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Workers report that individuals face considerable barriers obtaining child care, using this multi-tier system. First, individuals receiving ATAP must obtain information from the local administrator, which requires making an appointment and traveling to a different location. There is often a wait to obtain a list of child care providers, and the individual's receipt of self-sufficiency services are delayed while they are awaiting the information. For example, we were told that it takes about a week to obtain this information in Anchorage. DPA officials indicate this has been resolved through an internet application.

Workers transitioning from ATAP to self-sufficiency must take time off from their new jobs to arrange to continue receiving child care because they must move from PASS I to PASS II child care. Working individuals using PASS II or III child care must also take time off from work to meet with separate local administrators. Because local providers require frequent renewal of authorizations and renewal authorizations be done in person, workers must frequently miss work to continue receiving assistance with child care.

In addition, appointments with local administrators are not immediately available. Workers report that it can take a month to obtain an appointment with the local provider and two months before child care is authorized. We have been told that these delays cause "entry effects", in that ATAP-eligible individuals who do not want welfare but just assistance with child care must, nevertheless, apply for ATAP so they can obtain immediate assistance with their child care expenses.

Another problem has been the delay caused by processing backlogs. Although the waiting list for PASS III child care has been eliminated by DPA's transfer of additional TANF dollars to EED, the field reports that child care waiting lists have not yet been completely worked. In Anchorage, for example, the waiting list of 600 families was still being cleared at the time we interviewed staff.

### 6.2 Child Care System Recommendations: Improve the Delivery of Child Care

We recommend that child care be provided through a more user-friendly child care structure that eliminates delays and gaps; that child care assistance be "seamless", so that an individual moves automatically

between child care levels; and that the child care co-pay schedule be revised to eliminate payment cliffs. To accomplish this we recommend the following program changes:

### *6.2.1 Client-Friendly Child Care*

To create a seamless child care system that promotes employment and discourages needless welfare usage, the child care authorization existing as of the termination of ATAP should be used to continue child care funding, so that the movement between PASS I and PASS II does not require an individual to make additional appointments or complete additional forms. In addition, in-person appointments should not be required to continue authorized child care assistance; telephone contacts should be used except in extraordinary circumstances.

We also recommend that local administrator contracts should require that all child care services be provided in DPA one-stops. And finally, these child care contracts should require that applications for child care are taken and processed quickly, so that individuals are provided needed assistance without delays. Based on their success in providing timely PASS I child care, we believe that seamless child care that is immediately available can be most easily accomplished if authorization of PASS II and PASS III child care is also shifted to DPA. If administration of CCDF funds remains with EED, DPA should become the PASS II/PASS III child care provider under contract to EED.

### *6.2.2 Enhance Recruitment of Infant and Extended Hours Child Care Providers*

Workers report that infant and extended hours (evening/weekend) child care is in short supply or unavailable, particularly in rural areas. Fairbanks is attempting to reduce this problem: they have a new Resource and Referral (R&R) grant to recruit providers and to provide incentives for current providers to expand to these special categories. The need for more infant care slots will become even more apparent if Alaska reduces the period of exemption from work participation from 12 months after birth to 16 weeks as is recommended.

The Department of Education and Early Development should step up contractor efforts to recruit, train, and license child care providers who are willing to provide infant and/or extended hour child care. As a condition of their contracts, contractors must recruit and register new

child care providers. Although the provider in Nome now understands its obligations in this area, we were told that it took a concerted effort by DPA workers before the contractor agreed to register new child care providers.

### *6.2.3 Change the Child Care Co-pay Schedule to Eliminate Perverse Incentives that Result in Clients Forgoing Pay Raises/Employment Promotions*

The child care co-pay levels create funding "cliffs". For example, in Anchorage a three-person family with monthly income up to $1,423 would be required to pay only 3% of child care costs. Were the same family to have only one dollar more of income, their co-pay obligations would rise to 15%. Income between $1,779 and $2,134 obligates them to provide 25% of the cost, and income of $2,135 and $2,489 requires a 50% co-pay. Only 25% is reimbursed if earnings are $2,490 to $3,694, and no co-pay is available if income exceeds $3,694. Because of these funding cliffs, individuals with small increases in income face huge increases in child care costs, and the increases are especially steep if there is more than one child needing care. Clearly these cliffs create incentives to forgo pay raises and employment promotions.

There is also a problem in that the daily reimbursement rates in the rate schedule now being implemented provides a much higher reimbursement (an example was provided where the daily rates would yield $223 more for the month), for a whole month than the monthly rate, creating an incentive for individuals to create irregular work schedules so that they are paid based on a daily (attendance) rather than a monthly (enrollment) authorization. DPA is currently working with EED to modify the schedules.

We recommend that child care funding schedules be redesigned to create narrow changes in payment obligations that match narrow changes in income. If percentage changes are used to determine co-pay amounts, many more percentage levels should be used. We recognize that this will be a delicate operation, since the schedules must ensure that payments provided do not exceed available funding for child care. In designing its new schedule, Alaska may want to obtain payment schedules used by other states.

# 7. TANF Time Limits

## 7.1 Background/Findings Related to TANF Statutory Time Limits and Alaska's ATAP Program

Although TANF is a block grant, there are several specific statutory prohibitions that restrict state flexibility. A major restriction is the provision that a state can not use any part of its federal TANF grant to provide assistance to a family that includes an adult who has received assistance under any state program using federal TANF dollars for 60 months (Section 408(a)(7)). States are permitted to exempt families from the 60-month limit for hardship or because of domestic violence, but no more than 20% of the average monthly number of families provided benefits using federal TANF funds can be families headed by an adult who has received benefits more than 60 months. States violating this restriction are subject to a substantial penalty, a reduction of five percent of their TANF grant for the succeeding year (Section 409(a)(9)). Any month of assistance received while an adult was living in certain Alaskan Native villages with at least 50% of adults not employed are excluded in determining whether an individual has received assistance for 60 months.

Section 47.27.015(a)(1) of Alaska statutes repeats this federal requirement by providing that a family is not eligible for ATAP if the family includes an adult who has received benefits under ATAP or an applicable program of another state for 60 months, unless the adult has been a victim of domestic violence, is physically or mentally unable to perform gainful activity, is a parent providing care for a disabled child, or the family is determined to be exempt by reason of hardship. Alaska's statute further limits the number of long-term recipient families by providing that the number exempted "may not exceed 10 percent or the maximum percentage of families allowed an exemption under federal law, whichever is greater."

### *7.1.1 DPA's Proposed Sixty-Month Policy*

Long-term TANF recipients in some states are already beginning to reach their 60-month time limit. In Alaska a number of families currently receiving ATAP will hit the time limit in July 2002, five years after the effective date of TANF in Alaska. DPA has developed draft criteria to use to qualify clients for extensions beyond 60 months. The criteria provide for extensions for certain situations of domestic violence, incapacity of

the adult, caring for a disabled relative, and hardship. To receive a hardship extension, the caretaker must be complying with their FSSP and participating in work activities, but cannot earn enough to leave ATAP because of medical, mental health or functional limitations; or the family is impacted by a catastrophe; or the children are at risk of placement outside the home if assistance is ended. The draft procedures establish a process whereby there is screening and assessment of long-term recipients, collaboration with other agencies involved with the family, a Local Office Review Committee making extension decisions, development and monitoring of plans during the extension period, and periodic review of extensions.

### *7.1.2 Issues Based on Current Alaska Statute*

In our interviews, DPA staff voiced concern that, despite limited extension criteria, there may be a month when some families meeting the extension criteria cannot be paid without violating Alaska's statutory limit that not more than 20% of Alaska families subject to the time limit have received 60 months of benefits. DPA officials also point out that Alaska's statute is more limiting than the federal statute requires. PRWORA merely forbids states from using federal TANF funds to provide benefits for more than 60 months; Section 408(a)(7)(F) specifically permits states to expend state funds (e.g. TANF maintenance of effort (MOE) dollars) to provide benefits to families headed by an adult who has received federally-supported benefits for 60 months.

We concur with DPA's assessment that, if Alaska uses only state MOE dollars to provide benefits to such families, families with over 60 months of receipt will not be counted in determining for federal purposes whether Alaska has exceeded the 20% limitation. In fact, several Administration for Children and Families (ACF) issuances specifically advise states how to use their MOE to create "segregated" or "separate" state programs, to provide benefits to classes of individuals who are prohibited from receiving benefits using federal TANF funds. For example, Temporary Assistance for Needy Families Policy Announcement, TANF-ACF-PA-97-1, January 31, 1997 specifically advises that "[s]tates may expend their MOE funds on a broad range of activities without necessarily triggering Federal TANF requirements (such as time limits)." An ACF chart attached to the Policy Announcement shows that application of the time limit on assistance provision is avoided by creating a segregated or separate state program. TANF-ACR-PA-97-1 may be accessed online at http://www.acf.dhhs.gov/programs/ofa/pa97-1.htm.

### 7.2 TANF Time Limit Recommendations: Alaska Needs to Ensure That Long-Term ATAP Recipients Do Not Trigger Federal Penalties

We believe that states should be making every effort to move ATAP families as quickly as possible off welfare. However, for a number of reasons we support DPA's view that Alaska's more restrictive state time limit requirement should be eliminated. First, the federal requirement that not more than 20% of current recipient families can be headed by an individual who has received assistance for 60 months, is a "Catch 22" in that the more successful Alaska is in reducing it's caseload by finding work for employable beneficiaries, the more likely that the families remaining on assistance will be hard-to-serve. Particularly if the application rate for families who have never been on assistance remained low, a state with a hefty caseload reduction might reach the point where more than 20% of its remaining cases needed more than 60 months to achieve full self-sufficiency. Although we do not believe that Alaska has reached this point yet, it is important to make the change so it can be implemented when and if the need arises, to prevent being forced to deny benefits to vulnerable Alaska families who meet statutory criteria for extension.

Second, it makes no sense for Alaska to jeopardize its federal TANF funding, and the Alaska provision could result in the state losing a full five percent of its federal TANF grant because of a miscalculation that paid benefits to a few more long-term recipients than the 20% permitted.

Although we recommend that the Alaska statute be amended to permit DPA to use narrow criteria to extend benefits to some long-term recipients, we believe that, at the same time, DPA needs to make extraordinary efforts to insure that as few families as possible reach the 60-month limit.

More in-depth and intensive services are needed for families in danger of reaching the time limits because of multiple barriers. Although DPA is starting to identify individuals who may need more counseling or referrals because they are approaching the 60-month time limit, there does not appear to be any formal process in place yet to provide such additional assistance. We believe that a process that begins with "staffings" using case managers, supervisors, employment providers, and specialists in such areas as mental health, remedial education, and substance abuse treatment should be initiated for all clients who are within 18 months of reaching their time limits. These specialists would

work with the family to design a plan to move the adult(s) as quickly as possible to an unsubsidized job, and to solve family issues that may have prevented sustained employment in the past. The family should be followed regularly to ensure that the plan is being implemented.

Alaska may also want to consider creating a segregated or separate state program for families where the adult is working full-time but earnings are not high enough to eliminate eligibility for residual ATAP payments. Currently, these families are either refusing the small dollar benefit remaining, in order to protect their lifetime eligibility period, or they are in danger of reaching their 60-month limit. This would also require a state law change.

# 8. Alaska's Sanction Policy

## 8.1 Alaska's Sanction Rules and Procedures

TANF receipt for Alaska's TANF beneficiaries is limited to 60 months in their lifetime. Many workers advised that the current sanction policy hinders them from assisting beneficiaries to become self-sufficient within this 60-month time frame.

Current sanction policy removes the benefits of the adult from the assistance unit. This results in a benefit reduction of 40% for average sized families, while larger families lose a smaller percentage of their benefits. A beneficiary can "cure" the first sanction without penalty, but a second sanction lasts for six months even if the individual cures prior to the end of the period, and the minimum period assessed for a third sanction is 12 months. The sanction amount does not increase over time; thus the same reduction is imposed whether a fist, second or third sanction is imposed. The family's 60-month time clock continues to tick while a sanction is imposed. Thus, no services will be received before the clock expires for those individuals who suffer a first sanction and never cure. Workers report that there are a significant number of sanctioned clients who choose this option. In addition, they advise that individuals who do cure the first sanction but have a second sanction imposed are reluctant to begin work participation before the six months have run, since their participation will not restore the benefit loss.

Not only does the current sanction policy reduce the services that an individual will receive during the 60 months, but it also lowers Alaska's participation rate. This is because non-complying cases must be included in the denominator for calculating participation, except for the first three months of a sanction. While it was reported that there is a state Attorney General opinion that permits DPA to continue benefits beyond 24 months to non-complying individuals, the continuation of benefits to non-complying families may violate the intention of Section 47.27.030(b) of statute, which provides that: "Unless the members of the family who are not dependent children are all exempt..., the time period for receiving assistance may not exceed a cumulative total of 24 months unless each nonexempt person is in compliance with the work activity assignment made under AS 47.27.035."

Alaska's DPA workers are using a number of strategies to bring non-complying individuals in for work services. Notices are sent, the

clients are telephoned, and, in Anchorage and Fairbanks, workers make home visits. In some cases these efforts are successful. For example, a home visit may identify a barrier to participation that can quickly be overcome, or the individual may better understand the requirements and time limits and begin to participate. Anchorage advises that they have assigned a worker who, through repeated home visits to sanctioned clients, has brought 60% into compliance. However, workers also indicated a reluctance to impose sanctions because they believe that the current system uses up months while not creating sufficient incentives to participate. That at least some workers do not impose sanctions is supported by the data: only a small percentage of cases (four percent according to performance data) are in sanction status, but a much larger percentage of clients fail to participate the number of hours required. For example, in one office only 156 of 223 individuals who were assigned countable activities met the hours of participation requirement in the most recent month for which we were provided data.

### 8.2 Sanction Policy Recommendation: Make Alaska's Sanction Policy More Family Friendly

We recommend that Alaska develop a progressive sanction system, resulting in an eventual full-family sanction, but that the sanction policy be designed and implemented to protect vulnerable children.

Division of Public Assistance staff suggested and we support a more family-friendly sanction policy where sanctions are progressive as to amount but the individual can cure immediately upon performance. For example, the first sanction would reduce the benefit one-third, the second would cause a two-thirds reduction, and the full benefit would be lost if a third sanction had to be imposed. A minimum period of time, such as a week of actual performance would be required to reinstate the full benefit, to prevent "churning"—where a benefit is restored based on a promise to participate, but the individual does not keep their promise. Sanctions would proceed automatically to the next level after a certain period where the individual had not cured.

We agree with staff that such a policy would be more effective in motivating individuals to participate; it is less likely that an individual can afford to ignore a loss of two-thirds of the benefit than to ignore the current adult portion loss. Families subject to a full family sanction

would be effectively terminated; thus, their family's clock would cease to run and Alaska could remove them from the denominator for calculating the participation rate.

Many states have adopted similar policies. According to a recent report by the U.S. General Accounting Office (GAO/HEHS-00-44, Welfare Reform: State Sanction Policies and Number of Families Affected, March 2000), 37 out of 50 states terminate the family's entire cash benefit if a family member who is required to participate fails repeatedly to comply with work requirements, but the full family sanction is applied the first time that a family does not comply in only 15 of these states. The majority of these states (22) use a progressive sanction sequence before they reach the full-family sanction level.

The GAO and other reports about state sanctions also recommend methods to ensure that sanctions are not taken inappropriately and that vulnerable families are protected. According to the GAO report: 16 states require supervisory or other review of caseworker's sanction decisions; 31 states require caseworkers to attempt to contact family members to try to resolve the non-compliance; and five states require caseworkers to visit the homes of TANF families to discuss how to resolve the noncompliance. Tennessee uses a customer Service Review process to protect families from incorrect case closings; Kentucky provides a special review and services to sanctioned families (Welfare Information Network Issue Notes, The Use of Sanctions Under TANF, April 1999); and Delaware uses performance-based contracts to provide incentives for employment contractors to make home visits to attempt to convince no-shows to accept their services, has a contractor review case closings, and has developed a program of services for families permanently barred from TANF because of repeated non-compliance. (Chassman Barnhart Consulting program review). Because some states that conducted studies of sanctions found that non-complying adults were more likely to be "hard-to-serve" (GAO), some special services are recommended. Although admittedly these actions are labor-intensive, only a few families reach this level of sanction in a progressive system.

# 9. Providing TANF Services to Native Alaskans

## 9.1 Native Alaska Family Assistance Programs

Congress gave Native Alaskans the opportunity to operate their own TANF programs. Alaska has gone much further than most other states in making it economically feasible for Native Alaskans to operate TANF programs by providing state matching funds to Tribes that elect to run their programs. Although PRWORA does not require states to provide any funds to supplement federal TANF dollars that are diverted to Native Alaska Family Assistance Programs, the lack of state funds would result in less money per individual served available to Tribal TANF programs than was available under the old AFDC program, and less money per individual than is available to Native Alaskans who are served by the state rather than a Tribal program.

By agreeing to provide an equivalent state match, Alaska is both encouraging capable Native Alaskan groups to operate their own programs and assisting their efforts to run successful programs. The grants also attempt to provide for more accountability on the part of the Native Alaskan Family Assistance Programs and, by providing for equivalent assistance time limits and work participation requirements, help to ensure that self-sufficiency is a major goal of Native Alaska Family Assistance Programs. In addition, the agreements signed between the Native Alaskan groups operating TANF programs and DPA require Native Alaskans who fall within the defined groups being served to seek service from the Native Alaskan program rather than the state's TANF program. This avoids a difficult problem in other states, whereby the Tribes accept TANF dollars to operate programs but Tribal members are permitted (and may be encouraged) to seek TANF from the state instead. Further, the DPA grants avoid the problem of auditing merged state and other funds, discussed below, by providing that the state supplied funds are used only for cash benefits and administrative costs.

During this brief review of Alaska's state TANF program, we did not have the opportunity to observe the operation of the TANF programs operated by Native Alaskans. However, we were impressed by the understanding of the issues evidenced by the program administrators with whom we met and with their commitment to DPA's program goals, such as self-sufficiency.

### *9.1.1 State Provided Services to Native Alaskans*

Where TANF is directly operated by the Native Alaskan organizations, the onus of performance is somewhat shifted from the state to the Native group. For example, Tribal statistics do not have to be included in state statistics. We recognize that the results of failure will nevertheless plague the state down the road, if failure means that the families served remain dependent and economic development is slowed. Further, TANF is being reauthorized in fiscal year 2002, and Congress will utilize data from Tribal programs to determine whether to continue the program operations in its current form.

Failure to serve Native Alaskans adequately who depend on the state for self-sufficiency services may have more serious consequences. Not only will the progress of Tribal members lag because of failure to provide adequate services, but since the relative performance of these Tribal families is merged with performance for other Alaskan families, Alaska's state program will show lower achievements.

In addition, it is extremely difficult to audit funds provided to some Native Alaskan organizations because they are permitted to merge funds from different sources to meet family needs holistically.[2] For example, funds from several sources can be used to fund TANF case management services, without a rigorous accounting requirement for each funding source. Other non-profits receiving the same amount of funding from the same number of sources would ideally try to make the program delivery appear seamless to the recipient, but would be required to strictly separate funds for accounting purposes. Although the ability to combine funds more easily can assist Tribal program operators to achieve good results, this same ability means that a monitoring agency must concentrate more on outcomes and less on fiscal integrity and process steps in its review of the programs.

DPA administrators indicated that they believe TANF services should be provided by Native Alaskan organizations if at all possible. Thus, where a Native Alaskan group does not choose to operate a Native Alaska

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[2] P.L. 102-477, the Indian Employment, Training, and Related Services Demonstration Act of 1992, allows tribes to consolidate formula-funded employment, training, and supportive services into an integrated set of services. These "477 Programs" can be delivered through a single plan, budget, and reporting system.

Family Assistance Program, providing both TANF cash benefits and self-sufficiency services, DPA takes over the benefit part of the program but attempts to provide grants to the Native organization to provide the self-sufficiency services.

DPA admits that some of the Native Alaskan organizations with whom they contract have not furnished the services promised by the grant provisions to their populations. This problem appears to exist with Maniilaq Manpower, which currently holds the grant to provide case management services to the Kotzebue villages. As we documented above in Section 5, Native Alaskan clients who are supposed to be case managed by Maniilaq receive very few services. It was reported to us that Maniilaq is poorly managed, and because of its animosity to the state, is unwilling to commit resources to this grant. In addition, some of the villages served by Maniilaq (e.g. Selwick) are reported to be uncooperative; therefore, even if a competent grantee was on board, we were told that it would be difficult to achieve results in such villages.

An Alaska Regional official advised that if DPA didn't use Maniilaq the situation would be even worse because Native Alaskans will refuse services offered by non-Natives. However, the DPA Administrator does not concur. It does not appear that all other State Agencies have the same reluctance to provide services using non-Native non-local personnel. While in Kotzebue, we had the opportunity to talk with several non-local non-Native mental health workers who stated that believe that their services are accepted in the community.

However, where DPA uses a non-Native provider, DOL, in five Nome villages because no Native group agreed to accept the grant, the limited performance data we have (May, 2001 Overall Participation Rate by JAS Office) shows that DOL is only just about as successful as Maniilaq Manpower, with the overall participation rate for Nome DOL at 27.1% and for Maniilaq Manpower at 27.9% (however, the Maniilaq data does not appear to include the 16 mandatory Kotzebue families). Our limited time in these Coastal areas did not permit us to determine why DOL was unsuccessful.

In some Native Alaskan villages, there is not even an agreement to provide case management services. DOL only contracts for five of the15 villages in the Nome area. In the other villages state eligibility staff, without case management training or officially assigned duties in this specialty area, work with clients to develop Family Self Sufficiency Plans,

and then provide only limited monitoring of compliance. The Nome eligibility staff with whom we met indicated that they are not able to provide the services needed to assist these clients adequately.

### 9.2 Recommendations Related to TANF Services for Native Alaskans

It may be that Alaska is between the proverbial rock and hard place in regard to providing TANF services to Native Alaskans, but we believe that DPA needs to do more both to identify and evaluate the issues and to experiment with solutions. Although we cannot provide ideas for a sure-fire cure to the problems Alaska faces operating successful programs in Native Alaskan villages, we are making some recommendations that may move the state forward.

First, if DPA will continue to award grants for case management and other TANF services to Native Alaskan grantees, a substantial amount of technical assistance should be provided to the grantees. Federally approved Tribal TANF grantees have the opportunity to attend federal Administration for Children and Families (ACF)-sponsored Tribal TANF workshops, like the April 17, 2001 workshop on Substance Abuse, but funding is not provided in DPA case management and other service grants for attendance at federal technical assistance meetings, and we agree that paying for every village program to attend would be too costly. However, if DPA holds workshops for Native Alaskan grantees, they should feature successful practices from high performing Native Alaska grantees. In addition, DPA should ask ACF to participate in state-sponsored workshops and should work with ACF to secure technology transfer funding to invite representatives of successful Tribal programs in other states to present at Native Alaskan workshops.

Where it is determined that Native Alaskan providers are unable and/or unwilling to provide adequate services, DPA should attempt to secure the services of the best available other contractor or should attempt to provide these services using state workers. DPA should meet with other agencies (e.g. mental health) which have hired non-Native, non-local service providers and discuss what methods these providers have used to overcome cultural and other barriers to serving clients in Native Alaskan villages. To make it more feasible that non-Native contractors or state workers are able to succeed, we recommend that DPA ask its training staff to attempt to develop a training module on cultural diversity, that uses successful practices in other Alaskan programs and/or in other states. For example, although Oregon uses state TANF case managers to

work with Native American recipients, the state case managers are out-stationed on reservations and receive special training on developing case plans that take into account the particular needs and circumstances of their Native American clients (Welfare Information Network, Welfare Reform in Indian Country: Current Trends and Future Directions, June 2001).

## 10. Food Stamp Program

### 10.1 Background/Findings Related to the Food Stamp Program/TANF Program Coordination

A common complaint nationwide among public assistance administrators and analysts is the misalignment of many aspects of the Food Stamp Program to TANF. While the federal government has granted states a great deal of flexibility in designing their TANF programs, until recently very little flexibility has been granted with regard to the Food Stamp Program. This has resulted in conflicts in both eligibility standards and the underlying philosophies of the two programs.

While the primary focus of TANF is assisting people to become self-sufficient through employment, the Food Stamp Program does not view supporting employment as a primary role. Rather, its primary goal is to provide a nutritional safety net to those eligible. As a result the eligibility process in TANF has become much more streamlined and consistent with ways to motivate people to work. On the other hand, the Food Stamp Program has become increasingly complex to administer and often undermines the work goals of TANF.

For example, the Food Stamp Program reporting requirements actually increase for working clients versus non-working clients. This is because working clients must report even very small changes in income on a monthly basis. It is entirely possible that many working clients opt out of the Food Stamp Program because of the complexity of eligibility rules and/or interruption to their work schedule required in order to comply with mandated food stamp administrative office visits. Yet failure to access Food Stamps could put the stability of an entry-level employment situation at risk.

While encouraging employment is not the primary goal of Food Stamps, there is a relatively small Employment and Training (E&T) component in the program. However, the requirements and the activities are quite different from TANF. The experience derived in TANF with regard to work preparation and ways in which to motivate clients could be very advantageous to the populations served by the Food Stamp E&T component.

While we believe a major overhaul of the Food Stamp Program is in order at the federal level, there has been some positive movement in allowing more state flexibility. Our recommendations below are in line with those opportunities.

### *10.1.1 Alaska's Organizational Structure Is Not Optimal for Food Stamp/TANF Coordination*

An additional issue in Alaska which further exacerbates the disconnect between TANF and Food Stamps is a structural one. Within DPA there is a policy unit that oversees all the DPA programs except Food Stamps. Food Stamps is housed in a separate unit under a different manager. Managers of both units reported that communication and coordination are often issues. Additionally, it appeared from our interviews that there are actual philosophical differences between the managers that accentuate the programmatic differences between the TANF and Food Stamp programs.

For example, the manager of the Food Stamp Program has chosen to de-emphasize the E&T component. In fact, field staff reported that it is virtually non-existent. The other policy manager believes work should be a much more central activity for this population. Furthermore, the Food Stamp manager has not pursued the options available to better align TANF and Food Stamps, while the other policy manager believes better alignment is critical. Many of the interviewees in the field offices expressed frustration with this philosophical disconnect between the two programs.

## 10.2 Food Stamp Program Recommendations: Take Steps to Align Food Stamp and TANF Policies

We recommend that DPA review what other states have done either through state plan amendments or waivers to better align the Food Stamp Program and TANF. For example, through a waiver, Oregon was able to create a more integrated and comprehensive Employment and Training program for both TANF and Food Stamp clients.

Another example worth pursuing is the use of the concept of categorical eligibility to align the eligibility rules for TANF and Food Stamps. For any population reached by a TANF funded service, the state is allowed to use less restrictive TANF eligibility rules in areas such as resources and vehicle exemptions. The state of Delaware has been particularly creative

and expansive in its use of categorical eligibility to eliminate Food Stamp resource requirements for all residents with incomes under 250% of the Federal Poverty Level. This permits residents (with incomes low enough to qualify) to receive Food Stamps even though they have resources such as automobiles needed for employment, that might otherwise make them ineligible.

A third example is the ability for states to provide a transitional Food Stamp benefit for clients moving from TANF to work. This greatly reduces the reporting requirements for the working client and ensures a stable benefit amount for a set period of time. It has the additional side benefit of potentially significantly reducing a state's quality control errors and thereby reducing the chances for a federal monetary penalty.

The final recommendation is to merge the Food Stamp Program into the policy unit at DPA. This will better ensure a common philosophical approach across all programs. Short of restructuring, we recommend that the Director and/or the Deputy Director play a much stronger role in ensuring appropriate communication and coordination is taking place and to resolve philosophical differences. We recommend that, in concert with the work-first approach of the TANF program, the E&T component of Food Stamps be emphasized and utilized.

**AMERICAN INSTITUTE FOR FULL EMPLOYMENT**
**ASSESSMENT OF ALASKA'S WELFARE REFORM PROGRAM**

# SUMMARY OF RECOMMENDATIONS

## Introduction

The American Institute for Full Employment (AIFE), is a non-profit research and education institute located in Klamath Falls, Oregon, whose mission is to promote full employment—universal access to jobs with career potential for all who can work—especially those who are receiving public assistance as a substitute for the opportunities and rewards of paid work. Over the summer, at the request of Senator Green and Representative Dyson, AIFE prepared an assessment of Alaska's Welfare Reform Program. Completed in September 2001, the assessment identified recommendations in each of ten specific program areas.

Below is a summary of recommendations in which the recommendations have been organized in priority order within 3 categories. The categories—Legislative Priorities, Policy Priorities, and Management Priorities—denote the type of recommendations and which entitities should be responsible for implementing them. Page references (in parenthesis) refer to the original report "Assessment of Alaska's Welfare Reform Program." The assessment includes more detailed explanation of each of the recommendations.

## I. Legislative Priorities

| *Rec.#* | *Page* | *Task* |
|---|---|---|
| 7.2 | (34) | Amend the state statute to allow Alaska to use full flexibility allowed under federal law to expend benefits to some long-term recipients. |
| 8.2 | (37) | Develop a progressive sanction system which results in full-family sanction. |
| 7.2 | (35) | Consider using state MOE funding to create a separate state program for full-time working clients who remain elegible for ATAP benefits. |
| 2.2 | (10) | Strengthen the diversion program. |

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|---|---|---|
| 1.2 | (8) | Authorize a more complete wage subsidy program. |

## II. Policy Priorities (Does not require legislative action)

| *Rec.#* | *Page* | *Task* |
|---|---|---|
| 6.2.3 | (31) | Change the child care co-pay schedule to eliminate "cliffs". |
| 1.2 | (8) | Revise policy and practies for treating individuals limited by incapacity from full participation in work activities and require mental health/substance abuse treatment when needed. |
| 1.2 | (8) | Require ATAP clients claiming a disability to file for federal disability benefits. |
| 1.2 | (8) | Reduce the 12-month exemption period for parents of infants to 16 weeks. |

## III. Management Priorities (Does not require legislative action)

| *Rec.#* | *Page* | *Task* |
|---|---|---|
| 7.2 | (34) | Develop and implement in-depth and intensive services for families reaching the time limits. |
| 3.2 | (15) | Develop and implement clear outcome based performance standards for DPA staff and contractors. |
| 5.2 | (26) | Initiate true performance based contracting. |
| 4.2 | (20) | Strengthen the case management system. |
| 5.2 | (26) | Develop contracts that are multi-functional. |
| 5.2 | (26) | Award multi-year contracts with only the first year guaranteed. |
| 5.2 | (27) | Charge local DPA managers with greater responsibility for overseeing contract performance. |

| | | |
|---|---|---|
| 1.2 | (7) | Strengthen the "up front" process by engaging clients in employment activities as close to the first day of contact as possible. |
| 1.2 | (7) | Develop a standardized strength based assessment approach. |
| 1.2 | (8) | Increase utilization of work site training, e.g. subsidized work and community service. |
| 6.2.1 | (30) | Streamline movement between PASS I, II and III child care. |
| 6.2.2 | (30) | Increase efforts by EED to expand availability of providers for infant and extended hour child care. |
| 10.1.1 | (45) | Merge the Food Stamp Program into DPA's Policy Unit. |
| 9.2 | (42) | Increase accountability of some Native Alaskan grantees. |

# Bioterrorism Preparedness & Response in Alaska

Prepared by the Alaska Division of Public Health
For Presentation November 8, 2001

The terrorist attacks of September 11 and subsequent bioterrorist attacks on the United States utilizing anthrax bacterium as the agent of destruction has called into the play the resources and capabilities of the Alaska Division of Public Health.

The Division recognizes and wishes to acknowledge the support of the Alaska legislature for improvements to our state's basic public health infrastructure in recent years. Support for building the new state-of-the-art Biosafety Level III laboratory in Anchorage has been vital to our ability to respond to threats here in Alaska. If the laboratory (which opened in January 2001) were not available, we in Alaska would have had to send specimens suspected of anthrax contamination out-of-state for testing, which would have meant delays and heightened concern.

It is also fortunate the legislature provided funding for one-third of the Back-to-Basics initiative. While needed to combat issues related to infectious disease, the funds have been invaluable for strengthening our capacity to respond to situations where anthrax is suspected (consultation; lab testing; etc), for providing training to hospitals, private physicians, and other health care providers to learn how to recognize the symptoms of anthrax exposure and infection; for responding to questions from the public and private industry; for dissemination of health alerts; for development of anthrax protocols for emergency medical service providers; as well as other activities this situation has required.

The Division is also grateful for the State Legislature's support for our receipt of a Bioterrorism Preparedness grant from the Centers for Disease Control and Prevention these past two years. Participation in this program has paid off for Alaska. One of the major benefits has been meeting key partners in other state, federal, military and private agencies that were also preparing to respond to an event. Knowing key players streamlined our ability to respond to the current crisis.

<u>PUBLIC HEALTH RESPONSE</u>

- The events of September 11 activated the Alaska Public Health Alert Network (AK PHAN), which sent notification that afternoon to health care and public health workers across our state to be on heightened alert status to monitor for any possible unusual disease patterns. Following the subsequent identification of anthrax infection in Florida in early October, AK PHAN has been utilized numerous times to provide updates and additional information to health providers in Alaska. (Note: this network is brand new and was still under development when disaster struck. Additional work is required to complete it so it reaches every health worker in the state).

- ➢ The Epidemiology Response Team has manned it's 24-hour call-in service (toll-free number), responding to over 132 after-hours calls requesting medical guidance on anthrax issues during the last two weeks of October.
- ➢ The Alaska Public Health Laboratory in Anchorage has been on-call with services available 24 hours a day/7days a week. Microbiologists and laboratory technicians are working 18-hour shifts, and to-date have processed at total of 88 specimens from 46 incidents in which anthrax was suspected. Tests are performed on human samples (blood, sputum, nasal swabs) as well as suspicious substances found in mail and at various public locations.
- ➢ Public Health Nurses across the state have also been actively involved in gathering specimens for analysis by the lab (e.g., conducting nasal swabs) as well as responding to questions from the concerned public in their communities.
- ➢ The division has been coordinating response activities and developing response protocols with law enforcement (FBI, Alaska State Troopers, local police departments), the State Emergency Coordination Center (SECC), the AK Division of Emergency Services (ADES), local fire department HAZMAT teams, and the military.
- ➢ The Alaska Public Health Training Network, developed with resources from the Bioterrorism Preparedness grant, has sponsored the delivery of anthrax training courses put on by CDC for private medical clinicians and public health workers across the state.
- ➢ The division's Emergency Medical Services program developed and disseminated anthrax protocols for Alaska's emergency medical services (EMS) workers.
- ➢ The division has worked with the Department of Administration to develop mail processing protocols for state government offices.
- ➢ The division has also been in regular communication with the U.S. Centers for Disease Control and Prevention and other state health officials across the country to monitor this situation and share information.

LESSONS LEARNED FROM THE CRISIS SO FAR INCLUDE THE FOLLOWING:

- **Communications Systems** are vital to an effective response. Communications that do not rely on telephone technology or cellular technology are critical to assure the ability to coordinate a response.
    - o Although we have come a long way, we need improved communications links between public health and EMS centers around the state.
    - o The communications between ADES and the SECC and the Division of Public Health has been enhanced dramatically through the use of First Class, a secure Internet based communications platform maintained by ADES.
    - o The Alaska Public Health Alert Network (AK PHAN) is [illegible] partially developed. This system, when completed, will deliver emergency public health information to health care providers, laboratorians, health administers and first responders around the state. Without this there is no uniform way to reach all individuals, organizations and agencies.

- The **Isolation** of Alaska could potentially cause a problem in a bioterrorism event. Alaska may have unique challenges in responding to bioterrorism because of dependence on air travel and transport. For example, without air transport, we could run out of critical medical supplies or medications. If all flights were grounded, would we still have access to the National Pharmaceutical Stockpile within 12 hours?

- Rapid access to **medical supplies, medications, and antidotes** is critical in the event of a bioterrorism event:
  - The Division of Public Health must have real-time information about the amounts of key antibiotics available in pharmacies around the state, and a plan to mobilize these resources if needed.
  - We need to develop our plan to request, receive and distribute the National Pharmaceutical Stockpile.
  - Should Alaska have its own pharmaceutical stockpile? If so this will require not only resources to purchase the medications, but also personnel to maintain and rotate expiring drugs, and a secure site for storage.

- The existing **public health infrastructure in Alaska** is stretched thin and has gaps:
  - The state's public health workforce (epidemiologists, laboratory workers, public health nurses, emergency medical services coordinators, public health emergency planners, training coordinators, etc.) in order to respond to suspected anthrax incidents; to respond to public, health care provider and EMS concerns; and, to engage in required protocol development, coordination, and planning activities; have been unable to continue other important public health activities. Examples of specific weaknesses in the workforce include:
    - The Alaska State Public Health Laboratory in Anchorage is severely understaffed due to an inability to fill vacant positions due to low compensation levels. Vacant positions must be filled and additional microbiologist positions are required.
    - The Epidemiology Response Team requires additional staff in order to maintain the current pace and volume of inquiries from clinicians, law enforcement, private industry, and the general public.
  - The existing communication system needs to be enhanced to complete development of the Alaska Public Health Alert Network.
  - Alaska must maintain an adequate pharmaceutical stockpile with sufficient oversight by a trained pharmacist.
  - Sufficient equipment and protective gear for communication and investigative purposes is required.

- **Training** for health care, public health, and law enforcement personnel is critical.
  - The division developed the Alaska Public Health Training Network (APHTN) over the past couple of years using the federal Bioterrorism grant funds and program resources. The network enables us to rebroadcast

satellite programs over cable television to a number of communities across the state making participation in educational program, such as recent programs on anthrax detection and response, available in Alaska. We are currently working to expand access to communities that cannot receive programming via cable.

- Additional training requirements include:
  - HAZMAT training for public health personnel who might be involved in investigating a contaminated site
  - Additional bio- and chemical terrorism training for Division personnel to allow them to provide direct training for other health care personnel around the state
  - Ongoing in-state public health training through APHTN
  - Ongoing attendance and training for public health personnel at national meetings

# CERTIFICATE

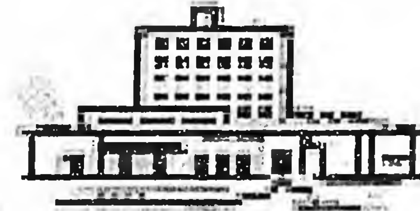
# OF

# NEED

# The Alaska Certificate of Need Program

## Department of Health & Social Services
## Division of Administrative Services
## Facilities & Planning Section
## Juneau, Alaska

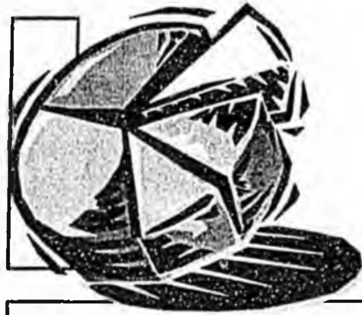
# Introduction



- A review process since 1976
- For Capital projects
- Applicants must show need
- Most projects approved, but extensive costs avoided
- 74% of States have CON
- States without CON regulate health care development by other processes
- State to state variation based on local factors

# The Need for the Program

- **Development Perspectives -**
  - There is a need for regionalization of services to ensure quality care and cost effectiveness
  - There is a need for public involvement
- **Payment Perspective -**
  - Medicaid pays 86% of Long-Term Care & about 20% of Acute Care costs
  - Total Medicaid expenditures in 2000 = $467.4 million
  - Hospitals & Nursing Homes = $148.5 million; 25% Acute Hospital; 11% LTC; 10% Inpatient Psych
  - Hospital & Nursing Home costs increased 38% since 92



# Certificate of Need Goals

- Improved Decision Making/Regionalization
- Increases Choice/Considers Alternatives
- Stretches Limited Resources
- Decreases Duplication
- Ensures Public Process
- Promotes Quality
- Cost Containment
- Promotes Program Stability
- Promotes Balance/Continuum of Care

# CON Program History

- Hill/Burton, 1122 Rev.
- 1976 (PL 93-641 - Health Planning & Resource Development Act, 1974)
- 1983 - $1M Threshold; Last Health Plan
- 1988 - HSAs Close; Planning Reduced
- 1990 - Routine Replacement Clause
- 1995 - Conversion of Assisted Living Beds
- 1996 - Moratorium on New Nursing Beds
- 1996 - Internet Page
- 1998 - Electronic Notification
- 1998 - CN Education
- 1999-2000 - Law & Regulations Changes

# Changes in CON Law - 1999

- All LTC bed conversions must submit a CON application, regardless of the cost
- New LTC review standards include:
  - Consideration of alternatives such as Assisted Living
  - Minimum use rates
  - Minimum number of beds
  - Financial feasibility, and
  - The financial effect on consumers and the State
- 2000 – Ambulatory Surgery allowed to move without a CON

# The Application Process

- **Who must Apply?**
  - $1 Million Cost
  - Health Care Facility
  - All LTC Conversions
- **How to Apply:**
  - Letter of Intent
  - 60-Day Wait
  - Pre-Application Conference
  - Application Packet

# The Review Process

- Review & Analysis
  - Site Visit
  - Criteria & Standards
  - Findings & Recommendations
  - Criteria & Standards

- Public Process
- Commissioner's Decision

# THE PUBLIC PROCESS

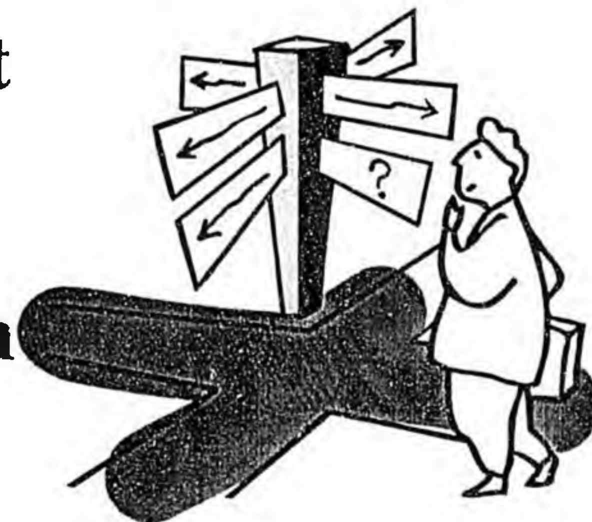
- 30-day written comment Period
- Public Meeting
- Notification of interested individuals
- Notice published in two consecutive issues of one statewide & one local newspaper

# APPEAL

- Must be written & submitted within 30 days after notice
- Must be sent to the Commissioner
- Levels of Appeal: hearing, legal case
- Solution attempted at lowest level

# Effectiveness of the Program

- CN is one of many tools for effective system development
- Since Program Inception, Over 500 additional beds prevented over $75 million in construction costs avoided, plus millions in operating costs.
- Some facilities developed better systems.
- Increased choice/balance in system.



# Applications Under Review/Expected

| | |
|---|---|
| Sitka 5 Nursing Home Beds | $25,000 |
| Ketchikan MRI Scanner | $1 Million |
| Providence 60-bed child/adolescent psych facility | $21 Million |
| Valdez Hospital Replacement | $24 Million |
| Providence N. Tower CON Modification | $ 6 Million |
| Expected 2001-2002: | |
| - API Replacement | $42 Million |
| - Fairbanks Kidney Dialysis | $ 1 Million |
| - Maniilaq 15-bed LTC Unit | $ 4 Million |
| - Wesley Rehab & Care Unit | Unkown |

# INSURANCE ACCESS

# The Anchorage Access to Health Care Coalition

## Summary of Activities and Data Findings

**October, 2001**

**Prepared by Catherine Schumacher, MD, MSPH[1]**
**Chair**

[1] Contact Information
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## Background

The Anchorage Access to Health Care Coalition was formed in 1998 with the purpose of improving access to health care for the medically underserved in the Municipality of Anchorage. The Coalition grew out of the efforts of the Anchorage Healthy Future project and the Anchorage Health and Human Services Commission. The Coalition has members from a broad base of the Anchorage Community, including Providence Health System, the Anchorage Neighborhood Health Center, the Anchorage Department of Health and Human Services, the Alaska Primary Care Association, the Alaska Department of Health and Social Services and Alaska Health Fair.

The Coalition has been concentrating on three main goals:

1. Collect accurate information about health care access in Anchorage
2. Educate policy makers and the general public about health care access in Anchorage
3. Provide a forum for discussion about various options for improving health care access in Anchorage.

The Coalition's findings are summarized in the following pages.

During the next year, the Coalition would like to concentrate on developing a network of health care providers to provide care to the low-income uninsured population in Anchorage, using models developed successfully by other communities.

The Coalition is grateful for the financial and in-kind contributions from United Way of Anchorage, Providence Health System, Robert Wood Johnson Foundation, National Bank of Alaska, Alaska Primary Care Association, State of Alaska, Collins & Associates, and Anchorage Neighborhood Health Center.

### Anchorage Access to Health Care Coalition Steering Committee

| Name | Affiliation | Phone |
|---|---|---|
| Catherine Schumacher, MD, MSPH (Steering Committee Chair) | Epidemiologist | 272-7778 |
| Joan Fisher, Vice-Chair | Anchorage Neighborhood Health Center | 792-6528 |
| Marilyn Kasmar | Alaska Primary Care Association | 272-6131 |
| Judith Muller | Alaska Health Fair | 278-0234 |
| Barbara Symmes | Providence Health System | 261-3190 |
| Cathy Feaster | Anchorage Dept Health and Human Services | |
| Terry Hamm | AK Dept Health and Social Services | 269-7854 |
| Anita Halterman | AK Dept Health and Social Services | 334-2431 |
| George Conway, MD, MPH | NIOSH | 271-2382 |
| Patricia Atkinson | Community member | 269-3639 |
| John Riley | Anchorage Neighborhood Health Center | 257-4615 |

# Key Facts about Access to Health Care in Anchorage

## WHO ARE THE UNINSURED?

- At least 26,000 Anchorage adults (14%) have no health plan[2]

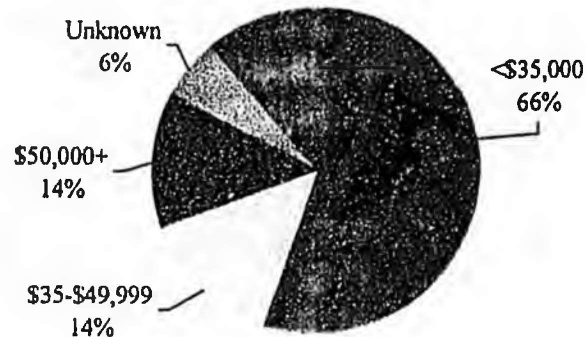
**Most of the uninsured are low income and are employed**

- Among the uninsured in Anchorage, 66% live in households where the annual household income is less than $35,000. Individuals working in low-income jobs are less likely to be offered health benefits. If benefits are offered, the low-income worker is often unable to pay his or her portion of the monthly premium.

- Among the insured in Anchorage, 71% are employed. The high cost of medical care leads to a high cost of insurance premiums. Therefore, many employers, especially small businesses, are not able to offer health benefits.

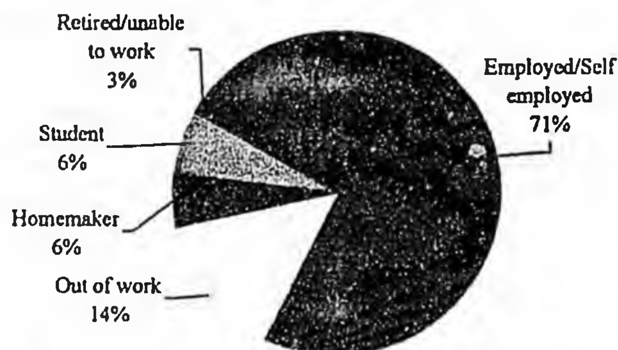
- Even individuals with a moderate income have difficulty purchasing health insurance if it is not offered through an employer. The least expensive individual family policy available in Anchorage costs $443/month with a $1000 family deductible.[3]

**Annual Household Income**
**Income Distribution of Uninsured Population in Anchorage 1991-1998**




Data source: Alaska Behavioral Risk Factor Surveillance System, Alaska Division of Public Health

**Employment Status of the Uninsured**
**Employment Distribution of Uninsured Population in Anchorage 1991-1998**




Data source: Alaska Behavioral Risk Factor Surveillance System, Alaska Division of Public Health

**Do the uninsured get the health care that they need?**

For many, the answer is **no**.

- Among the uninsured in Anchorage:
  - Almost half (43%) have been unable to see a doctor at least once during the past year due to cost
  - Nearly one-quarter (22.5%) have not had a routine checkup in the past five years

**Is lack of health insurance a "temporary" problem for people?**

For many, again the answer is **no**.

- Among the uninsured in Anchorage, more than seventy percent (70.6%) reported that it had been at least one year since they had health care coverage

**Many of the uninsured have chronic conditions that require regular medical care**

- Among the uninsured in Anchorage, 40% have high blood pressure, and 22% have elevated cholesterol levels.

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Data are from the Alaska Behavioral Risk Factor Surveillance System, 1991-1998. Diane Ingle of the Alaska Department of Health and Social Services performed special analyses to obtain Anchorage statistics.

[3] Individual policy rate quotes obtained from Hagen Insurance, Blue Cross Blue Shield of Alaska, Alaska Employee Benefit Specialists, and Mutual of Omaha, in Anchorage, April 2001

## HOW ARE PEOPLE AFFECTED BY LACK OF HEALTH INSURANCE AND OTHER ACCESS ISSUES IN ANCHORAGE?[4]

- **Many have experienced illness and high medical bills.**

> *"....And I was hospitalized. And the hospital bill was $8,500. Then I have no insurance. So I applied for public assistance. But I was denied. And the reason is that I'm not quite 65. I start to pay $50.00 every month to the hospital, but that is my problem. My income is only, you know, $800 [a month]. [I have] no idea how to pay off that much money."*

- **People who don't have health insurance experience a great deal of anxiety and concern about their lack of insurance.**

> *"Thank goodness I'm healthy. And take no medication. But it is a scary feeling. Because any minute that could turn around."*

- **Many see a doctor on a crisis basis only.**

> *"I ended up in the hospital with triple bypass surgery. And why? Because I didn't have the money to go and see a doctor and see how I was doing. You have to decide to go to the doctor or eat."*

> *"I don't go to see specialists because when I call and ask them what their fee schedule is, the average I've seen in town is $250 to $275 cash. CASH! On your first visit. That's when they'll see you."*

- **They frequently compromise on the services they need.**
- **They must spend time finding doctors who will see them.**

> *"When my mother-in-law was under Elmendorf's hospital care, they changed the policy so that they would no longer take anyone who was over 65, so I went looking for someone who would take her as a Medicare patient. I applied to 21 different doctors before I found someone,...before I could find someone to see her and oversee her medication."*

- **They look for ways to save on prescriptions**

> *"Are we going to buy prescriptions or are we going to buy groceries?"*

- **They go without dental care.**

> *"My girls missed their cleaning this time because our regular dentist didn't take Denali Kid Care. So they didn't go. I couldn't afford to pay it out of pocket."*

> *"Right now I'm utilizing all the free or reasonable clinics I can."*

- **They get creative about preventive care.**
- **They develop alternatives to going to the doctor.** Examples include using over-the-counter medications and following behavioral ways of maintaining their health, such as getting exercise and eating well. Others admit they simply ***"keep my fingers crossed."***

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[4] Information on this page obtained from the report "On the Edge: Living without Health Insurance in the City of Lights." The Coalition commissioned researchers Cathy Colwell and Diane Hoffbauer to conduct a series of focus groups with the uninsured and underinsured in Anchorage. The report presents their findings.

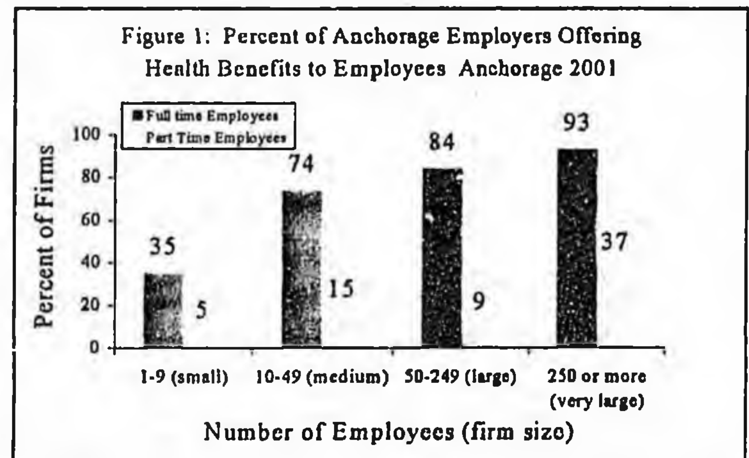
## Employer Based Coverage in Anchorage[5]

- The majority of Alaskans obtain health insurance through employer-based coverage[6].
- As the cost of health care and health insurance increases, Alaska businesses are finding it more difficult to offer benefits[7]

In the spring of 2001, the Anchorage Access to Health Care Coalition conducted a survey of private Anchorage employers in order to determine how many were able to offer benefits and if offered, the costs to both the employer and the employees. Below are some of the key findings.

**Key Points from the Survey**

- Overall, only 47% of Anchorage firms offer health benefits to full time employees
  - 46% offer major medical coverage
  - 38% offer dental coverage
  - 26% offer vision coverage
  - 42% offer prescription drug coverage
  - 37% offer some mental health coverage




- The ability to offer health benefits increases with firm size (Figure 1).

- The majority of Anchorage employers (70%) are small firms (1-9 employees); of these, only 35% offer health benefits to fulltime employees.

- Far fewer Anchorage small firms are able to offer health benefits than would be expected based on national data (60% nationally compared to 35% for Anchorage).[8]

- Overall, of firms that offer health benefits, 47% paid the full cost of premiums for health benefits for their employees, compared to 64% in 1993, indicating that the costs are now being shifted to the employee.[9]

- Overall, 43% of Anchorage firms offer benefits to dependents of full time employees. Few firms (19% of those offering benefits) pay the entire cost of insuring dependents of fulltime employees.

- Overall, only 16% of firms indicated that they offer any health insurance benefits for part time employees.

- The average costs reported by employers were <u>$378 per month</u> for employee coverage alone, and <u>$711</u> per month for family coverage.

- The high cost of premiums was the primary reason given for not offering health benefits (64% of those not offering benefits).

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[5] Data are based on the Employer Benefits Survey conducted by the Coalition during the spring of 2001
[6] Alaska Behavioral Risk Factor Surveillance System, unpublished data
[7] Myers DJ. The high cost of health insurance. Alaska Business Monthly 2001;August:16-21.
[8] Kaiser Family Foundation and Health Research Educational Trust: Employer Health Benefits 2000 Annual Survey.
[9] Alaska Department of Labor, 1993 Employee Benefit Survey. Data are for entire state.

# FACT Sheet

# People Without Health Insurance In Anchorage

Prepared by the Anchorage Access to Health Care Coalition* 903 W. Northern Lights Blvd, Suite 202 Anchorage, AK 99503-2400

April 2001

*The facts in this sheet refer to the uninsured who have no public or private health benefits, including no Medicare, Medicaid, Blue Cross, TriCare, Indian Health Service, or any other means to pay for health care, other than out of their own pockets.*

## Who are the uninsured?

- **Young:** 56% of the uninsured are between 18 - 34 years old[1]. Among children in Anchorage approximately 10% are uninsured[2].
- **Employed:** 71% of the uninsured are working, either employed by someone else or self-employed[1]. Because of the high cost of premiums many employers are not able to offer health benefits, or the employee portion of the monthly premium can be as high as 50 - 100% of the total cost[3].
- **Male:** 57% of the uninsured are male[2].
- **Low Income:** 66% of the uninsured live in households where the annual household income is less than $35,000[1]. However, even people with moderate incomes may not be able to afford insurance. The least expensive individual family policy available is $443/month with a $1000 family deductible[4].
- **Your Friends and Neighbors:** 13% of all people in Anchorage are uninsured[1].

## What is the cost of not having health insurance?

- **Fewer doctor visits:** 43% of the uninsured have not seen a doctor in the past year due to cost[1].
- **Less preventive care:** 23% of the uninsured have not had a routine checkup in over five years[1]. People without insurance are less likely to undergo routine screening tests such as mammography, Pap tests, blood pressure checks, cholesterol testing and colon cancer screening[5]. Many only see a doctor on a crisis basis [6].
- **Worse overall health:** Compared to people who report their health as "excellent" or "very good," adults who report "good, fair or poor" health were between two and three times as likely to have lacked insurance for at least one year [5]. Death rates for uninsured women with breast cancer are significantly higher compared to women with insurance[7].
- **Less access to comprehensive care:** A two-tiered system of care exists for chronically ill patients: the top tier for those who have the means to buy state-of-the-art medications and technology, and the bottom tier for those who do not[8]. Uninsured patients with asthma, diabetes, or hypertension are often denied the care readily available to those who have insurance[9]. Uninsured chronically ill people often compromise on the frequency and quality of their visits[6].

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* Supported by financial and in-kind contributions from United Way of Anchorage, Providence Health System, Robert Wood Johnson Foundation, National Bank of Alaska, Alaska Primary Care Association, State of Alaska, Collins & Associates, and Anchorage Neighborhood Health Center

- **Higher costs:** Uninsured patients may be charged more for services than insured patients[10]. Insurance companies often negotiate volume-based discounts for their participants. These discounts are unavailable to people who do not have insurance.
- **Less choice in providers:** Uninsured patients must spend time finding doctors who will see them without insurance. There is no system in place to spread the burden of providing care for the uninsured. Programs that do provide free or low cost care often have lengthy waiting lists.
- **Unreliable access to prescription drugs:** 30% of the uninsured cannot fill prescriptions because of the cost[9]. They may rely on doctors dispensing free samples, or try to enroll in pharmaceutical companies' indigent care program, a time-consuming and limited option[6].
- **More hospitalization:** The uninsured are more likely than those with insurance to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes[7].
- **No dental care or hearing aids:** The uninsured are more likely to go without needed dental care or hearing aids, impacting their quality of life[6,9].
- **Bankruptcy:** One out of four families filing for bankruptcy identify an illness or injury as a reason for filing[8].
- **Fear of illness or injury:** Uninsured people are financially vulnerable and live with a constant dread of major illness or injury[6].

***The costs are unacceptably high.*** Meaningful health coverage expansions must be found which have a broad base of support, transcending ideological, partisan, and interest group boundaries.[11]

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# Anchorage Access to Health Care Coalition
# 2001 Health Insurance Benefits Survey

## Preliminary Results

During the spring of 2001, 403 employers in Anchorage, Alaska were contacted by telephone and asked to participate in a survey about health insurance benefits and costs. The employers were selected from a sampling frame of Anchorage-based employers provided by the State Department of Labor. The sample excluded federal, state, and local governmental employers, and all employers who reported no employees for the past three months. The 5,992 remaining employers were then stratified by number of reported employees. A sample from each of four strata was then selected, using established sampling methods. Selected results of the survey are reported below.

Many of the results are reported by firm size. Total numbers (N) of private employers in Anchorage and employers surveyed is reported below:

| Strata | Total N | Sample N |
|---|---|---|
| Small (1-9 employees) | 4,202 | 112 |
| Medium (10 - 49 employees) | 1,423 | 109 |
| Large (50 - 249 employees) | 311 | 126 |
| Very Large (250 or more employees) | 56 | 56 |
| **Total** | **5,992** | **403** |

Approximately 76% (N = 305) of the employers surveyed responded to the survey. Of the non-respondents, 4% were found to be out of business, 9% refused to participate, 9% were part of another company, and 2% could not be contacted.

Following are some of the survey questions and answers:

***"Does your business offer group health insurance benefits to employees?"***
Only 47% of Anchorage firms offer health insurance benefits. The size of the firm is an important factor in whether health insurance benefits are offered; 34.5% of small firms, 74.4% of medium firms, 84.2% of large firms, and 92.7% of very large firms reported offering health insurance benefits to employees.

***If the business does NOT offer group health insurance benefits to employees (N = 94):***

- "Have you ever offered health insurance benefits?" *16% offered health insurance benefits in the past.*
- "Do you offer cash assistance for individual policies?" *Only 7% offer cash assistance to employees to purchase individual health insurance policies.*
- "What is the primary reason for not offering group health insurance benefits?" *The primary reason offered is that premiums are too high.*

209 employers indicated that they offer at least some health insurance benefits.

*Major Medical*
Overall, 33% of small firms, 74% of medium firms, 83% of large firms, and 93% of very large firms offer major medical coverage to full time employees. For part time employees, only 5% of small firms, 15% of medium firms, 9% of large firms, and 37% of very large firms offer major medical coverage to part time employees. Dependents of both full and part time workers are generally offered benefits slightly less often than employees.

*Dental*
Fewer firms offer dental coverage. In all, 25% of small firms, 65% of medium firms, 76% of large firms, and 90% of very large firms offer dental insurance to full time employees.

*Vision*

Vision insurance is even more uncommon. 20% of small firms, 37% of medium firms, 50% of large, and 71% of very large firms offer vision insurance to full time employees.

*Who pays for benefits for full time (FT) employees and their dependents?*
If major medical benefits are offered, the cost is usually either shared between the employer and employee (47%), or paid entirely by the employer (47%). Although almost half of firms still pay the full cost of benefits for their employees (if they offer them), the percentage has slid significantly since 1993, as shown below:

**Percentage of Firms Paying the Full Cost of Major Medical Premiums for FT Employees**

| Year | Small Firms | Medium Firms | Large Firms | Very Large Firms |
|---|---|---|---|---|
| 1993 | 77% | 63% | 58% | 47% |
| 2001 | 53% | 46% | 19% | 24% |

Very few firms pay the entire cost of insuring dependents of FT employees; it is far more likely that the employee pays the entire cost or it is a shared expense. Many firms indicated that their employees choose not to purchase the available insurance for their dependents.

**Dependent Major Medical Premium Costs**

| Who Pays? | Small Firms | Medium Firms | Large Firms | Very Large Firms |
|---|---|---|---|---|
| Firm 100% | 30% | 8% | 5% | 3% |
| Employee 100% | 33% | 44% | 38% | 26% |
| Shared | 23% | 39% | 48% | 63% |
| Benefit Not Offered/Unknown | 13% | 8% | 10% | 11% |

For part-time employees, only 16% of firms indicated that they offer any health insurance benefits.

*What is the total monthly premium per employee for major medical coverage (employee plus employer contribution)?*

**Cost of Premium**

| Firm Size | Employee Only Premium | Full Family Premium |
|---|---|---|
| Small | $400.90 | $701.10 |
| Medium | 337.10 | 736.10 |
| Large | 280.10 | 668.10 |
| Very Large | 269.50 | 649.30 |

*Have your rates increased in the past 12 months?*
64% of employers reported that they had a rate increase in the past 12 months; 90% of those were small and medium size firms.

*What is the total annual cost of health insurance premiums to your business?*
Only 55% of survey respondents were able to give a usable response to this question. The results are summarized below:

| Firm Size | Sample N | Mean | Minimum | Maximum |
|---|---|---|---|---|
| Small | 16 | 20,801 | $4,524 | $119,908 |
| Medium | 41 | 109,104 | 2,500 | 2,000,000 |
| Large | 43 | 404,278 | 15,000 | 3,600,000 |
| Very Large | 15 | 3,255,410 | 44,460 | 13,763,597 |
| **Total** | **115** | **$132,059** | **$2500** | **$13,763,597** |

*Have you changed insurance carriers or become self funded in the last two years in order to contain costs or get better benefits?*
34% of employers changed insurance carriers or became self funded.

# On the Edge

***Living Without Health Insurance***
***In the City of Lights***

A Report Submitted to

Anchorage Access to Health Care Coalition

December 18, 2000

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# INTRODUCTION

Concern about access to adequate health care, both on a national and a local level, has set in motion strategies to explore ways to increase access to health care as well as to document the perceptions, attitudes and knowledge of the general public about the needs of the uninsured. The findings from two recent surveys[1] indicate that while the general public supports safety-net medical care for the uninsured, the knowledge of who makes up the population of the uninsured and what solutions are available or possible lags behind that support. The Anchorage Access to Health Care Coalition (Coalition) is an organization designed to improve access to health care for those who are uninsured or in other ways medically underserved. It is particularly interested in understanding better the issues, problems and identifiers of those residents who make up the 15% estimated to be medically uninsured in the Municipality of Anchorage. To gain more insight into this topic, the Coalition commissioned this study to explore in depth the experiences and perceptions of those who are currently working but do not receive health benefits as well as the knowledge, perceptions and attitudes of those who provide programs or influence funding for access to healthcare.

The goal of this project was to examine the level of knowledge as well as the perceptions and experiences that influence the behavior of those who are uninsured or underinsured as well as those who establish policies and programs to assist in quality of life for Anchorage residents. Using the qualitative research method of focus groups and interviews, this study explored: (1) the range of employment of the uninsured; (2) the medical experiences they have had and the choices they have made as a result of being uninsured; (3) the perceptions of available medical programs to meet the needs of the uninsured; and (4) the perceptions of barriers and possible solutions to helping the uninsured meet their health needs.

Focus group research is intended to identify patterns and trends in the perceptions of a particular area of interest. It has as its structure a guided discussion of between six and ten participants who all share a common characteristic necessary to relate to the topic that is being discussed. The focus group is designed to be a permissive, non-threatening environment that allows participants to feel safe enough to share their perceptions, as well as agree and disagree with other members. It is understood that focus group participants, through their responses to each other, will influence the outcome of the discussion. Therefore, each focus group becomes a unique picture of the perceptions generated by a dynamic group interaction of people who identify with each other and feel comfortable disclosing emotions as well as thoughts regarding experiences and perceptions. Because of the qualitative uniqueness of each group, the focus group is repeated several times with different people to glean as much unique information as possible about the topic under investigation.

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[1] Results of these surveys are summarized in "Bolstering the safety net: A top priority for health care reform" in the September/October 1999 issue of Health Affairs.

This report is divided into three sections. The first describes the focus group research that was conducted. This section describes the uninsured and underinsured residents who attended the focus groups, the methods used to solicit information from these participants, and the findings of the five focus groups conducted.

The second section describes the investigation of awareness, attitudes and concerns of Anchorage community leaders. It describes the interview process used to collect data from established policy makers, business leaders and program directors and describes the findings from fifteen business leaders, policy makers, health providers and other community advocates.

The third section offers conclusions and implications for increased access to healthcare for Anchorage residents based on the perceptions of focus group members and community leaders.

## SECTION I: FOCUS GROUP RESEARCH

### Focus Group Participants

Twenty-seven men and women participated as members of one of five focus groups. All focus groups had a mixture of men and women and had from three to seven participants per group. Participants were predominantly Euro-American in ethnicity with the exception of one Asian, two African-American, and one Latino.

Four of the five groups were designed to include a range of ages and work situations. Participants in these four groups ranged in age from 22 to 67. These four groups reported an estimated income range from below $10,000 to between $41,000 and $50,000. The average income fell in the $21,000 to $30,000 category. Participants also ranged in education completed from some high school to college graduates. Both single and married adults were represented as well as single and married parents of dependent children.

Because we screened for those with no health benefits at all, we were surprised to find members of the groups who had some insurance. One had a medical plan through retirement from the state of Alaska, one with the Veteran's Association and one with the military. Several single parents had no insurance but did have Denali Kid Care for their children. One participant was operating on Cobra after leaving his place of employment to begin his own consulting firm, knowing that would end shortly. A last participant had health insurance with a $1300 deductible that he considered "worthless". All participants, regardless of whether or not they had some "safety-net" insurance plan for themselves or their children identified themselves as not having or anticipating not having adequate insurance to take care of medical concerns. These participants are identified in this report as being underinsured.

The fifth focus group was more homogeneous. Members of this group were men and women over the age of 55. All were working and had no health benefits at work. All but two were not eligible for medicare. This focus group was designed to identify specific concerns of the older worker who is either uninsured or underinsured for their needs. The majority of this group had incomes of less than $10,000. They had a similar range in education to the other focus group members; from having some high school to being a college graduate.

### Focus Group Procedures

The following research procedures were used in the focus group research:

**1. Recruiting and Selecting Appropriate Focus Group Members**

Focus group members were recruited in three ways. First, an advertisement was placed in the Anchorage Daily News urging anyone who was working but not insured

and who would like to discuss his or her experiences in a small group to contact the Coalition. Telephone numbers received from this advertisement were followed up with a call from the researcher. A focus group information form was filled out over the telephone to collect demographic data and to determine if the interested respondent was an appropriate candidate for a focus group. Participants were considered appropriate if they were working at least part time and receiving no health benefits at work.

In addition, focus group information forms with an introductory letter by Joan Fisher, CEO for the Anchorage Neighborhood Health Center, were placed at each Neighborhood Health clinic. Patients were encouraged to complete the form if they wished to be part of a focus group. These forms were gathered and given to the researcher. Follow-up calls were made to those respondents who indicated that they did not receive Medicaid. Finally, one group was formed through the Older Person's Action Group (OPAG) recruiting working seniors who were over age 55.

The small number in each focus group was due to a high number of people canceling or simply not coming to the focus group. The lack of attendance at the focus groups surprised us. While we can only speculate on why this occurred, it may indicate a degree of fragmentation those without health insurance may encounter in their daily lives. This was just one more thing to do, to get transportation, make the time, etc. It indicates the difficulty in connecting with this group of people. We worked hard to hear from them. It is no wonder they are generally not heard.

**2. Collecting Data**

A focus group discussion guide was designed and used with all five focus groups. Members of the steering committee of the Coalition reviewed the questions. Questions about specific kinds of medical service, such as dental care and hearing aids were added as new issues emerged during on-going focus groups.

Groups were held in three locations. One focus group was held at the Anchorage Neighborhood Health Clinic on 10th Ave. A second focus group was held in the conference room at OPAG. The other three groups were held in the conference room at the United Way Offices. In each location, the participants and the researcher and research assistant sat at a table where there was ample room to talk.

Special consideration was taken to make sure the noise level was low and other distractions were minimized. All focus groups used a moderator to facilitate discussion and an assistant moderator to take notes and to observe the flow of conversation, non-verbal cues, and other group dynamics. All sessions were audio taped.

Focus group members received an introduction at the beginning of the session advising them that their responses were voluntary, and that they could choose not to answer any questions presented to them. Confidentiality was explained and all participants and researchers agreed to abide by it. During this introduction time participants received instruction on how focus groups worked, what to expect in a focus

group, and an invitation to ask questions about the process at the conclusion of the session. A discussion guide was used to keep the conversation focused on the information pertinent to this study.

Following the session, participants were given a $20.00 honorarium for their time.

### 3. Analyzing the Data

Audiotapes were transcribed for analysis. Written focus group session notes were used to assist with the transcription. All records were maintained on file for further reference. The researchers developed coding categories based on the questions asked during the focus groups, and the five transcripts were marked accordingly. Using appropriate qualitative analysis techniques, the focus group and interview information was organized into systematic categories that could be reported in a meaningful way.

### 4. Summarizing the Results

This report includes summarized findings, representative participant quotes and conclusions.

## Focus Group Findings

### 1. Work and Health Benefit Background of Participants

There was a large diversity in the kinds of jobs in which these participants worked. Few participants held the same kind of job. Truck driving, clerical work, temp services, auto mechanics, sales, telephone surveying, medical assisting, convenience store work, office management, courier service, food service, janitorial service, engineering consulting and music performance were all mentioned by at least one participant. While several participants were self-employed, most worked for small businesses that could not afford to provide health benefits. Interestingly, two participants worked for small companies who contracted their services to the municipality or the state. Several participants worked two or more part-time jobs, none of which offered benefits.

For about one third of focus group members, the job they are currently working in is the first that has not offered them health benefits. This was particularly true for the seniors who were working. One company used to offer health benefits but was unable to continue due to high costs. For those who had been self-employed for a while, not having benefits was nothing new. However, it was a great concern to those who were just now going into business for themselves. One participant who is currently using his Cobra has been unsuccessfully exploring other options. He is very concerned about what will happen when his Cobra ends. This concern was also expressed by those who have recently stopped receiving health benefits due to a move, or to their company canceling health benefits due to increased cost.

**2. The Importance of Health Care Coverage**

Every focus group participant voiced their perception that health care insurance is extremely important; that it offers "security" and "peace of mind." Even those who see themselves as healthy, worry that some day they will have a major medical problem that they do not have the resources to handle

> *"Thank goodness I'm healthy. And take no medication. But it is a scary feeling. Because any minute that could turn around."*

> *"It is just second to daily needs. I'm keeping my fingers crossed that nothing serious happens."*

> *"It's a balancing act between reality and fear."*

> *"I worry because my family history is full of cancer."*

> *"Now it feels like tap dancing through a minefield. It is a daily grind because I am one accident from devastation."*

Others have had significant health problems that have required expensive medical care, and have cost the participant a great deal of money. Their understanding of the importance of health care comes from having to deal with their health and their medical costs on a daily basis.

> *"There's a physical, emotional, and economical effect."*

> *"I think a lot of it is having the security of knowing you can take care of emergencies"*

> *"Well, when you skip the physicals and stuff, because you can't afford it, when something happens you're scared."*

The reality that health can take a turn for the worst was of gravest concern to the seniors' focus group. While some seniors reported feeling fortunate that their health is still good, others have had serious problems. The contrast between being healthy and having something go wrong was most apparent in this group.

> *"If you're maintaining your health, you know, doing the things you're supposed to be doing, you know. I haven't had any problems that way."*

> *"Before 1998 my wife and I had regular insurance, so that in 1998 we retired, then I got a job ... had no insurance benefits. I had problems with my breathing. And I was hospitalized. And the hospital bill was $8,500. Then I have no insurance. So I applied for public assistance. But I was*

*denied. And the reason is that I'm not quite 65. I start to pay $50.00 every month to the hospital, but that is my problem. My income is only, you know, $800 [a month]. [I have] no idea how to pay off that much money."*

**3. Participants' Medical Experiences**

Participants were asked how long it had been since they had seen a doctor and how they currently meet their medical needs. Seven different themes emerged from their experiences with accessing medical attention.

**A. Many see a doctor on a crisis basis only.**

Most participants reported that they do not go to a doctor regularly or for what they consider to be minor concerns. They wait until they feel like they have no choice before they go, and frequently that means they go to a hospital emergency room or an urgent care clinic.

*"I ended up in the hospital with triple bypass surgery. And why? Because I didn't have the money to go and see a doctor and see how I was doing. You have to decide to go to the doctor or eat."*

*"A lot of time I haven't gone to the doctor when I think I have the flu, I think I have a urinary infection, or even sometimes when I have seizures because they send you a note if you're behind in payments, or they send the bill collector after you."*

*"I don't go [to the doctor] unless I'm dire sick, and the problem with that scenario is that you could be causing more damage to yourself than if you had equal access."*

**B. They frequently compromise on the services they need.**

For those with serious health problems, going to a doctor is a must. Conditions of diabetes, high blood pressure, a heart attack, cancer, or major surgery all keep participants going to see a doctor regardless of the cost. What they do instead of giving them up is to compromise on the frequency and quality of their visits. One compromise is to go to a "cheaper" doctor instead of a specialist. The general perception of each focus group was that, unlike a general practitioner, specialists were not willing to work with their patients.

*" I don't go to see specialists because when I call and ask them what their fee schedule is, the average I've seen in town is $250 to $275 cash. CASH! On your first visit. That's when they'll see you. And after that they may or may not bill insurance. Depends on how they feel about it.*

*But you must provide them with payment up front before the doctor will see you."*

*That's right. There's a sign on the counter. Payment in full due at time of treatment."*

*"I go to the regular doctor, but not to a specialist...It puts a risk on my kidneys. I know I could get better treatment, or that's what they lead me to believe."*

The seniors reported more support from specialists than did younger participants.

*"I went to the clinic to have a Pap smear. And they sent me to a gynecologist. And I told them when I went in, 'if this isn't necessary, I can't afford it.' So they said, 'come in, he wants to look at you anyhow.' And the doctor didn't charge me for the visit. He gave me an exam, and he gave me a procedure that he ordinarily charges $800 for. And he didn't charge me a dime."*

Another compromise is to only get part of what is needed.

*"I have to take pills, so I had to go in to get my med(ication) refills, and they did a quick exam, you know. But even at that, my lab work, I asked to postpone. So I didn't have any of my blood work done which monitors the level of the meds I'm taking."*

A final compromise is simply not getting preventative care at all.

*"I'd really like to have the benefit of preventative health care coverage. Just to have a little security. I'd like to go in and have all the tests they recommend. Be able to have the bone scans, to see if osteoporosis is a problem right now. I'd like to be able to have the regular tests of a yearly physical that costs well over $500 to $600. Even if you utilize the free clinics that they have for your shots, if you want to, your mammograms, pap smear, the blood work. You are still paying $65 a shot at some of these places. Even though it's cheaper, you still have to end up with a doctor's visit in order to evaluate them all. So there is no way that you can do preventative health care for under $500. That would be the very minimum using all the things that are free or cheaper."*

**C. They must spend time finding doctors who will see them.**

These participants look for doctors who will work with them. For the seniors, this meant doctors who take Medicare. For others, it meant allowing them to make payments on the services they receive. Moving from having health insurance to being dependent on

Medicare brought mixed stories from the seniors. For some, having an established doctor provided the transition from insurance to Medicare payments.

> *"You need to establish a physician now that will carry you on. My husband is in that situation and his doctor is seeing him on consignment. And that is because he was an established patient and he was unwilling to pawn him off on someone else. And I think that's the only choice we have right now: to establish yourself with a physician who will see you after Medicare takes affect."*

Being a long-term patient isn't always a guarantee of continued services, however. As one senior woman explained, much to the group's horror:

> *"My husband's doctor who was treating him for a number of years, when he turned 65, he wouldn't see him as a Medicare patient."*

And others have extenuating circumstances that find them searching for a doctor who will take Medicare when they don't have a regular doctor.

> *"When my mother-in-law was under Elmendorf's hospital care, they changed the policy so that they would no longer take anyone who was over 65, so I went looking for someone who would take her as a medicare patient. I applied to 21 different doctors before I found someone...before I could find someone to see her and oversee her medication. So there are a lot out there who will not donate their services."*

**D. They look for ways to save on prescriptions.**

The cost of prescriptions is another area where the uninsured, particularly seniors and those with chronic medical conditions, feel especially vulnerable. In the senior focus group, a discussion centered around the choices each must make on a daily basis:

> *"Are we going to buy prescriptions or are we going to buy groceries?"*
>
> *"Or pay the rent"*
>
> *"Yes, it's an either- or thing"*

Again, seniors were more aware of ways to save on prescriptions than were younger participants.

> *"When I didn't have money for insulin, I called the Diabetes Association and they paid for my insulin."*

*"I have a booklet listing the pharmaceutical companies and what their criteria are. Your doctor has to say that the doctor will provide free health care if they provide the free medication. That's not the norm. If your doctor'll write a letter and say you need this medicine and can't afford it, they will provide it for you. Like a three months supply, and then it's renewable."*

However, in all focus groups participants reported relying on their doctors' sample medications to treat many of the medical problems that sent them to a doctor. This catch-as-catch-can method of getting their prescription needs met was indicative of all the focus groups. They are at the mercy of kind doctors, safety-net programs that may or may not help them with prescriptions, and information that is not always available.

**E. They go without dental care.**

A particular form of preventative care that all focus group respondents agreed was cost prohibitive is dental work.

*"When I had insurance, I went, but I don't go now."*

*"My girls missed their cleaning this time because our regular dentist didn't take Denali Kid Care. So they didn't go. I couldn't afford to pay it out of pocket."*

Still another cost-prohibitive, but often necessary medical expense for seniors is a hearing aid.

*"Without a hearing aid, your quality of life just goes down. I know so many seniors who are depressed because they can't hear, but they can't afford a hearing aid. Why isn't that covered under some program?"*

**F. They get creative about preventative care.**

Some focus group participants, mostly in the senior focus group shared how they combine the different preventative types of opportunities they come across with overall medical attention.

*"Right now I'm utilizing all the free or reasonable clinics I can. For instance, they are giving flu shots at the senior center. Or if they do blood work. Drawing the blood work. They charge a $10 or 20 fee. The Mobile mammary gland testing is done on a sliding fee—a reasonable sliding fee scale. And then I do one doctor's visit a year to have her coordinate all that."*

*"I go to the University to get my teeth cleaned. It costs me $15.00. And they did a very thorough job. I know they're students, but they do a thorough job every time."*

Quite a few participants must get a yearly check up for either health or work reasons. Those who do so for their work do not have to pay for this and this provides them with care they otherwise would not get.

*" I have a CDL (commercial drivers license), so I have to get checked once a year. But the company pays for that."*

*"I'm a weekend warrior. So every three years I have to get a physical and they pay for it."*

Another way to get a check up that is paid for was to give blood.

*"For me, giving blood means getting some basic checkups."*

Participants reported several alternatives to going to the doctor. One single mom reported, and others agreed, that watching what is going on in the neighborhood helps them make a decision about their medical care.

*"Like just happened a month ago. In that particular situation I relied on a friend of mine. Her kids were sick, and she took them to the doctor. It was a virus, going around school. So I figured. Play the odds. Chances are pretty good that my girls have is the same thing. And I waited a week and it went away."*

A few participants use alternatives like homeopaths, herbal medicine, etc. However, most rely on over-the-counter medications and follow behavioral ways of maintaining their health, such as getting exercise and eating well.

*"Certain stuff you take to keep well. I take a lot of vitamins now. A lot of natural things that have helped me. Like teas and stuff."*

Others admit they simply

*"Keep my fingers crossed."*

**4. Safety-Net Programs Currently Being Used**

Participants reported a wide array of programs they utilize and for the most part, have had positive experiences with these safety-net programs. Seniors reported more knowledge of how to get their medical needs met than did the younger participants. This could very well be due to a more organized awareness campaign focused on the agencies

these participants are involved with. Programs seniors were aware of or used included preventative services offered at senior centers, the Diabetes Association, the University of Alaska Dental Clinic, the HAPI program and services through pharmaceutical companies and health organizations such as the Lung Association.

> *"I'm aware if you have a specific problem, like if you're a hemophiliac or a diabetic, or you can identify a lung disease, that those associations will help you. They have their own programs. But first you have to reach that diagnosis. And getting to that diagnosis is hard. So lots of people out there could be getting help through a particular organization but they aren't because they have to be properly diagnosed."*

Members of the other focus groups also were aware of or had used a few safety-net programs, particularly the Anchorage Neighborhood Health Clinic, Denali Kid Care and programs through Providence Hospital or the YWCA.

> *"I was near death when I went to the Neighborhood Health clinic. I went about a year and a half ago, and they said they let me slip through the cracks. I had started going to the chiropractor, had started having real pain in my neck, then I started getting dizzy spells and double vision, and went back to the health clinic. They spinal tapped me and . . . put me in the hospital immediately. She saved my life."*

> *"You know, I love the Anchorage Neighborhood Health Center. Before I had any insurance or anything, I didn't have a good job, I didn't have a good income, and you know, they sent me there. But for the first year, they really helped. Only cost me $15.00 every time I go there. So they really help people. Now I have more money, I pay more. But it is worth it."*

> *"The hospital put me into some kind of program from the pharmaceutical company. And they sent me a whole bunch of pills, free. 'Cuz I didn't have any money. And when I had the surgery. I didn't work for 3 months. And they gave me the pills. And that was pretty helpful. I didn't have to come up with that."*

> *"I'm a newcomer to Alaska and I've had 2 emergencies where I had to go the Providence Hospital on emergency. But I could not believe the way they treated me. It was great."*

> *"They (Providence Hospital) treat you like a real person, even when you don't have insurance."*

> *"The YWCA Encore Program is wonderful, and the help shoehorn people in so they qualify."*

### 5. Barriers to Using Programs

Focus group participants identified three different types of barriers to receiving safety-net services.

#### A. The Discontinuation of Programs

*"There used to be a program you could sign up at the health department to get dental work done. They won't even let you sign up anymore. The waiting list is so long. So actually they are only taking emergency dental people now."*

*"I was eligible for the HAPI program...but that's been discontinued. I have just got reinstated in August, but I think in January, at the new year, it will run out and they won't have a HAPI program any more. And I'll be back without any benefits at all.*

*"I was told I was eligible (for the HAPI program), then yesterday I got the letter. It said there is no more budget so they are closing the program. So no one can be enrolled. So I cannot go to the doctor."*

#### B. The Difficulty of Getting into Programs

They also expressed frustration at the difficulty of getting into a program.

*"The state places a lot of responsibility on the person to jump through hoops to qualify for medical care."*

*"I think programs actually make it tough for you. Just having them (the programs) makes the state look good, even if it is hard to get into it. Here's a program, but to qualify for it, Oh, my God."*

*Yeah, and then if you don't get signed up, you do look irresponsible."*

*"I was on the waiting list for Denali Kid Care for 7 months."*

#### C. The Lack of Knowledge about Available Programs

In every focus group there was a sharing of information about programs that members had found. Participants asked each other,

*"How do you find out about these programs?"*

*"Is there a list of safety net organizations out there?"*

### 6. Who Should Be Involved In Providing Health Care Coverage And How?

Although most participants want to see changes in accessing health care, most, but not all, are skeptical about the role of government in making it happen. Some would like to see the government regulate the high cost of health benefits, as well as the high costs of medical attention.

> *"I don't want to see the government controlling my health or my health care. But I cannot come up with another solution. Because physicians and hospitals and insurance companies are not going to police themselves. They've already shown us that."*

One member told a story about the medical treatment he received in Canada and wondered why the United States couldn't follow that example.

> *"My baby was only 6 months old. We were traveling and my baby developed a fever. So we stopped in Vancouver and we went to the hospital. They did not ask me, 'do you have money?' They didn't ask me 'do you have health insurance?' They didn't ask me 'Are you a Canadian citizen?' They didn't ask me nothing. They took the baby and they went....and they said, 'Please sit down.'. Right here (in U.S.) you go to the hospital, the first question is "do you have insurance?"*

However, others point to Canada as an example of problems with government controlled and regulated health care.

> *"In Canada, they say is the highest taxed place on the planet, because of their medical"*

> *"I also wonder if Canada has as good of quality of doctors as we do."*

> *"Yes, there's no incentive for doctors to be better."*

> *"I think we can learn from other countries though. See what they've done wrong. You know find out what they done wrong and not do it."*

There is a perception among these participants that the government is too corrupt to manage health care. When one participant suggested a possibility of governmental insurance, the group shook their heads. One member spoke for the rest of the group when she added, "*Uh uh. Like the scandals with the HMO's?*"

Many participants see government bowing to the special interest of the insurance companies.

> *"I don't think the government can do it because they're being paid by all these guys. And I don't think they will make good decisions."*

*"Lawmakers cater to those who contribute to their campaigns. They're going to dance to the beat of the insurance drum."*

*"I think it could be regulated to some degree, but that requires the backbone at the congressional level. And the insurance companies have enough of a lobby that it isn't advantageous for them to take that step. Right now, there are too many rewards on the other side of that. And until that changes, until it becomes more advantageous for the government to regulate, you know, then it isn't going to happen."*

Another perception is the tendency of the government to bureaucratize programs.

*"I don't think that the government would do a good job. They think in categories. You make this much, you go over here. It's all in how much you make. That seems to be the way it is. You know. They say everything is going so good for single parents. So single parents who've got 2 kids should have their kids on Denali care, right? I was on assistance, and I got 2 jobs, 2 part time jobs and they kicked me off because now I make too much money. So I couldn't afford the day care and pay for doctor's bills. So I dropped one job and they would not take me back. They said 'sorry, that was your own responsibility. You should have kept the daycare.' The government is screwing up. And they're going to do that. They're going to do that if they get more control than they have right now."*

**7. Paying for Health Insurance**

For many of these participants, it is simply the lack of accessibility to health insurance that they want to see changed. They are willing to pay for insurance if they could simply access it. No one in any of the focus groups advocated for free health insurance. They were all aware of their need to pay something. What they could afford to pay, however, ranged from under $10.00 a month to over $300.

*"I paid $250 out of every paycheck when I worked at the dealership. And then I still had to pay a $100 deductible. But it was right there."*

*"I would even say $300 per month...Even $300 a month is not outrageous. Compared to $3000 for the...But 5, 6, 7, 800 dollars. That's just too much. That's just ridiculous."*

For others, the gap in the services that health insurance policies provide is an additional problem. These participants want to see health benefit packages that are uncomplicated and easy to use as well as affordable.

**8. General Perceptions of Uninsured**

To a person, these focus group members agreed that there is a general perception of people who are uninsured as low class, or less of a person, or at least, "doing something wrong." These participants see the general public view that people are responsible for having health insurance and to not have it is irresponsible, or not being a good citizen.

> *"Yeah, they didn't take the right job. You know, they didn't wait for the right job"*
>
> *"Or they should have gone to college."*
>
> *"They think you're low class if you're not insured. It's like everything else. And that's the way Americans think. You know, you're down at the bottom if you're not doing all the things that the majority are doing."*
>
> *"People look at you. Get off the bus. Get yourself a car. Get yourself a job that gives you good health benefits."*

A different version of this perception is that people know there are programs out there and so think everyone is being taken care of. However, as one focus group discussion concluded,

> *"The state places a lot of responsibility on the person to jump through hoops to qualify for medical care."*
>
> *"I think programs actually make it tough for you. Just having them (the programs) makes the state look good, even if it is hard to get into it. Here's a program, but to qualify for it, Oh my God."*
>
> *"Yeah, and then if you don't get signed up, you do look irresponsible."*

**<u>Summary of Focus Group Findings</u>**

The experiences and perceptions of these uninsured and underinsured focus group participants can be summarized as follows:

**1. Range of Employment**

The range of employment of these participants demonstrates the diversity of those who are uninsured or underinsured. While many of the participants would be considered low income, particularly those seniors represented, a substantial number would easily be considered middle-class. Self-employment accounted for part of the lack of health benefits. However, most of these participants worked for small companies that did not have the financial capability or numbers of employees to offer health benefits or, in the

case of the seniors group, were involved in a program that could not support health benefits.

### 2. Attitudes about the Importance of Health Care Coverage

Health care coverage is a valued and desired commodity, according to these participants. Their lack of insurance caused them to be uneasy or nervous about their health. Those who had suffered major medical problems had first-hand knowledge of the effects of not having adequate insurance to cover the expenses. They certainly do not have the luxury of taking medical care for granted for themselves or their children.

### 3. Medical Experiences and Choices

Lacking health insurance frequently keeps people who consider themselves healthy from seeing a doctor or getting health exams on a regular basis. When healthy participants do choose to take preventative care, they tend to do it creatively. When a job pays for a periodic health examination as a requirement for employment, for example, these participants take advantage of it, and consider it a nice benefit. Others get creative and use programs designed to help keep people healthy. Getting flu shots and blood work done in community centers, finding inexpensive ways to get teeth cleaned, and taking advantage of mobile mammogram clinics are examples of how some of these participants stay healthy.

Health problems demand that people seek medical attention regardless of the cost. Those who must get medical attention on a regular basis for a condition such as diabetes, high blood pressure, etc. find that they look for ways to compromise between cost and necessity. Staying away from specialists whenever possible, getting the minimal amount done to stay healthy, and cutting back on the frequency of visits are all ways those with chronic health problems seek to maintain the balance between health and financial solvency.

Seniors looking forward to Medicare health coverage are concerned about choosing a doctor who will see them once they are eligible for Medicare.

Dental care is the most compromised, according to these focus group members. The prohibitive costs and the unwillingness of many dentists to work with payment plans keep the uninsured from taking care of their teeth. What care is done, is frequently done through inexpensive teeth-cleaning clinics rather than go to a dentist for a more full-service exam.

Hearing aids are another expense that seniors cannot afford frequently and the loss of hearing reduces the quality of a senior's life significantly.

The cost of prescriptions is very troubling to the uninsured, particularly the elderly who rely on many prescriptions for their quality of life.

The uninsured and underinsured compensate for infrequent or basic medical services or their inability to get prescriptive drugs by using over-the-counter medication, and watching their lifestyle. Taking vitamins, exercising, using herbal remedies and "eating right" are all alternatives these participants used to stay healthy.

These focus group members could be divided into two groups. One group is focused on hoping they stay healthy. This group keeps their fingers crossed, and simply does not get medical attention. They feel no control over their health needs. The second group takes action through trying to maintain a healthy lifestyle, both behaviorally and through alternative medicine, in order to postpone costly health care needs. Not having an insurance policy to take advantage of, this second group works at controlling their health care the only way they can.

**4. Programs that Meet the Needs**

Safety-net programs make a big difference to the uninsured and underinsured, these participants report. They were able to list several programs that help them stay healthy, or receive treatment they can afford, and they are very grateful for these programs. The Anchorage Neighborhood Health Clinics, Providence Hospital, and programs such as HAPI, Planned Parenthood and the YWCA's Encore program were the most frequently cited programs. Participants agreed that they do a good job and make the lives of those who use their services better. Some of those who have had to find inexpensive medications were familiar with programs that provide low-cost or free prescriptions.

Private clinics who cater to those with inadequate insurance or Medicare, such as the Anchorage Medical and Surgical Center, and community services such as the dental cleaning clinic provided at the University of Alaska, Anchorage are deeply appreciated. Finding a good doctor or good services, according to these participants, means finding people who are respectful to those without insurance, who take time, and who are willing to dispense samples and find other ways to lower the costs of medical care.

The greatest barrier to using these services frequently is simply not knowing about them. Having more information and a place to go to learn about programs would be useful, according to these participants. Sometimes, however, programs are difficult to get into, or a bureaucratic to the point of not being useful. And sometimes programs lack funding and are discontinued, as is the case with HAPI, or cannot keep up with demand.

## SECTION II: INTERVIEWS WITH COMMUNITY LEADERS

**Community Leaders**

Fifteen community members were interviewed in a two-part process. Ten assembly members, business leaders, and health and social service providers were initially interviewed by the steering committee of the Coalition. An additional five people were interviewed during the time period of the focus group research. The mayor of Anchorage had been previously interviewed when he was an assemblyman. A second interview was conducted with him later to see if being mayor had changed or added to any of his perceptions.

**Procedures**

The following research procedures were used in the community leader research:

1. **Recruiting Appropriate Community Leaders to be Interviewed**

   Community leaders were selected by discussions with the steering committee of the Coalition about the kinds of information they wished to gather. Community leaders selected during the time of the study were chosen to complement those leaders already interviewed by the Coalition earlier. A representation of government officials, private non-profit organization directors and public, municipal leaders was sought.

2. **Collecting Data**

   A semi-structured interview protocol was developed consistent with the interview questions asked to previous community leaders. Interviews were conducted face-to-face or over the telephone depending on the accessibility of the community member being interviewed. Each interview took approximately twenty minutes to one half-hour.

3. **Analyzing the Data**

   Written notes and summaries were analyzed. All records were maintained on file for further reference. The researchers used categories based on the questions previously asked. Using appropriate qualitative analysis techniques, the interview information was organized into systematic categories that could be reported in a meaningful way.

4. **Summarizing the Results**

   This section includes summarized findings of the interview data.

## Findings

### 1. Health Care Access Trends

Those who were interviewed agreed that there is a definite trend in more costly health care services and that these costs are getting more and more problematic for the general population. Even for those people who are insured and who have access to health care, the care is expensive. The majority of those interviewed also see a trend toward less access. As jobs get outsourced or contracted out, health care benefit packages get reduced or eliminated altogether. As jobs increase in the "big box" retail business and decrease in the oil industry, there will be more people making less money. Several already see changes. Providence hospital has seen an increase in charity care and a small business owner quoted a statistic of a 37% increase in medical insurance costs this year.

### 2. What is the Current Situation?

Health care providers and social service delivery providers were more apt to be aware of the current situation for those who have few to no health benefits. Government officials, both at the state and local level, knew very little about the situation for the most part. The two legislators interviewed both agreed that while they have constituents who have talked about this with them, they are not aware of any changes since the last legislative session. They deferred to the health and social services providers as the experts in this arena. One assembly member argued that health is a state issue and needs to be addressed as such.

The uninsured in Anchorage were described as those who have lost their oil industry jobs, those who are working in small businesses or younger people who choose not to spend their money on health insurance. Others referred to the indigent or the very poor when they described whom the rising cost and inaccessibility of health care affected. One businesswoman admitted that she believed Americans are spoiled with the expectation of health care coverage. This view was affirmed by one legislator who pointed out that not all American society believes that health care coverage is an entitlement.

Another aspect of the situation of health care access, brought out by health care experts, was that more and more people are not developing a sense of wellness or preventative care. According to one social services director, " Getting a check up is not in the developmental psyche [of those who do not have easy access to health care]. "

### 3. Barriers to Accessing Health Care

The community members interviewed identified four different barriers to accessing health care.

**A. Cost**

For some, the greatest barrier is cost. The cost of health benefits keeps employers from being able to offer benefits at all. When they are able to offer them, the cost of the deductible frequently keeps people from using their benefits. Finally, the cost of medical attention itself keeps people away from doctors for preventative and primary care.

**B. Lack of Information**

For those who do qualify for special programs, there is not enough information about those safety-net programs, according to some of those interviewed. Special populations, in particular, are excluded from the main information loop.

**C. Lack of Trust in Health Care and/or the Government Agencies that Sponsor It**

For some persons, particularly the new immigrants, a general distrust in government keeps some people from accessing services they could have. There may be language barriers or cultural differences in medical practices that keep these groups from feeling comfortable using the programs that are available to them.

Social Service providers and others who worked with low-income families pointed out that there is a perception among the poor that they will be stigmatized or judged if they use governmental programs. These suspicions keep people away.

**D. Social Issues**

Those who work the most closely with safety-net programs and their recipients included the many social factors that prevent people from getting good medical attention. Dysfunctional family structures, substance abuse issues, employment struggles, even transportation issues all prevent people from taking the time and effort to visit a doctor for a primary checkup.

**4. Resources Available?**

Most of those interviewed were aware of at least a few safety-net programs. Medicaid was mentioned as a way to access health care. In addition, Denali Kid Care was just about on everybody's list. Health care and social service providers were more aware of programs than their business or government counterparts. Providence Hospital, The Anchorage Neighborhood Health Center, and the University program for students were all mentioned. Some care providers were aware of special funds at social service agencies that were earmarked for emergency medical care. One legislator mentioned faith communities who support the health care of their membership. Only one businessman had no idea of any resources. He thought that perhaps if people had no coverage they were simply out of luck.

According to our government officials, we need to continue to talk about this problem. For legislators, assembly members and the mayor, having potential programs and solutions brought to their attention would be useful. They tended to talk more about the "big picture", keeping dialogue open, looking for solutions for different aspects of the problem. Using the permanent fund as a resource to make sure all Alaskans had major medical coverage was one solution that came from the legislators interviewed. Another solution voiced by several government officials was the need for small businesses and nonprofit agencies to come together to pool their resources to receive good health insurance benefits. Out of this group also came the concern that building government programs would be dangerous because it would allow for a lack of individual responsibility towards taking care of personal health needs.

Social service providers were more likely to talk about funding and education. The funding of preventative care was an aspect several providers agreed could be improved upon. One assembly member also advocated for the coverage of all health care for children. All the service providers and several business and government leaders discussed education as well. Education meant both educating the consumers as to what is available for them and the small business owners as to their options about offering benefits. Perhaps, suggested one assembly member, it is time to also start educating the insurance companies.

### 5. Necessary Partners

The legislators, as well as some municipal leaders, saw the main players in solving the problem of access to health care coming primarily from the ranks of the health providers. Most assembly members, however, not only saw providers but also employers, insurance companies and the uninsured themselves as necessary informants to this process. Others want to see "powerful people", not necessarily direct service providers, taking the initiative. Finally, churches, and other community organizations committed to quality of life, would be good partners in working on health care access.

## Summary of Findings

Community leaders are also in need of knowledge about programs. Their interviews suggested that information and education about what is available is a critical part of changing this problem.

## SECTION III: CONCLUSIONS AND IMPLICATIONS

While focus group participants and community members focused on different aspects of the health insurance dilemma, some common ground emerged. Both focus group participants and community leaders question who should be involved in providing programs for access to health care. Both focus group participants and community leaders share a belief that society frowns on those who are uninsured. These two conclusions are addressed separately below.

### Who should be Involved in Providing Programs?

Participants and community leaders alike were leery of too much government control of health needs. In addition, while focus group members believed health insurance companies need to be regulated to keep medical costs down, they were skeptical that politicians will use their influence to force this issue. The general perception was that the government is in the pocket of high-powered lobbyists and special interest groups, and that the people who need changes in health care delivery and coverage will not be listened to. State and local governmental leaders, on the other hand, reported their eagerness to hear about strategies for changing the situation of health care access.

Instead of government involvement, many participants as well as community leaders urged more support for businesses to offer reasonable health benefit packages, or for the government to support a way for those without work-covered health benefits to tap into health benefit packages available to state and local employees.

### Perceptions of the Uninsured

The belief that being uninsured represents something wrong about a person was shared by members of all the focus groups and several of the community leaders. They believe the general feeling of American society is that the responsibility for health care belongs to the individual, and when someone isn't insured, it means they have not gotten the right job, or the right amount of education, or are somehow to blame. This prevailing belief among those who are uninsured adds to the discomfort of not having insurance, and separates them from the "insured" in status as a citizen. A legislative and business view from the interviews confirmed that there are city and state leaders who agree with the philosophy that health care coverage is an individual responsibility. While no community leader agreed that the uninsured are "at fault" for their uninsured state, there were some leaders who spoke about people being "spoiled" by their expectations of health coverage, or question whether society truly believes in the entitlement to health care.

## Implications from the Research

It appears clear from the focus groups that health care access for the uninsured or underinsured tends to be random and scattered. It tends to be personality driven, unpredictable and inconsistent. Far more than their insured counterparts, those who are uninsured must become dependent on a doctor's "goodness of the heart" in providing samples or reduced cost for service, or even seeing them at all. They also must be persistent to get the services that are available by getting on lists, calling around for information and filling out the necessary paper work. These participants need access to a system that is not piecemeal, fragmented, or at the whim of a care provider. Community leaders add validity to these perceptions by their own confusion or lack of awareness about programs and what is available.

There are programs that are working and both focus group members and community leaders were aware of some and not aware of others. Instating, or reinstating programs that provide access to comprehensive care much like the Denali Kid Care program would help reduce some of the unpredictability of the current practice of the uninsured. Investigating programs that would allow insurance opportunities for workers by pooling through the chamber of commerce or nonprofit organizations are also important as are keeping dialogue open between the business community, health providers and governmental agencies. Community leaders interviewed want to see this problem solved. They want to continue a dialogue to determine strategies, both in the private and public sector. Focus group members are eager to find working solutions and are willing to pay for them. More information, continuing safety-net programs, and an effort at raising the consciousness of society about the problems of the working uninsured must continue to be explored.

# Appendix A

## Insurance Group Information Sheet

**Thank you for taking a minute to provide us with the following information about yourself. This information is strictly confidential and only will be used to help us form discussion groups for looking at health care and insurance concerns within the Anchorage area. Once we have contacted you about joining one of our discussion groups, you will become anonymous and this information sheet will be destroyed.**

Name: ______________________________ Phone: ____________________

_______ Male _____ Female Age: ______________________

Occupation: ______________________ Hours Per Week: _____________

Ethnicity: ______________________ Number of Children: _______ ___

_____ Single _____ Married _____ Separated _____ Divorced

Education:

_____ Some High School ______High School Graduate or GED
_____ Some College ______College Graduate
_____ Technical training _____ Other

Estimated Income During 1999:

_____ Below $10,000 _____ $31,000 to $40,000
_____ $10,000 to $20,000 _____ $41,000 to $50,000
_____ $21,000 to $30,000 _____ Above $50,000

Insurance Provided By: __________ Employer ______ Self ____ ___No One

Currently Receiving: _____ Medicare _________ Medicaid _____ Neither

Medical services used during past year:

________ Clinic (appointment) _____________ Clinic (walk-in)

_________ Hospital (appointment) _____________ Hospital (emergency)

_________ Private Doctor _____________ Other (what?)

The Anchorage Access to Health Care Coalition thanks you for your help.

# Appendix B

## Focus Group Protocol

### Introduction

I want to thank you for coming today and tell you a little about what we're going to be doing in this focus group.

Has anyone been part of a research focus group before?
[If yes, ask if they enjoyed it]

Most people find focus groups very enjoyable. It is similar to a group discussion about a particular topic. I think you will enjoy it too.

You will notice that there are two of us here. I am the moderator. My job is to ask you questions and listen carefully to what you have to say. It is important that everybody have a chance to be heard. Therefore, sometimes if **[pick name]** is sitting quietly listening, I may say, "**What do you think about this?** If you have something to add, you can say so then. If you don't have anything to say at that particular time, that's OK too. In a focus group you never have to say anything unless you want to

On the other hand, if **[choose another participant]** has a lot to say about a particular issue, I might stop him (her) and check to see if others have something to add. Also, let's say that the whole group is agreeing about something, but you disagree or have something different to tell us. That is important. I am interested in different opinions and thoughts about the topic.

You see that I have a tape recorder on the table. By taping what you say, I can listen carefully and don't have to worry about taking notes. I will listen later to the tape to remember better what you all said. No one but my research team and me will ever hear this tape.

I also want to introduce ________ who is the assistant moderator. Her (or his) job is to listen and to take notes as we talk to add to the information on tape. If you're all nodding agreement, for example, she will record that.

Today we are going to talk about some issues about health care insurance benefits. You are all a group of people who are working, but do not receive health benefits. We are interested in your opinions about this very important topic. Everything you tell us in this hour will be totally confidential. No names will ever be used to identify who said what. For example, when we report our findings, we will refer to you as "a woman in the focus group" or "a man in the focus group." If you have any questions about the research we are conducting, we will be happy to talk to you about it after the focus group is over. Now, we know your time is valuable, so if it is OK with everyone, let's begin. **[Turn on tape recorder.]**

**Warm up**

1. To begin, let's talk a little about your situation. What kind of work do you do? Do you receive any benefits at your job? Have you ever received health benefits in your work? Or been on anyone else's health care coverage (husband, parent, etc.) [IF SO] How long has it been since you had health care benefits?

2. How important to you is health care coverage? How has not having health care coverage affected your life?

**Access**

3. How long has it been since you visited a doctor for a routine check up?

4. How do you currently meet your medical needs? [probe for over the-counter medicine, home remedies, etc] Where do (would) you go to get your medical needs met?

5. How important do you feel it is for all people to have access to doctors and hospitals? To have safety-net hospitals for people who are uninsured?

6. What safety-net health care are you familiar with here in Anchorage?

**Cost**

7. Have you ever, in the last 12 months, wanted to go see a doctor but didn't because of the cost?

8. If you could buy health care insurance, would you buy it? What could you afford to pay per month for health care insurance [or how much would you be willing to pay a month for health care insurance?]

9. If you had to give up another benefit to have health care, what might you give up? [sick leave, employee discounts, etc.]

10. Who do you think should pay for providing health care insurance? Your place of employment? The Government? Would you support the idea of public dollars being used to provide you with health care insurance?

**Perceptions of the Uninsured**

11. Who do you think the general public perceives as the uninsured? Why they don't have insurance? What about the government's perception? Are these perceptions similar or different to those who are currently working and uninsured?

## Government Involvement

In a recent survey it was found that 49% of the public think the government should get involved with health insurance. Obviously, that means about half think the government should not get involved.

12. Do **you** think the government should be involved in providing health insurance? If it did so, what should its involvement look like? What concerns might you have about government involvement?

13. How much of an issue do you believe health care is currently to our governmental agencies (federal, state, local)? In thinking about such concerns besides health care as education, crime and violence, the economy, jobs, taxes, etc. where would you like to see health care coverage be placed as a priority? [RANK ORDER]

## Wrap-Up

14. To finish our time together, what one thing would you like the Health Care Alliance to know about your feelings regarding health care insurance?

## Appendix C