Key Informant Interviews

Addressing the high rate of Alaskans without health insurance

Prepared for:
State of Alaska
Department of Health and Social Services

McDowell GROUP
Research-Based Consulting
Juneau
Anchorage
Kodiak

August 2007

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State of Alaska
Department of Health and Social Services
Health Planning and Systems Development
(907) 465-3091

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Executive Summary

In order to assess the causes and possible solutions for Alaska's high rate of residents without health insurance, the Alaska Department of Health and Social Services (DHSS) received a State Planning Grant from the US Department of Health and Human Services. Under this grant, DHSS contracted with the McDowell Group to conduct a series of executive interviews with Alaska residents knowledgeable about the issue of health care and the uninsured. The project also included a discussion group with DHSS employees exploring the results of the executive interviews. The interviews followed a set protocol that included questions on Alaska's biggest challenge in covering more residents, current state and federal programs, the viability of several potential health coverage models, recommendations for improvement, and other questions.

Following are several themes that emerged in the course of the interviews.

The problem of the uninsured in Alaska is an urgent one, and is likely to get worse.

Many of those interviewed were very concerned with the state of health care in Alaska (including, but not limited to, the high number of those without insurance). Several said that although costs are high now, they will only get higher unless something is done to change the system. They pointed out many factors contributing to rising costs: nationwide trends; Alaska's shifting demographics; poor health indicators; and lack of competition among providers, among others.

More should be done to help the working poor, particularly families with children.

A common theme in the interviews was the idea that many uninsured Alaskans are working, but cannot afford health insurance for themselves or their children. Nearly all interviewees supported expanding eligibility requirements for Denali KidCare, and some supported a similar expansion of Medicaid.

The current system encourages excessive use of the Emergency Room, resulting in unpaid bills and cost-shifting.

Many of those interviewed discussed one of the consequences of Alaska's high rate of uninsured residents: they delay care because of high costs; their health problem worsens; they end up in the emergency room (the most expensive kind of care); they are unable to pay their bills; and costs get shifted to those who can pay.

The role of personal responsibility versus the role of government in health care.

Interviewees expressed a wide range of opinion on the role of personal responsibility in health care. Some believed that health care is a basic, human right, and the federal (and/or state) government should be providing it – or at least making sure it is affordable. Others said that individuals should be responsible for their own health care – for ensuring they are taking proper care of themselves, and for acquiring health insurance. Many contacts fell somewhere in the middle of this spectrum, saying that it is important that individuals have a stake in their health care, but that it is unreasonable to expect that everyone can afford the same level of contribution.

Alaska's Medicare system is deeply flawed.

Nearly all of those interviewed pointed out problems with Alaska's Medicare system: the reimbursement rates are much too low; there are not nearly enough doctors who accept Medicare to accommodate demand; and the bureaucracy and paperwork involved are burdensome to both provider and patient. Several contacts talked about how difficult it is for those reaching retirement age to cope with the shift to Medicare, where they receive a much lower level of care than they previously enjoyed, at a time when their health care needs are rising. The problems faced by Medicare were often referenced as reasons to avoid any expansion of the government's role in health care.

How will change be implemented?

Interviewees expressed a range of optimism and pessimism with regard to changing Alaska's health care system. Some believed that it should be undertaken in stages: beginning with expanding Medicaid and Denali KidCare, for example, eventually working into a single-payer or mandate model. Others believed that immediate, widespread change was achievable, considering Alaska's small population and assets (such as the Permanent Fund). Many suggested that instead of focusing on insurance, the state should be focusing on access to care. Others believed that prevention and wellness programs were necessary to effect real change in the state's health care system.

Please see the body of the report for specific comments by interviewees. These are grouped by question, subject of response, and informant category (Advocacy/Research, Providers, Unions, etc.).

Introduction

Nearly one in five Alaskans – about 117,000 people – have no health insurance.[1] Alaska is in the bottom quintile of all US states in the percentage of the population who are insured. In order to assess the causes and possible solutions for Alaska's high rate of residents without health insurance, the Alaska Department of Health and Social Services (DHSS) received a State Planning Grant from the US Department of Health and Human Services. Under this grant, DHSS contracted with the McDowell Group to conduct a series of executive interviews with Alaska residents knowledgeable about the issue of health care and the uninsured. The project also included a discussion group to explore health insurance issues and the results of the executive interviews with key DHSS staff.

Methodology

The list of key informants was developed jointly by the DHSS project team and the McDowell Group. In developing the list, the study team was careful to include representation from a variety of stakeholder groups: medical providers, hospital administrators, insurance companies, unions, employers, Native health care organizations, advocacy/research organizations, legislators, and social service agencies. Efforts were also made to ensure representation from around the state, including rural as well as urban perspectives.

A total of 50 out of approximately 70 targeted contacts participated in the interviews. Most of these were interviewed by telephone, while a few chose to submit responses in writing. All interviews were completed between May 1 and June 15, 2007. A list of informants and the organizations they represent is presented on the following page.

The interview protocol was developed by the McDowell Group in cooperation with the DHSS project team. In accordance with DHSS goals for this project, the questions focused primarily on insurance, although other health care-related issues arose in the discussions. The protocol included questions on Alaska's biggest challenge in covering more residents, current state and federal programs, the viability of several potential health coverage models, and recommendations for improvement, among other questions. The interview questions are provided in the Appendix.

A discussion group with nine DHSS staff was facilitated by the McDowell Group on July 9, 2007. The meeting addressed the findings of the key informant interviews and topics that were of particular importance to the attendees. The meeting also included a presentation of findings from other projects under the State Planning Grant: focus groups, household survey, and business survey.

[1] "Available Data on Alaska's Uninsured," presentation to Health Planning and Systems Development Unit, Alaska Department of Health and Social Services, December 2006.

Key Informants

Mike Andrews	Alaska Works Partnership
Jeff Backlund	North Pacific Seafoods
William Bjork	National Education Association Health Plan Trust
John Bringhurst	Petersburg Medical Center
Michele Brown	United Way of Anchorage
Teri Buckmeier	National Education Association Health Plan Trust
Jennifer Bundy Cobb	Alaska Association of Health Underwriters
Rep. Bettye Davis	State Senator; Senate HESS Committee Chair
Bill Doolittle	Alaska Mental Health Trust Authority
Jim Duncan	Alaska State Employees Association
Lt. Todd Emerson	U.S. Coast Guard, Kodiak
Pete Ford	Alaska Public Employees Association; Alaska Association of Teachers
Mark Foster	Mark Foster & Associates
David Frazier	David Frazier & Associates
Joel Gilbertson	Providence Health Systems
Brian Green	Anchorage Project Access & Cornerstone Clinic
Rosemary Hagevig	Catholic Community Services; Southeast Conference
Victoria Hampton	Alyeska Pipeline Service Company
Joanne Hanscom	Municipality of Anchorage
Duane Heyman	Alaska Health Care Roundtable
Steve Horn	Alaska Behavioral Health Association
Dr. Thomas Hunt	Anchorage Neighborhood Health Center
Rhonda Johnson	UAA Masters of Public Health Program
Jim Jordan	Alaska State Medical Association
Helen Kalk	Catholic Community Services
Don Kasheverof	Alaska Native Tribal Health Consortium
Marilyn Kasmar	Alaska Primary Care Association
Beth Landon	Alaska Center for Rural Health
Pat Luby	American Association of Retired People - Alaska
Dr. Richard Mandsager	Child's Hospital, Providence
Jerry Near	Retired (formerly in insurance; health care advocate)
Dr. Karen O'Neill	Norton Sound Health Corporation Health Aide Training Center
Karen Perdue	Statewide Health Programs, University of Alaska
Mike Powers	Fairbanks Memorial Hospital
Rashmi Prasad	UA Health Service Administration
John Riley	Alaska Public Health Association
Becky Rooney	State House HESS Committee Aide
Don Rush	Kodiak Island Providence Medical Center
Brian Saylor	UAA Institute for Circumpolar Health
Ann Secrest	American Association of Retired People - Alaska
Paul Sherry	Alaska Native Tribal Health Consortium
Alex Spector	Department of Veterans Affairs
Jim Towle	Alaska Dental Society
Mark Vinsel	United Fishermen of Alaska
Larry Weiss	Alaska Center for Public Policy
Jasper Wesington	Anchorage Neighborhood Health Center
Lon Wilson	The Wilson Agency
Peggy Wilson	State Representative; House HESS Committee Chair
Candace Winkler	Child Care Connection
Beverly Wooley	Anchorage Department of Health and Human Services

DHSS Discussion Group Participants

Michelle Lyons Brown
Pat Carr
Nancy Cornwell
Barbara Hale
Jill Lewis
Alex Malter
Alice Rarig
Jon Sherwood
Brad Whistler

Alaska's Biggest Challenges

What do you think is Alaska's biggest challenge in increasing insurance coverage to more Alaskans?

Summary

Cost

The most common responses referred to cost – Alaska's high cost of health care and health insurance when compared to other states, and the challenges in meeting those costs. Contacts said many factors contribute to Alaska's high costs: small population, geographical challenges, high cost of living, poor health indicators, lack of competition, payment structure, and the large number of part-time workers, among other factors.

Attitude

Some contacts said the public attitude towards general health care is a challenge to increased coverage in that it reflects "resistance to change," "apathy, "not having the will to do it," and a failure to "recognize the issue."

Personal Responsibility

Other interviewees said the attitude of people towards their own health care is a barrier; for example, getting young people to recognize that they need insurance, or getting people to take responsibility for their own health care. A couple of respondents said that some people do not purchase health insurance because it is simply not a priority for them – not because they cannot afford it.

Legal/Political

Some contacts said the biggest challenge lay with the legal/political system, which some saw as not doing enough to address the problem. According to one contact, "It's not on the radar of policy-makers."

Access

Several contacts said that to focus on "increasing insurance coverage" was itself an obstacle. They said the focus should instead be on access to and availability of care.

Payment System

One contact saw the multitude of payers as a roadblock – with so many payers, everyone wants to be "the payer of last resort." The employer-based system was seen as a drawback by some, who cited the high number of small business in Alaska. Many contacts said the current employer-based system is not effective.

Other Challenges

Additional challenges cited by interviewees included: lack of providers; lack of a forum to discuss the issue; and demonstrating the value of widespread health insurance. Two contacts said that the challenge lay in defining the uninsured – "I think there's a lot of misconceptions about who is uninsured, why they're uninsured, are they truly uninsured, and are they using the facilities that are designed to treat them."

Selected responses to question one are presented below. Comments are grouped first by the subject of the comment and, within subject areas, by the sector most closely associated with the person making the comment.

Selected Comments

Cost

Advocacy/Research

- *The way health care is structured in Alaska is expensive. There is fairly high overhead for administration. The question is how to expand access while still controlling for cost. Alaska is still on a fee-for-service system, it's one of the only states. With managed care in other states, fees are discounted or negotiated, or there are fixed rates per person served. In Alaska nobody is leveraging those costs.*
- *Finding a reasonably priced product.*
- *The cost of health care in Alaska; the cost of long term care.*

Employers

- *Health insurance costs more here because we're a small state in population and because we're kind of a sickly state. If you look at substance abuse, infant mortality, we tend to fair poorly. So because of that, our insurance rates per person are really high.*
- *The biggest challenge is the cost of a program.*
- *Cost. It costs more for health care in Alaska than it does other places in US. One of the problems is competition doesn't exist here. Doctors feel isolated; they can charge whatever they want.*

Hospital/Administration

- *Why does the high cost happen? Because of the demand for health care services, in combination with the high cost of living in Alaska. For all the third-party payers (such as TriCare, Medicare) that have caps on their payments to hospital for various services, the hospital has to increase charges to insured patients to cover the difference.*
- *The cost seems to be a big part of it. Those who don't get it through work find the cost is prohibitive.*

Social Services

- *The workplace model has changed. Our reliance on an outdated economic system is ill-founded.*
- *Money. I think there's a lot of people working in our economy who don't work sufficient hours in one organization to get sufficient coverage. It's hard for employers to cover the cost of dependent care. It's a huge issue. Some people make too much money to qualify for aid. It's a huge conundrum for a lot of employers and a lot of workers.*

Insurance

- *The cost is very expensive for people. They have to make choices between cars and travel and groceries and clothing. Sometimes they make good decisions and sometimes not.*

Unions

- *Health insurance coverage has to be affordable. The way that costs are increasing across US and in Alaska, we find that it's not affordable to a large segment of Alaskans.*
- *Making reasonably-priced benefits and services available, then maintaining the availability of those services.*
- *The willingness of medical service providers to charge maximum cost (gouge?) for their service is Alaska's greatest health care challenge. Current practices, frankly, make an argument for socialized medicine. Several relatively common medical procedures cost three and four times more in Juneau than the same procedure costs in Seattle. Medical service providers should be a good living…but the "profit motive," when applied to medical services becomes something very unpleasant, something we might call criminal in another context.*

Attitude/Perspective

Advocacy/Research

- *Getting people to recognize the issue and deal with it. For the percentage of people who are covered, it isn't a particular concern, so it doesn't impact them.*
- *The biggest problem is the focus on insurance. Addressing the insurance coverage is assuming we want the system to stay as it is.*

Employers

- *I think the biggest thing we need to make young people realize is, they need to have some type of health insurance…making younger people understand that they're not invincible, they do need coverage.*

Hospital Administration

- *Apathy. This is a quiet crisis, no different here than in the rest of the US. There isn't the political focus and employers still tolerate the situation. There is too much cost-shifting and it is making our business uncompetitive in the global market.*
- *Resistance to change.*
- *In this country, we have a system where health care is cheaper for a rich man than a poor man because of the amount of Federal tax forgiveness well-to-do people in America get because their insurance is tax-deductible. This raises a moral dilemma, especially given the nature of insurance itself, which relies on large numbers to make the sharing of risk affordable. If more Alaskans understood the issue better, I think they would be more supportive of an increased level of publicly funded health insurance.*

Insurance

- *There's an expectation that the financing of health care should come out of someone else's pocket.*

Legislative

- *Having the will to do it. Other states are doing it, there's no reason we can't do it.*

Providers

- *Will. We all recognize the problem, we have the resources, we just haven't decided it's a priority. It's about deciding that these people are not dispensable and that they need to be included in the political equation.*

Personal Responsibility

Advocacy/Research

- *We can have everybody insured and we'll just make the prices go up unless people take individual responsibility for their health and expenditure of health care dollars.*
- *The problem is the people with the most extensive coverage overutilize the system. They are still unhealthy because they don't address the root cause of their lack of health. They need to take personal responsibility.*
- *We have this idea in Alaska: a positive value of individual responsibility. It's not anyone else's responsibility to pay for this. I think there are some value conflicts.*

Employers

- *Employees don't understand what their benefit is worth, and what the benefit really is.*

Insurance

- *There is an element of the population who just don't want to have health insurance. They feel like they'll deal with it (sickness or injury) when it comes. They will just pay for it or file for bankruptcy. It costs more eventually to those of us who have insurance.*
- *Anybody can buy health insurance. It's a matter of if they want to pay for it. It's a matter of priority. It's a personal value judgment. What is affordable?*

Legislature/Policy

Advocacy/Research

- *Legislative support.*
- *Solutions will require the attention of the legislature.*
- *Political climate.*
- *The health care system is complex and policy makers face substantive disagreements over reform proposals.*

Providers

- *Legislation. Find the policymakers. The people making the policy regarding insurance are not the ones that are lacking it.*
- *It's not on the radar of policy-makers. We're focused on resource development and maintaining our sacred cow, the PFD. Health care is not on the radar. Biggest challenge is mounting some sort of effort that will bring this to light. Typically the health care industry has not had a strong lobby. People seem to talk about it, but they are not action-oriented.*

Access

Advocacy/Research

- *I think access to health care would offer a better focus, but somehow we have focused on insurance. It's really about access and the improvements to health status.*
- *I think the real issue is about access to health care, not insurance. But the biggest challenge regarding insurance is its high cost.*
- *Finding an alternate solution that provides access to health services.*

Hospital/Administration

- *The biggest challenge to providing services is availability, especially in remote places. Populations may not warrant specialists, but people still need the specialized care. There are large costs to pay out of pocket to go to Anchorage for care. As a result people may not get care that they need or may delay seeking care. Also, remoteness and weather make it difficult to access care.*

Unions

- *We have very little access to health care in the state. That makes us high-risk and more expensive to insure. It has a direct impact on the health of the community. Lack of access creates higher premiums. When individual gets access, if they can't pay, cost is passed on. Because of the high rate of uninsured, that increases premium growth. It's a vicious cycle.*

Payment System

Advocacy/Research

- *I think it's a jurisdictional issue. We have military, tribal, federal, private payers. Everybody wants to be the payer of last resort. Some people are dual or triple-eligible. They are often our neediest. Everyone assumes it's someone else's concern.*

Employers

- *We have large payers that are federal. They tend to fractionate an already small market.*

Hospital/Administration

- *I think the Medicare issue is one of the challenges—Medicare reimbursement is low.*
- *Federal programs are such a big part of payment system: Tricare, Medicare, Medicaid, Indian Health Service. The commercial market doesn't have muscle mass as in other states. Figuring out how to get government programs to play together is the big challenge. In many other states, if you can get agreement between Medicaid and commercial interests, you get a lot covered.*

Unions

- *Employer-based system of health insurance doesn't work well, especially in Alaska. We have lots of small employers who can't afford it. I believe we need to design a system that is not employer-based, but insures that all folks have equal access to insurance.*

Other

Advocacy/Research

- *Physician shortages.*
- *Relatively fragmented health care insurance and health provider market for a relatively small population.*

Hospital/Administration

- *Generally the lack of number of doctors. Seem to be adequate number of primary care physicians, but they're getting older. Not sure I see new physicians moving in. I think the number of specialty physicians is a challenge and the distribution of them.*
- *The challenge is to demonstrate that widespread health insurance is good fiscal policy as well as sound social policy; that it's cost-effective since the benefits of seeking care early in a disease cycle are well-documented. Children with insurance are more likely to have a usual source of care, to have access to preventive care, to get the health care services they need. Insuring children helps close the racial disparity gap, and helps improve social and emotional development.*

Employers

- *We have so many small businesses.*

Insurance

- *The first thing is understanding who really doesn't have insurance. The real question is, Who has ability to finance their health care in some way? There are a lot of people who have access although they're not taking advantage of it.*
- *The issue about uninsured is defining who the uninsured is. They are made up of different types of populations. The challenges of getting different populations insured are different. I'm not sure I believe the number of uninsured. People have outlets like the Anchorage Neighborhood Health Center. Do we have anybody uninsured? I think there's a lot of misconceptions about who is uninsured, why they're uninsured, are they truly uninsured, and are they using the facilities that are designed to treat them.*

Legislative

- *I think our biggest challenge is the number of people. A lot of insurance companies don't want to deal with us because we don't have the numbers. We have think outside of the box.*

Providers

- *The economy is the biggest issue. We need to get jobs to people.*

- *I believe that the biggest barrier has been the lack of a forum whereby the various medical care providers, payors, and regulators can meet to assess and debate the value of the various approaches that have been tried in different states to increase access and coverage. The related barrier is unwillingness to discuss/name where protection of profits is an issue.*

Who is Responsible?

Who do you think should be primarily responsible for providing health insurance to Alaska residents: State government, federal government, employers, or individuals?

Summary

This question was a challenging one for many informants because it was difficult to pinpoint only one responsible entity. However, it led to interesting discussion over why certain entities should or should not be responsible, and related topics.

Shared Responsibility

A popular response was that everyone is responsible for providing health insurance; that any solution should involve all four entities (state government, federal government, employers, and individuals). A number of respondents pitched a combination of two entities: state and federal government, for example, or state government and employers. Among those who identified one single entity in their response, federal government and individuals were the most commonly cited.

State Government

Some said that the state has an obligation to take the lead. Others said that defining and regulating health insurance should be a federal responsibility, but that, in the absence of federal action, the state must become involved.

Federal Government

The federal government was seen by some as the obvious responsible party, often with references to the dire state of the US health care system and the need for reform across the country, not only in Alaska. Others saw health care access as a basic human right that the federal government should provide its citizens.

Employers

Almost no respondents felt that employers alone should bear responsibility for providing health insurance. Many pointed out the large number of small businesses in Alaska when compared with other states, and how difficult it is for them already. Another common point of view was that the current employer-based system did not necessarily make the most economic sense, and that a new model of health care should get away from the traditional system. Two contacts referred to the history of health insurance, saying that the only reason that employer programs are the norm now is because of post-World War II wage freezes that encouraged companies to offer such benefits.

Individuals

On the other hand, many contacts saw health insurance as something that each individual is obligated to provide for themselves – and that if health care were provided automatically, there would be less incentive for people to take precautions and live healthy lives. Several contacts believed that Alaskans need to make health care more of a priority in their lives, and in their budgets.

Other

Several respondents believed that the responsibility for providing insurance depended on the particular segment of the uninsured. They felt that the government had an obligation towards certain segments of the uninsured (such as children and the disabled), but that other segments needed to take personal responsibility for their health.

Selected responses are presented below, grouped by the subject of the comment.

Selected Comments

Shared Responsibility

Advocacy/Research

- *It is a shared responsibility between the state and employers. Most employers would like to cover the costs, but there are not many affordable products out there.*
- *It should be combined federal/state role. I think it's primarily federal, secondarily state. I would put individuals third, employers last.*

Hospital/Administration

- *Leveraging all those systems to produce a health care delivery system in the state is maybe more realistic than trying to push one over the other.*

Social Services

- *I would say it's a combination. It's not going to be a single sector fix.*

Insurance

- *We all share some responsibility, depending on which segment of uninsured population we're talking about.*

Providers

- *Collaboration between state government, employers, and individuals. No one entity can bear the cost. It has to be a collaborative effort.*

Unions

- *There is responsibility on all levels. The federal government has to take some steps to do overall control of how costs are rising in this country. States have to step forward and do it on an individual basis, to design a program that works well for them. I believe states have to take a lead in addressing their own individual problems.*
- *I think health care has become such a severe national problem that it can only be effectively addressed nationally, probably by a federal or national health plan. However, the immediate problems of cost and availability of services are far more severe than any apparent willingness to effectively address those challenges, so I also think that the individual states must attempt to address the challenges because they seem more willing to act now.*

State Government

Advocacy/Research

- *Our state government needs to be more engaged in provision of care for its own residents instead of turning to federal government.*
- *The state has an obligation to care about everyone in the state. Employers are going out of business because they are shouldering that responsibility currently.*

Hospital/Administration

- *Insurance is a classic case where government intervention is necessary to organize the large population pools required and to adjust the incentive of the system, and our State is the best place for this responsibility to be discharged.*
- *The State must take the lead.*

Legislature

- *The State is going to have step in somehow. It's not the state's responsibility, but we're going to have to do something.*

Providers

- *I believe this is a government responsibility. More likely it will be successful if it's federal. I'd prefer to see a federal solution, but that said, many states are concluding that they have to move forward.*

Federal Government

Advocacy/Research

- *A national health service is the most effective way to cover access to health care in a cost effective manner. Individual states can't resolve it—they can tinker around the edges, but they can't resolve it at the state level.*
- *We need a national health care system.*
- *There has to be some sort of planning at the national level – not necessarily nationalized health care, but something to make it more equitable.*

Hospital/Administration

- *I always liked idea of a single payer health system, like Medicare. Alaska might be a great demonstration state because we're really unique. Small numbers make it manageable.*

Insurance

- *I don't subscribe to the idea of a government-run program. Government is already providing 50 percent of insurance. Government doesn't want to be in the business of health insurance. Every time someone has some sort of government coverage and some sort of alternative coverage, the government makes them use the alternative before they'll deal with them. The government doesn't want to step up on the programs it already runs.*

Providers

- *Federal government. Until we get to universal health care, there's many issues we're never going to be able to take care of.*

Employers

Hospital/Administration

- *It's tough for employers now because health care is so expensive. Most small business can't afford to provide care.*

- *Employers are already doing a lot, and funding health care coverage – especially family coverage – often asks them to take on a role that is in many cases beyond their scope.*

Providers

- *Our commitment to employer-based health care coverage is archaic and dangerous. It's dangerous because it has many risks. More and more small companies are dropping or reducing coverage; or going to higher deductible, higher risk sharing by employees; or using part-time employees to avoid health care liabilities.*
- *I sympathize with employers who can't afford to provide health care. One way to be able to afford it is for government to create pooled insurance risks. We should get away from employer-based coverage, but until that time employers can only make it happen with government assistance.*

Unions

- *It is irresponsible for employers not to offer coverage and think welfare will pick that up.*
- *Employers should be [responsible], but that is what I grew up with. Having a health plan was the way to retain workers and beat your competitors. It was the reason why people stuck with unions. But we need to get back to when employers could afford it and it was good for business. The government needs to develop a strategic approach to get us back on the right course so the employers can take over again.*
- *I don't see employers carrying the burden in the traditional sense at the rate of health care costs and premium growth.*
- *Employers have traditionally had a role, but only because unions developed the health insurance benefit concept. So employers have a presence in the discussion, but it is not necessarily a required or "natural" presence – if alternative provider systems can be developed and implemented, employers are not necessary components of a provider system.*

Individuals

Advocacy/Research

- *People should take responsibility for their health. Insurance shouldn't be free. When it's free, it has no significance, no attendant responsibilities.*

Hospital/Administration

- *Ultimately, individual citizens are primarily responsible for providing health insurance in the sense of their personal accountability for becoming educated about coverage options.*
- *Individuals must do what they can, but are clearly unable to access the large groups that make risk predictable and insurance affordable.*

Social Services

- *I think that there is a strong argument to be made for personal responsibility. But in this economy, there are so many people who try as they might, they won't ever be able to afford insurance.*

Insurance

- *In the end, it has to be individuals. It's not something that government can solve.*
- *Ultimately, we're all responsible for our own care. Everybody should be individually responsible.*
- *It's primarily personal responsibility. It's a matter of the choices people make. People spend on their wants, not on their needs. Our system bails them out. There is no penalty for not being responsible, there's a reward. People who get penalized are the responsible ones, those who take care of themselves.*

Providers

- *I think it's our own individual responsibility. When you have people with mental or physical disabilities, the government should step in.*

Unions

- *I think individuals really need to take control of their own personal health to help them become prudent consumers. When they do make decisions about smoking, drinking, those things that create more access problems. Every person has to be responsible for how they get health insurance.*

Other Comments

Employers

- *We need to come up with a system that encourages preventative medical care, encourages smart consumption of medical care. The way our system works right now, it incentivizes people to use most expensive, least effective medical care.*

Hospital/Administration

- *We should be talking about universal access rather than universal coverage.*
- *The biggest problem with health care industry is health insurance. We should get rid of all health insurance and just provide health care.*

Advocacy Research

- *We have a huge migrant work force. It's not working very well to have people covered during part of the year. But it's a politically difficult transition to make.*

Insurance

- *The issue is, which segment of the uninsured are we talking about? There are going to be segments that are access-challenged because of where they live. There are going to be those from socioeconomic standpoint are indigent and are unable to afford health care. We have a social responsibility to provide access and quality health care to those people. Whether state or federal or combination, there is a segment that needs it. There is another element of population that needs to be responsible. They need to educate themselves, make it a priority.*

Providers

- *There are so many different avenues for people if they really want to get back on their feet. The problem is, the individual who drives up in a Hummer, changes into homeless clothes, goes into clinic and begs. There's no criteria these people have to meet to make sure they qualify, there's a lot of abuse.*
- *At the level of municipal responsibility, I see public health as a municipal responsibility. Personal health is more a responsibility at the federal level. (Public health being STD's, immunizations, environmental health, food and water). The point is that if you multiply a dichotomy of systems across the country you get a patchwork system rather than a comprehensive system. Disparities result from that, and they end up costing more and they're unethical in the first place.*

Unions

- *We're all part of it. I think states need to step up and do our share. We could do all kids in Alaska, no problem. I don't know if we could do it in perpetuity, but we could do it now. I think it takes the feds and states [in combination] to do it for perpetuity.*

Do you think…

…the Medicaid program is effective at providing access to health care for low-income people?

…the Denali KidCare program is effective at providing access to health care for children?

…the Medicare program is effective at providing access to health care for seniors?

Summary

This series of questions generated the most consistent responses in the interview series. Although some interviewees were not very familiar with these programs, those that had experience with them tended to make similar comments.

Medicaid

Medicaid was usually viewed as effective at providing access to health care for low-income people. Contacts were complimentary of its coverage, its high reimbursement rate, its effectiveness, and the assistance it provides to low-income and otherwise disadvantaged Alaskans. However, contacts brought up a number of issues with the program. One was that it should cover more of the uninsured population. While a few contacts believed the reimbursement rates were fair, others thought they were too low, causing providers not to accept it. One contact brought up enrollment, saying that too many Alaskans enroll at the hospital (when care is most expensive).

Contacts made a number of suggestions as to how Medicaid could be improved. One suggested more emphasis on wellness; another suggested more focus on prevention. One interviewee believed that Medicaid funds should be shifted to focus on the beginning of life rather than the end of life. (Another contact brought up the same issue when asked about Medicaid.) One contact wished for coverage of substance abuse treatment under Medicaid.

Denali KidCare

Of the three programs under discussion, Denali KidCare generated the most positive responses. Interviewees generally saw it as effective, and extremely important in serving Alaska's uninsured youth. Nearly everyone who was familiar with it, though, believed that the eligibility requirements needed to be reinstated to their original levels, if not beyond. A couple of contacts found fault with the extreme, "black-and-white" nature of the cut-off, suggesting that there should be some sort of buy-in program for people who miss the eligibility requirements but still cannot afford health insurance for their children.

Medicare

Of the three programs, Medicare generated by far the most critical comments. Words used to describe the program included "disaster," "train wreck," "mess," "broken," and "dysfunctional." Very few people had positive things to say about the program. Complaints centered around four general themes: extremely low reimbursement rates, lack of providers willing to serve Medicare patients (due to low reimbursement rates), the excessive complexity of the program (particularly burdensome paperwork), and the dire situation of retirees (who are forced into the program, often coming from much more effective employer-based insurance).

Selected responses are presented below, grouped by program.

Selected Comments

Medicaid

Advocacy/Research

- *For the most part, it is very effective because of the relatively high reimbursement rate. It is far better than in other states.*
- *We're very lucky to have Medicaid in the shape and form we do in Alaska. It has good coverage.*
- *Medicaid is the single most effective program there is in Alaska, and it is reasonably good at providing access.*
- *If the target is to assure access to health care, it's somewhat effective, for people without insurance. But because many providers here aren't willing to take it, it's not effective.*
- *The program for pregnant women is wonderful, but there should be more coverage before/after pregnancy.*
- *Part of the reason we give Medicaid to all pregnant women is because it's a good investment. We have consensus on Denali KidCare. But we spend most Medicaid money at the end of life, keeping people alive. In most places in US, more Medicaid money is spent at the end of life. From a public health perspective, it doesn't make a lot of sense.*
- *Medicaid is a safety net. But the federal government is not paying enough to reimburse providers. Cost-shifting—entities are trying to have other entities pay. The biggest con about Medicaid is that the federal government is shifting the costs to providers. The private sector has to pay its own cost and pick up the deficiencies of the federal government.*
- *Medicaid patients are viewed as least desirable by providers and hospitals. It reimburses at a worse rate than Medicare. On the other hand, it's an essential program. I'm a tremendous supporter because it provides health care for the poor.*
- *I believe the cost effectiveness (risk adjusted $ per person) of delivering health care to the Medicaid (and Denali KidCare) target populations can be improved.*

Employers

- *They need more emphasis on wellness.*

Hospital/Administration

- *Medicaid is good for the dedicated population [but] only certain classes are eligible, like children, pregnant, mentally ill; it creates gaps. It doesn't cover chronic care—and the cost of care is based solely through reimbursement. This is a horrible situation, and will be contribute to unsustainable health care. It is also bad on preventative care.*
- *Too many people are enrolling for Medicaid benefits at the hospital, when they need the most expensive types of care. I'm sure it's a difficult issue, but the program could be more effective if more people knew how to enroll; we need to keep working to be certain that everyone who is eligible signs up and stays enrolled.*

Social Services

- *It takes a long time to get qualified. A lot of our seniors, some of them will die before paperwork goes through. If you're a poor child, it's fairly easy to get Medicaid for that period of time. Adults without children who are poor, I've filled out the paperwork for people who will die within 30 days, and it's hard to do.*

Insurance

- *It's extremely effective once people find out they're eligible for it. Denali KidCare does a good job of marketing to families with kids, but with Medicaid there are huge numbers of people who don't know they're eligible.*

Legislative

- *We keep throwing money at the problem but at the wrong end. We need to work at the other end: prevention.*
- *Most legislators aren't into health care. It's not oil and gas. All they know is cost keeps growing. Like education, they don't understand the funding.*

Providers

- *The eligibility is such a low rate. It's a disincentive for people to work, particularly if they can only get minimum wage. It's very hard because it can take years to increase your salary to the point where you make up for what you save by getting Medicaid/DKC.*
- *For those people it covers, it is a good option. It is missing a large segment that cannot afford insurance.*
- *Medicaid doesn't provide any reimbursement for substance abuse. That's something that needs to be fixed. Treatment is dependent upon grants from the state, which have been declining.*

Denali KidCare

Advocacy/Research

- *Denali KidCare is definitely effective, but the formula needs to be adjusted.*
- *I think a sliding fee from 200% up to 300% would be great. But Medicaid is also still fee-for-service. There needs to be a different approach.*
- *Denali KidCare is critical and it needs to be expanded to beyond where it is. It is extremely important that we do anything to expand the program. This is one of the few things that the state can do to improve access.*
- *It's a great program and also very effective.*
- *Eligibility standards are restrictive. There are people that need the services that don't qualify.*
- *Some states invested in advertisement, our state didn't invest very much. It relates to the philosophical view of policy makers: if they have to be sold it, they don't need it, and if they need it, they'll come find it.*

Employers

- *It was more effective before the eligibility rules were changed by the legislature. It went from being one of the best in the nation to one of the worst.*

Hospital/Administration

- *Denali KidCare up until four years ago really had got to a significant chunk of kids in the cracks with working parents. Now, four years later, with new eligibility levels, kids are dropping off. I'm starting to hear more anecdotal stories of people delaying care, kids not getting care. Parents can't afford access.*

Social Services

- *I'm a big proponent of looking at sliding fee scale for people who can buy into it.*

Insurance

- *On the downside, a lot of employers are aware of Denali KidCare and count on their lower paid employees to be on that plan for their kids.*

Medicare

Advocacy/Research

- *There is a significant problem because of the low reimbursement rate for providers. It's a deterrent for providers.*

- *Reimbursement policies are not going to work as more and more providers drop out – then seniors will have the same access problems as the uninsured.*
- *Medicare is a disaster. The access to care is diminishing. That is based on two factors: reimbursement rate to providers and the hassle factor. Medicare's amount of paperwork and regulation is unbelievable.*
- *Medicare is getting a lot of bad press in Alaska. The real issue isn't Medicare's payment structure. It's the payment in relationship to the already high cost for reimbursement for doctors in Alaska. The crisis is more due to baseline levels of reimbursement than it is to Medicare itself.*
- *Access to care is less effective under Medicare because people can't find physicians. It is really critical. The fact is that Medicare as a form of insurance doesn't guarantee access to health care or quality of care.*
- *Physicians are getting older. There was an expectation years ago that there would be a doctor surplus, so they tightened the admissions. But the surplus never happened. Now we are caught in that shortage.*
- *We don't have managed care. We have independent providers who don't want to take Medicare. You can have people over 65, retired with benefits, who can't find a provider. Health insurance is only one piece of the puzzle. You need willing and well-qualified providers. We don't have enough OB providers, we don't have enough geriatric providers.*

Employers

- *It's not paying doctors enough. Our doctors are not taking on new patients.*

Hospital/Administration

- *It's good insurance. It's better now that it is paying for some of the drugs.*
- *Virtually every senior knows they are eligible and enrollment is "relatively" simple and straightforward.*
- *They've made the drug program extremely complex. Those that have to deal with it are least able to deal with complexity. Seniors don't understand it.*

Social Services

- *The whole system is broken. The plan is not reimbursing for actual costs of care.*
- *My biggest complaint is they have eliminated the rural factor that used to be in the formula for payment. The paperwork is horrendous. From a consumer standpoint, the individuals find the paperwork perplexing as well. This is a system that could be simplified greatly.*

Insurance

- *My general feeling is that if we're going to spend government money on health programs it ought to be for young people under 18 rather than for people over 18. That's where our emphasis should be. If I were czar, I would have free medical care or low-cost medical care for all children but with strong educational programs. We spend money on people who are over age 65. All that money should be put into the other end of the age spectrum. Focus on preventative maintenance and education towards better health. Then you have healthier workforce who can work longer and take care of themselves at the end of their careers rather than have government take care of them.*
- *It's underfunded because it was ill-conceived. No one believed it would cost as much as it does. Because it's underfunded the working population that does have insurance has to pick up the balance of the cost. About probably 40-50% of Medicare is borne by working population in insurance premiums, driving down wages. You don't earn as much because so much is going into premium, that's going indirectly into Medicare.*
- *The government is in the insurance business. And they're not a responsible insurer. They're creating as many problems as solutions. They're not reimbursing at an appropriate rate, straining the rest of the system.*

- *I've seen more employers drop providing health insurance in last year than I've ever seen in my career. They are typically smaller employers, less than 10 employees. We're seeing first signs of a real problem.*

Providers

- *It's inexcusable that we're asking providers to be paid 40 cents on the dollar. I'm not sure why we think we can do that to physicians.*
- *I think Medicare programs are dysfunctional.*
- *The biggest issue is that if you don't currently have a primary care physician you can't get into a practice (at least in Anchorage). This is almost entirely a reimbursement issue (rates of reimbursement being inadequate). And there is a lot more paperwork for patients on Medicare. Physicians have to defend their decisions and prescriptions. So it's not just about the money but also about the work that you have to do for that money.*

Unions

- *Amount of paperwork and commitment is onerous. Many people don't participate for that reason.*
- *If you want to see health care in this country in 10 years, you need to come to Alaska now. It needs extreme reform. The Alaska providers cannot afford to offer Medicare right now. Reimbursement is 30% of what it should be. It's creating a lack of access for the elderly. Even if they've worked all their life, Medicare becomes primary insurance. Doctors aren't taking new Medicare patients. The train is about to wreck. Those turning 65 that have not had health problems, without primary physicians, they're not going to get care they need. They will end up paying out of pocket to a physician to avoid Medicare. Those that do have chronic health conditions will be forced to leave Alaska, and that will only be a temporary solution. We don't have the number of providers, we're 500 short of where we need to be. We're experiencing that crunch at a higher rate than in lower 48.*
- *My impression is that Medicare is burdened by much bureaucracy and regulation of minutia, but those defects might be resolved if Medicare was converted to a universal plan.*

Statutory and Regulatory Picture

Are you aware of any Alaska laws or regulations that are preventing the expansion of health insurance coverage to more Alaskans?

Summary

This question was difficult for many respondents to answer; many said they were not aware, or that they weren't familiar with the laws and regulations regarding health insurance. The most common reference was to the Denali KidCare eligibility levels, which contacts generally viewed should be restored to their levels of several years ago, if not beyond. Several contacts also referred to same-sex or domestic partner benefits; these respondents supported expanded coverage to this population, as well. Other issues that came up during the course of this question included: liability laws, Medicaid auditing, multiple payers, reimbursement rates, long-term care, dental care, and the need to review the current laws to increase affordability of insurance.

Selected responses are presented below.

Selected Comments

Advocacy/Research

- *The cutting of Denali KidCare eligibility at 175% of the poverty level leaves out lots of people who really need it.*
- *It is my understanding that we are still a managed care-free state. In fact Alaska has benefited because we have been a refuge for people who wanted to escape the provider environment in a managed care system.*
- *There have been substantial revisions to the liability laws. There is a whole host of things that need to be cleared up for electronic medical records. The industry is technologically backwards. This has a tremendous impact on efficiency and quality. There are significant efforts in Alaska to develop a system to deal with electronic medical records and their transfers.*
- *Access to care is hampered by regulations pertaining to Medicaid because they discourage physicians from participating. There has been an ongoing Medicaid audit program. It's part of being good stewards of public funds. But the audit program is lacking in due process. Some of the methods used for extrapolation are suspect statistically.*
- *In some states, it is a mandatory requirement that doctors cannot deny patients on Medicare. We don't have that law to gain access for our seniors to care.*
- *I could think of laws that would help expand it. It's the marketplace, it's the nature of insurance: very prone to adverse-selection. There are many young people who don't want insurance because they're invulnerable, others choose very cheap plans. The marketplace differentiates itself. Undesirable people are selected out, or have expensive plans. Health insurance is more prone to market failures.*
- *It may be timely and instructive to review Alaska laws and regulations that impose requirements on health care providers, health insurance providers, employers, employees, etc. with respect to health care and health insurance to ascertain to what extent those requirements impose costs that are reflected in a higher cost of health care and/or health insurance that in turn may reduce the affordability of insurance for employers and employees and lead to more self-insurance by employers, employees and unemployed household members.*

Employers

- *I think the issue is about the fractionalization of the markets. There's no economy of scale. It's not a legal issue. You have veterans, military, and Indian health. Not a lot of legal framework for those systems to use and share in the local market. They aren't using local capacity which then provides a better base for everyone, allows local communities to address needs of uninsured.*

Hospital/Administration

- *Legislation restricts who is eligible for Medicaid, Denali KidCare, and Medicare. The real issue is the reimbursement system. There are largely 150,000 Alaskans on these plans, and providers are cost-shifting to the commercial payers.*
- *Dentists have a monopoly. They control who gets to be dentists. They limit the supply of dentists. Demand is increasing, and costs keep going up. It costs 40% higher in Alaska than in lower 48. Government should get rid of this monopoly. Medicaid pays very little for dental care. It's hard to find a dentist that accepts Medicaid.*

Social Services

- *Long-term care insurance needs to be fixed. Most state employees sign up for it when they retire thinking that their daily activities are going to be covered. State's policies don't cover Alzheimer's. They're not covering adult day services in state. It's forcing people into higher level of care, which is lots more expensive.*

Providers

- *An example of statutory language that limits health care is language in Medicaid legislation that severely hampers mental health care delivery. The definitions of the kind of providers that are reimbursable are restrictive. For example, the state will pay services provided by a physician psychiatrist, a psychiatric nurse practitioner, a licensed clinical social worker, or a PhD psychologist. But masters-level trainees, i.e. LPCs and masters in clinical social work, cannot be reimbursed. We have staff that do good work but we can't get reimbursed for them. We just give that work away.*

Unions

- *Politics in general is the real limiter. We see programs that are designed to aid low-income seniors not getting funded. The poverty limitation on DKC is too low. I think we ought to err on the side of more kids than on fewer kids.*

Do you think this model would be effective in increasing coverage for Alaska residents?

What type of barriers do we face in Alaska in implementing this type of model?

Do you know of other models worth considering?

Which health insurance model do you think would be most effective at expanding health insurance to more Alaskans?

Proposed Models

Single Payer Model

An approach to health care financing with one source of money for paying health care providers, such as a publicly administered trust fund. Most proposals call for comprehensive health care coverage for all residents and would provide for choice of health care providers.

Dual Mandate Model

The dual mandate model requires that every employer offer health insurance, and that every resident has health insurance. It does not require employers to cover premiums, but the employer at least has to allow workers to pay their premiums pre-tax. Unemployed residents who don't qualify for Medicaid may receive a subsidy from the state to pay for premiums, depending on their income level.

Three Share Model

A health insurance program funded under a shared financing system. The government, employers, and employees would share financing. For example, an employee would pay $50, the employer $50, and the state $50 for a particular plan.

Expansion of Medicaid Waivers Model

This model would build on the current Medicaid waiver model. More waivers would be available to develop home and community-based programs, which would reach more of the uninsured population. An example of Medicaid expansion in Alaska is Denali KidCare.

Cafeteria Plans/Health Savings Account Model

These plans apply only to employed people. Each employee can pick and choose the programs they want to participate in. If you want more, you will have more taken out of your salary pre-tax. Employer contribution would vary depending on their desired level of participation.

Summary

Contacts were read a brief definition of each model and asked how it might work in Alaska. As might be expected, the models inspired a wide range of reactions among interviewees.

Single Payer

Of the five models, the one that generated the strongest opinions – both for and against – was the Single Payer model. Those in support cited the efficiencies it would produce and the money it would save. Some believed that the Single Payer model is the only one that will effectively cover all of the uninsured, and that it should be enacted on a national level. One contact believed that Alaska would be the perfect state to attempt the Single Payer model because of its geography and small population.

One of the strongest objections to the Single Payer model was the role of the government: opponents commented that the government is already ineffective in the health care programs they do run; that Americans (and especially Alaskans) tend to oppose government interference as well as taxation; and that health care should continue to be privatized to encourage competition and research. Several people mentioned Canada as a reason not to go Single Payer, often citing long waits for medical procedures in that country. A couple of people referred to the multiple health care systems already in place (Indian Health Services, military, etc.) as a barrier to the Single Payer model, saying it would be too difficult to reconcile the multiple payers. Many contacts recognized the model's merits, but believed that our society simply wasn't ready for this radical a change. One contact was particularly concerned about the potential impact on the number of doctors that Alaska would be able to recruit.

Dual Mandate

Many contacts recognized the Dual Mandate model as one being tried in other states, and were able to comment on it as a potential model for Alaska. This model, though supported by some, was seen as flawed by many of those interviewed. "Alaska has too many small employers for this to work" was a common reaction. Several people believed that it is a mistake to link insurance to employment. Supporters of this model appreciated that it covered all residents (at least in theory), and likened such a system to the requirement to have auto insurance.

Three-Share

Because the three-share model was the least-known among the five models, many interviewees did not offer their opinion on it. Others were hesitant because there were so many unknowns – whether the shares would necessarily be equal among the three payers, for example, and how much would be required of employers, if any. Those with positive views of the model valued the fact that it required investment from all three entities (individual, employer, government). Some particularly appreciated the required participation of the individual, echoing a theme that came up throughout these interviews: that if people don't have at least some investment in their own health care, there will be less incentive to stay healthy, and they will make poor decisions about their personal health. Using this same argument, some contacts objected that this model does not put *enough* burden on the individual. Others objected to the role of the employer in contributing, or thought that the state shouldn't have to contribute anything.

Expansion of Medicaid Waivers

The Expansion of Medicaid Waivers model was usually supported by interviewees, although most people viewed it as only one part of a larger solution. Those supporting this model referred to the success of Denali KidCare, and appreciated that this model would truly cover the uninsured (as opposed to other, employer-based models). Several contacts hoped that the cumbersome paperwork associated with Medicaid could be streamlined under a new model. Those who objected to this model pointed to the fragility of federal funding – "it's irresponsible to increase waivers one year then take them away the next year," one contact stated. Others thought it would be a disincentive to work. One contact would support the model if it addressed prevention – "anything you can do with prevention and/or outreach, you're going to save money in the long run."

Cafeteria Plans/Health Savings Accounts

Like the Waiver Expansion model, Cafeteria Plans and Health Savings Accounts were often seen a just parts of a larger solution. Many people pointed out that these models may help those who are already employed, many of whom already have insurance, but they won't help the uninsured population without jobs, or those in jobs that don't offer insurance. Supporters of these insurance models appreciated their flexibility, and the fact that they encourage people to take more control of their own health care. Some referred to the tendency to over-use health care when it is offered on an unlimited basis. However, there were many objections to these plans. Some believed that they gave too much control to people; that people would not make responsible decisions about their insurance levels. Others believed that these plans discourage people from seeking health care when they need it, and that delaying care would lead to higher costs down the road. Several people referred specifically to young adults in the population of those that never believe they are going to get sick, and as a result opt for the lowest levels of coverage.

Other Models

After discussing the five models, interviewees were asked if they knew of any other models worth considering. Usually the answer was "no." A few people referred to prevention, education, and/or wellness programs as alternatives. Several contacts referred to the Community Health Clinic as a good model to try on a statewide basis. Other models suggested included: Military Health System, Health Reimbursement Accounts, Pay or Play (two-share) model, and managed competition (Hillary Clinton model).

Preferred Model

Interviewees were also asked which of the five models they thought would work best in Alaska. Every model had its proponents. Some suggested that models could be combined, or that one model could be a start that would lead into a broader solution. Among all respondents who gave a clear-cut response to this question, the Single Payer Model was mentioned ten times. The Three-Share, Medicaid waiver expansion, and Dual Mandate models were each mentioned six times; and Cafeteria Plans/HSA's were mentioned twice.

Selected responses are presented below, grouped by model.

Selected Comments

Single Payer Model

Advocacy/Research

- *That would be the most interesting to me. We could tie it to the permanent fund. It's easier to find people because of the permanent fund. Because of our unusual boundaries, we wouldn't have people crossing into Alaska to get health care. Also, this is a Blue Cross state. There's not a lot of different insurers. We could pilot this program and lead the country.*
- *If this was a single-manager model (rather than a single-payer) then I could be supportive. But we have to recognize that the beneficiaries and the military are already excluded from this system. This system would only work for everyone else. If there is a single payer, we would end up only covering half of the uninsured.*
- *In a nutshell, this model is politically unattainable in the U.S. It is not going to happen for a very long time. There are so many economic interests in the existing system. We don't have experience with the centralized government that is needed.*
- *Will this impact the number of students going to medical school? If such a system were in place in Alaska, not elsewhere, what will that do in terms of recruiting physicians to come here? We already have to recruit, beg/borrow/steal doctors from other states. Would this program have a positive or negative impact? This is a huge issue.*
- *I think it's a model that could be effective. There was a lot of discussion around this in the early '90s. Barriers are that the political will was not here then. I think funding is also a barrier. If we're covering more people, there has to be enough money in the system. However, some people think the money is already being spent in the system, between charity care, bad debt, care for delayed treatment, etc.*
- *I'm much more in favor of single payer in terms of the government being the major transfer agent. I'm definitely in favor of this model, but I like the three-share idea. There should be multiple parties paying into a pool managed by government.*
- *I see the attraction but it's not usable in our state because of the jurisdictional issues (military, Indian Health Service, etc.). Single-payer model would be considered a threat to sovereignty by the Native population. The other piece: 1-in-4 Alaskans are eligible for military benefits. Those are things that people feel they've earned through service. There would be a lot of upset from that audience.*

Employers

- *I think it would be challenging. You'd have to come up with funding, and Alaskans are dogmatic about not wanting to be taxed, not wanting to give up dividend. We're a small population that is pretty wealthy. If we chose, we could easily provide health insurance for everyone. It would be a more efficient system.*
- *I think it would be very effective because it would wring a lot of administrative waste out of the system. It would be politically difficult because insurance companies would be cut out of the system as third party administrators.*

Hospital/Administration

- *This has to occur at the federal level, not at the state level. I don't think the American public will accept this system and it isn't efficient. It removes tensions between providers and insurers—this tension is healthy and is constantly challenging the industry to improve. The single payer model is monopolistic; we will become standardized and move to the lowest common denominator.*
- *I've lived in Europe and seen what goes on in Canada. People wait years for bypass surgery, for other operations. With all our faults, we at least seem to have efficiency. I'm not sure Americans are ready to go with something that falls short of our current efficiency.*
- *The single payer model would increase COVERAGE but may not increase ACCESS TO CARE. To increase the access to care, we have to work with the infrastructure we have.*

- *Massachusetts has had great success with this model and it could work here, though I think it runs counter to the political climate of the State. Given the relatively high levels of employment and employer-based health insurance, I think this solution is too big for the problem we face here in Alaska.*
- *Give money to the government to run something? That won't work. Who will be negotiating prices? It puts lot of faith in the government. As soon as they raise taxes to pay for it because of mismanagement, they pass the cost on to you.*

Insurance

- *In the short run it would increase access, but in the long run it can result in rationing of care. We have to collect money somehow to pay for the care. Generally that would be through taxes. But politicians don't like to raise taxes. Without enough money to fund the program you can do two things—cut fee schedules to doctors or ration care.*
- *The problem is funding it. I think that there would be a lot of cynicism about its implementation. I would suspect that people that don't know much would think it's a good deal. I would think hospitals and doctors would be opposed because they understand the economics. You'd have to bring in price controls.*
- *That doesn't fit well in our health care system. It's really not had a lot of support from the Canadians I've talked to. A lot of Canadians use US facilities because they can access it more efficiently. You have government running your health care: socialized medicine. Anything the government runs can be better done in the private sector.*
- *I don't believe this is the way to go. We have Medicare and Medicaid and it's not working. We're getting into rationed care and limited access and unfair reimbursement.*

Legislature

- *Canadians can do that because their taxes are 50% or more. The people are paying for it. Alaskans would never do that. A Canadian woman waited four years for a hip replacement, then when she could get in, her hip had deteriorated so much that she ended up in a wheelchair. Anything that's elective, they have to wait, sometimes years. Americans are too used to instant gratification for that.*

Provider

- *I would support a single payer model. I think the barrier is getting people to go along with it. If we could move forward, there's a lot of room for efficiencies in that model. Biggest barrier: it's socialized medicine. Anything with that word doesn't go over well.*
- *Like in Canada, you're going to have a cap on how much a physician can make. Anytime you put a stop to capitalism, you're going have people stop migrating towards those fields. Look at Canada, that's what has happened. Plumbers are making more than physicians. Patients get cheap care, but they are traveling to the US to get health care.*

Unions

- *Three main barriers to the single payer model: you'll be rationing care; no countries can prove that it has slowed costs; and it will lead to a lack of research dollars. In other countries with nationalized system, they ration care. If you need surgery in Canada, you wouldn't have access to the provider you wanted, and you'd have to wait two years. We are too used to having choices and getting health care when we need it. A nationalized system will create lack of access and won't reduce costs. Costs for health care are never going to go down in this country. Pharmaceuticals, biomeds, treatments in research: we're paying a good portion of costs into research, paying for wonderful treatments. We're cutting edge in those areas. If we went nationalized, that would stop. We would not be a leader in health care research.*

Dual Mandate Model

Advocacy/Research

- *It would need to be evaluated in the context of small businesses. We have so many commercial fishermen and small business owners. Our largest employers are struggling with this issue. I don't know how small businesses could afford it.*
- *Alaska has about half the percentage of people covered in employer plans than in other states. We have a high level of self-employed where having an employer-sponsored option may not be viable to address the uninsured issue.*
- *The challenge will be building into the model sufficient balance so you don't disrupt parts that are working in the system. If you create a mandate for employers except that the penalty is cheaper than what they are paying now, then it won't work. That's an example of how you could cause harm to something that is working – causing unintended shifts. That balance will be extremely difficult.*
- *This is a highly flawed approach and doesn't address the access to care issue. If you are rich then you have the ability to pay the premiums. But the law punishes low-income people.*
- *We need to separate employment from health insurance. I've become convinced that connecting employers with health insurance is unfortunate. It's a disincentive to provide employment period, which is also something we need in the economy.*
- *Something like that could probably work here. I think what's good about it is, it gets around this idea of balancing individual responsibility with business/corporate responsibility. Obligating businesses to have that option is a step up. People also have to be responsible for their own health. If you have to pay for your health care, you're more likely to value it.*

Hospital/Administration

- *I can't believe there are 44 million Americans without health insurance and that there are state laws that say that you have to have auto insurance, but that people can have kids and not have them insured. I am all for any kind of a program that would give health insurance to all of our citizens. A lot of the hospitals have bad debt write-offs for providing care to people who don't have insurance. People who do have insurance pay more. Something needs to be done to fix the system.*

Insurance

- *I would be in favor of that as long as the public understands that such a law would drive down wages in favor of health coverage. It would drive up prices and could drive more business overseas.*
- *I've never been a fan of thinking it's the employer's responsibility to take care of personal needs.*

Three Share Model

Advocacy/Research

- *If two-thirds of health care is paid for by somebody else without other structuring and restrictions and requirements, then you won't have individual responsibility to ensure effective utilizations and lifestyle changes.*
- *There is a moral hazard here: the tendency to use more of the service if they have no or little stake in the game. A three-way share probably would work better if there were some shifting in the stake depending on the level of services. For example, if preventative care was less costly to the individual, there would probably be more use of these types of services.*
- *I wouldn't be in favor of precisely this model in that it advocates exactly equal dollar amounts, but I am in favor of all three parties contributing.*
- *If 100 years shows anything, we like a mixed model. We like some personal responsibility, business responsibility, government responsibility. Mixing it up probably makes sense.*
- *I think it's important to give incentives for people to take care of themselves. FREE is not perceived as good care, even if it is good care. There are costs associated with every service. Being upfront about costs and splitting it seems like a good idea.*

Hospital/Administration

- *The major problem is the uninsured, whether working or not. This plan suffers from relying too heavily on employers to provide coverage that really has nothing to do with running their business. Personal funding will not be of much help to those with limited means. Results from a simulation study show that only about 10% of those taking up the credit would be individuals who were previously uninsured.*
- *People don't have an incentive to stay healthy if employers pay. This would make them be more responsible. Government should pay because they're part of the problem.*

Provider

- *Unless it was a very progressive type of fee base, where those who made the least paid nothing, I don't think it works. We can't expect that minimum wage people could pay the same share as a general manager. I lack trust in the current system to make those accommodations appropriately.*
- *I don't think the state should be paying a dime for it. It's each individual responsibility to make sure they have insurance unless they don't have mental or physical capacity to do it.*

Unions

- *Until you have providers contracted, it won't work, because costs will just continue to rise. I think most physicians know how to play the game and they will play it. It won't work in Alaska because specialists won't contract with facilities here in Alaska. Until you get providers to contract, mandating transparency so people can see what providers are all charging for procedures, you'll just pay more. This is Alaska, they're here for a reason. They're here to make money.*

Expansion of Medicaid Waivers Model

Advocacy/Research

- *This could be a very good policy, but we need to understand the fragility of rural community-based programs. If we forget ISSI or eliminate the resources for people with more severity, then we are screwed. We forget the reality of the situation.*
- *There are lots of possibilities with this approach. It could fit into the dual mandate and three share models. It could be a stand-alone activity or part of a more complicated set of answers.*
- *Once you move off of mandated benefits (disconnect the state from mandated federal benefits) you may not be able to provide the same level of care if/when the funding picture changes for the worse. With standard Medicaid you are required to accept federal money to provide certain minimum requirements. A waiver disconnects you from those minimum requirements. With a waiver you may have more flexibility with the offering, but what if fortunes change?*
- *Sure, but this would be a piecemeal solution. We need to bite the bullet and fix the whole system. Health care is considered a privilege when it should be considered a right.*
- *Medicaid waivers is a way to lurch towards single-payer model. It's a way to expand government insurance. It's a pathway to the single-payer model.*

Hospital/Administration

- *I think expanding the Medicaid Waivers Model is the best option of making substantial progress on a difficult issue.*
- *Some parts of system work well, like Denali KidCare, others are terribly bureaucratic. Waivers are a mixed bag. If you can do it like DKC, where it broadens, deepens the program without eligibility determinations, then I'm all for it. If it requires lots of eligibility determinations, we're just creating more work.*
- *That's not a bad idea if you could expand it with prevention programs. Anything you can do with prevention and/or outreach, you're going to save money in the long run.*

Social Services

- *Almost any model of that we would support. As an administrator, we'd have to find a way to streamline the paperwork. The DHHS purports to streamline but it always ends up as more work for us in the field.*

Insurance

- *You're going to attract certain kinds of individuals. Why work at all? People would work less so they could qualify.*

Legislature

- *If we had a steady stream of revenue we could depend on, we could do things like this. But oil production is decreasing 6 percent a year. If we increase benefits now, the only thing that will save us is if the price of oil increases. It's irresponsible for us as legislators to increase waivers one year then take them away the next year.*

Provider

- *It was only two legislatures ago that brought eligibility for Denali KidCare from 200% (percent of the poverty level) to 175%. Those were kids. If people are willing to deny care to kids, I can't see where there would be willingness to expand coverage to more adults. We need comprehensive coverage, not stop-gap.*

Unions

- *This won't address a large number of uninsured, but any incremental changes like this one is a positive step.*

Cafeteria Plans/Health Savings Account Model

Advocacy/Research

- *This is an employer-based program. It assumes people will make good choices to buy parts of a health plan, yet studies have shown that people don't know how to make good choices in cafeteria plans because they really don't know what is in their best interest. It really is mind-numbing complexity. The other problem is that some people will drain their spending down to zero and have no way to recover.*
- *These models would make it cheaper and great for healthy people, but not so great for people with high medical needs and costs. And it pulls healthy people out of the pool.*
- *One of the negatives: the idea that giving people incentive not to use health services is a good thing. Economists talk about "moral hazard." This HSA model to some extent relies heavily on this notion: there should be a cost to things, or they're overused. That idea is sound, but misapplied. Many health services that should be public health measures, we want people to go get check-ups, immunizations, health maintenance. That's where HSA's are very weak. There are some services that you shouldn't be thrifty about. Children should have well-child visits, etc. HSA's can work too well: people get super-thrifty, keep saving year to year, don't go to the doctor. Then they end up in the ER or worse. That's the great weakness. If HSA could separate essential care from the rest, it could be something that could work.*
- *These assume that you're employed in a company that gives health insurance. If you look at those who are uninsured, many of them are in high-risk occupations that don't have insurance. If you look at who are driving costs up, the unreimbursed care, millions of dollars that hospitals write off, they are in seasonal occupations: fishermen, loggers, pipeline, construction workers. They work in settings where these options may or may not be offered, but if they were, they might not be attractive. Largest proportion of uninsured are those young adults. They don't think they're going to get sick. They like the adventures. Not many resources. The cafeteria plan assumes that you'll choose something in your best interest. It won't do much for the portion of the population that are driving up*

the costs. It wouldn't address those most likely to be missed in existing system. It represents a solution to a teeny piece of the problem.

Hospital/Administration

- *This is a colossal mistake. It is sold as a great solution but it does nothing but raise the cost of health care. It provides incentives not to use health care, and puts barriers around preventative, routine care. This is destructive and puts first obligation on the patient, and will result in bad debt, charity care, and cost-shifting. People love consumerism, but with regard to health services, appropriate consumerism is a myth. I am not sure that individuals really want to take ownership of their health care.*
- *I like the idea of putting the incentives in the lap of those using the services. I worry about where health insurance is going. We continue to offer coverage for more and more things. When people pay out of pocket, they are way more conservative about the kinds of services they want or need. Providing incentives to consumer for saving money are worth looking into. I just think that when you're paying a premium you tend to want everything.*
- *Any time you give more responsibility to the individual, there's more of a chance that they won't manage the funds appropriately.*
- *These are generally good ideas, and widespread elsewhere. The lack of State income tax makes it less of an issue here, of course, and this approach does not really address the fundamental problem of employer-based health insurance. Such an approach would be very likely to encounter resistance from employers, and I believe rightly so, since they should be the best position to determine what their employees prefer.*

Insurance

- *It's a way to sustain an employer sponsored health plan. High deductible plans aren't the end of the road. The concern is that people are deferring care, and putting off the inevitable, and that the inevitable is more expensive.*
- *These plans shift the cost from employers to employees. It is not as painful to the employee as if they took benefits away completely. But it's not going to impact the uninsured in any way.*

Provider

- *I'm very skeptical of some cafeteria plans. I think that people are going to continue to try to keep as much money in their paychecks coming in. Therefore they're going to opt for lower health care. When they get hit with a tragedy or illness, they're going to be ill-prepared. Young people are particularly susceptible. We end up paying for it because they're not covered.*

Unions

- *HSA's can work, but they make the assumption that people can afford to set aside part of their payment. Many people live paycheck to paycheck. "Young immortals" never believe they're going to get sick. Their motivation to participate in HSA's isn't there. It should be available, but not a panacea.*

Other Models

- *We would save so much money by having single billing system. It could be a precursor to more dramatic reform.*
- *It's only in last 4-5 years there has been meaningful discussion about lifestyle changes and how important they are in the long term health and utilization of medical services. Education has impacted certain things like smoking. I think that over time we'll impact obesity. The fact is, we have no mechanism in place to teach people at the appropriate age how important these issues are or how to improve them. We took exercise out of our schools. If the schools don't think it's important, why should the individual? We err by not bringing health training more to the forefront at an earlier age.*
- *One component is prevention. The research has been done on closed plans where they have found a return on investment of 3:1. Some other research has shown that prevention can reduce medical*

costs 13:1. We need to finally recognize that demand reduction works. We can find how to reduce the demand for medical care. In Alaska, we constrain the public health infrastructure. They are our backstop for wellness programs. Public health funding should be quadrupled. This will have the largest impact on medical care. We would be remiss if we didn't take a good hard look at this strategy.

- *There are some local models worth looking at. In Philadelphia, the city runs a system of primary care clinics and behavioral health clinics. This needs to be looked at—this is probably a cost effective model. Also Community Health Clinics are really effective and really help to meet the needs for access to care.*
- *The managed competition idea is not new, but nobody talks about it because it's associated with Hillary Clinton, and seen as very complex. That is something that could be re-visited. It does induce competition and has the single payer principle. Intellectually it has more going for it than the pure single-payer.*
- *One of the groups that's working to expand health care in Alaska has tried to implement a voluntary agreement plan. Agreement among providers: "I'm willing to see five patients a month without insurance." Dozens of providers have signed up. It's not a model of payment, it's a model of a different kind of community response to the fact that some people out there can't pay.*
- *Looking at creative ways around pooling, covering small businesses would be a good initial step.*
- *The model of the Community Health Clinic.*
- *The Military Health System model: It's a kind of single payer. It works well for the military. Tricare is the insurance but it's all funded by the federal government. Everyone is insured, all get the care they need. There are minimal out-of-pocket costs.*
- *I think the Pay or Play (two-share) model makes sense. If everyone is in the system, everyone playing, the rate of inflation will [be controlled]. When healthy people waive off it's a problem. If we can get everyone back in the pool paying something it would be good.*
- *Get rid of all insurance. Outlaw everything but catastrophic insurance. It should be a menu-style system; people should see what costs what and shop around. Competition would drive down prices.*
- *Health reimbursement accounts are different from HSAs. I think employers could start using HRAs instead of offering a high deductible plan which has discriminatory issues and also limits access to care because of the high deductible. What the HRAs can do is help employers take the leap to a high deductible plan at lower premium cost and then self-fund the difference between the high deducible plan and the 80/20 traditional benefit plan. That way, they're only paying premiums on a lower covered plan; they're making up benefits by self-funding it. It does increase exposure to risk, but it's limited. It has tremendous savings because they're not funding premiums for claims that may occur, only funding premiums for claims that do occur.*
- *We need a system which is as universal as possible, which assures approximately equal care for all, is reasonably priced for whoever is paying the "actual" cost, and allows medical care providers to support themselves and their families in reasonable comfort.*

Preferred Model

- *I would pick one that emphasizes the participation of the individual. I would make the individual responsible for routine health care and have some provision for assistance with major health issues like major surgeries and life-threatening diseases.*
- *I think the best approach would be based on a dual mandate with elements of Medicaid waivers and the cafeteria plan.*
- *The three-share seems most practical. Personal responsibility needs to be part of this. People will take care of themselves if they are active participants in sharing the costs—ownership is really important. However, there has to be alternatives because there will always be people who just need to be taken care of. Both of these populations need to be addressed.*
- *Probably something like the dual mandate plan or the three-share—something that shares responsibility. It makes it clear that there's individual responsibility and community responsibility.*

- *My guess is that the most likely solution is fused model between three-share and dual mandate. There should be a sliding fee so that employee contribution is going to be dependent on their income to some extent. Employer contribution would be dependent on number of employees, size of compensation.*
- *The dual mandate model would be the easiest to implement. It's the closest to what we have right now. There is more opportunity for success with something less radical.*
- *A variety of approaches have the potential to accomplish some increased health coverage and access to care for uninsured Americans. However, to achieve this result in the low-income population, expanding publicly sponsored health insurance emerges as the most effective and efficient of the different strategies. Expanding public insurance programs is a highly targeted means of extending coverage to previously uninsured individuals with the lowest income and the poorest health.*
- *I am a proponent of Medicaid waivers if they are done appropriately; if administrative costs to manage them are not cost-prohibitive.*

Additional Comments

- *A physician shortage is happening across the country. Some places are worse than others. It will be interesting to see how things shape up. There obviously is a need to have sufficient numbers of providers.*
- *All these models could work but the population of US is so used to fact that we can go to the doctor and if we need an MRI, Catscan, we get it right then. If we go to any of these models, we're going to get the same as Canada, Europe, Australia: they're paying people to go off of their health plan. Of all of them, I would prefer to see one where the individual has to pay something.*
- *We need to completely re-design chronic care management and cost containment. But we are not there politically. Do we really need to put new hips in 92 year olds? The last three months of life care take up to 50 percent of Medicaid costs. We need to make tough choices. Look at an premature child that may spend most of their life in a hospital—we are willing to spend $1 million on that life, however, think what that same $1 million could do for preventative care for many more kids.*
- *I personally think that we should spend money on a "certificate of need" system and have government involved with that arena before it steps into the single payer or regulatory arena. If a doctor wants to build a new clinic or buy new machinery or a hospital wants to build new wing, they have to apply to regulatory commission. You have to show there's a need for it and it's not a duplication of services in the community. We have labs all over town here. We have duplication between Providence and ANTHC and regional hospital, and probably duplication from doctor's office to doctor's office. Technology is advancing so fast. Everybody wants the latest and greatest when they get really sick. It's not cost-effective for us to do open-heart surgery, or have a burn center, or treat leukemia in Anchorage. It's more convenient. But it's more cost-effective for that person to go to Seattle for major problems.*
- *There's a lot about our system that works. Even if 15% of population is uninsured, that means that 85% are. How many of 15% is uninsured because they can't afford it versus don't want it? We have systems (Medicaid, Medicare), we have private insurance, high risk pools, lots of mechanisms that do a pretty good job. Can they do better? Sure. We need to look at programs that need to be enhanced, use them with uninsured populations that they're designed to target.*
- *We've got $40 billion in the Permanent Fund, and we don't want to invest in health care for our citizens. It's difficult to understand how we're in this position. So many of our citizens don't have health care. We rank #1 all the wrong statistics: sexual abuse, alcoholism.*
- *Although our tradition has involved employer contributions as the primary funding source for health insurance, the variety of employers (especially employer sizes) and the fact that health insurance costs then become intertwined and interwoven with a worker's basic hourly pay motivates me to seek another basis of both funding and insurance source if at all possible. Any insurance system, except perhaps a Three Share Model, funded primarily, or even significantly, by employer contributions will complicate the providing of benefits, and will also probably result in dilution of benefits and differences in benefits, because of the many different situations and types of employers. A three Share*

Model (if the employer costs are low), Single Payer or Medicaid Expansion are the only models that reasonably assure equal benefits and (maybe) reasonable pricing for the individual user/family. The other models would inevitably permit continuation of our current, unacceptable spiral of ever-increasing costs.

Do you have any other recommendations to increase coverage of Alaskans who are currently uninsured?

If you had one minute to talk with state leaders about increasing coverage of uninsured Alaskans, what are the main points you would want to make?

Is there anything else related to the topic of Alaskans needing health insurance that you would like to make?

Summary

These final questions in the interview gave contacts a chance to focus on the issues they most cared about, as well as to bring up ideas that were not covered previously.

A popular topic in these last few questions was the simple, and urgent, need to change the current system – and that without change, it will only get worse. Contacts mentioned frequently the need for the legislature, in particular, to address the issue. But many also felt that residents needed to become more aware and involved in decision-making around health care policy. Several contacts pointed out that it is in the best interest of the state to have healthy (and thus more productive) residents.

A number of interviewees brought up the "delay of care" issue, pointing out that the current system encourages people to delay getting the health care they need due to cost; their symptoms get worse; they end up in the emergency room (the most expensive type of care); then, unable to pay, their costs are shifted to those who can. These comments, particularly with regard to emergency room (over)use, were echoed throughout the interviews; it was clearly an urgent topic among respondents.

A related issue that was raised often in these last few questions was the need for more preventative and wellness programs. One contact, echoing comments made by others throughout the interviews, suggested that too much money was being spent at the end-of-life instead of investing in health promotion and prevention. Another pointed out that many things outside of the health care system affect our health: food quality, air quality, water quality, education. S/he suggested that the state spend more resources on providing healthier environments (such as more bike paths, better car mileage, and better public transportation) and on early education programs such as Head Start.

Several interviewees brought up the need to increase eligibility levels for Medicare, particularly Denali KidCare. Other topics mentioned several times was the need for a long-term care plan; the aging of Alaska's population; the shortage of providers; and the difficulty employers face in providing coverage; among other topics.

Selected responses are presented below.

Selected Comments

Additional Recommendations

Advocacy/Research

- *I think it's time for the state of Alaska and residents to be more meaningfully engaged in their own health and social service programs, financially and otherwise. Until we are financially more engaged, we're not paying attention to what's going on. The first step is for legislature to agree that this is something we need to get involved in.*
- *Re-establish some health systems planning apparatus. We need forums for discussions of these issues. We use to have a state plan, but we have no forum. We are isolated and there is not place for a flow of information.*
- *A significant element is the whole idea of electronic health records and web-based information. Internet is not staying still. Web MD is showing up. The industry is in a high state of evolution and flux. The state needs to make a material investment in electronic medical records as well as the policies needed.*
- *When we talk about being uninsured, there's a difference between being uninsured and not getting care. Even though someone is not insured, they still get care when they walk into an ER. The cost of that gets spread throughout the rest of the system. They put off going to the ER, and they get worse.*
- *From a pure access standpoint, expanding Denali KidCare is important. Also, figuring out a partnership between the state and small employers. How can you help those businesses offer coverage?*
- *It would be really helpful, but probably unlikely, to develop a strategy that eliminates the duplications, like for tribal vs. non-tribal services. This is just added cost. It takes a lot more money to maintain separate, yet parallel systems. We need to build more bridges to encourage more economies of scale.*
- *We need to think about long-term care. We need to make the plan mandatory—and everyone chips in. This will make it more palatable. We need a paradigm shift. We warehouse our elders rather than treating them like kings.*
- *Employers are paying an unfair share. There is a perception that only people "on the dole" are uninsured and that just isn't true—there are working families, self-employed, etc.*

Employers

- *If you go the route of pooling, take one step further: self-insurance. I've heard some places that do that; there are incentives built into the system for people to seek preventative care. It's cheaper if your claims are lower, then people do more up-front. Overall claims go down, and costs go down.*
- *Education for young people. If a young person makes minimum wage, they can't afford insurance. The state should allow them to buy into Medicaid based on salary.*

Hospital/Administration

- *Something has to be done for Medicare so that elders don't lose coverage when they turn 65.*

Insurance

- *If you give people the choice, and they choose not to be part of the system, it shouldn't be possible for them to then file for bankruptcy because of health issues. Everyone has <u>access</u> to care. It's not a function of access. It's a function of how we're going to get more people to pay.*

Providers

- *Where we are today, we are a long ways from single payer. We should encourage legislators to increase eligibility wherever possible. Where there are options to cover more people we should do it, for example, for domestic partners. We should help to facilitate any type of development of increasing insurance pools to lower rates. We need to be supportive of those.*

- *I believe a lot in the Project Access model. Other urban centers could adopt it (Fairbanks and Juneau, primarily). It could be grown locally on the backs of private charity and good will.*

Unions

- *We do have copious amounts of Permanent Fund monies which, if used intelligently, might well provide or help to provide meaningful benefits for all Alaskans.*

Advice to State Leaders

Advocacy/Research

- *We need to get the public more engaged and involved in decision making around our health care system. They need to see a connection to their lives.*
- *The fact is I think there is a finite amount of resources available. As we increase amount of cradle-to-grave insurance, we increase the utilization of health services. It's not necessarily productive. It's an interesting blind spot we have: we equate frequency of visits with good health. Nothing could be farther from the truth.*
- *Don't get wrapped up in insurance. It's about improvements in the health status. The problem is bigger than financing.*
- *There is real need. Without intervention it is going to be continue to get worse and it needs to be rationally coordinated within the state.*
- *It's all fine and good to increase insurance, but we need infrastructure to provide the health care. We need the doctors.*
- *It looks like we have to take the incremental approach (a state-run, one-payer program is not viable at this point.) There have been proposals to expand Denali KidCare, to expand Medicaid, to let people buy in to Medicaid coverage. These things let us close in from either end of the age spectrum and then address/subsidize the working age people.*
- *The state should have a law that doctors should treat people under Medicare.*
- *The division of insurance should hold public hearings for companies who want to raise insurance rates.*
- *The state should heavily subsidize community health clinics. It is pathetic how little the state is paying.*
- *There is a large presumption in the legislature that people who are uninsured are people who aren't working. And that isn't true. Working Alaskans are uninsured and can't access insurance because it is so expensive. The other thing is that legislators need to recognize that it is economically beneficial because healthy people lead to higher productivity, get jobs and have a positive impact on our economy.*
- *We need to look at long-term care. The majority of payments are out of pocket. People think Medicare and IHS covers LTC and it doesn't. Younger people don't understand their need to save and plan for LTC until it is too late.*
- *We need a business health coalition. These were active in the early 90s. These were meetings of mainly HR people who met on a monthly basis to discuss insurance issues and what they are doing to lower health costs. Unions were also at the table in these discussions.*
- *The supply of providers is very problematic. Enable UA to train far more nurses. Funds should be earmarked for scaling up the nursing program.*
- *We should shift our insurance coverage to prevention and primary care. We're spending most of our money at end-of-life rather than investing in health promotion and prevention. We've decreased our investment in our kids, in developmental programs. We have to ration health care.*
- *A unique aspect that is underappreciated in Alaska is how multi-cultural and diverse our urban centers are. Culturally-appropriate services for ESL is a big issue. It's related to health insurance. If we have recent immigrants who come from a setting where there was not health insurance, the idea that you have to have it is not understood. We need to make sure we invest in marketing in more than one language so people know what is available.*

- *Encourage a broad public discussion of more sharply defined options through wide dissemination of Governor's Health Care Task Force discussions. Provide adequate funding and support to Governor's Health Care Task Force to enable them to more sharply define options that might work in Alaska. Encourage public participation and comment in the Governor's Health Care Task Force process.*

Employers

- *Our health indicators are overall really abysmal. The health and wellbeing of our families, our citizens, is critically important to the health and wellbeing of the state. It's becoming more and more challenging for people to get the health care they need. We've got small population and part of the population is covered (Alaska Natives). To cover comprehensively the rest of the population would not be a stretch.*

Hospital/Administration

- *Don't focus on coverage. Focus on access. Take up the rallying cry so we don't become more economically uncompetitive in the global market.*
- *We live in a great nation and it's a shame that we have 44 million Americans that are without health insurance, and a large part of that is children. Studies show that people without health insurance end up with more health needs. They go without preventative care or with things getting worse than it should have gotten due to neglect. We're a leader in everything else. We have great professionals and technology and we have the best of the best, and I don't think we're managing it the way that we could.*
- *We need a lot more prevention programs. They lucked out with the price of oil going up. The state has to say, we're not an insurance company. We're the payer. We need to do something to lower the costs. They need to help people become healthier. If you're on Medicaid, you don't have incentive to be healthy. We need accountability.*

Social Services

- *How interconnected health is with other issues they care about. Children with health issues aren't going to learn and will become a burden on the system. Adults needing health care will end up on welfare, not able to work. The leading cause of bankruptcy is health catastrophe. Untreated illness, particularly mental, is causing our prison population to rise. We can't have a thriving economy or quality of life without people's health being attended to. I'm talking about preventative health as well as wellness. We're dealing with the tail end of the problem. There is too much use of the emergency room. The other big problem we're seeing is dental. That's an acute lack in Anchorage. The ERs were reporting to us that they're seeing three patients a day that are dental issues. All the people need is pain management until dental work is done. That is a growing problem.*

Insurance

- *It's a very big social problem. It's probably not solvable by government. Unless they make it very clear, understand that it's going to cost a lot more money, will have to raise taxes, or shift revenue from what we perceive to be important programs into health coverage.*
- *Let's not overlook that, though it's expensive, health care provision is driving our economy, especially in Southcentral. If you weighed that all out, where are we at?*

Legislature

- *Public health is doing all they can to get info out to communities. What they need to do to make sure people are responsible for their health.*
- *Insurance should cover well-baby checks. If babies can get those from the beginning, it could save us a lot of money in the long run. Also, allow parents to have insurance be able to keep children on until 25 years regardless of school or not. There are all kinds of things we can do in that light.*

Providers

- *We need to make health care a priority in the state. It's not a priority. We can afford to do it, but we choose not to.*
- *I would point out that most uninsured are employed and are contributing to the economy. I would point out that there is an ethical lapse of not providing a basic human right for one-fifth of our citizens.*

Unions

- *I always felt the living wage concept is a good one. I also like the idea of that the State could be a leader by requiring companies that bid on state contracts be required to provide health care insurance to their workers.*

Final Comments

Advocacy/Research

- *There is a major overarching strategy that the state should take: 1) lay the foundation for intelligent decisions (research); 2) take incremental partial steps where it makes sense; 3) and maybe we should sit back and watch what is happening in other states. Let them make the mistakes and let's learn from them. Let's position ourselves to take advantage once the knowledge becomes available. In the meantime, if there are small things to do, like Denali KidCare, etc. then definitely proceed on those.*
- *I'd love to see the state figure out some way to use its leverage to be a purchaser. It could be an efficient provider. It could deal with quality, also, provide some level of pay for performance. There is some hesitancy. The state doesn't think PFP (Pay-For-Performance) works. I don't think the state is looking at quality seriously.*
- *PERS and TERS are screwed up. Health care should have been decoupled from retirement benefits. HSA under Tier 4 is a disaster—people will use up their assets in four years. It is cheaper to insure all of us than what we are currently spending on health care. We need to take a hard look at the cost and benefits of home and community based care to avoid use of the emergency room and treat at a much lower cost.*
- *There's lots of things that impact our health that have nothing to do with health care system. We should be investing in early education. Protection of health food, air, water. Investment in Head Start, adequate mental stimulation and physical activity. We could invest in healthier environments. More bike paths, better car mileage, better public transportation. I recognize the tremendous importance and value of the health care system in keeping individual people healthy. But one of the obligations of the state is to look at other investments that allow people to be healthy.*
- *We need to make sure the state decision makers know there are no uninsured people—someone has to pick the costs and the state is picking up an inordinate amount. Also, the senior population is growing fast. We are losing doctors. We can't replace them fast enough. We need to be more aggressive in attracting them (perhaps pay off their loans).*
- *Invest in areas that focus on life expectancy and overall health. Look at mortality and morbidity, plan from that point of view rather than "getting 100% coverage." That's not the holy grail. It does matter that everyone has health care entitlement. Not every form of health service, but basic health care is an entitlement. The government and all those involved need to shift from being completely concerned with health insurance coverage as the answer.*

Employers

- *To help the fish processing sector, we need a statewide middle-income risk pool. This would benefit the more professional processor worker class (as opposed to highly seasonal). This would make for a much larger pool, and be more affordable. It might be more likely to catch some of the migrant workers, too.*

Hospital/Administration

- *I do think the more responsibility an individual has for the financial part of it, the more prudent they are in making selections. Studies have shown that more isn't always better. We have a health system that provides way more than in other countries. But the overall welfare doesn't seem to be better.*
- *One way or another, society pays the cost of treating the uninsured. People without health insurance postpone necessary care and forego preventive care - such as childhood immunizations and routine check-ups - completely. They use the Emergency Room more frequently, and because the uninsured usually have no regular doctor and limited access to prescription medications, they are more likely to be hospitalized for health conditions that could have been avoided altogether.*
- *While many approaches have the potential to increase health coverage and access for uninsured Americans, expanding publicly sponsored health insurance offers the most targeted and efficient strategy to achieve this result in the low-income population. Through an expansion of public insurance programs, coverage can be extended to previously uninsured individuals with the lowest income and the poorest health… the relevant research literature suggests that the following are key elements in the structure of an effective program to meet the coverage and care needs of the low-income uninsured population:*
  - **Eligibility**. Basing eligibility for publicly sponsored health coverage on low income, without categorical restrictions, could substantially reduce the number of uninsured Americans and assure coverage for those least able to pay.
  - **Participation**. Simple enrollment and recertification processes that minimize burdens on applicants are likely to promote participation. Well-designed outreach is also important.
  - **Use of Premiums**. Premiums can be expected to depress participation among people living in or near poverty. In the low-income population, the use of premiums to generate revenues for financing needs to be balanced carefully against the goal of increasing health coverage.
  - **Scope of Benefits**. The relatively poor health status and multiple health problems of low-income Americans, combined with their limited ability to afford care out-of-pocket, mean that comprehensive benefits are important to provide protection adequate to meet the diverse health needs of this population.
  - **Use of Cost-Sharing**. Even at low levels, cost-sharing can adversely affect access to care for low-income people. Given current gaps in access for this population and efforts to promote better management of chronic disease, the use of cost-sharing should be weighed judiciously and, if adopted, relate to income.
  - **Access to Care**. Having health insurance is necessary but not sufficient to assure access to care. Continuous coverage, adequate provider networks, coordination of care, and elimination of a variety of both financial and non-financial barriers to access are needed to realize the full potential of coverage.
  - **Financing**. Financing that is determined by enrollment and utilization directs public dollars most efficiently to meet health coverage and care needs. Federal matching of state spending permits the costs of coverage to be shared, and can promote national priorities while preserving state policy discretion. A federal-state financing partnership that accounts for countercyclical pressures at the state level, the national trends causing costs to rise, and the federal government's greater fiscal capacity could provide a strong and sustainable source of support for a program of health coverage for low-income Americans.

Social Services

- *We're a small population, there's no reason we can't get on top of these issues. We've got money, it's a question of where we put it. Whether you think it's individual responsibility or corporate, it doesn't matter, the fact is we have lousy health outcomes. It hurts everybody.*

Insurance

- *I think nailing down the number of uninsured in the state is important. And then finding out, do people have a method for financing their care/insurance. I would contend that the group whose only option is to file for bankruptcy is smaller than we think.*

Providers

- *Funding continues to decrease for behavioral health. We've created a system that provides only emergency and crisis services. For someone chronically, mentally ill, adult, male, there are no services for that person. Those people show up at hospital ERs, or get in trouble with the law and end up in*

jail. The state doesn't fund anything for those people. If you have chemical dependency problems on top of that, you have no support, no help.

Unions

- *I wonder how technology will change this issue. Technology is great, but expensive. Some procedures are designed to support technology. Docs and nurses wages have increased, but really it is the cost of technology that is driving up our costs.*
- *Transparency. We've got to get transparency and hold providers' feet to the fire in providing costs so that residents can make prudent decisions on what's reasonable. We're requiring high deductible plans, and relying on them to make responsible decisions, but we haven't given them the tools of transparency to make prudent decisions.*

DHSS Discussion Group

As part of the Key Informants project, McDowell Group facilitated a discussion group among nine employees of the Department of Health and Social Services on July 9, 2007. The meeting addressed the findings of the key informant interviews and topics that were of particular importance to the attendees. The meeting also included a presentation of findings from other projects under the State Planning Grant: focus groups, household survey, and business survey. Following are general themes that emerged during the discussions.

People want to exercise personal responsibility for health care decisions and insurance. They need a system that facilitates effective individual action by minimizing cost of care, supplying information (informed consumers), eliminating barriers to access (for services and insurance), and recognizing realistic limits (based on ability to pay) for individual financial contribution.

Alaska faces emergency situations:

- Among the highest costs of care in the nation
- Lack of access to services under Medicare
- Gaps in coverage, for example families between 175% and 400% of poverty
- Demographic trends will place increasing, and likely unmanageable, demands on the system (e.g. long-term care)

Alaska faces barriers:

- Geography and population mean lack of scale efficiencies
- Shortage of statewide advocacy groups (e.g. for children) to educate the public and galvanize legislators
- High seasonal and non-resident employment
- Private sector (insurance) strategies have not improved Alaska situation

Alaska has pockets of opportunity:

- Positive attitudes toward Medicaid (as a partial model)
- Growing motivation in the business community to find new solutions (need better avenue for their input)
- State is in a position to exert leverage over market prices
- A commitment simply to getting everyone insured would strengthen the whole system and make other reforms more achievable.

Progress toward reform will require that discussions move beyond code words and political ideologies and address the components of the problem:

- Cost of care (including lack of cost controls in Alaska)
- Difference between access to care and access to insurance (including a better understanding of what people are in each group)
- Roles that employers can and can't be expected to play
- Need for political commitment to fundamental principles before solutions can be crafted
- Fragmented coverage solutions risk increasing already high administrative costs
- Vested interest in the status quo and fear of the unknown

Selected comments are presented below.

- *I believe in personal responsibility, but there has to be an effective way to do it. It's often difficult with health care. Some people's needs will always exceed what they can take care of… Most people are perfectly willing to assume a high degree of responsibility if they think it's going to be effective. But they don't want to put a lot of money into something when it's not going to provide.*
- *Doctors are saying they don't want single payer medicine. Doctors and dentists are fearful it would be similar to Medicare, which is perceived as being dysfunctional. They would rather come up with convoluted models.*
- *Is education [regarding insurance] happening to where we can have the information and have advice? It's a touchy area. I don't think that most people have the information to make wise decisions.*
- *For the uninsured population, to try to negotiate [insurance], it's so confusing. To think people can go out and choose the right plan…it's overwhelming.*
- *Another aspect is when you're sitting in clinician's office, they feel compelled to order all these tests, in some cases because of liability and malpractice. We've developed a standard of care. There is some truth that the increase in expenditures is increased utilization that is not critical. Doctors feel compelled. Can you shift enough payment over to the patient that it pushes him or her away from getting that third MRI scan in a year?*
- *My own opinion is, you should provide incentive to use their health care in a judicious way. The only way you get to that is to look at people individually, at the portion of their income they'd have to spend. The system we have now, even for those insured, the premium is so high. $200 is a lot more money to them than it is to me. I don't see how to provide for that imbalance.*
- *Our data shows that we've reduced the number of uninsured. But Blue Cross premiums have increased. It doesn't make sense.*
- *Many people with chronic problems want to be healthy. There's a thought that some of these people are abusing themselves. Maybe, but I think it would be helpful if there were more appreciation that people do not like to be sick, they don't like to be in pain. Most people will say they'll do what they can to follow good advice, to take care of themselves.*
- *One of the biggest thing to resolve is: are the costs appropriate or inappropriate?*
- *From a political standpoint: any time you move towards a new model, someone will hit you over the head with it…even though you're only trying to make small degree of progress.*
- *There are so many people who are middle class and up who have vested interest in the current system. They don't want it to change that much. A lot of influential people are in that position. Do we want the federal government to step in?*
- *People are nervous about "rationing of care" but we already have that. We have controlled access to care. You have to pick the dimensions and criteria for rationing. Economic status? Need? We need to decide what's fair.*
- *There is anecdotal evidence that health care costs are too high here. We don't have the same drivers here as in other states where costs are going up. We have few controls on cost. There are not a lot of provider agreements.*
- *Some proposed solutions increase the complexity of determining who is eligible and who isn't. The administrative overhead will increase, figuring out who is eligible and who isn't.*
- *Alaska is a good example of what's wrong with our system. We are a small population state. We have high percentage of military, significant VA population, high percentage of IHS, served by Medicaid, and private insurance; it shows all the complexity of a health care system in small state. It would be interesting to total admin costs for all these plans.*
- *What we don't know is if early life investment affects end of life costs. We all die sometime. But is anything we do in between going to make us die cheaper? Do costs go away? Costs in middle (costs of chronic disease): those can be saved with prevention.*
- *Do we have the will to say, you don't get good end of life care?*

- *This is a looming crisis. 15-20% of health care money spend in the last year of life. How long are we going to wait? The longer we wait, more brutal it could be. What age do we stop doing hip replacements? Americans have gone farther and farther to individual concerns.*
- *Many people would prefer not to give up the benefits they have to help those less fortunate.*
- *We need leadership at the state level. We don't have that. I think until you get top politicians in this state to take on theses issues, we're all tinkering around the issues.*
- *Alaska is one of seven states that doesn't have a children's advocacy organization. That's where these issues come from in other states. We don't have strong statewide advocacy with regards to children.*
- *[Regarding Three-Share Model:] It's got to be something where it's simple to move the money around and manage enrollment so employers can be attached to it. It can't be burdensome on employers. They're not going to put time/energy into helping us manage a program they see as ours.*
- *Engaging business leadership in state is critical. They are probably more open now than they used to be.*
- *When you look at other industrialized nations, they provide health care in different ways, but they all do it. Until you can get everybody at the table all willing to do it, we're going to spin our wheels. You want enough of an outline that you don't waste their time talking about high-concept ideas. People do it different ways and make it work. The idea is that almost every other society/culture, there is an acceptance that this is a right that you have access to affordable health care. Every place will complain about how long it will take to get a certain operation. There's always going to be compromises, sometimes end-of-life compromises.*
- *Medicaid is a good model. It can't solve of our problems because of laws about income eligibility. It partners with the feds so there's a lot of moving pieces. You can't fully depend on Medicaid. It could be a model for universal payer systems. In and of itself, it's not going to get you where you need to go. You look at so many working families that are uninsured.*
- *I think people need affordable health care, not affordable health insurance.*
- *I like the re-insurance idea. We have resources like the Perm Fund. You help the small employers. That's intriguing to me. It's a small enough group, that might be an idea the state could handle.*
- *I was always thinking that once middle class people start feeling effects of this, you'd think you'd have the groundswell to do something. But I don't see it in this state.*
- *We have a situation emerging in places like the Kenai. There is not a good level of coverage through employment. There are providers and community health centers. There is competition for health care dollars, but there aren't enough dollars to take care of the people who are there. What puzzles me is how to find models that will work across the state. The other thing is Kenai and Kodiak is there are hospitals. They are the ones getting hit with ER visits by people who can't pay.*
- *Medicaid supports low-income people, and the entire health care system. We spend time trying to make sure that policy decisions don't undermine other parts of system. Somebody is always trying to dismantle the system. It has to stay strong. You can use that same model. You get everybody insured, using a couple of different models, couple of different payers, then you insure access to health care to everybody. There's all these different ideas on how to do that. You have to have political will to do it. We've got tons of information, but until you have political will you can't do it. All these arguments (keeping money in the state, being able to shore up system, huge employment sector) tend to make more sense, than just saying we need more money for Medicaid.*
- *The costs were estimated for single payer system they were very close to what was already being put into health care system. I applaud the department for keeping these subjects alive. There needs to be better communication out there between people who are suffering and people who can provide relief. There needs to be handful of people who can stick their necks out.*
- *I'm reluctant to patch problem of uninsured without dealing with cost, you've changed nothing. The costs will continue to rise.*

Appendix

Interview Protocol

Can you provide me some background on your experience with health insurance issues?

What do you think is Alaska's biggest challenge in increasing insurance coverage to more Alaskans?

Responsibility

Who do you think should be *primarily* responsible for providing health insurance to Alaska residents? State government, federal government, employers, or individuals? Others?

Medicaid/Denali KidCare/Medicare

Do you think the Medicaid program is effective at providing access to health care for low-income people?

Do you think the Denali KidCare program is effective at providing access to health care for children?

Do you think the Medicare program is effective at providing access to health care for seniors?

Statutory and Regulatory Picture

Are you aware of any Alaska laws or regulations that are preventing the expansion of health insurance coverage to more Alaskans? If so, what are they?

Health Insurance Models

(For each model described below)
Do you think this model would be effective in increasing coverage for Alaska residents?

What type of barriers do we face in Alaska in implementing this type of model?

Three Share Model

A health insurance program funded under a shared financing system. The government, employers, and employees would share financing. For example, an employee would pay $50, the employer $50, and the state $50 for a particular plan.

Dual Mandate Model

The dual mandate model requires that every employer offer health insurance, and that every resident has health insurance. It does not require employers to cover premiums, but the employer at least has to allow workers to pay their premiums pre-tax. Unemployed residents who don't qualify for Medicaid may receive a subsidy from the state to pay for premiums, depending on their income level.

Single Payer Model
An approach to health care financing with one source of money for paying health care providers, such as a publicly administered trust fund. Most proposals call for comprehensive health care coverage for all residents and would provide for choice of health care providers.

Expansion of Medicaid Waivers Model
This model would build on the current Medicaid waiver model. More waivers would be available to develop home and community-based programs, which would reach more of the uninsured population. An example of Medicaid expansion in Alaska is Denali KidCare.

Cafeteria Plans/Health Savings Account Model
These plans apply only to employed people. Each employee can pick and choose the programs they want to participate in. If you want more, you will have more taken out of your salary pre-tax. Employer contribution would vary depending on their desired level of participation.

Do you know of other models worth considering?

Which health insurance model do you think would be most effective at expanding health insurance to more Alaskans? And why?

Recommendations

Do you have any other recommendations to increase coverage of Alaskans who are currently uninsured?

If you had one minute to talk with state leaders in both private and public sectors about increasing coverage of uninsured Alaskans, what are the main points you would want to make?

Is there anything else related to the topic of Alaskans needing health insurance that you would like to make before we end this interview?