

Understanding Barriers to Health Insurance of Uninsured and Sporadically Insured Alaskans

Summary of Focus Groups with Individuals, Small-Business Employers, and Health-Insurance Representatives

PREPARED FOR

Alaska Department of Health and Social Services
Office of the Commissioner
Health Planning and Systems Development

FUNDED BY

Health Resources and Services Administration
Grant #P09HS05505

PREPARED BY

Rosyland Frazier
Virgene Hanna
Meghan Wilson

April 2007

Institute of Social and Economic Research
University of Alaska Anchorage
3211 Providence Drive
Anchorage, Alaska 99508

ACKNOWLEDGEMENTS

Project Oversight

Health Planning and Systems Development, Alaska Department of Health and Social Services

Pat Carr, Unit Manager
Alice Rarig, Planner
Nancy Barros, Project Coordinator

Health Planning and Systems Development
Office of the Commissioner
Alaska Department of Health and Social Services
P.O. Box 110601
Juneau, Alaska 99811-0601
(907)465.3091



We want to thank everyone who participated in the focus groups and shared with us their experiences and opinions.

This document may be found on the following Web sites:

Alaska Department of Health and Social Services
<http://hss.state.ak.us/commissioner/Healthplanning/publications>

Institute of Social and Economic Research
<http://www.iser.uaa.alaska.edu>

EXECUTIVE SUMMARY

The Alaska Department of Health and Social Services (DHSS) contracted with University of Alaska Anchorage's Institute of Social and Economic Research (ISER) to learn more about specific groups in Alaska who don't have health-care insurance or who are more likely to have insurance sporadically. Among these groups were owners of small businesses who may lack insurance for themselves or for their employees; individuals engaged in seasonal employment; and specific populations that were identified, but for which detailed information is lacking. DHSS also requested information about Alaska Natives. In addition, DHSS requested information from health-insurance representatives selling plans to small businesses in Alaska. ISER conducted 16 focus groups to obtain descriptive information on perceptions of, and barriers to, health-insurance coverage among specific segments of Alaska's population.¹

DHSS provided ISER with two sets of questions. In the first set, DHSS wanted to learn more about what individuals and small-business employers think about the following questions:

- What does it mean to be healthy?
- What is your definition of health insurance, health benefits, and access to care?
- What are the benefits of health insurance?
- What keeps you and other people from having health insurance?
- What is your view of the coverage offered by Medicaid and Denali KidCare?
- What would you and your family value in a good insurance-benefits program?

These questions² and a second set,³ received from DHSS at a later time, were the basis for the questions asked of participants of focus groups.

Of the 16 focus groups—located in Anchorage, Palmer, Kodiak, and the Kenai Peninsula, ISER conducted 11 with individuals, three of which were composed of Alaska Natives—two in Anchorage and one in Kodiak.

ISER conducted four focus groups with small-business employers. These groups were also located in Anchorage, Palmer, Kodiak, and the Kenai Peninsula. One focus group was conducted with health-insurance representatives in Anchorage.

¹ ISER realizes that the responses participants gave express their own perceptions and opinions. These statements may not be technically complete or accurate. They are printed in this report as the participants presented them during the focus groups.

² This first set of questions is in the Scope of Work.

³ The second set of questions is from the grant guidelines which address qualitative research work conducted by the State.

FINDINGS FROM FOCUS GROUPS FOR INDIVIDUALS

A total of 89 people participated in the 11 focus groups for individuals. Of these, 73% did not have health insurance. Of the uninsured, 65% were employed and, of those, only 11% were eligible to enroll in an employer's health-insurance program.

The 27% of participants who did have health insurance felt it was very important to them and their families.

Focus groups for individuals discussed the following questions provided by DHSS:

- What is affordable? How much are the uninsured willing to pay?
- Why do uninsured individuals and families not participate in public programs for which they are eligible?
- Why do uninsured individuals and families disenroll from public programs?
- Why do individuals and families not participate in employer-sponsored coverage for which they are eligible?
- Do workers want their employers to play a role in providing insurance or would some other method be preferable?
- How likely are individuals to be influenced by availability of subsidies, tax credits, or other incentives?
- What other barriers—besides affordability—prevent the purchase of health insurance?
- How do the uninsured meet their medical needs?
- What are the features of an adequate, barebones benefits package?
- How should “underinsured” be defined? How many of those defined as insured are underinsured?

Individuals said the main reason they don't have health insurance is because it is too expensive. They believed that being healthy meant having access to affordable health insurance, and they wanted to pay what they could afford. Throughout the focus groups, participants said that they were responsible for their own health and that maintaining their health was related to having access to affordable health care. They believed that routine care, preventive care, and maintenance care for chronic conditions were important to their good health. They were especially concerned about detecting any illnesses or diseases early. Individuals did not view health insurance as an entitlement; they wanted to pay what they could afford for coverage. The average amount people said they could pay was \$100 a month per person.

Individuals participate in the public programs for which they qualify and are especially grateful for Denali KidCare. Denali KidCare had helped many families which, otherwise, could not afford health care. Individuals also participated in Alaska Comprehensive Health Insurance Association (ACHIA) and Medicaid. The income eligibility requirement is the biggest barrier to participation in public programs. Often people make too much money to qualify for public programs but not enough to pay for

their own insurance or their health-care costs. Fluctuating income, especially for seasonal workers, makes qualifying difficult. People get divorced or sell possessions to remain eligible for public programs because, otherwise, they could not afford health insurance. Individuals suggested that programs such as Denali KidCare offer sliding-fee scales to people when they are no longer eligible because of income. This would enable them to continue to have coverage.

People often did not participate in employer-sponsored insurance plans because they were too expensive. Many believed that government, either federal or state or some combination, should play a role in providing health insurance. Because of the enormity of the issue, some participants felt that the federal government should be responsible for health care. They pointed to national health-care systems—like those in Canada, New Zealand, Mexico, and Australia—as plans that might work in the United States. While participants remarked that this was what they wanted, their interest was based on stories they had heard, rather than actual knowledge of how these systems work. Also, nearly all participants believed that individuals had a responsibility to make a financial contribution to purchase their own health-care plans, and they were willing to do so.

Pre-existing medical conditions, being self-employed, and working in a business with a small number of employees all made it difficult for individuals to purchase health insurance. Some conditions, such as being pregnant or diabetic or having had a heart attack, made it nearly impossible for participants to obtain health insurance. And, if insurance was obtained, it excluded treatment for any pre-existing conditions. Some people discovered that they couldn't switch plans because of a pre-existing condition. The self-employed and those working in small businesses found premiums prohibitive.

Most of the uninsured had their medical needs met in hospital emergency rooms, in clinics with sliding-fee scales, and by paying out of pocket and incurring huge medical debts. Some uninsured did not get their health-care needs met. Still, some participants traveled outside Alaska or the country to get less-expensive health care. Participants from Kodiak and Kenai, in particular, had traveled or planned to travel to obtain health services. Some people combined visiting relatives or taking a vacation with getting medical treatment. Those who couldn't afford to travel outside Alaska to find cheaper health care shopped around their Alaskan communities but were often discouraged to find caregivers who refused to treat the uninsured or to discover health services were too expensive.

What are the benefits of health insurance? What should be included in a barebones plan? Individuals said the benefit of health insurance was to get affordable health care for themselves and their children. This care would include routine doctor visits, maintenance care for chronic diseases, and preventive care and screenings so that certain conditions could be evaluated at an early stage before they became serious. Health insurance would allow people to obtain medications and go to the doctor, dentist, eye doctor, and emergency room without worrying about how they were going to pay for the services they needed.

Many individuals shared experiences that could be described as their being “underinsured.” Participants felt that, in spite of making high out-of-pocket payments,

they still did not receive adequate coverage. Most were unhappy with the way the insurance companies dealt with them, believing they had paid for more coverage than the companies awarded them

FINDINGS FROM FOCUS GROUPS FOR ALASKA NATIVES

Thirty-one people participated in the three focus groups for Alaska Natives. Of the 31 participants, 61% (n=19) did not have health insurance. Of those without insurance, 13 were employed and two were eligible to enroll in their employers' health insurance plans. Six of the 13 employers did not offer health insurance.

Alaska Natives discussed their access to health care through tribally managed health-care⁴ facilities located throughout Alaska. They also talked about health services they received through public programs and private insurance. They discussed the following issues:

- Indian Health Service (IHS) coverage requires that Alaska Natives go to the facility in their service area.
- Travel to receive care at a larger facility can be costly.
- Quality of services varies because of high staff turnover.
- Waiting time to obtain appointments and receive services can be lengthy.
- Obtaining payment for services at a nonservice-area facility can be difficult.
- Some services are not offered through IHS.
- Case managers help eligible Alaska Natives enroll in public programs such as Medicaid and Denali KidCare.
- Some Alaska Natives have private insurance.
- Non-Natives in communities where there are only tribally managed medical facilities have to go outside their communities for treatment and medication.

IHS coverage requires that Alaska Natives go to the facility in their service area. In Kodiak, for instance, Alaska Natives first went to the Kodiak Area Native Association (KANA) clinic. If KANA could not treat the illness, the person was referred to the Alaska Native Medical Center (ANMC) in Anchorage. With the referral, transportation costs between Kodiak and Anchorage were covered. However, if Alaska Native patients did not get the referral or pre-authorization, travel expenses were not covered.

⁴ Members of federally recognized American Indian and Alaska Native tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS has area offices in different places around the United States. The Alaska Area Native Health Service works in conjunction with nine tribally operated service areas to provide comprehensive health services to about 131,000 Alaska Natives (Eskimos, Aleuts, and Indians). Through the provisions of P.L.93-638, there are 18 Title I contracts and one Title V compact with 22 annual funding agreements. Alaska Native tribes administer 99% of the IHS funds earmarked for Alaska.

During the focus groups, participants sometimes referred to their tribally managed health-care facility by name. Generally, however, they referred to these facilities and services as the "IHS clinics" or "IHS services." To stay true to the participants words, we have kept their convention of using IHS even though it is less precise.

Travel to receive care at a larger facility can be costly. People often traveled to Anchorage for regular checkups, oral surgery, or other specialty treatments that weren't available in smaller communities. Transportation was very expensive and sometimes not covered by IHS, and even if covered, the funds weren't always available prior to travel. This made it difficult for people who could not afford the cash expenditure. Not only was the transportation cost to Anchorage high, but so was the cost of time away from work. These costs prevented some from getting care.

Quality of services varies because of high staff turnover. Alaska Native participants said that the turnover of medical staff affected the quality of services provided by IHS clinics. Some found they had to explain chronic conditions over and over again to new doctors, who seemed to change every week.

Waiting time to obtain appointments and receive services can be lengthy. Participants were afraid that medical conditions would worsen while they waited for an appointment. They were frustrated by the inconvenience of being sent to a large community for health services.

Obtaining payment for services at a nonservice-area facility can be difficult. For in-state treatment away from the participant's service area, pre-authorization is required before IHS will pay the bills. When traveling outside Alaska, participants said they would seek care at the nearest hospital and show their Bureau of Indian Affairs card or tribal enrollment verification.

Some services are not offered through IHS. Not every medical, dental, or vision treatment was covered. Participants felt that IHS just covered basic needs and emergencies.

Case managers help eligible Alaska Natives enroll in public programs such as Medicaid and Denali KidCare. IHS facilities billed the public programs before IHS for services.

Some Alaska Natives have private insurance. Some participants received insurance through their jobs. This insurance gave them the flexibility to find a private doctor or obtain a second opinion. Some weighed whether to pay for insurance offered at work because they had access to services provided by IHS facilities. And sometimes employers did not offer insurance because they knew their employee had access to IHS services.

Non-Natives in communities where there are only tribally managed medical facilities have to go outside their communities for treatment and medication. In many rural service areas, IHS clinics were the only health-care service providers. IHS facilities would not fill prescriptions written by non-IHS providers.

FINDINGS FROM FOCUS GROUPS FOR SMALL-BUSINESS EMPLOYERS

Thirty-two people participated in the four focus groups conducted with small-business employers—one each in Anchorage, Palmer, the Kenai Peninsula, and Kodiak. These 32 participants represented 31 businesses that had two to 50 employees.⁵ Seventy-two

⁵ One business had two participants.

percent (n=21) of the businesses had two to 10 employees; 28% (n=8) had 11 to 50 employees.⁶ Eight of the 31 businesses offered health insurance to their employees.

Those businesses that did not offer insurance to their employees cited high cost as the overwhelming reason why they did not offer insurance to employees (n=21). The next most-frequent responses were that the costs of employee health benefits are too difficult to control (n=12) and the financial status of the organization prohibits the purchase of health insurance at this time (n=12).

Small-business employers responded to the following questions during the focus groups:

- What influences employers' decisions about whether or not to offer coverage?
- What are the primary reasons employers give for electing not to provide coverage?
- How do employers make decisions about the health insurance they will offer to their employees?
- What factors go into their decisions regarding premium contributions, benefits packages, and other features of the coverage?
- What would be the likely response of employers to an economic downturn or continued increases in costs?
- What employer and employee groups are most susceptible to crowd-out?
- How likely are employers who do not offer coverage to be influenced by expansion or development of purchasing alliances, additional tax incentives, or individual employer subsidies?
- What other alternatives might be available to motivate employers who do not now provide or contribute to coverage?

Small business employers understood the value of insurance to their employees; those who could afford to provide insurance saw that it paid off in terms of retaining employees. Those who could not afford insurance watched valued employees leave for jobs that did provide insurance. Some employees took jobs that gave them less satisfaction just so that they could receive health-insurance benefits. Some small-business employers offered insurance through their businesses as a way to get coverage for themselves and for their family members.

The high cost of health insurance was as big an issue for employers as for individuals. The initial cost to purchase a policy is high, and yearly increases made it impossible for most small businesses to offer health insurance to employees. Seasonal businesses, small professional corporations, and participants who work on a commission basis found it especially difficult to afford health insurance. Employers said that health insurance is also not cost-effective in businesses that have high employee turnover and temporary workers. Employers sometimes elected not to offer coverage when employees could get coverage through a spouse.

⁶ Two small-business employer participants did not complete the demographic questionnaire. See Table 23 in Appendix J.

Employers looked for the most benefits at the least cost. They solicited input from employees and tried to structure plans to fit the needs of their employees.

In an economic downturn, most small-business employers would stop offering health insurance because it was too expensive. They would also investigate other options for health insurance or care.

Small-business employers thought being able to be in a larger group would give them access to lower rates. (Health-insurance representatives did not agree that larger groups would provide more affordable insurance.)

FINDINGS FROM FOCUS GROUP FOR HEALTH-INSURANCE REPRESENTATIVES

The health-insurance representatives responded to questions similar to those asked in the small-business employer focus groups.

All five participants represented or sold health plans in Alaska. Four of the five had been representing or selling for more than 15 years. The majority of sales made by health-insurance representatives were to employers with fewer than 50 employees.

Health-insurance representatives said that employers were prompted by a sense of social responsibility to provide coverage to their employees. Employers were also aware of lost productivity in the workplace if they did not offer health insurance to their employees. This was particularly true of businesses with a greater number of employees and human resource departments that tracked productivity. In smaller businesses, employers felt employees depended upon them, and they wanted to help their employees as much as they could. Since these were small businesses, there was a sense of their being family members.

The addition of riders to health-insurance plans preventing coverage for a myriad of pre-existing conditions has discouraged some employers from offering health insurance.

Health-insurance representatives found that small-business employers wanted the most comprehensive coverage for the lowest premium (which at least one representative called an “oxymoron”). Some employers tried to structure plans to the needs of their employees. For example, a group of younger employees might mean an employer could use a higher deductible.

Health-insurance representatives found that more stable, permanent, full-time jobs; those jobs in competitive labor markets; and jobs in nonprofit organizations frequently had health insurance. Interestingly, health-insurance representatives found that nonprofits often had better packages than small, for-profit companies because the nonprofit organizations wrote benefits into their grant applications. Among health-insurance representatives, there was the perception that blue-collar workers, when given a choice, would rather have higher wages than health insurance. (Small-business employers did not share this perception.)

Health-insurance representatives said employers, in times of economic downturn, would “buy down,” meaning purchase less-expensive plans or increase the deductible, both of which would reduce premiums.

Health-insurance representatives said it was a misconception that Purchasing Alliances save money or that large and small organizations pay nearly the same per person in insurance costs.

Health-insurance representatives spoke about a number of different programs that could motivate employers to provide coverage; those programs include the following:

- Change state mandates as to what must be included in policies issues.
- Fund Health Savings Accounts.
- Fund Health Reimbursement Accounts.
- Offer mini-medical plans.
- Educate employees on the costs of unhealthy lifestyle choices.
- Obtain up-front pricing from doctors' offices, hospitals, and clinics to allow people to shop around.

In describing these options, however, health-insurance representatives noted a number of drawbacks, including the complicated nature of some plans and that out-of-pocket costs are still high.

INTRODUCTION

The Alaska Department of Health and Social Services (DHSS) was awarded funds from the Health Resources and Services Administration (HRSA) to examine options for providing access to affordable health-insurance coverage for uninsured Alaskans. This funding was to support in-depth studies of policy options and research into who and what groups in the state are insured and why. DHSS contracted with University of Alaska Anchorage's Institute of Social and Economic Research (ISER) to conduct focus groups to obtain descriptive information on perceptions of, and barriers to, health insurance coverage among specific segments of the Alaska population.⁷

The purpose of these focus groups was to learn more about specific groups of Alaskans who did not have health-care insurance or who were more likely to be sporadically insured. Among these groups were owners of small businesses who may lack insurance for themselves or for their employees, individuals engaged in seasonal employment, and specific populations that were identified but for which detailed information was lacking. The target groups included the following:

- The uninsured and those who serve and care for the uninsured.
- Employers, predominately small employers, who may or may not offer health insurance to employees.
- Those employed in specified sectors such as tourism or fishing and in large, national retail stores.
- Members of certain racial, cultural, ethnic, and geographic groups.⁸

ISER researchers conducted 11 focus groups with individuals located in Anchorage, Palmer, Kodiak, and the Kenai Peninsula.⁹ They explained the study and invited individuals to attend who were between the ages of 18 and 64, those who were currently uninsured or were at risk of not having insurance, or those who received health-care services provided by government-sponsored programs. Of those who participated in focus groups, 73% did not have insurance.

⁷ ISER realizes that the responses participants gave express their own perceptions and opinions. These statements may not be technically complete or accurate. They are printed in this report as the participants presented them during the focus groups.

⁸ The Scope of Work that guided this project specified that ISER include members of specific groups who don't have health insurance or are more likely to have insurance sporadically. Within those groups other groups were specified. When writing the findings from the groups, we found that we could not comply with IRB requirements for the protection of human subjects and provide as much detail about participants as we wanted. Specifically, we were concerned about maintaining the confidentiality of participants. This means that we cannot release the data in a manner that any individual might be identified. In some situations, the information participants gave, when combined with the community where they live, means individuals could be identified. The safest way to protect a participant's identity was to exclude the community where the participant lives. The state can contact us if they would like more information.

⁹ Groups from Southwest and Southeast Alaska, originally requested, were dropped due to budgetary considerations.

Alaska Natives who received services through the Indian Health Service (IHS)¹⁰ took part in two of the Anchorage focus groups of individuals and one of the Kodiak groups for individuals. DHSS wanted ISER to explore issues of the perception of access to health care and private insurance experienced by Alaska Natives.

ISER researchers conducted four small-business employer focus groups located in Anchorage, Palmer, Kodiak, and the Kenai Peninsula. Employers were selected if they had between 2 and 50 employees. Most of those who participated had from 2 to 10 employees. At the time of the focus groups, 27% of the small-business employers offered health insurance to their employees.

ISER conducted one focus group with health-insurance representatives. DHSS requested this particular group to gain insight on health-insurance brokers' unique perspective as sellers of health-insurance products to small-business employers. All participants represented or sold health plans across the state to small-business employers.

QUESTIONS FOR FOCUS GROUPS

DHSS provided ISER with two sets of questions: From the first set, DHSS wanted to learn what individuals and small-business employers think about the following issues:

- What does it mean to be healthy?
- What is your definition of health insurance, health benefits, and access to care?
- What are the benefits of health insurance?
- What keeps you and other people from having health insurance?
- What is your view of the coverage offered by Medicaid and Denali KidCare?
- What would you and your family value in a good insurance/benefits program?

These questions¹¹ and a second set¹², provided by DHSS at a later time, were the basis for the questions asked of participants of the focus groups. In the initial groups ISER discovered that the wording of some questions confused the participants; researchers revised the wording in both sets of questions for use in subsequent focus groups.

¹⁰ Members of federally recognized American Indian and Alaska Native tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS has area offices in different places around the U.S. The Alaska Area Native Health Service works in conjunction with nine tribally operated service areas to provide comprehensive health services to about 131,000 Alaska Natives (Eskimos, Aleuts, and Indians). Through the provisions of P.L.93-638, there are 18 Title I contracts and one Title V compact with 22 annual funding agreements. Alaska Native tribes administer 99% of the Indian Health Service funds earmarked for Alaska.

During the focus groups, participants sometimes referred to their tribally managed health care facility by name. Generally, however, they referred to these facilities and services as the "IHS clinics" or "IHS services." To stay true to the participants words, we have keep their convention of using IHS even though it is less precise.

¹¹ This first set of questions is in the Scope of Work. See Appendix B.

¹² The second set of questions is from the grant guidelines which address qualitative research work conducted by the State. See Appendix B.

Individual and small-business employer responses to the first set of questions, based on focus group findings, are provided in the following paragraphs. They are cross-referenced to the responses to the second set of questions in the body of this report.

What does it mean to be healthy?

Individuals responded to this question in terms of their ability to receive health care and insurance to pay for health care. Throughout the focus groups, people said that they were responsible for their own health and that maintaining their health was related to having access to affordable health care. Routine care, preventive care, and maintenance care for chronic ailments were important to their good health. They were especially concerned about diagnosing illnesses or diseases early.

Small-business employers believed that a healthy business was one that succeeded by sustaining itself through making money and growing. Business owners talked about balancing the health of their business and the costs of providing health insurance to their employees. They understood that providing health-care benefits was a good way to retain employees, cut training costs, and increase productivity.

What is your definition of health insurance, health benefits, and access to care?

Individuals did not distinguish between health insurance and health benefits. Health insurance was a means to help with, or to pay for, health-care services. Health benefits were the services that were covered by the health insurance. More detailed information on desired health benefits is found on page 31 in response to the question, “What are the features of an adequate, barebones benefits package?”

For people who couldn’t get the care they needed in their community, access to care was often a question of how much it cost to travel to Anchorage. For those who lived in Anchorage and in communities with hospitals or clinics, people received care through emergency rooms, sliding-fee-scale clinics, or other providers; some went without care. Others received support for care through public programs; others paid out of pocket; and some did not pay for services. Still others were not getting their needs met at all because they didn’t have enough money or didn’t qualify for public programs. More detailed information on access to care is found on page 27 in response to the question, “How do the uninsured get their medical needs met?”

Small-business employers, like individuals, did not differentiate between health insurance and health benefits. More detailed information on health insurance and benefits is found on page 60 in response to the question, “How do employers make decisions about the health insurance they will offer to their employees?”, and on page 61, “What factors go into employers’ decisions regarding premium contributions, benefits packages, and other features of coverage?” Small-business employers did not respond to the question of access to care.

What are the benefits of health insurance?

Individuals said the benefit of health insurance would be to get affordable health care for themselves and their children. This care would include routine doctor visits, maintenance care for chronic diseases, and preventive care and screenings to have conditions diagnosed at an early stage before they became serious. Health insurance would allow people to obtain medications and go to the doctor, dentist, eye doctor, and emergency room without worrying about how they were going to pay for the services they needed.

Small-business employers found that providing health-insurance benefits attracted new employees and helped them retain the employees they had. They found that employees interpreted the provision of benefits as a sign they were valued. More detailed information is found on page 55 in response to the question, “What influences the employer’s decision about whether or not to offer coverage?”, and on page 57, “What are the primary reasons employers give for electing not to provide coverage?”

What keeps you and other people from having health insurance?

Cost is the number one reason that both *individuals* and *small-business employers* go without insurance. Other barriers include pre-existing medical conditions for individuals and the inability of the self-employed and small-business employers to get affordable group insurance. More detailed information is found on page 17 in response to the question, “Why do uninsured individuals and families not participate in public programs for which they are eligible?” and on page 25 in response to the question, “What other barriers, besides affordability, prevent the purchase of health insurance?”

More detailed information about how *small-business employers* decide to carry insurance can be found in the answers to the questions, “What influences the employer’s decision about whether or not to offer coverage?” on page 55 and on page 57, “What are the primary reasons employers give for electing not to provide coverage?”

What is your view of the coverage offered by Medicaid and Denali KidCare?

Individuals were very grateful for Denali KidCare and felt they received important care for their children that they would otherwise not be able to afford. People were more vocal about their support for Denali KidCare than for any other public health service. For many participants, the most difficult part of public programs such as Denali KidCare and Medicaid was the income requirements for participation. People who did not qualify because their income exceeded the guideline often could not afford to pay for health insurance. Some were in occupations where their income fluctuated radically during the year. Those who made too much money to receive Denali KidCare suggested the program offer a sliding-fee scale for those whose income was above the guidelines, allowing them to contribute to their children’s healthcare and providing coverage for their children. More information on Medicaid and Denali KidCare is found on page 17 in response to the question, “Why do uninsured individuals and families not participate in public programs for which they are eligible?”, and on page 27, “Why do uninsured individuals and families disenroll from public programs?”

Some *small-business employers* knew when their employees were participating in public programs; some did not. A few mentioned that they were grateful for these programs because they couldn’t afford insurance for their employees.

What would you and your family value in a good insurance/benefits program?

Individuals believed that the most important health benefits were routine visits, maintenance care for chronic diseases and illnesses, preventive care, and screenings so that minor conditions were detected before they became serious and much more expensive. Well-child check ups and immunizations were also very important. And catastrophic coverage was also needed. More information on what people would value in an insurance/benefits program can be found on page 31 in answers to the question, “What are the features of an adequate, barebones benefits package?”

This report is divided into three sections based on the type of participant. The first section focuses on individuals—people who are uninsured or sporadically insured. The second section discusses groups held with a subset of individuals—Alaska Natives. Groups held with employers from small businesses and a group with health-insurance representatives is the focus of the third section.

In each of the three sections, ISER explains the methodology for selecting focus group members; demographics of the participants; health and employment questionnaire results; how data were collected and analyzed; and findings, including questions posed and answers received. Individual responses are kept separate from small-business employer responses. However, because there was only one group of health-insurance representatives, their responses are in the same section as those of the small-business employers. Their responses are separated to distinguish which group gave which response.

Finally, we offer conclusions addressing the perceptions of, and barriers to, health insurance for the uninsured and for the sporadically or underinsured as well as the provision of health insurance by small-business employers.

Appendixes A through J contain the forms, tools, and instruments used in this project and all supporting documentation.

METHODOLOGY AND PROCEDURES FOR FOCUS GROUPS FOR INDIVIDUALS

RECRUITMENT

Alaska Department of Health and Social Services (DHSS) provided local contacts in each community to the Institute of Social and Economic Research (ISER) for recruiting individual participants to the focus groups. These contacts were frequently a public-health nurse or an employee of a community health clinic, a nonprofit organization, or some other type of health-related agency. Even after DHSS requested their help, ISER research staff found that most local contacts were still uncomfortable providing a list of names and telephone numbers for potential individual participants and had to develop new ways to increase the effects of recruitment efforts to locate more participants. In addition to DHSS-provided contacts, ISER used face-to-face interviews, newspaper ads, flyers, messages sent via E-mail ListServes, radio station announcements, and word-of-mouth to recruit participants. Also, ISER obtained a toll-free telephone number so potential participants could call to ask questions about the project and to determine whether they wanted to volunteer.¹³ The organizer of a statewide conference, attended by Alaska Natives, recruited two entire focus groups.

SCREENING AND SELECTION WITH DEMOGRAPHIC QUESTIONNAIRE

ISER developed a demographic questionnaire to recruit and select representatives from the groups that were identified by DHSS. The demographic questionnaire was the tool used to identify a cross section of the target group willing to share their experiences and opinions related to health insurance. Participants had to be between 18 and 64 years of age and, currently, not have or be at risk of not having health insurance. We also tried to include people who had been uninsured for the past three months. Researchers took advantage of reports from other states—located on the Web site of the State Health Access Data Assistance Center (SHADAC)—and after reviewing demographic questionnaires, chose questions that were appropriate to select the target populations identified in the Scope of Work. The demographic questionnaire format had to be revised for each target group.

Excluded were people younger than 18 and older than 64; those with a family or household member who worked for an advertising, public relations, or market-research firm, for a health-insurance company or any type of health-care company, or for DHSS; those who had participated in a focus group in the past 6 months; or those who were not willing to share their opinions on health insurance.

ISER attempted to recruit a minimum of 12 individuals for each focus group with the expectation that no fewer than six would attend; in two instances fewer than six people attended.¹⁴

¹³ Table 10 in Appendix J includes information on the number of calls and people contacted to recruit participants for each focus group. Detailed information on recruitment for each group is located in Appendix A.

¹⁴ Table 2 in Appendix J includes information on the number of people who completed the demographic questionnaire. Table 10 in Appendix J includes the number of people called, scheduled, and who attended

INSURANCE AND EMPLOYMENT QUESTIONNAIRE

All participants completed a brief questionnaire prior to the start of the focus group. Staff from DHSS and ISER jointly developed the content of the questionnaire, which was divided into two series of questions—one for participants who were currently covered by any type of health plan or insurance and those who were not.

Those participants who were currently covered by any type of health insurance answered questions about plan benefits and source of insurance. The questionnaire also asked about the importance of insurance to the household and the risk of losing coverage within the next 12 months. Participants who did not have health insurance responded to questions regarding past coverage, current eligibility to enroll in an employer-sponsored health plan, and reasons why they do not have insurance. All participants answered a series of questions about employment status for themselves and, as applicable, for their spouses. These questions included the type of job, hours worked per week, industry, number of people employed by the business or company, and employment permanence. Participants were also asked about enrollment in public programs.¹⁵

DISCUSSION GUIDES

A discussion guide¹⁶ is an aid for the facilitator to make certain that all topics are discussed in each group. The discussion guides began with an introduction to the project, ISER, and the purpose of the focus group. During this introduction, facilitators instructed participants on how focus groups work and what to expect during the focus group and invited participants to ask questions about the process. They also advised participants that they could choose not to answer any questions. Confidentiality was explained, and all participants and researchers agreed to abide by it. Participants read and signed consent forms agreeing to participate in the group.¹⁷

Two discussion guides were developed—one for Alaska Natives and one for other individuals—for the focus groups with individuals. The discussion guide contains the questions asked in each group. One facilitator, a native Spanish speaker, translated and led the Spanish-speaking focus group, using the discussion guide for individuals.

INSTITUTIONAL REVIEW BOARD

All research at the University of Alaska Anchorage (UAA) that includes people is reviewed by the Institutional Review Board (IRB). The IRB's main role is to ensure that the research fulfills the requirements of federal regulations that protect human volunteers

each focus group. One Alaska Native focus group had two participants, as did the English language group in Kodiak; in one instance more than 12 attended.

¹⁵ A copy of the Health and Employment Questionnaire is in Appendix F.

¹⁶ISER reviewed discussion guides from other states reports located on the State Health Access Data Assistance Center (SHADAC) Web site. ISER developed questions for the discussion guides by using the questions provided by DHSS. These questions are in Appendix B. Copies of the discussions guides are in Appendix C.

¹⁷ See Appendix F for copies of the consent forms.

in research. ISER submitted necessary information to the IRB, which determined that the necessary safeguards were in place, and ISER received approval to proceed.

SPECIAL CONSIDERATION

ISER facilitators did their best to ensure that there were no distractions while the group was underway. All focus groups used three people—a facilitator, an assistant to take notes, and a third person to check people in and out of the group and to document the distribution of questionnaires and the participant supports.¹⁸

DATA ANALYSIS

ISER made audio and digital recordings of each group and later transcribed them. A staff member also made written notes while the group was underway for use in clarifying any confusion that might occur in the transcripts. ISER developed coding categories based on responses to the questions asked during the focus groups; two researchers coded the eight transcriptions. Verbal responses to the questions were organized into systematic categories or codes using Atlas Ti software for qualitative analysis, and we used SPSS for the quantitative analysis of the demographic as well as insurance and employment questionnaires.

¹⁸ Participant supports were 300-minute calling cards which were distributed to participants at the conclusion of the groups.

FOCUS GROUP COMPOSITION: TARGET COMMUNITIES AND POPULATIONS

The Institute of Social and Economic Research (ISER) conducted 11 focus groups for individuals; target populations identified included the following:

- The uninsured and those who serve and care for the uninsured.
- Those employed in specified sectors such as tourism or fishing and in large, national retail stores.¹⁹
- Members of certain racial, cultural, ethnic, and geographic groups.

We conducted focus groups in the communities of Anchorage (4), Palmer (Matanuska-Susitna) (1), Kodiak (4), and the Kenai Peninsula (2). Three of these focus groups were with Alaska Natives. The information on the next three pages is from all participants in the individual groups, including Alaska Natives. The next section, Focus Groups for Alaska Natives, presents their perceptions about the services provided by IHS.

Community, Insurance Status, and Subcategories of Individuals in Focus Groups

Community	Specific Populations	
	Insurance Status	Subcategories
Anchorage	Uninsured	Minorities, students
Anchorage	Uninsured	Veterans, homeless, minorities
Anchorage	Indian Health Service (IHS)	Alaska Natives
Anchorage	IHS	Alaska Natives
Matanuska-Susitna	Uninsured	
Kodiak	Uninsured	Immigrants, seasonal workers
Kodiak	Uninsured	Immigrants, seasonal workers
Kodiak	Uninsured	
Kodiak	IHS	Alaska Natives
Kenai Peninsula	Uninsured	
Kenai Peninsula	Uninsured	Immigrants, seasonal workers

DEMOGRAPHICS

A total of 89 individuals participated in the 11 focus groups for individuals. Of these, 78 completed the demographic questionnaire. The demographic questionnaire, described in the methodology section, was used to select diverse representatives among the groups identified by the Department of Health and Social Services (DHSS).²⁰

¹⁹ We were unable to identify people who worked for large, national retail stores to participate in the focus groups. During the selection process, some participants identified themselves as students in the demographic questionnaire. However, when they completed the insurance and employment questionnaire, they identified themselves by their employment status.

²⁰ A copy of the demographic questionnaire is in Appendix D. Tables compiling the responses are printed in Appendix J.

Based on those who completed the demographic questionnaire, about 75% of focus group participants were 41 to 64 years of age, and 24% were between the ages of 18 and 40. Forty-five percent of the participants were White; 35% were Alaska Native or Native American; 14% were Hispanic; and 6% were Black, Asian, or Pacific Islander. Sixty-nine percent were females and 31% were males. Thirty percent of the participants were high-school graduates, and 32% had some college background. Almost half (49%) of the participants were married.²¹

Looking at specific population characteristics, 37% of the individual participants were below U.S. poverty guidelines. When asked how many years they had lived in the United States, 75% were born and raised in the United States. The countries of origin listed by those not born in the United States included China, Cuba, El Salvador, Guatemala, Mexico, Philippines, Russia, and Tonga.²²

INSURANCE AND EMPLOYMENT

All 89 participants filled out the Insurance and Employment questionnaire.²³ Prior to the start of each focus group, participants completed this brief questionnaire, the content of which DHSS and ISER staff developed jointly. Topics included the following:

- Place of employment.
- Length of employment.
- Health insurance/coverage.
- Eligibility for government health programs.

Seventy-three percent (n=64) of all participants in the individual focus groups did not have health insurance.

For the 27% (n=24) who were insured, health insurance was very important to them and their households. Nearly all of those with insurance (91%; n=21) were the primary beneficiaries and, of those, most received insurance from their employers. A few obtained insurance through their spouses or purchased a plan on their own.

Of the 27% (n=24) who were insured, 38% (n=9) said that their insurance could be extended to their spouses and 42% (n=10) said coverage could be extended to their children. Most of the insurance plans included dental and vision care, prescriptions, and preventive services. However, one-third said their insurance included mental health services.

²¹ See Tables 3 to 7 in Appendix J for a complete breakdown of these demographic characteristics from the questionnaire.

²² See Tables 8 and 9 in Appendix J for responses from the questionnaire on poverty level and years living in the United States.

²³ A copy of the Insurance and Employment Questionnaire is in Appendix F. The responses to all the questions are located in Appendix G. Responses do not always add up to 89 or 100% due to missing answers for individual questions.

Although nearly everyone who had insurance thought it was very important, two participants feared losing it in the next year because of the expense or job relocation.

Of the nearly three-quarters of participants who were uninsured, 65% (n=40) were employed; of those, only 11% (n=4) were eligible to enroll in their employer's health-insurance program. Those who were employed worked for a number of entities including government (19%), private companies (22%), nonprofits (27%), and family businesses (2%). Thirty-one percent (n=18) were self-employed, and 17% identified themselves as seasonal employees.

Half of the uninsured participants were employed at businesses that had between one and 15 employees. The remaining uninsured participants were evenly divided between businesses with 15 to 100 employees and those with more than 100 employees.

Of the 73% (n=64) who had no insurance at the time of the focus groups, 18% (n=11) had been insured for some period of time during the last year. These 11 participants who had intermittent coverage during the past 12 months were insured through their workplace, their spouse's workplace, Medicare, Medicaid, or other sources. These individuals had health insurance coverage for at least 4 months, and some had been covered the entire year but had just recently become uninsured.

The remaining 53 participants had no means, beside themselves, to pay for their medical bills when they went to the doctor or hospital. We asked these uninsured participants to mark the main reason—from a list of reasons—why they have not bought health insurance on their own. "Cannot afford it" or "too expensive" far exceeded any other reasons that were marked.

Interestingly, 33% (n=29) of all participants in the individual focus groups were unemployed. Of the 29 unemployed participants, 15 were receiving support from public assistance programs such as Food Stamps, Temporary Assistance to Needy Families, and Supplemental Security Income.

QUESTIONS AND FINDINGS FOR INDIVIDUALS

This section contains the key points and illustrative quotations in response to the following questions:

- What is affordable? How much are the uninsured willing to pay?
- Why do uninsured individuals and families not participate in public programs for which they are eligible?
- Why do uninsured individuals and families disenroll from public programs?
- Why do individuals and families not participate in employer-sponsored coverage for which they are eligible?
- Do workers want their employers to play a role in providing insurance, or would some other method be preferable?
- How likely are individuals to be influenced by availability of subsidies and/or tax credits or other incentives?
- What other barriers besides affordability prevent the purchase of health insurance?
- How do the uninsured get their medical needs met?
- What are the features of an adequate, barebones benefits package?
- How should “underinsured” be defined? How many of those defined as “insured” are underinsured?

WHAT IS AFFORDABLE? HOW MUCH ARE THE UNINSURED WILLING TO PAY?

- Health insurance is too expensive.
- They’d be willing to pay a premium amount averaging about \$100 per month for an individual.
- A sliding-scale or percentage of income could be used to determine premiums.
- They would be willing to pay more for “full coverage.”

Health insurance is too expensive. Although many people specified a monthly premium that they felt they could pay and believed that health insurance was a service that should not be free, many also found health insurance too expensive and were unable to fit it into their budget at all.

I’ve made several attempts at insuring, but it is just unaffordable for a single family.

There’s no money in my budget for insurance.

Sometimes we can’t afford it. Because the rent is too expensive; then the babysitter charges a lot for the children. Then one buys and pays for everything and sometimes you are left with \$20 and there is no contest.

I worked for a company that didn't offer insurance and so I didn't have insurance and neither did my family at the time, and we went many years without because we, quite frankly, just couldn't afford it.

I just don't make the money and my employer does not make the money to go and get coverage, so I think in the long run that's probably going to be one of your basic reasons why most people do not have health coverage. They just simply can't afford it and they just can't afford to go to the doctor.

Many specified \$100 a month for an individual as the premium they felt they could afford to pay. Affordable, monthly premiums ranged from \$50 per month for an individual to \$600 for an entire family per month. Individuals viewed the money needed to pay for health insurance as money that would otherwise be used to help pay for necessities such as car insurance, food for their children, or rent.

My income borders just a little bit above qualifying for public assistance, which means I can't qualify to get public assistance so I'm looking at very limited possibility and absolutely no deductible ... so I'm looking like at \$50 to \$100 a month I could probably — I could cancel the car insurance and that would be great. ... And while I wouldn't mind paying something because I don't think it should be for free, I can't begin to pay \$350 a month for insurance. I mean, that's half my rent. ... Yeah, and so I have very small amount that I could pay. I mean, that could be the tank of gas and a gallon of milk for my kids right there.

I can tell you what we're paying now is \$201.50 a month for our ... it's similar to major medical and pays with a \$1,000 deductible per incident, not per year so if we had six incidents within one year, we have to pay \$1,000 for each incident and it's only emergency room and hospital. Anything that happens in the doctor's office is not covered even if it's connected with the incident. ... As far as what we could afford? I wouldn't want to pay more than \$400, and I think \$400 would be stretching our budget.

We have three in our household and it's \$100 a person is what I figured up I could afford—\$300 a month, so \$100 a person.

Some participants suggested using a sliding-fee scale or percentage of household income on which to base the premium. Individuals thought insurance companies could set premiums like sliding-scale clinics set their fees. However, some found even sliding-scale clinic fees failed to take into account a person's expenses, resulting in charges that were still too high. Another suggestion was to base premiums on 10% to 20% of net monthly income, up to a maximum of \$150 a month.

It would be good if they would do it like that clinic that looks at how many members in the family and evaluates how much you made during the year. We feel that would help us; that they would take into account our income. Because sometimes the prices go to a level of income that one does not have and then that's where it hurts.

Some participants were willing to pay more for “full coverage.” When discussing the amount participants were able to afford and willing to pay, individuals spoke about benefits like dental and vision plans and prescription coverage as added items that would

make the health insurance “full coverage.” Some participants said they would be willing to pay more to get these services.

I would pay \$150 just for me, but I tell you that my base is, I think, living proof—your basic six months dental, X-ray, your one pair of glasses a year including exam, and I’m talking about paying 100 percent and your basic annual checkup; but I also want a mammogram and my pap included in there because those are the only things that I really worry about right now, and I’d do medications at 50 percent. Anything that I wanted above that, then I’d be willing to pay more, a percentage higher, like \$200, or whatever. It’s just what I’m already used to.

If dental (included) I would be willing to pay more because I just paid \$600 for one son.

WHY DO UNINSURED INDIVIDUALS AND FAMILIES NOT PARTICIPATE IN PUBLIC PROGRAMS FOR WHICH THEY ARE ELIGIBLE?

- People don’t participate because they don’t have specific information about the programs.
- Individuals try to participate in public programs but some are confusing, and purchasing a plan from Alaska Comprehensive Health Insurance Association (ACHIA) is expensive.
- Denali KidCare helps many families which otherwise could not afford health care.
- Income eligibility makes it difficult for people whose income fluctuates.
- People get divorced or sell possessions to remain eligible because otherwise they could not afford health insurance.

People don’t participate because they don’t have specific information about the programs. Participants in both the homeless group and the Spanish-speaking group thought Medicaid was only for women and children. Some thought that Medicaid covered a woman during pregnancy but ended once the woman delivered her baby. However, people did appreciate being able to qualify for Medicaid when they didn’t earn very much money. There were concerns that it did not cover people who were not U.S. citizens, and participants debated how long a foreign-born child had to live in Alaska before being eligible for Denali KidCare.

Medicaid’s for women and children. You can’t get on that ... Medicaid you got to have children.

Yes, sometimes it is good. When one’s earnings are low, it covers you, but when one earns more, then it does not cover you. But when there’s no work it covers you.

I used it and it covered all my pregnancy.

Me, too; but there is a problem; if you are not a resident, you do not get it.

It’s good but they only give it to us when we are pregnant and not after. ... They cut you off. And then you cannot tie your tubes. ... But you can apply to Denali KidCare for your children. They do give it to the children, but not to you.

We all are paying taxes whether or not you are a resident.

I wish that ... it would be fair, that they would give it to people with or without a worker's permit, residents, for all, not just because they are citizens. Well, that it had a requirement, that it be fair, that's what I wish.

Are you paying taxes and working here for the benefit of the nation? So then if your child was born in another country he or she does not qualify for Denali KidCare.

I have a child that was not born here. Two years ago after being here for 5 [years] they gave it to him for 6 months and then took him off. Now that he has been here 7 years they have given it back to him.

We also have a lot of people who come looking for services through us but their health insurance won't pay ... I have had a lot of ignorant, unthinking people say, well you know, if you just get on Medicaid then you don't have to worry about it ... that's what they say was oh well, you can get on Medicaid and then his hospital bills will be covered and you can get a personal-care attendant to come in ...

People try to participate in public programs but some are confusing, and purchasing a plan from ACHIA is expensive. People are eligible and enroll in ACHIA, Medicaid, and Denali KidCare. Of the few participants enrolled in ACHIA, one had problems with the application paperwork, and another said the health condition that caused her to apply to ACHIA was deemed a pre-existing condition and would not be covered for the first six months she was enrolled.

Nobody will touch me with a 10-foot pole except for ACHIA. ... It's the high-risk pool that Alaska has and they will cover me for \$1,700 a month, and it will not cover heart for six months. I said, forget it. I'll just play Russian roulette and go without insurance because I'm not paying \$1,700 a month when it won't even cover heart.

They [ACHIA] are giving me some paperwork eligibility trouble so I don't even know if I have that yet.

Denali KidCare helps many families that otherwise could not afford health care. Parents were eager to express their desire to continue this program. Many shared stories of how beneficial the program has been for their children. Some spoke of the life-saving treatment their children received—treatment they might not have sought if they hadn't had Denali KidCare. Others spoke of routine treatment that has been a blessing.

When Denali KidCare first came into existence, it was a Godsend to us. My husband jumped on it immediately and all of my children. We were struggling extremely hard because my youngest one would start crying for no reason. It was his teeth and we had gotten him in to a dentist. He was a friend of ours and we were able to pay, you know, so much. At the time, my husband was working, but it was a total Godsend for Denali KidCare, you know, for us. Otherwise, my children would not have gotten the excellent care that they needed. I mean, I still have two children that do have Denali KidCare and it's wonderful. It's blessed us. I had a son several years ago that had complaining about his stomach. I touched it and he went through the roof. I called up my other son's pediatrician and he took him in. He was at 4:00 or 5:00 that evening into surgery. If we wouldn't have had Denali KidCare, I don't know where we'd be now.

Preventive care is what is needed. My son had [a] need for surgery because of an illness. I pushed for more help from the doctor because we had Denali KidCare to use for health care. The doctor caught the condition; it would have affected his kidneys; we never would have had the surgery without Denali KidCare. Because of Denali KidCare we pushed to get a diagnosis.

Income eligibility requirements make it difficult for people whose income fluctuates.

The seasonal nature of some occupations in Alaska created difficulties for respondents around the state. Parents talked about how difficult it was when their income rose and their children were dropped from the program. Participants suggested that Denali KidCare introduce a sliding scale so families could pay a fee to keep their children enrolled if income exceeds the guidelines.²⁴

I've checked into Denali KidCare before and we don't qualify for that, and then because our income fluctuates so much with the fishing industry, we can never tell how much you're going to make.

We've been on Denali KidCare before, but now we make too much, \$700 over, to qualify. ... Make it a sliding fee. Make it a percentage range—if they make more, then they pay a percentage. For example, if you make \$5,000 you're no longer eligible because the cut-off is \$3,000. So continue to cover them by charging a percentage for the amount over the qualifying amount. Do not cut them off completely.

But with work here in Kodiak being there one day and not the next, thank God they keep paying for the appointments.

People get divorced or sell possessions to remain eligible because otherwise they could not afford health insurance. A couple of families offered stories about how they are changing their assets and household composition to qualify for public assistance with health care. One family is selling a recreation vehicle which will allow one family member who has cancer to qualify for a public program. In another family the couple is divorcing so that a medically needy spouse can qualify for Medicaid and their child can receive Denali KidCare.

We've never been married. We've been engaged for 16 years. It turns out, that is a fabulous benefit. The state has agreed we co-own all our assets but the cars are exempt and the house is exempt because those are needed. We have an R.V. that we're in the process of selling and once that is sold and the money is put towards bills, then [name] will...I won't qualify but we are two separate families so [name] is going to qualify for Medicaid it looks like.

We have to get divorced because it does not matter if I work eight hours a day making minimum wage job. I will still be over the income level in order to provide health care. We can't be together. We can't have a relationship. So that has to be the most ridiculous, stupidest thing I have ever heard of is to force people to get divorced in

²⁴ Health insurance representatives spoke about Denali KidCare. Some thought people pulled their kids out of their private insurance plan and found a way to qualify for Denali KidCare even though “they’re nowhere near being qualified.” Another health insurance representative said he didn’t see this “gaming” but did see people try to get their kids on Denali KidCare because their employer’s insurance plan did not provide adequate coverage.

order to get health coverage covered by the State. We can't even live together. Now at the time I don't know who was supposed to help him get in and out of the car and all that stuff. Generally, you would think your spouse would do that but I couldn't be there and live there because if the social worker came over and caught me there, you'd lose benefits.

WHY DO UNINSURED INDIVIDUALS AND FAMILIES DISENROLL FROM PUBLIC PROGRAMS?

- Participants do not disenroll if they are still eligible for the program.

Individuals only leave the programs when they become ineligible. When participants' income rose above the limit that enabled them to participate in the programs, they reported that their incomes had not risen enough to allow them to purchase private insurance or to pay for medical expenses. Seasonal workers in the fishing and construction industries have an especially difficult time maintaining eligibility because of the fluctuations in their incomes. The paperwork involved in applying and reapplying was overwhelming to many participants and they didn't reapply.

WHY DO INDIVIDUALS AND FAMILIES NOT PARTICIPATE IN EMPLOYER-SPONSORED COVERAGE FOR WHICH THEY ARE ELIGIBLE?

- Employer-sponsored coverage is too expensive.
- The cost of employer's coverage keeps increasing.
- Coverage is too limited compared to the cost.

People do not participate in employer-sponsored coverage because it is too expensive. Not only is it expensive, but the costs of coverage keep increasing and the coverage is decreasing.²⁵ Both full-time and part-time employees are opting out of employer-sponsored coverage because of the high costs. Some people observed that they began with employer plans that were pretty good; however, that changed as employees were required to contribute to plans, the deductible grew, and coverage lessened. Employer-sponsored coverage is also becoming more expensive for spouses and children of those employed, causing some families to have insurance for only the employed member of the family.

I work for a [business] here in Anchorage and when I first started working there, about eight years ago, it was just like an automatic thing when you were employed and you got insurance and all of that and just automatically got it. Last year they started charging us a premium for our insurance, and this year the premium went up and we had an option whether to have a high deductible and all of that so it's definitely becoming more and more expensive and getting less services for the insurance that we have.

...I work at [a business]. I'm a part-time employee there and I don't have insurance because I can't afford it because it was going to be a whole paycheck if I get

²⁵ Many people, especially seasonal workers, could not get insurance at their business because they did not work enough hours or for long enough periods of time. Often people felt that employers provided job opportunities that specifically would not qualify the worker for employer-sponsored coverage.

insurance and I had a [medical procedure] two years ago and I'm still paying for that.

In my case my husband has insurance, but for me to be able to enroll in the coverage we have to pay \$300 monthly. And maybe that is what he gets in his paycheck; so then it's of no value.

For a short time the insurance that my husband had we also covered myself and kids, but the price just kept going up and up and up and we couldn't afford it so since I've been here we haven't had it.

The plans that they give you don't really include anything. They're high deductible and it's really no more than catastrophic coverage.

Ten dollars and \$12 an hour—people cannot afford to spend 30 percent of their income on their insurance, especially when that insurance doesn't cover this, that, and the other thing.

DO WORKERS WANT THEIR EMPLOYERS TO PLAY A ROLE IN PROVIDING INSURANCE OR WOULD SOME OTHER METHOD BE PREFERABLE?

We asked participants who they felt should be responsible for providing health insurance. They responded with the following:

- Federal government should have a role in providing health insurance or some type of national health-care program.
- State government should provide health insurance or mandate employers to provide health insurance.
- Government programs like the State Children's Health Insurance Program (SCHIP), Denali KidCare, should be expanded to the general population.
- About one-third of respondents did not think employers should provide health insurance, but other participants did think employers had a responsibility to provide coverage.
- No matter which entity provides health insurance, nearly all participants believed that individuals are responsible for their own health-care needs.

Federal government should have a role in providing health insurance or some type of national health-care program. Because of the enormity of the issue, participants felt that the federal government should be responsible for health care. They pointed to national health-care systems like those in Canada, New Zealand, Mexico, and Australia as plans that might work in the United States. While participants said this was what they wanted, their interest was based on stories they had heard, rather than actual knowledge of how these systems work. Also, nearly all participants believed that individuals had a responsibility to make a contribution to their own health-care plan.

I think there should be a national health insurance policy and plan. Individuals need to make some kind of contribution whether it be some sort of a co-pay so that the system isn't abused, but then there also needs to be a component that somehow rewards people who make healthy choices...

In Mexico there are free government institutions. There are hospitals and clinics where they provide help to people with fewer resources.

I think there ought to be some sort of national healthcare like in other countries. I mean, you pay into it. Your whole productive life you have paid taxes and into health-care programs wherever you worked, and it's just...right now it's a hodgepodge.

I would like to see us go to socialized medicine, where the federal government...so nobody's denied medial care. I really would.

Isn't that the government's responsibility? I think the federal government.

I think it's got to come from the feds. I think they are the ones that are going to have to fix this problem because we've got a huge problem with the insurance companies, and they have a lot of power. It's going to have to take somebody who's pretty powerful and more powerful than the State of Alaska.

I believe the government has a responsibility on the basis of what we pay as far as our taxes and the fact that I am a citizen of the United States of America, and I believe there needs to be a basic floor, just like was established with Social Security in order to give people an opportunity to take good care of themselves.

State government should provide health insurance or mandate employers to provide health insurance. Some participants felt that the state had the infrastructure and knowledge to provide health insurance, yet others felt the state should mandate employers to provide health insurance. A few participants mentioned Hawaii as a state that required employers to provide health insurance.

I think it should be like Hawaii's. I think it should be state-mandated—that when you're employed as a full-time employee because you're benefiting your employer if they decide to use you full-time.

And it all depends on how educated an individual is and whether they have a job or not, so those who aren't able to have jobs, I think it would be better if it was under the state.

So just make it that if you're a full-time employee, your employer pays a minimum of this...Because it is working really well in Hawaii. You don't hear any bad things about there, and if you're indigent—and I'm not even sure what exactly indigent means—because I've been laid off here before and have just unemployment which isn't a whole lot, and if that makes me indigent, I don't see why I couldn't go to social services like you do in Hawaii.

Government programs like State Children's Health Insurance Program (SCHIP)—Denali KidCare—could be expanded. Participants spoke about health care being the responsibility of “government”—not specifying federal, state, or local—rather than businesses. Businesses should provide coverage if they can, but “government” should provide a safety net for those people who cannot get health insurance through an employer. One participant used SCHIP as an example of the type of program provided by a combination of federal and state resources.

I believe everybody has a right to adequate healthcare. I think that because you do have the SCHIP program in place, you have that money—and it is federal and it is

state. It comes from state revenues. I think if you rework that plan and you make it so that anybody who does not have health insurance...you have to make the employers accountable and say, if you can afford it, you have to carry it. But if you cannot afford it, for people who have small businesses where they cannot get health insurance at a reasonable rate, then I think those people should be able to apply for health care. I think if you have a catastrophic illness and you have a spouse who makes too much money or you own too many assets of what have you, I don't think you should be penalized. I think you should be able to be a part of that program. I think if you do get health insurance, but you have a pre-existing condition and they say okay, but you're not covered for a full year, that you should be able to apply to that program to receive health care so that your health does not deteriorate while you are waiting for that health-care insurance to kick in.

It doesn't seem to me that providing health insurance is an inherent function of an employer. It makes more sense to me that that would be something government should work for and should provide but really, I'm going to take it one step beyond. I think, sort of philosophically speaking, who should be responsible for health care is individuals.

About one-third of respondents did not think employers should provide health insurance, but other participants did think employers had a responsibility to provide coverage. Many participants were sympathetic to how expensive it was for businesses to provide health insurance to their workers, but many still believed employers had a responsibility to provide plans to their employees. Participants looked for benefits when applying for jobs; they considered benefits part of their pay. And, again, participants voiced their opinions that individuals must not solely rely upon employers, but should take responsibility for their own health care.

If it's a big company, I would expect to have coverage. That would be one of my questions at the time of my hiring interview—what kind of insurance we have and what kind of benefits.

It should be mandatory for employers to provide it. ... Are you asking whose responsibility it is to provide or whose responsibility it is to get the medical insurance? I mean, if it's provided, then it's the person themselves, but if it's a question of whether they have access to it or not, then it would be the employer.

I think there's got to be some...it would be great for employers to have to provide it, but we have all these small businesses that it would cripple. I know our council—just in what they're paying for workers' compensation—it just blows my mind, and it would put them out of business if they had to provide health coverage for their employees.

I think the employer should have the opportunity to have that choice.

It comes out of your pay. If your employer is paying your insurance, that's not a donation. That's part of your pay. Benefits are part of your pay when they calculate it.

I expect if I'm going to work for an employer, I'm going to get medical coverage and it's going to come out of my pay and that's the only reason I'd ever go to work for anybody.

Individuals are responsible for their own health-care needs. Whether they believed that government—federal, state, or a combination—or employers should provide health-care insurance, the bottom line for people in nearly every focus group was that individuals were responsible for their own health care. Often, this meant that individuals should be required to pay something for their care. In some cases it also meant that they should be responsible for finding insurance or health care that they could afford. “Nobody owes us healthcare,” one participant said. There was no sense of entitlement. However, one person suggested that health-insurance companies should be responsible for making their policies affordable. Participants did not want to be taken care of by the government; they wanted to be responsible for themselves.

I'm saying it's ultimately the individual's responsibility—not an inherent responsibility certainly of the employers and not necessarily an inherent responsibility of government.

Some sort of a sliding scale, but people do need to contribute to it on their own and take some responsibility for their own health coverage.

... responsible for their own care because we are responsible for ourselves. I mean, that's like making the government take care of you. ...But it should be, but if you can't do it, then somebody should be able to help you. But other than that, I think it should be your responsibility to take care of yourself. It's like taking care of yourself pretty much.

Well, you have to seek insurance companies or someone that will take you on board. That way, you'll be secure and know that you have some kind of insurance. It's up to you as an individual.

I think ultimately you're responsible for insurance yourself to a certain age.

I think it should be everybody's own responsibility.

We are responsible. Nobody owes us healthcare.... Yeah, I don't think any of us want a free ride; we just want to be able to breathe. I think that I am responsible to pay for my own health care.

No one is responsible for anybody. I'm not responsible for anyone but me and, therefore, it's my responsibility to have health insurance. If I can't afford it, I don't get it. ... Being self-employed, were any of the insurance plans out there even halfway affordable, I'd have it; but they're way out of sight.

Obviously the insurance companies...I mean, I kind of agree with what he is saying down here. I mean, the insurance companies need to find some way to make it more accessible for people who can't afford insurance. So I guess you could probably say [that] if we have to pick, the buck stops here; I guess I'm going to go with the insurance companies and, second, the government; third, the doctors; and, fourth, me, myself, and I.

HOW LIKELY ARE INDIVIDUALS TO BE INFLUENCED BY AVAILABILITY OF SUBSIDIES AND/OR TAX CREDITS OR OTHER INCENTIVES?

- Concepts of subsidies and incentives were too vague for almost all individuals to offer a response.
- Using the example of the Earned Income Tax Credit, participants were supportive of a tax credit but were concerned that a tax credit would not benefit those who do not pay taxes; that it would only help those in certain income brackets; and that the benefits would not be spread out over the year.

Using the example of the Earned Income Tax Credit, participants were supportive of a tax credit, but were concerned that a tax credit would not benefit those who do not pay taxes; that it would only help those in certain income brackets; and that the benefits would not be spread out over the year. Participants did not initially understand what a tax credit was or how it might work. After holding a few focus groups where respondents could not answer the question, the Earned Income Tax Credit was used as an example of how a tax credit might work. While they were supportive, they felt that a once-a-year tax credit wasn't sufficient because medical payments are on-going throughout the year. There were also worries that the tax credit could be taken away at some future time.

Of course, that's a great idea.

Well, if it's like the earned income, I'm all for it because I mean, then you can plan for it. You can put a little bit out of each month if you know you're going to have that and if they're going to have that program every year, but then the same thing is what if you're doing it for five or ten years and all of a sudden they just up and say, well, you know, "we're not going to have this program no more."

Okay, that makes a lot of sense if you're a taxpayer, but over the last few years, I have not made anything so I have not paid taxes since 2002. ... I have been pretty much unemployed for the most part, other than occasional casual day labor and food stamps. And, like I said, I've applied and reapplied for SSI ... and always got an unfavorable ... so I do not pay any taxes because I'm not making anything. So see, I'm kind of like out of the loop there...it wouldn't mean diddly.

If you do that, you have to make sure that you are not penalizing the people who are in that middle-income bracket and who make too much to get any kind of assistance, but don't have enough to pay for their own health coverage.

Therein lies the problem [it's a once-a-year tax credit]—You still have to make those payments.

WHAT OTHER BARRIERS, BESIDES AFFORDABILITY, PREVENT THE PURCHASE OF HEALTH INSURANCE?

- Pre-existing medical conditions.
- Being self-employed or in a business with a small number of employees makes it difficult to get group insurance rates.

Participants who had pre-existing medical conditions or prior illnesses found it difficult, if not impossible, to get health insurance. Being pregnant, diabetic, or having had a heart attack made it nearly impossible for participants to obtain health insurance. And if insurance was obtained, it excluded treatment for any of the pre-existing conditions. Some people found that they couldn't switch plans because of a pre-existing condition.

If you've had allergies, that's out. If you've had anything, and in my particular case with the heart attack, they don't know why I had it. They'd always said you're not in [a] high risk pool. I didn't need a stent. My veins were wide open. The best they can come up with is I had coronary artery spasm and all the literature says they don't know what causes coronary spasms. My cholesterol and all those numbers are fine but then once you've had something, they won't touch you even though you're perfectly healthy. It's tough.

If one insurance company drops you for an illness, it's virtually impossible to get insurance from another company because then it's pre-existing.

Well, my first wife was pregnant at that time so we were in the ...with the pre-existing condition you couldn't have bought insurance at any price, so we were just dumped—no warning. You know, we have to give them six months notice via the pre-existing condition, but they don't have to give us six months notice so that we can have continuing coverage.

We applied for another kind of health care and they accepted me, but they refused my husband because they said he was 10 pounds overweight. And they said, why don't you go on this temporary insurance for six months and lose the weight and reapply; and in hindsight, that's what we [should have done]. I should have gone on it anyway and he should have taken the temporary. But anyway we took the temporary, and it went into effect September the 1st, and I had a heart attack on September the 5th. And after the six months were up, nobody will touch me with a 10-foot pole.

About two years ago, we checked into some health insurance and found one that we thought we might be able to use, and they phoned me to do a phone interview. They wanted our entire medical history for our entire lives, which I, in my naivety, was honest, and I would be honest again. A child that had tubes put in when he was 18 months old and never took an antibiotic after that— they said they wouldn't insure us and that they would never cover anything ear-related for him. I take thyroid, it's what keeps me healthy. They will never cover anything thyroid-related for me. One child had a skin rash that they got a Hydrocortisone cream prescribed that we probably could have gotten over the counter. They would never cover anything skin-related for that child.

I was very frustrated because we would be the model family for an insurance [company]. We never go to the doctor. We rarely...only if we really have something that we can't handle at home... but they excluded everything that we had ever had done. We had a child that had a concussion because of a bicycle accident, and they excluded everything on him because...and yet, my kids are very healthy, so it's very frustrating.

I would love to use Denali KidCare but with my daughter—she has pre-existing conditions and so she is...I cannot move her forever off of this Blue Cross policy that we have because it's a pre-existing condition, and no one will ever take her. So she's a dependent the rest of her life and she'll have problems you know—10 years down the road and she'll have to be a dependent the rest of her life. But I'm hamstrung so whatever Blue Cross says, I have to jump into the hoops.

Being self-employed or in a business with a small number of employees made it difficult to get group insurance rates. Real estate agents, artists, and attorneys were some examples of self-employed professionals who typically did not have insurance. One self-employed person in real estate pointed out that there is a loophole in the law that prevents “independent contractors” from getting group insurance rates.

Haven't had health insurance since March of 1996 when I quit [a business] to become self-employed, and I looked into health insurance, probably a good two or three years after that, and just made a couple of inquiries and found out it was real expensive and haven't looked into it since.

Yeah, so I'm self-employed and, unfortunately, I'm in the real estate industry and our industry had been fighting with Congress and the insurance companies for years. To collectively have over 1,000,000 realtors out there that should be able to get a group plan you would think, but since we're all independent contractors, that's the loophole in the law.

My employer has never been able to afford health insurance and I've worked for him since 1984.... My employer looked into it one time when it was a bit bigger firm, and they couldn't afford it then. There was no hope of it.

What I work for is a lawyer and they've never been able to afford health insurance.

It's all [that] most small tribes can do to afford workers' compensation insurance. They can't even think of offering health or life insurance.

HOW DO THE UNINSURED GET THEIR MEDICAL NEEDS MET?

- Do not get their needs met.
- Use hospital emergency rooms.
- Search for care they can afford.
- Save for medical costs, pay out of pocket, make payments, and use credit cards.
- Travel outside the state and to other countries.

Some uninsured are not getting their health-care needs met. People treat themselves at home or delay seeking medical treatment because they cannot afford it.

About ten years ago I had [a] gall bladder problem and they said [it] would cost \$12,000 for surgery. I only make about \$800 per month. I started doing something natural and I'm still here; I didn't have surgery.

What if my kid ...I have a child that should have gone to the doctor, and I was very reluctant to take him because I knew as soon as I walked in the door, it's \$100.

Hospital emergency rooms provide quick care and under the law cannot turn people away. However, for those who can pay their bills, emergency-room costs are much higher than costs of a clinic visit for the same ailment.

I go to the emergency room because they give you quick care. I mean, they will bill you. At least you can get seen and see if they'll put you on something else. I mean, I don't pay them because I don't have money, but they still see you because it's the law. They have to see you. ... People don't understand they do have programs to help you; and they say you can't pay your bill but you have to follow-up with them. If you don't fill out the paperwork and get it back to them. If you can't pay it, you can't pay it.

The reason I said that is [that] my son had tonsillitis Christmas Eve, and we did go to the hospital emergency room and the bill was astronomical for what would have been similar care at the ENT doctor. I would attempt to go to a family practice doctor first or a specialist, and if it did require hospital care then you have to go to a hospital. ... there's a lot of shopping around and to walk into the emergency room for even outpatient care is very expensive.

Individuals search for care they can afford. They seek care at clinics with sliding-scale fees, or if they don't qualify for sliding-scale fees, they continue to shop for more affordable care. The process can be intimidating for some and the out-of-pocket costs high.

A lot of the workers I know don't have medical insurance and due to the high cost of purchasing private insurance, they just can't afford it. So I'm glad that they opened up the Kodiak Community Health Center, and they do a sliding fee for people that have [low incomes].

Our family has used the community health center, and we feel that we've gotten excellent care. Because we had four, five, six children, we qualified for the sliding scale....we no longer qualify for the sliding scale so, to my surprise, the last time that I went in, instead of paying about \$40 for a visit, the bill was \$120. ... The difference between those who are getting help and those who are uninsured but don't qualify for help is too large because if you pay right then and there, you get a 20 percent discount, so that made it \$100. That's still ... to go in repeatedly for a condition, impossible. So Dr. ..., bless her heart, she called me with test results, and I said, "you know, we're no longer on the sliding scale," and she said, "I would be happy to do as much as I can over the phone with you," which was wonderful. But what if I need to go to the doctor?

I'd probably go out there to the Cottonwood Clinic because that's where I go now. I'd just as soon see a PA as to go see a doctor because most of them are better quality.

There's a medical clinic in Anchorage that offers a paying scale where I've had dental work done, and it was quite excellent. It's the best dental care I've ever had under those circumstances, and it's in Anchorage and they do offer it on a sliding scale.

I had an incident a few years ago where I had a knee lock up and, not having insurance, I had to go through the phone book and ended up calling several clinics.

One, in particular, would not see me or make the appointment because I did not have insurance. I ended up going to a primary-care place and it was all out of pocket and I'm probably still paying on that. But that's one thing I noticed and it's kind of intimidated me to the point where I don't want to call these places because they're going to deny me because I don't have insurance, and apparently some of these places aren't even taking insurance. I know, I work at a clinic that we do not take Blue Cross, so it's a hit and miss type thing. So I've gotten to the point where I'm careful on ice, and I just limit what I'm doing so that I don't have to go through that.

People save for medical costs, pay out of pocket, make payments, and use credit cards. Rather than buy insurance, one participant invested the money and used it when needed for health-care costs. Many others arranged to make payments over time; still others charged medical expenses to their credit cards.

And we checked about 14 years ago for the whole family and that would just cover catastrophic, and it was about, at that time, about \$14,000 a year. We thought we can take that money and reinvest it and live a healthy lifestyle, preventative medicine already, so that kind of has been the way we've worked. Never once have we ever come even remotely close in the year...one year, that was with the pregnancy, a broken collarbone, and one child who had a hernia—and that was like a \$10,000 year for us for health care out of pocket.

Just about two weeks ago, I was with a friend who has three children who just had their teeth taken care of, and they were offered something called—I think it was called smile care—and what it was ... you're allowed to pay the price of your visits off over the next 18 months, and I said, "Well 18 months, you're supposed to see a dentist more than every 18 months, so you're not even going to be done paying for this by the time you have to see the dentist again." It doesn't make any sense to me, but people are really desperate. We want to take care of our kids' teeth. You know, I don't want to be a negligent mom, and dentists will tell you to come in every six months.

When my husband was going through his chemo, each treatment is like \$1,500 or \$1,600. When we first went in there, we told them we do not have insurance. They [asked] how much can you afford to pay? We gave them a monthly figure. In the time that it took us to pay the bill, which was long after he was clear, they never once charged us interest, and they chose somebody every year ... they would put a name in a hat of their people, and they would forgive your final bill. We had \$2,000 left to go, and we were chosen and they forgave us.

... and in collection you have to pay it all at once because there they do not allow installments. ...And with interest.

The dentist [name], they let you make payments, but when you go in for, let's say a tooth extraction or something, that's cash on the money. I mean, you got to pay then unless you got ... I mean, I was in there one day and I tried to work out a plan and it blew me away. She says, no it was 700 bucks to get a tooth pulled, and I gave her my credit card, and I said, "can I make two payments with the credit card. I'll give you the credit card number and run it and give me a month." No, got to have it today.

No, they ask you for a credit card, and they take a little bit out each month. I've been paying for three years now.

My husband had a \$3,700 doctor bill in January. He has an appointment for a specialist later in February, but I don't know how I'll pay. I used my credit card for prescriptions and other expenses. Just one week ago, I borrowed \$4,000.

People travel outside the state and the country to get health-care services that they feel are as good as those in Alaska and a lot cheaper. Participants from Kodiak and Kenai, in particular, traveled or planned travel outside the state and the United States for health services. Many people combined visiting relatives or taking a vacation with getting medical treatment.

Trips outside Alaska for health care

We did use a dentist in town here this past year. Our 17-year-old wasn't able to go with us [on the most recent trip outside] and we were really very surprised at how high the dental was. I mean, to have three fillings and have his teeth cleaned and X-rays done was very surprisingly high. We've confirmed our decision to go outside as much as we can and have it done.

My husband recently got a knee replaced in September. He had a general run-through the system check-up done at Stanford when he was down there with friends, and that's in San Francisco. To get that knee replaced, he got an estimate of costs of \$90,000. Ninety thousand dollars to get that knee replaced and he was going to have arthroscopic work done on his other knee. Well, he got it done at Scott and White University Hospital in Temple, Texas, for \$35,000. End of subject, period, paid for lock, stock, and barrel; and he got some of the best care in the nation for a third of what Stanford charged. You have to be a shopper for medical care as well.

California—the surgery was probably half or a third of what it would have been here.

We go outside for dental care and optical care. That's bad for Alaska's economy, but we can use frequent-flyer miles and go to Arizona and save money by doing it that way.

For dental and vision you save it until it's vacation time.... I had a root canal and crown down below and it was \$1,500. It was \$2,500 when I had it here, so that's less than airfare and the whole thing.

I've been to Virginia for dental work many times. I always go there to the dentist that my parents go to because it's so much less expensive than here ... It costs a little less than half usually for a regular dentist visit and cleaning and whatnot.

We go back to Arizona, where we lived prior to moving here, for dental and optical ...for the most part our entire family goes within every two years—year and a half to two years.

Trips outside the country for health care

A lot of the people I know that work in the cannery goes to the Philippines for a vacation and then that's where they do their dental.... Check-ups. When I was 13 years old, I had to fly to the Philippines just to get my teeth pulled. My parents didn't have any insurance so...It was cheaper ... And for a visit.

I have gotten my teeth done in El Salvador.

I know fisherman that tell me that they go to Mexico. They go to the Philippines to get their work done. They schedule a vacation to get their dental work done. Some other ones that are on a lot of medications and they said twice a year they go to Canada to buy their meds. And it's like, doesn't anybody see that there's something wrong there. It's unbelievable to me. Scary.

Our long-term plan is we have major medical in our company, and we're headed to Thailand as soon as one of us gets sick. We watched that "60 Minutes" program a while back and a lot of Americans are doing it. I just talked to a guy the other night that got \$10,000 worth of work done over there that would have cost \$100,000 over in America, and they're U.S trained doctors and nice hospitals. I'm not going to play the game that they're playing here and just keep paying the money for nothing. I feel I'm pretty healthy, and if I have something major medical happen to me, I'm out of the United States headed to Thailand. I do guided tours all summer and I get people from all over the world. We have the worst health-care system of everybody. Australia—theirs is rated tops [among the nations]. So is New Zealand. America is way behind the curve, and we're getting further and further behind all the time. It's just getting crazy here.

I know two people that just this winter went to Thailand for cancer check-ups—you know, the scoping and everything. They said it was like taking a trip to down in the States as far as the money, you know, \$1,000 versus up here you're looking at \$20,000 or \$25,000.

If I get sick, I go to Russia; if I need surgery, I go to Russia. The surgery and medicine cost \$2,000 there; here in the United States it's \$30,000, sometimes more. Once before I had to go to Russia because they—the doctors—told me I had cancer. I went to Russia for treatment and came back and was told that I did not have cancer anymore....

WHAT ARE THE FEATURES OF AN ADEQUATE, BAREBONES BENEFITS PACKAGE?

- Routine annual exams and preventive care
- Maintenance care for chronic conditions
- Prescriptions and immunizations
- Dental and eye care
- Catastrophic care
- Additional benefits discussed included the following:
 - emergency services for broken bones or other urgent care needs
 - ambulance
 - prenatal care and delivery
 - transportation to doctor appointments
 - extended care and assisted living
 - holistic, alternative health care such as chiropractic, dietetic, and herbal
 - lab tests, X-rays and procedures such as colonoscopy

Routine annual exams by a doctor, preventive care, and maintenance care for chronic conditions. Participants were keenly interested in having access to preventive care. There was a strong sentiment that routine exams would allow them to identify conditions before they became severe or required extensive medical procedures. Well-doctor checkups that provided basic services for pap smears, male checkups, and shots for their children were very important. One participant also talked about monitoring chronic ailments, like diabetes, and doing routine checkups to catch complications before they worsened.

More prophylactic, well- doctor checks, and the pap, and pelvic, and the male check-ups. The how are the kids growing, the shots, and the things they don't get at school. Preventative medicine. Yeah, and then there's the URIs—the regular doctor visits would be in that category.

And even though I do not work outside of my home, I do have my sons and husband who work, but do not have insurance. And yes, it is very necessary at least for check-ups; truly, at times it is better to have check-ups for prevention rather than wait until something is well advanced.

Check-ups.

But when you're talking about a basic plan and you want preventative, a lot of times those go hand-in-hand because what they're going to do—a smart company and a smart program and a smart program that you're in—see you can get all kinds of medical...is the reason they'll do preventative is because they want you in every six months to check your teeth so that you don't end up with these expensive procedures and root canals and those kinds of things. Same thing with eyes. They don't want you to come in there when you have a cataract so bad that the procedure—instead of them doing preventative six months earlier which would have cost \$500—is now going to be \$20,000 because they have to do surgery and all that kind of stuff. So all of that should be under a basic preventative and a whole package deal.

Maintenance and prevention.

And one of the things you should have on there, that should be in all health insurance and it's not—and a lot of them are very reluctant to do it—any diabetic is supposed to have their eyes checked yearly by a medical association ... and a lot of insurance don't want to go that route.

Well, good, like we all see how expensive medicines are and consultations that for just the little while you go there, they give you a great bill and one does not have with what to pay; and necessary that it be for all that is important.

Prescriptions and immunizations closely followed preventive and maintenance care in the order of importance in a barebones insurance plan.

Well, under medications you most certainly want to include immunizations. That's the most cost-effective way of dealing with disease right there.

Dental and eye care were frequently requested by participants.

Basic dental and regular check-ups.

Catastrophic care that included hospitalization and surgery were important.

Catastrophic is what I think is the most importantly one.

Additional benefits discussed included emergency services; ambulance services; prenatal care and delivery; transportation to doctor appointments; extended care and assisted living; holistic, alternative health care such as chiropractic, dietetic, and herbal; and lab tests, X-rays, and procedures such as colonoscopy. Many of the alternative treatments discussed were to provide preventive treatment, a theme that ran through this discussion.

I would include in holistic maybe some non-traditional preventative treatments such as dietitians or people who can help identify what you're doing wrong that might cause long-term complications so that you can be proactive in it...

I work with a lot of seniors, and just getting rides for them back and forth to the hospitals and stuff, I don't see how they do it. I would say rides or some kind of a taxi service or something...

HOW SHOULD “UNDERINSURED” BE DEFINED? HOW MANY OF THOSE DEFINED AS “INSURED” ARE UNDERINSURED?

There is no one definition for what it means to be “underinsured.” The State Health Access Data Assistance Center (SHADAC) identifies three approaches to determine whether a person’s health care is adequate.²⁶ The first approach looks at a family’s ability to pay out of pocket for health-care needs, premiums, and deductibles and how these costs impact the family income. A second approach looks at the adequacy of coverage and how well it protects the health-care needs of the insured. The third approach involves the perceptions of those covered by insurance—Do they feel their needs are being met or unmet?

The overwhelming majority of participants are “underinsured” by these standards. They spoke about their insurance using all three of these measures.

Many felt that that the amount they paid out of pocket was very high and that they still did not receive adequate coverage. A catastrophic illness could send them into bankruptcy or divorce, and premiums were the cost of a house payment.

We are a family of four and we could not pay for health insurance. That is the reason; there is no other. Now, that we make the effort to try to pay for health insurance, it is ironic... Not too long ago we had to visit the doctor; it was not an emergency, but it was a whole lot of money. Our insurance is fighting this. It does not cover you; that is what I want to say. The cost is a lot but if you want to have insurance with ample coverage, you have to pay much more. Then it's the same; because it does not cover the dentist or the eye doctor; it does not cover... Basically it is for emergencies only.

Yeah, it's more than a house payment. Besides, my husband is paying almost \$600 a month just for himself, and if you added that to mine, forget it. So that's my story.

²⁶ For a complete copy of the SHDAC article “Measuring the Adequacy of Coverage or Underinsurance,” see Appendix I.

Well, in one of my situations, I had taken out catastrophic insurance just on myself because I couldn't get it on my husband. I started out—it was about \$146 a month. I was told at the time that it wouldn't go up and this is what it will be. Well, when I finally ended up dropping them, it was almost \$400 a month for just myself, and I had had nothing in between. Every year it just kept going up.

When I worked in [a business] full-time I had to pay a premium of \$107 per month. When I went part-time, they started taking out double that amount, and then to have to go on and pay the \$200 deductible. I ended up basically working for the premium. I began to look at it—am I working for the health insurance premium?

We were paying \$14,000 a year for our family, so I switched to an HSA program so it's a lower premium with a high deductible. I have a medically fragile daughter so we spend a lot of money for her insurance, so we end up spending that anyway but there's some tax benefits. I'm glad I have insurance because of my daughter and other incidents that may come up, but I feel trapped in spending a huge percentage of our money for this, and I would like to see some changes in the industry itself.

Yes, well annually, yes, that's our... okay, \$5,000 deductible and so we never meet our deductible. It's costly per month and whatever doctor's appointments we have, we pay out of our pocket, so only twice have we used the major medical. I had knee surgery and then my husband had an accident and fell.... So those are the only two times that we've ever used it, so anyhow I feel like we're paying out a lot of money for very—for nothing really unless something happens. I've looked into other options.

When my husband was diagnosed with cancer, we went to a lawyer to see what legally could be done to save something that we had because we knew there would be huge bills coming. He said well you have a few options. You can get divorced or you can declare bankruptcy or you can lose everything you have and pay the bills. And I don't know, none of those were options.

Participants were unhappy with how they were dealt with by insurance companies; they were not getting the coverage they thought they had paid for; and they had to spend more money than they could afford to get their health-care needs met.

Participants spoke about added costs of access to health care—they had to pay too much money to get to Anchorage to see a doctor. These were costs that their health insurance did not cover. Participants spoke of insurance not covering dental or eye care. Programs like Medicaid and Denali KidCare had restrictions that greatly impacted some people.

My husband and I did have insurance and he was doing some hooking up of a gas line and slipped off the wrench and hurt his arm—thought he might have broke his wrist or something. So we called to check and see if that would be covered, and we were told that that sounded more like it was an illness and not an accident. So we said what are we paying for this for? Because then we just wanted a basic plan that if you broke an arm or if you broke a leg or something like that, it would be covered and that's what we had at the time. Well, then we cancelled that. About six months or a year maybe after that, he was diagnosed with cancer. So after all of those bills, we sold everything to pay for everything because we didn't have it. We managed to get all that paid and started over. So now it's, well, once you've got the big C letter over your head. Now we get a quote for us to get a catastrophic policy and it's anywhere

from \$700 to \$1,200 a month, and he's been cancer free now for nine-and-one-half years. But we're still dealing with the big cancer.

I have a problem with getting in and out of Anchorage for regular checkups or to see a specialist. Over the years there's a couple of times when I had to go in for a knee operation or another operation. I had to borrow money to go to Anchorage because they couldn't cover the transportation part of it. It's very expensive for each trip. I had to borrow like \$600 just for the airfare this way and back.

But it's the same with the pre-existing clause. You're paying ... for that 12 to 18 months—you're paying the premium but you better not be seen by a doctor or a hospital for that condition. You will pay out of pocket.

I started out with \$146 a month catastrophic. I was up to \$300 and something a month. I got kicked by a horse and went into the emergency room and my bill ended up being \$4,995. I was \$5 shy, but it didn't make any difference so that was my \$5,000 catastrophic. At that time because I had internal bleeding they had to do a C.T. Scan and they found I had a gallstone, so my physician said that this would probably be a good time to get it taken care of. Never knew I had one before. He said that it's normally like a \$5,000 to \$10,000 surgery. He got a hold of the insurance company and they said, oh no, that's pre-existing; we wouldn't cover that. So seeing the \$5,000 had went out of my pocket, I had been paying them \$300 and something a month. After discussing it with them—I just can't believe it, and I had had them at that time for roughly three years.

There are a lot of what seems like a lot of little escape clauses in every insurance policy. They say, oh yeah, you have medical coverage and then about 30 pages into the fine print, you find out that, oh, your health coverage only covers certain little things but they don't pay for like any kind of assistive equipment or any braces or...

People who have this supposed wonderful Medicare system that is supposed to be this insurance policy for their health and their medication and doctor visits—hospital visits, all of that. A lot of the time they buy into this and they think, oh great, everything's going to be covered. But then when they have to go to the hospital, then that's when they find out that there are so many days that Medicare will cover, and there are only so many procedures that Medicare will cover; and you have to choose a policy or a program that Medicare will pay for and you have to choose a provider that Medicare will pay for. If you have a doctor who is not on their preferred-provider list, then you have to pay that.

I don't have seven grand. Denali KidCare does not cover it, even though it is a medical condition, but because her face is not totally distorted, they...now they do cover it in Florida. If we lived in Florida they would have covered it. But they don't cover it up here. So she has headaches and constantly has a jaw moving. I'm sorry, that's basically it.

FOCUS GROUPS FOR ALASKA NATIVES

Alaska Natives took part in three focus groups—two in Anchorage and one in Kodiak. Alaska’s Department of Health and Social Services (DHSS) wanted researchers from the Institute of Social and Economic Research (ISER) to explore Alaska Natives’ perceptions of access to health care and private insurance.

METHODOLOGY AND PROCEDURES FOR FOCUS GROUPS WITH ALASKA NATIVES

Recruitment

Again, DHSS provided contacts for recruiting individual participants for the focus groups. The organizer of a statewide conference, attended by Alaska Natives, did the entire recruitment for two groups held in Anchorage. Because these participants came from villages across the state, they presented varying perspectives and experiences.²⁷ In Kodiak a tribally managed health-care facility provided ISER with names and contact numbers of potential participants.

Demographic Questionnaire

ISER revised the format of the demographic questionnaire that had been created for individuals by selecting questions appropriate to this group of participants. Participants completed this demographic questionnaire.

ISER attempted to recruit a minimum of 12 individuals for each focus group with the expectation that no fewer than six would attend. In one instance, two attended; at another group for Alaska Natives, 22 attended.²⁸

Employment and Insurance Questionnaire

All participants completed a brief questionnaire prior to the start of the focus group. DHSS and ISER staff jointly developed the content of this questionnaire, dividing it into two series of questions—one for participants currently covered by any type of health plan or insurance and one for those who were not. Those who were currently covered by any type of health insurance responded to questions about plan benefits and sources of insurance. They also were asked about the importance of insurance to the household and the risk of losing coverage within the next 12 months. Those participants who did not have health insurance answered questions regarding past coverage, current eligibility to enroll in an employer-sponsored health plan, and reasons why they do not have insurance. All participants were asked a series of questions about employment status for themselves and, as applicable, their spouses. This included the type of job, hours worked per week, industry, number of people employed by the business or company, and employment permanence. Participants were also asked about enrollment in public programs.²⁹

²⁷ Table 10 in Appendix J includes information on the number of calls and people contacted to recruit participants for each focus group. Detailed information on recruitment for each group is in Appendix A.

²⁸ Table 2 in Appendix J includes information on the number of people who completed the demographic questionnaire. Table 10 in Appendix J includes the number of people called and scheduled as well as those who attended each focus group.

²⁹ A copy of the Employment and Insurance Questionnaire is in Appendix F.

Discussion Guides³⁰

A discussion guide is an aid for the facilitator to make certain that all topics are discussed in each group. The discussion guides began with an introduction to the statewide project, ISER, and the purpose of the focus group. During this introduction, facilitators instructed participants on how focus groups work and what to expect in a focus group. They invited participants to ask questions about the process and also advised them that they could choose not to answer any questions. Confidentiality was explained and all participants and researchers agreed to abide by it. Participants read and signed consent forms agreeing to participate in the group.³¹

Questions in the discussion guide for Alaska Natives took into account that Alaska Natives receive medical services through the Indian Health Service (IHS), provided via tribally managed health-care facilities. Since IHS facility locations are limited in Alaska and throughout the nation, DHSS wanted ISER to explore perceptions of access to health care and private insurance.

Institutional Review Board

All research at the University of Alaska Anchorage (UAA) that includes people is reviewed by the Institutional Review Board (IRB). The IRB's main role is to ensure that the research fulfills the requirements of federal regulations that protect human volunteers in research. ISER submitted necessary information to the IRB which determined that the necessary safeguards were in place, and ISER received approval to proceed.

Special Consideration

ISER facilitators did their best to ensure that there weren't any distractions while the group was underway. All focus groups used three people—a facilitator, an assistant to take notes, and a third person to check people in and out of the group and to document the distribution of questionnaires and the participant supports.³²

Data Analysis

ISER made audio and digital recordings of each focus group and transcribed those recordings at a later time. An assistant facilitator made written notes while the group was underway; those notes were used to clarify potential confusion in the transcripts. ISER staff developed coding categories based on responses to the questions asked during the focus groups, and the three transcriptions were coded by two ISER researchers. Verbal responses to the questions were organized into systematic categories or codes using the Atlas Ti software for qualitative analysis. We used SPSS for the quantitative analysis of the demographic and employment questionnaires.

³⁰We reviewed discussion guides from other states' reports located on the State Health Access Data Assistance Center (SHADAC) Web site. We developed questions for the discussion guides by using the questions provided by DHSS. These questions are in Appendix B. A copy of the discussion guide used in the Alaska Native focus groups is in Appendix C.

³¹ See Appendix F for copies of the consent forms.

³² Participant supports were 300-minute calling cards which were distributed to participants at the conclusion of the groups.

ALASKA NATIVE FOCUS GROUPS COMPOSITION

Demographics

Thirty-one people participated in the three Alaska Native focus groups. Of the 31 participants, 25 completed the modified demographic questionnaire, two of whom identified themselves as White and the remaining 23 as Alaska Native or American Indian.³³ Eighty-four percent (n=21) were female, and 16% (n=4) were male. Thirty-six percent (n=9) were 51-to-60-years old and 28% (n=7) were between 41 and 50 years old.³⁴ A little over half—52% (n=13)—were married. The remaining 12 were single, including two divorced and two widowed individuals.³⁵ Thirty-six percent (n=9) of the 25 were high-school graduates or had a GED. An equal number had some college. Three participants had less than a high-school education, as did three who had bachelor degrees. One participant had an advanced degree.³⁶

Findings from Insurance and Employment Questionnaire³⁷

All 31 participants completed the Insurance and Employment Questionnaire. We learned from this questionnaire that of the 31 participants, 39% (n=12) were covered by some type of insurance or health plan.

Findings from those with private insurance

Six of the twelve who had private insurance thought that their spouses could be added to their plan, and seven thought their children could be added. Eleven of those with health insurance had a dental plan; ten had vision services; nine had prescription coverage; seven had preventative health services; and six included mental-health services.

All of the people with insurance thought it was important for them and their households; most of them rated it “very important.” Two participants thought that they, or someone in their household, might lose their health insurance because of increasing costs, possible job relocation, or an employer cutting back on benefits.

Findings from those without private insurance

Of the 31 participants, 61% (n=19) did not have health insurance. Of these, 13 were employed but only two were eligible to enroll in the employers’ health-insurance plans. Six of the 13 participants’ employers did not offer health insurance. Other reasons for not being enrolled in an employer’s health-insurance program included not having worked long enough on the job to qualify for health insurance, not working enough hours to qualify, and self-employment.

Seven of the participants had some type of health-insurance coverage for at least six months during the preceding twelve months. These plans included insurance through their employer, insurance through a spouse’s employer, Medicare, Medicaid, Sears Roebuck, and Workmen’s Compensation.

³³ See Table 12 in Appendix J.

³⁴ See Tables 11 and 16 in Appendix J.

³⁵ See Table 15 in Appendix J.

³⁶ See Table 17 in Appendix J.

³⁷ A copy of the Insurance and Employment Questionnaire is in Appendix F. Responses to all the questions are in Appendix G.

The reason most of the 19 workers said they were not insured was because they could not afford to buy insurance. A majority of the 19 responding to the questionnaire stated that someone else helped to pay for their medical bills when they went to the hospital or to a doctor. Most often that was the Indian Health Service.

Employment findings

Of the 31 participants, 77% (n=24) were employed, and most of those worked for a nonprofit organization (n=13).

Nineteen percent (n=6) of the people participating in the Alaska Native focus groups were unemployed. Reasons for unemployment included disabilities, retirement, and lack of jobs in the community. These unemployed were receiving public assistance that included Temporary Assistance to Needy Families, Public Housing Subsidies, Social Security Income, Social Security Disability, Unemployment Insurance, and Disability retirement.

FINDINGS FROM ALASKA NATIVE FOCUS GROUPS

Eligible Alaska Natives and American Indians are entitled to medical care through the Indian Health Service (IHS). Alaska Natives discussed their access to health care through IHS facilities located in different communities across the state. They also discussed health services they received through public programs and private insurance that supplement IHS, and they talked about the following issues:

- Medical problems can lead to use of public programs for which people didn't know they were eligible.
- Lack of information about programs and requirements can be personally expensive.
- Travel to receive care at a larger facility can be costly.
- Quality of services received varies because of high staff turnover.
- Waiting time to obtain appointments and to receive services can be lengthy.
- Some services are not offered through IHS.
- Some Alaska Natives had private insurance.
- Non-Natives in communities where there were only tribally managed medical facilities had to go outside their communities for treatment and medication.

Medical problems can lead to use of public programs for which people didn't know they were eligible.

Then for those who can't afford health insurance, they'll [ANMC] help them to either apply for Medicaid, Denali KidCare, or any services provided by Public Assistance. They'll have them go there [Public Assistance] so that they can take care of whatever; for the most part of the health payment they're needing to pay for, they want some other program to help pay for it besides IHS.

But then I think most hospitals nowadays have a care coordinator where they have the applications right there. ... they just call up Public Assistance and see if they meet the guidelines.

They ask you first what kind of ... you have Medicaid or Medicare ... so they take that out before they, you know, they go through that. If you don't have any, then they just help you.

Lack of information about programs and requirements can be personally expensive.

For in-state treatment at non-IHS facilities, pre-authorization is required before IHS will pay the bills. When traveling outside Alaska, participants said that they would seek care at the nearest hospital and show their BIA card or tribal enrollment verification. Some get a letter from Alaska Native Medical Center (ANMC) so that they can be reimbursed for medical expenses while traveling.

But they...all the villages come here if the...from each village if they need to be seen by a doctor. They have health people that go to training for health services and they send them in and then KANA...the doctor sees them here and then if they need additional help they go to Anchorage. They get sent up to Anchorage.

It happened to me before and I had to pay \$700 and some-odd bill by myself because I didn't go through the proper steps. It was before I knew, but if you go through the proper steps and you're covered by IHS then they pay all your bills but it has ... you have to make sure you let them know that you're KANA and call the on-call doctor and things like that; but I didn't know that so I ended up having to pay a steep bill.

If you have a really bad health problem, the doctors have to sign a referral.

We'd have to go to the nearest hospital and have our insurance pay for it, if we have insurance, and then the remainder we'd have to take care of it or, like [a name] said, bring along our BIA card and give those cards to the billing place at that hospital and have them get a hold of the IHS somehow.

...tribal verification enrollment form and they would probably bill IHS.

When I travel, if I'm going to be any length of time, I get a letter from the hospital—ANMC—and then I can be reimbursed if I do have a medical need when I'm traveling or if there is services wherever I am, but other than that ...

Travel to receive care at a larger facility can be costly. Often people traveled to Anchorage or to other large communities for regular checkups, oral surgery, or specialty treatments that weren't available in smaller communities. Transportation was very expensive and sometimes not covered by IHS. Even when it was covered, the funds weren't always available prior to travel. This made it difficult for some people. Not only the transportation costs were high but also the cost of time away from work and personal responsibilities. These costs prevented some from getting care.

I have a problem with getting in and out of Anchorage for regular checkups or to see a specialist. Over the years there's a couple of times when I had to go in for a knee operation or another operation; I had to borrow money to go to Anchorage because they couldn't cover the transportation part of it. It's very expensive for each trip. I had to borrow like \$600 just for the airfare this way and back.

Well, part of that is you're not just going to an appointment. You still have bills to pay at home, and you're losing time from work; and if you have young children, you have to find a way to accommodate. So it's more of the incidentals of just the basic transportation is an issue.

When the airfare to the hospital gets too expensive, they won't go. Because they don't have any money to pay for their airfare to go into the hospital to get their medical needs taken care of, so they just stay home.

I think it depends on the situation. I know I just had—they did a biopsy on my prostate and it wound up my prostate was larger than it should be, so I wound up having a catheter and there went two months of, you know, just worst two months of my life. I wound up going to Anchorage twice throughout that ordeal and that was because they wanted to—if they were going to operate on me, they wanted to do it there.

But they'll send you to Anchorage for oral surgery if you need that. If you have impacted molars or wisdom teeth, then they'll ship you up to Anchorage if they can't do it here.

Even without IHS services, insurance coverage of transportation issues is very difficult. I just had to spend nine months in Anchorage for medical treatment because my insurance would only cover one round trip per calendar year, and the treatment I needed was not available in [community]. So the transportation issue was a big deal. I try to coordinate medical appointments around business trips.

Quality of services received varies because of high staff turnover. Alaska Natives felt that the turnover of medical staff in the IHS clinics affected the quality of services they received. Some found they had to explain chronic ailments over and over again to new doctors who seemed to change every week.

Yeah, because unfortunately my mom's tribe has a really high rate of diabetes so, automatically, "are you diabetic?" And it's like, why don't you read my file and I'll come back next week when you've briefed my history because I don't want to have to parrot my information to you again and, literally, I'll just say, "I'll cancel my appointment."

It depends on which doctors they bring in over there, too. It really depends on that ...

There's a continual change over of doctors there ...so you can't have someone that follows you right through your life really. I mean, that would be ideal. I mean, I don't know that that could happen here because, since I've been here the 20 years, there's just been multiple doctors ...And some are better than others.

That's the problem down at [regional clinic], you know—sick with one doctor and they got somebody else in there and you got to see whoever that's going to be.

Yeah, that happens a lot ... I say that happens a lot in any corporation, you know—[regional clinic] you get a different doctor every week.

Waiting time to obtain appointments and to receive services can be lengthy.

Participants were afraid that medical conditions would worsen while they waited months for an appointment. They were frustrated by the inconvenience of being sent to Anchorage for services when treatment was available closer to their home. One family's

solution was to use IHS for emergencies and to use the spouse's private insurance to see a local medical provider in a timely manner. Participants suggested that IHS contract for medical services in locations where there weren't any IHS facilities. One participant who lived near Alaska Native Medical Center still found it difficult to get timely treatment and, when she did get treatment, she felt it was inadequate. She had to complain at length and threaten to go for a second opinion before doctors would order the procedure that turned out to be necessary. She spent six months in pain, unable to work, waiting for treatment, and wondering whether free treatment was worth it.

Plus the deal with like IHS, you have to wait when your medical problems should be fixed now. They make you wait sometimes six months to a year for an opening if they're on IHS and that's a big problem—the wait.

Another thing that I found out, I guess, with IHS is that they do have contracted services. So a lot of times I ask them, "Why are you sending me to Anchorage when Ketchikan has that service available? Why can't you contract those services to minimize expenses?" I tell them I have a relative in Ketchikan I could stay with who actually lives walking distance from the hospital for ... because most of the medical services are in real close proximity ... and it's like well no, we have these services available in Anchorage or Sitka and I go, but I need those services now. The services you're wanting to provide is three or four months away and that's where we, at least my family, only utilize IHS for emergencies and then, like I said, with my wife's insurance we have, there's another provider in the community that we see on a regular basis.

One of the things that I find with IHS—and I feel bad because living right here in Anchorage it's easy access and all of that—but here the Native hospital and Southcentral Foundation seem to be run like an HMO and they have their protocols to get to. It doesn't matter what. My sister had an injury to her knee on July 4th, and they finally did an MRI after she threatened to go for a second opinion, and it was like six months down the road. They didn't even take an X-ray or anything. They were just like—we're going to treat this conservatively and didn't really know what they were treating. She begged for X-rays and all of that and they're like, well, it won't change our opinion. Well, when she threatened to go for a second opinion, then they said well we'll do an MRI before you leave. They found all kinds of issues and now they're saying, "Oh, you need a full knee replacement." Well, she went through six months of pain, not working, and all that. It created havoc in her life, and so if you're having free care but it's not good care, is it really worth it.

Some services are not offered through IHS. Not every medical, dental, or vision treatment was covered. Participants felt that IHS just covered basic needs and emergencies.

And there are certain things that they don't pay for. They have a list out at KANA in the office; when you go to the examining room, there's a paper there that states which services they will not pay for ...

Anything that's not really an emergency and that if it's ... I mean, they won't do any like extra things at all. I mean, it has to be very basic needs.

We were just thinking of some of the things that weren't covered—like a crown; if you needed a crown and dental work, that's not covered—they'll do fillings and certain things.

... cosmetic things like partials and crowns, braces, what else. [aren't provided by IHS].

But they'll send you to Anchorage for oral surgery if you need that. If you have impacted molars or wisdom teeth, then they'll ship you up to Anchorage if they can't do it here.

Some Alaska Natives had private insurance. Some participants received insurance through their jobs. This insurance gave them the flexibility to find a private doctor or a second opinion. Some weighed whether to pay for insurance offered at work because they had access to IHS facilities. And sometimes employers did not offer coverage because they knew their employee had IHS.

When I was employed two years ago, I did, yeah. They paid for the majority of everything—dental, medical, vision, and retirement. Yeah, so the job I did have, they paid for pretty much everything, besides my Indian Health coverage. ... Well, in my case, when I worked full-time at my job, having that extra insurance for me—because I preferred to get another opinion or I'd rather go to a different, private doctor—so I would use my insurance, and if I really had to, then I would go to KANA because I had excellent medical insurance.

The last time I was working steady here in Kodiak, they had insurance; but they didn't really offer it to me because I had KANA.

I have private insurance, but it's almost not worth paying the ... however much I pay each pay period ... to have it because I can go to KANA, you know? I've thought about discontinuing it. So it works that way, too—I pay about ... I don't even know, but like \$60 or \$70 a month or each pay period which is twice a month for my insurance, and I honestly don't even know what it covers because, like I said, I have KANA. But if people have to pay ... and so when I go to the doctor, I don't have to pay a co-pay or so much percent or whatever because I've got KANA. But if you have to pay that much money on top of paying your insurance, I wouldn't even want insurance. I mean, it's too bad for the people that can't go to KANA because they don't have it or people that can't go see a doctor because they don't have proper insurance.

I think extra [private health insurance] would help because like one of the other people was saying, you know, like in my case, I did want a second opinion. From my previous employer, I had insurance through them and was up at ANMC, and we were going around in circles and taking too long to do stuff for my feet. So I got on the phone and made an appointment at two other hospitals for a second opinion.

Some employers do not offer private insurance to Alaska Natives because they assume the Alaska Natives are covered through IHS.

But, you know, I think if they find out that you have KANA and go through KANA, they think no, I don't need to do that so they won't. They won't provide health insurance.

Non-Natives in communities where there were only tribally managed medical facilities had to go outside their communities for treatment and medication. In many rural areas, IHS facilities are the only facilities offering health care. IHS facilities would not fill prescriptions written by non-IHS providers.

I am not eligible for IHS-funded services, but the only medical [care] available in [community] is an IHS facility, which I access when I have to. Normally, I would come to Anchorage, but that costs a lot of money to do that.

One other issue is for anyone, whether they're an IHS beneficiary or not. If the only medical treatment available in the near vicinity is IHS, my non-IHS doctors cannot write me a prescription that I can get filled at an IHS facility. They will only take prescriptions from their providers and their employees, and that's not negotiable and you can't work something out.

METHODOLOGY AND PROCEDURES FOR FOCUS GROUPS FOR SMALL-BUSINESS EMPLOYERS AND HEALTH-INSURANCE REPRESENTATIVES

RECRUITMENT

Small-business employers

The Institute of Social and Economic Research (ISER) used flyers, announcements on the radio, announcements at Chambers of Commerce and business luncheons, and ads in local newspapers to recruit small-business employers. ISER obtained a toll-free telephone number so employers could call to learn more about the project. Also, Alaska's Department of Health and Social Services (DHSS) provided ISER with a list of local contacts in different communities for recruitment. One of these contacts advised ISER to use the local Chamber of Commerce directories to locate potential participants. ISER researchers estimated the number of calls needed to obtain the desired number of participants. They used a random-number chart to identify a starting number in the directories and then calculated an interval used to generate a list of potential participants. The demographic questionnaire determined who met the criteria for participation.

Health-insurance representatives

To recruit the health-insurance representatives for focus group participation, researchers used the list of insurance agencies in the Anchorage Chamber of Commerce directory as well as the Anchorage Communication Systems telephone directory. This group took longer to recruit than the small-business employers because it was necessary to screen out insurance agencies that did not offer health insurance products. In addition to directory lists, ISER staff also made an announcement at one of the monthly Health Underwriters' Association meetings and arranged for an announcement at a Premera Blue Cross brokers' meeting.³⁸

SCREENING AND SELECTION WITH DEMOGRAPHIC QUESTIONNAIRE

In developing a demographic questionnaire for recruiting participants, ISER researchers took advantage of reports from other states located on the State Health Access Data Assistance Center (SHADAC) Web site and reviewed several models for demographic questionnaires. They then chose questions that were appropriate to identify and select the target populations identified in the scope of work.³⁹

Small-business employers

Participants had to be between 18 and 64 years of age and work in a company that made its health insurance decisions locally. The company had to employ between 2 and 50 employees and had to, at the very least, consider offering health insurance to its employees. Excluded were people younger than 18 and older than 64; those with a family or household member who worked for an advertising, public relations, or market-research firm, for a health-insurance company or any type of health-care company, or for DHSS;

³⁸ Detailed information on recruitment is printed in Appendix A.

³⁹ A copy of the Demographic Questionnaire for Small Business-Employers and Health-Insurance Representatives is in Appendix D.

those who had participated in a focus group in the past six months; or those who were not willing to share their opinions on health insurance.

Health-insurance representatives

Health-insurance representatives had to be sellers or brokers offering health-insurance products for two or more years to companies operating in Alaska. They also had to work with small businesses that had 2 to 50 employees.

ISER attempted to recruit a minimum of 12 individuals for each focus group with the expectation that no fewer than six would attend the group. However, in two instances fewer than six people attended. The Kenai small-business employer group and the health-insurance representative group had five participants in each. One day prior to each group, ISER staff made confirmation and reminder calls to each scheduled participant.⁴⁰

HEALTH-INSURANCE QUESTIONNAIRE

Employers completed a brief insurance questionnaire prior to the start of the focus group. Staff from DHSS and ISER jointly developed the content of the questionnaire. The questionnaire was divided into two series of questions—one for employers who currently offered health insurance and the other for those who did not. Those participants who currently offered insurance answered questions about when their plan refused coverage, waiting periods, coverage for spouses and children of employees, percentage of premium paid by employer, which groups of employees are offered insurance, type of plan, and changes that have occurred in the health plan in the last year. For those companies that did not offer insurance, we asked why employers may not offer health-care coverage to their employees; if the company was currently trying to find ways to offer health insurance to its employees; the likelihood that different incentives make it easier for companies to offer health insurance; and what their perception was on varied health-insurance-related statements. All participants were asked about the percentage of health-insurance premiums that should be paid by the worker and by the employer. (Health-insurance representatives were not given this questionnaire.)

DISCUSSION GUIDE⁴¹

A discussion guide is an aid for the facilitator to make certain that all topics are discussed in each group. The discussion guides begin with an introduction to the project, ISER, and the purpose of the focus group. During this introduction, the facilitator instructed participants about how focus groups work and what to expect during the session and invited them to ask questions about the process. The facilitator advised participants that they could choose not to answer any questions. Confidentiality was explained and all participants and researchers agreed to abide by it. Participants read and signed consent forms agreeing to participate in the group.

⁴⁰ Table 27 in Appendix J includes information on the number of small businesses screened and scheduled as well as how many attended each focus group.

⁴¹ Copies of each discussion guide are in Appendix C. Again, we took advantage of the other state reports located on the State Health Access Data Assistance Center (SHADAC) Web site and reviewed several prior models for discussion guides. ISER used the questions outlined in the Scope of Work and those later provided by DHSS to develop questions in the discussion guide. These questions are in the Appendix B.

Two discussion guides were developed—one for small-business employers and the other for health-insurance representatives. The questions in the discussion guide for health-insurance representatives were drafted to address them as sellers and brokers of health insurance, rather than as employers potentially purchasing a health-insurance plan for themselves and their employees.

INSTITUTIONAL REVIEW BOARD

All research at the University of Alaska Anchorage (UAA) that includes people is reviewed by the Institutional Review Board (IRB). The IRB's main role is to ensure that the research fulfills the requirements of federal regulations that protect human volunteers in research. ISER submitted necessary information to the IRB which determined that the necessary safeguards were in place and ISER received approval to proceed.

SPECIAL CONSIDERATION

ISER facilitators did their best to ensure that there weren't distractions while the group was underway. All focus groups used three people—a facilitator, an assistant to take notes, and a third person to check people in and out of the group and to document the distribution of questionnaires and the participant supports.⁴²

DATA ANALYSIS

ISER made audio and digital recordings of each focus group and transcribed those recordings at a later time. An assistant facilitator made written notes while the group was underway; those notes were used to clarify potential confusion in the transcripts. ISER staff developed coding categories based on responses to the questions asked during the focus groups, and the five transcriptions were coded by two ISER researchers. Verbal responses to the questions were organized into systematic categories or codes using the Atlas Ti software for qualitative analysis. We used SPSS for the quantitative analysis of the demographic and employment questionnaires.

⁴² Participant supports were 300-minute calling cards which were distributed to participants at the conclusion of the groups.

FOCUS GROUP COMPOSITION FOR SMALL-BUSINESS EMPLOYERS AND HEALTH-INSURANCE REPRESENTATIVES

COMPOSITION OF SMALL-BUSINESS EMPLOYERS FOCUS GROUPS

The state Department of Health and Social Services (DHSS) asked University of Alaska Anchorage's Institute of Social and Economic Research (ISER) to run focus groups with employers in businesses that had fewer than 50 employees. ISER conducted four small-business employer focus groups—one each in Anchorage, Palmer (Matanuska- Susitna Borough), Kenai Peninsula, and Kodiak. There were 32 attendees in these groups—representing 31 small businesses.⁴³

The initial contact with participants was by telephone. ISER used the demographic questionnaire to select eligible participants. Of the 31 employers who participated, 29 completed the demographic questionnaire.⁴⁴ The responses of these 29 employers provide the demographic information for the small-business participants.

Number of Participants in Focus Groups for Small-Business Employers Who Completed Demographic Questionnaire by Place of Focus Group

	Number Attending	Of those Attending, Number Who Completed Demographic Questionnaire
Anchorage	8	8
Palmer	9	9
Kodiak	9	7
Kenai	5	5
Total	31	29

INFORMATION FROM DEMOGRAPHIC QUESTIONNAIRE

The small-business employer groups had more women, 59% (n=17), than men, 41% (n=12). The majority of businesses had been in operation more than 10 years.⁴⁵

At the time of the focus groups, 27% (n=8) of the small businesses offered health insurance to their employees. Six of these offered Premera Blue Cross; the other two policies were John Alden and King County of Seattle. Only three businesses that did not currently offer health insurance had offered it in the past.⁴⁶

⁴³ There was one business that had two participants in a focus group.

⁴⁴ Two employers attended the groups without completing the demographic questionnaire.

⁴⁵ See Tables 21 and 22 in Appendix J.

⁴⁶ See Tables 29 and 30 in Appendix J.

When asked if, in the last few years, someone in their company had contacted insurance carriers or brokers to obtain information about providing health insurance to their employees, 67% (n=15)⁴⁷ said they had.

While the state requested businesses to have two to 50 employees, 72% (n=21) had two to ten total employees. Twenty-eight percent (n=8) had 11 to 50 employees. When asked specifically about full-time employees, 79% (n=23) of the small-business participants had one to 10 full-time employees. Most of the small-business employers had employees who were hourly wage earners (n=24) and salaried (n=10).⁴⁸

Participants had varied roles in the decision-making process in selecting health plans for employees. Half (n=15) were the sole decision maker; a third (n=10) were part of the group who made the final decision; and ten percent (n=3) made recommendations to the final decision maker. The remaining two were with businesses that did not currently offer health plans.⁴⁹

SMALL-BUSINESS EMPLOYERS' INSURANCE STATUS IN RESPONSE TO HEALTH INSURANCE QUESTIONNAIRE

Five of the 31 businesses offered flexible spending accounts which allow employees to pay for health and/or dependent-care expenses with pre-tax money. When asked what percentage of a worker's health-insurance premium should be paid by the individual worker and what percentage by the employer, there was a wide distribution in the responses—from 0% (neither individual nor employer should pay) to 100% (individual or employer should pay all).⁵⁰

Of the 31 businesses, eight offered health insurance to their employees. These companies offered health insurance to their employees because their employees expected it, because it rewarded loyalty, and because it was the “right thing to do.” None of the plans refused coverage to any employee with pre-existing health conditions. However, the plans all had waiting periods greater than 30 days—with two plans requiring up to 60 days, four plans up to 90 days, and two plans required more than 90 days—to be eligible.

In six of those plans offered to employees, coverage could be extended to their children; employees could extend coverage to their spouses in seven of the plans. The percentage of the premium paid by the employer for coverage of children and spouses varied.

To the question about which groups of employees are offered health insurance, employers responded: hourly employees, salaried employees, and part-time employees. No business offered health insurance to temporary employees or to seasonal employees.

⁴⁷ See Table 26 in Appendix J. The question was part of the demographic questionnaire. It was not asked of all business participants.

⁴⁸ See Tables 23, 24, and 28 in Appendix J.

⁴⁹ See Table 25 in Appendix J.

⁵⁰ A copy of the insurance questionnaire is printed in Appendix F. Responses to all questions are located in Appendix G.

Of the eight businesses that offered health insurance, seven had a preferred-provider plan. In seven of the eight businesses, the employees had a co-payment when they visited a physician. Most companies did not offer a cafeteria-style health insurance plan or a catastrophic plan. There had been no interruption in health benefits since the companies began sponsoring employee health-care coverage. However, in the past year, half of the companies had an increase in employee costs. And five of the eight employers that offered health insurance had seen their company costs increase.

High costs were predominately the reason that businesses did not offer health insurance. Specifically, those businesses that did not offer health insurance cited the overwhelming reason for not offering health insurance was that premiums were too high and expensive. Following this were that costs of employee health benefits were too difficult to control and that the financial status of the organization prohibited offering health insurance at this time.

Half of those who didn't offer insurance said their company is currently trying to find ways to offer health insurance to their employees. The questionnaire asked about incentives to motivate the companies to offer health insurance. On a scale of "very likely," "somewhat likely," "not at all likely," and "don't know," lower premiums received the most "very likely" responses. Incentives that followed lower premiums were, in order of importance: (1) implementation of a small-business purchasing alliance to get group coverage, (2) elimination of required minimum employee participation, and (3) the ability to offer very basic catastrophic hospital coverage.

From a list of 11 statements about health care, participants most strongly agreed with the statement that hospital bills are inflated to pay for uninsured health care. A close second was that providing health insurance to more Alaska residents would make financial sense overall. The statement they mostly strongly disagreed with was that providing health insurance to more Alaskans is an employer responsibility.

COMPOSITION OF HEALTH-INSURANCE REPRESENTATIVES FOCUS GROUP

DHSS requested a health-insurance representative focus group to gain insight into the health-insurance representatives' unique perception as sellers of health-insurance products to small-business employers. All five participants in the health insurance focus group completed the demographic questionnaire described in the methodology. All participants represented or sold health plans to Alaska small-business employers. Three of the participants were male and two were female.

More than fifty percent of their health-insurance business is to small-business employers with two to 50 employees. Participants also sold to businesses of varying size, including those with more than 100 employees.⁵¹

Four of the five participants had been representing or selling health-care plans to Alaskan employers for more than 15 years; one had been selling health plans between two and five years.⁵²

⁵¹ See Tables 16 and 17 in Appendix J.

⁵² See Table 18 and 19 in Appendix J.

Among the top 20-ranked insurance companies writing health insurance in Alaska—based on the 2005 Alaska accident and health market share of direct premiums written—I SER asked these health-insurance representatives which companies their organizations currently represent.⁵³ They responded in ranked order: All of the participants represented health plans from Premera Blue Cross and Principal Life Insurance Company, followed by Aetna (3); Great West (3); Guardian, Lifewise, Metropolitan Life, and Starmark with two each. Other companies included Avemco, Fortis, Hartford, Reliastar, Standard, Symetra, and United.

⁵³ See Alaska Division of Insurance, Alaska life and Health insurance Companies, <http://www.dced.state.ak.us/insurance/consumerinfo.htm> for the list of top 20-ranked insurance companies. Table 20 in Appendix J shows the companies with which health-insurance representatives in the focus groups have worked.

QUESTIONS AND FINDINGS FOR SMALL-BUSINESS EMPLOYERS AND HEALTH-INSURANCE REPRESENTATIVES

Small-business employer and health-insurance representatives were asked the following questions:

- What influences the employer's decision about whether or not to offer coverage?
- What are the primary reasons employers give for electing not to provide coverage?
- How do employers make decisions about the health insurance they will offer to their employees?
- What factors go into their decisions regarding premium contributions, benefits packages, and other features of the coverage?
- What would be the likely response of employers to an economic downturn or continued increases in costs?
- What employer and employee groups are most susceptible to crowd-out?
- How likely are employers who do not offer coverage to be influenced by expansion/development of purchasing alliances, additional tax incentives, and individual employer subsidies?
- What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Focus group responses to these questions are printed on the pages that follow. The small-business employer and health-insurance representatives participated in separate focus groups yet were asked similar questions. Responses of both groups are collected in this section; under each question we distinguish responses of small-business employers from those of the health-insurance representatives with separate headings. We also made an effort to distinguish which bulleted responses are from which group. In some cases they did agree; however, in many cases they had separate points of view on the topics discussed.

WHAT INFLUENCES THE EMPLOYER'S DECISION ABOUT WHETHER OR NOT TO OFFER COVERAGE?

Small-business employers

- It helps to attract and retain employees.
- It is a way to obtain insurance for the owner's family.

Health-insurance representatives

- Employers have a sense of social responsibility to provide coverage.
- Employees are more productive when they have insurance.

Small-business employers said that offering insurance helps businesses attract and retain employees. Employers understood the value of insurance to their employees and even noted that offering health insurance seemed to encourage employees to be healthier. Those who could afford to provide insurance saw that it paid off in terms of holding onto employees. Those who could not afford insurance watched valued employees quit for jobs that did provide insurance. Some employees took jobs that gave them less satisfaction just so they could have benefits.

Small-business employers

Our company was trying to find out different ways that we could offer benefits to the guys that dedicate their lives to our business without having to give tons of it to the IRS. One of the ways was to offer them health insurance as a benefit, so whereby they keep their own money in their pocket and it becomes a benefit to those that stick around ... Yeah, and they feel like they're part of the company when they have something like that ... and in the world of carpenters, they kind of come and go. The ones that stick around—if you can offer them something like that, they feel like they're part of a bigger picture instead of just temporary tool belts and seems to work real good and it's paid off.

Yeah, I'm really tired of training my competitors' people.

And we all do that because we can't afford it, and it's not that we don't want to offer it; it's that we can't afford it.

And they [employees] should take, if the opportunity comes along, where they can get health insurance.

Oh, yeah I hired this one girl and she was phenomenal I had her for about two months and a resume she put in with [a business] came back, and they said “Oh yeah, we have an opening.” I said “you can't afford not to take that position. You've got to go. I mean, say nice things about us when you get over there, but I can't keep you here.” I said, “you're a young woman with a new husband and you're going to have kids, so go to work for these guys.”

Left for a benefits package.

I had two of the very best employees I've ever had who apologized when they were leaving because they liked working for me and they liked doing what they were doing, but they had to go find a job where they had insurance...I know people who have quit jobs that they found interesting and they really loved and went and got a boring office job that they did not like because their family needed health benefits.

Some small-business employers offered insurance through their business as a way to get coverage for themselves and their family members. One participant found getting insurance through their business made it possible to insure a family member who had breast cancer as a pre-existing condition. Another had their kids come to work for them and this was a way to make sure they had insurance.

Small-business employers

We needed it personally for our family because we weren't able to buy good health insurance on our own because of pre-existing conditions like breast cancer.

Also just like ... our family. I mean our oldest kids came back to work for us, and it was a way that everybody could get health insurance because it's a very important thing; and it was a way that we could offer it as a benefit to them.

Health-insurance representatives said that employers are prompted by a sense of social responsibility to provide coverage to their employees. Their employees depended upon them and they wanted to help their employees as much as they could. Since these were small businesses, there was a sense of their being family members.

Health-insurance representatives

I think that there are still a few employers around that believe it's part of their social responsibility.

Health-insurance representatives said that some employers were more aware of lost productivity in the workplace if they did not offer health insurance. This was particularly true of businesses with a greater number of employees and human resource departments that kept track of productivity.

Health-insurance representatives

I guess I would add that if they have a more sophisticated human resources department, they tend to be a little more aware of lost productivity when employees don't seek medical care when they need it.... Generally, if you have a group under 25 [employees], they usually don't have even someone that's dedicated to just HR; and even 25 to 50 [employees], somebody may be called or their title might be HR Manger or HR Director, but they often wear other hats, too.

.....a business case can be made for providing it because you have more productive workers and it's good for your business.

WHAT ARE THE PRIMARY REASONS EMPLOYERS GIVE FOR ELECTING NOT TO PROVIDE COVERAGE?

- Costs are high:
 - Limited number of health insurance companies and policies to choose from in Alaska
 - It is difficult for small businesses to be part of a large group plan
- Employees have coverage from another source.
- A variety of other reasons:
 - Dependence upon commission-based employees
 - Employee turnover, including seasonal and part-time workers
 - Insurance riders for pre-existing conditions discourage coverage

The high cost of health insurance is as big an issue for employers as it is for individuals. The initial cost to purchase a policy is high, and yearly increases make it impossible for most small businesses to offer health insurance to employees. Seasonal businesses find it especially difficult to afford providing health insurance because during the slow parts of the year it's too expensive.

Small business employers

We have nine employees besides my husband and me in our business. We don't provide insurance right now. We have in the past, but we just couldn't afford the premiums.

We don't have health insurance and we have four employees besides ourselves and just haven't been able to find something that we felt we could afford.

I have probably 10 employees now. It's a somewhat seasonal business so it comes and goes. We don't offer health insurance. We're a non-union shop and the issue for us is the expense. That's the main issue.

We have offered it before, but it was too cost prohibitive because we're seasonal, and during the slow parts of the season, it's too expensive. There's two of us full-time and two seasonal.

We have a lot of [military] folks and, of course, they have their own insurance, but I would like to be able to offer it but the affordability just makes it out of reach

Small-business employers have a limited number of health insurance companies offering policies to choose from in Alaska, which means less competition.

Small business employers

I found that there wasn't very many things available to be able to have a good comparison ... a lot of companies don't deal in Alaska or [community].

Employers don't provide coverage because many of their employees have health insurance through other sources such as their spouses, public programs, or the Indian Health Service.

Small business employers

I'm the only full-time employee. I do not have insurance. My husband is a commercial fisherman and he carries insurance on himself. One of my employees is a [military] dependent so she's got insurance that way. One is retired State and she's got insurance that way; and one was Alaska Medicaid.

The hotel has two full-time employees and three part-time employees, and it does not offer insurance. My husband is one of the full-time employees; we have coverage through my work and I have my work because it offers insurance. [Woman participant has second job, in addition to hotel, to have insurance coverage.]

And I get the spouses [of those in the military] ... I don't have one right now but I've had in the past—spouses who will work for me ...

Employers were less likely to offer health insurance to certain types of employees such as real estate agents and other employees who work for a commission.

Commission-based employees are often considered “self-employed.”

Small-business employers

I'm sure, like many, I kind of fall through the loopholes. When you're commission-based, you're considered self-employed; so some of our agents would like to have insurance but they're kind of on their own for that. We've looked into group plans

three different times for our company in the last five years and when we started, and each time the cost had me turning gray.

Employers who experienced high employee turnover, a high percentage of part-time workers, or seasonal workers often did not offer health insurance.

Small-business employers

...we see a lot of turnover in my industry, not agent-wise because the agents are on their own; however, the desk person (indiscernible) property management, those types of jobs a lot of times are filled by [military] spouses Every two or three years they're gone....

...because I don't have any money and because my employees don't stick around long enough. They're all high school kids.

One of the issues for me is turnover and managing a serious health plan for employees that might be with you for a couple of months and then are gone. I have a few core employees, but if I'm offering insurance for employees, I need to be offering it for everyone ... I think there's a lot of turnover in this town just in terms of people moving in and out, and so it becomes quite a burdensome process to manage insurance if you have a lot of turnover. And that may be true of some of the rest of the businesses in town as well.

I don't provide health insurance and I have three part-time employees—two are high school girls and the other one is a part-time retired school teacher with a federally employed husband; and I personally have federal retirement insurance, so I don't really need it at this point; however, in the past I have lost employees because I didn't have it...

The addition of riders to health-insurance plans preventing coverage for a myriad of pre-existing conditions has discouraged some employers from offering health insurance.

Small-business employers

And plus the riders that they would put on some of the health issues with some of the people that we had at that time. They gave us quotes with, in my opinion, ridiculous riders waiving certain coverages and bottom line is it's pretty frustrating. So everybody in our office is pretty much on their own.

Health-insurance representatives

And the other thing that's happened is now that... it used to be that you could bring your group into the plan without any underwriting; and in most cases, that has now gone away because of the risk problems.

HOW DO EMPLOYERS MAKE DECISIONS ABOUT THE HEALTH INSURANCE THEY WILL OFFER TO THEIR EMPLOYEES?

Small-business employers and health-insurance representatives

- Employers looked for the most benefits for the least cost.
- Employers solicited input from employees and tried to structure plans to fit the needs of their employees.

Health-insurance representatives found that small-business employers wanted the most comprehensive coverage for the lowest premium, which at least one representative called an “oxymoron.”

Health-insurance representatives

... they're most of the time looking for the most comprehensive coverage they can get for the lowest premium. High benefits, low cost, that's sort of an oxymoron but that's what they say they want.

Employers solicited and used input from their employees to decide whether or not to have a plan. Some employers tried to structure plans to fit the needs of their employees; others put whether or not to have insurance up for a vote.

Small-business employers

We put together a plan and did a proposal to the employees and nobody wanted to participate. So I can imagine the same type of thing happening with somebody who's got a wife who's got a really good plan or a spouse who's got a really good plan—they may not want to [be a] participant, and so I need that flexibility to tailor a program to the business needs of my employees.

We look at it annually. I have clients who are brokers so every year I send out an employee survey and say this is who we got and this is who wants to participate and what do you have and [a broker] calls me back and says, you still can't afford it.

Health-insurance representatives

...I've had employers put it to a vote to select benefits.

And whether that's because of the wage or they think they're invincible or some are even sophisticated enough to know that we have a high-risk pool so that if something happens to them they can get covered but yeah, I think the employer reads their employees. If it's small enough they talk to their employees and figure out what they want and often it's a choice that people make to not have insurance.

...what I see is employers trying to structure to fit the personality of their group. If it's a bunch of 25-year-old guys, they can get by with the \$2,500 deductible with the co-pays. If it's a bunch of people my age, they're probably going to want to go with maybe a lower deductible or add some extra stuff in there like dental and vision, that kind of stuff.

WHAT FACTORS GO INTO EMPLOYERS' DECISIONS REGARDING PREMIUM CONTRIBUTIONS, BENEFITS PACKAGES, AND OTHER FEATURES OF COVERAGE?

Small-business employers

- Does the spouse of an employee have coverage?
- What is the hardship of COBRA coverage after an employee leaves?

Health-insurance representatives

- There is a perception that blue-collar workers would rather have higher wages than health insurance (small-business employers disagreed).
- More stable, permanent, full-time jobs; jobs in a competitive labor market; and jobs in nonprofits frequently had health insurance.
- Seasonal, part-time jobs and those with high turnover were less likely to have coverage.

Small-business employers felt that they would be duplicating coverage by offering insurance when the spouse of an employee already had health-insurance coverage.

Small-business employers

You duplicate coverage. I mean, I look at my guys, and one works for the city and one's go ... they all got health insurance, my three or four main guys that are with me are insured through their wives or spouses or one's part-time at the city and they get free health insurance, so if they need something, you kind of help them out.

Some small-business employers talked about the hardship of having to pay premiums for current staff and the additional premiums for staff who left and elected COBRA coverage.

Small-business employers

One of the drawbacks that we found when we were looking at insurance is if we have people that leave, then we're required to pay a lot of money to keep them insured for a year like through Cobra. So we might have budgeted enough money for eight people to have insurance. Well, two of them leave and then we somehow are going to have to have insurance for 10, because we replace those two and the two that have to be insured for a year is still on us; and so I don't know what we can do about the regulations.

...that was an issue. Even if we found the money for eight people, well, could we have enough money for 16? Because the possibility is we would have to do that for a year, and could we cover it? So it would be a big problem.

Among health-insurance representatives there was the perception that blue-collar workers, when given a choice, would rather have higher wages than health insurance. (Small business employers did not share this sentiment.)

Health insurance representatives

I think sometimes employers take a look at their employee group and, more often in the blue-collar sector, you'll see employees who would rather have a buck an hour more than insurance.

Health-insurance representatives found that more stable, permanent, full-time jobs; those jobs in competitive labor markets; and jobs in nonprofits frequently had health insurance. Interestingly, health-insurance representatives found that nonprofits often had better packages than small for-profit companies because the nonprofits wrote benefits into their grant applications.

Health-insurance representatives

Some industries—like, for example, architects and engineers ... very, very competitive labor market now, and so if you're in that industry and you have even a \$500 deductible, that's considered crappy benefits in that industry. Where, if you're oil-field industry and you have a \$500 or a \$1,000 deductible, that's pretty normal. So there's a lot of difference from industry to industry.

And if you're a nonprofit, the deductible is \$100 ... And we have a lot of small nonprofits in Alaska, and they operate off grants mostly; and every time a grant is obtained, normally a fair level of employee benefits are built into the grant, so you don't see high deductibles very much in the nonprofit community unless it's a struggling nonprofit.... Nonprofits—we got a lot of those in that category, and it amazes me every day when I get another one with [a] phenomenal benefits package, and I've got an employer with 10 or 15 employees that's struggling to put in a \$2,500 deductible claim.

Health-insurance representatives did not expect health insurance to be available in food and service industries where work was seasonal and turnover among employees was high.

Health-insurance representatives

Where they have a more stable, permanent, full-time, year-round workforce ... the ones where it's more difficult for them to afford it is where they're very seasonal or have a lot of part-time employees, which tends to be tourist industries, fast food industries, restaurants—a lot of restaurants and service-industry type of companies—because of the lower wage—tend to be the ones who either don't offer benefits or the benefits are only available to a select group, like the management group and not the wait staff or the housekeeping staff.

WHAT WOULD BE THE LIKELY RESPONSE OF EMPLOYERS TO AN ECONOMIC DOWNTURN OR CONTINUED INCREASES IN COSTS?

Small-business employers

- They would stop offering health insurance.
- They would investigate other options such as rely upon a spouse to go back to work, get health care outside the United States, or look for a new program that might help small businesses.

Health-insurance representatives

- Employers would “buy down,” meaning purchase less expensive plans or increase the deductible, both of which would reduce premiums.

Small-business employers who had been through an economic downturn in the past dropped health insurance because it was too expensive. They would do this again. However, not all companies are equally affected by an economic downturn.

Small-business employers

.... I think from my perspective, it is declining and some people said they used to provide insurance, but they might not be now because of that. I have less employees now than I've ever had actually. And I've been doing this for 24 years. This is not a booming economy.

It's such an up and down, depending on the seasons or depending on if they're from out of state and up here fishing...

I think it's also based on what industry you're talking about it's affecting. Am I affected in real estate? No. I mean, we're busy with ... families moving in or another boat coming in, so it depends on what you're doing as to how you're going to be affected by that.

Small-business employers spoke of a number of other options—Options such as relying upon a spouse to go back to work; getting health care outside the United States; and looking for new programs that aid small businesses, offering a glimpse into the way some small-business employers are thinking.

Small-business employers

Our long-term plan is my wife had a job years ago with the State and she's Tier One. She'll just go back and finish her year and a half she's got left and then retire some way, and we'll rely on that for a long time.

Our long-term plan is we have major medical in our company, and we're headed to Thailand as soon as one of us gets sick.

Well, we're hoping one of these potential programs or studies looking into a group-type health plan that would cover small businesses will take off. I've read that there have been items about that in the last few years. Nothing has come up that we know of yet, but we're always looking for something that would be good coverage but a better buy.

Health-insurance representatives said employers, in times of economic downturn, would “buy down”—meaning purchase less expensive plans or increase the deductible, both of which would reduce premiums.

Health-insurance representatives

Buy-down the medicals; higher deductibles.

I think we're at a point now where we have ... I haven't seen in the past. The last couple of years, the employers are really willing to listen to anything you want to offer up as an idea for them to be able to continue to have good health-care coverage for their employees and just be able to do it and be able to afford it. I think, too—also I mean—I like to make the distinction to my groups but ... and we all know this and so I'm going to sound probably like an idiot saying it—but the cost of health insurance is driven by the cost of health care, and it's a message that we all, I think, try to really drill through to the employees and stuff. If they are over utilizing it, it's just going to cost more and it's not just a realization. I mean, it's everything. There's a lot of really good stuff we have now, but it's expensive. Drugs are expensive. Biotech drugs can be really, really expensive. All the new testing that we have—I mean, all of this stuff is really positive and it's great, but it's really expensive.

WHICH EMPLOYER AND EMPLOYEE GROUPS ARE MOST SUSCEPTIBLE TO CROWD-OUT?

“Crowd-out” was not a term with which the small-business employers or our health-insurance representatives were familiar. We explained that the concept concerns the substitution of public for private health-insurance coverage. The phenomenon arises only if the actions taken—people substituting public for private coverage, or employers changing their insurance offerings because of the availability of public programs—would not have occurred in the absence of the public program. If people would still have become uninsured, even without the public program, then crowd-out was not applicable. Even with this explanation, most people could not describe any specific employer or employee groups that were most susceptible. However, after reviewing the small-business focus group transcriptions, it appears that in Kodiak where there is a fairly high level of government employment, resulting in insurance coverage for spouses, the economic structure of the community may encourage crowd-out.

Health-insurance representatives

I would make a comment that probably you might have that issue a little bit with the Alaska Native Medical Center. When an employer finds out that they've got people who are qualified for those benefits to work for them, they make it pretty clear that they just assumed they weren't going to apply.

HOW LIKELY ARE EMPLOYERS WHO DO NOT OFFER COVERAGE TO BE INFLUENCED BY EXPANSION/DEVELOPMENT OF PURCHASING ALLIANCES, ADDITIONAL TAX INCENTIVES, AND INDIVIDUAL EMPLOYER SUBSIDIES?

Small-business employers discussed purchasing alliances with an eye toward saving money. Health-insurance representatives said the purchasing alliances do not save money and that large and small organizations end up paying nearly the same per person in insurance costs.

Small-business employers found insurance costly even when part of a larger group.

The only way we were able to get good Blue Cross, Premera was by joining the Better Business Bureau about 10 years, maybe 12 years ago because they offered a group plan which, when we started, was a very good deal; and it was shortly after we were turned down for a private plan, but it has become so expensive that it's becoming a burden.

Health-insurance representatives do not think small businesses will save money with alliances.

The only thing I would add to that is, especially among that group of employers, there is a pretty strong ... what I consider to be a misconception about the concept of buying in bulk or large company benefits. Econom[ies of] scale in health insurance and that is really overstated, if you actually look at it. Very large companies spend per-unit cost almost as much as small companies. Now, you have variations depending on if you pick this small group that's had bad claims; sure they pay a lot more than that particular instance. But I think if you broke down the unit cost of health care and health insurance over a population size that's statistically valid, that economy is a scale in health insurance is a misnomer. Big companies can save on certain things but the claims make up most of the cost of the premium, and so when you start looking at economy as a scale you can't really touch the claims because that's directly related to the number of people, so you're really only talking about overhead and some of the fixed costs. But that group, the small employers, they really believe "Hey, if we can band together, this will save us a lot of money."

Health-insurance representatives

I think it's worth pointing out that there's a definite difference between the pooling that is done by insurance companies and the pooling that employers mistakenly believe is going to help them with cost because when you create an association for the purpose of buying insurance, you get differing entities and differing employers with differing levels of claims that are bunched together, and they think that by having these numbers they are really going to get a price break and, as has already been stated, that's probably not going to happen. Generally, what happens within these associations is that the membership of the associations is not structured to balance out among these folks ... is well, really the difference in these claims experiences and what you have is you have people who qualify to become a member of the association and buy insurance who present a higher risk than maybe the rest of that group, and they have an adverse effect on the experience of that group, and what I have seen over the years is that associations that band together and say "we're

going to buy insurance,” they start out fine but over the years as the impact of the unhealthy groups is felt on the overall picture, the rates keep going up. The healthy groups tend to pull out of this association and that leaves a situation where the health of the people who are left is accelerating the rate increases; and I haven’t seen an association yet that really works well, not one that was put together as an association to say “yeah, we’re going to buy insurance.”

Respondent 1: *They can get a better rate on their own and so the association myth—I’ll call it—is unless you’ve got a humongous population of people that are being insured, these associations that are put together, I have not seen one work yet.*

Respondent 2: *I would agree with what he said and, basically, just add that unless the association is set up with everybody on board on the front and understanding that they may pay more in years where they have good claims experience. In other words, they agree up front that they may be subsidizing other members and they’re fine with it, that’s really the only hope you have for really long-term running of an association plan. But what you typically find, as has been said, is every year each group makes its own economic decision about participating in the plan or not and whether or not that’s a good thing for their group. They usually don’t know for sure because association plans wouldn’t want to share the information that, you know, here’s what you paid in and here’s what you cost because that makes that decision all the much easier. But even without the information, the groups tend to think they know what their bills are and the health of their group, and they make an economic decision every year about whether or not they’re going to participate; and what happens is the phenomena that he just described, and it kind of just becomes a death spiral when you have all of the groups that are subsidizing the unhealthy ones leaving. You’re left with nothing but the unhealthy ones, and there’s not enough inflows into the plan to cover the cost of the bad risk.*

One small-business employer voiced opinions on the current tax incentives for health insurance. Another employer commented that he felt additional incentives would be a good way for the federal government to involve itself in encouraging employers to provide health insurance for employees.

I am just going to add that, thank goodness, we’re able to pay for our health care and things under a pre-tax situation. I agree with you though—if there were additional incentives by the federal government to induce businesses to make an incentive with their employees to get health care, and to provide health care would be an excellent way that the federal government could get involved.

Small-business employers were more interested in affordable insurance than in “subsidies” or “tax credits.” One small-business employer did respond that making insurance more affordable, perhaps through subsidies, would help small-business employers.

WHAT OTHER ALTERNATIVES MIGHT BE AVAILABLE TO MOTIVATE EMPLOYERS NOT NOW PROVIDING OR CONTRIBUTING TO COVERAGE?

Small-business employers offered many suggestions as alternatives to motivate them into providing and contributing to health-care coverage, including the following:

- Give employers who provide health-care coverage a break on what they have to pay for workmen's compensation coverage.
- Relax state requirements for what constitutes a group.
- Suggest creative solutions to providing health care for their employees.

Health-insurance representatives spoke about a number of different programs that could motivate employers to provide coverage:

- Change state mandates as to what must be included in policies issued.
- Fund Health Savings Accounts.
- Fund Health Reimbursement Accounts.
- Offer mini-medical plans.
- Educate employees on the costs of unhealthy lifestyle choices.
- Obtain up-front pricing from doctors' offices, hospitals, and clinics to allow people to shop around.

Small-business employers who pay health-care coverage should get a break on what they have to pay for workmen's compensation coverage.

Small-business employers

You know what makes it really hard for our company? I'm not a whiner but we do like to give the guys the insurance and stuff, but then when you give that to them, then you turn around and get socked with the outrageous work-comp insurance, too. It's like you're giving them insurance and then you get just hammered on the work comp. It's like, couldn't they give you a credit if you're providing your guys with some health insurance; couldn't work comp back off? I mean, I know that's not the same but that's like 100 grand a year just for one policy. That's insane ... That would be the one nice thing I would like to see come out of this is if a small business does offer their employees some kind of health plan, it would be nice to at least get some kind of a token pat on the back or something. I mean, I know they're two different policies, but wow.

Small-business employers suggested the state relax underwriting requirements so that more diverse "groups" could be formed.

Small-business employer

Well, I know it would be beneficial from a... from the government's side for them to relax some of the guidelines for underwriting. I think I looked at it one time and one of the rules is you could not put together a trade association with the specific intent of providing an insurance product. It was like, excuse me, how does that make any sense

to anybody. I mean, realistically, you and I could be the members of an association because we both provide a certain service to our customers, and we could go around and sign up and have a little mailbox guy here in town or anybody else who provides those services since we're under the same industry classification; and then we could finally put together a pool through that association that would be big enough to provide some cost benefits, but apparently that's illegal.

Employers created options that included setting aside money for their employee's health-care costs and private agreements with health-care providers. One employer puts aside a set sum of money per employee for health-care costs. The employee brings in receipts and is reimbursed. Another employer is talking with a local dentist about setting up a Health Maintenance Organization-type system for his employees to receive dental care.

Small-business employers

For our employees we put so much money a year into an account that they can use for any medical expense, so I don't know if you'd call that a medical savings account or not. But our agency puts it in, and when you go to the doctor and you have a bill, you bring it to us and from your amount of money that we have allotted for medical—since we don't offer insurance—we will pay those bills out until there's nothing left in your account.

Since I can't cover catastrophic and there's just no way for me to buy the policy, what if I put together, you know, let's say I went out and talked to Dr ... and said "Hey, you know, ... here's what I want to do with my people. I'll put aside some money so that they can come and, if you can give me a discount, I'll send all of my employees to you for cleanings." And then I go get a practitioner and say what you would do for physicals. If I ... negotiate ... and not HMO in that I'm going to go do this regionally or anything else. I was just looking at my little business. If I can't get them catastrophic, maybe I can get them some preventative, and that's specifically what I was targeting is cleanings, physicals, you know, something that I could afford to give them to help them prevent long-term medical expenses.

Health-insurance representatives suggested the State relax what is mandated to be included in insurance policies.

Health insurance representatives

Considering allowing employers to purchase a plan that does not include a lot of the things that are currently mandated benefit offerings under the State of Alaska, and I'm not talking about taking out things like mammograms and those types of preventive screenings. Those are certainly needed, but I think that if you peeled out a lot of things that are currently there, such as chiropractic and mental health and some of those kinds of things that add a significant portion to the cost, that a lot of employers would be able to afford that barebones plan; and those who want to then add those other things back in could do that.

Health Savings Accounts (HSAs) are an option health-insurance representatives think are good ideas but that still have some drawbacks. Employers fund a savings account for their employees or employees fund it themselves and use the money from the

account to pay for health care. The drawbacks are that employers may not want to fully fund the accounts. When employees leave, the account leaves with them.

Health-insurance representatives

I'll tell you from my perspective with HSAs and the small employer. If it's not a group of pretty sophisticated people like attorneys or doctors—a small group of attorneys or doctors or something that have discretionary money themselves—it's difficult for a group of employees. HSAs are all individual little plans and, generally speaking, an employer is not going to put the full funding up front; the biggest issue I personally have with the HSAs in a group setting like that is prescriptions. You can't have co-pays with HSAs, so you have this person who truly thinks it's \$10 a month to pick up their prescription. They stand in line at Carrs, people are behind and they go up and the pharmacist says that'll be \$280. Well, they don't have it in their account and maybe they don't have a credit card. I mean, there's difficulty, but if the employer funds their entire amount up front, that employee leaves the next day and have that in their bank account. Then the new employee that comes in needs to get funded fully, also. So it's a dilemma. Other than the prescription thing, I think it's a great idea. If we could have a prescription phase-out that stuck to the individual over five years or something and start out with a co-pay and then add percentages, then I think they'd be great, but I have difficulty with them.

So they still have to have an FSA to have the advantage that an HSA would have but an employee contributes to. So I'm just saying that the system is somewhat confusing in terms of the financing vehicles we try and introduce consumerism using spending accounts of some sort. They've got differing rules depending on what type of account it is and, if you could pick some of the best aspects of each and just simplify it, that might make things a lot easier.

Right. It gets a lot more complex when you start adding these things in—requires a lot of additional education with the employees.

Health Reimbursement Accounts (HRAs) are similar to HSAs except that the employer owns the account so that when an employee leaves, the money is available to fund the employee's replacement.

Health-insurance representatives

A lot of employers are adopting the health reimbursement accounts, which is a similar concept to the health savings account, but it's different in that the employer typically would own the funds that are being funded and, therefore, they have more discretion over what those funds can be used for, so they could go to a higher deductible; and they say okay, we're going to fund up to \$2,000. You have a \$2,500 deductible. We're going to fund up to \$2,000 of that for you so, in essence, you're going to have a \$500 deductible employee. Or they could say okay, we're going to put this in here and it's available for deductibles and vision so they have more discretion over it, and the employee doesn't get to take those dollars away if he leaves. So the employer's got that pool, if you will, for the new employee to come in. That's where we're seeing a lot more interest in doing something a little bit different.

Mini-medical plans may be confusing to employees. These plans provide select benefits and the employee can choose to add more, but it is not insurance. They offer a specific amount of money for a medical service. For instance, a mini-medical plan will charge an employee \$50 a month and pay \$150 a day of hospital costs. The employee must pay the balance of the medical bill. These plans are most commonly mentioned by seasonal employees.

Health-insurance representatives

. . . mini-med a lot of them are called.

The kind of nice thing about that, too, is if it's a fish-processing plant or one of these industries where they are seasonal, generally these—whatever you want to call them—mini-meds or select benefits, it's like an AFLAC type plan and are portable ...if the employer will generally pay for a core plan and the employee can buy up to a richer plan if they want to or not. If they don't want to, then when they're no longer with that employer they can take it kind of like COBRA, and then they pay for it themselves. But there are some real dangers in that. I mean, it's difficult—I have found that it's difficult—and I have some of these plans ... to communicate to employees that it's not insurance. You are just going to get \$300, but it's going to cost you \$1,500 so there's still going to be the write-off. But often you'll have people who don't speak the language well, and that complicates things; and then you'll have people that maybe aren't of a high education, and that complicates things—and just a variety of reasons and it's not insurance. It's not what you ... it's not insurance. But it's sure better than nothing.

And I think the point that she's making is you're taking a group of people that have had nothing and now they have something, and they think ... the danger is that they now think, they have insurance. "Oh, we have health insurance? Wow, I've never had it. It's great."

Right, so you have to be very careful in how you explain what it is to people so that they understand how it works.

Lifestyle education is the key to reducing costs of insurance according to health-insurance representatives. This includes educating people on the costs of unhealthy lifestyle choices.

Health-insurance representatives

I think we need, first of all, public education on healthy lifestyles. That's number one. We need to cut out these people drifting unnecessarily into diabetes and other conditions that are basically lifestyle casualties, if you will; and another thing we need to educate the public on is perception. As it was just stated, the person going in—if they've got a \$25 co-pay for an office visit, they think that's all that has to be paid. That is the tip of the iceberg, and it is very difficult, and I understand that the providers have difficulty, too, because they don't know what they're going to have to provide, but there is no transparency on the part of most providers letting people know how much it's going to cost for this visit or this procedure, and because people don't know and in a lot of cases people don't have a choice, they need the treatment, and they're going to get it anyway; but if they know that this hospital over here can

do the same thing for a little less or that doctor will do something for a little less, that would be fine. But, unfortunately, there's no price list that people can go to.

Up-front pricing from doctor's offices and hospitals would help people choose the least expensive care.

Health-insurance representatives

If you've got the codes, you can call two or three doctor's offices and see what they charge for that basic code. But I challenge you to call the hospital and get any clue ...what that might cost. They have no idea.

CONCLUSION

Too expensive. That virtually summarizes what individual Alaskans and of small business employers told University of Alaska Anchorage's Institute of Social and Economic Research (ISER) about why they don't have health insurance themselves or don't offer it to their employees.

Of 89 individual Alaskans who attended focus groups in Anchorage, Palmer, Kodiak, and Kenai, 73% had no health insurance, and most of the 27% who had some coverage said it was inadequate. Among the 31 small businesses who attended ISER focus groups in those same communities, 74% did not offer health-insurance programs for employees. Overwhelmingly, these individual Alaskans and small business employers said health insurance was just too expensive.

We also held a focus group with five Alaskans who sell health insurance, who talked about the problems of uninsured Alaskans from the industry perspective and about possible alternatives to standard health insurance.

The number of people attending the focus groups was small, and they don't represent a random sample of Alaskans. ISER used a variety of means—including contacts in local communities, advertising in newspapers and on the radio, and sending out flyers—to recruit participants. The people who came felt strongly about this issue, so it could be argued that their characteristics may be different from those of uninsured Alaskans in general.

Still, ISER researchers believe participants provided valuable information and insights about who uninsured Alaskans are, why they are uninsured, what they could afford to pay for insurance, and what they've done to get health care in the absence of insurance.

WHO CAME TO FOCUS GROUPS?

Many Americans are under the impression that uninsured people are mostly young and single, or unemployed, or have minimum-wage jobs, or don't have much education. Many people who attended the focus groups do not fit that profile. The table on the next page shows some of their characteristics. Keep in mind that not all 89 participants answered all questions. The percentages in the table are calculated based just on those who answered specific questions, and the table cites numbers who answered.

Of those who answered employment and income questions, 87% had jobs and 63% had incomes above the poverty line. Among those who reported their age, 75% were older than 40. More than half who reported their education levels had at least some college education and about 15% had at least four-year degrees. Among those who reported their background and ethnicity, three quarters were life-long Americans and they came from many different ethnic groups.

A second table on the next page shows some of the characteristics of the small business employers who attended the focus groups. Nearly three-quarters had fewer than 10 employees, and only 26% offered their employees health-insurance plans. Most of their employees (79%) worked at least 30 hours per week, and almost all (90%) were paid more than minimum wage.

Characteristics of Individuals at ISER Focus Groups?* (89 Alaskans Attended)	
Percent without insurance (N=88)	73%
Percent who had jobs (N=62**)	87%
Age (N=78)	75% over age 40
Ethnicity (N=88)	45% White 35% Alaska Native 20% Other Minorities
Education (N=71)	53% at least some college 16% 4-year degrees
Marital Status (N=77)	49% married
Income below poverty line (N=78)	37%
Percent lifelong U.S. residents (N=53)	75%
*Percentages of those who answered specific questions. Some people did not answer all questions.	
**Of the 62 who answered the question, 14 were retired or disabled.	

Characteristics of Small Business Employers* at ISER Focus Groups (31 Representatives Attended)	
Share with 10 or fewer employees	72%
Share with 11-50 employees	28%
Share offering health insurance for employees	26%
Number of years in business	78% more than 10 years
Percentage of workers employed at least 30 hours per week	79%
Share of employees paid more than minimum wage	90%
*Includes owners, managers, or officers of businesses. For all questions, between 28 and 31 provided answers.	

WHAT DID PARTICIPANTS TELL ISER?

Individuals, businesses, and Alaskans who sell health-insurance made a number of points that we believe could help the Department of Health and Social Services deal with the very difficult questions of what Alaskans need and how to help the uninsured.

Desired Coverage

- For individual Alaskans having insurance would allow them to get routine, preventive care, as well as regular care for chronic conditions. They were especially concerned about detecting any illnesses or diseases early.
- Denali KidCare is one public program that almost all participants were aware of and would like to see expanded.
- Most participants—both individuals and business representatives—said they want and are familiar with health-insurance packages that includes coverage for visits to doctors, preventive procedures, and dental and vision coverage.

Cost

- Uninsured and under-insured Alaskans are willing to pay for it. But on average they can only afford to pay \$100 per month per person.
- Small business employers in the focus groups would like their employees to have insurance. But few can afford it.
- Focus group participants praised the program, but said that many families with incomes too high for Denali KidCare still can't afford private health insurance. Many suggested that if the program were expanded to cover children in families with higher incomes, the state could charge participants on a sliding-scale, according to their ability to pay.

Personal and Social Responsibility

- Uninsured and under-insured Alaskans don't see health-insurance as an entitlement.
- Small business employers believe their inability to provide health insurance has cost them valuable employees, and some see providing insurance as a social responsibility.
- Individual Alaskans and small business employers agree that they share responsibility for their own health. But they feel that having access to affordable health care is critical to staying healthy.

Personal Dilemmas

- Alaskans without health insurance often just don't get care when they need it. Some participants talked about delaying treatment until their condition became so serious they had to go to the emergency room—and then incurred huge bills they couldn't pay.

- One participant described getting divorced so at least a spouse could be eligible for Medicaid coverage.

Lack of Information

- Individual Alaskans at the focus groups discovered that they didn't know about all their option for participating in public programs.
- Small business employers are not always aware of the health-coverage options that may be available to them, even though they have looked for ways to get affordable coverage. In every focus group, participants said they had learned something they hadn't known about public programs or private-industry alternatives.
- The overwhelming majority of individual Alaskans in the focus groups did not understand how tax credits might help them pay for health care. They couldn't see how a tax credit would help when they didn't have very much income, and they envisioned that the credit could only help them at tax time, while they needed help throughout the year. This is not to say that credits wouldn't be helpful in some cases—only that most people do not understand how credits would work.
- Small business employers were much more likely to understand the potential value of subsidies or credits they might receive if they provided health insurance for their employees. They were especially interested in the concept of purchasing alliances—that is, joining together with other businesses to make coverage more affordable by forming a larger pool of beneficiaries. But representatives of the health-insurance industry said that such larger pools do not in fact reduce costs. Clarifying this apparent misunderstanding would be very helpful to small-business owners.
- Representatives of the health-insurance industry described several alternatives to standard health insurance plans, including savings accounts, health reimbursement accounts, and mini-medical plans. But they also acknowledged that some of these alternatives may be complicated and difficult to understand and could require substantial out-of-pocket expenses.

The ISER focus groups gave Alaskans the opportunity to talk about how important health insurance is to them. They welcomed that opportunity, and many described themselves as desperate. They were eager to share their stories, in the hope that public officials will understand the problems they face in trying to pay for health care for themselves and their children. They understand that they need to take responsibility for their own health, and they are willing to pay for health care. They just can't afford it.