants generally recognized that the medical needs of Native Americans far exceed the resources of the IHS. Most Native American participants expressed concern about the quality of services provided through IHS facilities and they chafe at the time consuming bureaucratic requirements that they must live with in securing contract medical services off the reservations. While some would prefer more freedom of choice, they all generally expressed appreciation for IHS as a safety net program. Many expressed the wish that IHS could expand rather than contract its role in the state. Participants (both Native American and White) also expressed their belief that the federal government is not living up to its treaty commitments.

? Despite widespread reporting of low-income families, Medicaid coverage was quite limited in terms of eligibility, length of enrollment, and scope of benefits, according to focus group participants. At the same time, the Children's Health Insurance Program was almost universally hailed as a "good" and valuable state program

Opportunities for education about health insurance issues emerged from focus group discussions. For example,

? Do the uninsured really pay less than insured residents of the state for hospital and medical care? In order to induce increased coverage, a public campaign may be needed to help small businesses and individuals understand that insured residents of the state are subsidizing the uninsured.

? Much confusion was expressed among participants (especially in the individual or small group markets) about the precise extent of their benefit scope, co-payment requirements, and what their health insurance companies will pay for. Many were frustrated that they

didn't have more dependable or understandable information available to them about their options, the implications of the choices they make, and their consumer rights.

The summaries of individual focus groups that are presented on the following pages were derived from extensive notes and audiotapes; they capture the essence and details of each session. In some cases, grammar and wording have been changed to improve clarity of this report. We anticipate that these summaries of the qualitative research conducted for the SPG program will provide policymakers with a better understanding of uninsured individuals' beliefs and perspectives that may then help to enable effective program design in the future.

Focus Group #1: Lower Income Adults

Wednesday, September 26th, 6-8 p.m.
Sioux Falls, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	M	20's	Single	Self employed: landscaping, anything out of doors
2	F	20's	Lives with boyfriend	Works at a wing bar and grill, makes $6.50 an hour
3	M	40's	Single	Self employed: works with cars, farming hand
4	F	20's	Single mom (1 kid)	Unemployed: quit job at daycare
5	F	50's	Single mom	Delivers papers (part time)
6	F	20's	Single mom	Unemployed: looking for a job
7	F	30's	Boyfriend, two kids	Delivers papers (part time)
8	F	30's	Married with two kids	Housewife
9	M	30's	Lives with girlfriend and kids	Delivers papers (part time)

B. Experience with Health Insurance

Almost no one in the group has health coverage. Most participants work in jobs that do not offer health benefits or they have lost jobs that did offer it and are now un- or self- employed). Many of the younger participants do not worry about coverage because they believe they will remain healthy. They do not think they need it. Those with children have them covered through the CHIP program. Many of the participants expressed that they worry most about obtaining coverage for their children.

1. Not covered. He had health insurance through his parents until he graduated from college and then received coverage through a former job at the hospital. He can't get coverage on his own because it is too expensive. He is on anti-depressants and, due to the break in coverage, would have a hard and expensive time getting coverage now. He currently pays $100/month for his medications.

2. She is not usually covered. She has had Medicaid for a month (since becoming pregnant). She works at a chain restaurant where the owner doesn't offer insurance to anyone except the managers. (He is also a silent partner in DAKOTACARE.) She works more hours than the managers but cannot get any coverage. Other franchises offer it; providing coverage to workers is the owner's choice.

3. Not covered. He had coverage through a job at the hospital but doesn't any longer. He bought it earlier this year but canceled it because he didn't use the benefits and doesn't foresee any risk. Basic health insurance would cost him $80/six months, the same as two trips to the doctor.

4. Not covered. She had coverage through her parents and then had Medicaid when she was pregnant. She was told she was eligible for Medicaid after pregnancy, but was denied when she applied. She doesn't have a job. It would cost her $80/3 months for individual basic coverage, which is more than she can afford. Medicaid covers her daughter and she is most concerned about her daughter's health.

5. Not covered and has never had coverage as an adult. She wants insurance for her husband (in prison) who just had surgery and is still very sick. She just can't afford it. The penitentiary paid for recent expenses (over $80,000).

6. Not covered and is not sure if she has ever had coverage.

7. Covered. She has disability insurance through Medicaid. Before Medicaid, she was not covered for a year.

8. Not covered. She had coverage through her husband's employer, but he was laid off. She also had Medicaid when she was pregnant and her children are covered by CHIP. Her mom has Medicare and is sick with COPD. Medicare doesn't cover all of what she needs for respiratory treatment. She looked into buying a private plan for the whole family (mother, 14 kids, and their children) but it was very expensive considering the mother's existing illnesses ($100 a month/per person) and it wouldn't cover prescription drugs.

9. Not covered. He has only had insurance when he had a job that provided it.

C. Barriers to Coverage

The biggest barrier to coverage for this group is cost. Most are either unemployed, self-employed, or making very low wages in a job that doesn't provide health insurance. Most cite the problem of large deductibles as the main barrier to coverage because it defeats the point of having insurance. Individuals end up paying most of their medical costs regardless of whether they have insurance or not.

1. Deductible was $500 when he had insurance and the prescription coverage was good (which made him feel insurance was worth it). He expressed deep anger and defiance toward the health insurance industry. He doesn't think the business should be so profitable and believes such profit is ethically wrong. He resents that health (or lack of it) can dictate your entire life.

2. She thinks health insurance is "too scary to figure out" and she has a fear of getting ripped off. As she has Medicaid now, she doesn't have to think about it. She mostly cares about her baby being covered and her being covered while pregnant.

4. Is most bothered by the deductibles. She has seen $2,500 deductibles.

8. She thinks that the deductibles are worse than the premiums. "What's the point [of insurance]?" she wondered.

9. He had a deductible that was $2,000.

D. Consequences of No Health Insurance

***Some participants believed that they can get the medical care they need and "work with" the hospital to pay off the bill. Others asserted they would not be able to get treatment unless they have the cash in hand. They also expressed that the care they would receive is sub-standard (due to both the area fac*ilities and one's lack of insurance). In general, this group believes hospitals are fairly ruthless in their quest to get paid. Overall, the participants' biggest worry was about getting sick and creating a "lifetime of debt."**

1. He hasn't needed medical care since he has been uninsured. He knows he is "very lucky." He would go to McKennan because it is a non-profit and charges by sliding income scale. His biggest worry is "a lifetime of debt if he gets sick."

2. She gets the care she needs but can't foot the bill. She has an outstanding bill of $15,000 (from surgery when she was 19 years old). Sioux Valley did surgery despite her inability to pay because she needed the care. She pays what she can and they give her "grief". She understands that if you make an attempt to pay on the bill regularly then that is (legally) good enough. She pays ten dollars every month. However, the bill was still sent to a collection agency which calls her at work she thinks this is inappropriate. She is most worried about "getting in a car accident, or getting cancer, or heart attack" for she knows her family couldn't pay the bill.

> *"It is really depressing to wake up every day to those medical bills and know it is from being sick."*

3. He pays "up front" when he needs to go to the doctor. He did have a dog bite and the hospital couldn't do anything for him, yet they charged him anyway. He is "worried about debt and figuring out how one will pay it."

4. She says that "you could be dying on the operating table and you need to pay up first". She just doesn't go to the doctor, even when she had pneumonia. She thinks that after 90 days if your bill is unpaid, it gets sent to a collection agency. She says that if she had cancer she would get health insurance, so as not to leave bills to her family.

5. She doesn't think it is easy to get medical care if you are uninsured because one needs to have enough money. She doesn't think doctors will work out a payment plan. Her son has Medicaid and she has difficulty getting authorization to get care, even for the emergency room.

7. She thinks you need to have the money "up front." Stores won't fill prescriptions without cash. Even at free clinics, the bill has to be paid for at some point. She would go to Sioux Valley Hospital if need be. Her son was hospitalized for 24 hours and it cost $6,000. Her biggest worry is her mother. She "can't even afford to bury her when she dies."

8. Her daughter has Medicaid coverage and doctors are hesitant to treat her without getting pre-authorization. She needs to call ahead of time, life threatening or not, "otherwise Medicaid won't pay." She won't get needed medical care unless her husband forces her to go. She simply cannot afford medical care and doesn't see the point of getting care as she thinks doctors often misdiagnose you. "Why pay $1,200 just for misdiagnosis?" She reported that a collection agency called about a ten-dollar medical bill at work. Her employer said it was

not okay, got on the phone, and told the guys off. Her biggest worry is her mom. Even together, her brothers and sisters can't pay for her medical care and keep their own families alive. Insurance companies won't touch her because of her pre-existing condition.

9. He would go to the VA hospital and would probably get routine care. In case of an emergency he would go to a local hospital and pay the bill. He thinks the underlying problem is that the price of health care has gone sky high, which makes insurance that much more expensive.

E. Willingness to Pay for Coverage

Responses ranged from $0 to $100/month. The general consensus among the group is that they wouldn't pay a monthly premium if it meant taking money away from food for their children to eat.

1. $100/month.
2. $10/month.
4. $30-$50/month.
7. $25/month.
8. She won't take away from her kids to pay for health insurance for her or husband. She might be able to pay $20-$25/month.
9. $50-$75/month.

F. Government-Sponsored Health Insurance

Over half of the participants have had some experience with government sponsored programs such as Medicaid, Medicare, or the VA. Many of the participants were aware of the CHIP program. They expressed satisfaction that the programs exist, although a few of them emphasized the cyclic nature of government aid as a problem. In addition, programs do not seem to help people out of their situation. They help them only temporarily, ultimately dropping them before their bad situations have realistically improved.

2. On Medicaid because of pregnancy. Child will be covered.
4. Had Medicaid while pregnant.
5. Son has Medicaid.
7. Covered by Medicaid through disability.
8. Had Medicaid when pregnant. Mom has Medicare. Children are in CHIP.
9. Goes to VA hospital.

"You try to get ahead but you lose the benefits. There isn't any real progress."

G. Public Preferences

The general consensus among low-income participants is that the government bears a great deal of the responsibility of providing health care and coverage to people who need it. While

some expressed belief that it is also the responsibility of the individual, they were in agreement that taxes should be increased to provide a type of socialized health care.

1. He asserted that all Americans should pay equal percentages of their income towards health insurance. He thinks health insurance should be federally covered. "It is not a state responsibility because it needs to consistent from one place to the next."

"It is not a state responsibility because it needs to be consistent from one place to the next."

2. She believes the government should be responsible for health insurance as a last resort. The money should "come out of taxes, it is worth it." She also wants to "have employers assume some kind of responsibility" and make "the system easier for employers to give it." She thinks it "is the responsibility of individual, as well." She doesn't want to be on Medicaid, but she needs it.

3. He thinks the states should be responsible for providing health insurance. He thinks others would agree with higher taxes for this purpose.

4. She thinks "individuals should be responsible." They should "pay something, but not a gross amount." "Insurance payments should be in relation to what they are making. There needs to be more assistance for those who can't afford it, which can vary depending on income." "Medicaid should cover moms for longer than two months. Government needs to help us wholeheartedly, not giving and taking something else away."

5. She thinks the "rich people should pay for it." She also can't believe the prisons are so well off and have cable.

7. She thinks "All employers should offer it even to part-time workers, regardless if employees can afford it; then it is their choice to go uninsured." "SD needs to deal with the fact that it is the lowest paying state."

"South Dakota needs to deal with the fact that it is the lowest paying state."

8. She thinks the money should come from the cigarette tax. She also thinks they should use payment plans so people don't get dropped if they can't pay their premiums. They should "do anything you can to get everyone covered."

9. He thinks that payment for health insurance should be based on a "percentage of income." Also the "government should pay some and the individual pay some." He wants "affordable healthcare for everyone." "Can't get blood out of a turnip."

H. Other

? She doesn't understand why it is so difficult/expensive. If the "time with a doctor is so small, why is it so expensive?"

? He thinks the "cost of health insurance too high" and that it "shouldn't be that profitable" (translates too expensive). He does claim to understand that liability is an issue, as are technological advances.

? The cost of prescription drugs is a major worry. Some think prescription drug prices is what is driving up the cost of healthcare. All say they are ready to go to Canada and Mexico for medicine.

? The general consensus among the group is that Sioux Falls is a "tight city." For example, South Dakota ranks especially low for providing for the population compared to Minnesota and Tennessee.

? The group agreed in their thinking that it is in the employers' best interest to provide insurance.

Focus group #2: Small Business Employers & Employees

Wednesday, September 26th, 8-10 p.m.
Sioux Falls, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	M	50's	Married with kids	Cashier at a store
2	M	60's	Single	Farmer
3	M	50's	Married with 2 kids	Farmer
4	F	30's	Living with boyfriend	Cashier at bar and grill
5	F	30's	Married with 3 kids	Counselor and owns business
6	F	30's	Married with 5 kids	Owns food carryout and delivery company
7	M	40's	Married with 2 kids	Painter
8	M	40's	Married with 2 kids	Death caretaker (funeral home, cemetery)
9	M	40's	Married with 1 kid	Owns drywall business
10	M	40's	Single with 4 kids	Farmer
11	F	30's	Divorced, no kids	Unknown
12	M	30's	Single	Music instructor

B. Experience with Health Insurance

The majority of this group reports having some form of health care coverage, although most cite it as inadequate. All agree that, as small business owners/workers, health insurance is difficult to afford. Most participants were underinsured; high deductibles and limited benefits continually arose as centerpieces of concern. In many cases, one spouse maintains a job to enable access to insurance for the entire family. In another case, an employer is prevented from providing insurance option for her employees due to high costs.

1. Covered. He has health insurance, which includes dental benefits, through work. Cost: $62/month; family members can join for a bit more. Previously inquired into insurance options when he was self-employed and found prices were "outrageous."

> "It is really difficult to afford health insurance if

2. Covered. He purchases health insurance through a private company and reports that his deductible is $5,000. He has no employees.

3. Covered. He has health insurance through his wife's group policy. She works for the State. He has no employees. He notes that some companies won't cover farmers or farm workers because it is such dangerous work.

4. Not covered. Health insurance is not offered at her place of work. She could get health insurance in 90 days through her boyfriend if she married him.

5. Covered. She receives insurance through her husband's policy. Health insurance is very expensive for family – there is a large deductible, no dental or eye benefits, and limited coverage.

6. Covered. She has coverage under husband's policy for four more days. As a business owner, she was going to cover full time and part-time employees if they stayed for an extended period of time. She tried to establish a plan to keep employees by paying for an increasing percentage of insurance over time, but it still wasn't enough for people to go for it. A minimum of four people is necessary for a group policy. A single policy, with six people and a $500 deductible would be $200/month per employee plus more for dental—a huge monthly expense.

> "This system, where it is difficult for small businesses to provide

7. Not covered. Neither he nor his wife has insurance, but their children have coverage through CHIP. Work doesn't offer insurance options for either of them. He was covered two years ago when wife had a different job, but it's not so important because they didn't often use medical services.

8. Covered. He is covered under his wife's, not his company's, policy. His wife started full-time work to get health benefits. He tried to purchase private insurance for two years, but it was too limited in its benefits and also too expensive. His company is too small to cover its employees; insurance is simply too expensive for the small group.

9. Covered. He is covered by wife's policy through the State. It is limited (no eye glasses or dental) and "too expensive." He notes that his father pays "an amazing amount" just for a supplemental policy to Medicare.

10. Not covered. He has not had insurance for 25 years, when he had it through a company he worked for in Texas. He is a farmer with no employees.

11. She has not had insurance for ten years when she had it through a previous husband.

> "It's difficult for small businesses

12. Not covered. He has not had insurance for five years since he quit corporate world. Now, as self-employed individual, he doesn't want to pay for it because it is too costly.

C. Barriers to Coverage

Most participants find paying the monthly insurance premium the most troublesome of all health care costs. Many complained about low wages in the state and pointed out that the price of health insurance rises while wages don't. (Often a worker must spend one week's wages to pay monthly health insurance premium costs.) Some commented on the high deductibles they have and expressed frustration with the fact that such a large sum of money had to be spent up front before insurance kicks in. Others voiced unhappiness that even with coverage, "surprise charges" arise—costs that health insurance company won't cover. Finally, most of the group agreed that it seemed "stupid" to pay so much in monthly premiums for something (health care) you don't use.

1. Monthly premium. He doesn't like having to "fork out $ every month when you are just getting by."
2. Monthly premium. The next time premiums are raised, he's ready to drop his insurance.

"Insurance costs go up, wages don't. Something has to give."

3. Co-pay and the overcharge [what the insurance company doesn't cover]. "You think you have it paid for and you really don't."
4. Monthly premium, "depending on what you get for it". She doesn't like that you can get Viagra but not birth control pills.
5. Deductible. It is increasing too much; $2,000/family.
6. Monthly premium.

"How can anyone understand what they have [in terms of coverage]?"

7. Monthly premium. Wages are too low and it is too big a chunk out of paychecks.
8. All the surprises that are excluded
9. Monthly premium. Wages in state are too low to support insurance increases.
10. All of them [charges] bother him. "Paying monthly premiums makes you realize you are healthy for the month." If something happens, at least you need to know you can get taken care of. One feels "naked" without coverage.

"I'd take food from away from my kids to pay

11. Monthly premium. It takes a real chunk out of one's income.
12. Deductible. It can't be paid over time and one needs to put cash up front.

D. Consequences of no Health Insurance

Participants with what they perceive to be adequate coverage don't report having trouble obtaining quality care. They believe that they can get the care they need as long as they can pay the bill. Some of those not covered believe that the care they get is sub-standard, often because they seek care at a community health center or what they believe is a charity hospital. The consensus among those not covered is that one must try really hard not to need medical care—only go when in dire straits. The group largely believes that insurance and drug companies are to blame for the high cost of health insurance. Several members of the group expressed deep self-reliance and belief in the efficacy of home treatments.

1. Before he was insured, he went to a community health center where individuals pay a designated amount that is based on a sliding fee schedule. Although this was acceptable, he had to force himself not to go to doctor because of the cost, which was sometimes too high despite the sliding fee. There were times he just didn't go but should have because he couldn't afford it.

"It is very hard to get good care without insurance."

3. He goes to the hospital only when care is needed. His family has insurance, but he still pays about 50% of the bill. He recognizes how important it is to have insurance. As he noted, once you have that insurance card, you can get care without too much trouble. You might get a huge bill, but at least you get the care.

4. She has been fortunate in that she hasn't needed any healthcare. She is a big fan of preventative care, but insurance doesn't pay for it.

5. She finds it very easy to get care. She asserts that people can get care when they need it, even if they are uninsured. They just need to foot the bill.

"Once you have that insurance card, you can get care without too much trouble. You might get a

6. She has never been turned away when she needed care. Instead, she gets "unbelievable amounts" of care. She believes she is charged differently (more) than those who do have insurance. She investigates what doctors bill to those with insurance and demands that she pay that amount.

7. He wouldn't go for medical care unless he broke a bone. He took children in for care, but the bureaucracy was dreadful. CHIP has improved care for uninsured children. "CHIP is a great program where the doctors are on top of things."

10. He believes that costly medical care is harder to get without insurance and that the quality of care diminishes when you aren't covered. You may love your kid, but the care isn't there if the insurance isn't." He had a very bad experience with his son when he couldn't get necessary care because of the lack of insurance.

"The first heart attack is in the hospital, the second is when the medical bills come."

11. She hasn't had to go to the doctor. She occasionally goes the ER with migraines, which costs her $180.

12. He goes to community health center when he needs care. He thinks the quality of care there is low. He has not been refused treatment, except for dental care, for which lots of cash is needed up front. If he needed medical care he would go to any lengths to get it, and might even lie if it would help.

E. Willingness to Pay

This group volunteered to pay much higher rates than the previous group (lower income persons) for a complete health insurance plan. Responses ranged from $25-$250/month in premium costs.

1. $75/month.
2. $25/month, but really prefer to pay some percent of what you earn. He would pay $150/month for good coverage.
3. $150/month "would be struggle for single person."
4. $80/month
5. $150/month
6. $100/month
7. $200/month
8. $250/month, "for family of four."
9. $170/month
10. $100/month
11. $225/month
12. $250/month

"How can anyone understand what

"I came into world w/out insurance and leave w/out it (at end)."

The group agreed that although high premiums bother them the most, they are also troubled by high deductibles (which don't ever have a payment plan to stretch out front end expenses) and the cost of needed services and items that are rarely covered, including: braces, dental, and preventative maintenance.

F. Government Sponsored Health Insurance

A few participants had experience with government-sponsored programs and the general consensus was disapproval of such programs. This group strongly believes that individuals should take care of themselves and not accept charity care. At the same time, those with children in the State Children's Health Insurance Program (SCHIP) are very pleased with it.

1. She eventually qualified for Medicare and paid $46/month for Part B. Doctors seemed to forgive a certain amount of their bills because she had Medicare coverage. Obtaining Medicare supplemental insurance would be almost impossible due to pre-existing conditions.

10. He goes to Veteran's Administration for care and recognizes that VA is not considered insurance. In his mind, it is still health care. As a former military enrollee, he was promised (at age 18) that he would have access to VA treatment for life. He doesn't look for charity programs. In fact, he is taking his son to Vietnam for extensive dental work; this choice is cheaper for him than other available options.

12. For him, even though he is eligible, it is a matter of principle that he didn't sign up for government assistance. The medical community steered him there but he didn't go. He had a bill in excess of $50,000 for cancer treatment and chemotherapy medication costing $800/week. He got many bills written off after petitioning hospitals and writing numerous of letters. Currently he has a balance of $17,000. It is now impossible to get coverage due to the pre-existing condition clause.

G. Public Preferences

This group did not have many ideas to offer, which may be attributable to their expressed belief in America's free enterprise system. Those who did speak called for the government to impose some regulatory rules within the health care industry to limit premium increases. They agreed on the importance of individual responsibility in taking care of themselves and following medical guidelines. They generally like the system in Canada and Europe although they fear taking the power to make decisions out of the doctor's hands and placing it with the bureaucracy.

5. The government should be the watchdog. Need some regulatory force that makes this system fairer. "The insurance companies are ripping us off."

8. The government needs to set the guidelines on what companies should provide at what cost. The preventative care duty falls on providers and us. It is to their (health care organizations) benefit to catch things early. He suggested a program in which your payments stay constant if you go in regularly for preventative care.

4. As a business owner, you don't see savings for under six employees. Large companies have it better because the risk is smaller since it is spread over a greater number of people. Big companies love this because it makes things easier for them. Smaller companies, especially restaurants, are riskier and thus more expensive. It is also a huge chunk of money for employees to pay out—one week's pay just for health insurance.

H. Other

? Something called a "vanishing deductible" came up in which case one's deductible diminishes when a person doesn't use the insurance; it was on an individual plan, not group.

? A participant emphasized (to much agreement) that medical decision-making should remain with physicians and consumers, not the government or insurance bureaucracy.

? One person said she simply needs health insurance for peace of mind.

Focus Group #3: Farmers and Ranchers

Thursday, September 27th, 7-9 p.m.
Yankton, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	F	40's	Single	Loan officer at a credit union
2	M	50's	Single	Farm and ranch worker
3	M	60's	Married w/kids	Farmer
4	M	60's	Married w/2 kids	Federal insurance adjuster for farm service agency
5	M	70's	Widower w/8 kids	Retired farmer
6	F	50's	Single w/3 kids	Works in farm community
7	F	30's	Married w/3 kids	Teacher for Headstart
8	M	40's	Married w/3 kids	Works in community school
9	M	50's	Single	Farmer
10	M	50's	Single	Farmer
11	F	50's	Married w/2 kids	Farmer
12	M	50's	Married w/4 kids	Farmer
13	F	50's	Married to # 12	Farmer's wife

B. Experience with Health Insurance

Most participants in this group have some kind of health or accident insurance, but with high deductibles. All know people who are uninsured. Farmer and rancher participants have either individual policies or coverage through a spouse. All covered participants have problems with the insurance companies paying what they say they will. Participants worry about insurance companies pulling out of the state, the dangers that make farmers more risky to insure, and the threats of growing old. Everyone complained about the cost of insurance and the constantly rising premiums.

1. Covered. Purchases (on her own) BCBS because no group plan is available at work. She tried to get other coverage because her current plan is $305/month, but was advised to keep it because of the current situation with companies pulling out of the state. She went to the hospital and, due to a technical issue, ended up paying the bulk of the bill. Her insurance premium on her current plan went up 28% within two weeks.

2. Not covered. He has accident insurance but no medical plan. He has high blood pressure and can't afford medicine. His friend gives him free high blood pressure medicine.

3. Covered. He has an accident policy, which is purchased individually, and also receives some health coverage from his wife's job. He used to own a business that offered a small group plan, but rising insurance costs caused him to continually cut benefits. He lost insurance when he sold the business.

4. Not covered. He doesn't purchase insurance because it is too expensive and difficult to deal with; he has gone without health insurance for 15-20 years. His wife has disability coverage.

5. Covered. He has Medicare and a supplemental policy to cover what Medicare doesn't.

6. Covered. She has catastrophic medical insurance with a $5,000 deductible.

7. Covered. She is covered through her employer, who pays a percentage of the total premium and covers everything (except glasses). Her 50 year old father pays $4,500/6 months for health insurance.

8. Covered. He is covered through his employer and pays $150/month. His parents pay $850/month for their health insurance. He had a job-related accident many years ago and sued the company afterwards because he couldn't work. After six years, he is still fighting this. He fears he won't be able to get coverage if he loses his current plan; no on else will ever cover him.

9. Covered. He has an individual policy with a $1,500 deductible and also a special cancer policy.

10. Covered. He has an individual policy that costs $350/month for an individual and includes a $2,000 deductible and limited benefits. He had a major medical problem a few years ago concerning his ability to breathe at night. The insurance company paid the hospital bill, but not the surgeon. He ended up paying $18,000 because the insurance company called the procedural "dental" although it was a throat issue.

11. Not covered. Has not been covered for 12 years. He quit his job and is no longer covered.

12. Covered. He is only covered until December, when the insurance company is pulling out of the state. He is applying for a new coverage plan. He believes that State law requires that coverage be made available to them, but so far no one will take them.

13. Covered. She has coverage until December. The policy has a $2,500 deductible.

C. Barriers to Coverage

Respondents believe that the primary barriers to coverage are the high and escalating premiums charged by individual insurers, the flight of insurance companies from South Dakota, and the limited benefits that companies provide. They feel exploited by both insurance companies (unexpected expenses that insurance companies won't pay) and physicians, who seem to live very well.

1. The premium is so high. She thinks that people without insurance get charged less by the hospital and doctors..."it doesn't seem fair." Her dad has Medicare and still pays a lot for his medical care.

> *"It's not fair how you pay premiums for 18 years then they [insurance companies] drop you."*

2. Monthly premium is so high. Doctors are too rich. Seems unfair.

3. The gap between what insurance companies say they will cover and what they actually cover or don't pay for bothers him most. He saw a specialist and had to pay for care out of pocket. "There seems to be no rhyme or reason about what insurance companies pay for." It seems to depend on what you can pay. He believes that because his mother-in-law doesn't own anything, her supplemental policy to Medicare doesn't cost as much. Because he owns so much land and machinery, he is worried for the future.

4. Monthly premium is the main issue. It has to be paid. The next concern is the high deductible. Co-pays aren't as big an issue as long as they are reasonable.

7. Told a "good story:" Mom was very sick, had bills of $1 million and only had to pay $5,000 of it.

> *"Moving equipment (on the farm) has no mercy, and insurers know this."*

10. His major concern is the surprise payments he didn't expect to make. He doesn't worry about drugs because his brother is a pharmacist.

11. Money is the main issue. He can't pay the premiums. $400/month for a family is too much to pay, especially with a deductible of $1,200 ("and that's conservative").

D. Consequences of no Health Insurance

Overall, this group would go to the hospital or clinic if they needed medical care. Those without health insurance said they would go only in case of an emergency; many haven't been to the doctor in years. They believe that, even without insurance, they can get the care they need provided they have the money in hand.

2. He doesn't have any medical problems. He would go anywhere they took him in the case of an emergency.

3. He had a friend who was diagnosed with high blood pressure. After that, his friend couldn't get insurance after that, couldn't pay bills, and died of a heart attack.

4. He has been lucky the last few years. He gets vaccinations and pays for it out-of-pocket while his wife gets regular medical care through her insurance..

6. Her boyfriend has a medical bill of $69,000 and no insurance. She believes that "They [the hospitals] are ruthless. They called him the day he got home for money and gave him 5 years to pay the bill off." Now the man is diagnosed with cancer and no one will treat him unless he comes up with the money. He could lose his farm over this issue. "I

> "Greed is the bottom line of this whole

won't let them take everything I have for my health." She offered to pay the hospital $25,000 for his surgery and they wanted to see a financial statement.

8. He hasn't been to dentist since 1981.

9. He believes it is easy to get care if you have cash in hand.

11. Has no idea where she would go for medical care, whoever would take her. Last went to doctor 16 years ago. Kids get immunizations at the courthouse but they haven't needed to go to the doctor. Has a friend without health insurance who wouldn't be seen by a provider because he couldn't pay $30,000 up front for care.

E. Willingness to Pay

Responses varied from $0-$150. Respondents generally agreed that the level of monthly premiums should be dependent on an individual's income, especially for farmers and ranchers.

"What if food went up 30% in a year?"

1. $150/month, obviously because she pays $300 right now.
2. $25-$50/month.
3. $60/month, double if it covered everything.
4. Zero, that is why he doesn't have it now. Couldn't afford anything.
5. Zero if it was a question of affording everything else first.
6. $125/month gladly.
10. Percentage of income, 5%.

F. Government Sponsored Health Insurance

A few participants have had experience with government programs.

1. Her sister has Medicare.

4. His wife has disability with Medicaid. It works for basic care, but specialists present a problem because the program doesn't cover anything.

5. He has Medicare.

G. Public Preferences

Many in this group believe that doctors and drug company representatives are the main problem in health care. Participants agreed with the idea of the government should play a role in the regulation of costs. Many thought government should offer basic health care like

the Indian Health Service. The most debated idea was the socialization of medicine (similar to Canada), which exposed wide philosophical differences.

1. The government should put a cap on health insurance premiums. She doesn't like HMOs and managed care isn't the way to go either.

"Cost [of health insurance] is ridiculous; can't get

3. He believes that basic needs could be covered across the board if most Americans would pay taxes for this. There needs to be coverage for preventive care and a method to deal with the abuse of ER usage. Payments could be based on a sliding scale. It is unfair for taxpayers to shoulder bills if there is no regulation to protect against abusing services.

4. He notes that private insurance is okay through work. The responsibility lies on every one: government, individuals, and private companies. Drug company reps and employees shouldn't make that much money and he believes that is why health care is so expensive. "We should follow Germany and Canada because there it works *better* than here—not perfect, but better."

6. She could see some solution involving insurance payments coming out of paychecks.

8. He believes that health companies are responsible and thinks we should socialize health care and make it like IHS.

9. He doesn't think that doctors should be paid that much. Farmers get the short end of the stick; farm prices are too low and the stress can make you crazy.

"This should be a happy time for us [harvest season], but stress and worries are taking over."

10. He believes that doctors shouldn't have to charge that much. He thinks we need to socialize medicine; some of our real estate taxes should go to health, not just education.

Focus group #4: Farmer/Rancher

Friday, September 28th, 9-11 am
Winner, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	F	30's	Married with 2 kids	Rancher
2	F	30's	Married with 3 kids	Housewife (works PT at hospital), husband is rancher/farmer
3	M	30's	Married with 2 kids	Ranch hand
4	F	Late 80's	Single	Great grandmother on ranch
5	F	Late 50's	Married with 4 kids	Lives on a farm
6	F	50's	Married	Housewife
7	F	40's	Married with 1 kid	Housewife and beautician, husband is farmer
8	M	70's	Not married	Retired policeman, farms

B. Experience with Health Insurance

Half of this group is insured although all complain about the cost of insurance. They all want insurance but can't afford the cost or the hassle of dealing with it. Those insured through an individual policy pay hundreds of dollars each month. High deductibles are common among these participants. Pre-existing conditions are a predominant problem, including obesity and cancer.

1. Not covered. She had insurance 3 years ago, but could no longer afford it. She had accident insurance but it just wasn't worth it either. "Kids come first." She thinks that doctors and hospitals are more flexible and charge you less if you don't have insurance. "The bills end up the same and the hassle is less."

2. Not covered. Although insurance is offered through her job at the hospital, the high cost ($450/month for her family, with a deductible of $500/person) precluded her from purchasing a policy. It would have cost more than her weekly paycheck and the plan didn't include dental, eyes, and prescription drugs. In the past, she had a different job that, although dreadful, provided benefits that were so good that many people kept their jobs simply for that reason. It was a big company with locations across the USA. She believes there should be a way to make these kinds of benefits possible for everyone, whether they work for small or large firms.

3. Not covered. He believes that companies will insure neither he nor his wife because they are overweight. Medicaid covers both of his children and his wife had Medicaid when she was pregnant. One of his children has special needs and he believes that "Medicaid covers

children well." In retrospect, he thinks he should have gotten health insurance when he was younger, but he just didn't think about it. When he thought about it after marriage, it was too late. His wife had insurance through work for a while, then carried it over on an individual policy. After the insurance department came and said that some company had to take her, she was offered a policy that they just couldn't afford.

4. Covered. She reports that she has had the same policy for 30 years and that both coverage and cost are fine. For example, throughout her husband's 16 years with cancer and her two cancer diagnoses, the company covered them well. Her policy covers 80% of prescriptions but doesn't cover dental expenditures. She also has Medicare and a combined accident insurance (it pays some hospital and disability). She now pays $500/month for a policy supplemental to Medicare. They raise premiums constantly.

"I can't afford it, but I can't afford not to have it."

5. *Covered. She now has a different health policy from her husband. Her husband, who had kidney cancer, is "stuck" with his old policy. She, however, was able to switch to a better plan that costs the same as the old plan. They pay a combined $600 a month for health coverage. She feels insurance has too many loopholes. For example, her husband's policy doesn't pay unless he is in the hospital. He was in the hospital for two days, but doctor listed it as outpatient visits. As a result, his insurance didn't cover anything. Her premium went up $50 this year.*

6. Not covered. She recently dropped her policy that had a $2,500 deductible. She had a policy with one company, switched to another, and got a 15% surcharge because she is "overweight." (Note: she doesn't appear overweight) Her husband now has Medicare with a supplement, but before he had Medicare they were both uninsured. When they had insurance years ago, they rarely sought medical care; when they went to the doctor they still "paid a ton". She thinks you get charged more when you are insured.

7. Covered. She and her family purchase insurance, but the cost is high (premium just went up $200/month and deductible is $1,500). They will probably have to give it up because of the cost.

8. Covered. He has Medicare and a supplemental policy. Before Medicare he had only accident and not health insurance. He believes his former employer offered only accident insurance, not health insurance.

C. Barriers to Coverage

Many of these participants share the view that hospitals and doctors charge the uninsured less than the insured. Many are frustrated by health insurance company behaviors and their decisions to deny payment..

1. Believes she can get cheaper healthcare without the insurance. The uneven monthly income of agricultural families makes it hard to pay monthly premiums or hospital bills.

2. She can't afford insurance and there are so many stipulations, such as "above and beyond customary charges." Wages are low in South Dakota and insurance prices are high.

3. He talked to employer about offering group health plan, but it just wasn't feasible for him to provide health insurance because his boss employs just a few people. Wife drives bus for school district, but district doesn't insure her because she is not considered a full-time employee since she works less than 20 hours a week.

5. She had surgery (ankle replacement) and everything in the treatment was claimed by the insurance company to be above and beyond customary charges. She thinks having a policy will get her cheaper rates than those without insurance. Even at $300/month, she doesn't think she can be without insurance. The rental of the bone stimulator for her ankle is more than she could pay on her own.

> *"First the cost of the premium is a problem and then you get the medical bill."*

6. It is so frustrating that insurance policies have so many loopholes; companies make promises then they don't cover something. Believes there is too much freedom for insurers to move around.

D. Consequences of no Health Insurance

The biggest concern among this group is that an incident would arise that would require care, which would rack up huge bills that would be sent to a collection agency. The fear is that this would lead to a loss of farm/land, which terrifies many participants because it is a very real possibility. However, they cannot afford the alternative [health insurance]. As a result, people don't often go to the doctor, even when they really need to see someone.

1. She just doesn't go unless it is something grave. When she calls for her children, the doctor gets there because he knows it is really serious. She hasn't been to doctor in 5 years nor a dentist in 2 years. Her employer will help pay the bill. She worries about getting really hurt, which would cause her to lose everything.

> *"If you're sick and have no health insurance, you should go to the vet because it is so much cheaper."*

2. Don't go for medical care. Hospitals will work out a payment plan, but they charge you interest, which is not cheap. Either way, she cannot afford medical care. She thinks she would get the care but would lose everything in order to get it .

3. He wouldn't go anywhere for care. Even though he has aches and pains, he won't seek care and feels that there isn't anything he can do about it. He could lose his place [land]. Once he got sick and should have been covered by the farm's policy for workers, but he wasn't.

5. If absolutely necessary, he would just try and work with the provider to set up some payment plan. For his children, who are on Medicaid, they go where they are told to go. For young people, there is the idea that providers could "rob you of your future." However, she does believe in the hospitals and doctors of South Dakota and thinks the quality of care is good.

6. She would go and seek care if she had to, but generally tries not to. She just takes aspirin. She noted that 30 years ago providers could not add interest on bills and they shouldn't now. "What is the

> "We just don't go for medical care unless the children

difference between big doctor bills and big insurance bills?"

E. Willingness to Pay

Summary: Responses range from $150-$200 month.

1. Same as number 2.
2. $150/month and a $500 deductible for the family per year. She wants prescription and dental benefits. Her husband hasn't been to a dentist since he was 12.
3. $200/month.
4. Couldn't afford much although would pay a couple of hundred dollars/month.
5. $150/month, per person.
6. $155/month.

> "If you don't pay one month, you

F. Government Sponsored Health Insurance

Many participants in this group have had experience with government programs. Most have been pleased with them although some noted that these programs make it beneficial to be poor. The programs aren't structured to help you to improve your situation. There were differing opinions about government's involvement in healthcare. They described it as socialized medicine.

1. She took part in a program in which her husband got free glasses. "It was a good deal. It pays to be poor."
2. She had Medicaid for her first pregnancy. She works at a hospital and knows that the VA pays little for care. Believes there is nothing for preventive care under Medicare. Medicare should pay for drugs that help you get healthy or stay healthy. Yet you still aren't making enough to afford anything. She makes $37 too much each month to qualify for Medicaid.
3. He feels blessed to have Medicaid coverage for his children.
4. She has Medicare and says that even though you are paying for it, there is still a lot that they won't pay for. She says it needs to be something bad for them to pay for it.

> "They cycle of government programs is dreadful because the second you

5. Her husband is a veteran and went to the VA hospital, but they said he had too high of an income and didn't qualify for care. The VA shouldn't be able to discriminate among the veterans.

6. Her husband has Medicare. "We have to be very careful that we don't take something on that is going to bite us."

"Medicare should pay for drugs that

8. Medicare works well for him.

G. Public Preferences

1. Believes drug industry is a problem.

2. The insurance companies shouldn't be allowed to have all these payment and coverage loopholes. Is unfair for farmers. Hospitals are running understaffed. You can't change one thing to make this work.; you need to look at everyone who is exploiting it. There is a need to look at the prescription drug industry.

3. "Go back to the barter system." Give your doctor some eggs and a cow in exchange for treatment. His relative does that. Doctor hunts on his land in exchange for drugs.

5. "There are a lot of people who are 'sue happy'." It should be harder to bring a malpractice suit against a doctor; it needs to be legitimate. That would cut down on insurance costs of doctors and lower consumer costs.

6. We [as individuals] should be responsible but the premiums should be reasonable. "The insurance companies, hospitals, and government need to get costs down." Doctors and hospitals have been the biggest problem. "Why can't they get the people the care they need at a fair price?" Need to get back to what doctors charge and why. She thinks that careless practice "oopses" are the problem. Nurses shouldn't be allowed to work such long shifts. The same barter approach worked with her: her doctor came hunting on her land in exchange for half payment of eye surgery.

"We want to be responsible and don't want a hand

7. She thinks malpractice with the doctors is the problem. Needs some way to get rid of that.

8. "No solution to the system. It is a mess."

H. Other

? "Health insurance in this state is a rip off. The industry cannot compare to anything else in this commercial world. The standards are ridiculous and so abnormal."

About rising insurance costs..."What if the farmers raised the price of food 28% in one year?"

? "Let's go to Mexico to buy our drugs."

? The fact that wages are down South Dakota makes getting health insurance that much harder to afford.

? Story came up where farmers vaccinate themselves with the animals' vaccines (lots of laughing over this one).

A. Focus Group #5: Native Americans

Saturday, September 29th, 1-3 p.m.
Rapid City, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	F	40's	Single with 5 kids	Waitress/dishwasher at restaurant
2	F	50's	Married with 4 kids	Retired roofer
3	F	40's	Single with 4 kids	Teacher at alternative school
4	F	40's	Single with 2 kids	Works at a daycare
5	F	40's	Married with 4 kids	Student
6	M	50's	Married with 1 kid	Office manager at tribal facility
7	F	40's	Married with 3 kids	Works in bankruptcy department and is a student as well
8	M	40's	Married and expecting a baby	Works on a landscaping crew
9	F	28	Single with 4 kids	Secretary
10	F	40's	Married with 3 kids	Student and entering national guard
11	M	40's	Married with 4 kids	Construction worker

B. Information Specific to Native American Population

All focus group participants live and work in the town but are also enrolled in federally-recognized tribes. Tribal members and their children are eligible for direct health care services through the Indian Health Service (IHS) if they are enrolled.[58] The application requires supplying numerous forms, such as birth certificates, Social Security numbers, etc. Some children have pending enrollment. One participant's children have been pending for 16 years (since birth). They can get services while "pending" although they are incessantly bothered about it.

Most participants use the Sioux San (IHS hospital) in Rapid City for outpatient care. While they are pleased with the culturally sensitive medical treatment they receive, they highlighted problems in other areas: not enough space, daylong waits for service, not enough drugs, etc. Many participants, in addition to utilizing the Sioux San hospital services, also go back to their home reservation to receive medical care because it is free on the reservation (due to their status as enrolled members of Indian tribes). They criticized the quality of most IHS care.

[58] The Indian Health Service is neither an insurance program or an entitlement program, such as Medicare. Services are funded each year by the U.S. Congress and cover an estimated 60% of health care needs of the eligible American Indian and Alaska Native people. (Source: http://www.IHS.gov.)

They do think about private health insurance plans, but are fairly unfamiliar with what is available.

C. Experience with Health Insurance and/or the Indian Health Service (IHS)

Most of the participants do not have insurance. They rely on direct IHS services or IHS-contracted services for care. A few have, or have had, private insurance. Most do not enroll in health benefits when it is offered through their jobs due to the high expense. Many work in jobs with little employment security. IHS services are received free of charge. While they acknowledge the benefit of IHS, they would like to have improved and more complete services available to them through the IHS.

1. Not covered (other than IHS services).

2. Not covered (other than IHS services). She once had full insurance coverage through her employment on the police force, but she no longer has that job. She believes no insurance company will take her now because her job as a roofer makes her "untouchable". When she worked on a federal contract on an airforce base, she had to get health insurance for six months; it cost $6,000 for three people in her family. She had to get a loan to pay for the insurance. Her husband fell off of a roof and their insurance dropped them; her husband couldn't work for months due to the injury.

3. Not covered (other than IHS services). Her job offers it and she will be covered once she pays the first premium. However, the monthly premium is too high to cover her family ($182/month, for her).

4. Not covered (other than IHS services).

5. Not covered (other than IHS services).

> "It's hard to come up with the money for health insurance. We'll put food on our tables for the kids

6. Covered. He knows he is very lucky to have a job that gives him full coverage and believes that the laws need to be changed to assure proper wages and sufficient health coverage.

7. Not covered (other than IHS services). She has had good experiences with IHS. Typically, her doctor refers her to contract health services, the board reviews her information and she gets approved and receives needed services. For a while she had some insurance through her job. It cost $26 a week for full coverage.

8. Not covered (other than IHS services). He had it once but the deductible was very high. The insurance only covered him when he was working on the job within the grounds. He expressed bitterness, commenting that coverage seemed to benefit the employer (tax break) more than it benefited him (too many limitations of what gets reimbursed).

9. Not covered (other than IHS services). Insurance was available to her through her job, but the premiums were too expensive ($180/month), so she didn't purchase it. She knew she could go to Sioux San for some care. Currently, her daughter needs braces and she doesn't know what she can do (IHS used to offer braces but not any longer).

10. Not covered (other than IHS services). She had a job in a meat-packing plant that offered insurance options after six months of employment. However, the situation wasn't fair because the job itself inflicted many injuries and workers could get fired if they were injured.

11. Not covered (other than IHS services). He hasn't been to a doctor in 20 years.

D. Barriers to Coverage

Participants in this focus group, which may be characterized as a group of individuals making the transition from reservation to urban life, underscored two main barriers to coverage. Often caught between these two worlds in uncomfortable ways, these individuals: (1) typically work in low paying jobs in which employers do not offer health insurance and most employment is unstable; (2) are aware of IHS service limitations and the burdensome requirements placed on them to secure contracted health services; and (3) have difficulty paying monthly premiums because their employment status often changes monthly. The participants also agree that the high deductible presents problems when many of them do not have money saved up for care. A few commented that the overall cost of healthcare is a problem when you just don't have the money.

2. Premium is a barrier.

3. Premium is a barrier. She hates to pay it when she doesn't know if she is going to be sick. Yet, she hates the stress of not knowing what is going to happen and feeling unprepared for something serious. She always thought that IHS was going to be there and "they are chipping away at it."

> "If you are out of a job, that monthly

4. Monthly premium. Don't know if you will have a job that month.

7. Deductible. She would rather pay a premium every month (taken out of her paycheck) than save a big chunk in case of emergency.

8. Premiums, deductibles, and co-pays are all problems. He feels that if you have enough money you can shift the costs around. Otherwise everything hits you hard. It is offensive to someone who is really sick because they can't pay on any front.

9. Both the deductible and premium present problems. It is like car insurance**:** money feels wasted if you don't get into an accident or get sick. It just doesn't work out. She has bad credit from having a baby (she could only afford 2 prenatal visits). Health services are not free for Indians if you don't live on a reservation or near an IHS facility.

E. Consequences of no Health Insurance

While all have access to IHS, all participants experienced problems as a result of not having health insurance, ranging from not getting needed treatment to jumping through bureaucratic loops to get treatment. The overall consensus is that the care they receive at IHS is not at a desired level of quality. Some have hospital bills to pay off and many avoid getting treatment because they simply cannot afford it.

1. Her sister had health problems, she went to IHS, and they couldn't get her help without other insurance and she didn't have the money**.** She went to a doctor about a broken bone and didn't have Medicaid and needed it to get service. She believes that there is insufficient help on the reservation.

2. She still has bill from having a child at a Rapid City hospital, and she can't get referral from Sioux San. "They won't take care of the issue." She also she got caught in tangle of referrals. She needs to drive down to reservation (more than 100 miles away) to get referred to go to the hospital where she lives (in order for IHS to pay the bill), the number of required signatures is overwhelming, and she once had a disastrous experience at Sioux San Hospital. She had to be taken to Rapid City Regional Hospital (ER) because she had been given the wrong shots (shots were to be given to another woman).

> "What happens when you get sick after you

3. This is another example of contract health bureaucracy. When she called an ambulance because of chest pains, she was taken to Rapid City Regional, but she needed a referral from Sioux San (even though the hospital didn't have cardiac center). She asked that the Regional Hospital at least notify Sioux San, but they didn't. Now she is stuck with the bill. In addition, her sister went to IHS on Rosebud reservation and received inadequate treatment. After a year, IHS finally sent her to Sioux Falls where they discovered that she had cancer. If her sister had insurance, her cancer would have been found earlier and she could have gone to a decent doctor, possibly preventing death. Contract IHS services don't pay "unless it is life or death, which you can't always identify."

6. He had to travel "all over the place" for his son's medical problem in order to get necessary IHS approval. He feels that he could have lost his son in all the time wasted. The situation is unnecessarily complicated and is a nuisance for everyone. He often resorts to his grandmother's remedies for health care.

> "IHS treats symptoms instead of finding out what is wrong, they barely look into it.

8. He is very healthy and got dental work from Sioux San. He rages against the red tape Indians have to deal with. "If you are Native and have no insurance they will kick you out and let you die on the street." You need to "jump through the bureaucratic hoops" in order to get a tooth fixed. His wife is pregnant and it scares him because he believes that the doctors in the IHS system are low quality and "from all over the place." Yet he doesn't want to complain about IHS because at least it is some care that is available. He's heard that some others try to claim Indian heritage in order to receive IHS care. He recognizes that white folks have it bad, too.

9. She has bad headaches and can't get the healthcare she needs. She is on a list to get "contract health," which means she is on a list to go to a specialist, but has been on the list for quite a while. When she had Medicaid through her student status, she got an appointment for a CT scan the next day. Her daughter had an ear infection and she knew it, but simply couldn't get care because she couldn't afford the doctor and drugs. Her daughter went without care and now she thinks her daughter may have hearing loss as a result. Even though Sioux San is free, she feels it is not quality health care. "We guinea pigs to them (IHS doctors)." She resorts to medicine men for health care and spiritual guidance and lives near the Black Hills for that very reason. She is going to a medicine man for her headaches. She reports that she got dreadful treatment from Sioux San that "didn't make any sense."

F. Willingness to Pay

Summary: Responses range from $35-150/month.

1. Would go up to $100-$150/month if insurance really covered many services.
2. Up to $100/month, based on income.
3. Up to $100/month, based on income.
4. $75/month.
5. $75/month for herself and kids.
6. Would pay whatever it took and would want a raise if it cost more than he could afford.
7. $100/month for whole family.
8. Would base it on percentage of paycheck, go along with Social Security, Unemployment Insurance, etc. and do it like Canada. Socialized healthcare.
9. It all depends. She would pay $100/month for a whole family. That would be a lot, but she would do it.
10. $35/month.
11. $35-$45/month.

G. Government Sponsored Health Insurance

Everyone in this group has had experience with government programs, primarily the IHS and Medicaid. All agree that their elderly population dies too quickly to be eligible for Medicare. Some of their children have Medicaid. Problems regarding quality of IHS care was described above.

1. Her kids have Medicaid.

2. Her parents died too soon [to get Medicare]. Her grandmother wouldn't take drugs given to her in the hospital because she believed "they are out to kill you."

3. Her Medicaid experience was negative. Her children couldn't see a dentist because providers wouldn't accept Medicaid or said that they were full. Accessing dental care is difficult, even through IHS.

6. His parents died too soon [to get Medicare].

8. He reported that they all die too soon to reach the eligible age for Medicare coverage. There aren't any nursing home facilities on reservations (that they know of), but they wouldn't put parents there anyway because it isn't culturally acceptable. He discussed the need to break the welfare cycle.

9. Her grandmother lived until 104 years. In Indian communities, the elderly aren't placed in nursing homes. They are taken care of at

"The social programs need to focus on getting people out of the welfare system

home. Her grandmother had Medicare for a while, thought it was great, and was treated quickly.

10. Her grandmother finally has Medicare. However, she worked ("off the books") for 25-30 years and wasn't able to qualify at first for Medicare.

H. Public Preferences

For the most part, this group would prefer an improvement in IHS services, facilities, and doctors. They like maintaining cultural heritage through their health care system, although several mentioned that they would like mainstream health insurance with low premiums, perhaps based on income and related to their jobs.

1. She wants to get a good job that would make it possible to afford insurance. She thinks companies should expand the definition of "family" for coverage purposes (For example, her sister is the caregiver for someone else's children because the mother has cancer).

2. She would like to see an improvement in Sioux San and hiring of better doctors by IHS.

3. She sees the importance of maintaining cultural knowledge and the need to avoid stereotypes. As a result, she likes visiting Sioux San to see her relatives because she knows they are going through the same things together. She would prefer an upgraded IHS, and think that IHS needs to pull its own facilities up to a consistent level. She thinks one of the Rosebud facilities is beautiful, but nobody knows how to use it. She likes the idea of a national health care system and would like to see tribes do something about it. She wants to stay together as a community and thinks the government should play a big role in making that happen. In her mind, Native Americans at one time were the healthiest people and they need to get back to that; they need doctors who are sensitive to the historical aspect of health and illness.

4. She maintains that there is a strong need for better doctors in the IHS facilities because she believes many of them don't know what they are doing.

5. She also wants better doctors.

6. He corroborates the sentiment that IHS is really lacking. In his mind, Indians would need less insurance if IHS improved. Need good and upgraded facilities. "If they can do it for the white folks why can't they do it for them at Sioux San?"

7. He wants to be mainstreamed rather than rely on IHS. He wants to see everything improve, especially better IHS facilities and cheaper quality care for everyone.

8. She would like to go mainstream, as it offers freedom, but would prefer to go to IHS because it would be community/culturally based.

9. She believes that all people are entitled to needed health care with lower premiums and thinks there should be income guidelines and graduated premiums that take family size into consideration.

10. She thinks there should be job-based health insurance for everyone, especially for those in manual jobs.

11. He wants better IHS facilities and more Native American providers.

I. Other

Many participants identified the need for both emergency and preventive healthcare. The need for preventive primary care is great for Indians, due to their predisposition to many diseases (including diabetes) and general health trouble from poverty and environmental causes. A few discussed the implications of language barriers and the difficulty of the alcoholism that pervades their culture.

? She believes that preventive healthcare is of utmost importance. IHS used to offer preventive healthcare but now it is the individual's responsibility. She also cites the need for coverage when emergency hits, especially for Indians because Sioux San doesn't accept emergency cases. Additionally, the elderly don't understand English well and doctors need to understand this. The facilities need to provide interpreters.

? She believes that preventive care is most important, especially in Indian communities due to environmental health issues and genetic make up. She cites the lack of societal recognition of the impacts of stress due to poverty, the challenge of moving off of reservations, racism in society and court systems, exploitation of spiritual lands, etc. There is a need to combat alcoholism and drugs. Why doesn't society consider alcoholism a disease? People need to get treatment for this, especially because it causes people to lose their jobs.

B. Focus Group #6: Native Americans

Monday, October, 1st, 3-5 p.m.
Eagle Butte, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	F	20's	Single	Waitress
2	F	20's	Single with 4 kids	Part-time waitress
3	F	20's	Single	Desk clerk for Super 8
4	M	30's	Married with 2 kids	Disabled and unemployed
5	M	40's	Married?	Private contractor
6	F	40's	Single with 4 kids	Unemployed
7	M	20's	? with 5 kids	Unemployed
8	F	30's	? with 3 kids	Unemployed
9	F	50's	Single	Does all kind of work: secretarial
10	M	20's	Married with 3 kids	Unemployed
11	M	40's	Married with 5 kids	Construction worker
12	F	30's	Married with 5 kids	Housewife

All focus group participants currently live on the Cheyenne River Reservation. While most are long-term residents, some have recently moved back to the reservation for economic or health reasons.

B. Experience with Health Insurance

Most participants have had access to private insurance at some time or another, usually through their employer. A number of them turned it down when offered, due to its high expense and the fact that they have access to IHS. Many of their children have Medicaid coverage.

1. Not covered (other than IHS services). She had insurance through her former job.

2. Not covered (other than IHS services). She sometimes goes to IHS, but her children don't because she had bad experiences with IHS. The family often goes to see a private doctor who has her own practice here in town. Her brother has insurance through his job.

3. Not covered (other than IHS services). She goes to IHS and a nearby family clinic for care. Previously she received limited insurance for a year through her job at convenience store, but she never used it "even though she paid $30/month". The extent of coverage depended on how one was paid.

4. Covered (Medicaid). He would go to Rapid City Regional hospital because the treatment is much better than other alternatives. The food is better, too. There is a shuttle that provides transportation from the reservation to the hospital three times a week.

5. Covered (Medicaid). He would take his family to Pierre or Rapid City for care because the facilities and treatment are better than those on the reservation. His wife has insurance through her job, but it doesn't include him. He has to get referred "out of here" even though he has Medicaid.

6. Not covered (other than IHS services). She goes to IHS, but service is slow and she takes her children elsewhere when they are really sick. She had insurance through her job at HeadStart, but lost coverage when she quit. Her daughter got sick out of town and Medicaid wouldn't pay for care because she wasn't going through a PCP.

7. Not covered (other than IHS services). He had insurance through his job at HeadStart, but quit. He got the option to keep his health insurance through COBRA, but he opted out of the coverage. His children have Medicaid and go to Gettysburg for better treatment and correct diagnoses. He took his son to the ER and should have been covered, but he ended up having to pay $82 for 15 minutes because he didn't go through a PCP (says it was Sunday and the doctor couldn't be reached). He once paid $36 every two weeks for health insurance.

8. Not covered (other than IHS services). She goes to IHS for care. She worked for IHS and could have gotten another insurance program, but it was too expensive.

9. Not covered (other than IHS services). In the past, she had health insurance through her job. She goes to IHS but has had terrible experiences there, including a misdiagnosis. "They almost killed my grandpa with incorrect medication."

10. Not covered (other than IHS services). He goes to IHS and his family goes to a downtown clinic because it has faster service. He has never had insurance through a job.

11. Not covered (other than IHS services). He has had jobs in the past that provided health insurance, but now he is self-employed and doesn't get it for himself. He could have kept BCBS through his past job, but he thought he wouldn't need it. He paid for insurance for a few months and just never used it. He thought that IHS would deal with whatever came up.

12. Not covered (other than IHS services). She goes to IHS but the kids go elsewhere; they have Medicaid.

C. Barriers to Coverage

The main problem in this group is that many do not have steady jobs or jobs at all. They operate on very little money and have nothing to spare for health insurance.

1. She was covered by her uncle's insurance until age 25. She never thought about it until she was on her own and now she doesn't know what to do.

2. She has never looked into private insurance.

3. She has never thought about private insurance.

4. She would stick with Medicaid rather than IHS because Medicaid is interested in customer satisfaction.

"Why pay for years [for health insurance] when you never get

5. She said that nobody keeps the money around to pay for health insurance.

6. If she could afford insurance she would get it so she wouldn't have to go through IHS. However, everything is too expensive without a job.

7. He "would buy health insurance in a second" if he could find an affordable option. He would love the freedom of not having to go through IHS.

8. She sticks with IHS because she wouldn't pay for insurance through a job. She has never needed anything beyond what IHS could offer.

9. She is trying to get a job and thinks about health insurance often. She wants quality medical care and hates going to IHS for medical services. She is used to Minnesota where it is a lot cheaper than on the reservation.

10. He doesn't know much about insurance, has never had coverage, and has always gone to IHS. He hasn't ever thought about health insurance and imagines that it would be expensive.

11. He thinks insurance is more expensive here [on the reservation] because more people die out here. He also said that insurance is just not worth it when you can go to IHS.

12. She thinks that health insurance is too expensive and has the belief that there is no need to pay for insurance when they can get free treatment. She reported that it would be different if they lived off the reservation or far away from an IHS facility. She doesn't know how much insurance costs. She did work at Spiegel (catalog) but there is a 6 month work requirement before insurance begins.

D. Consequences of no Health Insurance

The main problem in this location is the lack of access to care and not just quality care. It is unlikely that an improved health insurance situation would meaningfully change the access issue, although it would shorten the referral time to adequate treatment. Another problem is the lack of consumer choices. The main consequence is that the participants get treated in IHS facilities even though many believe services are inadequate. They go to IHS facilities because they can't afford to go elsewhere.

1. She feels that the doctor at the family clinic cares about them. The doctor lives in the community and this fact is a big deal because it shows that she is invested in the community. All the other doctors just come and go. She thinks insurance isn't that important because she is single, but with kids it is more important. Long-term insurance would be important to have access to better care.

"The problem is just getting off of the reservation for

2. Her brother can go anywhere for care because he has insurance. The IHS doctors are difficult to understand because they aren't from the area and don't speak English well. She recounted a story about a time when she was pregnant and had gallstones. The doctor thought she had kidney stones and it was only upon being referred out that she was correctly diagnosed. Babies can't even be delivered at the local IHS hospital. She had a problem with confidentiality through IHS--everyone found out she was pregnant before she knew. She reported that she would spend her money to get insurance if she could afford it.

"Getting referred out is a job in

4. He has had great difficulty scheduling appointments, and obtaining referrals has been equally challenging.

5. He reports that the difficulties of getting good care include getting prompt referrals from the IHS. Should he have an accident, there would be a long lag time between the incident and treatment. He believes better treatment comes with insurance and, at the very least, there would be greater access. He wants to have some good doctors here, has had problems with confidentiality through IHS, and notes that even the pharmacy up here is terrible because there are long wait times.

6. Thinks if you paid a bit, such as a co-pay, the quality of service might improve.

7. He toughs it out here [at IHS] because he doesn't have insurance. He doesn't think care would improve if people paid a fee such as a co-pay because he doesn't think they [the doctors] care. They just want to get in and out. Six years ago, an accident involving his daughter occurred and it took hours for and ambulance to come and then another 45 minutes for transport to take her to Minnesota. She couldn't even get a cast at the IHS hospital and there is no decent outpatient treatment either.

8. She doesn't think insurance matters here because the area is so remote. She will always go to IHS.

"If you are a paying customer you can demand better care."

9. She thinks care is poor because the doctors know services are free, thus it doesn't have to be up to industry standards. She has some kind of condition and can't get the correct pills from IHS; they only give her ibuprofen. Three years ago they told her she was pregnant, then that she had cancer. She went to Rapid City and was told she was fine.

11. He believes that IHS provides terrible care—you would bleed to death. The doctors are straight out of school and inexperienced. If you have an accident here you can't get treatment and insurance doesn't matter here**. "**If you can't get off the reservation it doesn't matter if you have insurance in the case of emergency."

12. She thinks that Sioux San is terrible because the doctors are just starting out. If you get a good doctor, they end up moving on quickly. She feels like a guinea pig (reiterated by numbers 7 and 11). IHS here is like a clinic. You have to be seen even to get ibuprofen. That seems to be the only thing they give out. The problem with getting real drugs is that you can't get the correct diagnosis to get the drugs.

"If you can't get off the reservation it doesn't matter if you

E. Willingness to Pay

Responses range from $25-$60.

1. $40/month.
2. $30-$50/month.
3. $30/month.
4. $35-$40/month.
5. $25/month.

6. $50/month with a job.
7. Couldn't pay more than $20/month (unemployed). Would pay $40-$50/month if he had a job and insurance included everything.
8. $30/month.
9. $35/month.
10. $50/month.
11. $50-$60/month if he was making $8-$9 an hour and it was permanent.

F. Government Sponsored Health Insurance

Many participants have children on Medicaid and a few have older family members with Medicare. Some of them don't have any family over the age of 65.

4. He gets Medicaid, but his family doesn't. He is on disability, but neither his wife nor children have coverage.
5. Has Medicaid.
7. Kids have Medicaid.
9. Mother has Medicare.
12. Kids have Medicaid.

"It's harder off the reservation for non-Indian people who have no health

G. Public Preferences

Opinions here varied between an improved IHS, socialized medicine, insurance provided by employer, a group tribal policy, and personal responsibility. Many ideas were expressed but no real consensus.

3. She believes people should be able to get insurance through work.

4. He thinks the government should be providing for them and taking care of their healthcare by paying more attention to funding (equality throughout reservations) and the distribution of resources.

5. He believes that if you can afford it, health coverage is your responsibility. He thinks the tribe needs to come up with a financing system that would kick in something if people gave something (matching). That way they would have the resources to improve facilities and treatment. Other ideas are designing a bigger group that would provide for them all or requiring employers to offer insurance. Insurance shouldn't be optional because then no one takes it.

6. She likes idea of job-based insurance for all jobs.

7. He also believes that coverage is a personal responsibility. Employers should encourage it through education. Given their geographic area and the unemployment rates, he thinks the coverage should be a group policy through the tribe, which would enable the unemployed to participate also.

9. She also believes that coverage is the responsibility of the government and oneself. "They put us on the reservation and need to take care of us." It is stated in the treaty. She wants something that is tribally based and considerate of those who can't get jobs. She also wants better doctors here.

10. He agrees that better doctors are needed here.

11. He thinks there should be national insurance for everyone.

12. She also thinks responsibility lies with the government and oneself. Considering the government is already helping pay for it, it should stay that way. Given what one can afford, one should pay something as well. She also wants better doctors here at IHS.

H. Other

? Access to dental care is a real problem. Many people voiced the difficulty of getting dental care.

? Thinks IHS referral money gets abused. Some people get unnecessary treatment so some doctor can get paid.

? Thinks of this reservation is like a "foreign country" and compares it to Africa. You "can't even have babies here." Coming from Minnesota she thinks it is crazy how no one can get even adequate treatment and cannot believe the situation.

? Coverage should be equal for everyone. Indians do have a break in that they have the IHS care system. Off the reservation it can be very difficult for anyone to get treatment.

C. Focus Group #7: Older Americans

Tuesday, October 2nd, 7-9 p.m.
Pierre, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	F	60's	Married with 4 kids away	Rancher's wife
2	F	65+	Married with 6 kids away	Probation officer and social worker
3	F	60's	Married with 5 kids	Field nurse with IHS
4	F	60's	Married with 8 kids away	Housekeeper
5	F	65+	Widow with 5 kids away	Retired, raising grandchildren
6	M	60's	Married with kids away	Private consultant/grant writer, raising brother's 7 children
7	F	70's	Widow, no kids	Retired from Indian learning center
8	F	70's	Married with 9 kids	Retired: worked PT at laundry and dry cleaning place
9	M	70's	Married to #8	Works part time for church
10	M	60's	Married to #1	Rancher/farmer
11	F	70's	Widow with 4 kids	Retired nurse
12	F	65+	Widow with 8 kids	Works in development
13	F	65+	Widow with 2 kids	Retired from working in elderly center
14	F	65+	Married with 8 kids	Works for GreenThumb
15	F	65+	Widow with 6 kids	Works for GreenThumb

B. Experience with Health Insurance

Most participants in this group have Medicare coverage in addition to enrollment on a reservation, which permits them to use IHS facilities. Many are not clear on how their bills get paid (what their insurance covers) and some have elaborate mechanisms that enable them to get the care they need without paying high costs. Those who purchase insurance on their own or through work complain about the high expense.

1. Covered. She has her own policy that she and her husband pay for. The policy is expensive and she cannot get another policy because she just got a new knee and no one else will take her with the pre-existing condition costs. They pay $499 a month with a $500 deductible.

2. Covered. She has Medicare and is covered through her job. She doesn't deal with Medicare that much because her insurance pays first. Cost is a major worry for her and she has "tons

of bills" as a result of inpatient visits and therapy. She turned her bills over to the IHS business accountant because Medicare was denying payment on them. He called the Medicare office for her and she explained the situation. She "took for granted that those bills were taken care of...but they keep coming...it scares me...the figures." The bills obviously aren't getting paid. She feels she did get better care because she had insurance. She said another woman in the hospital with her didn't have insurance and "got kicked out sooner and she was sicker."

About IHS contract services...."It is hard to get in the hospital

3. Not covered. She was covered until December last year through her work. They wanted her to pay an extra premium, so she dropped it because it "irked her." A new premium of $42, on top of the other premium, was added. All she has now is IHS; she lives on the reservation (Lower Brule).

4. Covered. She has Medicare with no supplemental policy.

5. Covered. She just got Medicare and is enrolled in Rosebud Reservation. She went to the hospital and the hospital refused to admit her. She was really hurt and the doctor said "I could get fired if I admit you." She does have the blue Medicare card and she showed that to him and they still wouldn't admit her. She has called Medicare and she can't figure it out (seems like an IHS contract facility issue). She tried to attain Mutual of Omaha coverage and they wouldn't take her because she is diabetic, yet they continue to solicit her.

"The CHIP

6. Not covered. He was always previously insured through jobs and he paid extra for his wife's coverage ($485 a month). "Insurance is really expensive and it gets hard when you don't have consistent income." Right now he and his wife are without insurance because they can't afford it. They can go get IHS if they really need to, but because they live in Pierre it isn't very convenient. Some of their grandchildren are on the CHIP program.

7. Is over 65 but doesn't think she has Medicare. She worked for 33 years and is not covered by her current job.

8. Covered. She has Medicare Parts A and B. She doesn't need much care because she is healthy. He (#9) needs more care.

"Insurance is really expensive and it gets hard when you

9. Covered. He has Medicare Parts A and B. He doesn't have coverage through work but they (#8 and #9) go to IHS because they live within the area. They then get referred out as needed. They just went to the doctor here in town, but he didn't know Medicare wouldn't pay for the visit and he ended up paying the bill. He discussed the IHS referral system, claiming that he is satisfied with his "system" of driving to one reservation for referrals and to another for prescription drugs. He drives hundreds of miles (round trip) to accomplish this but it works for him. (Seems like this process helps to avoid Medicare's co-payment and deductible requirements.)

10. Covered. Married to # 1.

11. Covered. She has Medicare. If she has to see a specialist, she sees IHS first and then gets a referral to a non-IHS facility. She hasn't had any trouble getting referrals.

12. Covered. She has Medicare Parts A and B and also Blue Cross supplemental. She pays for her own compressor (oxygen), but doesn't pay much out-of-pocket. She ends up with a $17 bill and IHS covers it.

13. Covered. She has Medicare Parts A and B and that works fine for her.

14. Covered. She has Medicare Part A.

15. Covered. She has Medicare Parts A and B but has to go through IHS for a referral. She also bought extra hospital insurance and has not used it yet. She isn't exactly sure how it works.

C. Barriers to Coverage

Cost is the main issue. However, a major underlying barrier to care is the fact that many of the participants live in remote areas with low access to care.

3. Cost of care is too high. She is not insured and has enjoyed good health. She worries that she will need care as she gets older. She isn't very comfortable with IHS and feels that they might not take care of what she needs.

4. Premiums are too high for Medicare supplemental. She checked out some coverage and found one that was $138 a month and didn't cover anything. It didn't cover drugs but took care of the rest of what Medicare didn't pay. That was still that is too much.

10. Doesn't have enough money to pay for insurance because it has gotten so expensive and keeps going up. When one gets sick, the rates just go up again. "We pay $700-$800/month for private insurance. You just run out of money." He just had a major heart attack and has no idea how much it will end up costing. They have to pay the first $5,000. The ambulance hauled him 24 miles and it was $168. He also got a $3,500 shot, treatment, and a $14,000 helicopter ride. He thinks lawsuits are a problem and that the drug market is a mess. For the most part, he thinks doctors are trying to do their best and recognizes that they are trying to make a living and have taken an oath.

"We pay $700-$800/month for . . .

11. Medicare and IHS didn't pay for the alternative medical practitioner [doctor?] that she was seeing.

12. She is worried about medical bills. She had congestive heart failure and it cost her $2,000 for care. Medicare paid for some of it and IHS paid the rest. Medicare does pay for her medicine (oxygen, pills for oxygen) and IHS pays for other drugs.

13. Takes herself to the hospital when she needs care. She has a doctor she likes and isn't worried about costs.

14. She knows people who get sick and the ambulance won't take them in. It is hard to get to hospital on one's own (unless you own your own vehicle).

15. No one will come to get her if she gets sick. An IHS referral is needed otherwise you must pay for care yourself. You must wait for your care provider to refer you, which could take days.

D. Consequences of no Health Insurance

As many of these focus group participants are not covered beyond IHS, they must shuttle around to get the care they need. The health care bureaucracy was described as incomprehensibly complex, not only between the IHS and the White world, but also from one tribe/categorization to another. Yet despite these complexities, they say that they wouldn't get care without IHS because they cannot afford other options. Some just go without care and drugs because they cannot afford them.

5. She shuttles all around to the reservation to get treatment and has long waits to get drugs. She calls it a "bureaucratic mess" in terms of where you are enrolled, etc. She is called an Urban Indian and gets treated "last in line" (behind those who live on a reservation). She is still getting unpaid bills for husband who died a year ago. IHS picked up some bills but they have left her with some, including the bill for $750 to transport him a block and a half. Her neighbor had the same problem ($450 for a block and a half of transportation).

6. He takes care of his grandchildren before anything. "But I don't tell my doctor, too embarrassing to tell him you don't have enough money." Costs skyrocket every year and it worries him. Ambulance service in the area is controversial. County commissioner sets rates and it seem outrageous.

> "I get a prescription from a doctor and just don't go fill it because it is too expensive. When you are

7. She is worried about high bills if something serious happens and she can't get to IHS.

8. Never goes to the doctor. She doesn't even go for mammograms or pap smears. Nothing.

9. He goes to a clinic where he gets drugs cheaper (Fort Thompson, IHS hospital). Still he ends up paying several hundred dollars in drugs (said Ft. Thompson doesn't pay bills if person enrolled in Rosebud). He is worried about getting very sick and getting the necessary care. Some people can't even get down there.

10. You just can't afford to avoid the doctor or ignore your bills because then they come after you. The cost of living is escalating.

11. Thinks alternative doctors are the answer.

> *"I worry about paying medical bills. The income isn't there and you can't get water out of a dried cactus."*

14. She often to IHS for high blood pressure. She would have to go without [the medicine] if she had to pay for it.

15. There is no way she could pay for it (drugs and doctor visit at IHS), if she had to.

E. Willingness to Pay

Responses ranged from $0-200/month. Some of these participants have no monthly income.

1. A couple hundred dollars would be cheap compared to what they are paying now.
2. $150/month.
3. Had paid around $450 through a job but really couldn't afford it.
4. $150/ month.
5. After bills (rent, cable, telephone), she has $44 a month to live off of.
6. Couple of hundred dollars. He spoke about nationalized medicine and the benefits of it. "Why can't we do that?"
7. $200/month.
8. Same as #9.
9. Would pay a couple hundred dollars/month although he is happy with his current system.
10. Same as #1.
11. Would pay whatever they asked if she actually got everything she needed.
12. Can't pay anything. Lives one check to another.
13. Can't pay anything.
14. Is broke shortly after payday because of bills. That is all she can afford in her life.
15. Is barely making it payday to payday. She can't imagine paying anything because she can barely afford to live.

F. Government Sponsored Health Insurance

This is covered in the other sections. Most participants have Medicare and one has had experience with CHIP.

G. Public Preferences

This group didn't identify one party who they think bears the responsibility for expanding health coverage. The dominant idea was for everyone (implying government, insurance companies, tribes, hospitals, and drug companies) to get together and figure something out. Some floated the idea of socialized health care, but it wasn't too popular.

1. It is our own responsibility if we can afford it. The cost of everything should be kept under control: drugs, doctors, and hospitals.

2. Likes # 3's idea and wants to see better care for everyone, especially those off the reservation.

3. Thinks it is her responsibility. Also thinks that IHS owes Native Americans health care. Not just for certain things, illnesses, but for all things. Doesn't think that it should be reserved to

the facilities on the reservations. Native Americans should get free healthcare everywhere. Wants government to give everyone health insurance cards.

6. Bring the costs of health insurance under control. Costs for employers are increasing too. As a result, more employers are offering less coverage because they can't afford it either. It is really a big problem when you are locked into a company [meaning that due to a pre-existing condition you can't switch to another company] and you can't see a ceiling to it. They are living payday to payday here and it is scary.

9. Wants to be able to stay here for service. He goes all over the place for referrals but he isn't paying thousands of dollars.

10. Thinks some of the responsibility falls on younger people of the nation; if the older folks can't afford it, someone needs to help them. It is out of balance that people should make so little and insurance should be so expensive. If they are making less than $15,000 a year, they cannot afford health insurance. Thinks corporations are the problem (in addition to lawyers).

11. Get everyone together and see if they can work something out, for everyone. They need to cut down on the wasted time and money.

12. Same as 13 and 14. Wants a card that makes it all unified and accessible for Native Americans.

"We need the power of everyone to solve this

13. Wants affordable health insurance.

14. Wants cheap health insurance.

15. All in all, this is terrible. If you have money, you can do anything. Because we don't have it, the situation "makes it bad for us."

H. Other

There was much discussion about the value of alternative medicine.

1. Alternative medical providers treat aches and pains, headaches, toothaches, etc. She doesn't know what they would do about diabetes.

6. Alternative medicine has worked for treating cancer. A lot of teas are made from plants and roots.

10. We have gotten so far away from nature that our foods could knock us out. Wants to get back to good, natural food.

11. Alternative doctors use different plants. Alternative treatments work for high blood pressure and infections.

14. Most of us used to live out in the country where everything was homemade. The processed foods give everyone diabetes. She believes that they are alive because of the past way of life.

She tries to tell younger kids what is good for them: The "fancy foods" give everyone diabetes.

One final discussion involved the difficulty that persons 55-65 years face in getting insurance.

? The insurance companies really take advantage of people between 55 and 65. They keep raising premiums over and over and it just isn't right. She thinks that is the main problem is for those between 55 and 65 who are trying to get covered on their own and not through a job. This is even more important because older persons need and use a lot of health care.

D. Focus Group #8: Small Business Employers & Employees

Wednesday, October 3rd, 7-9 p.m.
Aberdeen, South Dakota

A. Grid of Demographic Characteristics

Participant Number	Sex	Age	# in HH	Working situation
1	M	50's	Married with 2 kids	Owns a business
2	M	40's	Married with 5 kids	Film maker and contractor
3	M	40's	Married with 6 kids	Small industrial business owner
4	M	50's	Married with 2 kids	Runs 3 businesses
5	M	50's	Single	Works in sales
6	F	50's	Married with 0 kids	Investment broker (owns office)
7	F	40's	Married with 2 kids	Manager at natural food store
8	F	40's	Married with 5 kids	PT secretary and owns 2 businesses
9	M	40's	Single with 2 kids	Owns a business

B. Experience with Health Insurance

Everyone in this group has had experience with job-based health coverage and many provide it for their employees. Everyone talked about the increasing cost of health care insurance and their personal debates as to whether it is worth it or not. From their discussion, it is clear that having a family greatly influences that decision.

1. Not covered. He hasn't had health insurance for 8 years. He was paying $600 ever six months, with a $5,000 deductible. He felt it just wasn't worth it for how often they go to the doctor**.** "The hell with it, I just ain't paying it." He thinks you get medical services for less when you don't have insurance. "You tell them you aren't covered and they drop the price." He just visited Sweden and loved their health care system.

2. Covered. Company covers half the cost of employees and children, which works out to $60-$70/month per employee. Knows that DAKOTACARE negotiates certain prices with providers. He always felt that if he pays cash for care he should get those rates as well.

3. Covered. Has 15 persons in families working for him and he pays $72,000/year to cover them. Employees don't pay anything for the premium. He changes insurance companies every year to achieve new discounts for his workers. They are a big enough group that they can change plans frequently. When they were smaller they were rated individually, which caused problems. The fact that the average age of the group is getting higher sends the premium up. It is a constant battle and he spends three months of every year dealing with health insurance issues. For the last five years premiums have gone up 10-15% annually.

4. Covered. He has insurance, but it is expensive and costs several hundred dollars a month. He is looking into changing it and is tempted to change every two years. It seems that the cost goes up every year. He knows his deductible is high (over $5,000), but he hasn't been sick a day in his life and doesn't believe the cost is worth it. If he were single he wouldn't have insurance; it is only because of his family he gets it. He doesn't trust insurance companies. His brother's wife had a baby and the bills were huge. There were a lot of services listed on there that she didn't get and the hospital said it didn't matter, they were getting $800 dollars (from the insurance company), no matter what.

5. Not covered. Hasn't been covered for as long as he can remember.

6. Not covered, but husband is.

7. Covered. Has health insurance through husband's work. Her employer pays $200 and they pay the balance of approximately $200/month with a $1,000 deductible. She knows of a company in town that will cover employees or give them $50 a month. If you want your family covered you pay the difference (between $50 and the cost of insurance). She agrees that providers charge less if you don't have insurance. A friend of hers had baby at the same time as another family—same day, doctor, and hospital—and one cost three times the other. The uninsured family paid $600 for their services and the other family's insurance company paid three times that.

8. Covered. She has family insurance through her husband's job. They don't pay much for it. The deductible is $500 for the first three members, $1,500 max. Was pregnant before they were on the plan and insurance covered everything except for the deductible and co-pay. The coverage and treatment were great even though there were complications. Value of health insurance in terms of cost of services used is high on their family's budget.

9. Not covered. He wants to have health insurance but doesn't know how he can get it for a low cost. His children are covered through their mother who works in a hospital as a nurse. He hasn't had insurance for 6-7 months and has never had health problems.

C. Barriers to Coverage

Rising costs and riders that prevent coverage of certain diseases, thereby adding significant cost to the price of their policies, are major problems. Bureaucratic hassles in dealing with insurance companies were also noted, but seemingly uncontrolled rising health care costs were the overriding concern.

1. Cost of coverage. He had a hard time trying to get coverage. He would have had to get a physical, which would have cost at least $400 dollars because he hasn't been insured for years. If he didn't meet the insurer's standards, he would be ineligible for coverage and he would have to pay the $400 dollars for nothing. He had a policy that wouldn't cover him on a motorcycle. Rising premiums are a major problem.

> "Health insurance is a runaway train. There is no end in sight to the

2. They switched companies several years ago and considered individual policies. Company put a rider on everything and wouldn't cover anything. "You try and play the game, shuffling around the costs." It is tough to get an HMO in the state because there is no competition. There are basically two insurance companies who influence all the hospitals (or clinics) in the state.

3. When you switch coverage you never get exactly the same thing as before although you try. Last year Wellmark went up 17%, but then they come back and try to woo you with lower costs. There are no cost controls on health insurance. His company knows that health insurance is a benefit for the employee that works out to be over $2 an hour in value. As an employer, he doesn't want a ridiculous deductible and he wants a low co-pay for the families. They can afford a 10% increase each year but even that isn't constant because it can go up more than that (his friend's went up 30% in one year). He sees that insurance companies are leaving from the group market and this worries him.

> "If the cost of living is going up 3%, why are insurance and health

4. One might not want to go through the hassle, medical examination etc. Insurance wouldn't cover him when racing stockcars or while at work at the fire department, although he was covered when at work. He doesn't use it [his policy] that often. The only reason he has it is for the possibility that he has a half a million-dollar bill. If it isn't tragic, he would just pay it out of pocket. Since he hasn't used it a lot for 20 years, he feels he shouldn't be paying that much in premiums.

5. Cost. If you have a few kids, you can't afford it. With a high deductible, you can come up with the money to pay your bill and/or hospitals will work with you. You need health insurance to prevent/protect against bankruptcy.

6. Thinks that the lack of competition in the area is a serious problem. She works in the mental health field and can testify that the quality of care is poor due to lack of competition. She knows that insurance companies are dropping out of South Dakota and knows of a situation where the woman is getting dropped and she has cancer. She thinks the middle class is disappearing because of these high medical costs.

> *"It is a balancing act to find something that works for everyone and still won't break the bank."*

7. She agrees that the quality of care is poor in parts of South Dakota and thinks there is a problem with the coverage of preventive medicine (mammogram and Pap smear).

8. She thinks there is a matter of trust with the insurance companies. The book (explaining her policy) is huge and it changes every year. It would take forever to go through it. You don't actually know what the companies will cover and what limitations are in place. The problem is that the premium is going up uncontrollably. Each medical visit costs a lot, especially with five kids each getting sick. The family has had lots of major bills. Paying that hospital bill is hard because the interest is so high. It seems unfair when you feel like you have suffered and then the bill just goes on forever.

> "*If you have anything that's worth anything, you need that health*

9. Thinks that the quality of care in town is horrible.

D. Consequences of no Health Insurance

The biggest concern for this group is the thought of losing everything in the event of a health disaster. Many state that they have health insurance for this very reason. They can't imagine losing everything they have worked hard for because of an illness.

1. He has never had a problem with no insurance because he hasn't been sick. His solution to having money for medications is taking double the number of pills if they are expired. (He even called the drug company to make sure that it is okay.)

3. His mother takes a pill that is $3.50/day. She is ready to go to Mexico twice a year to get her drugs because she believes she will save tons of money.

4. Has a friend who "beat the system." He has a huge hospital bill and was not insured; he pays a dollar every month. # 7 says that the hospital will put collection agency after you. #2 says that the county will go out and grab everything you have (liens on property).

7. You can lose a business over an ailment if you don't have that protection [health insurance]. There should be regulations over medical price increases, or at least explanations as to why it is happening. She is in the natural health business and thinks that folks shouldn't be so quick to run to the doctor, but rather look at what they can do on their own. She also thinks it is a problem that insurance companies won't acknowledge natural health care. She believes 95% of our health issues are nutrition related. When her children were young she would hold out as long as possible before going to the doctor. (She thought they would get sick just from being in the office). In her mind, companies are leaving the state because of the low population in South Dakota. (A property insurance agent told her that)

> "If you worked your whole life for something, it can all

8. She has a friend in town who works in the hospital. She gets insurance (from her job) yet pays $700/month for her husband's drugs. She has to work solely to pay for his medication. (He has diabetes.) Cancer is her biggest worry in terms of getting on-going care and paying for it.

9. He went to the hospital in the city and it wasn't a big deal. He thinks they billed him less because he is uninsured. He worries about his kids (is divorced) although the mother provides insurance through her job. He takes care of his body as best he can. He has a friend with an overdue medical bill and doctor says he won't see her until she pays the bill.

E. Willingness to Pay

Wasn't discussed in this session

F. Government Sponsored Health Insurance

No one in the group has significant personal experience with government programs and their opinions are divided between those who think positively about the programs and those who wouldn't want to accept help and "live that kind of lifestyle".

1. Has a friend in Seattle who isn't working because he is getting "tons of money" through disability.

2. He thinks government help is better in Minnesota. Believes that if you take advantage of all the programs you can in Minnesota, you would have the same standard of living as someone making $42,000. In South Dakota, it would be the equivalent of someone making $5,000.

4. He has neighbors who are receiving money from the government, but "they aren't living very well." He says that isn't the life for him and points out that you would have to choose to live your life that way (collecting support from the government).

G. Public Preferences

The predominant thought in this group is for the government to impose regulations on the insurance market and/or the hospitals, doctors, and drug companies. People weren't too enthusiastic about the concept of socialized medicine. They just want the market to be made more affordable.

1. Regulate increase of insurance.

2. His employees requested health insurance in place of a raise. If you have a large group, it works out. However, if you have a small group "you pay through the nose." He thinks everyone should get together into blocks of businesses, through whatever system, and then insurance would be affordable. Other suggestions are putting a cap on insurance increases and dealing with the issue that perhaps there is a charity situation in which the folks with insurance are compensating for those without.

3. The individual should be responsible as long as the insurance costs remain realistic. As an employer, he provides health insurance as a benefit. You keep your employees that way. "There are idiots who can't figure this out."

4. Regulate insurance companies to be similar in price. He wants equal rates and increases; they are out of hand.

5. The individual is responsible given the way society is set up now. The medical profession designed it that way and like it that way. He thinks the insurance business is already regulated to a degree and believes that price increases in the medial field are the problem. He suggests that the pharmaceutical companies are the ones driving up insurance costs.

"We have to be careful about bringing the government into our lives, but something has to be done about the medical and pharmaceutical industry."

6. She believes medications are essential and she can't understand why they cost so much more here.

7. Regulate pharmaceutical companies, doctors, and hospitals because it will then trickle down to the insurance market. She doesn't want to move toward socialized medicine.

8. Problem is with doctors. She doesn't think that patients should pay for the doctor's mistakes. (It doesn't work that way for other industries. "You need to make your mistakes right.") Believes doctors aren't held to that same degree of accountability. Doctors need to have a conscience.

9. Thinks the government should give physicians a needed conscience.

H. Other

? The population is aging, especially in South Dakota, and it adds to the problem of high health insurance costs.

? General consensus among group is that non-profit hospitals are causing problems. They buy other hospitals, destroying competition (except for surgery), and are "ripping off the community."

? "It's not fair, the whole system."

? She suggests that there should be reimbursement for all students to stay in the state. The state needs to keep its valued and future resource. Believes life is stacked against the middle class.

Attachment A
Focus Group Guide

South Dakota State Planning Grant Program
Identifying South Dakota's Uninsured and Designing Options for Health Coverage

Focus Group Discussion Guide for Uninsured Individuals

Focus Group Objective: Identify what factors influence individuals to purchase or otherwise obtain health insurance. Highlight personal consequences of living without health insurance. Discuss ways in which health insurance coverage could be expanded to those who are currently uninsured.

Introductions (15 minutes)

Moderator Introduction

Welcome, my name is _____ and I'd like to thank you for taking the time to share your opinions with me tonight. Tonight we will be talking about health insurance in South Dakota.

I'd like you all to feel comfortable. Has anyone ever participated in a focus group before? If you need to get up and get a drink, or use the restroom, please feel free to do so.

(The moderator will point out any recording devices and talk about why we are recording.)

- Everyone's participation is valuable. Feel free to say whatever you think.
  - I work for an *independent* research company; my job will not be influenced by anything that is said here tonight.
  - We need to hear everyone's honest opinions and it is important that I hear from everyone.
  - I may call on you or ask for your views specifically.
  - I may interrupt you to move the conversation on.
  - I am not trying to single anyone out, or cut anyone off; I am just doing my job.
- There are a couple of "rules" I'd like us to follow tonight: speak one at a time, and speak up; no side conversations; and the best answers are what is TRUE for YOU.
  - I want everyone to "agree to disagree." Tonight we will welcome all different points of view. There are no right or wrong answers.
  - I just ask that we not have more than one person away from the table at a time.

General Introduction

- Let's start the evening by going around the table and introducing ourselves. (*Moderators go first)* I'd like each of you to tell us 5 things: your first name, your current occupation, your family situation and what you like to do in your spare time.

? I'd like to now ask you more about problems or issues that you or others might face getting health insurance or health care.

Demographic Grid

	Sex	Age	# in HH	Working	Occupation	Income
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

For Native Americans

[Ask each respondent]

? Do you live in town or on a reservation?

? Are you enrolled on a reservation?

? Do you qualify to receive medical care through the Indian Health Services?

? Do you think of IHS as medical insurance? Why or Why not?

? What medical services you might need are NOT provided by the IHS?

Health Insurance Coverage for Adults (40 minutes)

[Ask each respondent]

A. Coverage by Employer

1. Do you currently have health insurance coverage, such as coverage you get through a job, or through the government, or that you purchase on your own?

2. Have you ever had health insurance? What happened that you no longer have health insurance?

3. Are you currently self-employed, employed by someone else or unemployed?

4. For those of you who work for a company, does your employer offer any type of health coverage for its employees? Are you eligible for that coverage now? (Probe: Why not eligible for coverage through employer?)

5. If you are eligible for employer-sponsored health insurance, why do you not sign up for it?

B. Barriers

6. What are some of the reasons that you, and others you may know, might not buy health insurance on your own or sign up for coverage? (Probe: healthy or not, expensive, can get care anyway, etc.)

7. What concerns you most about the cost of health insurance? (Probe: monthly premium, deductible, co-payments.)

8. Do other members of your household have health insurance? If so, how (through work, government, or individual policy)?

9. What difficulties does your household experience if some members have coverage and others don't?

C. Consequences of No Insurance

10. If you got sick or needed medical care, where would you likely go for care?

11. Who would pay the bill for that care? (Probe)

12. Since you've been uninsured, has it been difficult or easy for you to get medical care if you needed it? (Probe: for examples how it may be difficult)

13. What most worries you and your friends and family about not having health insurance? (Probe)

D. Willingness to Pay

14. How much, if anything, would you be willing to pay each month out of your own pocket for a health plan that provides basic coverage for doctor visits, hospitalization and prescription drugs?

15. What is the one thing that could change in your life that would make you go out and want to get health insurance?

The Government and Health Insurance (15 minutes)

1. Have you ever been enrolled in a public health insurance program? If so, what happened so that you are now not on the program?

2. Do you believe that you, or other members of your household, are eligible for public health insurance programs? If so, have you signed up? What is keeping you from signing up?

Summary (20 minutes)

In this section, the moderator will recap the items discussed and things learned in the discussion. Respondents will be asked to recap their main points.

- Are there any other comments that you would like to make at this point?

- Is there anything that we missed? Please explain.

There is one last thing I'd like to do tonight before you collect your stipends and go home. I'd like to go around the table and have each of you tell me two things:

1. Who do you think should be responsible for providing health insurance coverage? Individuals? Employers? The Government? Other?

2. What would be your recommendation to increase health insurance coverage of individuals throughout the state?

(Thanks, provide instructions on stipends, and close.)

Attachment B

Personal Stories of the Uninsured from Focus Groups (Fall 2001)

South Dakota State Planning Grant Program
Personal Stories of the Uninsured from Focus Groups (Fall 2001)

Lower-Income Worker

Worker is a single woman in her twenties living in Sioux Falls. She lives with her boyfriend and is pregnant. She works at a chain restaurant where she makes $6.50 an hour. She does not get health insurance through her job as the restaurant provides health insurance only for the managers. She has repeatedly spoken to the owner about this injustice. Since she is currently pregnant, she has Medicaid coverage. Several years ago, when she as 19 years old and uninsured, she got very sick. Although she was able to get the medical care she needed, she did not have the money to pay for her care. She currently owes the hospital $15,000 and pays $10 every month. She said, "it is really depressing to wake up every day to those bills and know it is from being sick." She wishes that government and employers would assume some of the responsibility for providing health insurance, although she recognizes "it is the responsibility of the individual, as well." She doesn't want to be on Medicaid or "take money from the government" but she needs coverage for herself and her future baby.

Small Business Employer

Employer is a married woman in her thirties living in Sioux Falls. She has five children and owns a carryout and delivery restaurant. She is currently covered under her husband's health insurance policy but it expires in four days (from the time the focus group was held). As a business owner, she has investigated health insurance options quite thoroughly for her employees. She has considered offering limited benefits, such as covering full time employees only under certain circumstances. She's also explored the option where employees would pay a diminishing percentage of the premium the longer they stayed with the business; however, that option was unacceptable to the employees. She has found that with a small business, it is very expensive to cover a number of employees less than six. (In South Dakota, one only needs four people for a group policy, but it is impossible to afford. She was quoted a rate of $200/month for an individual (with a $500 deductible and no dental). She believes that because a small business (especially a restaurant) is such a small risk pool, it is even more expensive than other group policies. She asserted that America's health insurance system discourages entrepreneurs and small business owners. On a personal note, when she has been uninsured, she has always received the care she needed, although she "always gets billed unbelievable amounts." She understands she gets charged more than those who have health insurance because insurance companies have struck "deals" with the hospital. Her personal approach is to find out what the insurance companies pay for medical care and demand providers that she pays that same rate. "It seems to work." She would be willing to pay $100/month in health premiums to cover herself. She believes the state needs some improved regulatory force to make the health insurance system "fairer."

Another employer is a married man in his forties living in Aberdeen. He has six children and is the owner of a small agricultural business. He has fifteen employees working for him and pays $72,000/year to cover them, their dependents, and his own family. His employees aren't charged any part of the premium. He wants his employees to have health coverage. His strategy for containing his costs is to change insurance companies every year to get the best quote. They

never get exactly the same coverage (year to year) although they always aim for it to be comprehensive. For the last five years their premiums have gone up 10%-15%. His biggest complaint is that there are no cost controls in place for premium increases. He calculates that the company can afford a 10% increase in rates every year, however the insurance companies often go for more than that. He cannot understand why the cost of living increases 3% and the insurance companies raise rates by 17%. As an employer, he understands that offering health insurance is a major benefit for his employees that is the equivalent to $2/hour. He believes that this benefit helps him keep his employees. He does believe that the individual is responsible for covering himself as long as costs remain realistic.

The third employer is a married man in his fifties living in Aberdeen. He has two children and owns his own business. He has no health coverage now nor has he for the past eight years. At that time, he was paying $600/six months with a $5,000 deductible for his health insurance. He decided that it just was not worth it given how often his family saw the doctor. He also thinks that you pay less for medical services when you don't have insurance. He claims that if you tell providers that you aren't covered and they drop the price. The biggest deterrent to having health insurance is the cost. For example, he thought about getting covered again but would have had to get a physical for the insurance company. That would have cost $400 and if he did not then meet their standards that would have been $400 wasted. He rarely gets sick and has had relatively no trouble getting care. When he gets sick, he takes old prescriptions that he has not used up. "Since the pills are so old I just take double." He would prefer to have some state regulations in place to control the increasing price of health insurance.

Farmer/Rancher

Farmer/Rancher #1 is a married woman in her forties living near Yankton. She has two children and is a farmer. She has not had health insurance for the past twelve years. After she quit her job to work on the farm, she lost her insurance. Money is the primary issue for her family. She simply cannot afford a premium of $400/month with a $1,200 deductible for the entire family. Another issue is the fluctuation of farm income from month to month; some months there is no income, but still health insurance premiums must be paid. She has no idea where she would go to get care if it were needed. She has not been to the doctor in sixteen years. She once took her children to the courthouse for inexpensive immunizations but "thankfully they haven't needed to see a doctor." No one in her family has visited a dentist in years.

Farmer/Rancher #2 is a married man in his thirties living near Winner. He has two children and works as a ranch-hand in addition to owning his own land. The children are covered by Medicaid. As both he and his wife are overweight, no health insurance company will accept them for coverage at a price that is affordable. His wife had to get Medicaid coverage while she was pregnant. He talked to his employer about getting health insurance through work, but it hasn't been feasible. The rancher employs a few people and can't afford a small group policy. His wife now drives a school bus but doesn't qualify for school district health insurance because she works part time. When he needs health care he simply doesn't go. He is afraid "they will take his land" if he can't pay his medical bill. He also had an experience where he was injured while he was working and should have been covered by the farm owner's insurance policy but the farmer didn't want to file a claim because it would have raised his premiums. He suggested that we "go back to the barter system" where a person could give his/her doctor some eggs and a

cow in exchange for treatment. (His cousin does that where his cousin's doctor hunts on his land in exchange for prescribed medicine.)

Older Americans

Older Americans #1 and #2 are married and in their early 60's living near Pierre and they are ranchers. Their children are grown. They purchase their own individual health insurance policy which costs $499/month with a $500 deductible. Older American #1 has a new knee and she believes no other insurance company will accept her with this condition. The couple is "stuck" with this plan until they turn 65 and have Medicare coverage. They both believe the system is "a mess", especially given that when you get sick your health insurance rates go up even more than usual. Older American #2 just had a major heart attack and had to be transported by helicopter to Minnesota. They have no idea what it will end up costing them. He claims that, especially as a rancher, the money isn't there for unforeseen health expenses. Older American #1 believes that the insurance companies can take advantage of the 55 to 65 population because often those people want to retire early; yet they cannot sacrifice coverage (due to failing health) and the insurance company is at liberty to raise premiums every year at ridiculous rates. They both believe that it is the responsibility of individuals to provide health insurance for themselves; however, they believe that government should help make medical costs more affordable.

Native American

Native American #1 is a single woman in her forties living in Rapid City. She has four children and teaches in an alternative school. She is Native American and is enrolled on a nearby reservation although she doesn't live on it. She has access to the Indian Health Service (IHS) facilities on the reservation and to an IHS hospital (Sioux San) in Rapid City. She does not have health insurance through her job. While her job offers a plan, premiums would cost $182/month for an individual. Considering her whole family's needs, this price is too high. She thinks that the monthly premium is the biggest deterrent to health insurance. She hates to pay it when she doesn't know if she or a member of her family is going to be sick. However, she also does not like feeling unprepared if something adverse happens. She is willing to pay $100/month for a comprehensive plan although she also likes the idea of basing it on income. She has had some experience with Medicaid (her children) and it was a negative experience in terms of limited access and choice. She always thought that IHS was going to be there and believes "they are chipping away at it." One criticism of IHS is that contract services won't pay unless it is life or death, which isn't always obvious. IHS treats symptoms instead of finding out what is wrong. She also thinks there is a problem in not having a consistent family doctor. She sees some value in maintaining a culturally based system. She likes that when she goes to Sioux San for care she feels valued as a person. She thinks the federal and state governments should have a role in making the healthcare system better but also likes the idea of the tribe taking responsibility, as she wants to stay together as a community. She emphasizes the importance of preventive medicine, especially in Indian communities where they confront serious environmental and genetic health issues. She mentions the stress due to poverty, racism, and exploitation that Indians constantly deal with on the reservation and especially if they try and move away from it and improve themselves.

Native American #2 is a married man in his twenties living in Eagle Butte. He has five children and is currently unemployed. His children have Medicaid coverage so they go off the reservation and get correct diagnoses and better treatment than through IHS. When he was working, he was offered insurance after a time. After he quit he could have continued coverage but he declined. As he is unemployed he couldn't afford more than $20/month in health premiums. If he had a job and the plan covered everything he would pay $40-$50/month. While he is thankful his children have Medicaid, he believes the state bureaucracy is a problem. (For example, his son had to go to the emergency room on a Sunday, but his PCP could not be reached, hence he got stuck with the bill.) If he could find insurance and afford it, he would sign up "in a second." He wishes he did not need to depend on the IHS because "they are incompetent;" because he cannot afford anything else for himself, he must go there. He also raised the issue of health care access in their remote area. Regardless of whether one has insurance coverage, it takes "forever" to get an ambulance or a flight to Minnesota if necessary. In general, he thinks that health insurance is an individual's responsibility. However, employers should encourage it through education about the benefits of coverage. Given the situation in Eagle Butte, he likes the idea of a group policy to be made available through the Sioux tribe then the unemployed would have a chance to participate too.

Native American #3 is a married man in his forties living in Eagle Butte. He has five children and works in construction. He had health insurance through past jobs but, now that he is self-employed, he does not purchase it for himself. He could have kept Blue Cross/Blue Shield through his past job, for some period, but he thought he would not need it. "I assumed that whatever came up would be taken care of by IHS." He says that the main impediment to health coverage is "they just don't make enough money on the reservation. It is too much money to pay out every month if you can already get some kind of treatment for free (IHS)." The only situation where someone would get additional health insurance is if his or her employer offered it, although that is rare on the Cheyenne Reservation. He also thinks that people will not pay the necessary premium, given the chance that they might not ever need the coverage. "Why waste the money?" Despite all this, he believes that IHS is terrible and that "they would let you bleed to death." He claims that the doctors are inexperienced. He also points out that given the access issue in the area, insurance matters very little. "If you can't get off the reservation [in case of emergency] it doesn't matter if you have insurance."

Appendix E:
Methods and Approach for Employer Survey and Focus Groups

APPENDIX E: METHODS AND APPROACH FOR EMPLOYER SURVEY AND FOCUS GROUP

The SPG team's approach to data collection was to begin by reviewing available secondary data concerning employment characteristics in South Dakota. Lewin reviewed other national surveys with questions about employment-based health insurance (such as the Robert Wood Johnson Survey of Employers) and the employer survey designed for the State of Iowa as part of its SPG program. The advantage of this approach was that the validity of many survey questions had been established, and questions used were generally recognized by policy experts as those that best capture the marketplace dynamics influencing the availability of employment-based coverage.

The questionnaire was designed by The Lewin Group, in consultation with Baselice & Associates, Inc. of Austin, Texas (who conducted the telephone survey), and the South Dakota Interagency Work Group staff. South Dakota Interagency Work Group staff provided valuable design input and approved the questionnaire prior to its use. As in the Survey of the Uninsured, the questionnaire used in the Private Employer Survey evolved into a tool uniquely suited for the purposes of the South Dakota SPG program.

The sample frame was intended to be broadly representative of all private businesses in South Dakota. All private businesses (non-government) in South Dakota with two or more employees were included in the universe from which to draw the sample of potential survey participants. Self-employed persons or firms with only one employee were not included in the sample. The sample of employers, recruited for up to 20-minute telephone interviews, was based on a random selection of one-tenth of the entire South Dakota Business Directory File. The sample of 6,197 business records was segmented into zip code regions (n=3) to ensure regional proportionality. The sample file was segmented even further by SIC code to ensure different businesses were represented. As an estimated 53 percent of private establishments offered health insurance in the United States in 1996[59], it was also important to assure that a similar proportionality of firms that offer and do not offer health insurance was achieved in survey participants. The number of completed interviews totaled 401 (with 222 firms offering and 179 firms not offering health insurance)[60].

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[59] 1996 Medical Expenditure Panel Survey – Insurance Component Sponsored by the Agency for Health Care Policy and Research.

[60] For every one completed telephone interview, there were .69 refusals and .29 mid-interview terminations. Overall, 5,795 dials were initiated (13.14 dials for completed interview). Although 444 interviews were completed, 43 cases were removed from the data files because they were self-employed respondents.

Appendix F:
South Dakota Survey of Private Employers - Questionnaire

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South Dakota Survey of Private Employers - Questionnaire

1. How would you categorize the kind of work your company does?

2. Including yourself, about how many total people are employed in your company at all of its combined locations?

3. Of this total, how many people are employed by your company in South Dakota?

4. Of the employees in this company...

   ? How many earn less than $10,000 per year?
   ? How many earn at least 10,000 but less than $20,000 per year?
   ? How many earn at least $20,000 but less than $40,000 per year?
   ? How many earn at least $40,000 but less than $100,000 per year?
   ? How many earn $100,000 or more per year?

5. Are the majority of your employees.....
   Of the remaining employees what category makes up the next largest group?

   ? College Graduates
   ? Skilled Laborers
   1. Manual Laborers
   ? Service and Clerical
   2. Other Workers

6. Does your company offer health insurance to your employees?

   ? Yes
   ? No
   ? Unsure
   ? Refused

7. Does your company offer health insurance to company retirees?

   ? Yes
   ? No
   ? Unsure
   ? Refused

EMPLOYERS CURRENTLY OFFERING EMPLOYEE HEALTH INSURANCE

8. Are you self-insured, such as the company bears full financial responsibility for benefits, or are you fully insured by the carrier?

   ? Self-insured
   ? Fully insured by the carrier
   ? Partially self-funded with stop loss
   ? Other
   ? Unsure
   ? Refused

9. On average, about what percentage of the insurance premium for worker coverage is paid by your company?

10. About what percentage of the insurance premium for dependent coverage, such as spouses and children, is paid by your company?

11. What percentage of your full-time employees are eligible for health benefits?

12. Are any of the following groups excluded from the health coverage your company offers?

- ? Part-time workers
- ? Seasonal workers
- ? Other temporary workers
- ? Non-management workers

13. For each of the following items I read, please tell me if it is a reason for not offering health insurance coverage to part-time, seasonal, temporary or other workers your company might have.

- ? Coverage is too expensive
- ? Coverage isn't needed to attract or retain workers
- ? Employees didn't want health insurance
- ? Employees are covered elsewhere
- ? Employees didn't like benefit options
- ? Employees don't want to contribute money for premiums
- ? Coverage includes too much administrative hassles and paperwork requirements
- ? Workers are eligible for public coverage such as Medicaid or Medicare
- ? Free clinics and hospitals are available
- ? Company isn't required to do so

14. How many of the eligible employees currently in your company have declined health coverage?

15. What is the main reason your employees decline coverage?

- ? Covered by spouse's plan
- ? Covered from some other source
- ? Too expensive/price
- ? Plan does not meet needs
- ? Employees are rarely sick
- ? Too much hassle
- ? Took cash instead of benefits
- ? Do not want or need it
- ? Other reasons (Specify)
- ? Unsure
- ? Refused

16. Do employees have the option to take cash or additional pay instead of health benefits?

- ? Yes
- ? No
- ? Unsure
- ? Refused

17. How many of your employees take cash or additional pay instead of health benefits?

18. How many health plans offered by your company do workers have to choose from?

19. Does your company offer...

- ? An HMO Plan
- ? A PPO Plan
- ? A traditional fee for service or indemnity plan

20. Does your company offer prescription drug benefits either as part of its health plan or as a separate benefit?

? Yes
? No
? Unsure
? Refused

21. Are there any employees currently in your company who are excluded because of particular health problems or pre-existing conditions?

? Yes
? No
? Unsure
? Refused

22. For each of the following items I read, please tell me if it is a reason why you ***offer*** health insurance benefits to your employees.

? To comply with union bargaining agreement
? To attract or retain workers
? To boost employee morale
? To increase employee productivity
? To increase employee tenure
? To ensure employees remain healthy
? To take advantage of tax benefits
? To be a good corporate citizen
? To cover the business owner and his/her family
? Employees want or expect it

23. Of all the reasons I just read, which one was most important to you as an employer?

? To comply with union bargaining agreement
? To attract or retain workers
? To boost employee morale
? To increase employee productivity
? To increase employee tenure
? To ensure employees remain healthy
? To take advantage of tax benefits
? To be a good corporate citizen
? To cover the business owner and his/her family
? Employees want or expect it
? Other Reasons
? Unsure
? Refused

24. Over the next year, do you expect the premiums your company pays for health insurance to...

? Decrease
? Not change
? Increase a little
? Increase moderately
? Increase a lot
? Unsure
? Refused

25. Please tell me if your company expects to do any of the following if a premium increase occurs.

- ? Reduce health benefits offered
- ? Discontinue health benefits totally
- ? Increase employee share of total cost of premiums
- ? Increase out-of-pocket co-payments for employees
- ? Reduce annual increases in wages, or reduce wages outright
- ? Raise prices of goods and services sold
- ? Reduce company profits or make budget cuts elsewhere
- ? Substitute part-time for full-time workers

Now I would like to read you some statements about health insurance. For each item I read, please tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with that statement.

26. Health insurance costs are high because some employers do not offer health coverage.

27. State funds should be used to help employers of lower-wage workers afford coverage.

28a. Employers should be **responsible** for providing coverage for their employees.

28b. Employers should be **required by law** to provide coverage for their employees.

29. Individuals should be required to provide coverage for themselves and their families.

28. Employers should be responsible for at least <u>offering</u> coverage to their employees, even if the employer contributes little or nothing toward paying premiums.

EMPLOYERS CURRENTLY NOT OFFERING HEALTH COVERAGE

29. In your own words, what is the major reason your company does not offer health insurance coverage?

32. Regardless of your last response -- For each of the following items I read, please tell me if it is a reason why your company ***<u>does not offer</u>*** coverage.

- ? Company has an employee or employees with medical conditions
- ? Coverage isn't needed to attract workers
- ? Employees are covered elsewhere
- ? Employees say they do not want it
- ? Employees didn't like available plan options
- ? Employees don't want to contribute to the premium costs
- ? Company can't find plan that meets employees' needs
- ? Company has concern over maintaining coverage if rates increase later on
- ? Coverage includes too much administrative hassles and paperwork requirements
- ? Workers are eligible for public coverage such as Medicaid or Medicare
- ? Free clinics and hospitals, and the Indian Health Service, are available
- ? Coverage is too expensive for this company to afford

33. Did your company offer health insurance at any time in the past five years and then decide to drop it as a benefit?

? Yes ? Unsure
? No ? Refused

34. Which of the following is the main reason your company dropped coverage as a benefit?

Which is the next reason your company didn't do so?

? Our application was denied ? Not needed / not wanted
? Some workers were excluded ? Covered elsewhere
? The plan did not meet our needs ? Other reasons (specify)
? The premiums were too high ? Unsure
? Not enough employees ? Refused

35. Has your company ever considered offering insurance coverage for your workers?

? Yes ? Unsure
? No ? Refused

36. Although you considered offering insurance coverage at one time, which of the following is the main reason your company did not do so? Which is the next reason your company didn't do so?

? Our application was denied ? Not needed / not wanted
? Some workers were excluded ? Covered elsewhere
? The plan did not meet our needs ? Other reasons (specify)
? The premiums were too high ? Unsure
? Not enough employees ? Refused

Now I would like to read you some statements about health insurance information you may have received at your company. For each item I read, please tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with that statement.

37. The information was made clear to me.

38. I found the information objective.

39. I could tell whether I was being offered a good deal or a bad deal.

40. I was able to compare the information with information from other sources.

41. For each of the following items I read, please tell me if that statement has ever applied to any of your employees while working for your company.

? One or more employees have been unable to get the health care they needed because they were uninsured.
? One or more employees have been faced with large out-of-pocket medical health expenses.
? One or more employees have left my company to take a job that offered health

insurance benefits.

42. In general, would your uninsured employees be willing to accept reduced pay raises, or forego their next pay raise, in exchange for your company obtaining health insurance for them?

? Yes
? No
? Depends (on amount we, the employer covered
? Unsure
? Refused

43. Companies sometimes provide health benefits in other ways. Please indicate if any of the following benefits are provided by your company:

? The company pays employees' medical bills directly.
? A contribution to the cost of coverage is provided when an employee is covered by a spouse.
? The company employs a nurse or doctor who provides care on site.

44. How many of your employees do not have insurance of any kind?

45. How many of your remaining employees have coverage from...

? A spouse's employee plan
? Retiree Health Plan
? Medicare
? Medicaid or Children's health insurance program
? Indian Health Services

46. Do you anticipate changing your employee benefits to include health coverage in the next five years?

? Yes
? No
? Unsure
? Refused

47. Which one of the following is the main reason you will do so?

? Our business is doing well enough to afford it
? Workers getting older
? Workers needing or wanting health coverage
? Increased competition for labor
? Adding staff or an outside person or firm to administer plan
? Unsure
? Refused

Please tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with each of the following statements.

48. I would be more likely to offer coverage if the costs weren't so high.

49. I would be more likely to offer coverage if I weren't so concerned about unpredictable price increases each year.

50. I would be more likely to offer coverage if it didn't involve so much time and paperwork.

51. I would be more likely to offer coverage if I could obtain comparisons of health plans and premiums from an objective third party.

52. How much would your company be willing to contribute per employee each month toward coverage?

? Under $50
? $50 to $99
? $100 to $149
? $150 to $199
? 200 or more
? Nothing
? Unsure
? Refused

53. Would you be interested in participating in an insurance program for your employees if it was subsidized by the state or the federal government?

? Yes
? No
? Depends on amount subsidized
? Unsure
? Refused

54. Which one of the following best describes why you would hesitate to participate in such an insurance program?

? The administrative burden
? The stigma of, or not wanting to get involved with, the government
? Not wanting to get involved in health care
? Depends on the amount subsidized
? Not knowing amount of subsidy
? Concerns other than subsidy
? Unsure
? Refused

55. Are any of the following other concerns you have about offering coverage?

? Unfamiliar with the process
? Do not want to take the time to set up and manage an insurance plan
? Do not know who to call
? Cannot tell if we are getting a good deal

56. For each of the following items I read, please tell me if it would help you to offer coverage for your employees.

? Lower monthly premiums
? Stabilized premiums at renewal time
? Reduction of paperwork
? Government subsidized coverage
? Objective information and coverage options
? Integration of health insurance with other business insurance
? Unsure
? Refused

For each of the following items I read, please tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with that statement.

57. Health insurance costs are high because some employers do not offer health coverage.

58. State funds should be used to help employers of lower-wage workers afford coverage.

59. Employers should be **responsible** for providing coverage for their employees.

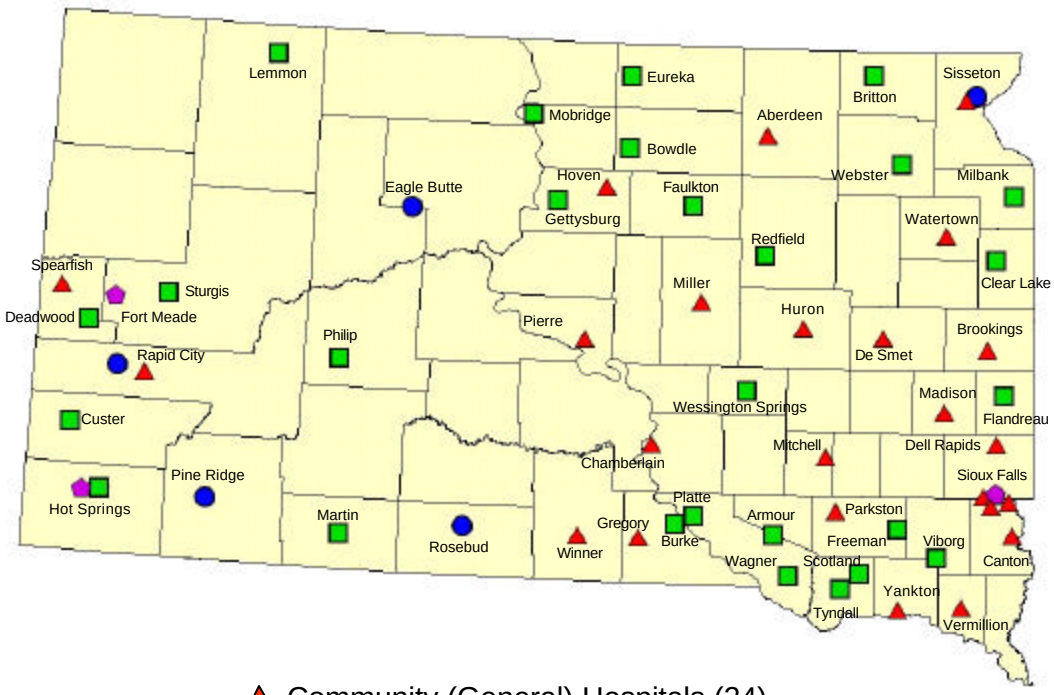
60. Employers should be **required by law** to provide coverage for their employees.

61. Individuals should be required to provide coverage for themselves and their families.

62. Employers should be responsible for at least offering coverage to their employees, even if the employer contributes little or nothing toward paying the premiums.

Appendix G:
Map of South Dakota Health Care Sites

Appendix G:
Distribution of Hospital Resources in South Dakota



- Community (General) Hospitals (24)
- Critical Access Hospitals (27)
- Indian Health Service Hospitals (5)
- Veterans Administration Hospitals (3)

3/29/02

Appendix H:
Estimation Methodology for Policy Option Analysis

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Estimation Methodology for Policy Option Analysis

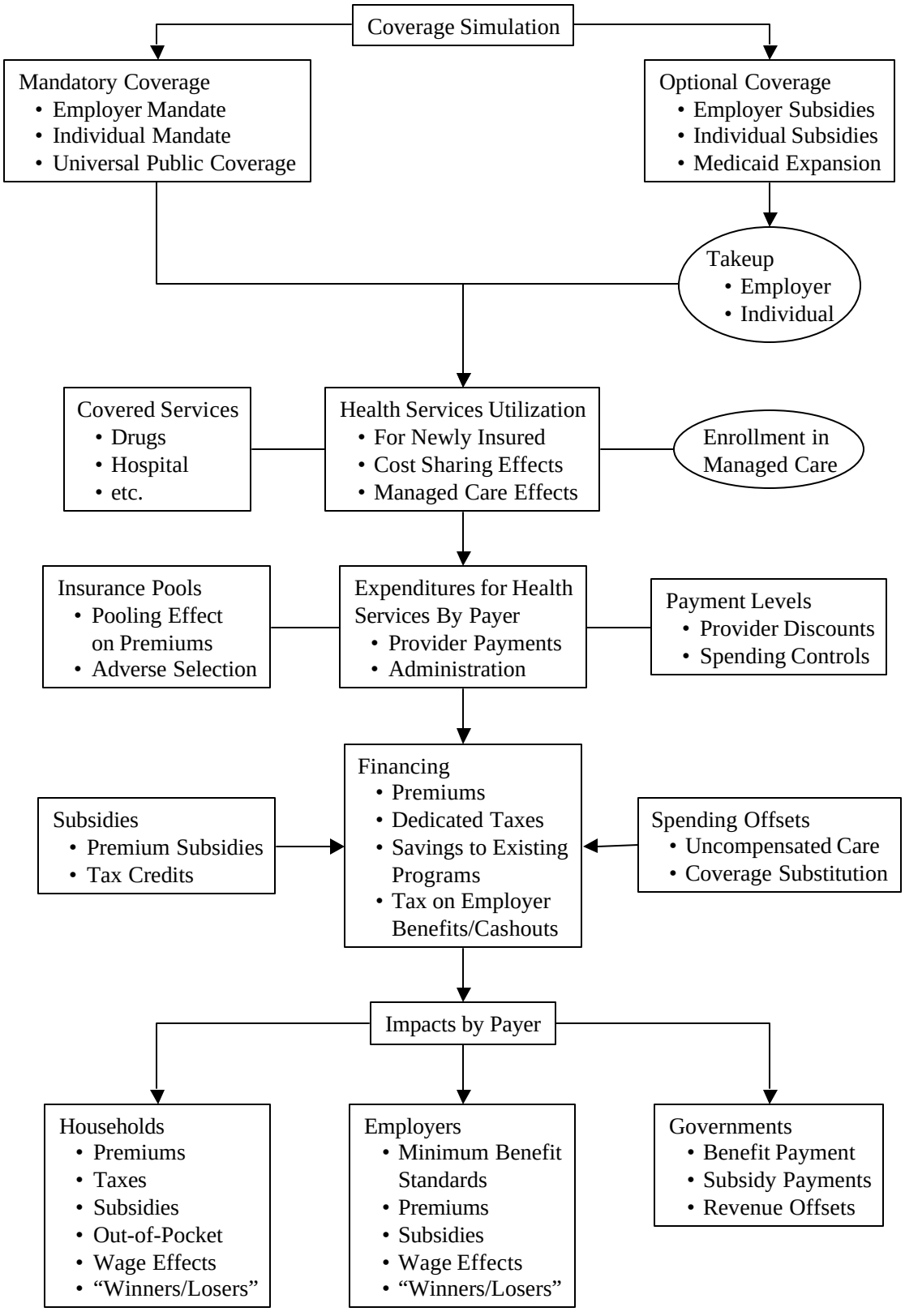
The Lewin Group's Health Benefits Simulation Model (HBSM) is a microsimulation model of the U. S. health care system that Lewin has adapted to simulate individual state health care systems. Used for over 15 years to estimate thousands of legislative and regulatory proposals at the national and state levels, the HBSM has withstood scrutiny from many disparate stakeholders. The model is designed to analyze policies ranging from narrowly defined Medicaid coverage expansions to broad-based reforms such as changes in the federal 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 for South Dakota using available state-level data from national and state sources.

The federal data used to develop estimates for South Dakota includes the South Dakota subsample of the March Current Population Survey data (1998-2001), provided by the Bureau of the Census and the 1996 National Medical Expenditure Panel Survey (MEPS) data, provided by the Agency for Healthcare Research and Quality (AHRQ). Lewin also used the survey of employers conducted by the Kaiser Family Foundation and Health Research and Education Trust (HRET), which provides extensive data on health benefits provided by employers. The model incorporates other data on health spending and health care use in South Dakota from various other state and federal sources, as well.

Lewin created HBSM to compare 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. Lewin "ages" all data so that they are representative of the population in 2001 based on recent economic, demographic, and health expenditure trends in the state. These "base case" data serve as the reference point for simulations of alternative health policy options.

Lewin estimates the impact of health policy initiatives using a series of methodologies that apply uniformly across all coverage simulations. The model first estimates how specified state policy options would affect the number of persons covered, sources of coverage, health services utilization, and health expenditures by source of payment (***Figure 1***). The model identifies persons and/or firms that would be eligible to participate in various programs such as Medicaid expansions, employer tax credits, and premium subsidies for individuals. The model then estimates enrollment among eligible individuals and/or employers. This simulation is based upon multivariate models of how coverage for these groups varies with the cost of coverage. Finally, the model simulates enrollment in Medicaid or SCHIP expansions based on a multivariate analysis of historical take-up rates under these programs including a simulation of "crowd-out," the substitution of public for private coverage.

Figure 1
Flow Diagram of the Health Benefits Simulation Model (HBSM)



Significantly, the HBSM facilitates comparisons of different policy approaches *using uniform data and assumptions*. For example, simulation of Medicaid take-up rates and tax credit/premium voucher policies use uniform take-up equations and modules. Likewise, uniform methods simulate changes in health services utilization as attributed to changes in coverage status and cost-sharing parameters. The model uses a series of uniform tables for reporting the impacts of these policies on households, employers, and government. This uniform approach assures that program impacts for very different policies can be generated and evaluated in a consistent format.

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

The various steps included as part of the simulation modeling are as follows:

? **Establish a Baseline:** HBSM is based on a representative sample of households in South Dakota, which includes information on the economic and demographic characteristics of individuals as well as their utilization and expenditures for health care. To adjust the 1996 Medical Expenditures Panel Survey (MEPS)**,** Lewin uses the South Dakota sub-sample of the March Current Population Survey (CPS), making it reflect the population characteristics of South Dakota. Lewin also uses the Kaiser/HRET survey of employers in simulations of policy scenarios involving employers. In addition, these data are adjusted with estimates by the Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), and various state agencies, to show the amount of health expenditures in South Dakota by type of service and source of payment.

? **Determine 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 the coverage expansion proposals. Monthly family income determines eligibility for Medicaid or other income-tested subsidy programs. 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.

? **Model Program Participation:** Many of the health reform proposals developed in recent years would rely upon providing incentives for individuals to obtain coverage voluntarily rather than mandating coverage. This voluntary approach 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 used to simulate enrollment among persons who become eligible under proposed expansions in these programs. Lewin has also developed multivariate models of how changes in premiums affects the decision to take-up private insurance coverage.

- **Model Employer Responses:** The model simulates the impact of policies affecting the employer's decision to offer insurance and the resulting impact on employee coverage. Employer tax credits exemplifies a policy 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 and then simulates the corresponding impact on workers who have been assigned to each of the firms in the South Dakota database.

- **Estimate Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the specific coverage provisions of each proposal. For tax credit proposals and premium vouchers, program costs equal 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 (such as Medicaid), costs equal the costs of the health services used by enrollees. These cost estimates are based on the cost of covered services received by those individuals in the household database estimated to enroll in the program. Included costs are those reported in the 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 simultaneously estimate the impact of several policy options and their interactions. For each option, the model estimates the impact on health expenditures in South Dakota by type of medical service and the changes in costs for various stakeholder groups. HBSM provides information on federal and state government costs to expand coverage, as well as estimates of how new policies may affect employer costs by firm size and industry. Finally, it provides estimates of the impact of these reforms on household health spending by income, age, and several other population groups.