

The Uninsured: A Study of Health Plan Initiatives and the Lessons Learned



NIHCM
FOUNDATION

Introduction

The number of Americans without health insurance rose to 41.2 million in 2001, up 1.4 million from 2000.¹ Of the 1.4 million Americans who joined the ranks of the uninsured in 2001, 800,000 – 57% – lived in households with incomes of \$75,000 or greater.² A further increase in the number of uninsured is widely anticipated for 2002 and 2003, attributable to the continued sluggish economy, state budget crises and rising health care costs.³

The uninsured are a heterogeneous population. They reflect the full spectrum of Americans. Indeed, broader swaths of the population are increasingly vulnerable to the loss of coverage. As the configuration of the uninsured changes to include a greater percent of middle- and higher-income people, strategies to address health insurance gaps must expand as well.⁴ The population of uninsured people with household incomes of \$75,000 and above grew 14% in 2001 (from 5.8 million to 6.6 million) compared to a 2.7% growth rate in the number of uninsured with household incomes of \$25,000 or below (see Figure 1).

Although the dividing lines are porous and always in flux in real life, it is useful from a policy standpoint to place the 41.2 million uninsured (2001) into three categories according to both their eligibility, or lack thereof, for public insurance

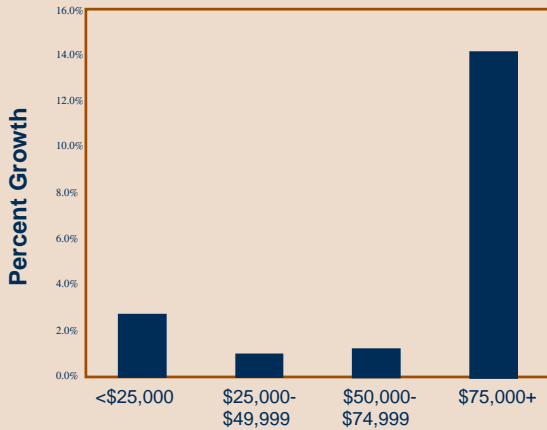
programs and their income bracket: (See Figure 2)

- Those eligible for public programs but not enrolled. Over 14 million uninsured Americans, most of them low-income, fall in this segment.
- Low-income people who do not qualify for public programs. About 9 million uninsured Americans fall in this segment.
- Moderate- to high-income Americans. About 18 million uninsured people fall in this segment, with 11.4 million having incomes over 300% of poverty or \$54,300 for a family of four.⁵

The diversity and growing income stratification of the uninsured requires a segmented approach to addressing their plight rather than one single, simple solution.

- *Eligible for public programs but not enrolled:* Many low-income uninsured people eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) are not enrolled. This is because they may be unaware of the programs or how to enroll. Many are also reluctant to participate because of the stigma associated with state "welfare" programs. And the paperwork can be quite

FIGURE 1: UNINSURED GROWTH RATE BY HOUSEHOLD INCOME



SOURCE: NIHCM Foundation analysis of U.S. Census Bureau data, 2002.

burdensome for potential enrollees who are poorly educated. Enhancing and simplifying eligibility, streamlining enrollment, and improving outreach are widely promoted as key paths to broaden coverage in this population group. Concerns going forward center around the ramifications of state budget crises.

- *Low-income but not eligible for public programs:* Affordability is the biggest issue for the low-income uninsured who are not eligible

for public programs. A family of four in this segment earns between \$18,100 to \$36,200, and therefore has limited resources to purchase insurance. Because a large portion of this group is employed either full-time or part-time, some advocate increasing employment-based health insurance coverage using targeted state and federal subsidies. Others suggest expanding public programs to cover this group.

People between 100% and 200% of poverty would benefit most from programs that seek to identify those in a health insurance “transition” – those families, for example, where the breadwinner has lost a job and health coverage and whose children may be eligible for SCHIP. Likewise, people dropped from Medicaid because they move into the workforce and are no longer eligible may qualify for transitional Medicaid if they get a job that does not offer coverage. Hundreds of thousands if not millions of people fall into these transition gaps each year and could be helped by proactively identifying their status.

- *Moderate- to high-income:* While access and affordability remain a problem for some people and families in this segment, many appear to be able to afford to buy health insurance (either at

FIGURE 2: TARGETING SOLUTIONS FOR THE UNINSURED

Reasons for being uninsured differ, therefore, solutions will too.

Eligible for public programs but not enrolled Over 14 million ¹	Low-income ~9 million ^{1,2,3}	Moderate- to high-income ~18 million ^{2,3,4}	
	<200%FPL	200%-299% FPL 6.4 million ^{2,3}	300%+ FPL 11.4 million ²

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Awareness • Enrollment hassle • Relevance • Stigma | <ul style="list-style-type: none"> • Affordability • Not offered at work • Transitions | <ul style="list-style-type: none"> • Perceptions of Affordability • Value (Cultural, age) • Small employer/individual market • Transitions (Employment, age) |
|---|---|--|

Developed by NIHCM Foundation for RWJF sponsored project. Data is based on 2001 numbers.

1. NIHCM Foundation estimates based on data from the Urban Institute.
2. U.S. Census Bureau, Current Population Survey, 2002 Annual Demographic Supplement.
3. Within these categories, the uninsured are not eligible for public programs.
4. Nearly one million uninsured who are above 200% FPL are eligible for public programs and are therefore included in the 14 million who are eligible for public programs but not enrolled. Estimates based on Urban Institute data and CPS 2002.

FACTORS CAUSING LACK OF INSURANCE

Americans have short-term gaps in coverage or lack coverage for longer periods for a variety of reasons. These have been well documented and researched in recent years and include:

- **Age** – Young adults (18 to 30) are far more likely to be uninsured, primarily because they change jobs often, have more periods without a job, and are more likely to work part-time and at jobs where insurance is not offered. Almost 60% of the uninsured were younger than age 35 in 2001.
- **Ethnicity** – Hispanic Americans are three times and Black Americans are two times as likely to be uninsured as White Americans.
- **Employment** – People who own or work in small businesses (less than 25 workers) in 2001 were half as likely to have health insurance as those who work at companies with 100 or more employees.
- **Eligibility** – Millions of people lack coverage because of employer and public program eligibility criteria. Employers for example may have waiting periods before new employees can sign up for their health plans. They may also not cover temporary and part time workers. States can have elaborate eligibility criteria for Medicaid, SCHIP, and other public programs.
- **Transitions** – People lose coverage primarily when they change, or lose a job, retire before age 65, or age out of a parent's policy. Close to half of those who lose a job have a gap in coverage for at least one month. Medicaid and SCHIP enrollees may lose coverage when they lose eligibility. A quarter of Medicaid enrollees cycle off the program in any given year.
- **Income/Affordability** – Poor and near-poor Americans are more likely to be uninsured. They simply can not afford it. However, increasing numbers of middle income and even higher income people are uninsured.

work or on their own) but do not do so. About 11.4 million uninsured people make over 300% of poverty. Reasons they do not purchase insurance vary. One study shows that many individuals in this category perceive premiums to be more costly than they in fact are and that nearly one quarter would purchase insurance if they knew the real price.⁵ Some of the nonpoor opt out of buying insurance because they do not see a need for it, whether it be due to cultural reasons or because they do not see the value in it. For young healthy people, this is particularly an issue because in effect they subsidize health care expenditures of older, less healthy individuals. Those who work in small businesses or are self-employed may not be offered insurance or opt out. For this group, solutions look quite different than for a family that has been on and off the Medicaid program several times during the last five years.

While federal and state lawmakers have understandably and appropriately focused resources on expanding health insurance coverage among low-income Americans, and particularly children (under SCHIP), the trend to increasing numbers of nonpoor uninsured is

forcing attention to solutions targeted at this group as well.

Expanding coverage among this group will likely involve private sector initiatives and programs that may sometimes be constructed in collaboration with government or supported by government.

For nearly two decades, private health plans have experimented with designing products to reach uninsured individuals and small businesses. In 1985, Highmark Blue Cross Blue Shield launched the Caring Program for Children. The program targeted uninsured children not eligible for Medicaid who lived in households with incomes up to 200% of FPL. The program was replicated nationwide by many other health plans and eventually served as an inspiration and model for the national SCHIP program (enacted in 1997). And today, it is integrated with Pennsylvania's SCHIP program to cover kids up to 300% FPL.

Most recently, again working with the state,

MORE NONPOOR AMERICANS ARE UNINSURED. WHY?

In 2001, 11.4 million (28%) of the 41.2 million Americans without health insurance lived in households with incomes at 300% of the federal poverty level or above.

Increasing numbers of non-poor Americans are uninsured for a variety of reasons:

- **An increase in the number of Americans in middle and higher income brackets.** In 1980, 13.4% of American households had incomes of \$75,000 or more. That rose to 18.6% of households by 1990 and 24.6% by 2001.⁷ Between 1998 and 2000, almost 6 million Americans joined the ranks of those living in households with incomes of 400% or more above the federal poverty level (\$72,400 for a family of four; \$35,440 for an individual). In contrast, the number of Americans living in households below 200% of poverty (\$36,200 for a family of four; \$17,720 for an individual) declined by 300,000 between 1998 and 2000.⁸ Even young adults who typically earn substantially less than their elders have shifted to higher income brackets over the years.
- **Labor market, business and economic trends.** Self-employment, part-time, contract and so-called “contingent” work became more common throughout the 1990s. In 2001, 7.3% of all workers (9.8 million) were self-employed, up from 6% (7.1 million) in 1990. About 23 million people (17%) in the nation’s full-year work force of 134 million worked part-time in 2001.⁹ Health coverage is less likely in both situations; about one in four (23.6%) self-employed people are uninsured, for example. Likewise, 22% of part-time workers were uninsured.¹⁰ Many part-time workers are members of households that also have another working member. These workers, however, may not have insurance even though their household income may exceed poor or near-poor levels.
- **Costs and premiums.** More middle and upper income Americans are uninsured because of escalating health care costs. During the past two years health care spending increased by \$204.8 billion, or 16.8%, totaling over \$1.4 trillion in 2001.¹¹ Health care costs went up largely because of increasing spending on hospitals and prescription drugs. These increases have driven the rise in health insurance premiums. In 1998, the average cost of employer-sponsored health insurance was \$3,817 per employee. That rose to \$5,646 in 2002.¹²
- **The retiree factor.** Retiree coverage has steadily declined since the early 1990s. Two-thirds (66%) of U.S. companies offered retiree health benefits in 1988. That declined to 34% of companies in 2002.¹³ About 18% of early retirees were uninsured compared to 12% of those aged 55 and above who remain employed. Low-income 50 to 64 year olds (household income below \$25,000) were most at risk of having no health insurance – about 30% lacked it in both 1989 and 1999. But the proportion of middle and higher income 50 to 64 year-olds with no coverage rose between 1989 and 1999, from 12% to 14% of middle income (\$25,000 to \$75,000) and from 4% to 6% of those earning \$75,000 or more.¹⁴

the Blues plans in Pennsylvania participated in adultBasic in June 2002. Subsidized with money from Pennsylvania's share of the tobacco settlement funds, this new program is targeted at residents aged 19 to 64 who have been uninsured for at least 90 days, are not eligible for public programs and whose incomes fall below 200% FPL (\$36,200 for a family of four). As of January 2003, adultBasic had enrolled 45,600 Pennsylvanians, up from 11,874 in September 2002.¹⁵

Reasons for the study and description of initiatives

A large volume of research over the last decade has examined government efforts to expand health insurance among low-income Americans, primarily through the Medicaid and SCHIP programs but also through many innovative state programs and market reforms. Relatively little recent research, however, has focused on efforts to get more of the nonpoor uninsured to buy health insurance through their employer or on their own. The primary impetus to this study was the need to better understand how private health plans have tried in recent years to reach the uninsured, and to identify the lessons learned from these efforts.

Limited by design, this study examines in detail 13 initiatives by 10 health plans that do not rely on government funding to expand health insurance coverage among the uninsured in the late 1990s and into 2002. The 10 health plans are evenly divided between for-profit and not-for-profit organizations. Six of the initiatives targeted the small group (small business) market, and seven targeted the individual market (See Table 1 on page 6). While health plans began addressing the uninsured primarily by crafting privately subsidized individual products, they have increasingly moved towards economically viable products for the small group market. This report describes the initiatives and assesses their enrollment of uninsured people, as reported by the plans. It also provides a detailed analysis of the design of the initiatives, lessons learned in creating and marketing them,

and factors that increased their chances of success.

Findings and Lessons Learned

I. Health plan interest in reaching the uninsured

Health plans interviewed for this project state that they are increasingly interested in finding workable solutions to expanding health insurance coverage – for social, political and business reasons. They recognize that those without health insurance face negative health and financial consequences. In addition, they realize that the uninsured have a profound effect upon the entire health care delivery system. Uncompensated care is financed by the insured through taxes and higher premiums.¹⁶ Providing coverage for the uninsured has the potential to make health care delivery more affordable and efficient.

Plan representatives interviewed for this project also worried that failure to find collaborative public sector/private sector solutions to the uninsured problem would lead eventually to government intervention unfavorable to the insurance industry. Few health plan decision-makers want additional restrictions on their product rates, benefits, or other attributes.

Instead they would prefer to create new, innovative lines of products that would increasingly appeal to small businesses and low to moderate-income persons, including those lacking insurance. Plan representatives stated that they would like to work with the government to find the right balance of flexibility to create such products, recognizing the inherent tension between attracting younger, healthier workers with less expensive coverage and providing protection for older, sicker workers.

Health plan representatives saw opportunities to expand coverage in the small group and individual markets.

TABLE 1: DESCRIPTION OF INITIATIVES

Small Group Products

WellPoint's product for firms with two to 50 employees, **FlexScape**, offers an array of PPO and HMO options. Depending on price, benefits vary from basic catastrophic to comprehensive packages with a range of deductibles and coinsurance levels. FlexScape became available in California in April 2001. (Enrollment as of January 2002: 797,000, 63% previously uninsured.)

Chamber Choice is a product for small businesses with up to 50 employees. Endorsed by the Greater Kansas City Chamber of Commerce, the product was created in 1994 by Blue Cross Blue Shield of Kansas City to address the low rate of small businesses which offer insurance to employees. (Enrollment as of October 2001: 39,600, 30-35% previously uninsured.)

Mid America Health Choice is a comprehensive health plan with low copayments and coinsurance for small businesses with two to 50 full-time workers. Mid America Health (formerly known as Health Net) developed Choice in 1994 in response to the Greater Kansas City Chamber of Commerce's challenge to expand health insurance to small businesses. The product was changed and reintroduced in 1998. (Enrollment as of October 2001: 15,000, 25% previously uninsured.)

Affordable HealthChoices (AHC) is a low-cost, employer-based hospital indemnity product for uninsured small businesses with two or more employees. Launched in 1999 by Aetna Inc., it offers hospital and some medical services paid in fixed-dollar amounts with no coinsurance or deductibles. (Enrollment as of October 2001: 2000.)

Small Business Health Insurance (SBHI)* is a low-cost product for small employers with two to 50 employees for the working uninsured in parts of New York City. It ran from 1999 to 2001 as a two-year demonstration project by Group Health Incorporated in partnership with the New York City Health and Hospitals Corporation and the Office of the Mayor. (Enrollment as of July 2001: 515, 17% previously uninsured.)

Blue Cross & Blue Shield United of Wisconsin's **Buy Direct PPO** became available in October 2000 as a low-cost option for small employers, start-up businesses, and the working uninsured. Model 1 has lower premiums, but higher out-of-pocket costs for employees; Model 2 has higher premiums with lower out-of-pocket costs. (Enrollment data not available.)

Individual Products

Established in 2001, WellPoint's individual product, **PlanScape**, is designed to provide the general public and the nonpoor uninsured with affordable health coverage. Like FlexScape, enrollees may choose from an array of PPO and HMO options with benefits ranging from catastrophic to comprehensive services. (Enrollment as of January 2002: 815,000, 49% previously uninsured.)

Special Care* is a low-cost indemnity plan for uninsured Pennsylvanians with incomes too high for public assistance (at or below 185% FPL), but too low to afford commercial health insurance. Through a coordinated effort begun in 1992 by four Blue Cross Blue Shield plans, Special Care offers physician, hospital, medical, and surgical coverage with first dollar coverage and limited out-of-pocket costs at half the price of other products. (Enrollment as of July 2001; over 61,000, all previously uninsured.)

In 1990, Kaiser Permanente (KP) began the **Dues Subsidy Program** to cover low-income people who could not afford or did not have access to health insurance. The Dues Subsidy Program in California now has three plan-subsidized comprehensive benefit products: **Child Health Plan-1*** for children with family income between 250%–300% FPL; **Child Health Plan-2*** for noncitizen children with family income up to 250% FPL; and **Steps*** to move adults and families with incomes of 100%–300% FPL to full cost products via tiered premium levels. (Enrollment as of May 2002: 1,953, Child Health Plan-1; 3,131, Child Health Plan-2; and 14,501, Steps. All previously uninsured.)

Memorial Advantage* is a health cost assistance program for St. Joseph County, Indiana residents with incomes at or below 200% FPL. Started in 2001 as a two-year pilot, Memorial Advantage offers preventive medical, emergency, and hospital services. The program is sponsored by Memorial Health System along with a medical group, pharmacy, medical foundation, and physician specialty groups contracting with Memorial. (Enrollment as of July 2001: 250, all previously uninsured.)

BlueCare is an insurance plan for low-income uninsured individuals residing in Montana. With a coalition of providers and hospitals, Blue Cross Blue Shield of Montana launched BlueCare in July 2001 to provide limited benefits such as medical, hospital, and prescription drug coverage. Initially available to those with incomes up to 150% FPL, eligibility was increased in April 2002 to incomes up to 175% FPL. (Enrollment data not available.)

* Indicates subsidized product.

- *Small group market* – This study shows that some health plans have attempted in recent years to broaden coverage among small firms by providing a wider choice of benefit packages, increasing cost sharing, and cross-subsidizing premiums. Some health plan representatives stated that they would like more flexibility to craft products that appeal to the smallest employers (under 10 workers) who are the least likely to offer coverage.
- *Individual market* – Several health plan representatives said that their plans want to make coverage more broadly available to young adults. The large portion of young Americans who are uninsured skews the age range of the covered “pool” of the population. Enrolling more of this low-risk population could actually help make health insurance more affordable for everyone else since their premiums will cross subsidize care of less healthy older Americans. Some health plans created less expensive products through subsidies or by modifying product features to reach low-income, part-time, and temporary workers to aid their communities.

Health plan administrators said they were interested in trying new programs and products to target the uninsured. Such initiatives could be vital to extending coverage in a time of tightened government budgets. And generally, if such initiatives can be financially viable, they will grow without dependence on government funding which can rise or fall with tax revenues and other external factors.

Health plan representatives stated that tax credits or other subsidies would be beneficial to helping them provide services more broadly to the uninsured.

II. Enrollment

The findings here are mixed. Six of the programs met enrollment targets, with 25% to 100% of enrollees having been previously uninsured. These programs can be said to have been a success based on scope, enrollment targets and realistic expectations. Five of the initiatives did not reach enrollment targets, though they did reduce the number of uninsured people, if only marginally, in their market areas. Two of the programs failed to get off the ground under their initial designs – primarily due to marketing problems. Both were being relaunched in 2002 after data collection and analysis of this study ceased.

Among initiatives targeted at the small group market, Chamber Choice, launched by Blue Cross Blue Shield of Kansas City, had enrolled 39,600 people as of October 2001. A third of the small firms signing on had not offered their workers coverage before and four in ten of the workers enrolled were uninsured when enrolled. Wellpoint Health Network’s FlexScape program in California had enrollment of 797,000 as of January 2002 (including some consolidation into this program from previous small group programs.) According to company data, close to two-thirds (63%) of enrollees in FlexScape were uninsured when they signed up. Mid-America Health Choice, also in Kansas City, enrolled 15,000 people by October 2001, a quarter of whom were previously uninsured.

Among initiatives in the individual market, Special Care in Pennsylvania had enrollment of 61,000 previously uninsured people as of June 2001. Wellpoint’s PlanScape (in California) had enrollment of 815,000 as of January 2002, 49% of whom had been uninsured for varying periods of time before enrolling, according to company data. Kaiser Permanente’s Steps program had 14,501 enrollees as of May 2002, all of whom had been uninsured. Kaiser’s Child Health Plan I and II had 5,084 enrollees (aged 0 to 18) as of May 2002, all of whom were also previously uninsured.

A detailed presentation of the findings can be found in Tables 5 and 6 of the full report. Detailed descriptions of the initiatives can be found in the Appendix of the full report.

III. What Produced Success and Lessons Learned

Generally, health plans that were successful in reaching the uninsured developed products that were affordable and attractive. And they marketed them aggressively. In addition, they effectively managed situations in which people were transitioning out of one form of coverage into another, or one job to another.

Affordability: Keeping products affordable was central to success. Studies and health plan data show that most people who are very price sensitive or have been previously resistant to the purchase of health insurance do not want to pay more than \$100 to \$150 per month for individual insurance and not more than \$250 to \$300 a month for family coverage. The monthly premiums of initiatives described in this report ranged from a low of \$50 for an individual to \$300 for a family of four.

Such pricing forces tradeoffs. And keeping health insurance affordable is no small task in a time of escalating health costs. Most of the successful initiatives examined in this report used innovative product design, flexible and reduced benefits, enhanced cost sharing, and/or reduced profit margins to keep premiums as low as possible.

Most of the products in both the group and the individual markets were age-rated (premium varied according to age of applicants) but not all required medical underwriting – the process by which insurance is priced according to health status or past health care use and experience.

A few of the initiatives depended importantly on “cross-subsidies” within a health plan’s scope of business. That is, the company expected much smaller profit margins in the product line aimed at reducing the number of uninsured than in its other lines of business. Some products, particularly in the individual market, were totally subsidized by the health plans.

Marketing: Marketing was critical to the success of private initiatives, particularly in the small group market. The mere existence of affordable health insurance does not guarantee that the

target population will purchase it. Successful initiatives used multifaceted approaches to marketing.

In the small group market, a multi-pronged marketing strategy yielded greater success. Small group initiatives that attracted more than 10,000 members used direct mail, many brokers, the Internet, toll-free telephone numbers, and television, print, and radio advertisements. Among these different strategies, health plan administrators indicated that brokers were essential in securing new members. Programs that had difficulty with enrollment either did not use brokers or worked with a limited number to recruit customers.

Among initiatives in the individual market, health plans were more likely than those selling small group products to use direct approaches such as distributing flyers and holding community events as part of a marketing campaign. Generally, health plans that conducted extensive market research to determine which channels and messages would most effectively reach their target population were more successful.

Transitions: Americans generally lose health insurance coverage when they lose a job or change jobs. Medicaid enrollees frequently lose coverage when their eligibility status changes. SCHIP enrollees may also be dropped if a family’s income rises above the eligibility cut off. Young people often lose coverage when they “age out” of their parent’s coverage (generally around age 21 to 25). Dependents may also lose coverage if an employer alters their plan to make such coverage more restrictive or expensive.

Studies overwhelmingly show that many people are unaware of their health insurance alternatives, and especially their eligibility for public programs, when they lose coverage. They may also overestimate the cost of health insurance in both the small group and individual market.

Transitions offer opportunities for creativity and public/private partnership in developing products to bridge the various sources of insurance. Successful health plan efforts

managed these, identifying populations at risk of such transitions (such as those coming off Medicaid and the young who change jobs frequently). In some cases, over-aged dependents were allowed to retain coverage until they found alternatives or were transitioned into solo coverage. In another example, rates were guaranteed over time for enrollees in their late 50s and early 60s – to attract and retain the uninsured in this population group. Other initiatives provided subsidies to cover those in employment transitions for a number of years as well as partnered with the public sector to cross-refer applicants.

TABLE 2: LESSONS LEARNED

Marketing: Multifaceted approaches were generally associated with higher enrollment, particularly in the small group market. Brokers were essential in securing new members for small business products. Overall, health plans that did extensive market research to determine which marketing channels would most effectively reach their target population fared better than those that did not.

Benefit Design: Whether the benefit package was comprehensive or more limited did not appear to be the determining factor in appealing to the uninsured or meeting a program's enrollment target. Several health plans used market research to help refine their benefit packages, with one plan determining the composition of benefits around price points that the uninsured could potentially afford. This strategy attracted a large number of uninsured.

Affordability: All of the health plans attempted to keep premiums low since affordability is the most important reason people lack coverage. Lower premiums, however, did not guarantee higher enrollment because (a) the premium could have remained out of reach (b) the product's benefits may have been viewed as insufficient for its price; (c) the product may have seemed less desirable in comparison with the company's other offerings; or (d) insufficient marketing. Products using methods such as rate stability, reduced profit margins, and enhanced cost sharing fared better than those using other approaches. Although some products were cross-subsidized within the plan and others were profit-making or break even, this aspect of financing was not a defining factor in attracting the uninsured.

Target Population: Many programs restricted program eligibility because of limited funds or in order to avoid duplication with other coverage for the uninsured. But some products with extremely narrow target populations experienced difficulty reaching eligible people while those with less restrictive criteria had greater success. Plan-subsidized products tended to target lower-income uninsured individuals whereas several profit-making products were aimed at covering uninsured small business workers. Some non-subsidized products specifically identified their target market as people with incomes over 200% FPL. Greater opportunities to partner with the public sector exist for plan-subsidized models, as their target populations often share similar characteristics.

Providers: Realizing that provider networks can enhance the value of health insurance products, nearly all the health care organizations used the same network for their uninsured initiatives as for their other products. While a broad network does not guarantee the success of a program, a restricted panel seemed to have negative consequences on enrollment.

Program Duration: Pilot programs allow a health plan to try new, unproven, or otherwise risky approaches to coverage. Yet some pilots with limited availability due to service area, income, or number of potential enrollees experienced marketing and enrollment difficulties. One health plan was able to bypass some of these issues by enrolling current members into its new products.

Transitions: Products that addressed age, income, and public/private transitions generally achieved greater success in enrollment than those that did not.

Enrollment and Operations: A multi-step enrollment process may be cumbersome to applicants. Health plans found that streamlined application processes enhanced enrollment.

Recommendations

The findings from this study yield various recommendations as described below in Table 3. They are based in large part on the comments from health plan staff about the successes of and barriers to their programs. Other recommendations, with detailed explanations, may be found in Section IV of the full report.

Conclusion

This study, while necessarily limited to an analysis of a small number of initiatives, suggests strongly that private health insurance plans can play an important role in extending coverage to some uninsured Americans. Such efforts are most likely to be successful (and efficient) when targeted at people employed in small businesses and at nonpoor people who do not qualify for public programs. Continued health plan commitment to programs that target the uninsured is critical.

TABLE 3: KEY RECOMMENDATIONS

Marketing

- Use a multifaceted marketing approach to reach well-delineated target population. Health plans creating products for small businesses should consider using brokers as a key element of their marketing strategy.
- Allocate sufficient resources to support aggressive marketing during the three months prior to product launch as well as one to two years after the program's introduction.

Benefits Design

- Conduct research before creating products to determine the right mix of cost and coverage.
- Design benefits around price categories.

Financing

- Consider alternative methods to lower premiums such as rate stability, reduced profit margins, and enhanced cost sharing mechanisms.

Target Population

- Define a target population to support a multifaceted marketing approach. A target population that is too narrow or spread among too many states may hinder marketing strategies.
- Moderate-income populations (income exceeding 200% FPL) may yield highest enrollment.

Providers

- Use the same provider network as your other commercial products. A limited provider panel may diminish the product's value.

Program Duration

- Analyze whether creating a pilot rather than launching a full-scale product may become a barrier in reaching the uninsured, due to limited health plan commitment.

Transitions

- Partner with state programs for cross-referrals from public programs and to target people likely to be between sources of coverage.
- Allow "aged-out" dependents to remain on a parent's policy.

Enrollment and Operations

- Make enrollment procedures easier by providing materials in multiple languages and limiting the length of the application form.

The study also demonstrates the success of public/private partnerships in launching programs aimed at expanding health insurance coverage. And it points to new opportunities for public/private sector collaboration aimed at identifying people who are entering insurance transitions. Such efforts could enhance enrollment in *both* public and private insurance programs. In addition, partnerships aimed at enhancing outreach and marketing could make millions of Americans more aware of their health insurance options, both public and private. The study underscores that solutions to the uninsured problem are more likely to be found in coordinated efforts to address the various segments of the uninsured population.

At the same time, the study indicates a promising new model: that of financially viable programs and insurance products targeted at the nonpoor uninsured. Innovative product design, and the flexibility to create such products, is essential to the success of such initiatives. Over time, such programs could build and solidify to help millions of people avoid health insurance gaps and reduce the number of nonpoor uninsured.

Creating health insurance products that are affordable to an increasing number of Americans requires tradeoffs. While optimal comprehensive coverage is widely desired by many, and perhaps most, people shopping for health insurance today, it is simply too expensive for some small businesses and low- to moderate-income individuals. Carefully crafted and appropriately regulated insurance products that adequately protect enrollees against high medical costs can be affordable and desirable. Many health plan companies are convinced that a market exists for such coverage, and that choices in the marketplace are vital to attracting uninsured people who can afford to buy coverage on their own. Several initiatives profiled in this study indicate that well-designed marketing appears successful in identifying and enrolling people who desire such coverage.

All that said, the results of this study underscore what many past studies have found,

that significant reductions in the number of uninsured Americans will be achieved only through combined government and private sector efforts.

Finally, lasting solutions to the problem of health insurance coverage in the U.S. will continue to be difficult to achieve in the face of sharply rising health care costs. Such costs make health insurance an ever more expensive commodity and product, meaning not only that fewer businesses and people can afford it but that government may have to scale back coverage as well. Government attempts to expand coverage must be accompanied by policies that seek to control health care costs.

The full report may be accessed at <http://www.nihcm.org/UninsuredFull.pdf>.

Notes

1. Robert Mills, U.S. Census Bureau, *Health Insurance Coverage: 2001*, (September 2002), www.census.gov.
2. Mills and Census Bureau as cited in note 1.
3. Stephen Heffler et al, "Health Spending Projections for 2002-2012," *Health Affairs* (February 7, 2003), web published: pages W3-54 to W3-65, <http://www.healthaffairs.org>.
4. Susan Brink, "Living on the Edge: The Uninsured Used to Exist on the Margins of Society. Now they are Most Likely Next Door," *U.S. News & World Report* (October 14, 2002): page 58-66; Julie Appleby, "More High-Income Americans Go Without Health Insurance," *USA TODAY* (November 22, 2002), page B1; John M. Broder, Robert Pear, and Milt Freudenheim, "Problem of Lost Health Benefits is Reaching into the Middle Class," *The New York Times* (November 25, 2002), page 1.
5. This report uses Federal Poverty Guidelines as defined in the Federal Register, Vol. 67, no. 31, February 14, 2002, pp. 6931-6933.
6. California HealthCare Foundation, "To Buy or Not to Buy: A Profile of California's Non-Poor Uninsured"

(Oakland, CA: The California HealthCare Foundation, April 2000).

7. U.S. Census Bureau, *Money Income in the United States, 2001*, Appendix A, Table A-1, www.census.gov.

8. John Holahan, The Urban Institute, Presentation at a conference on "State Efforts to Expand Health Insurance Coverage," November 18, 2002; data based on Census Bureau Current Population Surveys.

9. U.S. Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey*, 1990 and 2001.

10. Paul Fronstin, Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured* (December 2002).

11. K. Levitt et al, "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, January/February 2003: 154-164.

12. John Gabel et al, *Employer Health2Benefits, Annual Survey 2002*, Kaiser Family Foundation/Health Research and Educational Trust, September 2001; and Gabel et al, "Job-Based Health Benefits in 2002: Some Important Trends," *Health Affairs* (September/October 2002), pages 143-151.

13. Ibid.

14. AARP, *Beyond 50: A Report to the Nation on Trends in Health Security*, (May 2002), www.aarp.org.

15. Pennsylvania Insurance Department, "adultBasic: Health Insurance for Adult Pennsylvanians," (January 29, 2003), <http://www.insurance.state.pa.us/html/adultbasic.html>.

16. N.M. Kane and W.H. Wobbenhurst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," *The Milbank Quarterly*, Vol. 78, No. 2 (2000): 185-212.

A PUBLICATION OF THE NIHCM FOUNDATION

About the NIHCM Foundation

The National Institute for Health Care Management Research and Educational Foundation is a nonprofit organization whose mission is to promote improvement in health care access, management, and quality.

About This Executive Summary

This executive summary was written with support from the Robert Wood Johnson Foundation. The authors are solely responsible for the content in this study, and take full responsibility for any errors herein. The study is not in any way meant to represent the views of the Robert Wood Johnson Foundation or any other organization.

Nancy Chockley, MBA, Amy Chung, MHS, Steven Findlay, MPH, and Linda Kotis, JD, of the NIHCM Foundation all contributed to this project. NIHCM Foundation would like to thank the administrators and staffs of the health plans who participated in this study for generous portions of their time.

NIHCM Foundation would also like to thank the following people for their insights in guiding the project and for their time in reviewing early drafts:

- *Jack Ebeler*, President and CEO, Alliance of Community Health Plans
- *David Helms*, President and CEO, AcademyHealth.
- *Vivian Riefberg*, Principal, McKinsey and Company, Inc.,
- *Dhan Shapurji*, Vice President, Strategic Planning at Anthem Blue Cross Blue Shield
- *Craig Tanio, M.D.*, McKinsey and Company, Inc.
- *Dana McMurtry*, Vice President, Health Policy, WellPoint Health Networks

Finally, the authors and the NIHCM Foundation are grateful for the support of the Robert Wood Johnson Foundation. Anne Weiss, Senior Program Officer at the Foundation, offered invaluable guidance throughout the project.



NIHCM
FOUNDATION

1225 19th Street, NW
Suite 710
Washington, DC 20036
TEL 202.296.4426
FAX 202.296.4319
WEB www.nihcm.org