Wyoming State Planning Grant
Research Report to the Task Force
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Section 1. Executive Summary

In July 2002, the State of Wyoming was awarded a State Planning Grant (SPG) from the Health Resources and Services Administration (HRSA). The purpose of this grant was to support efforts in Wyoming to expand health insurance coverage. Activities included in the grant were collecting and analyzing data, diagnosing problems, identifying solutions, and developing new strategies and policies.

Funding was awarded to the Wyoming Department of Health (WDH). A subcontract with the Center for Rural Health Research and Education (CRHRE) at the University of Wyoming (UW) provided for data collection and analysis on the nature of the state's uninsured and strategic research on the approaches that could be used to provide them with coverage. This report represents the results of those research activities.

Overview of data collection and analysis activities

The data collection and analysis phase of this project was intended primarily to provide information needed to develop coverage options. Working in cooperation with other SPG states, both those funded previously and in 2002, Wyoming has made use of previously developed materials as well as its own expertise in data collection and analysis to assure accurate and useful results.

Data collection and analysis for the Wyoming State Planning Grant project had two primary goals. First, we wanted to understand the nature of the uninsured population of the state by collecting information on insurance coverage among individuals and families. Secondly, we wanted to understand the availability of insurance coverage through employers in the state. The approaches used to achieve each of these goals are described in the following sections.

Individuals and families

The data collection and analysis activities carried out for individuals and families in Wyoming consisted of both quantitative and qualitative studies. The diverse approaches provide access to different dimensions of human experience and assure that an accurate picture of the state's uninsured is captured.

Quantitative studies

To collect information on uninsured individuals and families in the state, a multiple-element approach was used to both reduce potential sources of error or bias and provide a cost-effective means of getting demographic as well as attitudinal information.

Household surveys

Data on uninsured individuals and families in Wyoming were collected through household surveys. A two-page survey was formatted for self-administration and sent to a stratified random sample of mailing addresses in the State. The mail survey followed full "Dillman method" follow-up procedures, including a postcard reminder and then a second mailing of the questionnaire to non-respondents. These "short-form" mail

surveys were distributed to 5,050 households in September 2002. Follow-up materials were sent out in October and November to non-respondents.

A more extensive "long-form" household survey, which included attitudinal questions and more complex demographics (particularly questions about family members without insurance) as well as all relevant questions from the short-form survey, was developed for telephone interviewing. A stratified random sample of households in Wyoming with telephones was acquired, including both listed and unlisted numbers via Random Digit Dialing. At least 10 callbacks were attempted for each household.

Finally, the short-form document used for the mail survey was reformatted for use in telephone interviews. The sampling frame consisted of (a) those non-responding households from the mail-out survey for which phone numbers were available with the purchased sample of addresses, and (b) non-responding households from the long-form telephone survey, including refusals, terminations, and households not reached.

This three-pronged approach allowed pooling of the three surveys. The total number of responses in the pooled dataset was 5,511, for an overall response rate of 85.45%. Statewide analysis on all items included in the short-form survey should yield a margin of error of about 1.5 percentage points. Statewide analysis of the items appearing only in the long-form survey should have a margin of error of about 2 percentage points. As mentioned earlier, comparisons across the three different forms of the survey will counteract biases resulting from one or another approach.

Group quarters surveys

The methodology used for selecting samples for the mail and telephone surveys was directed at individuals or families living in permanent (that is, non-seasonal) homes in Wyoming. However, one significant group of residents not covered in the survey were residents of group quarters, such as assisted living facilities, boarding homes, and transitional living facilities (i.e., soup kitchens or homeless shelters). Given the significant number of responses from individuals collected from the other surveys, we conducted face-to-face surveys for group home residents on insurance status. Targeting this population specifically assures that their situations will also be reflected in the data, reports, and recommendations.

Qualitative studies

Focus groups and in-depth interviews – qualitative research methods – were used to supplement the quantitative research. The purpose of these studies was to understand the reasons individuals are uninsured and explore their ideas for enhancing access to health insurance and care. The group interaction and diverse viewpoints raised during these discussions were intended to allow examination of complex attitudes, beliefs, knowledge and experiences. Barriers to obtaining health care and insurance, along with opinions about private or public programs and incentives were also ascertained.

Focus groups

Focus groups were generally limited to 6-8 persons. Groups representing uninsured persons, small employers, and health care professionals were conducted in different

locations around Wyoming to help assure variation among the respondents. The focus groups for individuals were held in community sites readily accessible to the participants. The health care professionals met at a statewide conference. Semi-structured interview questions were used to stimulate the participants to talk about their attitudes and beliefs about being uninsured and ways to enhance access to care.

A brief, voluntary questionnaire was distributed at the beginning of each focus group to ascertain demographic and background characteristics of the participants. All interviewees were guaranteed anonymity, and any quotations used will not be attributed to a specific person. Participants in the uninsured and small employer focus groups were offered modest compensation at the end of each focus group.

Key informant interviews

In addition to the focus groups, sixteen in-depth interviews were conducted in various locations throughout the state with "key informants" including insurance industry leaders, members of health care provider organizations, business community representatives, and WDH staff in programs that provide services to the uninsured. The methods and the materials needed to interview these stakeholders and key informants were based on the information obtained in the surveys and focus groups. Like the focus groups, the in-depth interviews were audio-taped and transcribed verbatim and were used to identify the core concepts and themes through qualitative analysis.

Household survey comments

On the short-form (mailed) household survey, we invited comments from the respondents regarding health insurance. Several hundred responses were received. These were transcribed verbatim, coded, and analyzed using qualitative research techniques.

Employers

In addition to collecting data about individuals and families, the Wyoming SPG project collected information about employer-based health insurance coverage. The purpose was to understand the demographics of employers with respect to those that do and do not offer health insurance to their employees. We are particularly focused on small employers (those with two or more employees but fewer than fifty), since such employers are numerous in the state and employ a significant number of Wyoming residents. As with the research on individuals and families, we used both quantitative and qualitative methods to collect data on employer-based health insurance in the state.

Quantitative Studies

In partnership with the Wyoming Department of Employment (DOE) Research and Planning Section, SPG researchers were able to access data from quarterly benefits surveys administered by DOE since 1999. DOE also agreed to increase the sample size of its Fourth Quarter 2002 benefits survey and to stratify its sample and validate county or regional data. In addition, an expanded employer survey was developed that included new questions on attitudes and perceptions about the cost and complexity of

offering health insurance to employees. This expanded survey was distributed to employers across the state as part of the benefits survey administration for the First Quarter 2003. The responses to this expanded survey will be used to develop a statewide profile of business attitudes towards health insurance.

Qualitative studies

In addition to the DOE surveys, four focus groups for small employers were conducted. These focus groups, two of which involved small employers who offer insurance and two that involved employers who did not, were designed to provide more subjective information on the problems of small employers with respect to insurance benefits. The transcripts from these focus groups, like those of the individual groups discussed earlier, were transcribed verbatim and coded for analysis.

Highlights of research findings

The results of the various data collections on individuals, families, and employers have produced a clear, Wyoming-specific picture of its uninsured population.

Analysis of Wyoming-specific data from the household survey shows that:

- Of Wyoming residents, 14.1% are not covered by some form of health insurance (13.1% of children 18 years old and younger and 14.5% of adults);
- When counties are ranked using number of uninsured and population, it can be concluded that counties with a low population have a greater percentage of uninsured;
- The age group with the largest percentage of uninsured is 40- to 44-year-olds (27.7%), while the second largest group is 20- to 24-year-olds (24.9%);
- While 50% of those individuals earning less than $5,000 annually are uninsured, the next largest percentages are found among those earning between $15,000 and $20,000 (30.6%) and between $30,000 and $40,000 (26.5%) annually;
- Of those currently uninsured, over 66% either have never had health insurance or have not had it in two years or more;
- 11.6% of <u>all</u> respondents reported that someone in their household was eligible for health insurance through their work or union, but was not covered. This was true for 23.7% of the <u>uninsured</u>. The primary reasons cited for this were the cost or the value.

Among the findings from the data in the employer survey are the following:

- 72% of employers in Wyoming offer health insurance to their full-time employees, but only 10% offer it to their part-time employees;
- Of the major industries in the state, those with the lowest percentage of offering insurance to their full-time employees are agriculture and food service establishments;

- Fewer than 47% of the firms in the state with under 10 employees offer health insurance to those employees;
- 58% of the full-time employees who make less than $15,000 per year are NOT offered insurance by their employer;
- Employers who do offer insurance say they do so primarily because their employees want it and because it is needed to recruit the best people, while employers who do NOT offer insurance primarily say it is because insurance is too expensive;
- Nearly 43% of employers NOT offering insurance responded that allowing purchasing pools for group coverage could lead them to do so. A similar number, approximately 40%, said that making the state health plan available to private employers could lead them to offer insurance. Fewer than 30% said tax credits or legal mandates would do so.

Major themes arising in our uninsured focus groups and interviews with key informants included:

- The uninsured seek health care only when they really need it and will stop taking medication if they cannot afford it;
- Most uninsured participants do not have insurance because their employers do not offer it or they were unemployed, and the cost of individual insurance was more than they could afford;
- Uninsured persons often do not participate in public programs because they make too much money to qualify but not enough to afford private insurance;
- Most uninsured participants would take a job without benefits if they had to, but would prefer a job with health benefits.

Key themes about employer-based coverage included:

- Most small employers balance higher salaries for employees against offering them benefits;
- Several participants said they had shopped around for insurance plans but could not find any insurance program to cover their employees;
- Most employers would prefer a plan that would include both routine and catastrophic coverage.
- Employers would consider cost-sharing or dropping other benefits such as dental coverage before eliminating health insurance in case of economic problems or increasing costs.

Solutions identified by the focus groups centered around the problems of high cost of both insurance and health care, as well as low wages. Several participants acknowledged that there were multiple solutions and no “silver bullet.” Expansion of public programs was one of the most frequent recommendations, along with expanding and supporting safety net programs and expanding employer-based coverage. Increasing personal responsibility for healthy lifestyles and payment of health care costs

was also commonly recommended. Other recommended solutions included cost control, addressing health care provider shortages, tort reform, and restructuring insurance benefit programs to make them simpler.

Overview of strategic research

The SPG Task Force was assembled with the purpose of evaluating options and identifying new strategies for covering the uninsured that would work best in Wyoming or, alternatively, the best strategies to build on existing programs. This group will use our research results in conjunction with other available information to study in depth the selected coverage options and to investigate creative ways to finance these options. Ultimately, the Task Force is responsible for the recommendations in the strategic plan.

Background studies

Strategic research capability has come from Human Capital Management Services (HCMS) Group, a private firm based in Cheyenne, Wyoming. HCMS has access to a large database of insurance and health care usage records from several major national firms. The data from our household surveys has been integrated with this data, extended with other data available from WDH, Medicare and Workers' Compensation to create a resource for analyzing the risks and benefits associated with health insurance coverage. In particular, HCMS has addressed the question of how health care services are utilized among various populations and developing a model of Wyoming's uninsured that will be used to evaluate the risk associated with expanding health insurance to various target groups.

Options evaluation

Our research initially identified 36 coverage expansion options. A collaborative options matrix was produced that identified the following as key components for each option.

- Target or implementation sections
- Targeted population
- Primary funding sources for each option
- Estimated cost and political or legal viability
- When available, comparator states or best practices were identified for the options.

The options were further delineated into four matrices by the following implementation sectors.

- Employer/business based options
- Individual based
- Public/state based
- Multi-sector based options.

The four options matrices were disseminated to the Task Force to facilitate the strategic planning process. After a facilitated discussion and overview of each option under consideration, the Task Force members, using a tally sheet method, ranked each option by viability. The tally process further winnowed the considered options to the eight that are discussed in further detail in this report. Six Task Force subcommittees were appointed and tasked with reviewing the viability of each option for possible inclusion in the Wyoming Strategic Plan. Each subcommittee was to develop a set of action items in preparation for making final decisions on options to be included in the strategic plan.

Options Currently Under Consideration

Wyoming has selected eight coverage options for continued study for possible implementation to insure our citizens. They are:

- increasing availability of catastrophic coverage plans to provide lower-cost access to high-deductible plans;
- encouraging consumer-driven health insurance approaches and providing education and support for medical savings, flexible spending, and reimbursement accounts;
- developing small employer purchasing pools to help small businesses have better access to health insurance plans for their employees;
- providing outreach to employers and individuals to help them understand what services are available and what needs are most important in the state;
- creating a “bare bones” primary care network based on Medicaid expansion and redistribution of benefits focused on primary care and wellness;
- offering state-funded seed grants for new community health centers to expand the safety net for uninsured residents;
- expanding the existing State Children’s Health Insurance Plan (SCHIP) program to include parents and/or allowing employer buy-in for adults whose children are already in the program; and
- allowing employer buy-in to the Wyoming state employees’ health insurance program or other established insurance program.

The Task Force subcommittees are currently evaluating these strategies as to their viability and cost. Target populations for these strategies include employees of small businesses, particularly those at low-income levels; persons in transitional periods of insurance, such as young people no longer eligible under their parents’ plans or older people changing careers; the self-employed, particularly in agriculture; and parents whose children are eligible for public programs. The goal of these subcommittees is to identify barriers to programs for these target populations and develop strategies to overcome these barriers and provide opportunities to increase the number of Wyoming residents with access to health insurance coverage. The recommendations of the Task Force will be incorporated into a strategic plan, dependent upon consensus, and delivered to the State.

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Section 2. Household Surveys

One of the major goals of the Wyoming State Planning Grant research program was to collect and analyze data on the nature of the uninsured population in the state. Initially, baseline data from nationally conducted studies was collected to help plan the development of options and strategies to assist these individuals and families. To assure a more accurate picture of the state's uninsured, however, a statewide survey of households with respect to health insurance was developed and administered. In this section, we describe the methodology and results of this research.

Baseline information from Current Population Survey

National studies are often used to estimate the demographics of Wyoming in the absence of local information. The two primary existing sources of data on Wyoming's health insurance coverage are the U.S. Census Bureau's Current Population Survey (CPS) and the Behavioral Risk Factor Surveillance System (BRFSS) for Wyoming. While somewhat limited in their ability to estimate the number and nature of the uninsured, these sources have provided valuable baseline information to support initial studies of the problem while further data was being collected and analyzed.

We have made significant use of the SPG Multi-State Integrated Database (MSID) managed by the Arkansas Center for Health Improvement. The MSID provides access to software that enables enhanced utilization of state-specific national data including BRFSS, CPS, and the County Business Pattern Census. Baseline information from MSID is presented in this section. In addition, we are working with MSID's developers to integrate state-specific datasets from our household surveys into the database to allow quick and easy access to the data.

Data from the March 2001 supplement of the CPS indicated that the uninsured population as of 2000 was 70,474, or about 14.3% of the state's population. Of these uninsured, just over half (51.4%) were female. 41.9% of residents between the ages of 19 and 34 were uninsured, despite this age group's representing only 19.0% of the overall population of the state.

According to CPS, the large majority (71.0%) of the adult uninsured in Wyoming were employed at least part-time; only 6.2% of the adult uninsured were unemployed, while the rest were defined as "not in the labor force." 78.3% of them had incomes less than $20,000 per year. However, less than half of the uninsured (41.8%) were found to be at less than 250% of the Federal Poverty Level (FPL).

Wyoming Household Survey Research

While baseline information is useful in some situations, a more recent and more detailed picture of the state's uninsured was necessary for the kind of strategic planning to be included in the SPG project. We therefore conducted our own household survey to get information on the availability of health insurance coverage among Wyoming's individuals and families.

Methodology

The sample used here is the final result of at least two data gathering methods and two different forms of the survey. The data were gathered during the last quarter of 2002 and the first quarter of 2003. A short form questionnaire consisting of 15 questions was mailed to a random sample of listed households in Wyoming, stratified by county, with 3920 usable responses. This figure excludes 130 respondents to the mail survey who reported that their households were occupied only seasonally or that they lived in group quarters. (Of these, 15 were not currently insured, a negligible number for the purposes of this analysis.) An additional 395 responses for the short form were obtained by telephone using listed phone numbers of non-respondents to the mail survey. Another 126 short form responses were obtained by telephone from non-respondents to the long form telephone survey, which used random digit dialing. Thus the total number of usable responses on the short form was 4,441. The number of responses on the long form totaled 1070, bringing the combined sample size used here to 5511. After weighting the sample to adjust for the disproportionate stratification, the weighted sample size is 5510. Deletion of missing data (item non-response) further reduces the effective sample size in some tables.

Table 2-1. Type of Survey Form Used in Sample

TYPE OF FORM	NUMBER (N)	PERCENT
Short Form – Mail	3,920	71.1%
Short Form – Phone	521	9.5%
Long Form – Phone	1,070	19.4%
Total	5,511	100.0%

A random sample of this size yields a margin of error of less than two percentage points, with 99 percent confidence. For subgroups of around 200 respondents, as when counties are considered separately, the margin of error would be about seven percentage points, with 95 percent confidence.

Within each household, a target person was randomly selected about whom most of the questions were asked. Unless otherwise noted, all results are weighted to represent the population of individual persons, taking into account the number of people in the household, the disproportionate sampling by county, and other features of the complex sampling that used both listed addresses and random-digit dialing. Also only year-round residents were considered in the description and analysis.

Key findings

Funding from the State Planning Grant allowed us to undertake a thorough study of health insurance in Wyoming for individuals and families, as well as for employers. In this section, we describe the key findings from the household surveys. The purpose of this analysis is to briefly describe the differential distribution of the uninsured in the

State of Wyoming. Focus in the first part will be upon the relationship between the percent of uninsured individuals and a number of demographic variables. After this description, there follows a more complex discussion of the interrelationship of the demographic variables.

Percent Uninsured in Wyoming

As stated above, the total number of respondents was 5,511. The number of uninsured in the sample is 770. The percent of invalid responses in terms of the dependent variable, percent uninsured, was 0.816%, N=45. See Table 2-2 below. When they are eliminated from analysis, this leaves the total of 5,465 valid responses and an uninsured rate of 14.08%. Using the 2002 population estimate[1] for the State of Wyoming of 498,703, this 14.1%[2] rate would give the State an estimated 70,217 uninsured persons.

We need to be aware of how a sample can deviate from a true population mean. With a sample of this size, we can be fairly certain with 99 percent confidence that the true mean or true proportion (percent) with which we are dealing is minus or plus about 1 percent.[3] Because of the sampling design and the size of the sample, we can be "confident" 99% of the time that the true number of uninsured will fall within a range of 69,515-70,919.

Table 2-2. Distribution of Uninsured and Insured Individuals: State of Wyoming

	Frequency	Percent	Valid Percent
No coverage	770	13.97	14.08
One or more coverages	4,696	85.22	85.92
Total valid responses	5,465	99.19	100.00
Respondent said he/she was covered, but gave conflicting response on question 10, "Types of health insurance"	6	.11	
Respondent had more than 5 "don't know" or not ""applicable answers on question10, "Types of Health insurances"	39	.71	
Total invalid responses	45	.82	
Total	5,510	100.00	

[1] http://eire.census.gov/popest/data/counties/tables/CO-EST2002/CO-EST2002-01-56.php on 8-30-03.
[2] The uninsured rate of 14.1% is rounded from 14.08%. The percentage of 14.1% will be used in referring to the insurance rate. Calculations will be done using two decimal places depending on the valid responses throughout the report so that accuracy to 1 decimal point place will be assured in the tables.
[3] Thus, **depending upon the number of responses to a question, the total N of insured will vary as will the total % of uninsured for the particular table.** The 99% confidence interval was calculated using the proportion of uninsured (.141) and the proportion of the insured (.859) in finding the standard deviation and using a *z* of 2.58 where s_p = .0046

Introduction to Discussion of Basic Demographic Characteristics

The descriptive variables which will be discussed first are those which are on both the short and long forms of the survey. For these descriptive variables, their frequencies and the population estimates will be presented. Then for each variable where appropriate, the basic relationship of the uninsured within the demographic variable, such as county of residence, age, income, etc. will be analyzed to indicate which groups may be lower or higher on the rate of not being covered by health insurance. For those tables which compare the uninsured with the insured, statistical tests of significance were run and unless specified for these cross-tabulation tables, the results were statistical significant at the $P \leq .05$ level or less.

Table 2-3: County Residence by Deviation from Average % of Uninsured (Weighted by County)

County	*Percent Deviation	Weighted N	Actual Sample N
Uinta	-3.80%	290	245
Teton	-3.60%	165	164
Carbon	-3.03%	232	239
Sweetwater	-3.02%	254	234
Sheridan	-2.34%	226	235
Albany	-2.26%	224	239
Natrona	-2.20%	253	264
Weston	-1.91%	237	243
Laramie	-1.91%	236	236
Hot Springs	-1.85%	215	240
Big Horn	-0.74%	238	231
Crook	-0.32%	238	237
Washakie	-0.32%	255	252
Converse	-0.13%	262	249
Platte	0.53%	230	239
Sublette	0.98%	222	203
Goshen	1.34%	231	247
Campbell	1.56%	286	248
Fremont	2.15%	257	261
Lincoln	2.32%	220	222
Park	3.41%	226	232
Johnson	6.66%	257	267
Niobrara	7.48%	225	233
Total	**	5,512	5,460

*The deviation is based on using the county weighted N for individuals so that analysis at the county level is a better estimate than of the weights for individuals used in most of this part of the report.

**Note that in using this form of statistically weighting, the average percent uninsured is 12.083% (N=666)of a weighted sample size of N=5512 for the State as a whole. The reason for the lower percent uninsured is due to the way the county weights were constructed. These weights were adjusted for the number of telephones per household as well as the number of individuals in the household, but the weights were not adjusted for the number of households in the county. The result is a more conservative picture statewide given the actual sample size for each county.

Calculation of County Ranking

The 23 counties were ranked from low to high by the percent uninsured in each county using the county weights to obtain this ranking. This process of finding the percent uninsured was the same used in the previous tables above, but county weights were used in calculating the percent uninsured and not individual weights which were applicable to the whole state. Then the average percent of uninsured across the counties (12.08%) was subtracted from the percent uninsured in each county. Note that county weights result in a more conservative estimate of the uninsured. Even though there were larger margins of error for each county, the ranking process as done is valid.4 Because of the range of possible error due to small sample size per county it is not possible to estimate the number of insured by county. For example, with an average margin of error across the counties of +7.00%, a population estimate of Laramie county could possibly range from a low of 2,727 uninsured persons to a high of 14,238 persons AND these numbers may not be accurate. Thus, the sample size per county is just not large enough to be used for population estimates.5

Results from County Ranking by Percent Uninsured

The purpose of the county ranking was to answer the question, "Will an ordinal ranking from low to high illustrate something about the geographical distribution of the uninsured?" If the 23 counties are divided into approximate the highest third, middle third and lowest third in terms of the ranking based on percent uninsured, several general statements can be made. The highest third of counties by percent uninsured--Goshen, Campbell, Fremont, Lincoln, Park, Johnson and Niobrara—contain 27.06% of the population of Wyoming. The lowest third of counties by percent uninsured—Natrona, Albany, Sheridan, Sweetwater, Carbon, Teton, and Uinta—contain 43.45% of the population of Wyoming. The middle third of counties by percent uninsured—Weston, Laramie, Hot Springs, Big Horn, Crook, Washakie, Converse, Platte, and Sublette—contains 29.45% of the population. Also those counties are distributed rather evenly across the State and are not concentrated in any one particular area.

Based on the ordinal ranking of the counties from low to high by percent uninsured, it is possible to conclude that those counties with a low population have a greater percent of uninsured in their county. But at the same time, the middle third of counties are quite

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[4] Note that the number of respondents by county are quite similar in the size of their N. As can be seen from Table 21, using an unweighted percentage of these numbers would severely overrepresent those counties with smaller populations and underrepresent those counties with larger populations. Even with the weighting by county, the margin of error will vary from about ±7.8 for Teton County with the smallest actual sample N=164 to ±6.1 percent for Johnson county with the largest actual sample N=267.

[5] The sample size which would be needed for a margin of error of about 1 percent would be an N of at least 500 persons from each county. This would mean a final state-wide sample of 11,500 which was considerably beyond the budget allocation for the data-gathering. However, the margin of error of ±1.0% does exist for state-wide generalizations using the individual weights as done in this section of the report.

similar, except for Laramie County which is –1.91% below the average. In fact, most of those counties (N=9) which are above the average in percent uninsured are relatively sparse in their population as a group, 30.06% of the population of the State of Wyoming.

Overall, when percent uninsured by counties is examined, there are more limitations to what can be stated than what can be. We cannot do population estimates by county because of sample size. We can rank the counties from low to high in terms of percent uninsured and infer that those counties at the two extremes of low and high are significantly different. However, we really cannot say that two or more counties which are adjacent in the ranking are really different from one another. A safe conclusion is that those counties with a high rate of percent uninsured (those with the high positive percents) are significantly different from those with a low percent of uninsured (those with a higher negative number). See Table 2-3.

Table 2-4: Percent Uninsured by Age and Population Estimates per Age Category

Age	Of those uninsured, %	Sample of those Uninsured, N	% Uninsured of total sample—used for Population Estimates	Population Estimates of Uninsured by Age
0-4	9.26%	71	1.30%	6,483
5-9	4.04%	31	0.57%	2,843
10-14	3.52%	27	0.50%	2,494
15-19	12.39%	95	1.75%	8,727
20-24	11.60%	89	1.63%	8,129
25-29	5.48%	42	0.77%	3,840
30-34	6.00%	46	0.84%	4,189
35-39	5.35%	41	0.75%	3,740
40-44	20.73%	159	2.92%	14,562
45-49	6.39%	49	0.90%	4,488
50-54	8.08%	62	1.14%	5,685
55-59	2.61%	20	0.37%	1,845
60-64	3.00%	23	0.42%	2,095
65+	1.56%	12	0.22%	1,097
Total	100.00%	767	14.10%	70,217

If there were no significant differences among these 14 age categories, the N per age group would be 5,015.5 per category. As can be seen from Table 2-4, there are a number of age categories which have a relatively high number of uninsured. Those individuals age 40-44 who are uninsured number 14,562. Two other age categories, age 15-19 and age 20-24, are also high in being uninsured with 8,727 and 8,129 individuals, respectively. Above the expected number of 5,015.5 is age category 0-4 with 6,483 uninsured. Also, those age 50-54 number 5,685 persons.

Table 2-5: Age by Percent Uninsured, Percent within each Age Category Comparison

Age	% Not covered	N
0-4	19.89%	357
5-9	9.97%	311
10-14	8.74%	309
15-19	21.64%	439
20-24	24.86%	358
25-29	18.34%	229
30-34	16.08%	286
35-39	15.24%	269
40-44	27.70%	574
45-49	9.40%	521
50-54	12.35%	502
55-59	5.70%	351
60-64	8.75%	263
65+	1.78%	675
Total	14.09%	5,444

In studying the uninsured, there is one age group that has medical coverage—those who are age 65 and over. In this group, there is a small percentage, 1.78%, who say they do not have coverage.

Age is a “good” indicator of some types of employment and access to medical insurance. From the table above, the age group that has the highest rate of being

uninsured is the category of age 40-44 years, 27.7%. This age is the age for individuals where career and job transitions take place. The next highest age categories are the age 20-24 and 15-19, 24.86% and 21.64%, respectively. These are two groups which are in transition from parental coverage to their own coverage. Note that the age categories between 15-19 and 40-44 are all above the average percent uninsured (14.1%) for the whole sample. Finally it should be noted that 19.89% of children age 0-4 are uninsured.

As discussed above in relation to the population estimates all of these groups have a significant number of persons who are affected.

Table 2-6: Percent Uninsured by Household Income – Population Estimates

Household Income	Of those Uninsured, %	Sample of those Uninsured, N	% Uninsured of Total Sample— Used for Population Estimates	Population Estimates of Uninsured by Income
Less than $5,000	8.56%	60	1.20%	5,984
$ 5,000 to 9,999	4.42%	31	0.62%	3,092
$10,000 to 14,999	5.85%	41	0.82%	4,089
$15,000 to 19,999	14.41%	101	2.01%	10,024
$20,000 to 29,999	15.55%	109	2.17%	10,822
$30,000 to 39,999	31.53%	221	4.41%	21,993
$40,000 to 49,999	6.99%	49	0.98%	4,887
$50,000 to 74,999	7.13%	50	1.00%	4,987
$75,000 or more	5.56%	39	0.78%	3,890
Total	100.0%	701	13.99%	69,768

Table 2-7: Percent Uninsured by Household Income – Comparisons

Household Income	% Uninsured	N
Less than $5,000	50.00%	120
$ 5,000 to 9,999	19.38%	160
$10,000 to 14,999	16.80%	244
$15,000 to 19,999	30.61%	330
$20,000 to 29,999	18.23%	598
$30,000 to 39,999	26.53%	833
$40,000 to 49,999	6.68%	733
$50,000 to 74,999	4.67%	1,070
$75,000 or more	4.22%	925
Total Uninsured	13.98%	5,013

The distribution above in Tables 2-6 and 2-7 of those uninsured by income is not a surprising finding. The only income categories where less than 7.0% of the individuals are not insured are those households with reported annual incomes of $40,000 or more. Households with less than $5,000 annual income report have 50.0% of the target individuals being uninsured. The level of not being insured drops with increase of income, but not consistently. Target individuals in those households with incomes of $15,000-19,999 and $30,000-39,999 report being uninsured 30.61% and 26.53%, respectively.

Having an adequate income is important for being insured, but the effect of an adequate income for medical insurance is not apparent until the household members earn more than $40,000 a year. The median household income for Wyoming residents for 1998 as reported by the U.S. Census Bureau was $37,203.[6] The median category for income in this survey was the $40,000-49,999, just slightly above the Census figure.

This distribution by income of how a substantial percentage of households under $40,000 lack coverage suggests that there exist real difficulties in being insured. This is especially the case for those under $5,000. The possibility of being uninsured is almost 1 in 3 for $15,000-19,000 group and over 1 in 4 for the $30,000-39,999 group.

[6] U.S. Census Bureau, Statistical Abstract of the United States:2002, Table 656.

Table 2-8: Percent Uninsured by Health of Target Person – Population Estimates

Described Health of Target/Birthday Person	Of Those Uninsured, %	Sample of those uninsured, N	% Uninsured of total sample—used for population estimates	Population estimates of number of uninsured
Good to excellent	27.15%	208	3.82%	19,050
Very Good	26.37%	202	3.71%	19.502
Good	23.76%	182	3.34%	16,657
Fair	20.37%	156	2.86%	14,263
Poor	2.35%	18	0.33%	1,646
Total	100.0%	766	14.06%	70,118

Table 2-9: Percent Uninsured by Health of Birthday/Target Person

Described Health of Target (Birthday) Person	% Uninsured	N
Excellent	11.82%	1,759
Very good	11.26%	1,794
Good	14.26%	1,276
Fair	33.40%	467
Poor	11.76%	153
Total Uninsured	14.06%	5,449

The perceived health of the target person or the birthday person was good to excellent (over 85%) if the person had health insurance. Only a small percent (2.8%) of the whole sample whether insured or not felt their health was poor (153 of 5449). However, of those who were uninsured, 22.7% felt their health was no better than "fair." In addition, 11.8% of those who felt their health was poor were uninsured. The key perception here of the uninsured is for those who perceive that their health is "fair." Evidence from a number of other studies indicate that only a "fair" evaluation of one's health is quite close to poor when the number of medical chronic and acute conditions are asked of such individuals. This evaluation can be tentatively taken to suggest that the uninsured may not be as healthy as those who are insured.

Table 2-10a: Percent Uninsured by Number in Household – Population Estimates

Number of Persons in Household	Of Those Uninsured, %	Sample of those uninsured, N	% Uninsured of total sample—used for population estimates	Population estimates by number in household for State
1	5.46%	42	0.77%	3,840
2	17.82%	137	2.51%	12,517
3	18.86%	145	2.65%	13,216
4	17.56%	135	2.47%	12,318
5	25.75%	198	3.62%	18,053
6	5.07%	39	0.71%	3.541
7	2.73%	21	0.38%	1,895
8 or more	6.76%	52	0.95%	4,738
Total	100.0%	769	14.06%	70,118

Table 2-10b: Percent Uninsured by Number in Household – Comparison

Number of Persons in Household	% Uninsured	N
1	9.07%	463
2	8.42%	1,627
3	14.44%	1,004
4	12.40%	1,089
5	24.69%	802
6	13.54%	288
7	25.30%	83
8 or more	48.15%	108
Total	14.07%	5,464

As the number of persons in a household increases, the percent of uninsured persons increases at a steady rate until households of size 8 or more is reached which have an uninsured rate of 48.2%. Of households made up of 1, there is a rate of 9.07% of individuals not insured and of household of made up of 2, the rate is 8.42% uninsured. This is in part a reflection of those who are widowed living alone and those over the age of 65. Households which may be made up of two adults with children fall in those categories of 3-5. It is when households are 5 and above, the percentage of uninsured persons rises considerably (24.69%), but especially those with 8 persons, 77.61%. The lowest rate is for household size of 9 or more.

Table 2-10c: Other Adults (excluding Birthday/Target) in Household With Health Insurance—Comparison

Number of other adults without /with coverage*	Of Those Uninsured, %	Sample of Uninsured, N	Of Those Insured, %	Sample of Insured, N	% of All Those Other Adults not covered/ covered—total sample
0 other adults covered	67.50%	515	17.49%	815	24.52%
1 other adult covered	20.97%	160	53.49%	2,493	48.91%
2 other adults covered	7.47%	57	23.15%	1,079	20.94%
3 other adults covered	3.28%	25	4.05%	189	3.95%
4 other adults covered	0.79%	6	1.42%	66	1.33%
5 other adults in household covered	0.00%	0	0.28%	13	0.24%
6 other adults in household covered	0.00%	0	0.13%	6	0.13%
Total	100.00%	763	100.00%	4,661	100.00%

When the number of adults other than the birthday/target person are examined by percent uninsured, the percent of such adults is 32.5% (N=248) of those who are uninsured in the sample. What it means is that just because the target person is not insured, it does not necessarily mean that all the other adults in the household will be uninsured, but at least one-third will fall into that category also. Another way of looking

at this group is that they are 4.57% of the total sample. This is 22,790 households of the birthday/target person who are uninsured.

Table 2-10d: Other Adults in the Household with Health Insurance

Number of other adults without/with coverage	**% Uninsured**	**N**
0 other adults covered	38.72%	1,330
1 other adult covered	6.03%	2,653
2 other adults covered	5.02%	1,136
3 other adults covered	11.68%	214
4 or more other adults covered	6.59%	91
Total	14.1%	5,424

Table 2-10e: Other Children (excluding Birthday/Target) in Household With Health Insurance?

Number of other Children without /with coverage*	**Of Those Uninsured, %**	**Sample of Uninsured, N**	**Of Those Insured, %**	**Sample of Insured, N**	***All Those Other Children not covered/ covered—Total Sample, %**
0 other children covered	75.79%	576	52.82%	2,462	56.04%
1 other child covered	10.53%	80	18.64%	869	17.51%
2 other children covered	10.00%	76	19.55%	911	18.21%
3 other children covered	2.37%	18	6.05%	282	5.53%
4 other children covered	0.26%	2	1.82%	85	1.60%
5 other children in household covered	1.05%	8	0.67%	31	0.72%
6 other children in household covered	0.00%	0	0.45%	21	0.39%
Total	100.00	760	100.00%	4,661	100.00%

*This column was obtained by adding the sample Ns of the uninsured and the insured together.

As with other adults in the household and their status of having or not having health insurance, the main focus of this table is comparing how many children are not covered for the uninsured as compared to the insured.

Table 2-10f: Other Children in Household with Health Insurance

Number of other children without/with coverage	**% Uninsured**	**N**
0 other children covered	18.96%	3,038
1 other child covered	8.43%	949
2 other children covered	7.70%	987
3 other children covered	6.00%	300
4 other children covered	2.30%	87
5 or 6 other children covered	13.33%	60
Total	14.1%	5,421

As stated above for other uninsured adults in the household, the same holds for other children without health insurance in the same household as the target person. Children are less likely to be covered with health insurance as seen by the low percent of children covered in the uninsured household.

Table 2-11: Percent Uninsured by Length of Time Since Last Covered – Population Estimates

Time since last being insured	Of Those Uninsured, %	Sample of Those Uninsured, N
Never Had Insurance	15.87%	100
Less than 6 months	16.98%	107
6 to 11 months	3.65%	23
12 to 23 months	1.11%	7
2 to 4 years	12.86%	81
5 to 9 years	27.46%	173
10 to 19 years	11.59%	73
20 to 39 years	2.38%	15
40 years or more	2.22%	14
Don't Know	5.87%	37
Total	100.00%	630

Table 2-12: Percent Uninsured by Length of Time Since Last Covered – Comparison

Time since last being insured	Percent	N
Less than 6 months	25.9%	183
6 to 11 months	4.2%	30
12 to 23 months	3.7%	26
2 to 4 years	16.1%	114
5 to 9 years	29.0%	205
10 to 19 years	12.9%	91
20 to 39 years	4.8%	34
40 years or more	3.4%	24
Total	100.0%	707

The modal length of time since a person who is presently uninsured is 5 to 9 years (29.0%) with "less than 6 months being the next highest category, 25.9%. Another relatively high category is from 2-4 years with 16.1%. Just examining three of the four highest time periods—"2 to 4 years," "5 to 9 years," and "10 to 19 years"—have total of 58 percent of those who are presently uninsured. Add in the last two time periods—"20-39 years" and "40 years or more"— and the total increases to 66.2 percent. In other words, being uninsured is not just a temporary phenomenon for many presently uninsured. This would mean about 46,484 uninsured persons in the State (based on estimate of 70,217) have been without medical insurance for at least 2 or more years. A little over 8 percent have been without medical insurance for more than 20 years, which likely means they have never had it.

Table 2-13: Percent Uninsured by Anyone in Household Eligible for Insurance Through Employer or Union But Did Not Sign up for it—Comparison

Someone eligible in household not covered	% Uninsured	N
Yes, someone is eligible but not covered	23.7%	615
No, everyone who is eligible is covered	11.3%	4314
Nobody is eligible in the household	24.3%	395
Total	13.7%	5324

Of the total sample, 12.0 percent of the households had someone other than the Birthday/Target person who was eligible, but had not "chosen" to sign up for the health insurance. The rest were either covered or not eligible.

When the above is examined by the % Uninsured, the percentage of those who are not covered or not eligible is more likely to occur in those households where the birthday/target person is herself and himself uninsured, 23.7 and 24.3 percent, respectively. Where everyone else is covered and the birthday/target person is not (11.3 percent of the time).

Table 2-14: Percent of Eligible Person in Household Not Covered Through Employer or Union—Main Reasons

Reason not covered	Of Uninsured, %	Sample of Uninsured, N
Cannot afford the cost	38.16%	228
Not a good value	25.89%	112
Person is healthy	6.25%	16
Care is available without it	16.16%	99
Expect other coverage shortly	3.12%	32
Some other reason (What?)	5.56%	108
Total	23.53%	595

Percent of Those Not Covered Main Reason Why Other Person(s) in Household Not Covered by Health Insurance Though Employer or Union—Comparison

The main reason given by the respondents for the person other than the target person not being covered in the household was "Cannot afford the cost," 40.8 percent. If we combine that reason with "Not a good value," which could be considered parallel in meaning to "Cannot afford the cost," the percentage increases to 58.7 percent—over one-half of those not covered. Another way of examining this group is that the N = 367 and is includes about 6.6 percent of the households.

When this relationship between the "eligibility of a person who is not on health insurance through employer or union" and the "reason not covered" is examined by the major dependent variable of "percent uninsured", the percentage of persons who say that they "Cannot afford the cost" increases to 62.1 percent and those who reported that it is "Not a good value" increases to 20.7 percent. Thus, for those households where the target person is uninsured, those two major reasons above that are given for others in the household who are eligible but not enrolled, total 82.8 percent.

The primary reasons for another person in the Target Person's household not being insured are that they cannot afford the cost (38.2%) or it is not a good value (25.9%). The latter reason may be a euphemism for not being able to afford the cost. In this case, over one-half of the target persons (64.1%) are not able to afford health insurance.

Note that of those eligible in the household, but who are not insured and who were not the target person, also fell into those who could not afford the cost. These are persons in a household with an insured target person who were 85.9% of the sample. This group of uninsured persons totaled 456 individuals which 76.5% of the 596 persons who were not the target person. See the following table for their distribution of reasons why they were not insured.

Table 2-15: Why Other Eligible Person Not Covered in Household by Percent Insured

Main Reason Why Not Covered	Percent of those who are insured	N
Cannot afford the cost	61.8%	228
Not a good value	74.1%	112
Care is available without it	83.8%	99
Some other reason (What?)	94.9%	157
Total	76.5%	596

NOTE: This table is different than others in that the percentages tell why an eligible, but uncovered, person in an insured target person's household is not in a health plan. The most common would be that they cannot afford the cost 61.8 percent of 228 individuals (N=141), but for the most part, those households where another person is residing who is not insured, but others are, appear to be more able to receive health care via some other route.

Table 2-16: Types of Health Insurance Held by Target Person

Type of Insurance Held by Birthday/Target Person*	**Percent	N
1 RR-Retirement Plan	1.5%	108
2 Medicare	10.6%	784
3 Veterans Affairs-Military	3.8%	282
4 Medicaid-KidCare-Title19	5.7%	420
5 Wyoming Health Insurance Pool	1.1%	80
6 Through Birthday Person's work-union	24.1%	1,784
7 Through someone else's work-union	22.5%	1,662
8 COBRA (Available for 18 months after leaving job)	3.2%	237
9 Bought directly by Birthday Person	1.6%	120
10 Bought directly by someone else	9.6%	713
11 Student health insurance	12.4%	915
12 Indian Health Service	1.4%	101
13 Other health insurance for Birthday Person	0.8%	62
15 Birthday Person has NO health insurance	1.5%	111
16 Don't Know	0.2%	15
Total	100.0%	**7,394

* Types of insurance are not mutually exclusive.
** In this table the percent is not based on the number just to its right, but is based on the total N of 7,394. The number is there strictly for information.

Respondents could check all the insurances that applied to them. There were 5,510 respondents to the survey. The number without health insurance totaled 777, 14.1%. This means that for those who had insurance, N = 4,732, the number of insurance types checked was 7,394 for an average number of health insurance types checked of 1.56 per person who had insurance.

The most common type of health insurance held by those in the total sample are those through the birthday person's work or union (24.1%) or through someone else's work or union (22.5%). Work, of course, refers to the person's employer. These two types account for a total of 46.6 percent or almost one-half of the responses. Medicare accounts for 10.6 percent.

Table 2-17: Number of Different Types of Health Insurance Policies Held by Birthday/Target Person

Number of Health Insurance Policies	Percent
1 policy	59.5%
2 policies	31.4%
3 policies	7.3%
4 policies	1.5%
5 policies	0.3%
Total	100.0%
N	4,788

When the target person is examined for how many types of health policies that are being held, a surprising percent have more than one—40.5 percent. Almost one-third have two policies—31.4 percent. Just over one-half, 59.5% have only one health insurance policy. A smaller percentage have more than 3 policies, 9.1 percent (3 + 4 + 5 policies).

Table 1-18: Frequency of Number of Different Health Insurance Policies Held by Birthday/Target Persons

Number of Policies	N	Total number of policies per category	*Percent
1	2,847	2,847	59.5%
2	1,503	3,006	31.4%
3	348	1,044	7.3%
4	73	292	1.5%
5	16	80	.3%
Total	4,788	7,269	100.0%

*Percent refers to percent of individuals in the category, not to the number of policies held by those in that category.

Over one-half, 59.5%, of the target persons were enrolled in one insurance program. A significant percent, 31.4%, carried two health policies with 7.8% having three or more health insurance policies or programs.

Since so many target persons indicated that they had more than one health insurance plan, what kind of plans were usually carried together by individuals in this sample? See Table 2-19 for the different types of insurance policies.

Table 2-19: Type of Health Insurance Policy by the Number of Policies(per type)

Type of Health Insurance Policy	1	2	3	4	5	Total
RR-Retirement Plan	13.9%	48.1%	27.8%	4.6%	5.6%	108
Medicare	28.2%	48.8%	16.9%	5.6%	0.5%	783
Veterans Affairs-Military	29.7%	37.8%	25.1%	4.9%	2.5%	283
Medicaid-KidCare-Title19	50.5%	33.8%	11.7%	4.0%	0.0%	420
Wyoming Health Insurance Pool	9.9%	59.3%	16.0%	7.4%	7.4%	81
Through Birthday Persons work-union	58.2%	29.5%	8.6%	2.9%	0.9%	1784
Through someone else's work-union	47.1%	39.2%	10.3%	2.6%	0.8%	1662
COBRA (Available for 18 months after leaving job)	14.7%	34.5%	34.5%	13.9%	2.5%	237
Bought directly by Birthday Person	25.8%	56.7%	13.3%	2.5%	1.7%	120
Bought directly by someone else	27.1%	50.1%	17.5%	4.2%	1.1%	713
Student health insurance	17.1%	59.3%	18.2%	4.4%	1.1%	914
Indian Health Service	53.5%	18.8%	27.7%	0.0%	0.0%	101
Other health insurance for Birthday Person	30.2%	49.2%	15.9%	4.8%	0.0%	63
Total	59.5%	31.4%	7.3%	1.5%	0.3%	7268

Since the respondents were able to check as many types of health insurance as they had, the above categories in Table 2-19 are a reflection of the number of type of policies run by the types of insurance policies. This gives us an overall picture of how many policies are connected with each individual type. Those who are most likely to have more than one policy are the following types: RR-Retirement Plan, Medicare, Wyoming Health Insurance, bought directly by the Birthday Person, bought directly by someone else, Student Health Insurance and other health insurance for Birthday Person. Those most likely to have only one health insurance policy are the following: Medicaid-Kid

Care-Title 19, Through the Birthday Persons work-union, Through someone else's work-union, and Indian Health Service. Several categories of individuals are likely to have their insurance spread over more than one type of policy: Veterans Affairs-Military, COBRA, and Indian Health Service to some extent.

The above analysis represents all variables that were included in both the short and long-form surveys, that is, all variables that can be applied at a county or statewide level. A summary of additional variables that were only included in the long-form survey, and thus are only applicable at the statewide level, can be found in Appendix 2.

Summary of group quarters interviews

The methodology used for selecting samples for the mail and telephone surveys was directed at individuals or families living in permanent (that is, non-seasonal) homes in Wyoming. Interviewing of seasonal residents was deemed inappropriate for the study, as options for increasing coverage to this population were not in the scope of the project. However, one significant group of residents not covered in the survey were residents of group quarters, such as nursing homes, assisted living facilities, boarding homes, and transitional living facilities (i.e., soup kitchens or homeless shelters). Given the significant number of responses from individuals collected from the other surveys, we decided to conduct face-to-face surveys for group home residents on insurance status. Targeting this population specifically assures that their situations can also be reflected in the data, reports, and recommendations.

Samples of group quarters for interviews were selected in seven counties, with an eye to broad representation but not statistical randomness. A nursing home and one additional facility in another category were selected in a partially randomized fashion for each county (except one, where no nursing home was selected). In Albany County, two additional sites, an assisted living facility and a boarding home, were selected to assure including at least one of each of these in the sample. Once the facilities had been selected, a random process was used to select which respondents would be interviewed.

Interviews of group quarters were conducted by a seven-member team, including UW students, graduates, staff, and a faculty member from Sheridan College. The majority of interviewees were retired, over sixty-five years of age. A total of eighty interviews were conducted in March, April, and May of 2003. In addition, a brief "General Group Quarters Survey" was sent to administrators of all but the transitional living facilities visited. Instruments were also sent to the state mental health hospitals, juvenile centers, and the Diocese of Cheyenne representing religious group quarters. Administrators of three-quarters of the interview sites responded to four questions specifically addressing the status of residents' health insurance, as well as to three questions on location and facility demographics.

Locations and dates when interviews were conducted:

- Albany County:
    - Ivinson Home for Aged Ladies (3/27 & 3/29)
    - Spring Wind Assisted Living Community (3/28)

    - St. Matthew's Cathedral--Soup Kitchen (3/28)
    - Laramie Care Center (3/29)
- Natrona County (4/3):
    - Shepherd of the Valley Care Center
    - Maurice Griffith Manor
- Fremont County (5/1):
    - Westward Heights Care Center
    - Showboat Retirement Center
- Sweetwater County (5/8):
    - Castle Rock Convalescent Center
- Laramie County (5/29):
    - United Medical Center-Transitional Care Unit (TCU)
    - Wyoming Coalition for the Homeless
- Campbell County (5/29):
    - Pioneer Manor
    - Campbell County Soup Kitchen: The People's Project
- Johnson County:
    - Veteran's Home of Wyoming (4/28)
    - Amie Holt Care Center (5/30)

Section 3. Employer Surveys

In addition to studying of insurance among households in Wyoming, we also wanted to understand the demographics behind employer-based coverage in the state. Since the large majority of insured people in Wyoming receive coverage through their employers, it is important to consider this viewpoint to get a complete picture of the accessibility of health insurance in the state. An additional goal was to collect information from employers who do and who do not offer insurance on the reasons behind their choices, in order to address the barriers for those who currently do not offer insurance to their employees.

Baseline information from Department of Employment

According to a Department of Employment (DOE) report published in 2001[7], 66.1% of employers in Wyoming offered health insurance benefits to their full-time employees. Only 13.8% offered insurance benefits to part-time employees. 58.5% of the companies surveyed offered dependent health insurance to their full-time employees, but only 12.2% offered it to part-time employees.

Firm size was a major factor in whether an employer offered health insurance or not. The DOE study found that only 44.3% of firms with fewer than 5 employees offered health-insurance to full-time employees, compared to 96.3% of firms with 100 or more employees. Type of business also was a factor. Government (92.1%) had the highest percentage of insurance coverage, while manufacturing, mining, wholesale, and services are above average. Agriculture (50.0%) and retail (45.3%) were the lowest among the groups.

Geographic regions, as defined by the DOE, did not differ greatly in the availability of insurance to employees. The northwest region of the state (including Sheridan, Johnson, Campbell, Crook, and Weston counties) had the lowest percentage (54.9%) of employers offering insurance benefits to their full-time employees, while the central region (Natrona, Converse, and Carbon counties) had the highest (67.6%). Of employers with employees in more than one region, 90.5% offered health insurance to their full-time employees.

The DOE study also looked at numbers of employees covered by health insurance in this report. Overall, the study showed that 94.7% of those employed full-time in Wyoming received health insurance through their employers. Only 28.7% of those employed part-time received benefits, however. 91.2% of full-time employees received dependent health insurance, but only 28% of part-time employees. By industry, only 81.6% of full-time agriculture workers received insurance benefits, as opposed to 96.0% of full-time mining employees and 96.4% of full-time finance/insurance/real estate employees. Over 90% of employees in all five regions and statewide had access to insurance benefits.

[7] Employee Benefits in Wyoming: 2000 (June 2001). Wyoming Department of Employment, Research and Planning Section.

Wyoming employer survey research

Our initial quantitative research plan, as outlined in the Wyoming State Planning Grant (SPG) proposal, was to develop and conduct a statewide employer survey based on those used by other SPG states. This would have required significant effort and time, both on the part of the Data Collection and Analysis workgroup and the Survey Research Center, who were also responsible for the development and implementation of the household survey. However, as we explored the mechanisms of an employer survey, we were directed to the Wyoming Department of Employment (DOE) Research and Planning Section. This group conducts research on wages and benefits offered by Wyoming businesses to assist employers and employees in determining whether or not they are providing and receiving competitive compensation. The Wyoming Benefits Survey has been distributed quarterly to a random sample of Wyoming businesses since a pilot study in 1999.

Methodology

The SPG project entered into an agreement with the DOE Research and Planning Section to enhance their benefits surveys and provide us with additional information on employer-based health insurance. This agreement consisted of several elements. First of all, DOE agreed to provide SPG researchers with access to the pooled data from the quarterly benefits surveys from 1999 to the present. By providing a much larger and more representative sample than would have been possible with a single survey administration, this allowed us to have more accurate results as well as ultimately perform some trend analysis.

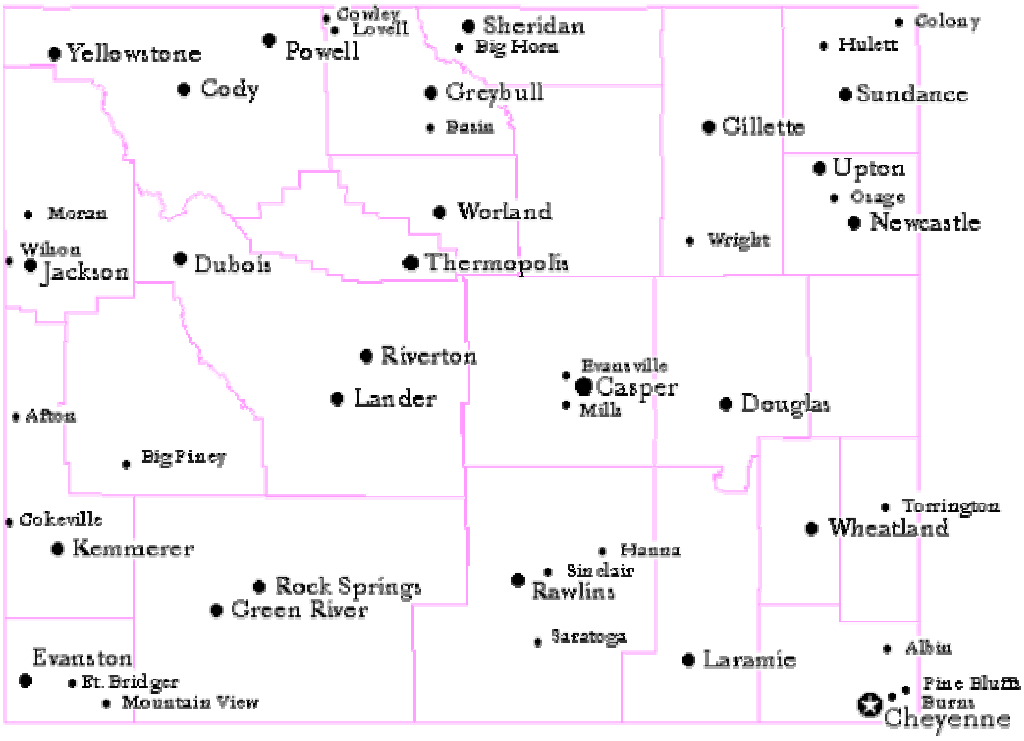
Second, DOE agreed to increase the sample size of its Fourth Quarter 2002 benefits survey from 400 (the usual number) to 1,142 and to stratify its sample to provide at least 100 responses in each county within its pooled data. Given the significant differences between county populations in Wyoming, many of them were under-represented in the pooled data and thus county-level estimates on health insurance questions could not be developed. The responses to this increased sample, when pooled with the previously collected data, provide more accurate geographically oriented estimates of employer information.

Third, an expanded employer survey was developed that included new questions on attitudes and perceptions about the cost and complexity of offering health insurance to employees. A stratified random sample of 500 employers was selected to receive the questionnaire and this sample was drawn from the most current Quarterly Unemployment Insurance (QUI) employer database available (DOE, 2002). This database contains the data reported by approximately 18,000 employers on a quarterly basis for Unemployment Insurance purposes.

The employers who were asked to participate in this expanded survey were randomly selected by looking at employment size class, industry, and region. According to the DOE, this type of random stratification was necessary to get an adequate sample because of the small number of large employers in Wyoming. A map of the large employers in the state is located below (see Figure 3-1).

Three hundred and twenty-two employers (or 64.4%) responded to the expanded survey. The responses to this expanded survey allowed us to develop a statewide profile of business attitudes towards health insurance.

Figure 3-1: Location of Wyoming's Largest Employers



Map from the Wyoming Department of Employment website, *Large Employer Report*, http://doe.state.wy.us/lmi/wylarge/toc.htm.

With about 100 completions per county in the pooled data, we expect the margin of error for a single county to be about 10 percentage points. Statewide estimates of the same data will have a margin of error of only about 3 percentage points. Since the margin of error at the county level is large, we have pooled the results into geographic regions (as is currently done by DOE), which also represent major economic influences in the state, to provide more reliable estimates. This pooling also protects the confidentiality of employers responding to the surveys, since in many Wyoming counties it would be easy to identify a particular employer simply by size and/or industry type.

Key findings

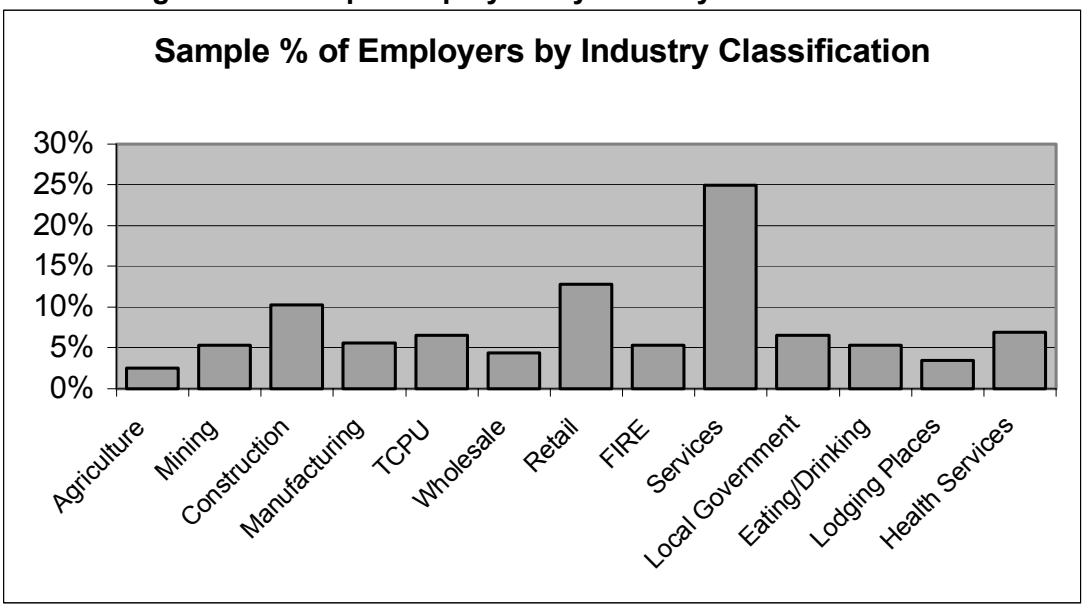
Sample demographics

The industry classification of employers in this survey is shown in Table 3-1 and Figure 3-2.

Table 3-1: Sample Employers by Industry Classification

Firm Classification	Percent
Agriculture	2.5%
Mining	5.3%
Construction	10.3%
Manufacturing	5.6%
TCPU (Transportation, Communications, Public Utilities)	6.6%
Wholesale	4.4%
Retail	12.8%
FIRE (Finance, Insurance, Real Estate)	5.3%
Services	25.0%
Local Government	6.6%
Eating and Drinking Places	5.3%
Hotels and Other Lodging Places	3.4%
Health Services	6.9%
Total	100.0%

Figure 3-2: Sample Employers by Industry Classification



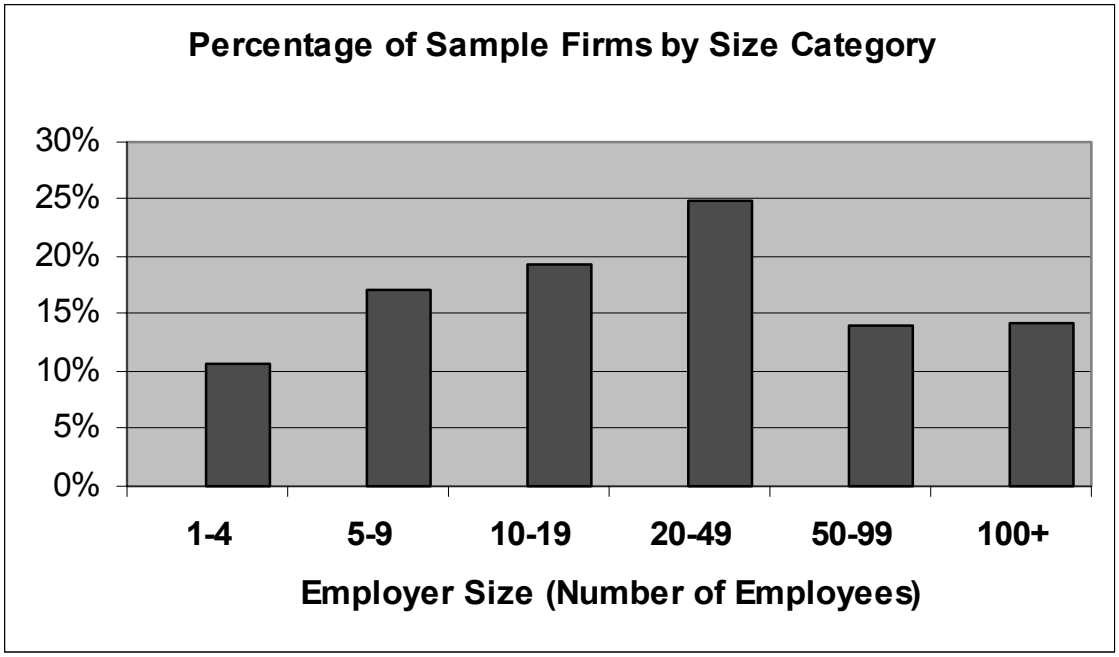
As indicated in both the table and graph, the majority of the state's employers are in the service sector with retail and construction next in line.

Employers were also broken down into firm size categories.

Table 3-2: Sample Employers by Firm Size

Employer/Firm Size	Percent
1-4 employees	10.6%
5-9 employees	17.1%
10-19 employees	19.3%
20-49 employees	24.8%
50-99 employees	14.0%
100+ employees	14.3%
Total	100.0%

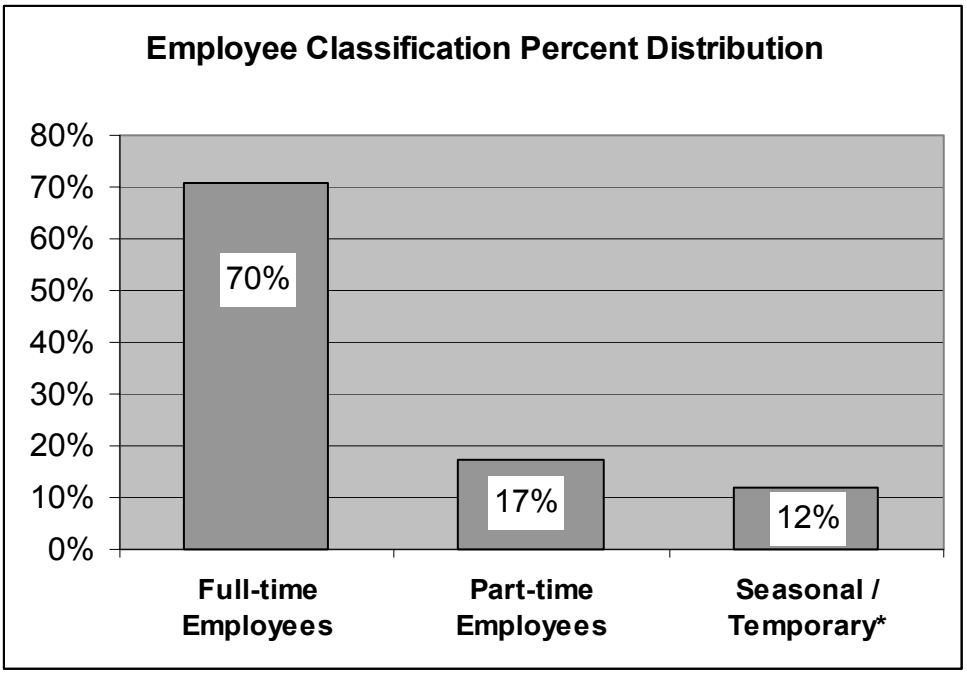
Figure 3-3: Sample Employers by Firm Size



As presented above, the majority of employers who participated in this survey have fewer than 50 employees (approx. 70%). This reflects the other data on the employer population in Wyoming.

As indicated in Figure 3-4 below, the majority of the workers employed by the respondents are full-time employees, with a smaller percentage of part-time (17%) and seasonal workers (12%) reported.

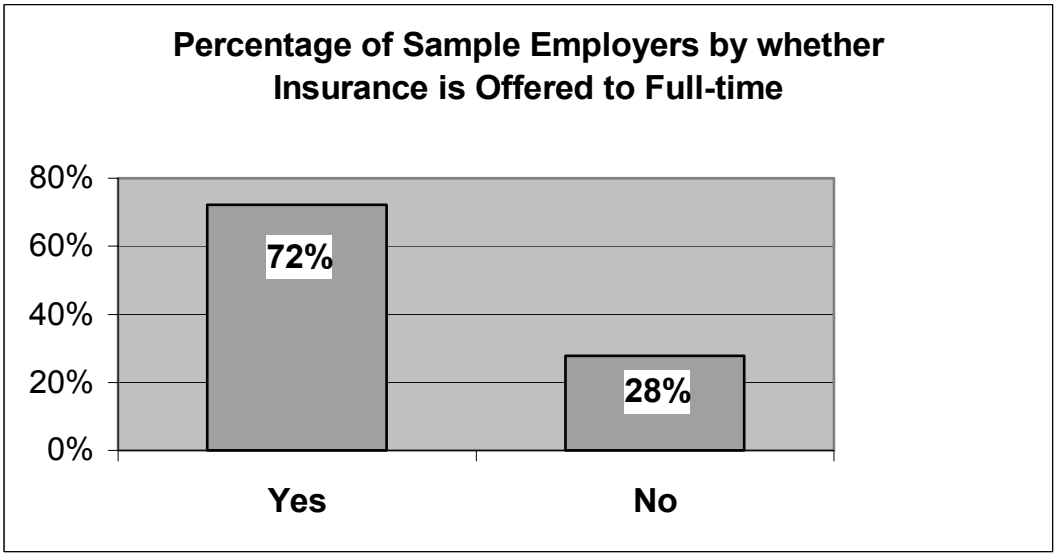
Figure 3-4: Types of Employees



Health Insurance as an Employment Benefit

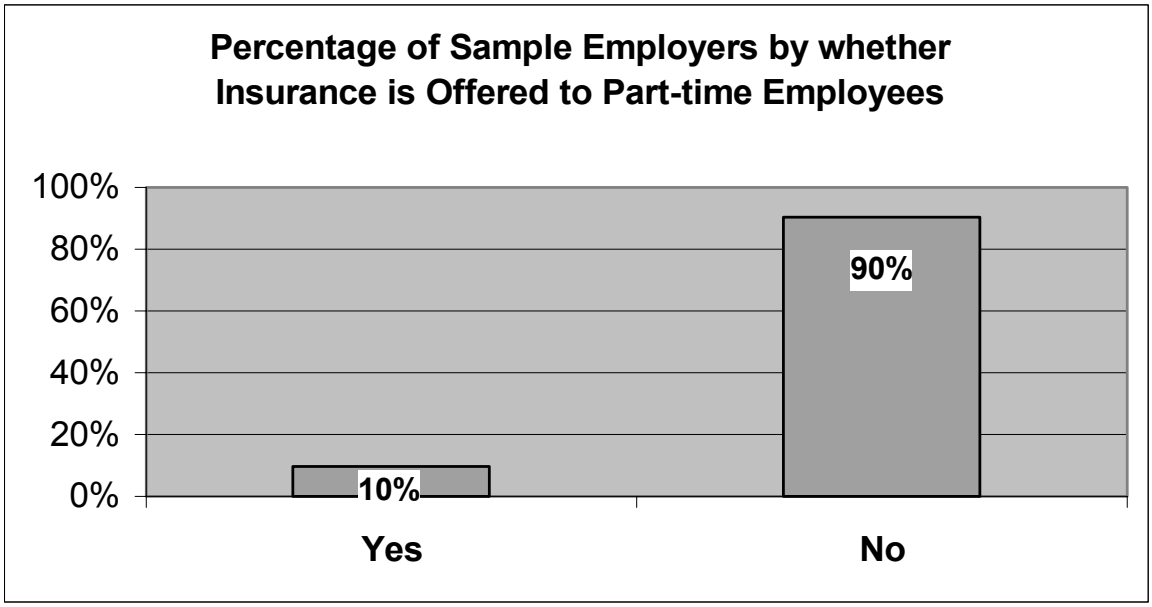
The following chart represents the percentages of employers who offer health insurance to full-time employees.

Figure 3-5: Percentage of Employers who offer Health Insurance to Full-Time Employees



A small percentage of employers also offer health insurance to part-time employees (see Figure 3-6).

Figure 3-6: Percentage of Employers who offer Health Insurance to Part-Time Employees



In summary, 72% of Wyoming employers offer health insurance to full-time employees while only 10% of employers offer insurance to part-time workers. When this information is paired with the variable of firm size, a pattern emerges.

Figure 3-7: Health Insurance for Full-Time Employees by Firm Size

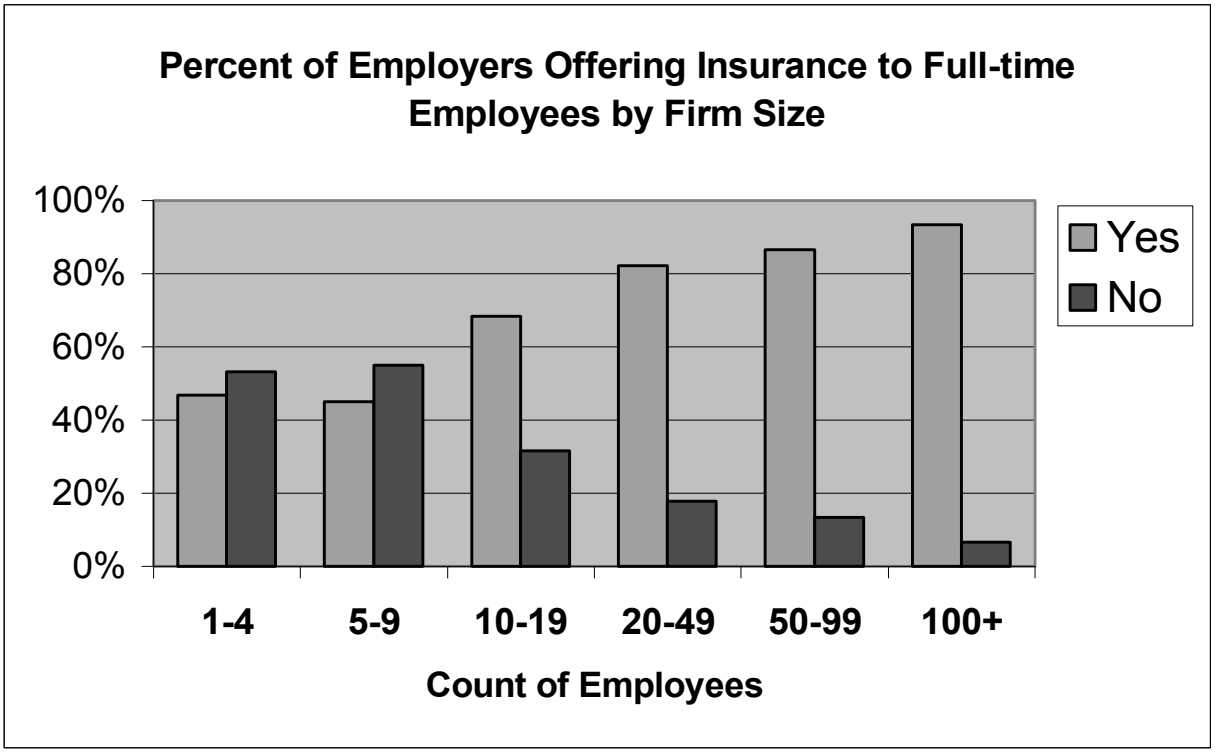
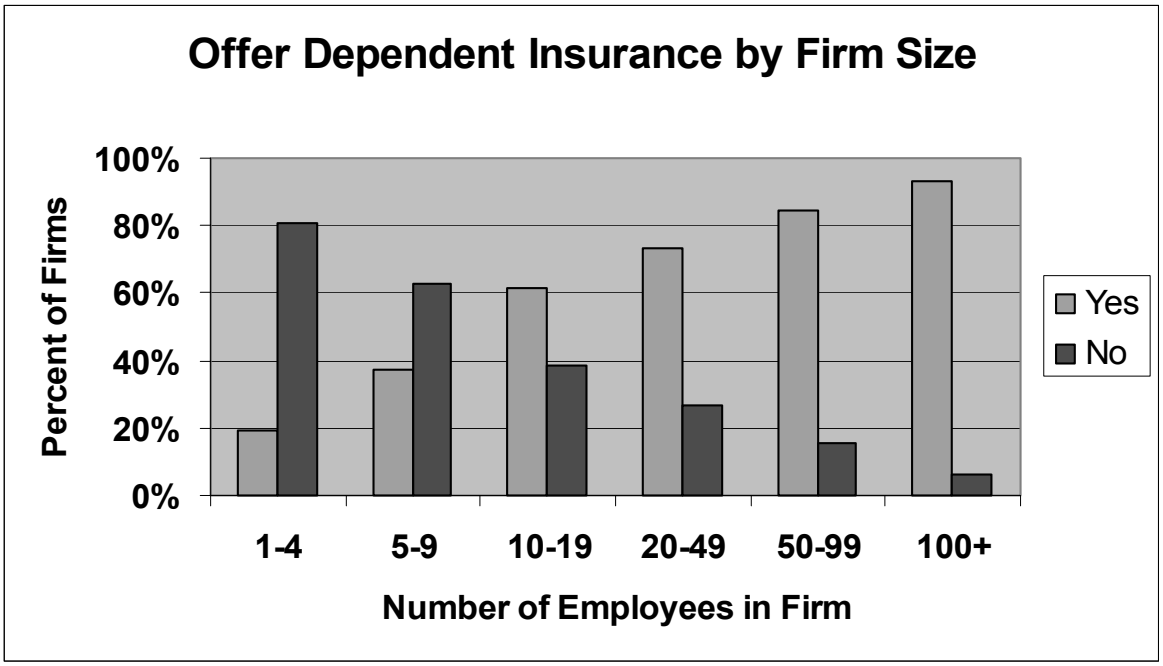


Figure 3-7 indicates that larger employers are more likely to offer health insurance to full-time employees. This follows what occurs nationally; the larger the company, the more likely employees will be covered by health insurance. This is important when looking at Wyoming employers. As stated above, over 70% of Wyoming employers have fewer than 50 employees. It follows that these employers are less likely to offer insurance.

Average annual salary can also be considered an indicator of the likelihood of insurance. As the average salary increases, it is more likely that the employee will be offered health insurance as a benefit. In Wyoming, the average salary of employees who work for employers who offer insurance is $39,385 per year where as the average salary of employees who work for employers who do not offer insurance is $25,136.

Some employers who do offer health insurance to employees also offer insurance to employee dependents. Figure 3-8 provides a break down of those employers who offer insurance to dependents by the number of employees working for the employer.

Figure 3-8: Percentage of Employers who offer Dependent Health Insurance by Firm Size



It can be noted here that again, the larger the size of the employer, the more likely an employee will be offered health insurance benefits for dependents. The availability of health insurance for retirees is much bleaker. Only 8.8% of Wyoming employers pay any of the cost of health insurance for retirees (See Table 3-3).

Table 3-3: Employers Who Pay Any Percentage For Retiree Health Insurance

	Number of Firms	Percent of Firms
Yes	19	8.8%
No	196	91.2%
Total	215	100.0%

Several factors determine which employees are offered health insurance by employers and which are not. Examining employer-based coverage by size and type of business shows that small employers as well as employers in retail, service, and construction are less likely to offer health insurance. The average yearly salary of employees also demonstrates this trend; the lower the average salary level, the less likely the employee will be offered health insurance.

Employers Who Offer Health Insurance

When employers who offer health insurance to employees were asked what the main reasons for offering health insurance were, the overwhelming reason given was that employees want it. Employers also stated that offering this benefit helps to recruit the best employees and helps to reduce turnover (see Table 3-4)

Table 3-4: Why Do Employers Offer Health Insurance?

Employers who currently offer health insurance to their employees were asked to respond to the following possible benefits of offering insurance	
	Percent agree with reason
Employees want it	77.8%
Needed to recruit the best people	57.8%
Reduces employee turnover	48.9%
Improves morale	44.0%
Should be a company responsibility	36.7%
Increases productivity	18.2%
Reduces absenteeism	14.2%

When these reasons are crossed with the variable of firm size, a pattern emerges. It seems that larger employers see this benefit as something employees want more so than smaller employers. Also, small employers don't see offering health insurance as important as large employers as a tool in reducing employee turnover, recruiting workers, or improving morale (Table 3-5).

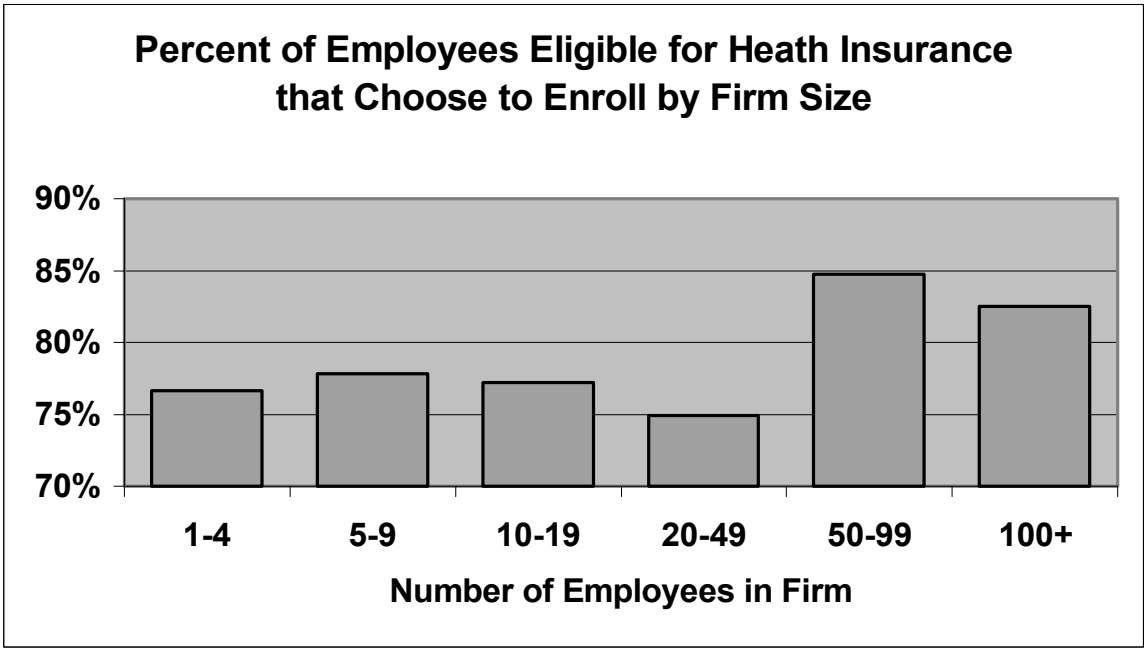
Table 3-5: Why Employers Offer Health Insurance by Firm Size

Employers who currently offer health insurance were asked to respond to the following possible benefits of offering insurance. Responses listed by number of employees in firm.

Number of Employees	Employees want it	Reduces absenteeism	Should be a company responsibility	Increases productivity	Needed to recruit the best people	Improves morale	Reduces employee turnover
1-4	66.7%	6.7%	26.7%	20.0%	40.0%	26.7%	26.7%
5-9	58.3%	0.0%	37.5%	0.0%	41.7%	20.8%	37.5%
10-19	81.0%	11.9%	16.7%	14.3%	61.0%	40.5%	47.6%
20-49	75.4%	6.2%	33.3%	10.8%	54.7%	43.1%	51.6%
50-99	84.6%	25.6%	38.5%	25.6%	66.7%	48.7%	59.0%
100+	83.7%	27.9%	60.5%	34.9%	67.4%	60.5%	53.5%

When employers who offer insurance were asked about the percentage of eligible employees who choose to enroll in health insurance programs, it was reported that all employers had 75% or more enrollment. Again, smaller employers had a slightly lower rate of enrollment than larger employers (Figure 3-9).

Figure 3-9: Employee Enrollment by Firm Size



Employers were asked about the cost of insurance to both firm and the employee. Table 3-6 represents total dollar amounts spent for 2002 by the company on health insurance costs.

Table 3-6: Insurance Costs for 2002, Total for Employer

		Frequency	Valid Percent
Valid	<$10,000	36	19.6
	$10,000-$50,000	56	30.4
	$50,001-$100,000	22	12.0
	$100,001-$200,000	21	11.4
	$200,001-$500,000	28	15.2
	$500,001-$1million	12	6.5
	>$1million	9	4.9
	Total	184	100.0

Employers also provided information describing the breakdown of premium payments: employer portion and employee portion (see Table 3-7).

Table 3-7: Breakdown of Premium Payments: Employer and Employee

Mean and Median dollar amounts employers and employees spend on basic health insurance (without dependents or additional coverage) per month				
Number of Employees		For a full-time employee who chose to enroll in your company's most basic health insurance, approximately how much was the monthly premium paid by employer?	And how much was the monthly premium paid by the employee?	Total monthly basic health insurance cost for each employee
1-4	Mean	$264	$76	$361
	Median	$159	$0	$165
5-9	Mean	$315	$62	$382
	Median	$255	$0	$293
10-19	Mean	$299	$24	$325
	Median	$239	$0	$278
20-49	Mean	$263	$75	$341
	Median	$263	$25	$310
50-99	Mean	$253	$56	$311
	Median	$256	$21	$310
100+	Mean	$275	$33	$309
	Median	$275	$23	$277

Employers who offer insurance were asked to indicate the availability of other types of benefits to employees. Most employees who have access to health insurance through an employer also have prescription drug, prenatal care, and mental health benefits (see Table 3-8).

Table 3-8: Other Benefits Offered by Employers Who Offer Insurance

Employers that offer health insurance responding yes to: "Do your employees have access to the following miscellaneous benefits, whether provided by your company or the insurance through your company?"

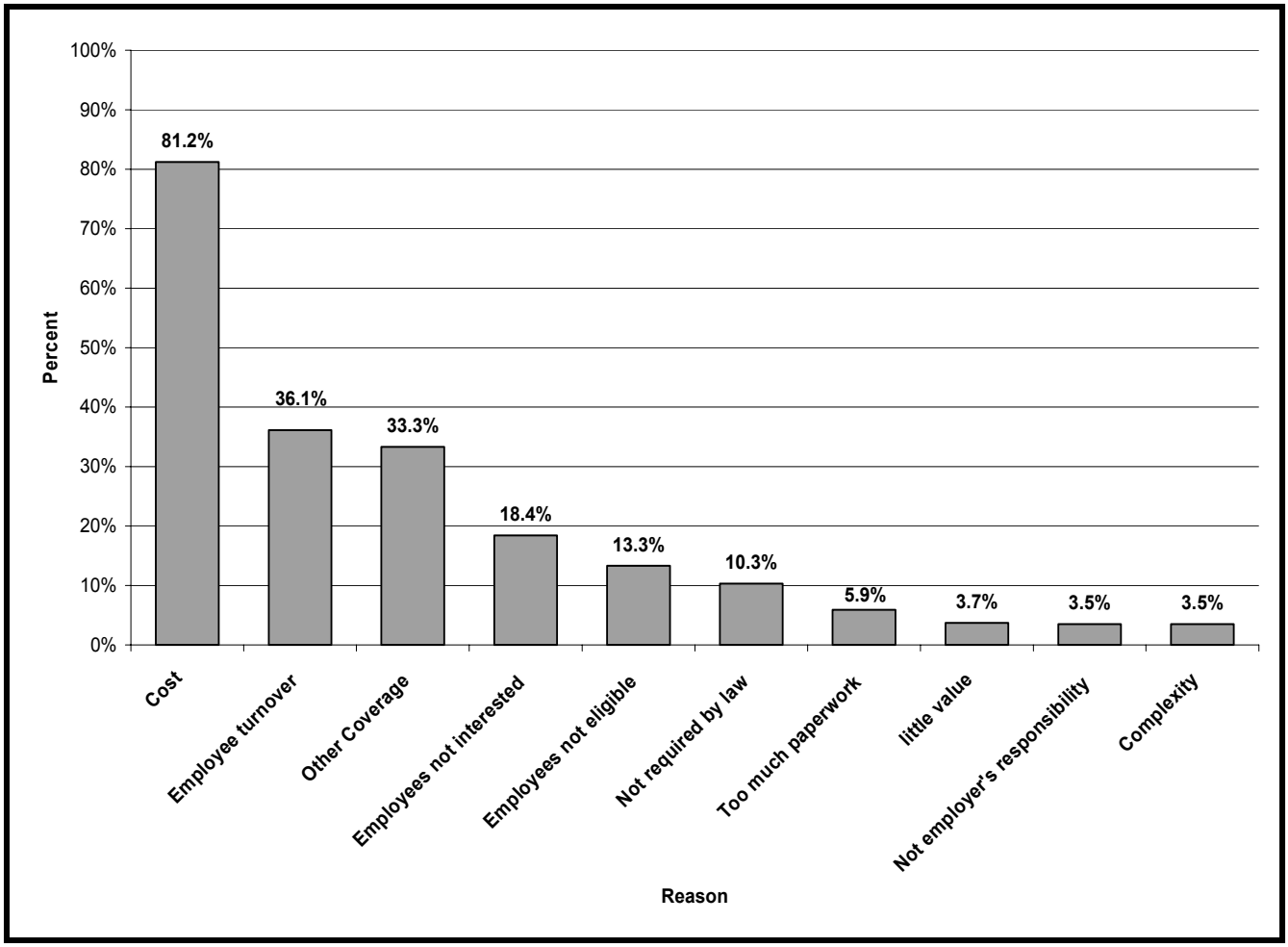
	Firms Offering Ins. to Full-time Employees		Firms Offering Ins. to Part-time Employees	
	Count	Percent	Count	Percent
Prescription drug coverage for full-time	206	94.1%	26	15.0%
Prenatal care for full-time	174	80.9%	23	13.5%
Mental health care for full-time	170	78.7%	24	14.1%
Preventive health care for full-time	159	73.3%	20	11.7%
Substance abuse treatment for full-time	157	73.0%	21	12.6%
Wellness Program for full-time	123	57.2%	17	9.9%
Medical Savings Account or Healthcare Reimbursement Account for full-time	56	25.3%	14	8.0%
Tobacco cessation treatment for full-time	47	22.6%	6	3.6%
Comprehensive Individual Medical Account, or otherdefined contribution plan for full-time	14	6.6%	1	*

*Categories with 3 or fewer valid cases are suppressed.

Employers Who Do Not Offer Health Insurance

As stated above, twenty-eight (28%) of employers surveyed did not offer health insurance to their full-time employees. When asked why they do not offer this benefit, 81% of those employers listed cost as the reason. Other responses were indicated much less often, including high employee turnover, employee coverage through other sources, employees not interested, employees not eligible, and not required by law (see Figure 3-10).

Figure 3-10: Reasons Why Employers Do Not Offer Health Insurance



(Total percentages more than 100% due to multiple answers given by single respondents)

When these responses are broken down by firm size, it is interesting to note that it is not the smallest employers who find cost the most prohibitive. In fact, employers who employ 20-49 employees stated cost as the most prohibitive reason why they do not offer insurance (see Table 3-9).

Table 3-9: Reasons Why Employers Do Not Offer Insurance by Firm Size

Employers NOT offering health insurance to their employees were asked to respond to the following possible reasons for not offering health insurance.

Number of Employees		Too expensive	High employee turnover	Most employees are covered elsewhere	Most employees are not interested in coverage
1-4	Count	10	4	6	3
	%	52.6%	21.1%	33.3%	*
5-9	Count	27	9	9	3
	%	90.0%	30.0%	31.0%	*
10-19	Count	17	10	6	7
	%	85.0%	52.6%	30.0%	35.0%
20-49	Count	12	4	4	1
	%	92.3%	33.3%	28.6%	*
50-99	Count	3	4	2	2
	%	*	66.7%	*	*
100+	Count	2	2	1	0
	%	*	*	*	*

*Categories with 3 or fewer valid cases are suppressed.
Note: Other reasons for not offering health insurance were posed to employers, but breakouts are not possible given small cell sizes.

Employers who do not offer insurance were also asked what could lead them to begin offering insurance to their employees. One situation that would prompt employers to begin offering insurance to their employees is the offering of pooling options that would allow employers to purchase group coverage with other employers (42.7%). Employers also stated that if the Wyoming State Employees Insurance Plan were made available, they would be willing to purchase insurance (40.2%) (See Table 3-10).

Table 3-10: Reasons That Would Prompt Employers to Offer Insurance

Employers who DO NOT currently offer health insurance to their employees were asked to respond to the following reasons that could lead to them offering insurance.*

	Percent agree with reason	Number agree
If pooling options were allowed to get group coverage with other employers	42.7%	35
If the state employee health plan was made available to private employers	40.2%	33
If Tax credits were increased	28.9%	24
Only if mandated by law	23.0%	20
If "defined contribution" plans were made easier to setup	4.8%	4

*An open-ended "other" category is reported elsewhere in this document.

Sample size is too low to get meaningful cell sizes with further breakouts.

When asked if the firm was currently looking for or considering ways to offer health insurance, 67.4% answered no. This means that only 32.6% of employers who do not offer health insurance are looking to do so (see Table 3-11).

Conclusions

While most Wyoming employers offer health insurance to their full-time employees, very few offer it to part-time employees. This is clearly a problem in industries where a large percentage of employees are part-time, such as food service, lodging, and retail. These industries make up a significant part of Wyoming's economy.

Fewer than half of Wyoming businesses with less than 10 employees offer insurance to any of their employees, and even fewer offer dependent insurance. For most of these small businesses, cost is the primary factor in their not offering insurance. Furthermore, it appears that very little can be done to change the minds of the majority of these businesses to consider offering insurance. Purchasing pools or making the Wyoming State Group Insurance program available for employer buy-in were listed by fewer than half of the respondents who did not offer insurance as possible incentives, and fewer than a quarter responded that a state mandate would be an incentive to offer insurance.

While employer-based insurance is perceived by many as the primary mechanism for working individuals to secure health care coverage, it is clear that in many cases, increasing access for employers to insurance programs is a difficult problem and will require creative solutions.

Table 3-11: Are Employers Who Do Not Offer Insurance Looking For Ways To Offer?

Would you say your company is currently looking for or considering ways to offer health insurance to your employees?

Industry		Yes	No	Total
Agriculture	Count	2	4	6
	%	33.3%	66.7%	100.0%
Mining	Count	1	1	2
	%	*	*	*
Construction	Count	4	9	13
	%	30.8%	69.2%	100.0%
Manufacturing	Count	2	2	4
	%	50.0%	50.0%	100.0%
TCPU	Count	2	3	5
	%	40.0%	60.0%	100.0%
Wholesale	Count	0	3	3
	%	*	*	*
Retail	Count	5	8	13
	%	38.5%	61.5%	100.0%
FIRE	Count	0	2	2
	%	*	*	*
Services	Count	9	14	23
	%	39.1%	60.9%	100.0%
Eating/Drinking Places	Count	2	6	8
	%	25.0%	75.0%	100.0%
Hotels/Lodging Places	Count	0	4	4
	%	0.0%	100.0%	100.0%
Health Services	Count	1	2	3
Estimated Annual Wage		Yes	No	Total
<$15,000	Count	4	24	28
	%	14.3%	85.7%	100.0%
$15,000-$25,000	Count	12	17	29
	%	41.4%	58.6%	100.0%
$25,001-$35,000	Count	6	4	10
	%	60.0%	40.0%	100.0%
$35,001-$45,000	Count	2	6	8
	%	25.0%	75.0%	100.0%
>$45,000	Count	4	7	11
	%	36.4%	63.6%	100.0%
Number of Employees		Yes	No	Total
1-4	Count	3	13	16
	%	18.8%	81.3%	100.0%
5-9	Count	8	21	29
	%	27.6%	72.4%	100.0%
10-19	Count	10	10	20
	%	50.0%	50.0%	100.0%
20-49	Count	5	8	13
	%	38.5%	61.5%	100.0%
50-99	Count	1	3	4
	%	25.0%	75.0%	100.0%
100+	Count	1	3	4
	%	25.0%	75.0%	100.0%
Total	Count	28	58	86
	%	32.6%	67.4%	100.0%

*Industry classifications with 3 or fewer valid cases are suppressed.

Section 4. Qualitative Research

Report Summary

Most residents of Wyoming get their health insurance through an employer. For those who do not have access to health insurance through an employer, obtaining private insurance can be difficult due to cost. Moreover, public insurance programs do not target the working poor and many do not qualify. To make things more complicated, Wyoming has a very high number of small employers who are less likely than larger employers to be able to offer health insurance.

Focus groups and in-depth interviews were conducted to learn more about how insurance is viewed and about barriers to obtaining coverage in Wyoming. These helped to describe more clearly the reasons individuals are uninsured, barriers to and benefits of having and/or providing health insurance, and the impact of being uninsured, as well as to identify and evaluate feasible alternatives for improving access to care. Focus groups were conducted with uninsured persons, small employers, and health care providers. Key informant interviews supplemented these groups. In addition, the comments made by the participants in the qualitative portion of the research, which includes both mail and telephone surveys, were included in this analysis.

Uninsured Individuals and Families

- How are the uninsured getting their medical needs met?

  When it comes to getting health care, uninsured people basically try to get by and seek care only when they really need it. Participants commonly reported that when faced with an illness or injury, they waited, cried, put it off, and evaluated things first to see if going to a doctor was *really* necessary. This quote by a 60-year-old woman exemplified what people do when they don't have insurance. She said:

  > *I try to stay away from doctors as much as I can simply because of the cost. So I will procrastinate to a point depending on what's wrong. I also read an awful lot, so I try to educate myself as to alternative things. Just recently I had a problem too, and … I had to get it checked out and it isn't an option to not, because it's not worth dying over $200, $300 worth of medical costs. Since my husband died, I've just … taken the attitude that I've never stuck anybody [health care providers] with any bills of any kind. I will pay some each month.*

  The participants in the survey described similar responses to illness and/or injury. They commented on avoiding doctors and going only if they were really sick because of the cost of health care.

  Participants described a tenuous and challenging balancing act—attempting to cover typical expenses for food and housing, while having to deal with routine and unexpected expenses for health care. One woman said she was "*terrified* " of health care expenses and wondered who would pay the costs if something happened to

her. Several participants with relatively serious chronic illnesses described weaning themselves off their medications because they could no longer afford them. Some participants felt they were treated poorly when they did seek health care because they didn't have insurance. They felt it was difficult to obtain care and that they were ignored by health care providers. They were frustrated that they had to pay upfront and felt they got "*the run around*" with referrals and diagnostic tests. Some participants felt cheated because although they were low-income individuals, they couldn't qualify for any assistance because they didn't meet the right criteria for various programs.

Health care providers and key informants echoed the challenges the uninsured face in obtaining health care. Primary care providers used a variety of means to provide care for their uninsured patients. Some clinics had billing offices that would work with clients to identify possible assistance programs and to arrange payment plans. Waiving charges, providing medication samples, and locating reduced-cost community lab fairs were common strategies. A variety of community resources were also used, including free clinics, tobacco coalition resources, community breast and cervical cancer programs, community medical funds, family planning clinics, and public health and public mental health agencies. Despite these resources, health care professionals experienced a variety of challenges in caring for uninsured patients. They felt that uninsured patients delayed care and came in only when they really needed help. Yet constrained resources made it difficult to provide the care they needed, and providers were frustrated by having their diagnostic and treatment decisions influenced negatively (e.g., only being able to order the bare minimum of diagnostic tests). One of the biggest challenges faced by the providers was the "patchy" resources available. Assistance programs and indigent clinics have limited eligibility criteria, so many people don't qualify and, for those that do, there are still limitations on what can be done. Providing diagnostic testing was also problematic. Few low-cost alternatives exist and most uninsured patients can't pay for them anyway, so often they don't get them done. In addition, providers faced significant challenges in obtaining specialty referrals, including dental care, for uninsured persons. Another significant challenge was ongoing medications for uninsured patients with chronic illnesses. Medication samples come and go and can't be relied upon, so it was difficult to keep patients on these long term. Indigent patient programs from the drug companies were used by some, but these were frustrating because of no universal application and eligibility criteria.

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

Uninsured participants describe a variety of benefits to having insurance, especially "*peace of mind*." As one person said, "*If anything bad happens [when you have insurance], you don't have to wonder*." Therefore, insured people feel less afraid and get better treatment. Consequently, insurance was a fairly high priority. For some participants, insurance was their highest priority, while for others, transportation and education ranked higher. Because getting to work was seen as fundamental to these participants, having transportation for work was a greater need

than health insurance if they had to rank them. However, they would prefer to have both.

Despite seeing a number of benefits and ranking health insurance fairly high, uninsured participants described a number of significant barriers to obtaining insurance. They typically did not have insurance because their employers did not offer it or because they were unemployed, and for most of them, the cost of individual insurance (premiums, deductibles, co-pays) were more than they could afford. For some, age and/or pre-existing conditions were barriers to having insurance. Low wages, few employers offering heath insurance, and/or divorce or death of a family member constrained people's abilities to obtain insurance. As one woman in a small Wyoming town said, "*The way I look at that is at my age [56 years old]… how many employers are even going to look at me to employ, let alone offer me [health insurance]*." Participants talked about the choices they had made and some, especially those with low wages, weren't sure that the benefit of health insurance was worth what a person had to pay for it. They made calculated risks such as the man who said, "*The thought of paying nearly 50%, well 40% of my income just for health insurance seems too high for me*." He also noted that, "*On the other hand… should something catastrophic happen to me, I have a lot to lose, too. I'm kind of stuck in a spot*." People had shopped around trying to find affordable health insurance, using the web and contacting companies or agencies they had heard about from friends or on TV, but they were unable to find coverage. This was discouraging, and one woman admitted that she didn't even look anymore because she knew she couldn't find anything that she would be able to afford. Some older participants with chronic health problems saw health insurance as virtually unrealistic for them. Several felt that insurance was difficult to understand and found that a barrier as well.

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

  Uninsured persons do not participate in public program, such as Medicaid and other safety-net programs because they feel that they "*fall through the cracks*." They make too much money to qualify for public programs but not enough to purchase private insurance or health care on their own. Some participants expressed feeling cheated because they have worked hard and yet can't get any public assistance. In addition, some perceived the application processes for various programs to be confusing.

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

  Participants felt that employer-sponsored coverage was very important. People said they would take a job without benefits if they had to because having a job and a steady income are very important, but they would prefer a job with health benefits. Several talked of the advantages employers have obtaining more affordable group policies. However, many of the participants voiced concerns about finding employers who offered health benefits because of many of the jobs in the tourism and service economy of Wyoming do not offer these benefits.

- How likely are individuals to be influenced by availability of subsidies? Tax credits or other incentives?

  Tax credits were not seen as helpful. As one participant said, "*You need to have an income in order to benefit*" and most had quite low incomes. Others weren't really sure how this would work and therefore didn't know if it would be helpful. Subsidies to help pay insurance premiums were perceived to have more potential. A number of participants felt that an affordable state health insurance plan on a sliding scale would help most.

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

  Participants were willing to pay for health insurance. Participants in one focus group debated the idea of a premium of $100 per month. But for some, premiums of only $10 or $20 would be possible. Other participants recommended sliding scale premiums based on a household's income. High deductibles were a barrier for many. For some, this meant a deductible of $2,500, but for others, even a deductible of $300 would be too much.

- What are the features of an adequate, barebones benefit package?

  Uninsured participants were split on this issue. One the one hand, people were very concerned about an overwhelming illness or injury devastating them and their families financially, emotionally, and physically. So for some, a catastrophic policy would be desirable. Yet others felt that there should be some provision for routine care, which also can be expensive, while many would prefer comprehensive coverage that included routine and preventive care and major medical and catastrophic coverage. Participants in one group wanted more standardization in policies and benefits so it would be easier to understand health insurance coverage.

Employer-based Coverage

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

  A variety of factors influence small employers' decisions about whether to offer health insurance. Most directly, it is a balance between offering higher wages versus offering a reasonable salary and health benefits. Employers offering insurance saw providing insurance as something they should do if it were financially feasible. According to the participants, offering health insurance helps attract and keep good employees. One participant commented that if you have insurance, your employees will get timely care and be more productive. For a few, offering insurance was a moral obligation. Even for those providing insurance, significant challenges were encountered in trying to provide insurance to their employees, including cost, wages of employees, and few insurance carriers in Wyoming.

  Those not providing insurance cited a variety of factors influencing their decision, including costs, primarily hiring part-time, seasonal or contract employees, employer costs to manage health benefit program-related paperwork, bureaucratic requirements, and understanding complex and changing rules and regulations. Several participants said they had shopped around but had been unable to find any insurance to cover their employees. One employer questioned whether providing health insurance was the responsibility of the employer; he felt it was ultimately up to individuals. Not providing health insurance had some negative consequences for employers. For some, it primarily affected their ability to attract qualified

employees. For a few, employees had left to go to other companies that did provide health insurance.

- How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

  Employers also made decisions about what type of coverage to provide. Most often, they tried to identify a reasonable deductible with an insurance plan that made sense. Some used cost sharing of the premium so they could maintain coverage, while others allowed their employees to purchase more coverage or choose a lower deductible.

  Some of the employers not providing insurance came up with other ways to provide some benefits to their employees. Some chose not to offer insurance but paid their employees extra so they could purchase health insurance individually. Some offered other health benefits such as dental care so their employees at least had some coverage.

  Employers were divided in their opinions about what would constitute a basic affordable package. Most would prefer comprehensive benefits that included both routine and catastrophic coverage. Some wanted more coverage of routine and preventive care, while still others focused more on making sure that employees had catastrophic coverage to cover very expensive care.

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

  Employers providing health insurance to their employees said they would want to continue this benefit if at all possible. They would consider cost sharing with employees (e.g., having the employee pay for part of the premium). Some offering other benefits such as dental coverage would drop these first before dropping health insurance for their employees.

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

  Exploring ways to increase the size of employee pools was the most commonly discussed strategy in the small employer focus groups. Employers recommended having the Chamber of Commerce or some other business organization administer a program in which employers could pool all their employees for purchasing of health insurance. The participants had mixed perceptions of tax incentives and subsidies. Employers were not very positive about direct individual subsidies or taxes; concern was expressed about how employees might spend these and whether the money would be used for health insurance or health care. Tax credits for employers were seen as positive if they could be applied to payroll taxes but were perceived as probably not large enough to make a significant difference.

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

  Employers discussed other solutions, including state-administered health insurance programs, national health insurance, training of employees to decrease injury and illness, and medical savings accounts. Increased competition and "*fixing*" health care in Wyoming were also recommended so that young people and innovative businesses would be attracted to Wyoming.

Root Causes and Solutions

- Root Causes

  The root causes of the growing number of uninsured centered on the high cost of health insurance, the high cost of health care, and low wages. The growing costs of health insurance and health care were related to an aging population, drug costs, malpractice costs, cost-shifting from government programs to the private sector, lack of competition, exodus of insurance carriers in Wyoming, lack of managed care, growth of expensive medical technology, and health care professional shortages. Low wages were attributed to the high number of small employers and a weak Wyoming economy.

- Solutions

  Participants in the focus groups, surveys, and key informant interviews offered a wide variety of solutions to enhance access to health insurance in Wyoming. Several participants acknowledged that there were multiple solutions and no "*silver bullet*." Participants ranged philosophically from those who wanted expanded government involvement in health care to those who wanted to minimize or even eliminate government involvement.

  Expansion of public programs was one of the most frequent recommendations. This included expanding existing programs such as restructuring Medicaid eligibility and benefits, expanding KidCare to include parents, increasing reimbursement levels of public programs such as Medicaid and Medicare, and taking advantage of federal monies to expand state programs. Some proposed new public programs such as national insurance, socialized medicine, or state sponsored health insurance for individuals and/or employers or self-employed persons. Participants also recommended supporting, developing, and expanding the safety net, including free clinics and community health centers for those who fall through the cracks.

  As noted previously, participants recommended a variety of ways to expand employer-based coverage, including purchasing pools, tax credits, and subsidies. In addition, other solutions were recommended, including making employer-based health insurance mandatory and paying for it like unemployment insurance, with employer and employee contributions.

  Increasing personal responsibility for healthy lifestyles and for payment of health care costs was commonly recommended. A number of participants thought individuals needed some economic stake in health care so that they would make positive decisions. Others thought incentives for healthy lifestyles such as reduced premiums would be helpful. Education about available programs, cost and effectiveness of health care, and specific treatments were also recommended.

  Some participants recommended ways to control costs and address health care professional shortages such as mandating discounted prices from health care providers, expanding the use of formularies to focus on lower cost effective drug therapies, pharmacy advocacy programs, and health care planning. Tort reform was recommended, as well. Finally, some recommended restructuring insurance benefits with standardized and simplified policies or by mandating minimum benefits.

Introduction

Approximately 14 percent of Wyoming's population is uninsured. Wyoming's small population, rural nature, small business economy, and lack of managed care create a significant although not insurmountable obstacle for residents to obtain affordable, high quality health insurance coverage. The State of Wyoming received a State Planning Grant in 2002 with the goal of developing a strategic plan to provide Wyoming citizens with access to adequate and affordable health insurance coverage. As a part of this project, several studies were conducted to learn more about the uninsured and the needs of small businesses, and to gain input from a broad cross-section of the population on the strategies that could work in Wyoming.

Project Goals/Objectives

As part of this larger project, focus groups and in-depth interviews were conducted to understand the reasons individuals are uninsured, barriers and benefits of having and/or providing health insurance, the impact of being uninsured, and to identify and evaluate feasible alternatives for enhancing access to care. Focus groups were conducted with uninsured persons, small employers, and health care providers. Key informant interviews with health care and business leaders supplemented these focus groups.

Focus Group Procedures

A total of 13 focus groups limited to six to eight persons were completed. Each group consisted of uninsured persons, health care providers, or small employers. Focus groups were held in different locations around the state of Wyoming to help assure variation among the respondents. For uninsured persons, variation in gender, ethnicity, income, and employment status was sought. For small employers, variation in type of industry (e.g., service industry vs. agriculture), size of business, and whether they currently offered health insurance were sought. We sought employers with 20 or fewer employees because these employers are less likely to offer health insurance than larger employers.

Semi-structured interview questions were used to stimulate the focus group participants to talk about their attitudes and beliefs about being uninsured and ways to enhance access to care. Uninsured persons were asked about their experiences being uninsured, barriers to obtaining health insurance, perceptions of possible solutions, and incentives for enhancing access to health care and health insurance. Small employers were asked about their attitudes and beliefs about providing health insurance for employees, barriers to providing health insurance, and attitudes and beliefs about possible solutions and incentives for employers to provide health insurance. Health care providers were asked about their experiences working with the uninsured, their sense of the barriers to caring for uninsured persons, and perceptions of possible solutions.

We followed the focus group protocols recommended by Dr. Richard Krueger, a focus group expert who has been involved with the State Planning Grant process nationally. The focus groups were held at community sites readily accessible to the participants. To promote participation, refreshments were served and each participant received a

modest compensation at the end of the focus group. A moderator asked questions and facilitated discussion at each focus group. An assistant moderator also attended each focus group to help facilitate discussion as needed, observe interactions, and document nonverbal behaviors in field notes. Each focus group lasted approximately 90 minutes. The focus groups were audio taped and transcribed verbatim for in-depth analysis. After the transcription, the moderator of the focus group reviewed the transcript for accuracy, and corrections were made as needed.

Uninsured Persons Focus Groups

Focus groups with uninsured persons were held around the state: Laramie, Cody, Sheridan, Douglas, Jackson, and Rawlins. A different group at high risk for being uninsured—clients of free clinics, retail and service workers, construction and other temporary workers related to boom industries, low-income adults in their 50-60s not yet eligible for Medicare, and specific minority populations known to have barriers to health care, including Hispanics[8] and Native Americans—was targeted at each focus group. We were unable to obtain permission to conduct a focus group on the Wind River Indian Reservation, so we did not complete a focus group with Native Americans.

A total of 33 people participated in the uninsured person focus groups. (See Table 4-1.) Participants ranged in age from 20 to 69 years, with the majority of the participants ranging in age from 30 to 59 years. Over three-quarters of the participants were women. Education levels ranged from those without high school education to those with college degrees. Forty percent had a high school diploma. Three-quarters of the participants were Caucasian, but Hispanic and Native Americans were also involved in the focus groups. Finally, more than three-quarters of the sample were employed.

[8] We are using the term Hispanic in this report. We recognize that some of the participants prefer this term, while others prefer Latino.

Table 4-1: Sample Description of Individuals Participating in Uninsured Focus Groups

Demographic Characteristic	N	Percentage (%)
Age		
20-29	2	6%
30-39	10	30%
40-49	5	15%
50-59	13	40%
60-69	3	9%
Gender		
Women	25	78%
Men	7	22%
Education		
Less than high school	4	12%
High school/GED	13	40%
Some college	9	27%
College degree (Associate or Bachelor)	7	21%
Race		
Caucasian	25	76%
Hispanic	7	21%
Native American	1	3%
Employment Status		
Employed	25	78%
Unemployed	7	22%

Small Employer Focus Groups

Focus groups with small employers were held in Casper and Rock Springs. In each town, two focus groups were completed—one with small employers offering health insurance and one with small employers not offering health insurance. The participants (N=21) in the small employer focus groups had anywhere from 1 to 22 employees, with an average of 10.8 employees across all the employers who represented restaurant and food services, travel and tourism, manufacturing, entertainment, publishing, health and social services, retail, financial/legal and insurance, home and auto repair/maintenance, and several small nonprofits. The participants represented organizations that had been in business from 1 to 100 years. Fifty-seven percent offered health insurance, while 43% did not. Very few offered dental (N=5), vision (N=3), life (N=3), or disability (N=1) insurance to their employees.

Health Care Provider Focus Groups

To gain a better understanding of the challenges faced by those providing services to the uninsured, focus groups were conducted with two broad types of health care providers.

- Health Care Program Managers/Directors, State Officials, and Health Care Professionals
  - Program Managers/Directors, State Officials, and Health Care Professionals at the Wyoming Primary Care Association Visioning Conference in Cheyenne
  - Members of the Minority Health Committee in Cheyenne
- Primary Care Providers
  - Physicians[9]
  - Nurse practitioners[10]

Primary Care Providers

Five family nurse practitioners (FNP) participated in the nurse practitioner (NP) focus groups. One NP, who was unable to participate at the last minute, provided written answers to the questions. One FNP had seven years of experience and was currently working in a private internal medicine practice. Another was in her first year of practice in a private family practice clinic. One FNP had five years of experience in both family practice and internal medicine in private clinics. Another FNP with seven years experience had worked in a variety of family practice settings in Colorado and Wyoming, including private practice, student health, an urgent care clinic, and an indigent clinic. One FNP was currently working in a publicly funded indigent clinic. And the last FNP had 13 years of experience and was currently working in a publicly funded family planning clinic. Three physicians were interviewed separately because a common time could not be found to hold the focus group. One physician was a pediatrician with 25 years of experience in Wyoming. Another was an obstetrician-gynecologist with six years of experience in Wyoming. The last physician was an internist in his first year of practice.

Health Care Program Managers/Directors, State Officials, and Health Care Professionals

A variety of program managers/directors, state officials, and other health care professionals (HCPs) participated in two focus groups in Cheyenne, one held at the Wyoming Primary Care Association Visioning Conference and the other at the Minority Health Meeting. Included among the 20 participants in these two focus groups were representatives from advocacy organizations, federally funded clinics, education, psychology, nursing, Indian health organizations, and various state health and social service organizations.

Key Informant Procedures

In addition to the focus groups, 16 in-depth interviews were conducted with key informants, including insurance industry leaders, safety net providers, business and health care leaders, state officials, professional organization directors/officers, and health care professionals. These were fairly unstructured interviews focusing on ascertaining perceptions of the causes and solutions to the problems of no insurance.

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[9] Because of significant scheduling problems, physicians were interviewed individually. It was impossible to find a common time.

[10] The nurse practitioners were from across the state, so this focus group was done by phone because of the distances among participants.

The key informant interviews lasted from 20 to 60 minutes. Like the focus groups, the interviews were audio taped, transcribed verbatim, and verified for in-depth analysis.

The following individuals were interviewed. We have identified their affiliation at the time of the interview.

- Lloyd Wilder, Wyoming Insurance Department
- Patricia Guzman, Wyoming Department of Health, Children's Insurance
- Ralph Hayes, Employees Group Insurance Program
- Dan Perdue, Wyoming Hospital Association
- Roger McDaniel, Wyoming Department of Family Services
- Kenneth McBain, CHC of Central Wyoming
- Emily Quarterman, Wyoming Department of Health, Community Health Planner
- Beverly Morrow, Wyoming Primary Care Association
- Kerry Hall, Delta Dental
- Dave Athey, Express Pharmacy
- Tim Crilly, Blue Cross/Blue Shield of Wyoming
- Wendy Curran, Wyoming Medical Society
- Kelly Jankofsky, Trilegent Corporation
- Iris Oleske, Wyoming Medicaid
- Bill Schilling, Wyoming Business Alliance
- Peter Reis, Wyoming Business Council

Survey Comments

Finally, because of the volume of comments provided by people participating in the household surveys, these comments were analyzed as well. The participants in the mail and telephone surveys included both insured and uninsured people. Comments ranging in length from one sentence to several pages were returned with the surveys or provided to the telephone interviewers. These comments complement and extend the findings in the focus groups and the key informant interviews.

Data Analysis

The data set is quite large, approximately 610 pages of transcribed interviews, focus groups, and comments from the survey that requires a fairly complicated process for comprehensive analysis. After the interviews were transcribed and verified, an initial review was held. Following this initial review, the transcribed interviews were transferred into a qualitative data analysis software program. Coding categories were developed, and the transcribed data were formally coded using these categories. Several trained coders reviewed each transcript categorizing the data according to the established coding scheme. After the findings were synthesized, they were distributed to the moderators, assistant moderators, and some of the participants for their review to see how accurately the summaries fit with their experiences and what was discussed in the focus groups. Those who reviewed the findings felt that the findings were a representative and accurate summary of their experiences or of those of the focus group participants.

Findings

The purpose of this type of "qualitative" research is not to quantify (e.g., tell us the number of uninsured) but to describe the phenomenon under investigation, in this case the experience of being uninsured, caring for the uninsured, or trying to provide health insurance to employees. Consequently, in this section, we have made every attempt to provide rich detail and description and to use the words of the participants. Please note that with the exception of the key informants, all names used are pseudonyms. We only used the key informants' names when we felt it was important to know the actual source of the quote. Otherwise, we referred to them simply as a key informant.

Uninsured Individuals and Families

Meeting Health Needs: Between a Rock and a Hard Place

Impact of Being Uninsured

To understand how uninsured persons and their families meet their health care needs, the reality of what it is like to be uninsured must be understood. Uninsured persons in the focus group provided rich descriptions of the challenges they faced in attempting to balance expenses for their everyday lives such as food and rent with purchasing health insurance and paying for health care. Essentially, they described being "between a rock and a hard place." The following participant may have said it best: "*You cannot afford health coverage, and you certainly cannot afford not to have coverage*." Most of the participants had relatively low incomes and had little left to pay for insurance. So people "*live paycheck to paycheck*." One person said, "*You've got to have something to live on, you've got to pay for heat, your electricity ... gas*," and that leaves little room for paying for health insurance and/or health care. Another said, "*In my last paycheck, my company paid $350 for two weeks. I'm paying rent, I'm paying for my food, and not have enough money for the insurance.*" Many, like the following woman, made every attempt to pay for their health care: "*Since my husband died, I've...taken the attitude that I've never stuck anybody with any bills of any kind. I will pay some each month; they're going to have to take it as I have it because I want to live and remain healthy*."

However, some of the participants were having significant troubles making ends meet. They had financial debts, and some were dealing with collection agencies and/or facing bankruptcy. Some paid their bills late, spent their savings paying for medical care, "maxed" out their credit cards, depended on their extended families for assistance, and/or simply did without things. One mother said, "*My check has been small and then like I said we just skip a bill for two months or…we go to the food bank here...we do without*." Another person said, "*And then I had pneumonia…Had to be hospitalized for three days. That little experience cost me $10,000 and I'm an uninsured person. I have a husband. He works for somebody that only provides a wage*." In a few cases, people actually stopped their medications because they couldn't afford them. One woman who had a very serious illness said, "*My condition from 10 years ago or so…when I started taking medication for bipolar. It's not my body; it's my mind. But I weaned myself off of it because I know I'm not going to be able to get it…I went off three medications somewhere around Thanksgiving. And [I'm] just winging it ... Just do each day as it comes.*" Living this way is not easy. One person put it bluntly, "*I have found out that*

just living on a very limited income is enough to make you depressed if you weren't." Several described being scared and even terrified that something bad would happen and they would lose everything. One woman said:

> *I'm terrified of getting pregnant. I don't know how I would afford to be able to pay for that without me having insurance... I realize a child would probably be covered under my husband, but what would happen to afford hospital bills. It's terrifying*.

Being uninsured is a "family affair," with whole families having to deal with the problem. One family was dealing with a seriously ill child who did not have insurance and had very large medical bills. Another man told of his wife having to have surgery. Because she had no insurance, they lost a significant portion of their savings, paying $5,000 out of pocket for her care. He said:

> *When it came to my wife's double mastectomy they made us, that was the doctor out of...Denver. That was upfront because we had no insurance. I had to pay that before we even got to the hospital. To write a check. Straightaway...Had I not been able to do that, it would have been a catastrophe*.

And for some, one catastrophic health event can devastate the entire family. One participant said, "*She sent me to a cardiologist. I ended up owing $48,000 for surgery and hospital and paid $2,000 to the cardiologist and $2,000 to the surgeon helpers.*" Not only do large medical bills impact the family, participants noted that they can negatively affect the community. One woman said poignantly:

> *Coming from...a child with a serious illness to the point where by the time he got so ill [with] his diabetes that he needed a kidney transplant...had no insurance whatsoever. So having gone though that and realized that...he will never own anything. He will never be out of debt from his transplant situation and his ongoing therapies...But God forbid that we have 500 or 5000 people in that same situation because then there would be no economy left for anybody*.

The key informants and health care providers saw similar effects of being uninsured. One state official said:

> *So I think the effect is that these children or these families, they go without the care and then they end up, the children end up living and their parents living sicker and then they end up dying younger from a disease that could actually have been taken care of...if they would have accessed the care earlier.*

Many commented on the balancing act that uninsured persons must undertake, attempting to provide for their families and pay for health insurance and health care. One state official said

> *What happens is they make such low wages so the patients, the families, the kids ... they have to decide well should I fill my refrigerator to be able to feed my children or pay my daycare or do I go out and spend $300 plus on a health insurance premium where I'm still going to have to pay a deductible and co-payment and that sort of thing.*

One physician said, "*Just a lot of people that just are doing the best they can to make ends meet. They are paying their other bills but can't afford the $700 a month or so that it costs to insure a family*." One nurse said, "*People fear and worry of serious injury and illness which could lead to death and possible bankruptcy*." A physician said, "*People feel embarrassed about it. They feel guilty.*"

Health and Illness Behavior

Like most people, uninsured persons attempt to maintain their health by having a positive attitude and making healthy life changes such as eating right and exercising. But illness and injury presented significant problems for uninsured persons. One woman, when asked what she does when she gets sick, said simply, "*Cry a lot.*" Uninsured persons said they evaluate the situation and decide whether it is serious or not. Commonly, people said they put off getting care, as this person said, "*Put it off as long as possible, if it's not real bad. And then when it is, I guess you've got to come in*." But usually, people avoided seeking health care as much as possible. One person said frankly, "*I try to stay away from doctors as much as I can simply because of the cost*." Several tried ignoring or fighting off the symptoms and the health problem, hoping they would go away. One woman in chronic pain from arthritis said, "*I just fight it. I fight it every single day when I get up. I thought, 'I don't ache this morning. I really don't ache. I can get out of this bed, walk across this room' and do you know...I'm hurting everywhere.*" Many talked about using home remedies and other self-care activities such as taking over-the-counter medications, staying off their feet, and reading about the problem. One person had this approach: "*I take three aspirin and if I'm still alive three days later....*" Some used available community resources such as churches, public health, and health fairs although often they found these services to be inadequate or incomplete. A few depended on prayer and faith. One woman said, "*I'm going to control it with my state of mind and my spirituality*."

If the situation was serious, care was sought. Not surprisingly, parents took their children in for care sooner than they would go for themselves. ("*In the case when the son, their kids are ill, she doesn't think twice to go to the doctor*.") While they valued having a good primary care provider to go to—"*It's important that you have a good doctor, too, that you can depend on and that can diagnose you, who's going to know what's wrong with you and know your history and help you. And also a dentist.*"—finding someone to see them was difficult. One participant had this experience:

> *Last year when my sister died, I tried to seek treatment because I was grieving and not really functioning very well. And I contacted the hospital and I contacted three area psychiatrists and was told by two of the psychiatrists they couldn't see me because I have no coverage or they wanted cash up front which I didn't have.*

Participants also had trouble meeting dental needs. One participant noted, "*There's lots of dentists in town that won't take new patients*." Another said, "*If you have a terrible toothache and they want money up front, then you're in trouble*." Some shopped around for medical and dental care. One woman talked about having to "*convince them [health care professionals] to go ahead and take care of you*." If they could get in for care, participants talked about working with clinics to charge the bill and pay it off slowly. They would also ask the provider for free samples of medications. Some went to other states for care, including surgery. For some, the emergency room was their place of last resort because they knew they would get seen and receive care.

The health system was also seen as a maze that was difficult to negotiate. People had trouble understanding the costs of their care, including medications, and felt there were too many bureaucratic barriers such as pre-authorizations and "legalese" in insurance and other health care documents. One man said:

> *The last doctor bill I had, I needed some sort of chart that defined all the numbers and abbreviations and everything so I knew what I was paying for...I'm looking at this thing going, "This means nothing to me. It's just a bunch of charges on here. I don't have any idea what I was charged for." And I got somebody on the phone and made them sit down and explain each one of these things. Otherwise, how else would I know?*

Another person said emphatically:

> *The whole system's messed up...The doctor's got to make money. The hospital's got to make money. The insurance people want to make money. If nobody's making money, then there're no providers. But on the other hand, the amount of people who can't afford medical care has just quadrupled.*

The participants in the survey described similar responses to illness and/or injury. These participants, who included both insured and uninsured people, commented on avoiding doctors and going only if they were really sick because of the cost and/or of stopping medication because of the expense. One person wrote bluntly, "*My family does not see a doctor unless it is something that we cannot handle ourselves because the cost is outrageous*." Another wrote, "*I've denied myself drugs at times because I can't afford them and they aren't covered by Medicare or insurance*." If participants had to see a physician or nurse practitioner, they tried to set up payment plans so they could pay a little each month and asked for drug samples to keep down medication costs. Finally, they were also very concerned that something bad might happen and cause them to lose everything. One person wrote, "*If I have to go to the hospital for any services, I will probably have to declare bankruptcy because I won't be able to pay the bills. Right now I can't even afford one office visit to a doctor let alone pay for a prescription*." And for some, these high bills were a reality. One person wrote, "*I became quite ill – 1995, ran up a hospital bill of $58,000, on which I am still paying on. Don't believe I will live long enough to pay it off, but keep trying.*"

Again, the experiences of the key informants and the health care providers with uninsured persons mirrored the above findings. Physicians and nurse practitioners (NPs) found that patients delayed medical, dental, and mental health services. They

had used little or no preventive services and had trouble purchasing medications and returning for follow-up. One person commented, "*They can't afford the therapy so you can diagnose them, recommend the treatment, but they can't get the medication, go to the therapist, you can't do follow up*." Several talked about the difficulty that uninsured persons have negotiating the system. One doctor put it this way, "*If you don't have a 'PhD in health care in Wyoming', how would you know what to get, who to get it from, where it is, how you do it?*" Cultural and language issues compound this problem. So again, the emergency room is often used as a source of care. "*The ER isn't the place to go but the reason they're going there is because there isn't any other place to get health...care.*" Health care providers also observed patients going to other states to receive care.

Managing Care for the Uninsured

Managing care for uninsured patients is not easy according to the health care providers in the focus groups. Patients without insurance have an impact on health clinics. The participants were seeing anywhere from a few uninsured patients a day up to 10-20 percent of their caseload. Ninety percent of the caseload of one participant employed by an indigent were uninsured. Providers must decide how to handle such cases. As one physician said, "*It means I often waive my charge to them, which raises my cost to other people or lowers the amount of money I have to pay my staff to run my practice.*" Some developed strategies for helping deal with the financial aspect: sliding scale fees, writing off or not charging for visits, setting up payment plans, or having the business office help people find financial assistance. Physicians and NPs used samples, generic medications, and medical assistance programs to help patients get the medications they needed. They used available community resources such as free clinics, health fairs, screenings programs like the Breast and Cervical Cancer Program, and other community means.

Ultimately, however, providers felt constrained in the care they could provide. One physician said bluntly"

> *It impacts me...limiting the number of laboratory tests and x-rays that I might order to just the bare essentials...Choosing the medication based on what I have available for samples . . ., rather than based on what I think is the best drug clinically*.

Providers identified a number of significant unmet needs for their patients without insurance. Repeatedly, they were frustrated by the difficulties in obtaining needed screening and diagnostic tests. This was particularly an issue in preventive care when patients didn't get timely screenings because they were unable to or didn't value it. One physician noted, "*You can go down to family planning and get help with pap smears and women's health. You're not going to get a colonoscopy if you don't have insurance*." Moreover, following up on positive screening tests was also challenging. One nurse practitioner said:

> *You'll get them in for those screening things, like the Wyoming Breast and Cervical Cancer, but then what do you do with the results that you find… If*

you're screening for high blood pressure and you find that, then you're stuck because they can't get treatment.

Not only was preventive care, especially screenings, challenging, but so was arranging for needed diagnostic tests. A nurse practitioner commented, "*If someone comes in with cardiac chest pain who may need a stress test or cardiac cath [catheterization], there's no way for us to pay for that*." Primary care providers found treating patients without insurance difficult, especially getting medications, therapies, mental health, substance abuse counseling, dental care, and vision services. Referrals to specialists were difficult to arrange. Finally, although the physicians and nurses used a variety of community resources, the safety net in their communities was patchy because of inadequate funding and lack of coordination between agencies and high demand, and these inadequacies were compounded by gaps in the rural health care system in general. Providers were also frustrated because all safety net programs have specific eligibility criteria, so patients often didn't qualify for assistance. One nurse practitioner said:

I do have access to the Free Clinic or I can refer people to there, which is wonderful. However, like I had a woman a couple of weeks ago who really needs some help...and she doesn't have insurance, however she doesn't qualify there and she makes too much money. So that's probably...my biggest challenge is people who don't qualify for...the resources we have in town.

Barriers to Purchase of Health Insurance: Money, Money, Money

Uninsured persons saw a variety of benefits to having insurance: better treatment, care when needed, peace of mind and contentment, less fear, help with catastrophic health expenses, no upfront payment for care, ability to get in for care rather than let things go, ability to get preventive care, and avoiding leaving their medical bills to their children. Indeed, for most of the participants, insurance was of relatively high importance. Uninsured persons were asked to rank the following in terms of importance: clothing, education, entertainment, health insurance, and transportation. Consistently, transportation, education, and health insurance were ranked highest. Health insurance was typically ranked 1, 2 or 3. One person ranked health insurance high because of a chronic condition, saying "*I think [it's] the major priority at my age and life set right now with having diabetes and realizing that...the older I get the more serious it will be.*" For some, it was not as high a priority as education and transportation. Transportation was often ranked over insurance because "*You're not going to be able to get to work to get the money to pay for the insurance.*" For some, education was of highest priority because if "*You get further on with your education and get a good job, you are much better off.*"

Despite the value that people placed on having health insurance and their ranking it fairly high in terms of importance, uninsured participants perceived significant barriers to obtaining health insurance. The number one reason cited was cost. This exchange in one of the focus groups illustrates the economic barriers to obtaining health insurance:

Moderator: *I'd like for you to tell me or describe the main reason that you do not have insurance*.

Margie: *Money*

Bob: *Money*

Kathy: *Money*

Richard: *Money*

Veronica: *No money*.

Susan: *Money*.

People typically did not have insurance because their employers did not offer it or because they were unemployed. Low wages and few employers offering heath insurance constrained people's abilities to obtain insurance. One person said, "*I only had one job ever in this town where I had benefits included in the job.*" One woman said, '*I had really good jobs, but the insurance that the company offered was so high that I wasn't able to afford it to cover myself and my son."* Another said, *"But see even my pay at $7.50 an hour, 40 hours a week. I couldn't afford $80.00 every two weeks [for the premium].*" For some, age and/or pre-existing conditions were barriers to having insurance. One woman had this experience: "*I'd call major insurance companies on health insurance for me and my daughter, but none of the insurance companies would cover me because of my legs and they wouldn't cover my daughter for the first year because of her asthma.*" Finally, for one young participant, health insurance had not been important until his daughter was born. He said, "*I never had a reason to have it really.*" He was just about to start receiving health insurance through an employer and went onto say, "*I just had a baby daughter three months ago almost. That was the main reason I got it because you never know when something's going to happen to her.*"

Participants talked about the choices they had made and for some, especially those earning low wages, the benefit of health insurance wasn't perceived to be worth what a person had to pay for it. They made calculated risks, such as this man who said, "T*he thought of paying nearly 50%, well 40% of my income just for health insurance seems too high for me*." He went on to note that "*On the other hand...should something catastrophic happen to me, I have a lot to lose, too. I'm kind of stuck in a spot.*"

The participants had a variety of patterns of past insurance coverage. Some had been uninsured for long periods of time. Others had been covered until recently or were anticipating coverage in the near future. For a few, a change in family structure through a death of a family member or a divorce affected their insurance coverage. For one woman, a divorce led to being uninsured. She said, "*When I was divorced from my first husband, my son had just come down with diabetes. We had 100% medical through the coalmines. When I divorced him, I had no insurance.*" For others, the spouse or partner was the wage earner and had no employer coverage for family members or they were unable to afford that coverage. One woman said, "*I have a husband. He works for somebody that only provides a wage*." Some had been insured through an employer but because of a job change, no longer had insurance. One person said, "*I had insurance for 12 years. I've been without insurance for seven months. I just got insured*

1 month ago; then I changed employment so now I have a three-month waiting period. Plus I have diabetes so I have pre-existing. . . ." One woman's Medicaid coverage had ended.

People got information about health insurance from a variety of sources: mail, family recommendations, the Internet, TV, informational sessions at work, and the yellow pages. Some had shopped around trying to find affordable health insurance, using the Web and contacting companies or agencies they had heard about from friends or on TV, but they were unable to find coverage. One participant responded to an ad—"*I mean it was just a shot in the dark. I got some ad in … my mail. It was like 'get affordable medical… care or insurance.' And it was like, 'Oh, I'll just bet.' So anyway, I filled this out and then I was called and we go through the big physical and … I already knew [I wouldn't get it].*" These kinds of experiences were discouraging, and one woman admitted that she didn't even look anymore because she knew she couldn't find anything she would be able to afford. Some participants felt that their employers didn't tell them about insurance options. Some older participants with chronic health problems saw health insurance as an unrealistic option. Several felt that insurance was difficult to understand and found that a barrier, as well. One woman put it this way: "*Me and insurance are like putting me behind a brick wall to see if I can see through it. I just [don't] comprehend.*" When a participant recommended that people read insurance policies very closely, another man said, "*Even though I don't understand them.*"

Generally, participants were quite negative about the insurance industry, which was perceived to be profit motivated, "big business," and practicing unfairly and even fraudulently. One man said, "*The insurance companies play games even if you are paying the premiums. … You'll go in and say 'Well, I need such and such to be done.' Then they'll say, 'Well, we're not going to cover that because it's not reasonable and customary.'*" Another said, "*I have a tough time buying the fact that insurance companies are losing money because they're the biggest financial institutions in the world.*"

Participants in the survey reported similar barriers to getting and maintaining insurance as the uninsured persons in the focus groups did. Again, cost came up repeatedly: "*I'm 55 and can't afford the premium*"; "*Our children are covered by Wyo KidCare, but my wife and I have no insurance because of the cost for insurance today*"; a 62-year-old female respondent was "*uninsured because of cost*"; and "*Our insurance was over $700.00 a month. That is almost one half of our monthly income. It came to eating or having insurance*." Other factors such as age, pre-existing illness, and few insurance carriers also affected their ability to have insurance. One person wrote, "*Being upper middle-aged and having some medical problems, no other company will give us insurance without putting riders on us. So we are stuck*." Some also were skeptical about health insurance and the health insurance industry. One wrote, "*It has so many loopholes and 'fine print' that it is almost like I have no health insurance.*" Another wrote, "*We still have $1,000 deductible, but that means nothing since the insurance company always claims that the medical bills are over 'usual and customary' and they won't pay or recognize about 20% of the expenses, or more, and they don't include the costs of medications.*" Another wrote, "*We have to watchdog the insurance company for errors*." Some survey participants also questioned the cost-benefit of health insurance, as well.

One person wrote, "*I pay more and more every year for health [insurance] and they cover less & less.*" Another wrote bluntly, "*We pay too much for insurance and get very little in return*."

Participation in Public Programs: Falling through the Cracks

Uninsured participants did not participate in public programs such as Medicaid and other safety net programs because as one woman said, "*I fell through the cracks of the system.*" They made too much money to qualify for programs but not enough to purchase private health insurance or health care on their own. One woman lamented:

> *When I had all this problem going on with my teeth, I had gone to the Welfare Department and asked them, "Isn't there anybody that can help me?" Or there should be some kind of a fund. And they said, "Helen, we would pay for everything if you had your children living with you." But because my children live with my ex-husband they wouldn't. And I don't know what difference does that make. My income doesn't go up any more.*

Another had this experience:

> *I needed to have emergency surgery and it was a life and death situation and I had gone to the doctor and I was told to go to Departmental Services [DFS] to try to get some assistance. And because I was going to be out of work for a while. The problem that I ran into is I was told that I needed to, my ex-husband was not paying child support because I didn't want him to know where I was for my own safety. So because I did not receive child support I did not qualify for any assistance from the state or any other kind of benefits.*

Some participants expressed feeling cheated because they worked hard and yet couldn't get any public assistance. One woman said, "*Because I worked and I felt I was penalized because of that ... and so I think there needs to be something put into place for families that are working, going to school....*" In addition, some perceived the application processes for various programs to be confusing.

Health care providers noted similar problems. One provider said, "*They [uninsured] usually end up falling through the cracks as far as being able to quality for other services that are like Medicaid and things like that because they have a job and they have a little bit, but they don't have enough to have enough money to have health care.*" Another responded, "*The working poor who don't qualify for Medicaid or Kid Care, they're just a little over income and since insurance. . . in this country is tied to employment they often don't have employers that provide insurance so they're just kind of out in the cold there, fall through the cracks*." The key informants managing these assistance programs reinforced these comments. Patricia Guzman from Wyoming Department of Health Children's Insurance program outlined the limitations of state assistance:

> *You have a lot of times where the parents will call and they're grateful that … their children can be enrolled [in KidCare], but then they want to know if we have anything available to them, and unless they're at a very, very low*

poverty level that Medicaid could cover, there's no coverage. Because the only other coverage is for the aged, blind and disabled in this state.

Again, people participating in the survey had similar experiences. One person said simply, "*I can't receive any health coverage through DFS, or Medicaid or Medicare. I have tried and was told no.*" Another wrote, "*I can not make ends meet, but apparently we make too much to qualify for any state or federal assistance.*"

Employer Role in Providing Health Insurance: Great if You Can Find One

Uninsured persons felt that employer-sponsored coverage was important. One person felt that "*It [health insurance] should be a part of the employment package, paid by the employer, even...if the employee has to be compensated less.*" One participant recommended that the employer pay 50 percent of the premium and the employee the other 50 percent. People said they would take a job without benefits if they had to because having a job and a steady income was very important, but they would prefer a job with health benefits. Several talked of the advantages employers have in obtaining more affordable group policies than what they could obtain as individuals. One person noted:

Usually group plans are less expensive than an individual can get it on his own. Number 2, groups are usually set up so that they are not discriminatory, they have to take you. They're not going to ask you whether you smoke or whether you have had this disease or that disease. The group will take you whereas individual's insurance companies may or may not or may exclude things. Groups won't exclude them.

But obtaining a job with benefits was difficult for some of the participants. One woman said in the focus group with adults in their 50s and 60s not yet eligible for Medicare, "*The way I look at that is at my age. . . how many employers are even going to look at me to employ me, let alone offer me... [health benefits]?*" Another woman responded saying, "*I'm seeing that the insurance thing is unrealistic for most of us. I've just decided to stay in my primary 20 hour a week job because if nobody's going to hire me full time and give me benefits or enough time to give me benefits, I might as well stay where I like it because it has a bearing on my overall well–being....*" Participants described their frustration about trying to find a job with benefits. One man said, "*I don't know a single employer in town...of a service industry where you can get any kind of insurance. It's just not even thought of.*" Another said, "*I would say most of the people in Cody fall in the same category . . ., because it's mostly service jobs in one way, in one form or another. They just don't offer insurance. But that's what Cody basically is ... service jobs.*" One person suggested that employers be required to provide health insurance. "*Maybe it should be more pressure on the businesses or your work...it should be mandatory they offer it to you....*" But another countered, "*That would make it hard on them though... They can't afford it either.*"

Impact of Subsidies, Tax Credits or Other Incentives: Subsidies Better

Uninsured persons in general did not see tax credits as helpful. As one uninsured person said, "*You need to have an income in order to benefit*," and most of the

participants had low incomes. One woman put it succinctly: "*Tax credit? What good would that do?*" One of the key informants put it bluntly:

> *Tax credits for families...unless it's done like an earned income credit where you actually get cash back, it's not worth it because I'm telling you when you were at that level of income...a) you may not be paying very much in taxes and b) the whole tax basis is take those dollars and turn them into quarters. And you have to be making something to buy the insurance in the first place to think about getting tax credit for it.*

Other uninsured persons were not really sure how tax credits would work and therefore didn't know if they would be helpful. But several thought if it worked like a child deduction, it might be helpful. One man said:

> *If it's income based, now we're talking there's a huge difference between somebody who obviously makes 25,000 or somebody who makes 50,000 how much of a tax break [would help] people. Presumably health insurance is the same cost for both groups. It probably should be like a flat sum to deduct a certain amount. Just like you would deduct for a child.*

Uninsured persons perceived subsidies to help pay for insurance premiums as more helpful. One woman commented, "*As far as a subsidy, yes, if they're going to pay for it [the premium] – fine. Then totally – yeh. Or like 75%. Otherwise no.*" Another said, "*For the state to pay insurance or the state to have a low premium insurance, that would be excellent.*" A number of participants felt that an affordable state health insurance plan with sliding scale premiums would most helpful.

Affordable Coverage: Depends on Your Income

Uninsured participants were willing to pay for affordable and useful health insurance. Participants in one focus group debated the idea of a premium of $100 per month. One woman said,

> *What would help would be if the state had some sort of health insurance that people could afford. I mean even if we had to pay...buy our own health insurance at a reasonable rate. . . If we had some kind of plan that was affordable for the average person...like 100 bucks a month, just about anybody can afford that for something of that importance.*

Another added, "*But one that would just cover catastrophic care, 100 bucks a person.*" But for others, only a smaller premium was manageable: "*If they had low premium insurance that would be excellent...make us responsible for $10, $20.*" Others recommended sliding scale premiums based on household income. One woman suggested premiums be a "*flat percentage for everybody*."

High deductibles are a barrier for many, so some participants recommended avoiding high deductibles. One woman recommended a $1,000 deductible, while another responded, "*That's workable. Even if it was 2,500. That's workable. When it's $5,000 deductible, and like I said two days in the hospital, it's crazy.*" For this woman, a deductible of $5,000 would not be workable. On the other hand, for another woman,

even a small deductible would be problematic: "*but your deductible is $300. That wouldn't work because I need that $300 [to] survive.*" A high deductible for some effectively makes the insurance unusable, "*But I certainly couldn't afford the deductible to go utilize the insurance.*"

Features of Adequate, Barebones Benefit Package: Catastrophic vs. Routine Care

Uninsured persons were split on this issue. On the one hand, people were very concerned about an overwhelming illness or injury devastating them and their families financially, emotionally, and physically. So for some, a catastrophic policy would be desirable. One woman said, "*If it [insurance package] could be some...for things that are bigger than that. I could afford...to pay for my little things like my monthly pills that I take.*" Another said, "*And that's my major concern. Catastrophic coverage.*" Yet others felt that there should be some provision for routine care, which can also require fairly significant out-of-pocket expenses. One woman said, "*In addition to that [catastrophic coverage] I think that we need some kind of coverage just for yearly checkups. Preventive, so it may save money in the long run. Because if you find something at the beginning rather than two years down the road, it's going to be a lot easier to take care of.*" Many would prefer comprehensive coverage that included routine and preventive care and major medical rather than just catastrophic coverage. Participants in one group wanted more standardization in policies and benefits so it would be easier to understand health insurance coverage. As one person said:

> *I don't think those things should be inconsistent with the person applying on their own – say if they are self-employed or had a business of their own and it was just family working there. I think they should be offered the same choices and the same deductibles and the same pre-requisites from place to place or person to person.*

Employer-Based Coverage

Decisions About Whether to Offer Health Insurance: Salary vs. Benefits

Employers' decisions about whether to offer health insurance were influenced by a variety of factors. Most directly, the decision is about balancing a reasonable salary with health benefits. One employer put it this way, "*Choice between offering insurance or raising the hourly wage.*" Another said, "*But the stability, that's something to them more than pay.*" This employer put it into context by saying:

> *An employee lives on what he makes and...if it costs him $8 an hour to live and he's making $8 an hour, and then you're going to say, we're going to take $.25 an hour our of your paycheck to cover the overage of insurance, all the sudden he's in the negative. He can't make his house payment, or he can't make this or that and then...It ends up coming out of the employer's pocket one way or the other.*

Another small employer felt they were in a no-win situation. He said, "*Although the market appears to be competitive to try to get good...people to work for you, you almost have to have that benefit if that's what you're looking for. It's a no-win situation for small*

employers." Basically, employers need to offer health insurance to compete for good employees, but they can't afford it. Several key informants who were involved in business described a similar balancing act. One key informant said:

> *We have also seen that as a company we battle the premium war trying to decide. Those decisions are made at the corporate level, but still our company battles what percentage of cost to pass on to our employees to still be offering a benefit that's meaningful to our employees, yet doesn't bankrupt our organization or keep us from doing other things.*

Employers Providing Insurance

Employers offering insurance saw offering health insurance as something they should do if it were financially feasible. One employer put it this way: "*Yes, I feel it is a necessity. There's a lot of people who don't. And I made the choice to because when I started business I didn't have to; I chose it.*" Offering health insurance helps attract and keep good employees. As one employer said:

> *I think it's important for attracting and keeping good employees...you don't pay a lot of money, but you have the health insurance benefit and a retirement benefit and it's hard to get people to work in a kitchen, but we've had a good track record with longevity and I think that that's had something to do with it. Most people who work in kitchens work weekends, and so between the benefits and the restaurant hours, we have a couple of things going for us.*

A key informant who was also a businessperson noted that he offered insurance because "*If I have to replace an individual, it's going to cost more than what it costs for the insurance."* One participant commented that if you have insurance, your employees will get timely care and ultimately will be more productive. She said, "*Sometimes things heal themselves, but usually, eventually they're probably going to need to go to a doctor, which means taking more time away from work. I think that's another benefit, if you'd get care when you really need it you'd be a more productive employee.*" For a few, offering insurance was a moral obligation. One employer said, "*I see it as a moral obligation, if it's financially achievable.*"

Employers trying to provide health insurance to their employees encountered significant challenges, including cost and group size. Cost was a significant issue. One employer said, "*We find we have to play with the deductible. And we've had to reduce our deductibles and now we're $1,000 deductible and our insurance is going up 25-30% practically each year for the last five years.*" Some employers felt that the lack of competition among insurance carriers in Wyoming was a problem that led to increased costs for employers. One woman wondered, "*I've heard from various sources that because of some of Wyoming's laws is why we have so few carriers in the state and I don't know if that's it. The other one that I heard is the reason that our rates are so high is...Wyoming has a lack in population.*" Another attributed high costs to the economy. Aging employees who increase the premium costs of insurance were also seen as problematic for small employers. One person put it this way: "*But it kind of hurts when the insurance company is age-based and primarily all older women [work for us] and so*

we really pay through the nose because of our ages." One of the key informants who worked with small employers around the state confirmed that cost was a significant issue. He said:

> *As I called on small employers, probably the major...concern I have heard from there is either, 'I can't continue to offer health care because the premium increases are so large,' or... 'Are there any ways that I can do something that's kind of a stopgap' because most small employers really care about their employees and believe that health care is a significant benefit to help both them and the ...employee.*

For many of these small employers, group size was also a significant problem. One employer, who had 15 employees, had only one employee participating in the insurance benefit. Some of the other employees were part-time so weren't eligible for the benefit, and some employees had insurance through spouses. So attempting to find affordable insurance for one employee was very difficult. Other employers described similar situations with very small groups.

Employers Not Providing Insurance

One of the most significant factors affecting employers not providing insurance was cost. One employer put it bluntly: "*Cost was so excessive for a few employees.*" One employer found cost to be a greater problem because employees didn't want to share costs. She said, "*And you don't have employees that are willing to really share the costs.*" The employers felt part of the problem with increasing costs was related to older employers in small groups. One employer said, "*But after a single incident of angioplasty, a heart attack, any type of stroke, any type of problem like diabetes, anything like that which becomes more common after the age of 40, it sky rockets the cost of insurance."*

Another barrier was the "hassle," as one employer put it. An employer said,

> *A lot of employers opt out because...if you've got 20 employees, my paperwork that I would submit would be that thick because I have to do a census on every employee and each of their dependents and their health conditions, who they see, and what medication they're on...Some employers don't want to go through the hassle.*

The bother was compounded by what were perceived to be ever-changing rules and regulations about insurance. One employer said succinctly, "*It is so confusing. The rules are changing constantly.*" Another said, "*Every time we quote a new group I learn a new rule.*" Rules about participation stimulated the most discussion and were perceived to be confusing and inconsistent. One employer talked about these participation rules:

> *They [some of his clients] didn't understand that employees could opt out up to a certain number. There's a percentage that has to remain. Number 2, if they opt out, they have to qualify to opt out. Number 3, besides opting out if they have life insurance on the policy, even those that opt out and are not*

employees within the group and are not taking the insurance, they have to be on the life insurance.

In response, another employer said, "*Crazy.*"

A number of these small employers had few employees eligible for benefits. Most of their employees were seasonal, part-time, or contract. One employer said, "*We don't provide insurance for our employees because we are a seasonal company, not necessarily the year-round job when insurance can be affordable.*" Accessibility was a factor for some employers. Several participants said they had shopped around but had been unable to find any insurance to cover their employees. One employer said, "*You just can't get it. Don't have enough people or you have part-time people*...." Finally, one participant questioned whether providing health insurance was the responsibility of the employer, feeling it was ultimately up to the individual. He said, "*I really am just not sure that it's the employer's responsibility for health care. It's our own personal responsibility.*"

Not providing health insurance had some negative consequences for employers. One employer found not providing insurance primarily affected her ability to recruit employees. She said, "*They've not left because of it [not providing insurance], they have just chosen not to come on board, so they knew right up front it was something you couldn't offer.*" Another employer did find that employees left to go to other jobs because of benefits. She said, "S*o a lot of people did leave and go like to Boise Cascade because they paid more and they have insurance. So...why not go if you've got benefits.*" One employer felt that not offering health insurance had increased workers' compensation costs. He said:

> *What I'm finding out is since...the cost of insurance is so high and there's seemingly more people out of insurance...I'm seeing that there's more of a struggle to determine whether or not an injury is work related...They're out there on the weekends or evenings for whatever. They don't have insurance and they go into the employer and claiming a worker's compensation injury...Its insurance and its health care so they're [workers' compensation costs] are going up for the employer on that side of the fence.*"

Another employer chimed in after this, saying, "*The last 3 years, Workers' Comp [Compensation] has gone up 63%.*"

Decisions About Type of Coverage: Playing Around with Deductibles and Premiums

Employers also made decisions about what type of coverage to provide. Most often they "played" around with the deductible to come up with an insurance plan that made sense. One employer said, "*I couldn't afford the deductible. So I had the choice to change my deductible or have to stop offering the benefit down the road.*" Some explored cost sharing of the premium so they could maintain coverage. One employer used to pay 100 percent of the premium but now was paying 75 percent of the premium, with the employees picking up the rest. Some employers allowed their employees to purchase more coverage or a lower deductible. One employer provided a $1000 deductible, but employees "*can lower it*" if they want to. One employer subsidized family coverage. One employer was able to offer comprehensive insurance through a

national union. Others came up with creative solutions to maintain the benefit. One employer used cost sharing of the deductible. She said, "*We have a $250 deductible and a $500 deductible. . . This year we offered to do a $1000 deductible but after the employee uses the first $500 of the deductible, we will pay the second $500... We really felt that would save us rather than ...paying for the $500 deductible.*" Shopping around at times was beneficial. One small employer was able to save money. He said, "*So we took a hit … Then in the meantime, I was searching around and looking and we're a small company in the...travel [business]. I found this outfit out of Billings...and we saved $50,000 last year.*" Some employers tried self-funding their insurance programs, but this was problematic. As one employer put it, "*You get a few catastrophic illnesses and your fund goes down in a hurry!*"

Some of the employers not offering health insurance came up with other ways to provide some benefits to their employees. Some chose not to offer heath insurance but paid their employees extra so they could purchase health insurance individually. One employer said, "*So we don't offer it, we pay our employees extra.*" Another employer didn't offer health insurance but because of the nature of the company's work, offered both dental and vision coverage. She said:

> *We're providing dental and vision. [In this business employees] spend a lot of time working on very small pictures and you get really frustrated. . . We affectionately refer to it as covering. . . eye squinting and teeth gnashing. But that pays for two dental cleanings a year and one vision check. . . And my employees have been really pleased with that. It's like the illusion of providing insurance.*

She also offered a wellness program to the employees.

Similar to participants in other focus groups, employers differed in their opinions about what constitutes a basic affordable package. Most would prefer comprehensive benefits that included routine outpatient care, including health promotion and screenings, along with catastrophic coverage. One employer recommended that health insurance cover preventative care such as eye exams, one pair of glasses, checkups once a year, and other necessary procedures such as mammograms. Others, however, felt the emphasis should be on catastrophic care. One employer said, "*Something less comprehensive but more catastrophic... to pay for hospitals and things like that. So if you're looking at minimum, I would...get a policy that would cover something catastrophic so it wouldn't force me into bankruptcy*."

Response to Economic Downturns: Increased Employee Cost-sharing

Employers providing health insurance to their employees said they would want to continue this benefit if there were an economic downturn. One employer said:

> *I see it as a moral obligation if it's financially achievable...if it gets to that point. You know right now we're having to rethink our benefit plan. So if it came to keeping the benefits and lowering pay, I'd have to say we would probably drop the benefits. But as long as it is financially possible, we would like to keep a reasonable pay scale and benefits package.*

Some would consider cost sharing with employees (e.g., having the employee pay for part of the premium). One employer said, "*I think our first option would be to look at more sharing of costs by our employees.*" Some employers who offered other benefits such as dental coverage would drop these before dropping health insurance for their employees. An employer said, "*I agree...with everyone else that I will offer benefits as long as I can. With us, we have a separate dental that might go first, or I would ask the employees to pay all of the premiums, but that would be before the health insurance.*"

Impact of Purchasing Alliances, Individual/Employer Subsidies and Tax Incentives: Pooling Employees

Exploring ways to increase the size of employee pools was the most commonly discussed strategy in all the small employer focus groups. One employer said, "*I could see a purchasing agreement to kind of work with you to get groups together that would be fairly diversified, could be beneficial.*" She recommended that all the employers from similar businesses/organizations could get together to find a way to negotiate insurance rates. Increasing group size was seen as a way of decreasing insurance costs for employers. As this employer suggests, "*It becomes a group of 500 people versus an office of 8 people. . . Of having groups with the number of people that the insurance company can dilute, so the one with the heart problem and the 25 year old – it kind of washes.*" Some employers recommended a state program, while others recommended having the Chamber of Commerce or other business group administer a program in which employers could pool all their employees for purchasing health insurance. One employer asked, "*Why does the state feel they have to administer a group? Why can't the Chamber of Commerce and the small business groups be the administrator to pull 'in the group'?*" Another recommended a state program for part-time employees. He recommended that:

> *The state set something up like that for...a minimal amount of people. . . Part-time workers would probably become a nightmare, but if they did set up it might be a whole bunch of employers that are providing minimal coverage, you could cover them better. . . There are probably more part-time workers than full-time workers in the state.*

Others, however, were hesitant about state initiatives. One employer said, "*I'd be hesitant about a state- level initiative. . . because of the cost. I've never seen the state get a hold of a project and do anything that doesn't compound the bureaucracy and increase costs.*"

The participants had mixed perceptions of tax incentives and subsidies. Employers did not say much about employer premium subsidies. They were not very positive about employee subsidies or taxes, expressing concern about how employees might spend these. Would they be used for health care or something else? One employer said this about direct employee subsidies: "*I don't always have responsible employees that would do that with the extra money. How could I control what they do with it? That's the problem I see with that.*" Tax credits for employers were seen as positive if they could be applied to payroll taxes but were perceived as probably not large enough to make a big difference. One employer said this about tax credits: "*That wouldn't help me at all.*" Another employer said:

> *I don't think tax credits...that doesn't get rid of the red tape and the qualifying and underwriting of the company. I think a lot of employers would offer the coverage that they legally could. So it's not always the money. The money is a factor; I'm not taking away from that. So a tax credit wouldn't hurt and I don't think a tax credit would be large enough to really assist.*

One employer thought tax credits could be helpful. She said, "*If it [an insurance premium payment] were set aside separately, with saying 'OK, here is your insurance money; it is not going to be taxed.' That would be a whole different ballgame. It would be much more appealing. It would actually be a benefit.*" Another thought it could be helpful if it was applied to payroll taxes. She said, "*I would prefer rather that than having it being a tax credit on the income of the business; I would much rather see it be a tax credit towards the damn payroll taxes. It's driving me nuts.*"

Other Alternatives to Motivate Employers: Decreasing Health Care Costs and Supporting Small Businesses

Employers discussed other solutions to motivate them to purchase health insurance for their employees. Some had specific recommendations, while others thought the situation would not be resolved without doing something about high health care costs and providing better support for small business. Several employers were part of larger corporations or national franchises and recommended that those larger organizations assist in providing health insurance. One employer, whose business was part of a large national franchise, had attended their latest convention. She said, "*They're looking at saying, 'Hey, if we provide this insurance for all our motels, what kind of break will you give us?'*" Others recommended purchasing through national professional/industry organizations. One employer lamented that it was difficult to get discounted rates during the first year anymore. He said, "*Where it used to be you could shop because they want your business...they'll give you a discounted rate for the 12 months. They don't do that anymore because the rate is changing every 15 days*."

More broadly, supporting small businesses and strengthening the Wyoming economy were seen by some as the ways to enhance access to health insurance. One employer said:

> *We can't attract industry here yet because the wages are so low... [The] working man's going to say, "Go to Wyoming and I can make $18 an hour, go to Denver I can make 23, 24." Where's he going to go? Why do you think Denver's growing in leaps and bounds even though they're in a downturn? Why does our population not even grow enough to employ our kids who graduate from high school?*

Another employer recommended ways of helping support small businesses. He said, "*One, if there're a lot of small businesses in Wyoming ...at least that may be a good start if you can offer things for them, they may not leave and then the whole economy base of Wyoming will start to build.*" He went on to say, "*A lot of small businesses are here and they've been here and they're here to stay. And I see a lot of bigger businesses getting tax breaks and tax credits to move in and then...less than four or five years down the road, they collected it all and they're gone.*"

Increased competition and "fixing" health care in Wyoming were recommended so that young people and innovative businesses could be attracted to Wyoming. One employer said, "*I don't see anything helping that until insurance is cheaper and more widely accessible.*" Another employer said that issues like skyrocketing drug costs were federal issues that "*need to be addressed federally. And of course we have to talk about...getting the overall cost of medical care [under control].*" He went on to say that the state then needs to find a solution that will work in Wyoming. He concluded, "*The point is it is getting to the point where [health care costs] have to be addressed or they will eventually break and then it will be addressed.*" Others emphasized that the lack of competition has increased costs. One employer said, "*Competition makes the rate go down. The less competition with them pulling out, it's going to go up.*" Others cited health care professional shortages as a problem that needed to be fixed. One employer said, "*We have no competition in Wyoming because we don't have the doctors. We've got a shortage.*" Finally, several recommended more and tighter regulation of the pharmaceutical and insurance industries.

Root Causes and Solutions

Participants in all groups were asked about solutions to the problem of access to health care for uninsured persons. Some of their responses have been discussed in the previous paragraphs, specifically in relation to tax incentives, subsidies, and purchasing alliances. However, the participants recommended other solutions, as well. In order to put these solutions into context, we asked key informants what they thought the root causes of lack of insurance were.

Root Causes: High Costs of Health Care and Insurance and Low Wages

The root causes of the growing numbers of uninsured persons were centered on the high cost of health insurance, the high cost of health care, and low wages. Ralph Hayes from the Employees Group Insurance Program emphasized the increasing costs of health insurance. He provided the premium history for the state plan and said:

> *Back in 1981...a single policy generally ran about $45, for a family about $95, which at the time seemed rather expensive. However, now we are in 2003 and a single policy has gone from $45 to $358 and family has gone from 95 to $828, so we've almost seen a 10-fold increase in cost increase in the cost, total cost of health insurance in roughly 21, 22 years.*

One key informant said:

> *Individuals are saying, "I can't afford the insurance, my premiums are too expensive, and the coverage that I receive for the premiums isn't comparable to what I'm paying for the insurance." I think the root cause, the underlying cause of insurance being unaffordable, is the underlying cost of medical claims, medical services, and that's what hospitals charge, what doctors charge and what pharmaceutical benefit management companies charge for their prescription programs.*

A number of key informants pointed out that wages had not kept pace, so people struggle to purchase insurance. One informant explained what a family of four living at 185 percent of the poverty level would experience. At that level, "*Their actual income...ends up being around...$2000 to $2400 a month. Now you think of raising a family...on that and all the expenses of rent and insurance on your car and the whole bit. It really does not leave money for people to have insurance.*"

The key informants identified a number of factors contributing to low wages and high health care and insurance costs. Aging populations and drug costs were frequently described as major culprits in the rising cost of health care. One informant said:

> *We also have an aging population. The baby boomers, which is the mass group of people out there, as they're aging are getting to the point when you look at probability charts and where are you going to need health care? The older we get, the more health care we're going to need and so that additional usage on the system is driving the cost up.*

Malpractice costs (including the premiums and defensive medicine practices) were frequently identified. One key informant said, "*Lawsuits have occurred...so the medical profession [tries] to inoculate themselves against being sued so they may order more tests and then the costs go up for those tests that may be unnecessary.*" Cost shifting from governmental programs to the private sector was also seen as a cause. Iris Oleske, from Wyoming Medicaid put it this way:

> *I know that one of the things that happens in the health care market place is that government programs, like Medicaid and Medicare, don't pay our own way. We don't pay nearly as much of the cost of doing business as we should for the people we serve. So that cost that we don't pay gets pushed along to those who can pay.*

The lack of competition in health care also contributes to high health care costs. Key informants felt that the lack of insurance carriers was a specific problem. One informant said:

> *We're also seeing an exodus of insurers wanting to serve the Wyoming market and that's primarily because we have a dominant player in the health insurance market and that's Blue Cross and Blue Shield of Wyoming. They have about 35% of the insured market in the state of Wyoming. And then they are larger than their next largest 10 competitors. And what happened is up until the last year or so, Blue Cross and Blue Shield of Wyoming actually had a net underwriting loss for like five years consistent years on their entire book of business. And so...you can understand why the small players in the market are bailing out. Number 1, they can't complete. Number 2, they can't get a reasonable return on their investment.*

Some talked about the growing use of medical technology, health care professional shortages, and the lack of managed care in Wyoming. Finally, others attributed high costs to public expectations and attitudes. One key informant noted that "*We have communities in Wyoming that really, albeit small and albeit spread out, they demand a*

full array of services in their communities . . .The problem is having, they have those demands and those desires. . . but prudent business judgment wouldn't support those kinds of services."

Low wages were attributed to the high number of small employers and a weak economy in Wyoming. One informant said:

> *I think it's because we don't have any. . . large employers that offer entry level. . . jobs where people can [work], that may have a high school education, but not a lot of skills, and so these people...are working at jobs like restaurants and things like that. I've been in towns that have more manufacturing and these people may not have a lot of skills when they got there, but they had a high school education, they could teach them skills at a job and work their way up into a plant or whatever and we just don't have that type of thing.*

Bill Schilling from the Wyoming Business Alliance said of Wyoming's economy:

> *The other issue in Wyoming is basically we have a, what I would characterize, as a weak economy. The economy is basically supported by the mineral industry...We have a very restricted economy. Restricted in the sense that often times what you would characterize in Wyoming as a middle class family...where one spouse works for city government and the other is a teacher. It's not middle class as you do find in say Salt Lake or Denver where one is an account executive in an advertising firm and the other is a small business manufacturer... and so that private economy vitality just does not exist in our state, in any high percentage.*

Solutions: No Silver Bullet

Participants in the focus groups and interviews identified a wide variety of solutions to enhance access to health insurance for Wyoming citizens. Several participants acknowledged that there were multiple solutions and that no "*one of these is a silver bullet*." Participants ranged philosophically from those who wanted expanded government involvement in health care to those who wanted to minimize or even eliminate government involvement. On one end of the spectrum was this survey participant who wrote:

> *The problem of out-of-control drug and medical services which were caused by the government meddling in the first place. All this is heading to is more socialist programs to have the taxpayer subsidize the health program. Where in our constitution does it guarantee all our medical needs will be paid by the government?*

In the middle were those like this survey participant:

> *We firmly believe something must be done statewide or nationally. We are farmers and ranchers. . . We, a couple, pay $788 a month for a policy with a $5,000 per person deductible. They tell us it's going up another 20 some percent next year. . . The insurance company we had dropped all policies in*

WY, at least that's what they told us, so we were picked up by another company. Being upper middle aged and having some medical problems no other company will give us insurance without putting riders on it. . . We are at the mercy of Mother Nature and the grain and cattle markets. . . We need the state or nation to address this problem. Why can't we be put into a statewide group policy to help get reduced rates? It is not fair for us to be subsidizing government employees, teachers, and the poor and have no help in getting reasonable rates for the rest of us.

On the opposite end of the spectrum was this person: "*I think the USA should socialize medicine. There should be free insurance for everybody.*" Some participants who were not advocates of government involvement said things such as "*I'm not a real big fan of governmental intervention and establishing programs in place. But I think in this regard, it's going to have to take some sort of intervention by...either the state or federal government or both to come up with some incentives to help individuals purchase insurance.*"

Some felt that Wyoming was unique and therefore required unique solutions. One key informant said:

Wyoming is unique and we keep saying we're unique because we are small and we have little managed care. We have basically primary care services and high level secondary services, but we don't have a lot of tertiary care such as for brain stem injuries and burns and major transplants and things like that. So we have to go out of state to receive that care.

Another person noted, "*It makes us different than a lot of other states because we do have so many small employers and our towns are kind of isolated; they're not real close to other big centers. And so, I think our options are limited for that situation.*" Alternatively, one key informant said:

Wyoming can't be separated from the rest of the country's issues. We're very, very dependent on insurance providers from out of state. The major players in the insurance market, they have a local presence, but they are owned, managed from out of state and that's where the decisions are made… We're certainly subject to the same kind of health care inflation and the same demands for care.

Several participants emphasized that solving this problem would require collective action. One key informant said:

My belief is you have to get everybody in the room. . . You've got to get the consumers in there, you've got the regulators, you've got to get the service providers in there, you've got to get the federal government contractors in there, and you've probably got to get the legislature in there and you've got to say, 'Okay, this is what we've got in Wyoming. Now what are each of you going to give up to make the situation better?' And it's just tough. It gets politically untenable when you're talking to some of these individuals and it's a discussion that needs to take place.

Expansion of public programs was one of the most frequent recommendations. This included expanding existing programs (e.g., restructuring Medicaid eligibility and benefits, expanding KidCare to include parents, increasing the reimbursement levels for public programs such as Medicaid and Medicare, and taking advantage of federal monies to expand state programs). Patricia Guzman recommended Wyoming look at what other states are doing and said, "*There are also other ways other states are expanding like to parents of the children enrolled in the State Children's Health Insurance Program.*" She went on to recommend that the state strive to cover residents up to 200 percent poverty: "A*t 200% I really think we'll be able to hit a lot of the families in Wyoming.*" Iris Oleske suggested that Medicaid has the potential to be used as a "safety net" and said, "*I think we could find some combination of using Medicaid to purchase private health insurance to a much larger extent than we presently do. We can also use Medicaid to be the public health insurance that providers and individuals can buy if they can't find anything else in the market place.*" She provided these examples of what might be possible in an ideal situation:

> *If an employer offers insurance and it costs $300 a month to the employee, for those employees who qualify by way of income, we [Medicaid] could purchase that insurance for them. . . The other way to do it is if an employer can't afford to pay any health care coverage or can't afford to pay what an employee needs and here I'm thinking about an employee with special needs, for example, that they've been excluded from the group because of a pre-existing condition, because of a disability...the employer says, "I could get insurance for $50 a month cheaper but I have to exclude Fred." And we say, "Okay, why don't we buy Fred into Medicaid and he can have the full Medicaid package and you pay us a premium?" That's no more than you would be paying for your other employees.*

A physician urged that, "*The State Children's Health Insurance Program (SCHIP) program should...cover up to 200% of poverty [and] that the reimbursement for medical and dental services in the SCHIP and the Medicaid programs should both be at 100% of Medicare.*"

Some proposed new public programs such as national insurance, socialized medicine, or state sponsored health insurance programs for individuals and/or small employers or self-employed persons. One nurse practitioner proposed that "*The state of Wyoming could help by offering an insurance program for anyone not covered by his or her own insurance. Premiums could be small and based on sliding scale fee*." She acknowledged that this would require more taxes, "*either a state income tax or an increase in mineral severance taxes.*" Her recommendation was echoed by a number of the uninsured participants who wanted some sort of state program to help them obtain insurance. A number of survey participants recommended universal insurance or universal health care. One person wrote, "*It would only be fair to let everyone have national insurance. . . For national health care, up our taxes and make us pay a co-pay. At least then we would be guaranteed.*" Several key informants emphasized ensuring access through universal insurance of some sort. One said, "*After all these years in this business [health care administration] I have become a proponent for universal health*

care. Now, not socialized medicine by any means. But a system whereby every man, woman, and child in the United States can get health care and is covered for that in some way." A national insurance program was thought to save costs. One key informant said:

> *Just look at it logically. It makes sense to have a single payer system that would get rid of all the bureaucracy, it would get rid of the gouging, it would get rid of all the middle people involved in it, and allow providers to provide health care and not have to deal with all the paperwork. It would be simpler for patients, it would be simpler for the providers and it would be way, way cheaper than what we're doing now.*

For those advocating some sort of national system, many recommended looking at Canada's system.

Related to the above, participants also recommended supporting and developing the safety net, free clinics, and community health centers for those who fall through the cracks. Program managers and directors clearly articulated the challenges of providing health care to the underserved—low funding, health care professional shortages, reporting requirements, high demands for care, and lack of technical assistance. One uninsured person said, "*If they can't do a state health policy, then...back up your free clinics. Support them.*" Some participants wanted more health care providers to volunteer or provide free care. One uninsured participant said, "*Lawyers have to do pro bono work...I don't see why doctors can't.*" Others recommended better coordination among safety net providers. A health care professional said:

> *I think there is an abundance of safety-net type programs in Wyoming. However, what I think is lacking is the coordination of those available resources. . . We are adding more and more preventive services but without outreach and coordination with other programs, and you're using your valuable dollars where other programs can adapt.*

Several key informants strongly recommended expanding federally funded community health centers (CHCs) to enhance the safety net. Kenneth McBain, CEO of the CHC of Central Wyoming, felt that Wyoming is behind in the development of CHCs with only one in existence and felt that this was a good time because:

> *The Bush administration has adopted community health centers as one of its primary focus points for its health care agenda. And the marching orders are, "We want to create 1,200 new health centers in a five-year period." Now we're already into the second year of that. And along with that they're doubling the budget of the Bureau of Primary Health Care. The intent is to double the number of people being served by community health centers from 12 to 20+ million.*

Beverly Morrow, Wyoming Primary Care Association, echoed this saying that while CHCs are "*not the entire solution because they can't provide all the specialty care and surgery. . . we certainly think that having more community health centers in Wyoming would be a wonderful thing*." CHCs offer a variety of advantages—"one-stop"

comprehensive care for underserved persons; providing medical, pharmacy, mental, and dental care in one place; sliding scale fee for patients; and malpractice coverage through the Federal Court Claims Act. Satellite clinics administered by larger CHCs are also possible and make sense in small rural communities without enough resources to develop a full clinic. Both Mr. McBain and Ms. Morrow acknowledge there can be some challenges to getting CHCs, particularly getting beyond physician and community resistance. The application process is challenging and requires community support and a solid needs assessment. In order to be funded, the CHC needs to be in a medically underserved area or to provide care to a medically underserved population. Consequently, in order to develop CHCs in Wyoming, they recommend that the state needs to develop a support infrastructure to provide technical and funding assistance to communities wanting to apply for a CHC or a satellite clinic.

As noted in the previous section on "Employer-based Coverage," participants recommended a variety of ways to expand employer coverage, including purchasing pools, tax credits, and subsidies. In addition, other solutions were recommended to expand employer coverage. One key informant recommended funding health insurance the way unemployment insurance is funded. He wanted to eliminate individual choice about whether to participate in employer-based insurance and bring more young people into the system. He said:

> *I think one alternative to look at would be a funding system where the employer remains the pivot point and it's funded like we do...unemployment insurance with employee/employer contributions...which means if you work, you have coverage. And there would be some sort of mandated minimum coverage.*

Others recommended that efforts be made to help industry see the value of offering insurance to their employees. One health care professional said, "*But we start putting a spin on this that industry can hear, and they can begin to see the value of providing health insurance or health care onsite.*"

Increasing personal responsibility for health was also commonly recommended. One key informant said, "*But we need, as a nation, to educate ourselves and be willing to step out and say, 'We're going to take care of ourselves wherever possible. We're going to be more responsible for taking care of ourselves.'*" This could be done in a variety of ways, but participants recommended that people have an economic stake in their decisions. One key informant put it this way: "*The change comes as a result of economics. People will be responsible for better health care decisions when they have an economic stake in making a better decision.*" Some participants recommended various forms of Medical Savings Accounts (MSAs) as a way to increase individual responsibility. Lloyd Wilder of the Wyoming Insurance Department talked of MSAs and consumer driven benefits. He said:

> *Consumer-driven or consumer designed health benefits where an employer will say, "Look, I've got a budget for health care and this is all I can give you as an employee—you go out and make the best deal you can" or "I'm going to put so much in an account for you and there's going to be a deductible; then*

you can start drawing down from your account to meet eligible expenses". . . I think we're going to see a change, that there's going to be more consumer involvement in the design of their health insurance plans.

Others thought incentives for healthy lifestyles would help. One said, "*You reward people for lowering their cholesterol, for reducing their weight if they are overweight. For those things that are measurable. Better blood pressure, maybe a better stress test.*" When asked how people would be rewarded, she responded, "*Lower insurance rates*."

Related to personal responsibility were recommendations focused on education. Health care professionals and key informants thought that the public needs to be educated about what programs are available. One key informant said, "*One of the first is really educating the uninsured about what programs are available. And...enrolling them. . . There are plenty of federal programs as well as state as well as KidCare as well as employer's insurance and...I think part of that as an education in the value of health insurance.*" Others emphasized that we need to make certain that people know the true cost of health care. One person said, "*For the longest time, consumers have been insulated from the true costs of. . . what it is to provide care because they've had insurance plans or somebody else that was picking up the tab.*" One informant said, "*If...I take Lipitor, if there is a generic alternative and I don't know about it. . . then that's probably what I will use. On the other hand, if I have information and I know there are alternatives and I'm having to foot a significant part of the bill, I'll probably make a decision for lower cost medicine.*" Another advocated making sure that consumers knew, "*which providers...have the best results and which providers are the low cost providers, so people can make intelligent decisions on where to get health care.*" Uninsured persons also asked for more and better information. Participants in one group wanted more outreach with insurance companies coming to work or having an insurance counter at Wal Mart. One participant in this group recommended, "*Some place you can kind of trust to call them up and say... 'What kind of coverages are available and about how much should they cost?' And without [having] to go to a particular insurance agent and worrying about being ripped off.*" This information also needs to be available in other languages, especially Spanish, according to uninsured participants and members of the Minority Health Council. As one participant in the Minority Health Council said, "*Language barriers and cultural issues are real*." Members of this committee recommended cultural competency training be widely available and that good examples of culturally sensitive care be showcased for others to follow.

Some recommendations were focused on controlling health care costs and addressing health care professional shortages. Some people had very specific recommendations such as mandating discounted prices from health care providers, expanding formularies prescribers use when caring for patients, and developing pharmacy advocacy programs in which a pharmacist reviews employee medications and makes recommendations for cost-effective treatment plans. One health care professional recommended more case management, especially of complex clients who use many health care resources. Others regretted the lack of competition in health care in Wyoming due to the small number and isolation of health care organizations. Others were concerned about the small number of insurance carriers in Wyoming. Consequently, some strongly

recommended encouraging competition, although Bill Schilling acknowledged that "*The whole issue of competition is fine, but that's pretty hard to affect in a smaller state.*"

Health care planning was seen by some as a way to control costs. One person recommended, "*Some kind of a process. . . that starts addressing. . . the needs and demands and the desires of each community as far their health care services, what's available in the community, and what the. . . appropriate business model is for those services.*" Not only is some sort of process needed in order to do good health planning, but adequate databases are also required on health care use, practices, and costs. Wendy Curran from the Wyoming Medical Society talked about the limitations in data about outpatient care. She said, "*We don't seem to have very good data about our health care system, particularly for the outpatient settings, private settings. What the costs are. . . How much care goes out of state. We have little bits and pieces, but I don't think we have really good health data.*" She, along with others, proposed that better health care databases be developed and maintained in Wyoming. Ultimately, with better data, better decisions could be made. One key informant emphasized that successful solutions would require looking at the community's needs and goals, along with evaluating the cultural context of the community. This can be challenging because she feels that Wyoming residents don't always value health and health care.

A number of participants recommended tort reform. Some thought this was important because "*When you compare Wyoming's cost of insurance for physicians and hospitals to even surrounding states that do have the caps on the non-economic damages and their rates are significantly less, which means the doctors are staying.*" One physician felt that:

> *Limiting liability...and providing liability reform would just remove a whole fear level within the medical system, within the state, and in the country, too...And if we could go back to practicing true medicine where you order tests if you truly think they need a test, not so much, for lack of a better term, for a 'cover yourself test.'*

Participants also recommended ways to restructure insurance benefits by having simplified policies, standard benefits, or even mandated minimum benefits. Kerry Hall from Delta Dental of Wyoming recommended that health insurance be structured like dental insurance, in which 100 percent of preventive services are covered. He recommended that services be covered on both the "low end and on the high end," with the low end being preventive services and the high end being high cost services. The "middle of the road expenses" would be paid mostly out of pocket because individuals can pick up these costs. He feels this is a fairer system that encourages people to get things taken care of early. Alternatively, others recommended that routine care be paid by participants, but high cost care by covered. Dan Perdue from the Wyoming Hospital Association was "*in favor of trying to foster an environment where our hospitals could be more competitive in terms...of their bottom line and in terms of the services that they provide their communities.*"

Conclusions

The focus groups and key informant interviews provide rich and compelling information about health insurance beliefs, barriers, and solutions for enhancing access to health insurance in Wyoming. The uninsured participants described being "between a rock and a hard place," having difficulty meeting basic needs and paying for health care at the same time. Health care providers faced significant challenges attempting to provide care for the uninsured. Cost was the most significant barrier to obtaining health insurance, and uninsured persons did not participate in public programs because they "fell through the cracks" and did not qualify because they made too much money. The uninsured participants would like to have employer-based coverage; but having a job is of higher priority, however, so they would take a job without health benefits if necessary. Tax credits were not perceived to be helpful because most uninsured participants made too little money to benefit from them. Subsides and a state insurance program were viewed more positively. Affordable coverage that had a modest premium and ideally provided comprehensive benefits was desired although some participants preferred just basic coverage while others preferred catastrophic coverage.

These findings are similar to other research focusing on the uninsured. Consistently, the uninsured report delaying or going without treatment; balancing payments for health care with those for other basic needs; using home remedies, emergency rooms, free clinics, public health, or community centers; risking financial security; and feeling as if they are treated differently because they are uninsured (Academy of Health Services Research and Health Policy [AHSRHP], 2001; Budetti, Duchon, Schoen, & Shikles, 1999; Cox, Stockdale, Sarvela & Shannon, 2002; Feld, Matlock, & Sandman, 1998; Institute of Medicine, 2002; Orne, Fishman, Manka & Pagnozzi, 2000; Perry, Kannel, & Castillo, 2000; Satter & Brown, no date; Vuckovic, 2000). Moreover, uninsured persons receive less preventive care than those with insurance (DeVoe, Fryer, Phillips, & Green, 2003; Smaida, Blewett, Carrizales, Fuentes, & Robert, 2002). People in general, and uninsured persons specifically, perceive significant barriers to obtaining insurance, most notably cost, pre-existing illness, lack of employers providing insurance, and cultural barriers (Action Research and the Lewin Group, Inc. [ARLG], 2001; AHSRHP; Center for Cross-cultural Health [CCH], 2001; Cox, et al., Minnesota Department of Health [MDH], 2002; Smaida, et al.). For some, lack of information and difficulty understanding the US health care system have been barriers (CCH; MDH; Satter & Brown; Smaida, et al.). Uninsured persons are willing to pay for health insurance, but what constitutes affordability varies significantly with a threshold for a monthly premium of about $100 (AHSRHP; ARLG; Cox, et al.). Low and very low wageworkers may be able to afford only $10 to $30 per month (AHSRHP). Subsidies and tax credits are perceived as possible solutions, although tax credits generally garner more skepticism (AHSRHP; Cox, et al.). Uninsured persons also are interested in employer-based coverage but will take a job without insurance because working is a priority (Perry, et al.). Uninsured persons also want more information that is available in other languages, especially Spanish (CCH; Feld, et al.; Krueger & Associates, 2002a; Perry, et al.; Satter & Brown).

Health care providers working with uninsured persons face a number of challenges in providing quality care. Although a patchwork of organizations exists, dental care, low cost prescriptions, mental health and substance abuse services, and vision care have

all been identified as significant gaps in services (Wyoming Primary Care Association, 2002).

Employers valued being able to provide insurance. For some, it was a moral obligation, while others felt it to be a way to attract and retain qualified employees. However, providing health benefits was perceived by small employers as a significant challenge primarily because of cost but also because of hassles related to paperwork and bureaucratic requirements and having mostly part-time, seasonal, or contract employees. Employers providing insurance hoped to continue to do so in the face of an economic downturn, but most acknowledged that they would turn to premium sharing or eliminating other benefits to maintain health coverage. Employers were most positive about mechanisms to increase employee pools through some form of purchasing alliance. Tax credits could be beneficial if they were associated with payroll taxes.

Small employers in other states have voiced similar concerns and have offered similar suggestions for how to improve access of health insurance. Employers feel they have a social and moral obligation to provide health insurance (AHSRHP, 2001; ARLG, 2001; Cox, et al., 2001). They also perceive positive benefits to offering insurance such as being able to stay competitive in their business and attracting and retaining productive workers (AHSRHP; ARLG; Cox, et al.; Krueger & Associates, 2002b). For employers not providing insurance, cost is the major deterrent although few insurance carriers, seasonal or part-time employees, paperwork, and administrative costs are also factors (AHSRHP; ALRG; Cox, et al.; Krueger & Associates). Some employers don't feel it is necessary to provide health insurance because their employees have coverage from other sources (Krueger & Associates). In an economic downturn, employers anticipate having to increase cost sharing or reduce benefits in order to continue to offer health insurance (AHSRHP; ALRG). This is consistent with actions already being taken by small employers in response to economic constraints, including increasing the employee share of the premium, increasing employee cost sharing, switching carriers, reducing services covered, and tightening eligibility requirements (Short & Lesser, 2002). Purchasing pools are generally seen as most viable (AHSRHP), although tax incentives, increasing competition for health insurers, fixed rate increases, simpler health insurance plans, and subsidies have also been recommended (AHSRHP; ALRG; Cox, et al.; Krueger & Associates).

The participants in this study identified a number of solutions, including expanding public programs, supporting and enhancing the existing safety net, increasing personal responsibility including educating the public, controlling health care costs, addressing health care professional shortages, and tort reform. Participants in focus groups in Wyoming conducted by the Wyoming Primary Care Association (2002) also recommended promoting awareness, better coordination between existing programs, applying for grants to expand programs, establishing more community health centers, encouraging providers to provide more free care, and developing a state subsidized insurance program. These are also consistent with recommendations offered in others states (AHSRHP, 2001). Participants in other states have expressed mixed feelings about how much the government should be involved in solving the problem of the uninsured (Cox, et al., 2001; Krueger & Associates, 2002b).

Section 5. Strategic Research

To summarize what has been stated earlier, the overall goals of the State Planning Grant program were to define the scope and nature of the uninsured population in Wyoming, to improve our understanding of the reasons that this population exists, and to identify options, both public and private, that can reduce the size of this population and improve the health and productivity of the state's citizens. In this section, we describe the activities that have been carried out thus far in the last category and how the data reported in the previous section can be used to help develop recommendations and plans for providing better access to health insurance in the state.

Background studies

In addition to analyzing data from the household and employer surveys and focus groups, we have carried out background studies to aid in the strategic planning process. These studies include a literature review, an econometric model of expanding insurance coverage, and a risk analysis of insuring the uninsured.

Literature review

Even with good information related to the nature of uninsurance in Wyoming, strategic planning cannot be carried out without knowledge of possible solutions to the problem. With assistance from a graduate researcher attached to the Wyoming Statistical Analysis Center (WySAC), we have undertaken a background study on uncompensated care research. The results of this study are summarized in an annotated bibliography, which is included in Appendix 2.

Risk analysis on insuring the uninsured

As part of the State Planning Grant project funding request, we proposed the following:

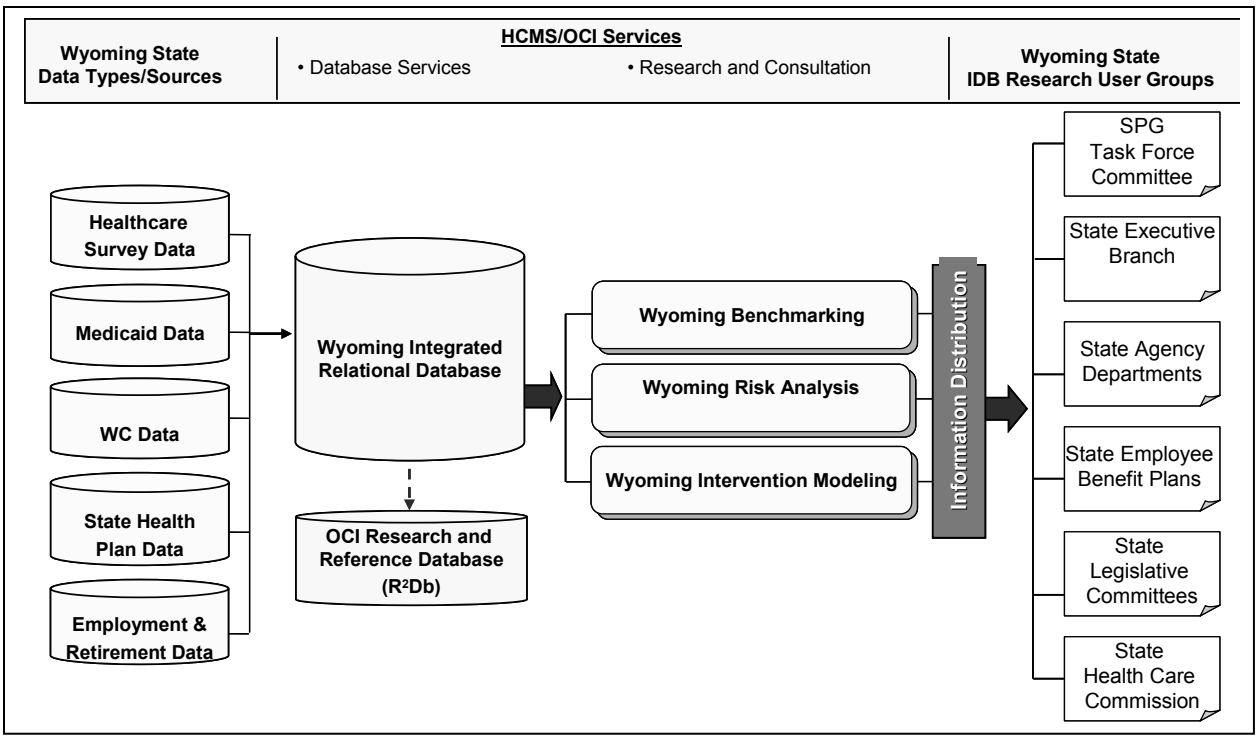
> *Additional analysis capability may be available through a subcontract to a Wyoming firm that specializes in data integration. The firm provides solutions for employers who wish to manage the risks associated with their health benefits programs – risks that include inflated benefits cost, poor employee health, and reduced overall productivity – using database and integrated reporting applications that link worker health and productivity. A subcontract with this firm would support the development of an integrated database that draws on the Project's baseline and survey data, extended with other data available from WDH, Medicare and Workers' Compensation to create a more complete picture of the risks and benefits associated with health insurance coverage. A Pareto benefit analysis will be conducted to analyze the existing status of the insured in the State to see how well benefits are being used and how costs could be reduced or redistributed to help offset the costs of covering the uninsured.*

This subcontract was established with Human Capital Management Services, Inc., (HCMS) a company recently established in Cheyenne by Harold H. Gardner, M.D. Dr. Gardner had previously been CEO of Options and Choices, Inc., and entered into an agreement with the CRHRE to build an integrated database to support analysis and consultation using benefits and usage data available through OCI and the household survey demographics collected as part of this project.

The approach to this work is based on the knowledge that benefits consumption frequently involves more than one benefit and that the consumption of health benefits is highly maldistributed in a population. This is known as the "Pareto Effect"[11], which is also known as the "80:20 rule." In general, this effect describes the phenomenon, found in many systems, where a relatively few number of causes produce a large proportion of the results.

Performing an initial risk analysis to identify the influence of this effect on benefits usage helps analysts better understand cost and utilization variables. In this project, once the uninsured population risks are better understood and options for intervention solutions are identified, risk modeling will help us first, to understand the cost and utilization implications of providing insurance to the currently uninsured and second, to serve as a baseline to evaluate program interventions.

Figure 5-1: Structure of the HCMS Integrated Database



[11] http://www.managers-net.com/paretoanalysis.html

An integrated database, combining the SPG household survey data with a variety of other benefits-related information, was constructed as shown in Figure 5-1. This database was used for the analysis described in this section and is available for additional analysis as requested. A number of other agencies and organizations will eventually use this database for research into health benefits usage and costs.

From this database, several Pareto analyses were performed to compare the usage of health care benefits among the general population in the database, rural employees in the United States, and rural employees in Wyoming. The results of these analyses are shown in Figures 5-2, 5-3, and 5-4.

From this analysis, we can draw some conclusions. Using a relatively small private employer sample of Wyoming employees, healthcare cost inefficiency associated with information risks and problems was lower in Wyoming than other similarly rural populations in the USA, and notably lower than a national benchmark of all employees.

The analysis further suggests that there has been little risk migration to Workers' Compensation, as is usually associated with managed care, and that there is less medical service demand in Wyoming and rural populations associated with disability income replacement than in the national benchmark. The analysis confirms that there may be access barriers to primary care in Wyoming and other rural populations.

Figure 5-2: Benchmark Pareto Analysis from Integrated Database

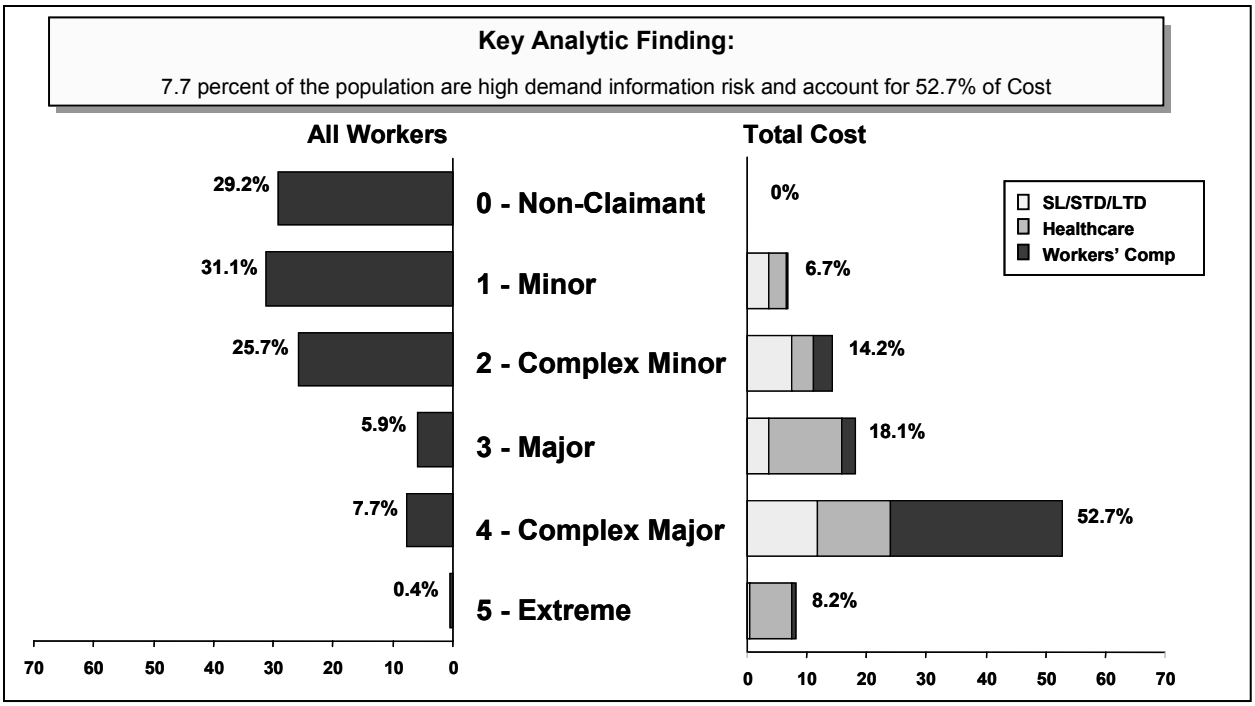


Figure 5-3: U.S. Rural Employees Pareto Analysis from Integrated Database

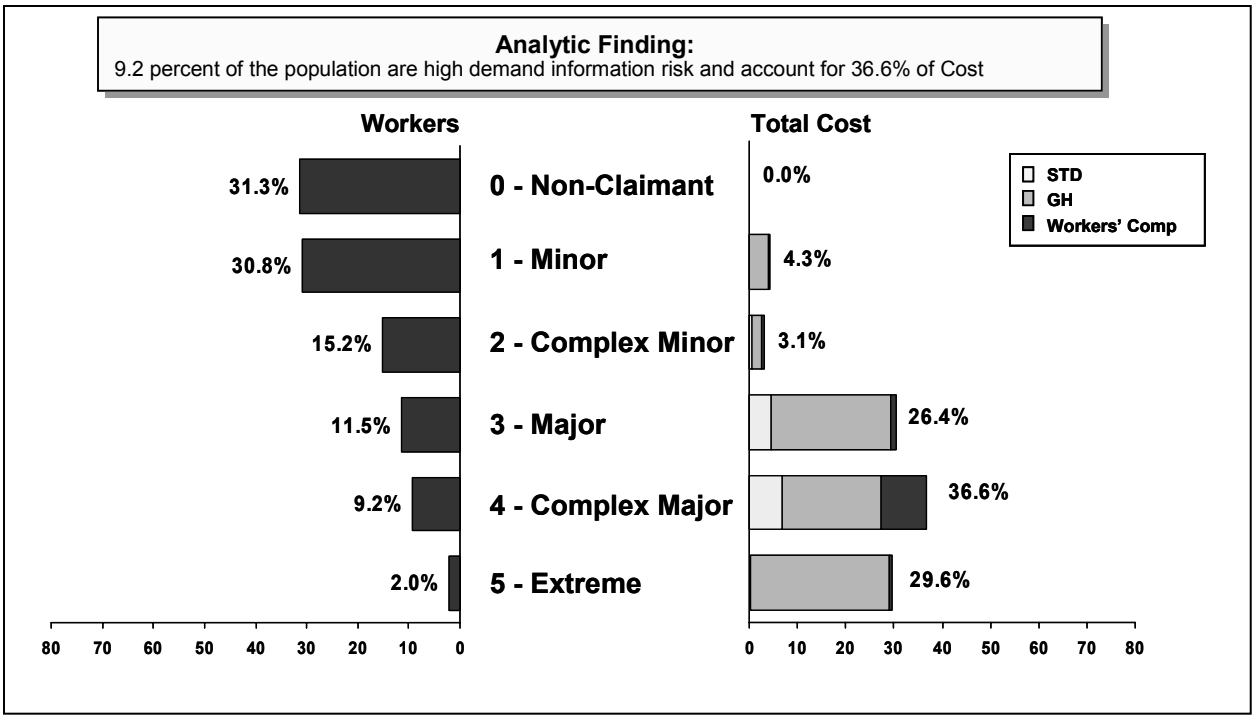
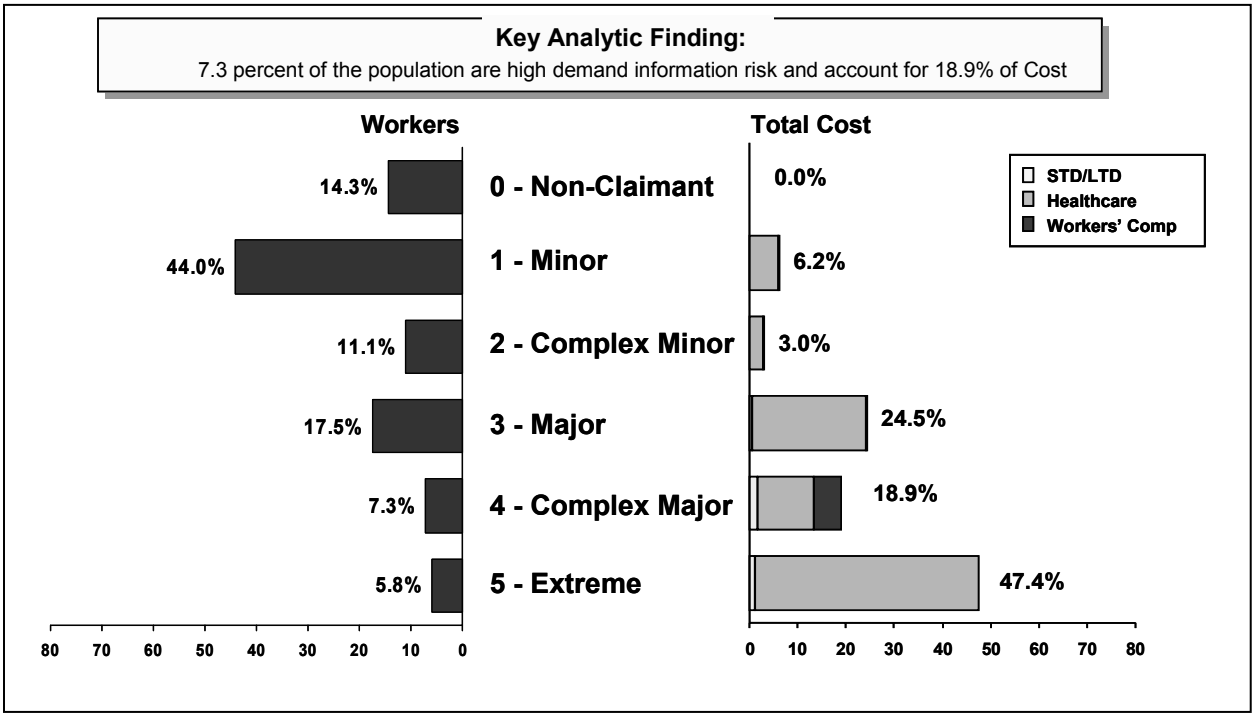


Figure 5-4: Wyoming Rural Employees Pareto Analysis from Integrated Database



A cost model was also developed using the Integrated Database. A "rural" population of over 70,000 employees was modeled using demographic data, as defined by federal MSA guidelines. The cost model used the formula below.

> *Employee Healthcare Cost = f (age + gender + salary + race + marital status + surrogate health status)*

This model was then applied to the means of the estimated "adult" population identified in the survey information.

Using a similar approach for a "rural" population of child dependents, as defined by federal MSA guidelines, the following statistical model was developed.

> *Dependent Healthcare Cost = f (age + gender + salary + race + marital status + surrogate health status)*

This model was then applied to the means of the estimated "children" population identified in the survey information.

Using cost information contained in the Integrated Database, demographic data from the Wyoming household survey were used to model healthcare costs for a rural population reflecting the characteristics of the uninsured in Wyoming. Preliminary conclusions from the model suggest that the uninsured population in Wyoming are of <u>significantly less than average</u> healthcare cost risk ($2,423 per adult and $810 per child). This is based on an assumed national average of around $4,600 per capita annual cost and using an estimated annual per capita healthcare cost for all residents in Wyoming of $3,800 annually.

Options and strategies evaluation

The initial guidance for developing a framework to consider options to expand health insurance coverage was provided by a work group comprised of UW faculty, Department of Health personnel, and other interested stakeholders. This workgroup initially identified thirty-six potential coverage options based on research from other states and input from the Task Force. Options were then further delineated into four matrices by the following implementation sectors:

- employer based options;
- individual options;
- public/state options; and
- multi-sector options.

The four options matrices were disseminated to the Task Force at the third task force meeting. Twenty-eight options were eliminated from consideration based on cost, or legal and political barriers. The Task Force then selected eight potential options for consideration. These options were:

- increasing availability of catastrophic coverage plans
- encouraging consumer-driven health insurance approaches
- developing small employer purchasing pool

- providing outreach to employers & individuals
- providing a “bare bones” primary care network Medicaid expansion
- exploring state-funded seed grants for new community health centers
- State Children’s Health Insurance Program (SCHIP) parent expansion and/or employer buy-in
- employer buy-in to state or other insurance programs

Policy evaluation process

Six Task Force subcommittees were appointed at the April 2003 Task Force meeting to review the viability of each of the eight remaining options. These subcommittees were:

- Small Employer Purchasing Pools
- Bare Bones Medicaid Expansion
- Health Insurance Outreach and Education
- Public Options for Direct Care
- SCHIP Expansion
- Employer Buy-In to Existing State Programs

The committees are currently meeting to evaluate their assigned options and develop recommendations. This work, along with the results of the previously described research, will enable each subcommittee to compile a report to be presented at the fifth Task Force meeting on October 24, 2003. These reports will be used to draft a strategic plan for increasing the insurance coverage in Wyoming. Recommendations from the Task Force at both the state and Federal levels, will be completed by November 14.

State Planning Grant Task Force subcommittees

In this section, we summarize the completed and ongoing activities of the Task Force subcommittees as of the date of this report. Each summary includes goals and action items developed at the April Task Force meeting, projected target audience for the options being discussed, research questions that address the effectiveness of these options, and information sources for answering those research questions.

General Questions for Options

The following is a list of questions that should be addressed in the subcommittee final reports, in addition to the research questions associated with the specific committees below.

- What other states have suggested similar programs? What were the target groups there? Were there states that rejected these options?
- What are the costs associated with these programs? Are they expensive, inexpensive, cost-neutral, cost-saving?
- Where could funds be found to support new programs?

- What are the barriers that need to be overcome to carry these initiatives forward? Are there Federal or State legislative changes that would need to be made?
-

Subcommittee Summaries

1. CHC Expansion (Publicly Funded Direct Care) Subcommittee

Goal: Develop a plan for expansion of publicly provided direct care facilities in Wyoming to better serve the needs of the uninsured.

Proposed Action Items:

- Study of Nebraska as comparator state
- Research feasibility of using grant monies for proposed expansion
- Research access issues/the reduction thereof
- Research on whether provider education series would increase utilization of existing resources

Final Outcome: Report to the Task Force on proposal for expansion of publicly provided direct care provision and feasibility issues

Target Audience: Low income adults

Research Questions: Compare number eligible for safety net vs. using them; usage of Medicaid

Information Source: CHC expansion group national studies; CMS

Work Status as of October 1, 2003: Research into current facilities in Wyoming is being conducted, as well as looking at programs in Montana and Nebraska. The committee is looking at the financial impact to existing facilities and providers when new community health centers or rural health care centers are opened in the area. The committee will review the legal and legislative restrictions on setting up new programs.

2. Employer Buy-In Subcommittee

Goal: Report to the Task Force on viability of allowing employer buy in to the state programs as a means to insure more Wyoming citizens.

Proposed Action Items:

- Meet with Ralph Hayes, Manager, Employees' Group Insurance State of Wyoming, regarding feasibility of buying into state employees group health insurance
- Discuss waivers for low income workers buy in to Medicaid on a sliding scale fee
- Study comparator states—Massachusetts, Wisconsin, Rhode Island, Maryland, Oregon
- Discuss increase in federal poverty level to increase eligibility for the unemployed

Final Action Item: Develop report for the Task Force outlining subcommittee efforts to investigate Wyoming employers to buy in to state programs, and the feasibility of implementation

Target Audience: Small business; employees

Research Questions: Percent of employers offering and not offering insurance; percent eligible, but not enrolled; makeup of Wyoming's employers; costs of care

Information Source: Employer survey; national studies; household survey; HCMS Group

Work Status as of October 1, 2003: The committee has reviewed the option of allowing low income families to buy in to the state employees health insurance plan. Initial review of this proposal has resulted in this option being abandoned at this time. The committee has moved its focus to looking at the possibility of low income families buying into the Wyoming SCHIP program either through direct payment of premiums to SCHIP or through employers paying premiums into SCHIP for their employees.

3. Medicaid Expansion (Bare Bones-Prevention) Subcommittee

Goal: Explore the viability of a prevention-oriented, reduced-benefit Medicaid expansion program.

Proposed Action Items:

- Conduct research on "Bare Bones" and Primary Care Network expansions of Medicaid
- Explore research on the experiences of Oregon and Utah in implementing a reduced-benefit, prevention-based Medicaid expansion
- Explore ways to transfer current health care funding to a new Bare Bones Medicaid program

Final Action Item: Develop report for the Task Force outlining subcommittee efforts to investigate a reduced-benefit Medicaid expansion program

Target Audience: Low income Wyoming citizens; children and adults

Research Questions: Percent uninsured by household income; percent uninsured by age

Information Source: Household survey

Work Status as of October 1, 2003: The committee has made the following recommendations:

- Current Medicaid coverage for current enrollees should be maintained as much as possible with only minor fine-tuning of the current Medicaid structure
- State and federal funds should be reprioritized on a small scale to allow for an expansion of coverage through a "Medicaid-Lite" benefit program.
- A Blue Ribbon Panel should be created to review condition-treatment pairs and develop recommendations for prioritizing services. Physicians, the Wyoming

Medical Society , social workers, family planning representatives, mental health workers, and the general public should be included in this process

- The newly-created Health Care Commission should be charged with looking at recommendations made by the Blue Ribbon Panel to finalize the structure of the limited benefit program based on the Panel's ranking of the various condition-treatment pairs in the context of Wyoming.

The subcommittee will meet again to review these recommendations and prepare their final report for the State Planning Grant Task Force.

4. Outreach and Education Subcommittee

Goal: Develop a plan for a "one-stop shopping" information and education center on health insurance for consumers (Web site, brochures, 800#...)

Proposed Action Items:

- Meet with representative from other programs that already proved outreach or information
  - Department of Family Services
  - Insurance Commission
  - Public Health
  - Others?
- Answer initial research questions
  - Compile list of information and costs for MSAs, HRAs, etc. (including information on changes to Federal rollover laws)
  - Look into value/affordability of catastrophic care plans (will people buy them?)
  - Find out where providers send people without health insurance for help and information (idea: conduct survey at Wyoming Rural Health Conference in May)
  - Investigate who is eligible for programs (especially public) but not participating and why not (WDH, household surveys, national studies)
- Investigate possible costs and funding sources for an outreach center
  - Wyoming foundations
  - National foundations or federal grants

Final Action Item: Develop report for the Task Force outlining subcommittee efforts to develop a plan for a "one-stop shopping" information and education center on health insurance for consumers

Target Audience: Low income families; employees

Research Questions: Compare number eligible for public programs vs. using public programs; What is the value of catastrophic care plans; Do people buy catastrophic care plans such as WHIP; Costs of MSAs and HRAs

Information Source: Household surveys; national studies, Wyoming Department of Health; insurance department

Work Status as of October 1, 2003: The committee is collecting data on current health program in Wyoming and how they are marketed. Committee member and/or SPG staff will attend a technical assistance workshop presented by the American Institutes of Research. The committee will also be investigating the costs and coverage provided by catastrophic insurance plans.

5. Purchasing Pools Subcommittee

Goal: To provide the Task Force with report on viability of purchasing pools in Wyoming.

Proposed Action Items:

- Review current research on purchasing pools from a variety of different sources including the U.S. General Accounting Office, the Commonwealth Fund, The Kaiser Foundation, the Economic and Social Research Institute, and publications from relevant scholarly journals
- Research the purchasing pools of Montana, New Mexico, and Colorado
- Explore the viability of purchasing pools in the current legal environment of Wyoming by meeting with an official for the Wyoming Department of Insurance
- Follow up on the status of purchasing pool legislation at the federal level

Final Action Item: Develop report for the Task Force outlining subcommittee efforts to investigate the viability of purchasing pools in Wyoming

Target Audience: Small businesses; employees

Research Questions: Percent of employers offering and not offering insurance; percent of uninsured working for small businesses; percent eligible but not enrolled

Information Source: Employer survey; national studies; Department of Employment; household survey

Work Status as of October 1, 2003: The committee continues to explore the viability of purchasing pools in Wyoming. Initial research indicates purchasing pools do not appear to reduce premiums effectively, but do provide the ancillary benefit of improving employee choice. The committee recognizes that to create a health purchasing pool in Wyoming, a legislative mandate will most likely be necessary. While the idea of a mandate can be unpopular to the citizens of Wyoming, the current health care situation may make the time right for such legislative actions. The committee is still researching the possibility of creating a purchasing pool with the current insurance providers in the state. The committee is also looking at the possibility of creating a purchasing pool by allowing employers and/or low income families to pay premiums to the SCHIP program.

6. SCHIP Expansion Subcommittee

Goal: Develop a plan for expansion of Wyoming CHIP program and report to the Task Force on Viability of such an expansion.

Proposed Action Items:

- Meet with Patti Guzman, Manager State Children's Health Insurance Program, for education and discussion of current CHIP program
- Research statute information to determine legal viability of CHIP expansion of federal and state levels
- Research comparator states, and models of CHIP expansion in other states (NCSL, NCOIL)
- Investigate cost feasibility issues
- Develop plan for administrative structure – could we use current staff?

Final Action Item: Develop report for the Task Force outlining Subcommittee efforts to develop a SCHIP expansion plan, and the feasibility of implementation

Target Audience: Low income parents; young adults (parents)

Research Questions: Percent uninsured by household income; percent uninsured by age

Information Source: Household survey; KidCare office; results from other states

Work Status as of October 1, 2003: The committee is collecting data on the current Wyoming SCHIP (KidCare) program as well as information on other states SCHIP programs. The committee will be looking at the cost of enrolling parents of current enrollees. This can be done with the submission to and acceptance by CMS of a waiver, but the funding must be available within the state before the change can be implemented. The committee will investigate two possibilities for expansion of SCHIP: 1) expand coverage to parents through the use of a waiver or 2) expand coverage by allowing parents or low income families to pay premiums to the SCHIP program for coverage.

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Appendix 1: Reference materials

- **Short Form Household Survey (Mail)**
- **Short Form Household Survey Written Comments**
- **Long Form Household Survey (Telephone)**
- **UW Hybrid Employee Benefits Survey**
- **DOE-UW Hybrid Survey Cover Letter**
- **DOE Employee Benefits Survey**
- **Employer Survey Matrix**
- **Focus Group Demographics**
- **Focus Group materials: The Uninsured**
- **Focus group materials: Small Employers**
- **Focus Group materials: Health Care Providers**
- **Key Informant Interview Materials**

Appendix 2: Research results

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2.1 Baseline data

a. Demographic Profile of the Uninsured in Wyoming

Source: March 2001 CPS, US Census Bureau

Gender	Estimated Uninsured	Percentage Uninsured	Wyoming Population
Female	36,193	51.4%	50.9%
Male	34,281	48.6%	49.1%

Age	Estimated Uninsured	Percentage Uninsured	Wyoming Population
0-5 years	3,402	4.8%	7.9%
6-13 years	8,963	12.7%	12.6%
14-18 years	5,508	7.8%	7.9%
19-24 years	14,499	20.6%	8.1%
25-34 years	15,032	21.3%	11.9%
35-44 years	9,277	13.2%	16.2%
45-64 years	13,793	19.6%	23.4%
65 years +	---	---	12.0%
Total	70,474	100.0%	100.0%

Race/Ethnicity	Estimated Uninsured	Percentage Uninsured	Wyoming Population
White, non-Hispanic	59,698	84.7%	91.4%
Hispanic	9,084	12.9%	5.4%
American Indian, non-Hispanic	1,692	2.4%	1.7%
Black, Non-Hispanic			1.0%
Asian or Pacific Island			0.5%
Total	70,474	100.0%	100.0%

Citizenship Status	Estimated Uninsured	Percentage Uninsured	Wyoming Population
U.S. Citizen, Native	65,219	92.5%	98.0%
Not a U.S. citizen	3,610	5.1%	1.1%
U.S. Citizen, Naturalized	1,645	2.4%	0.9%
Total	70,474	100.0%	100.0%

Educational Level	Estimated Uninsured	Percentage Uninsured	Wyoming Population
K-12, no high school degree	12,707	18.0%	13.4%
pre-school children	12,665	17.9%	21.9%
High school graduate	21,392	30.4%	26.8%
Some college or Associate Degree 2 yr	18,391	26.1%	25.6%
College Graduate 4 yr	5,319	7.6%	9.4%
Advanced Degree	---	---	2.9%
Total	70,474	100.0%	100.0%

Employment Status	Estimated Uninsured	Percentage Uninsured	Wyoming Population
Working	41,081	71.0 %	64.0%
Not in labor force	13,163	22.8%	33.35%
Unemployed	3,565	6.2%	2.65%
Total	57,809	100.0%	100.0%
Not included in this computation (includes Children and people in the Armed Forces)	12,665		

Income Levels	Estimated Uninsured	Percentage Uninsured	Wyoming Population
$0-9999	39,582	56.2%	48.0%
$10,000-19,999	15,568	22.1%	16.6%
$20,000-29,999	9,660	13.7%	11.9%
$30,000-39,999	3,274	4.6%	8.1%
$40,000-49,999	872	1.2%	5.4%
$50,000 and over	1,518	2.2%	10.0%
Total	70,474	100.0%	100.0%

Federal Poverty Level	Estimated Uninsured	Percentage of Uninsured	Wyoming Population
Under 50%	4,784	6.8%	3.0%
51%-99%	13,861	19.7%	8.2%
100%-149%	12,184	17.3%	10.7%
150%-199%	11,008	15.6%	9.4%
200%-249%	8,843	12.6%	10.5%
250% +	19,794	28.0%	58.2%
Total	70,474	100.0%	100.0%

b. Availability of Employer Offered Health Insurance

Source: Wyoming Department of Employment, Labor Market Information, Research and Planning, Employee Benefit Survey in Wyoming: 2001, http://doe.state.wy.us/LMI/

Percentage of Companies in Wyoming that offer health benefits to full- and part-time employees, 2000

Benefit Type	Full-Time	Part-Time
Dental Plan	43.2%	9.6%
Dependent Health Insurance	53.7	8.9
Health Insurance	63.2	10.5
Vision Plan	21.6	5.6
Wellness Program	13.2	1.9

Percentage of Companies in Wyoming, by Firm Size, that offer health benefits to full- and part-time employees, 2000

Benefit Type	Number of employees					
	1-4	5-9	10-19	20-49	50-99	100+
Full-Time						
Dental Plan	20.7%	35.6%	50.3%	56.3%	66.7%	87.1%
Dependent Health Insurance	27.4	50.5	62.5	75.2	75.8	93.2
Health Insurance	40.8	63.2	72.0	78.6	78.7	96.3
Vision Plan	9.2	15.8	32.0	28.8	26.7	45.1
Wellness Plan	5.3	7.5	9.4	14.8	35.0	38.9
Part-time						
Dental Plan	5.9	8.1	10.2	8.6	6.3	21.1
Dependent Health Insurance	2.9	8.2	7.8	9.3	10.2	23.8
Health Insurance	6.2	9.4	7.8	10.3	10.4	23.8
Vision Plan	1.8	5.6	7.0	3.9	4.3	14.9
Wellness Plan	1.5	0.7	0.9	1.0	0.0	5.8

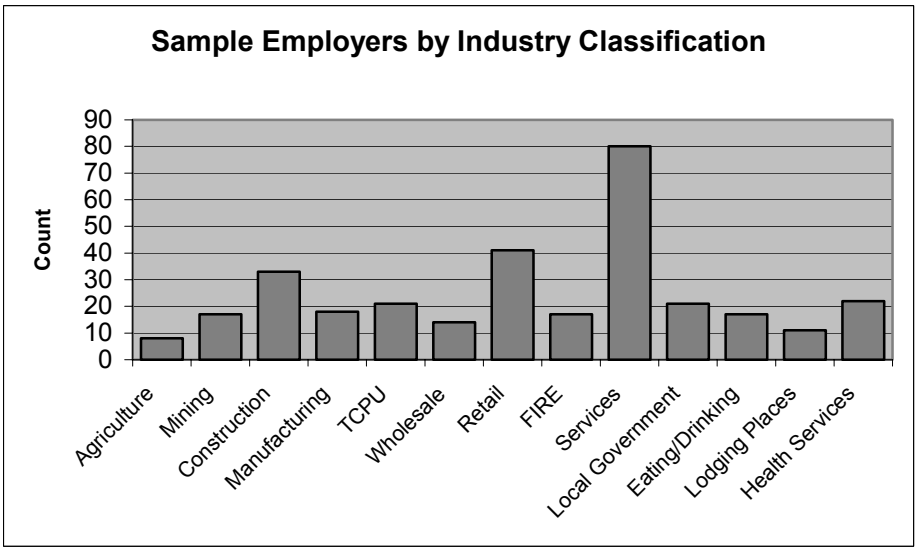
Percentage of Full- and Part-time employees in Wyoming receiving Employer Offered Health Benefits, 2000

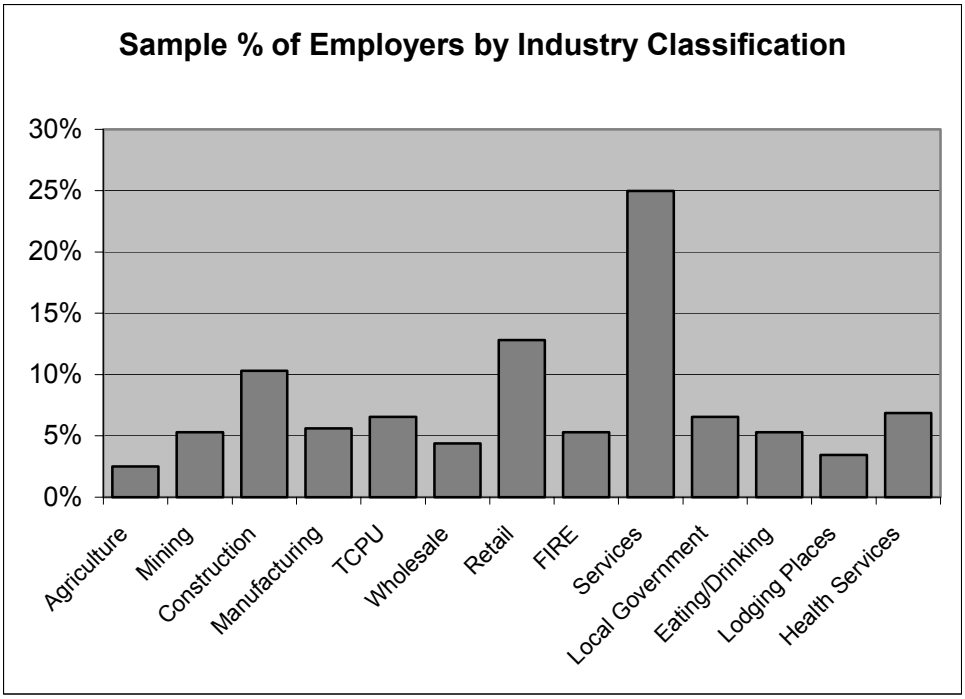
Benefit Type	Full-Time	Part-Time
Dental Plan	83.6%	19.8%
Dependent Health Insurance	92.0	23.8
Health Insurance	94.1	23.9
Vision Plan	46.1	16.0
Wellness Program	42.9	5.6

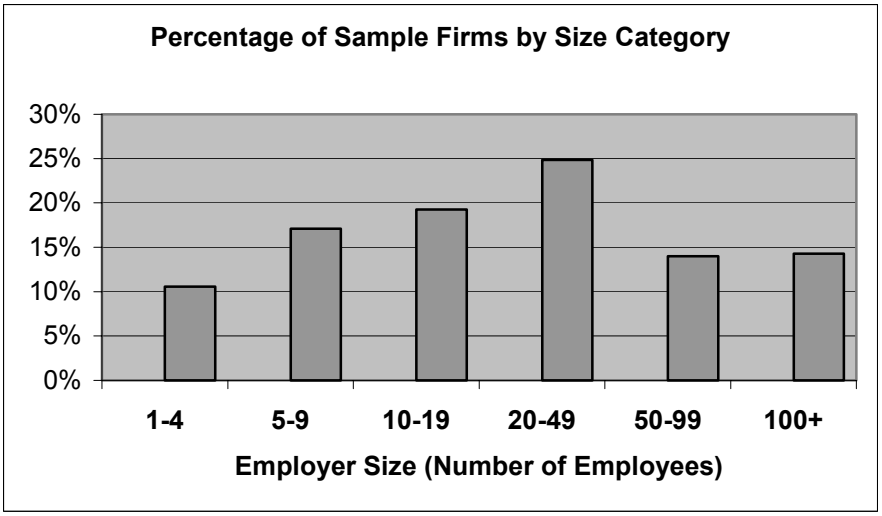
Average Percentage Paid on Benefits by Employers for Wyoming Employees, 2001

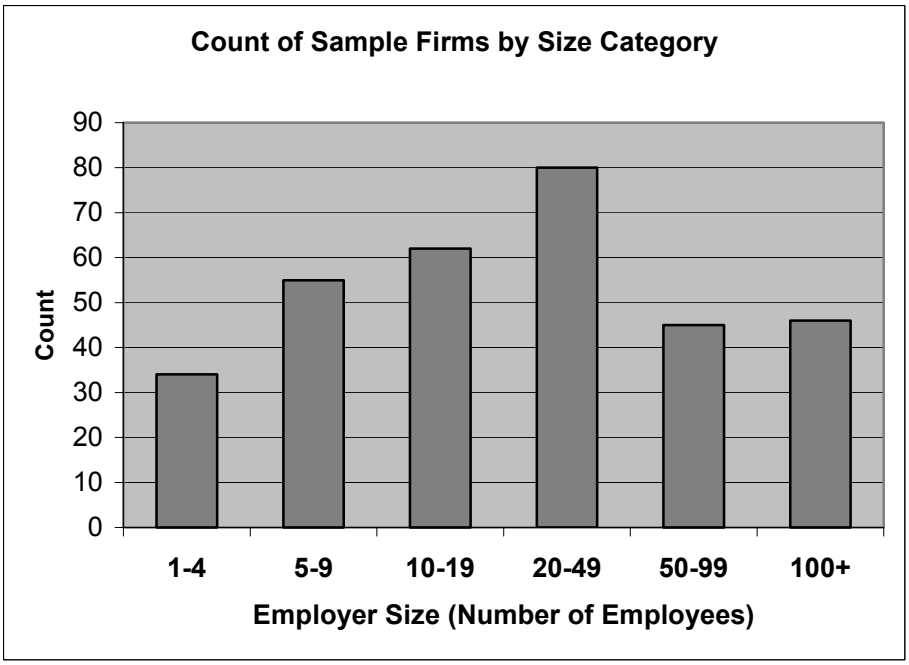
	Full-Time		Part-Time	
Percentage Paid on:	Mean	Mode	Mean	Mode
Health Insurance	79.5%	100.0%	46.8%	0.0%
Dependent Health Insurance	59.0	0.0	40.3	0.0
Dental Plan	75.9	100.0	46.1	0.0
Vision Plan	58.5	100.0	29.9	0.0

2.3 Employer Survey Data



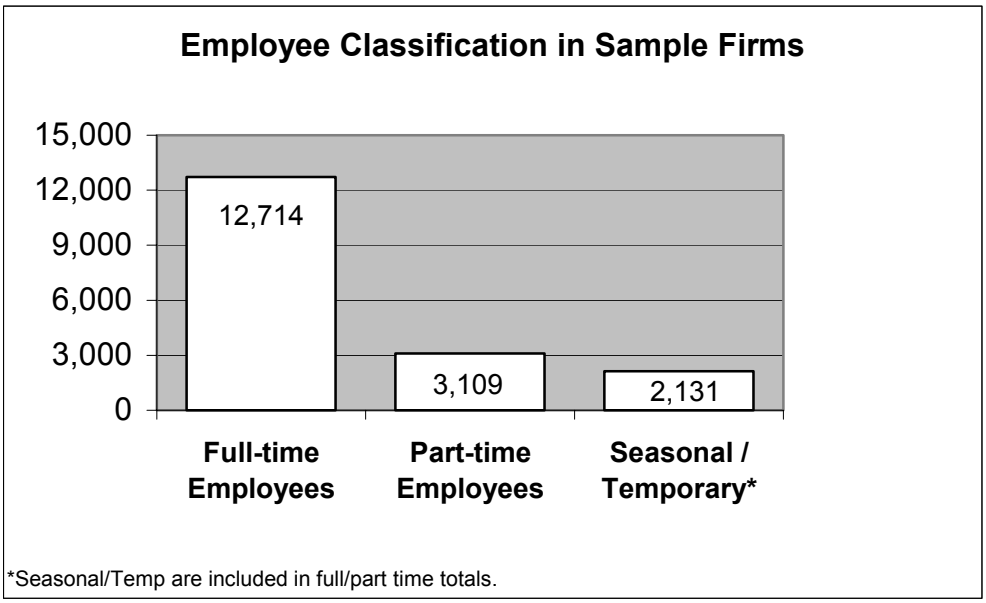


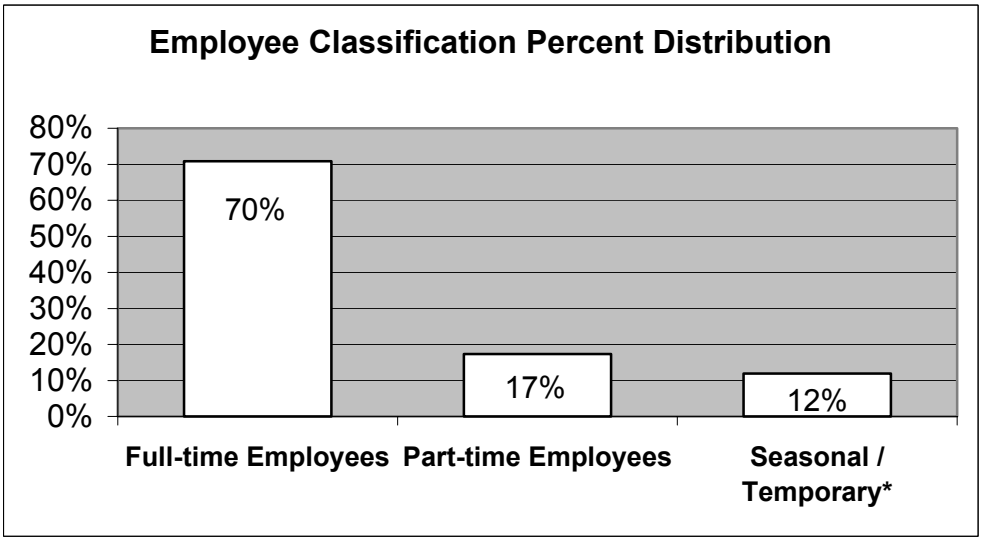


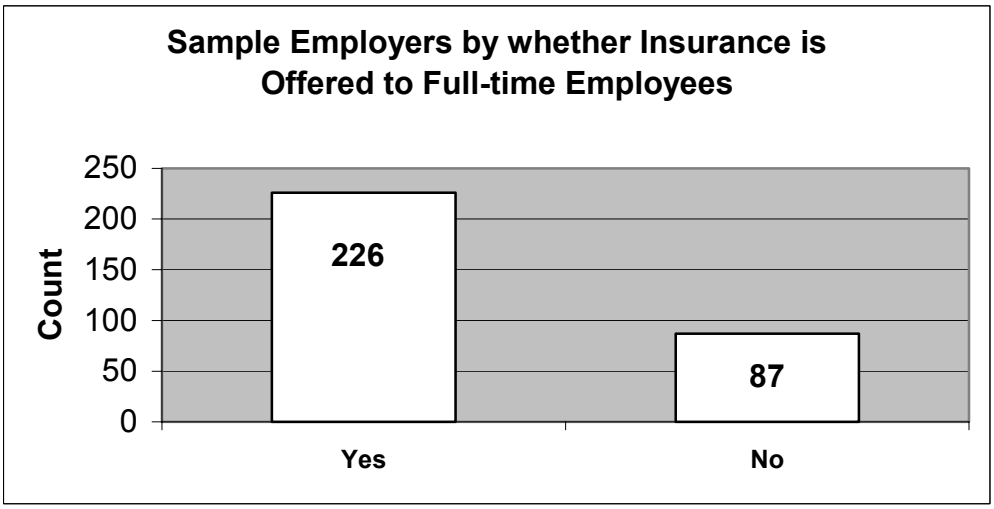


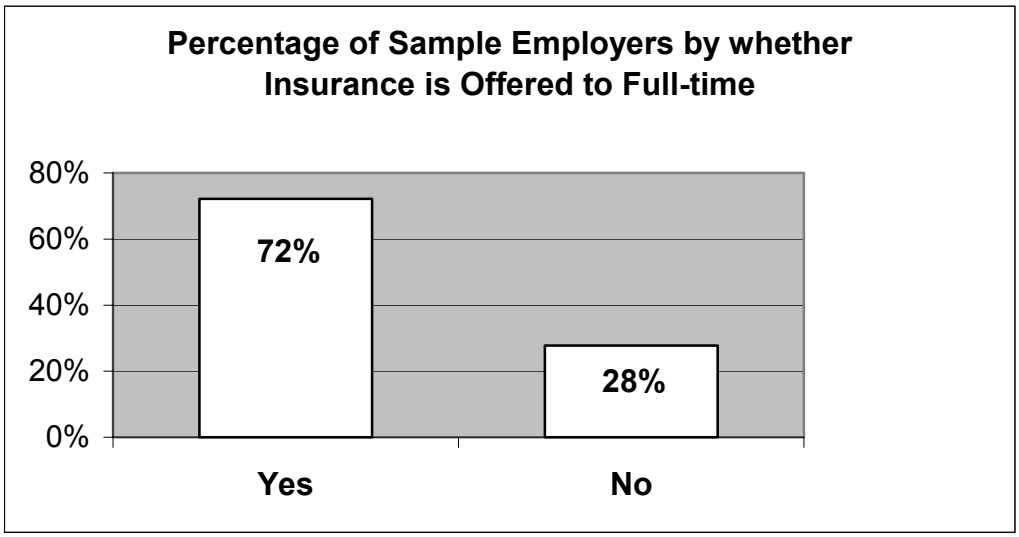
Sample Employers by Number of Employees

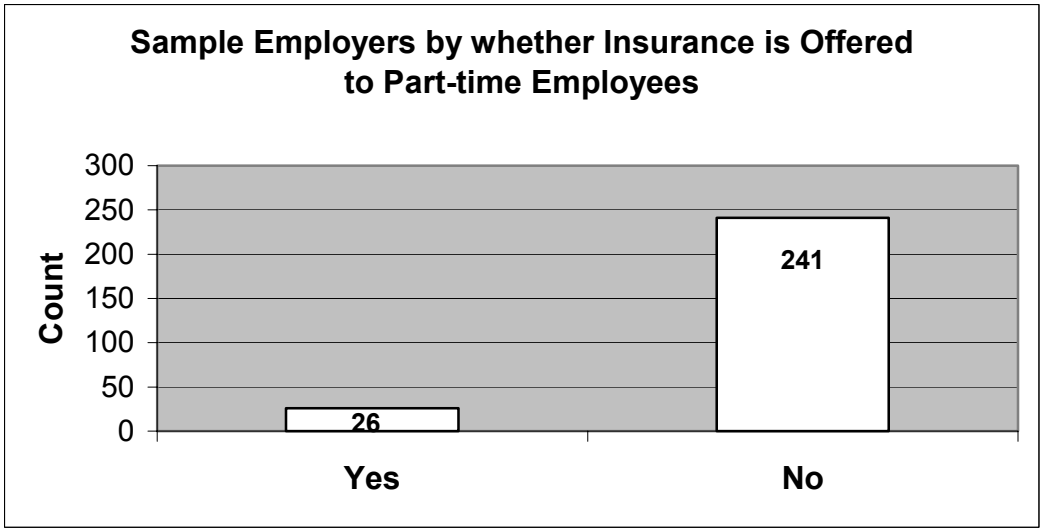
		Number of Employers	Percent of Sample
Employer Size Categories	1-4	34	10.6
	5-9	55	17.1
	10-19	62	19.3
	20-49	80	24.8
	50-99	45	14.0
	100+	46	14.3
	Total	322	100.0

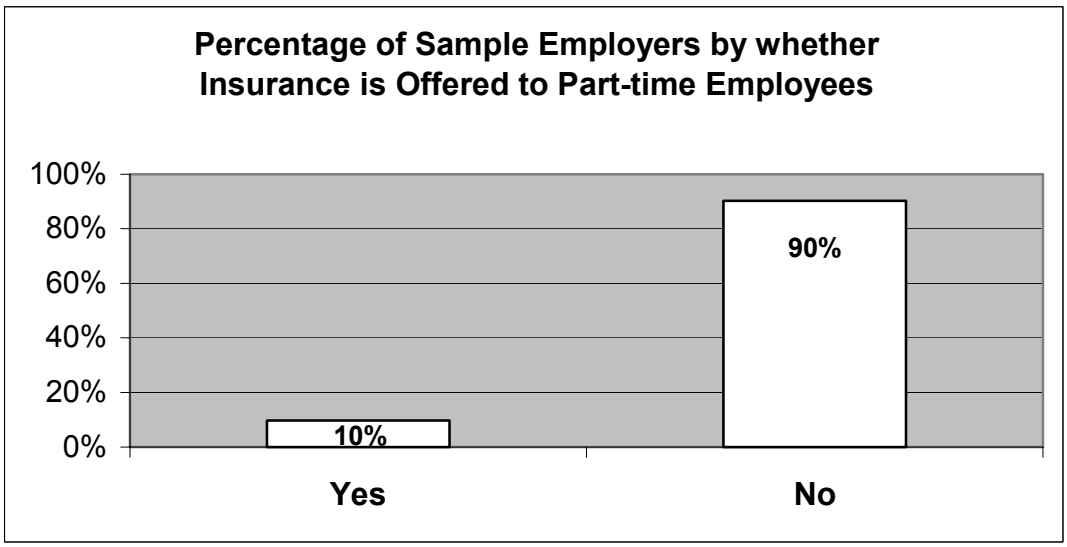

Employee Classification in Sample Firms
15,000
12,000
9,000
6,000
3,000
0
12,714
3,109
2,131
Full-time Employees
Part-time Employees
Seasonal / Temporary*
*Seasonal/Temp are included in full/part time totals.


Employee Classification Percent Distribution
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
17%
12%
Full-time Employees
Part-time Employees
Seasonal / Temporary*


Sample Employers by whether Insurance is Offered to Full-time Employees
Count
250
200
150
100
50
0
226
87
Yes
No


Percentage of Sample Employers by whether Insurance is Offered to Full-time
80%
60%
40%
20%
0%
72%
28%
Yes
No


Sample Employers by whether Insurance is Offered to Part-time Employees
Count
300
250
200
150
100
50
0
26
241
Yes
No


Percentage of Sample Employers by whether Insurance is Offered to Part-time Employees
100%
80%
60%
40%
20%
0%
10%
90%
Yes
No

Industry by "Do you offer health insurance to your full-time employees?"

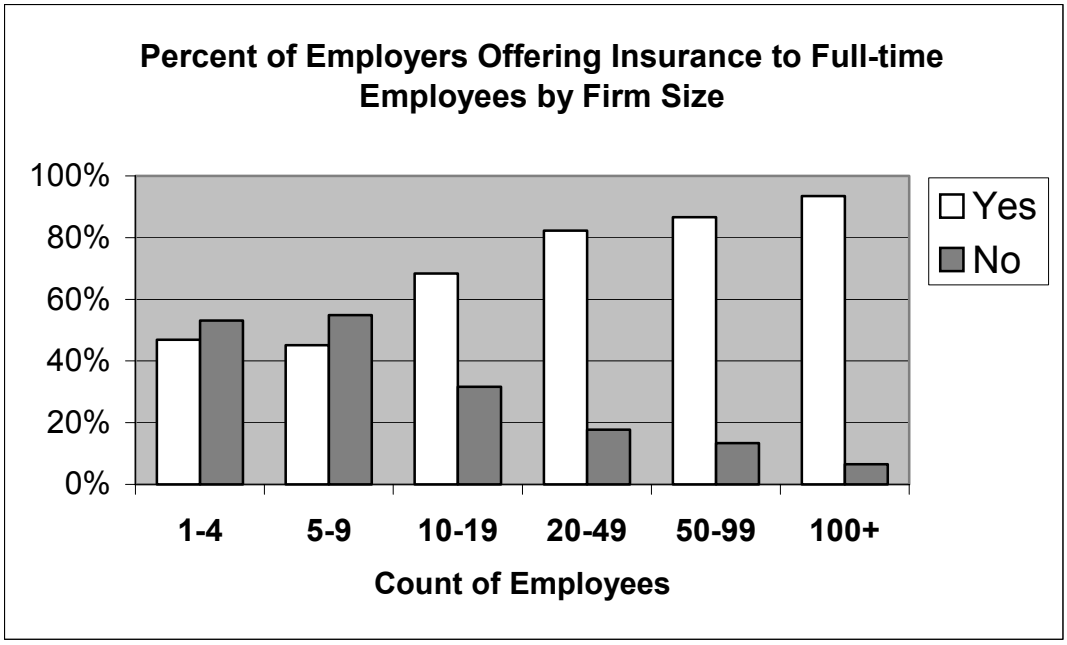
			Do you offer health insurance to your FT employees?		
			Yes	**No**	Total
Industry by SIC	**Agriculture**	Count	2	6	8
		% within Industry by SIC	25.0%	75.0%	100.0%
	Mining	Count	13	4	17
		% within Industry by SIC	76.5%	23.5%	100.0%
	Construction	Count	19	14	33
		% within Industry by SIC	57.6%	42.4%	100.0%
	Manufacturing	Count	14	4	18
		% within Industry by SIC	77.8%	22.2%	100.0%
	TCPU	Count	14	6	20
		% within Industry by SIC	70.0%	30.0%	100.0%
	Wholesale	Count	11	3	14
		% within Industry by SIC	78.6%	21.4%	100.0%
	Retail	Count	27	12	39
		% within Industry by SIC	69.2%	30.8%	100.0%
	FIRE	Count	14	3	17
		% within Industry by SIC	82.4%	17.6%	100.0%
	Services	Count	56	19	75
		% within Industry by SIC	74.7%	25.3%	100.0%
	Local Government	Count	21	0	21
		% within Industry by SIC	100.0%	.0%	100.0%
	Eating and Drinking Places	Count	8	9	17
		% within Industry by SIC	47.1%	52.9%	100.0%
	Hotels and Other Lodging Places	Count	6	4	10
		% within Industry by SIC	60.0%	40.0%	100.0%
	Health Services	Count	19	3	22
		% within Industry by SIC	86.4%	13.6%	100.0%
Total		Count	224	87	311
		% within Industry by SIC	72.0%	28.0%	100.0%

Industry by "Do you offer health insurance to your part-time employees?"

			Do you offer health insurance to your part-time employees?		
			Yes	**No**	Total
Industry by SIC	**Agriculture**	Count	0	8	8
		% within Industry by SIC	.0%	100.0%	100.0%
	Mining	Count	0	13	13
		% within Industry by SIC	.0%	100.0%	100.0%
	Construction	Count	0	25	25
		% within Industry by SIC	.0%	100.0%	100.0%
	Manufacturing	Count	0	13	13
		% within Industry by SIC	.0%	100.0%	100.0%
	TCPU	Count	2	14	16
		% within Industry by SIC	12.5%	87.5%	100.0%
	Wholesale	Count	0	8	8
		% within Industry by SIC	.0%	100.0%	100.0%
	Retail	Count	1	39	40
		% within Industry by SIC	2.5%	97.5%	100.0%
	FIRE	Count	3	11	14
		% within Industry by SIC	21.4%	78.6%	100.0%
	Services	Count	7	57	64
		% within Industry by SIC	10.9%	89.1%	100.0%
	Local Government	Count	4	16	20
		% within Industry by SIC	20.0%	80.0%	100.0%
	Eating and Drinking Places	Count	1	15	16
		% within Industry by SIC	6.3%	93.8%	100.0%
	Hotels and Other Lodging Places	Count	1	10	11
		% within Industry by SIC	9.1%	90.9%	100.0%
	Health Services	Count	7	10	17
		% within Industry by SIC	41.2%	58.8%	100.0%
Total		Count	26	239	265
		% within Industry by SIC	9.8%	90.2%	100.0%

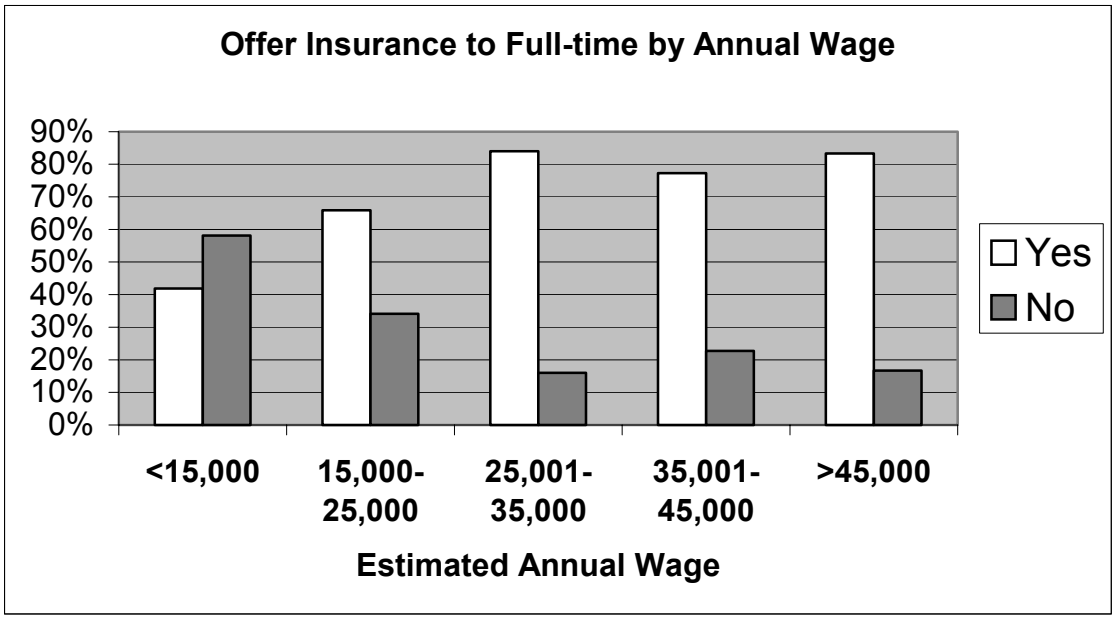
Number of Employees by "Do you offer health insurance to your FT employees?"

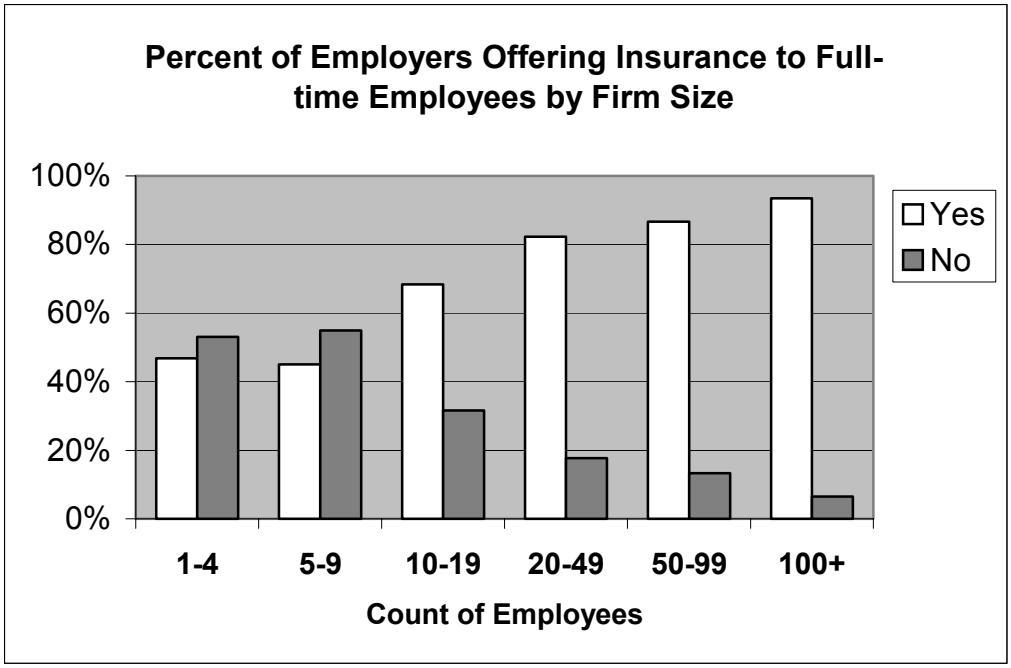
			Do you offer health insurance to your full-time employees?		
			Yes	**No**	Total
Number of Employees	**1-4**	Count	15	17	32
		%	46.9%	53.1%	100.0%
	5-9	Count	23	28	51
		%	45.1%	54.9%	100.0%
	10-19	Count	41	19	60
		%	68.3%	31.7%	100.0%
	20-49	Count	65	14	79
		%	82.3%	17.7%	100.0%
	50-99	Count	39	6	45
		%	86.7%	13.3%	100.0%
	100+	Count	43	3	46
		%	93.5%	6.5%	100.0%
Total		Count	226	87	313
		%	72.2%	27.8%	100.0%



Number of Employees by "Do you offer health insurance to your PT employees?

			Do you offer health insurance to your part-time employees?		
			Yes	**No**	Total
Number of Employees	**1-4**	Count	1	22	23
		%	4.3%	95.7%	100.0%
	5-9	Count	4	44	48
		%	8.3%	91.7%	100.0%
	10-19	Count	1	45	46
		%	2.2%	97.8%	100.0%
	20-49	Count	5	64	69
		%	7.2%	92.8%	100.0%
	50-99	Count	7	31	38
		%	18.4%	81.6%	100.0%
	100+	Count	8	35	43
		%	18.6%	81.4%	100.0%
Total		Count	26	241	267
		%	9.7%	90.3%	100.0%



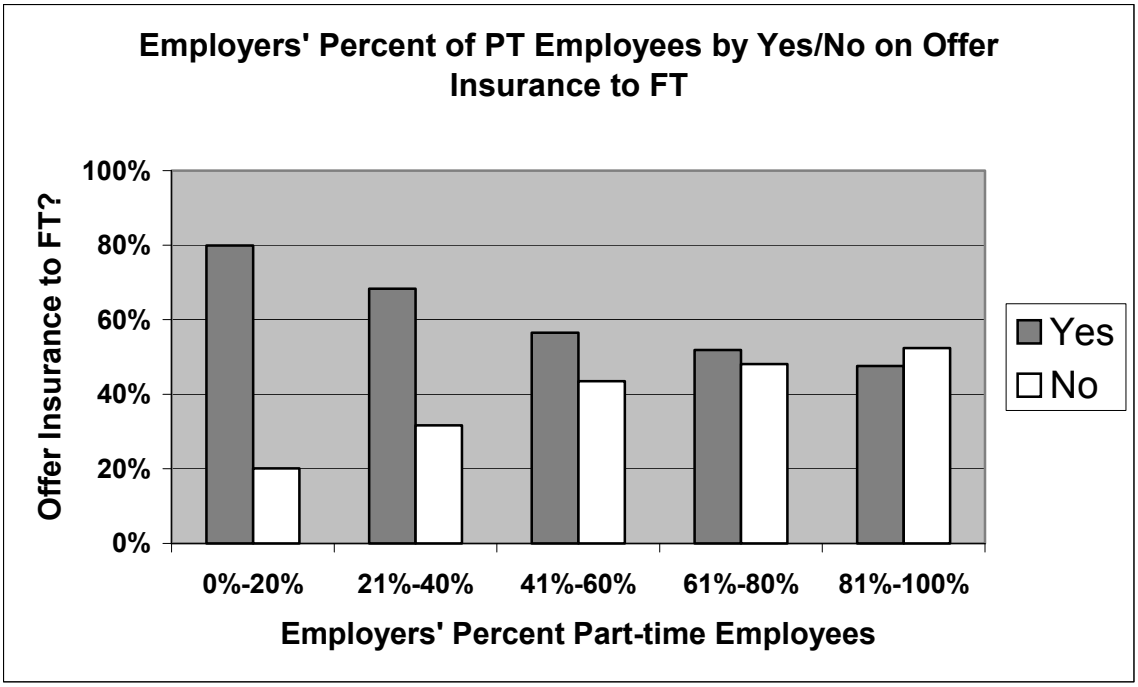


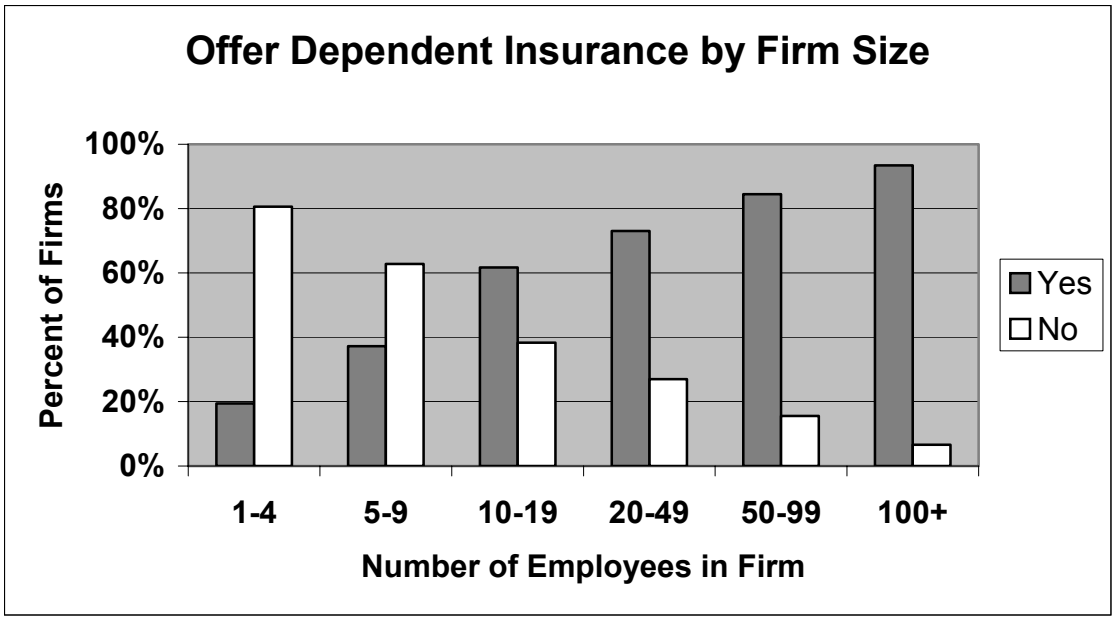
Estimated Annual Wage by "Do you offer health insurance to your FT employees?"

			9. Do you offer health insurance to your FT employees?		
			Yes	**No**	Total
Estimated Annual Wage	**<$15,000**	Count	18	25	43
		% within Estimated Annual Wage	41.9%	58.1%	100.0%
	$15,000-$25,000	Count	54	28	82
		% within Estimated Annual Wage	65.9%	34.1%	100.0%
	$25,001-$35,000	Count	58	11	69
		% within Estimated Annual Wage	84.1%	15.9%	100.0%
	$35,001-$45,000	Count	34	10	44
		% within Estimated Annual Wage	77.3%	22.7%	100.0%
	>$45,000	Count	50	10	60
		% within Estimated Annual Wage	83.3%	16.7%	100.0%
Total		Count	214	84	298
		% within Estimated Annual Wage	71.8%	28.2%	100.0%

Descriptive Statistics

Do you offer health insurance to your FT employees?		N	Mean
Yes	Estimated Annual Employee Wage	214	**$39,385**
	Valid N	214	
No	Estimated Annual Employee Wage	84	**$25,136**
	Valid N	84	





Firm Percent Part-Time by "Do you offer health insurance to your FT employees?"

			9. Do you offer health insurance to your FT employees?		
			Yes	**No**	Total
Firm Percent Part-Time	**0%-20%**	Count	155	39	194
		% within Percent Part-Time	79.9%	20.1%	100.0%
	21%-40%	Count	28%	13%	41
		% within Percent Part-Time	68.3%	31.7%	100.0%
	41%-60%	Count	13%	10%	23
		% within Percent Part-Time	56.5%	43.5%	100.0%
	61%-80%	Count	14%	13%	27
		% within Percent Part-Time	51.9%	48.1%	100.0%
	81%-100%	Count	10%	11%	21
		% within Percent Part-Time	47.6%	52.4%	100.0%
Total		Count	220%	86%	306
		% within Percent Part-Time	71.9%	28.1%	100.0%

Number of Employees by "Do you offer FT employees dependent health insurance?"

			10. Do you offer FT employees dependent health insurance?		
			Yes	**No**	Total
Number of Employees	**1-4**	Count	6	25	31
		% within Number of Employees	19.4%	80.6%	100.0%
	5-9	Count	19	32	51
		% within Number of Employees	37.3%	62.7%	100.0%
	10-19	Count	37	23	60
		% within Number of Employees	61.7%	38.3%	100.0%
	20-49	Count	57	21	78
		% within Number of Employees	73.1%	26.9%	100.0%
	50-99	Count	38	7	45
		% within Number of Employees	84.4%	15.6%	100.0%
	100+	Count	43	3	46
		% within Number of Employees	93.5%	6.5%	100.0%
Total		Count	200	111	311
		% within Number of Employees	64.3%	35.7%	100.0%

Number of Employees by "Do you offer a dental plan to full-time employees?"

			11. Do you offer a dental plan for FT?		
			Yes	**No**	Total
Number of Employees	**1-4**	Count	5	26	31
		% within Number of Employees	16.1%	83.9%	100.0%
	5-9	Count	13	38	51
		% within Number of Employees	25.5%	74.5%	100.0%
	10-19	Count	29	31	60
		% within Number of Employees	48.3%	51.7%	100.0%
	20-49	Count	46	32	78
		% within Number of Employees	59.0%	41.0%	100.0%
	50-99	Count	34	11	45
		% within Number of Employees	75.6%	24.4%	100.0%
	100+	Count	40	6	46
		% within Number of Employees	87.0%	13.0%	100.0%
Total		Count	167	144	311
		% within Number of Employees	53.7%	46.3%	100.0%

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2.4 Literature review

Annotated Bibliography
Uncompensated Care

Factors Affecting Provision of Uncompensated Care

Young, G.J., Desai, K.R., & Lukas, C.V. (1997). Does the sale of nonprofit hospitals threaten health care for the poor? *Health Affairs, 16*(1), 137-141.
This article addressed the effects on uncompensated care when nonprofit hospitals are acquired by investor-owned corporations. The concern is that investor-owned hospitals are less willing to offer care to those unable to pay. The study compared the pattern of uncompensated care three years before and three years after the acquisition, as well as whether the acquired hospitals opened or closed emergency departments during the three years following acquisition. Results indicated that acquisitions did not influence uncompensated care provided. Limitations were discussed, as well as possible factors, which would have affected the results.

Young, G.J., & Desai, K.R. (1999). Nonprofit hospital conversions and community benefits: New evidence from three states. *Health Affairs, 18*(5), 146-155.
This article addressed the high conversion activity, its motivating factors, and whether it impacts the amount of community benefits, namely charity care to the poor, that hospitals offer. The study systematically investigated both the short and long term impacts of nonprofit hospital conversions, focusing on four indicators (more comprehensive than previous studies). Results indicated no significant long or short term differences in uncompensated care, prices, or availability of unprofitable/non-reimbursable services. An increase in percentage of insiders on hospital boards was exhibited, but did not necessarily translate into less uncompensated care. The implication of decreased community representation was discussed, and policymakers were advised to stay open-minded about the gains and losses which can be expected from hospital conversions due to the lack of evidence supporting decreased community benefits.

Characteristics of Uncompensated Care

Cunningham, P.J., & Tu, H.T. (1997). A changing picture of uncompensated care. *Health Affairs, 16*(4), 167-175.
This article investigated the trends in uncompensated care offered by hospitals, community health centers, and private physicians. Hospital uncompensated care costs have remained relatively stagnant in the 1990's, while those costs of community health centers and private physicians have risen. Possible reasons for these trends and their implications for access to care were discussed.

Fishman, L.E. (1997). What types of hospitals form the safety net? *Health Affairs, 16*(4), 215-222.
This article addresses the position that safety net hospitals are in despite the available public financial support. An analysis was conducted to assess the hospitals with the greatest amount of uncompensated care burden. The hospitals were analyzed

according to their total margins, location, region, ownership, and payer mix. Hospitals involved in graduate medical education, teaching hospitals, as well as those that both support large uncompensated care burdens while maintaining large teaching programs were described according to their financial position. The concern centered around why those hospitals with the greatest uncompensated care burden, despite aid from state and local governments, were in worse financial position than other hospitals were, in addition to whether the current support structures are effective.

Mann, J.M., Melnick, G.A., Bamezia, A., & Zwanziger, J. (1997). A profile of uncompensated care, 1983-1995. *Health Affairs, 16*(4), 223-232.
This article investigated the provision of uncompensated care and the effect market conditions have on care for the poor. Most of the uncompensated care is provided by urban public and teaching hospitals, most of which are private. Sixty percent of indigent care is provided by private hospitals. Those hospitals with the greatest share of Medicaid patients and within competitive markets provide the greatest amount of uncompensated care. Competition plus great price sensitivity as a result of managed care can lead to decreased provision of uncompensated care. Financial losses from Medicare business reduced uncompensated care levels.

Responses to Uncompensated Care

Atkinson, G., Helms, D., & Needleman, J. (1997). State trends in hospital uncompensated care. *Health Affairs, 16*(4), 233-241.
This article addressed six state's responses geared toward preserving or expanding access to care. Coverage expansions, uncompensated care pools, hospital rate-setting, and public funding were discussed.

Bazzoli, G.J., & Andrulis, D.P. Strengthening the health care safety net: Hospital based services. Retrieved January 27, 2003
http://www.ahcpr.gov/news/ulp/safety/ulpsfty4.htm
This article, based on a presentation made by the authors, identified strategies for funding hospital uncompensated care and special challenges faced by hospitals and medical centers. Major categories of safety net hospitals, resources that make up the safety net, and factors affecting available resources for indigent care were outlined. Implications of declining hospital resources to support indigent care and some actions taken by communities to preserve the safety net were discussed.

State Best Practices/Responses to Uncompensated Care

Bovbjerg, R.R., Cuellar, A.E., & Holahan, J. (2000). Market competition and uncompensated care pools. The Urban Institute, Occasional Paper Number 35, 1-35.
This paper addresses three states' evolution of pool funding used to pay for uncompensated care. Post-deregulation targets of support are discussed, as well as the challenges to providing continued pool funding under price competitions. Advantages and disadvantages of pool funding are outlined, and an assessment of the recent developments of pool funds is included.

Minnesota Department of Health (1996). Uncompensated care. Health Economics Program Issue Brief 96-02. Retrieved January 30, 2003 from http:www.health.state.mn.us/divs/hpsc/hep/issbrief/96 02.htm. This article outlined the trends in uncompensated care costs of both hospitals and physician clinics in Minnesota from 1986 to 1994. Direct subsidies and cost shifting were discussed, as well as MN's rank among states with the lowest uncompensated care costs. Their low rank was attributed to the low rate of uninsured. Hospital reporting practices were discussed to outline accuracy of rates.

Minnesota Department of Health (1999). Department of health working definition of charity care and bad debt. Health economics Program. Retrieved January 30, 2003 from http://www.health.state.mn.us/divs/hpsc/hep/uncompcare/definition.htm. This article delineated the differences between charity care and bad debt and outlined the guidelines that healthcare organizations should follow to develop their criteria for provision of charity care. Qualification standards were listed for determination of charity care eligibility.