Alaska State Planning Grant Application

II. Table of Contents

IV. Budget

Electronically submitted.

Budget requests will be used for planning activities related to the expansion of health insurance to Alaska's uninsured population.

See Section V for a detailed line item budget and justification.

VI. Staffing Plan & Personnel Requirements

Project Personnel for Department of Health and Social Services Project Team
The Project personnel are located in the Office of the Commissioner, Alaska Department of Health and Social Services, in the Health Planning and Systems Development Unit. Unit staff have exceptional depth of experience with health system planning and program development. Their skills and educational background will help to realize all program expectations. Three staff positions (two at 100%; one at 50% time) will be newly hired specifically for this grant. The brief biographical sketches reflect skills & experience in community development, needs assessment, program evaluation, coordination of healthcare workforce activities, data sharing, planning & implementation of training, policy development and project coordination. The staffing plan described below & in the budget justification reflects matching of tasks with appropriate skills & knowledge. Each current staff member has partial funding from other HRSA and other compatible sources for related work, which is how the Health Planning and Systems Development Unit is able to tap the diverse and highly qualified staff.

- Pat Carr, MPH .10 FTE (Health Program Manager III), **SPG Principal Investigator**, as head of the Health Planning and Systems Development Unit, will serve as liaison to Department leadership; advise DHSS Project Team, oversee program effectiveness, infrastructure and policy alignment with internal and external partners to enable this program to succeed.
- Project Director (Planner IV) .50 FTE – *new hire*, **SPG Project Director** will manage the SPG project, keeping project on track, sustaining communication and reports with HRSA, providing leadership to entire project team, serve as facilitator for State Advisory Group and sustain quality and timely assurance of project work plan.
- Alice Rarig, MA, MPH, PhD. .25 FTE (Health & Social Service Planner III), **SPG Research Manager**, will provide expertise for planning and organizing the research projects (employer survey, household survey, etc.), for policy analysis, and advice to all data issues related to the project. Assure data quality measures are met.
- Nancy Barros, BA, MA. .50 FTE (Project Coordinator), **SPG Project Coordinator,** will have major coordination and communications responsibility for support to the Statewide Advisory Group, and will be the team member with major coordinating responsibility for the key informant interview and focus group tasks. Also responsible for working with Project Director to assure quality control of the project.
- Jacqueline Fowler, BA MPA. .25 FTE (Health Program Manager II), **SPG Budget & Contract Manager,** will be responsible for contract management, and budget tracking, and will have responsibility for assisting with the literature review, gathering and analysis of SPG state results and coverage options.
- Research Analyst, 1.0 FTE – *new hire* (Research Analyst III), **SPG Research Analyst**, will provide data analysis as directed on the results of prior and current surveys, support the qualitative and quantitative analysis of data collected. Review and investigate other states successful data gathering methods to be incorporated into Alaska's data sets.
- Administrative Clerk II/III, 1.0 FTE – *new hire* (Administrative Clerk III), **SPG Administrative Clerk**, will create, sustain and manage the file system management, travel clerk functions, communications (setting up teleconference arrangements and

meeting places). Also responsible for the complex process and variety of clerical support to the project staff.

- Cheri Walters, .10 FTE (College Intern II), **SPG College Intern**, will provide support to project team by entering data, compiling reports for meetings, organizing support materials for State Advisory Group meetings and assisting where needed.

Total staff time requested is 3.7 FTE. The titles in parentheses above are Alaska human resource job classifications.

In-kind Departmental Support:

- Anthony Lombardo, Deputy Commissioner of HSS, .05 FTE in-kind support, will chair the SPG Leadership Team and communicate regularly with Commissioner Gilbertson to keep him apprised of project progress, and ensure strong intergovernmental and interagency relationships.
- Jerry Fuller, Medicaid Director, .05 FTE in-kind support, will be on the SPG Leadership Team and DHSS Project Team to ensure liaison to the Tribal initiatives of DHSS, full access to Medicaid data and to policy discussions regarding Denali KidCare (S-CHIP) and waiver programs that might be enhanced or added.
- Barbara Hale, Medicaid Analyst, .05 FTE in-kind support, will assist with data, history and contacts related to Denali KidCare. Jon Sherwood, Renee Gayhart and other Commissioner's Office staff are also expected to participate regularly.

Brief Biographical Sketches of Key Personnel

SPG Principal Investigator - **Pat Carr, MPH**, (University of North Carolina, 1975). With over twenty-five years of experience in rural health, primary care, public health, and health planning, she has been employed as a Health Program Manager with the Alaska Department of Health and Social Services for ten years. She is Director of the Health Planning and Systems Development Unit in DHSS, Office of the Commissioner. She has managed statewide health programs and numerous federally funded grant programs. She worked as a university faculty member in Alaska and North Carolina to conduct research projects and teach graduate and undergraduate courses in community health and program planning. She has provided technical assistance to a variety of local & statewide organizations. She has written a textbook on health program planning, research reports, and program guides. She has held memberships and offices in statewide health professional organizations.

SPG Project Director – new hire. This position will require a minimum of a bachelor's degree & five years of professional work experience in planning and/or in performing planning functions. The Project Director will have the ability to supervise and coordinate subordinate staff, establish and maintain effective working relationships with various organizations within state government and other organizations, work independently and effectively, communicate both in writing and verbally. The position requires thorough knowledge of forecasting methodologies, statistical principles and methods, data gathering techniques and procedures, research objective and impacts. The Project Director will be able to assist in formulating policy, develop proposals for legislative action and be able to meet unusually short deadlines with a potential of high public scrutiny and impact.

SPG Research Manager - **Alice J. Rarig, MA** (Yale Graduate School 1970), **MPH** (Yale Dept. of Epidemiology & Public Health, Medical Care Administration, 1971), **PhD** (U. Mass. School of Public Health, 1993, major in health policy and management, minors in biostatistics and epidemiology) has worked as state demographer for Massachusetts from 1993-1997; Alaska Health & Social Services Planner III since 2000, managing the Data and Evaluation Unit for three years (responsible for evaluation projects and managing Healthy Alaskans 2010 work), and working in the Health Planning and Systems Development Unit managing primary care data resources, shortage designations process, program evaluations, hospital discharge data system, telehealth, and mapping. She provides expertise on data management, privacy issues, certificate of need, planning, policy analysis, mapping, data analysis and presentation, and performance management. She served as one of Alaska's representatives on the Robert Wood Johnsor Foundation sponsored Turning Point National Performance Management Collaborative.

SPG Project Coordinator - **Nancy Barros, BS, MA**, Organizational Management (University of Phoenix 1995), BA, 1993, has served in the DHSS for 4 years with one year as a Health Planner II in Medicaid financing, and 3 focusing on workforce development and primary care development tasks. She founded Missing Children of America, Inc. in 1981 and worked to start the National Center for Missing and Exploited Children. She has been the Director of a Red Cross Chapter and served a Fellowship in Region VII (Kansas City) for HUD as a Community Builder and Field Instructor at the School of Social Work at Arizona State University.

SPG Budget & Contract Manager - **Jacqueline Fowler, MPA, BA** (Elementary education/ major multiculturalism) has worked at DHSS since 2003. She came to Cordova, AK in 1983 and for 8 years there directed a non-profit organization. She was Assistant Director with Hope Community Resources, & Admin. Manager III with the AK Dept. of Education and Early Development where she oversaw budgets, personnel and programs. She worked for five years with the Health Promotion Program supervising staff conducting surveys for the CDC. She has served on local planning commissions.

SPG Research Analyst – new hire. This position will require graduation from an accredited college and two years of research and/or statistical analysis experience. The candidate will have the ability to gather, compile and analyze research data and present reports and summaries in written, tabular and graphic form; maintain statewide statistical information and develop appropriate reporting procedures; analyze situations accurately and adopt an effective course of action and work with a high degree of independence.

SPG Administrative Clerk – new hire. A high school diploma or the equivalent is required. This position will require the candidate to perform specialized complex clerical work and/or a wide variety of clerical services requiring independence, judgment, and initiative in determining office needs, in prioritizing and organizing work, and in determining the appropriate action to be taken. This is the advanced/lead level clerical class position. In addition the candidate will have a strong working knowledge of the use of computer systems and software in a business environment.

College Intern - **Cheri Walters**, attending the University of Alaska, Southeast studying business administration, she has been working as a College Intern for the Health Planning and Systems Development Unit since 2003 for data entry and other support functions. She will complete her BA in Business Administration in 2006. She worked previously for Nome Public Health Nursing office.

VII. Assurances

Healthy People 2010 and Healthy Alaskans 2010 Goals, Objectives and Targets:

Healthy People 2010 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) eliminate our country's health disparities. The program consists of 28 focus areas and 467 objectives. HRSA has actively participated in the workgroups of all focus areas, and is committed to the achievement of the Healthy People 2010 goals.

Alaska engaged in a broad and intense public-private collaborative three-year planning process (2000-2002) to adapt Healthy People goals and objectives to reflect Alaska's needs. The overall goals are to improve the health of all Alaskans, eliminating health disparities, consistent with national goals. Healthy Alaskans set a target for insurance coverage in its *Healthy Alaskans 2010* planning document[1] as a leading health indicator: no more than 5% uninsured by the year 2010, with no disparities between race or ethnic groups. The goals of the proposed project are to work toward achieving that target as the short term goal, and to make it possible to reach universal coverage in the long term consistent with the *Healthy People 2010* goal 1-1 of 100% coverage. *Healthy Alaskans 2010* also has a target of full insurance coverage for all Alaska children by 2010 (target 15-2), a target for full enrollment of eligible children in Medicaid or Denali KidCare (target 15-7), as well as targets for improvement in access to primary care related to geographic barriers, affordability of care, usual place to go for care, and provision of clinical preventive counseling.

In both Alaska and the U.S., the percent of all persons uninsured has increased instead of decreasing since 2000, according to the Current Population Survey (14.2 to 15.6 for all people in the U.S., and 18.7 to 18.9 (not a significant increase) for Alaska). The proposed project is intended to gain more precise information on the regularity and extent of insurance coverage of Alaskans in relation to their employment, public programs, and access to health care providers. The results of the data gathering should enable more definitive monitoring of progress toward both HP2010 and HA2010 objectives, as well as provide insights into the reasons for trends and patterns observed. The policy initiatives to be developed by the proposed project will be the first comprehensive statewide strategic planning process aimed to achieve the goals for 2010. Thus the proposed project is inherently linked to the national and state planning efforts to achieve 100 percent access and zero disparities.

[1] http://www.hss.state.ak.us/dph/targets/ha2010/default.htm has links to the three volumes of *Healthy Alaskans 2010.*

IX. Project Abstract: Governor's Designation Letter and Commissioner of Health and Social Services Letter; Abstract and Project Overview

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

March 1, 2005

Elizabeth M. Duke, Ph.D., Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Duke:

Alaska is pleased to apply for a new State Planning Grant (CFDA 93.256) to examine options for providing access to affordable health insurance coverage for uninsured Alaskans. I am designating the Department of Health and Social Services (DHSS) to be the lead agency for the project in Alaska, responsible for carrying out our application, if approved and funded. DHSS has the authority to oversee and coordinate the activities required, and it is the locus of a number of other related activities related to improving the health of our citizens.

I support the effort to research and develop new approaches to ensuring availability and affordability of health insurance. We need to better understand the characteristics of the uninsured, the barriers to coverage, and the dynamics of the health insurance and health care markets to make informed decisions about available or new potential options.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

cc: Joel Gilbertson, Commissioner, Department of Health and Social Services

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

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March 29, 2005

Elizabeth M. Duke, Ph.D., Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Duke

The State of Alaska Department of Health & Social Services is submitting an application for HRSA's State Planning Grant Program 2005/06 (CFDA No. 93.256). We have been appointed as the State's lead agency to oversee and administer this research and planning grant specifically to examine Alaska's uninsured. Governor Murkowski's signed letter, dated March 1, 2005 is included in this packet and designates DHSS as the lead agency for this project. DHSS Deputy Commissioner, Anthony Lombardo, will be the principal contact person. Working with him to oversee the DHSS Project Team will be Pat Carr, Manager of the Health Planning and Systems Development Unit.

The principle State agencies participating in this research and planning grant and serving on the State Planning Grant Leadership Team will be: the Commissioner of Labor and Workforce Development, the Director of the Division of Insurance, Department of Commerce and Economic Development, the Commissioner of the Department of Administration, the Director of the Division of Public Health, and the State Medicaid Director in the Department of Health and Social Services. The key agencies that will serve on the Statewide Advisory Group will be the Alaska Public Health Association, University of Alaska, Alaska Native Tribal Health Consortium, Alaska Center for Rural Health, Alaska State Hospital and Nursing Home Association, Commonwealth North (a business roundtable), Alaska Primary Care Association, and others.

We are looking forward to the State Planning Grant project as a way to help us work to achieve the Healthy Alaskans 2010 goal of improving the overall health of Alaskans. Through the project, we will gather and analyze data to help us find ways to cover the uninsured in Alaska. We anticipate that this information will be helpful to many other agencies and programs throughout the State as well. We hope to find information essential for legislative action. Alaska also will benefit tremendously from the successes of other states and we hope to utilize their efforts immediately.

Alaska has many unique circumstances to consider as we gather data on the uninsured. We intend to use some of the best practices of other states. In our most recent investigation with other states, as we have prepared for the grant application, we have realized that to serve this uninsured population we must concentrate on focus groups to gain a better understanding of the unique situation of the fishing, the tourist, the subsistence, the mining, the Alaska Native, the migrant and the seasonal populations of our large State.

We hope to create interest and a willingness to collaborate on ways to provide better health insurance coverage for all Alaskans. As we have worked to apply for this grant we have found new studies and a great deal of interest in helping with this overall activity. The project should give insight into likely impacts on the state of various alternative solutions. We look forward to the on-going frontier spirit and resourcefulness of the citizens of this great State to help resolve the need for health insurance.

We are requesting the grant sum of $964,000 as explained in detail in our budget section. With the partnership and support of HRSA we look forward to this next year so we gain greater insight for the benefit of all Alaskans.

Sincerely,

Joel Gilbertson
Commissioner

JSG:lb

Cc Anthony Lombardo, Deputy Commissioner
Pat Carr

Abstract and Project Overview

Project Title: Alaska State Planning Grant for: Expanding Insurance Coverage to the Uninsured
Applicant Name: Alaska Department of Health & Social Services
Applicant's Address: PO Box 110601, 350 Main Street, Juneau AK 99811-0601
Applicant's Phone Number: (907) 465-3091
E-mail Address: pcarr@health.state.ak.us

Current status of access to health insurance in the State
Approximately 122,000 Alaskans (19%) do not have health insurance. 12% of children lack health insurance. The age group with the highest proportion of uninsured is young adults 19-29.[2] Of the uninsured, 85 percent have at least one person in the family who works either full-time or part-time. About 26 percent of Alaska employees worked for small employers (fewer than 10 employees) in the year 2000, and less than one third of these small employers offered health insurance benefits. The most frequent reason given for this was the high cost of premiums.[3] Premium costs have increased since 2001, as they have nationally.

Earlier efforts to expand access to health coverage
In 1993, a legislative task force introduced legislation creating a single payer health care system including universal coverage and cost controls. Although never enacted, some incremental reforms recommended by this group were enacted: small group market reforms, the creation of a high-risk pool, and expansions to the Certificate of Need program. Throughout the 1990s, Alaska took advantage of many of the optional Medicaid expansions including Denali KidCare, Alaska's S-CHIP program. Denali KidCare is a Medicaid expansion, implemented in March 1999, enabling children 18 and under and pregnant women to be covered by Medicaid even if their families were not enrolled. In 2003, the legislature cut this program's eligibility level to 175% of the 2003 FPL, to be frozen at that level regardless of cost of living changes. Major outreach efforts resulted in the program enrolling the target number 11,600 in just seven months. In 2001, breast and cervical cancer patients were added to Medicaid as a categorically needy group. In the early 1990s, Alaska kept step with other states with Medicaid expansions for Early and Periodic Screening and Treatment, and an extensive program of home and community-based waivers to encourage use of assisted living and home-based options. In the private sector, the Anchorage Access to Care Coalition has developed a volunteer provider network for the city.

There is no capitated managed care in Alaska, and in general, insurance offerings are very limited. Policymakers are well aware of the lack of success of prior efforts, but now are increasingly aware of the direct and indirect costs and impacts on health status and wellbeing due to lack of insurance for nearly a fifth of the population. Major sectors of the population have at least partial coverage through public programs other than Medicare and Medicaid (19% are Alaska Natives with access to Tribal health programs, ten percent is military and dependents, and

[2] State specific data are based on tabulations for Families USA from the March 2001 and 2002 Current Population Surveys, which report health insurance status for 2000 and 2001, respectively. Tabulations are on file with Families USA.
[3] "Employee Benefits: Survey shows firm size to be a major determinant of whether they are provided," *Alaska Economic Trends*, April 2002, pp. 20-26.

Alaska has a disproportionate number of Veterans), so partnership with these programs is essential for reform considerations.

The state and federal government have invested enormous resources in the health care delivery system itself, with funding for operations and capital projects, and technical support to communities and provider organizations, for community health centers, hospitals, and diverse innovative programs, as well as recruitment, retention, and training of the health care and public health workforce. In concert with the President's Initiative to Expand Access to Care, and Alaska's Frontier Health Initiative, Alaska's Federally Qualified Health Centers now number over 90, managed by 22 not for profit organizations including several Alaska Native tribal health corporations. The Tribal facilities that are serving as Community Health Centers are open to non-Natives and thus represent a major expansion in health care access across Alaska.

Proposed project goals and accomplishments

The proposed project has two goals: (1) to assemble current data to describe the levels and nature of lack of health insurance coverage and its impact including review of past studies and existing data resources, also to study the hidden and not-so-hidden costs and other impacts of lack of insurance on state programs, businesses and people, and (2) bring policymakers and stakeholders (public and private) together with the Department of Health & Social Services as the convenor, to identify strategies that might work in Alaska's challenging environment to expand health insurance coverage, and to propose a coherent, comprehensive, coordinated approach to realizing the benefits of coverage for all.

A list of activities the State Planning Grant is expected to cover includes:

1. Household survey (covering all household members, using BRFSS sample design)
2. Employer survey (stratified sample by size; also need in-depth analysis of 2001 survey)
3. Focus group work with populations of concern – minority populations, seasonal occupations, part time workers, low income working families, etc.
4. Key informant interviews with business roundtable members (Commonwealth North has been studying primary care issues in Alaska this year), insurers, non-profit organizations (Foraker Group has been working with non-profits on insurance options), Alaska Native Tribal health care providers, military and VA, minority advocates, and others to be identified.
5. Analysis of existing survey, administrative and demographic data including Census 2000 socio-economic and occupational data, County Business Patterns, Current Population Survey, Behavioral Risk Factor Surveillance Survey, 2004 National Survey of Children's Health Alaska sample, Medicaid and Medicare enrollment and utilization data, Uniform Data Set information from community health centers and Alaska Hospital Discharge Data on payment sources and patients without coverage, and possibly RPMS data from the Indian health Service, to identify trends and patterns in coverage and characteristics.
6. Economic analysis of trends and impacts of the uninsured on Alaska's health care costs and cost-shifting.
7. Deliberations via Statewide Advisory Group (with key employers, providers, insurers, special populations, legislators) to review initiatives in other states and their levels of success, in light of emerging Alaska data, and to develop consensus on feasible, desirable

and acceptable strategies to cover those segments of the population who lack health insurance. A plan with key stakeholder buy-in for implementation will be the product.

8. Report to the Secretary of HHS and participation in national planning effort for mutual benefit of Alaska, the Department and other states.

Lead agency and other partners collaborating on the project

The Department of Health & Social Services, including the Health Planning and Systems Development Unit of the Commissioner's Office which will manage the project, has capacity to undertake some of the tasks directly (including the household survey). Other Departments of state government (Department of Labor and Workforce Development, Department of Commerce, Division of Insurance in Department of Community and Economic Development, and Department of Administration) have capacity to assist or carry out specific tasks, through interagency agreements, while other activities may be contracted out or supported with assistance of contracted consultants. Project oversight will be provided by a State Planning Grant Leadership Team led by Deputy Commissioner Anthony Lombardo. A Statewide Advisory Group will include representatives from public and private sector stakeholders including the University of Alaska and its research institutes, the Alaska Native Tribal Health Consortium, Commonwealth North business roundtable, provider organizations, insurers, and others.

Projected results in relation to goals of the project

Alaska will have the benefit of extensive knowledge gained by other states which have already had both planning grants and demonstration funding, for study design and for identification of model programs to meet the needs. Survey tools and focus group designs, and information about premium support programs, Medicaid enhancements and other options will be available to Alaska. The Robert Wood Johnson Foundation supported program at the University of Minnesota, SHADAC (State Health Access Data Assistance Center), will provide valued technical assistance. Other resources from SHADAC and HRSA are available to the project that will extend the effectiveness of the grant dollars. Legislative Health and Social Services Committees of both House and Senate, and the Health Caucus leaders, are invited to participate and will be provided with regular reports of progress, and with recommendations for policy initiatives for their consideration. It is hoped that joint effort and engagement during the project by legislative and executive branches will expedite statutory and regulatory changes that may be recommended.

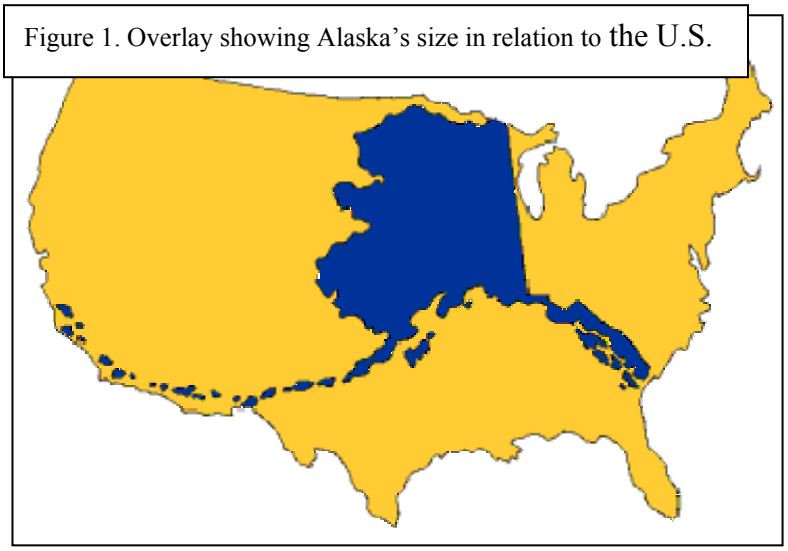
X. Program Narrative

1. Current Status of Health Insurance Coverage in Alaska and Other Background

Current Health Insurance Coverage Target:
The Alaska Department of Health and Social Services (DHSS) submits this proposal for a State Planning Grant for expanding health insurance coverage to the uninsured. Alaska's state government and many partners strive to address the goals and objectives of *Healthy People 2010* for longer healthier lives and elimination of disparities. *Healthy Alaskans 2010*, the Alaskan document adapting the national process to Alaska, includes a Leading Health Indicator for decreasing the percent of the population without health insurance from 19% in 2000 to 5% by the year 2010.[4]

Demography, Economy and the Health Insurance Market in Alaska:
Alaska has no managed care offerings. In many respects, Alaska is an unusual health insurance marketplace. Nearly ten percent of the state's population is military and dependents and nearly twenty percent are Alaska Natives with access to health care services through their tribal health corporation services, funded in part by Indian Health Service "compact" dollars (Sec. 638 of Public Health Service Act). The locations and organizational frameworks of the healthcare delivery system, described below, and the structure and geographic distribution of economic activity in the only Arctic state, the state with the nickname "the Last Frontier," profoundly affect the options for health insurance.

Figure 1. Overlay showing Alaska's size in relation to the U.S.



Alaska's 655,435 population in 2004 includes 86,000 people below the Alaska poverty threshold,[5] 122,000 people without any health care plan (19% of the population), and about 205,000 people (nearly a third of the total) who are members of minority race and ethnic groups: Alaska Native/American Indian, Asian, Black, Hawaiian or Pacific Islander, or of more than one race, who have poorer health status than the majority population. Although Alaska is the fourth smallest state in population, it is by far the largest in area, making up 1/5 of the US land area, extending over a thousand miles north to south and nearly 3,000 miles from the southeast tip to the southwestern tip (Figure 1).

[4] State of Alaska, Healthy Alaskans 2010: Targets and Strategies for Improved Health, Volume I: Targets. 2002.
[5] Alaska's poverty threshold is 125% of the national poverty threshold, reflecting the high cost of housing, fuel, and other goods and services in the Arctic state

The extreme geographic isolation of about 200 villages (of the total of 360 census designated places) along Arctic rivers, coastline and islands, and the small populations of these communities as well as some communities on the "road system," are challenges that underlie the effort to provide access to health care in an extreme frontier state with 1.1 persons per square mile in 360 communities. One quarter of the population lives in some 291 places with fewer than 2500 people. Employment in the conventional sense is low in these remote places (see appendix), including primarily government services (education, health and social services, and utilities support), whereas subsistence lifestyles (relying on hunting, fishing, gathering) and self-employment (e.g., in native crafts) are common, especially among Alaska Natives who are the majority populations here.

At the same time, there are mines, oil production facilities, and the associated shipping, supply systems and support services in several areas, including for example Prudoe Bay (North Slope Borough oil fields), Northwest Arctic Borough (Red Dog mine), and southeast Alaska (Greens Creek Mine), and there are fisheries and fish processing facilities from Unalaska to Ketchikan, providing jobs and, in some cases, health insurance benefits. Another major economic activity that provides seasonal jobs is tourism. Putting together these factors -- remote locations with small populations, seasonal employment for residents, very high levels and turnover of non-resident workers, geographic and climactic barriers to health care providers, and associated high costs – provides the picture to be addressed in considering options for health insurance and health care delivery.

Several national and international firms (oil and mining, for example) with activity in Alaska provide employee insurance in managed care plans based in other states such as Washington, Texas or California. In many cases the employees covered are not Alaska residents, but workers who rotate for six months or so at a time to Alaska-based facilities. The State Planning Grant project will attempt to document how many Alaska residents work for these companies, if they are offered such coverage, how many take advantage of the option if offered, and what their utilization patterns of health services may be. The project will also clarify whether in-state hospitals and physicians are able to provide services under these plans, routinely or only in emergencies.

Alaska's economy relies on oil extraction, fisheries, fish processing, tourism and mining which provide primarily seasonal employment. These occupations involve high risk of injury but provide limited health benefits. A strong trend to more service sector jobs from resource extraction and timber is contributing to a drop in average median household income, and increases in numbers of uninsured. So it is anticipated that lack of insurance of low income working people will continue to be a problem in the near future.

Recent Studies of Insurance and Lack of Coverage:

The Department of Health & Social Services (DHSS) supported the 2001 study of Alaska employers' health insurance offerings that showed patterns paralleling national patterns of small employers offering fewer benefits. Since few employers in rural areas employ 50 or more workers, this helps to explain the low level of insurance coverage, particularly outside the single metropolitan area (Anchorage). Medicaid covers 15% of the total population and 30% of

children under 18 (this includes the state children's health insurance program (SCHIP) Denali KidCare coverage).[6] *Healthy Alaskans 2010* goals 15-1 and 15-2 are to decrease percent of Alaskans without health insurance coverage from 19% to 5%, and bring percentage of uninsured children down from 15% in 2000 to 0%. The uninsurance estimate for Alaska children appeared to drop to 10.4% in 2001 and increase back to 13.3% in 2002, and 12.3% in 2003. Changes in CPS survey questions and sample size and design need to be checked to improve the interpretation of the fluctuating estimates.[7]

According to the Current Population Survey data for 2003, about 122,000 Alaskans do not have health insurance. That is about 19 percent of Alaska's population. (Twelve percent of children were uninsured in 2003 according to the CPS.) [8] Of the uninsured, 85 percent have at least one person in the family who works either full-time or part-time. The age group with the highest proportion of uninsured is young adults 19-29, since Medicare covers most people 65 and over, and Denali KidCare and Medicaid help to cover low-income children otherwise uninsured.[9] About 26 percent of Alaska employees worked for small employers in the year 2000 (firms with fewer than 20 employees).[10] The Alaska Employee Benefits Survey of 2001 found that fewer than one third of firms with fewer than 10 employees (accounting for about 11,000 firms in Alaska out of 14,700 total) offered health insurance benefits. The most frequent reason given (47 percent) was the high cost of premiums.[11] Benefit costs have increased since 2001. Alaska's uninsured population has increased according to the US Census Current Population Survey.

New data from the National Survey of Children's Health, State and Local Area Integrated Telephone Survey (1904 completed interviews in Alaska) has some data on coverage of children. Date are being analyzed by Department staff, in order to interpret the data with correct weighting. We will compare the responses for children with CPS data, and with BRFSS data for adults. The five questions related to health coverage can be cross-tabulated with health status information which may provide insights not previously available. (Note: BRFSS questions pertain to adults 18 and over; the SLAITS survey pertains to children under age 18.)

Previous analyses (not published) of Alaska's Current Population Survey data using three-year averages for the period 1994-1999 found that more than half of uninsured Alaskans were in families with incomes above 200% of the Federal Poverty Level (FPL). Also, increases over the period seemed to be equally distributed among families above and below the 200% FPL. The number of Alaskans with Medicare and Medicaid coverage over the period was increasing but the percent covered by these government programs was stable at 14-15% Medicaid, and 6% Medicare. CPS data indicated that the number of uninsured Alaskan children increased significantly from 23,000 to 33,000 just prior to implementation of Denali KidCare, possibly

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[6] US Bureau of Labor Statistics and Bureau of the Census, Current Population Survey (CPS) tables and reports online at http://ferret.bls.census.gov/macro/032004/health/h05_000.htm

[7] ibid.

[8] US Census Bureau Current Population Survey (Historical Table HI-4)

[9] State specific data are based on tabulations for Families USA from the March 2001 and 2002 Current Population Surveys, which report health insurance status for 2000 and 2001, respectively. Tabulations are on file with Families USA.

[10] US Census Bureau, *Statistics of US Businesses: 2000* (April 2003)

[11] "Employee Benefits: Survey shows firm size to be a major determinant of whether they are provided," *Alaska Economic Trends*, April 2002, pp. 20-26.

explaining the surprisingly large enrollment in the program in its first six months. Among those with private insurance in that period, the number of Alaskans with employment-based coverage appeared to drop from 375,000 to 361,000, while the number of persons with individually purchased coverage increased from 36,000 to 41,000 (6% to 7%). The CPS data indicated that the percent of all workers who were uninsured rose slightly to 21% for the 1997-1999 period. The rate of uninsurance was lowest in the public sector at 14%, highest in the private firms with under 10 workers (36%; these workers represented 22% of all uninsured workers in that period). Further analysis of the CPS data for more current period will be a valuable addition to the data in hand from the earlier DHSS work.

The Division of Insurance in the Department of Commerce, Community and Economic Development tracks insurance penetration on a statewide level with an annual survey, for the 40% of the market it regulates. The information collected includes the number of Alaskan's covered, premiums and claims paid. Their reports indicate that Premera Blue Cross/Blue Shield is the largest independent insurer (79%); the next largest insurer has just 7% of the comprehensive health insurance market; only seven companies have at least one percent of the market. About 60% of the private health insurance market is self-funded, and the Division of Insurance does not (can not under ERISA) regulate this portion of the market. Aetna administers the State of Alaska self-insurance program for its own employees. The Division of Insurance hopes that the SPG project will be helpful in studying this segment of the private insurance market.

Health insurance market data on regional levels has been sought by the Alaska Primary Care Association for several years' Marketplace Analysis reports. The Alaska Primary Care Office staff (now in the Health Planning and Systems Development Unit) has assisted in the search for this data.

Health Services Delivery System and Insurance Coverage:

The Health Planning and Systems Development Unit of DHSS is already is engaged in supporting Community Health Centers (CHCs) as valued expansions of capacity to provide primary care, oral health care and behavioral health services to the populations most at risk of poor health outcomes, assisting Critical Access Hospitals and Frontier Extended Stay Clinic demonstrations, and leading workforce development, recruitment and retention programs to support the health care delivery system and to address barriers to care.

The issues facing Alaska Natives differ from other groups: most Alaska Natives have access to health care services through their "tribal compact" (Section 638 of the Public Health Act) health care corporations, but this is not health insurance, is not portable outside of Alaska (sometimes not within Alaska) and has limits re choice; some Alaska Natives do have dual coverage with military, VA and/or employer or other program benefits. The Alaska Native Tribal Health Consortium (ANTHC) and the Alaska Native Health Board (ANHB) work with the Department on many levels to assure access to care and ensure availability of qualified staff. The State Planning Grant will provide an opportunity for in-depth discussions about the alternatives Alaska Natives would like to have available for health insurance. These organizations have a research unit and an epidemiology center that may be valuable partnership resources for this project. Alaska Natives' opinions and their health care choices when they do or do not have health

insurance, Medicaid coverage, and access to their own Tribal health corporation services, will be sought and analyzed through each of the project activities.

Information Gaps Related to Coverage:

Specific population issues that have been identified but for which detailed information is lacking:

(1) seasonal employees in tourism, fisheries and related industries (some residents and some out of state and alien workers) who
    (a) do not have insurance through this employment or
    (b) have insurance through the employment but not the rest of the year;
(2) low income workers and working families without insurance or with insurance for only the worker (some of these have children in Denali KidCare);
(3) workers who opt out of insurance because of cost and/or lack of available providers (notably young adults)
(4) employers who opt out of offering insurance because their employees are expected to have other forms of access to services (such as Tribal health services) or because providers are not accessible (e.g., support services for oil industry – although the oil industry provides coverage for its employees but often for out of state plans);
(5) small business options/access to health insurance products, and costs of those products, and specifics regarding the factors going into their decision-making about benefits to provide;
(6) groups including some Russian Old Believer communities who have subsistence fishing and farming economies, who have insufficient money economy to consider health insurance;
(7) retirees under 65 without coverage
(8) extent of private coverage supplementing Medicare coverage for retirees 65 and over.

The Current Population Survey data as noted has provided estimates of uninsurance and the characteristics of the insured and uninsured, with sometimes large fluctuations in estimated numbers and rates. An important task during this project will be to bring up to currency the analysis of CPS data and its reliability given Alaska's sample size and sampling design. Also, the challenges in interpretation related to income data and coverage questions needs to be addressed. How Alaska Natives' access to services is treated as "coverage" or not is a key methodological issue. The option of doing an annual state-based survey with the CPS questions has been suggested for consideration. The household survey using the core tool developed for SPG states will be used to seek this information for the project year. Behavioral Risk Factor Surveillance Survey data applies only to adults, as usually administered, and has limited questions on access to care and usual source of care, unless state added questions are used.

2. Earlier efforts to expand access to health coverage

In 1993, a legislative task force introduced legislation creating a single payer health care system including universal coverage and cost controls. Although never enacted, some incremental reform recommended by this group were: small group market reforms, the creation of a high-risk pool, and expansions to the Certificate of Need program.

Throughout the 1990s, Alaska took advantage of many of the optional Medicaid expansions including Denali KidCare, Alaska's S-CHIP program. Denali KidCare is a Medicaid expansion, implemented in March 1999, enabling children 18 and under and pregnant women to be covered by Medicaid even if their families were not enrolled, if family income was below 200% of the Federal poverty guidelines for Alaska. Major outreach efforts resulted in the program enrolling the target number 11,600 in just seven months. However, effective September 2003, the legislature cut the eligibility level to 175% of the 2003 FPL, to be frozen at that level regardless of cost of living changes. National CPS data has wide confidence intervals for estimates of the uninsured, so impact is difficult to ascertain using that data, but a current enrollment level of about 29,000 children together with children in families on Medicaid (about 36,000 in February 2005) appears to have reduced the rate of un-insurance among children from about 16% to about 12% as of 2003. In 2001, Alaska added women who have been screened and found to have breast or cervical cancer to Medicaid as a categorically needy group.

In the early 1990s, Alaska kept step with other states with Medicaid expansions for Early and Periodic Screening and Treatment, and Alaska has an extensive program of home and community-based waivers to encourage use of assisted living and home-based options. In 1998 Alaska implemented program changes to provide Medicaid coverage to the working disabled. The expansion allowed some working disabled clients to retain Medicaid coverage by disregarding certain amounts of income and resources.

In 2002 legislation was adopted establishing a regulatory structure for self-funded multiple employer welfare arrangements (MEWA) with the intent of encouraging the formation of financially sound MEWAs and expanding the viable health care insurance options for small employers in Alaska. In 2003 legislation was adopted allowing employers including the self-employed to form a group for purposes of purchasing health insurance with the intent of reducing the cost of insurance and expanding insurance options for employers, particularly small employers and the self-employed.. Alaska's high risk pool (Alaska Comprehensive Health Insurance Association) was enabled in 1992 to provide coverage to high risk individuals that are unable to obtain coverage in the private insurance market. In 1997 eligibility for coverage through the pool was expanded to include federally eligible individuals under the Health Insurance Portabiltiy and Accountability Act of 1996 and in 2003 eligibility for coverage through the pool was again expanded to include individuals eligible under the Trade Adjustment Assistance Reform Act of 2002.

Discussions at the Legislative Health Caucus (legislative sessions of 2004 and 2005), and conference sessions at the annual Alaska Health Summit have generated interest but have not resulted in successful comprehensive legislation. Concerns and objections to proposals for single payer and statewide self-insurance have included unknown costs to state general funds, uncertainty about risks of potential enrollees, and lack of a credible proposal for program management. Costs of the health care delivery system are high in Alaska (a recent study found that medical care charges average 25% higher than the lower 48), there is no capitated managed care in Alaska, and in general, insurance offerings are very limited. Policymakers are well aware of the lack of success of prior efforts, but now are increasingly aware of the direct and indirect costs and impacts on health status and wellbeing due to lack of insurance for nearly a fifth of the population. The universal health coverage proposal in 1993 was based on a report for the Health

Resources and Access Task Force which made recommendations that have been incorporated in the high risk pool and small group insurance pooling statutes.

The state and federal government have, on the other hand, invested enormous resources in the health care delivery system itself, with funding for operations and capital projects, and technical support to communities and provider organizations, for community health centers, hospitals, and diverse innovative programs, as well as recruitment, retention, and training of the health care and public health workforce. Six years ago, there were only two Federally Funded Community Health Centers in Alaska. In concert with the President's Initiative to Expand Access to Care, and Alaska's Frontier Health Initiative, Alaska's Federally Qualified Health Centers now provide care at over 90 sites. These Federally Qualified Health Centers are managed by 21 not for profit organizations, half of which are Alaska Native tribal health corporations, and one additional program is administered by a governmental entity. The Tribal facilities that are serving as Community Health Centers are open to non-Natives and thus represent a major expansion in health care access across Alaska.

As noted above, in Alaska, efforts to expand access to health coverage have focused on assuring availability of services rather than insurance: there are over 90 HRSA-funded community health center sites managed by 22 organizations; the Denali Commission, an Alaska-focused development entity modeled on the Appalachian Regional Commission model, has invested $137 million dollars in primary care facilities conceptual planning, construction and renovation; and the state Primary Care Office has facilitated Federal National Health Service Corps placements of medical students (Alaska SEARCH program) and Federal scholar and loan repayment programs plus technical assistance for recruitment and retention. The Indian Health Service also coordinates an extensive workforce recruitment scholarship and loan repayment program. Finally, the University of Alaska, and the Alaska Department of Labor both additionally have significant investments in the development of the healthcare workforce in Alaska. The Section 330 of the Public Health Act Community Health Center (CHC) program is intended to provide service to the uninsured low income population. The Uniform Data Set indicates that 37% of CHC visits were for people without health care coverage in 2001. 19% of visits were provided to individuals with regular Medicaid coverage, and another 8% were CHIP Medicaid visits.[12] The same report shows that 83% of Alaska CHC users had incomes below 200% of the federal poverty level in 2001.

As of December 2003, Alaska had 1164 private practice physicians. Over half of these physicians practiced in the Anchorage area. The bulk of the remaining private practice physicians were concentrated in the communities of Fairbanks and Juneau, with smaller concentrations in Ketchikan, the Matanuska-Susitna Valley, and the Kenai Peninsula. The distribution of private practice primary care physicians in rural Alaska is extremely sparse. The distributions of Dentists and Psychiatrists follow similar patterns to the overall distribution of physicians, however, the distributions of the latter two professional groups are more heavily concentrated in Anchorage. Finally, significant numbers of private practice dentists, and to a lesser extent primary care physicians, will not accept Medicaid reimbursement, or Medicare assignment. This further compounds the difficulty that many find in Alaska when attempting to access medical, dental, and behavioral health care.

[12] UDS Report State Summary for Alaska for 2001. Table 4. Users by Socioeconomic Characteristics.

The Alaska Fisherman's Fund is a special "workers' compensation" program established in 1951. It provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. The Commissioner of Labor and Workforce Development oversees administration of the program with the assistance of the Fishermen's Fund Advisory and Appeals Council. The council is composed of the Commissioner or his designee, who serves as chairman, and five members appointed by the Governor.

Other arrangements possibly used only in Alaska include local agreements for fish processors to cover workers' health care expenses. Self-insurance for workers' compensation that is allowed for firms that meet requirements under 8 AAC 46.010.

Of potentially on-going significance, a business roundtable in Anchorage called Commonwealth North has undertaken a year-long study of availability of primary care (2004-2005). This group has expressed interest in establishing an on-going interest group to explore private and public initiatives that would enhance Alaska's health care system in order to promote Alaska's economic growth potential. The group has noted the rapid growth of the health care system itself as part of the economy. The recognition of the relevance of coverage and an adequate delivery system may represent a turning point in the awareness of the private sector regarding health care.

Numerous conference sessions at the annual Alaska Health Summit have considered health coverage issues, and have resulted in recommendations for universal health care. Concerns and objections to proposals have included unknown costs to state general funds, uncertainty about risks of potential enrollees, and lack of a credible proposal for program management.

Costs of the health care delivery system are high in Alaska, there is no capitated managed care in Alaska, few insurers are willing to offer any products in Alaska.

Policymakers are aware of the limited extent of prior efforts, but they are increasingly appreciating the costs, direct and indirect, and impacts on health status and wellbeing due to lack of insurance.

A bill signed in June 2004 (HB260) is intended to increase volunteerism from health care providers by exempting health care professionals from liability for donated medical services. This bill also allows retired health professionals to volunteer when they no longer have malpractice insurance. They would still be liable for intentional harm or neglect but health professionals will be encouraged to volunteer services without the fear of lawsuits. The action was necessary for Anchorage Access to Health Care Coalition to continue developing a volunteer network of health care providers that will provide services to low income uninsured individuals in Anchorage. The Anchorage Project Access (APA), an innovative plan to increase access to health care for low-income, uninsured residents, is a partner of the national organization Physician Leadership Access Network. APA hopes to be ready to enroll patients in the Anchorage area where nearly half the state's population resides, by October 1, 2005. United Way, Providence Alaska Health System, Premera BC/BS, several private physicians, the Denali Commission, The Smiles for Kids Fund and the Libby Group, and the Simone Machamer Fund have all supported this effort.

On March 4, 2005, Governor Murkowski signed **SeniorCare** into law, which will extend the Senior Assistance program of $120 monthly checks to January 1, 2006. Qualified seniors with high prescription drug costs can also choose a drug subsidy of up to $1,600 per year. Older Alaskans who meet the income and assets test can choose which benefit they prefer. Over 7,200 older Alaskans now participate in the Senior Assistance Program. Another 2,200 older Alaskans whose incomes fall between 135% and 150% of the federal poverty level will be eligible for a $1,000 subsidy of out-of-pocket prescription costs.

Alaska's Turning Point community initiatives (Kenai, Fairbanks and Sitka) funded by the Kellogg Foundation in conjunction with Alaska's state Robert Wood Johnson-funded Turning Point initiative resulted in community level interest in insurance coverage. These communities attempted to document need, and worked on improving community awareness of available resources.

Awareness of approaches in other States to reduce the uninsured

We have looked at other states' techniques for studying the characteristics of their uninsured populations, tracking key trends, and developing strategies to address a variety of situations in order to expand access to health insurance. Alaska has a very large number of small firms (88 percent of all firms have fewer than 20 employees, employing 25 percent of all employees) many of which are located in rural areas. We will look to other rural and frontier states for examples of solutions that can be considered for such conditions. We have made contact with Texas and found that focus groups are extremely important for identifying issues, including traveling far distances to achieve good results. We learned from New Mexico how important an actuary and economist can be. Massachusetts let us know how critical it is to start the data gathering as soon as possible, because one year is just not enough time. They also let us know how important it is to get insurance carriers as well as insurance brokers involved in our focus groups or key informant interviews or in a workgroup. From Arkansas we recognized that the number one cause of bankruptcy is unpaid medical bills - a theory which may prove similar in Alaska. We continue to look towards the strong legislative initiatives like Hawaii's. Hawaii's experience is also valued because it has a strong tourist industry, as does Alaska. Overall we have learned there is no one-size-fits-all to find the best information and data or to find solutions for the uninsured. We have already recognized that our research might help to find additional ways to cover the uninsured in Alaska.

Among the strategies for study that appeal to us because they will help answer our specific questions, fill in gaps in our understanding, enable us to test data collection tools that may be useful for future tracking:

- Employer surveys – we can check for ways to integrate some good questions in ours (we probably want to replicate key questions of ours since it also replicated the 1992 survey; we want to do comparative analysis) – we might get at more specifics and details that other states have found they can do.
- Household surveys – our survey lab has capacity and resources for administering a 2000-2500 household survey over 5-6 months – we would almost certainly want to select from/adapt questions from other states' surveys; some of us would like to be sure to use

the CPS questions for starters – we'd like to be able to compare this survey's results to the CPS results. However we'll want to consult with SHADAC and likely a few of the experienced states on the questions.

- Focus groups – we should certainly scout out the most successful focus group questions and methods from the SPG states that have already done this work. We will most likely be hiring an Alaska firm to do the work but we want to guide the content and the targeting process. We expect to reach selected groups of employers; and selected population groups of Alaskans and seasonal workers who use health services in the state. SHADAC expertise will be used to guide the focus group design process, especially with respect to planning the questions for minority groups. The size and number of focus groups for different target populations will need careful consideration. Expert consultation is needed for this activity. University of Alaska Institute for Circumpolar Health Studies who have received training from Dr. Richard Krueger will be invited to assist in design and potentially in implementation; consultation from Dr. Krueger will also be sought.
- We are surveying other states' proposed solutions – we will be able to find out if some strategies thought to be workable have been rejected (and why); are there sets of strategies needed? Is incremental change appealing to most states or comprehensive, an array of changes being implemented in a coordinated way? We will make a checklist of approaches that have been considered and/or tried to take advantage of the work that others have done – and pros/cons.

What makes Alaska different?

The unusual characteristics of Alaska's demography, economy, geography and health care system are described above. Some summary points or particular relevance to the development of comprehensive data on health insurance coverage, and to development of options for addressing the need for affordable health coverage with engagement and buy-in of all the interested parties, are as follows:

- Seasonal issues: we have heavy summer tourism, and some winter recreational and shoulder season tourism (notably hunters, birders); the subgroups make different demands on the healthcare system; summer tourists are in general better insured than others we think. We also have seasonal (year-round but especially summer) fisheries bringing the fishing people here, and fish processors. Also, we have some migrating groups in-state (for fishing and hunting in particular), and rural-urban flow.
- Mostly rural/frontier: we have only one major urban hub, and a few major industries with large employers (oil, mining); military and government are also big employers – show percentage of workers who are in small/very small/self-employed firms (somewhat higher than most states in percentage? We aren't "unique" in this but at one extreme of the continuum we think)
- Cultural views toward insurance and its relevance, since subsistence living and self-reliance and communities caring for their own are traditional values and traditional ways of handling health-related challenges. Especially in light of the perceptions of limited benefits and high costs associated with insurance, or trying to access services that might be made available with insurance coverage, acceptable, appropriate and reasonable options will need to be carefully designed. Acknowledgement of the concept of insurance as non-traditional is necessary in the Alaska environment.

- No capitated managed care – and associated position of providers against managed care – make Alaska unusual.
- Exceptionally poor private health insurance market -- Small population combined with dispersed potential market (after the few big employers' needs are met), and lack of access to providers who can be signed up for "preferred provider" panels, results in very few insurance offerings, at very high prices. High unemployment rates and erratic and seasonal employment, high migration levels, make for unstable market.
- High risk population – due to northern location, risks in environment in work and play. The population is younger than the rest of the U.S. (only 5% elderly) and reflects a degree of "healthy worker effect" since many people leave the state when they do become ill, disguising some of the effects of exposure to high risk in state.

How is Alaska similar to other states?

Although many qualities of our population, place and economy set Alaska apart, there are common trends, characteristics and patterns, so many lessons can be learned from others:

- Transition of jobs to more retail sales and services; huge growth in healthcare industry which also includes many part-time jobs.
- Non-profits are mostly small and have trouble finding health insurance products that are affordable.
- Trends even for government and large employer benefits are for escalating costs of premiums, higher deductibles, more caps and limits, some "choice" or "menu" plans and other strategies.
- Many working families and individuals opt out because of premium costs.
- Many workers don't qualify (or dependents don't qualify) – must meet conditions for >20 hours/week, or length of employment, or job class (sometimes just managers have benefits).
- It's hard to convince young people of the need for insurance.

3. Statement of Project Goals

The proposed project has two goals:

(1) to assemble current data to describe the levels and nature of lack of health insurance coverage and its impact including review of past studies and existing data resources, also to study the hidden and not-so-hidden costs and other impacts of lack of insurance on state programs, businesses and people, and
(2) bring policymakers and stakeholders (public and private) together with the Department of Health & Social Services as the convenor, to identify strategies that might work in Alaska's challenging environment to expand health insurance coverage, and to propose a coherent, comprehensive, coordinated approach to realizing the benefits of coverage for all.

These goals require two major areas of activity to be undertaken in a synchronous fashion – the data gathering and analysis, with progress reported as expeditiously as possible, and the process for developing consensus, setting the groundwork for all the interested parties to work together to choose an approach to address the state's needs.

As part of the first goal, the project will

(a) Describe the uninsured in Alaska more precisely and clearly than previously possible to support the effort to design effective strategies for expanding coverage of the uninsured,

(b) Develop reliable tools for routine monitoring of lack of insurance, offerings and take-up rates, and barriers to coverage.

(c) Determine economic impact (overall, marginal) or burden of the uninsured on the state's costs, on health care providers, and on insurance costs – this is considered essential to developing the buy-in of policy-makers.

As part of the second goal, the project aims to

a) Evaluate potential applicability and acceptability of traditional and non-traditional approaches to covering the uninsured in Alaska.
b) Through a collaborative effort with participation from business leaders, the health insurance industry, consumers, at-risk population groups including Alaska Natives and other minority groups, legislators, state agency planners, and state staff, develop consensus on strategies and rationale for reaching the target for 2010 for health coverage, and ultimately for complete coverage.

The State plans to support these goals by renewing the interagency collaboration of past years' work to (1) accomplish surveys and to develop a routine way of monitoring who is lacking health insurance, (2) by doing the appropriate comprehensive data collection, using stratified samples and targeted interviews and focus groups, to confirm or illuminate reasons for being uninsured, and in parallel with the data collection and analysis efforts, by (3) engaging with a broadly representative and influential Statewide Advisory Group to work together to tackle the problem of the uninsured in Alaska.

It is hoped that the combination of the data gathering and analysis, and the strategic planning effort, will positively affect the environment for successfully implementing changes through both public, private and joint efforts. Administrative, legislative and voluntary initiatives may result from this process. We expect that the opportunity to examine the successful change in other states, and the challenges they have faced, may increase the comfort level with strategies that selected for further consideration in Alaska. The Alaska project will be especially attentive to approaches to use with seasonal or other special populations. Every effort will be made to take an integrated, comprehensive approach although we are aware that reform may be incremental.

Alaska has some unusual delivery system characteristics to consider. Could people with limited "coverage" but not regular health insurance such as Alaska Natives be able to acquire affordable health insurance, along with other people who currently are unable to purchase such options? Are the delivery system costs and geographic distribution limitations presenting constraints, and if so what are the acceptable determinations? Alaska's studies of problems of lack of insurance and potential solutions may result in approaches that have not yet been developed by other states. Sharing potential solutions with other rural and frontier states will be of value to all.

4. Project Description

4.A. Detailed Project Narrative

A.1. Overview of Tasks and Action Steps:

The Alaska State Planning Grant Project will focus on the four major expectations of project management, primary data collection and analysis, secondary data collection and analysis, developing a plan and options for covering the uninsured, and preparing a final project report.

The Alaska State Planning Grant will update and review past studies, and to study the hidden and not-so-hidden costs and other impacts of lack of insurance on state programs, businesses and people. This project will help provide the comprehensive data for understanding and addressing issues of the uninsured and health care access. It will complement other current DHSS studies, such as one developing a predictive model for Medicaid caseload growth.

The Health Planning and Systems Development Unit and the Medicaid program have the expertise and interest to participate in such a project. The baseline information will be necessary and very useful for guiding decisions for the reconfiguration of Medicaid and Denali KidCare as federal budget priorities and program reconfigurations challenge current methods of assuring access to health services for Alaskans. The costs for employers and employees for private health insurance benefits keep escalating, resulting in efforts to shift costs, reduce coverage or drop coverage altogether, which shifts burdens onto the public systems.

A.2. How Alaska's State Planning Grant Project will approach data collection and analysis:

A list of activities the State Planning Grant is expected to cover includes:

- Household survey (covering all household members, using BRFSS sample design)
- Employer survey (stratified sample by size, potentially for Anchorage and balance of state; administration of this survey may depend on availability of other survey data regarding employer benefits; resources should enable extra analysis of 2001 Alaska data)
- Focus group work with populations of concern – minority populations, seasonal occupations, part time workers, low income working families, etc.
- Key informant interviews with business roundtable members (Commonwealth North has been studying primary care issues in Alaska this year), insurers, non-profit organizations (Foraker Group has been working with non-profits on insurance options), Alaska Native Tribal health care providers, military, Coast Guard and VA, minority advocates, and others to be identified.
- Analysis of existing survey, administrative and demographic data including Census 2000 socio-economic and occupational data, County Business Patterns, Current Population Survey, Behavioral Risk Factor Surveillance Survey, 2004 National Survey of Children's Health Alaska sample, Medicaid and Medicare enrollment and utilization data, Uniform Data Set information from community health centers and Alaska Hospital Discharge Data on payment sources and patients without coverage, and possibly RPMS data from the Indian health Service, to identify trends and patterns in coverage and characteristics.
- Economic analysis of trends and impacts of the uninsured on Alaska's health care costs and cost-shifting.

A.3. How Alaska's State Planning Grant Project will develop coverage options and design programs that provide health insurance coverage to uninsured citizens:

There are a number of options and issues that Alaska is likely to consider throughout the State Planning Grant Project. These options and issues include: targeted expansion groups (e.g., parents of SCHIP children, early retirees, young adults ages 19 - 20); delivery system(s); program administration (including eligibility determination and enrollment process); coverage and benefits (similar to State, Federal employees, Medicaid, or other credible coverage); cost-sharing (co-pays, premiums); portability; integration with existing public and private programs, (e.g., Medicaid, Medicare and SCHIP coverage, State programs); interaction with employer-sponsored insurance, including plans for studying or avoiding crowd-out; cost-containment; necessary waivers (under existing program authorities); necessary State or Federal legislative changes (not under current authority); and/or private sector options (e.g., high risk pools, employer options, market reforms).

A.4. How Alaska's State Planning Grant will make decisions on options and approaches to full coverage:

Three groups will be organized to assist the State in reviewing and guiding the goals, tasks and activities of the State Planning Grant. These groups include the DHSS Project Team, the SPG Leadership Team and the State Advisory Group. These three groups will make decisions on what to include or exclude from the plan (i.e., a description of the process for reaching consensus and making decisions) and how to approach full coverage, and will provide guidance on the management of the overall SPG Program project.

The Department of Health & Social Services including the Health Planning and Systems Development Unit of the Commissioner's Office which will manage the project has capacity to undertake some of the tasks directly (including the household survey administration, through the DPH Survey Lab, and much of the analysis of existing data). Other Departments of state government have capacity to assist or carry out specific tasks, through interagency agreements, while other activities may be contracted out or supported with assistance of contracted consultants. Project oversight will be provided by a State Planning Grant Leadership Team led by the Commissioner of DHSS designee Deputy Commissioner Anthony Lombardo, and including the Medicaid Director, and designees of the Commissioners of Labor and of Economic Development. A Statewide Advisory Group will include representatives from public and private sector stakeholders including the University of Alaska and its research institutes, the Alaska Native Tribal Health Consortium, provider organizations, Commonwealth North business roundtable that has been studying primary care services in the state, and others.

A.5. How Alaska's State Planning Grant will prepare its report to US DHSS:

The DHSS Project Team, the SPG Leadership Team and the State Advisory Group will provide input and approval of the report to the HHS describing the uninsured population, expansion options and the partnership(s) necessary to implement its design.

Alaska will have the benefit of extensive knowledge gained by other states which have already had both planning grants and demonstration funding, for study design and for identification of model programs to meet the needs. Their survey tools and focus group designs, and information about premium support programs, Medicaid enhancements and other options will be available to Alaska. The Robert Wood Johnson Foundation supported program at the University of Minnesota, SHADAC (State health Access Data Assistance Center), will provide valued technical assistance. Other resources from SHADAC and HRSA are available to the project that will extend the effectiveness of the grant dollars. Legislative Health and Social Services Committees of both House and Senate, and the Health Caucus leaders, are invited to participate and will be provided with regular reports of progress, and with recommendations for policy initiatives for their consideration. It is hoped that joint effort and engagement during the project by legislative and executive branches will expedite statutory and regulatory changes that may be recommended.

A.6. Meeting Conditions of the Grant Award:

We will meet the specific conditions of the grant award. The Project Director will attend quarterly grantee meetings in the Washington, DC, Metropolitan area during the grant year. We will meet the reporting requirements in a format and timeframe as directed by the Project Officer. Both financial and activity progress reports will prepared and submitted based on guidance provided by the Project Officer. We will work in cooperation with HRSA and other states to prepare consolidated national reports. The Alaska State Planning Grant is committed to acting as a resource to other grantee States and other interested non-grantee States.

X. 4.B. Project Management Plan: Work Plan Matrix

I. Project management plan

Task I.A Manage the State Planning Grant Project				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Organize SPG Project Team, including assign/hire capable staff, define job duties & management plan	Sept. 05	DHSS as defined by Governor's letter, dated March 1, 2005. Principal Investigator, Project Director	Project management plan developed. Key staff selected to manage, monitor & mobilize project plan. Staff will include: project director, project coordinator, policy analysis and research staff (for management and analysis), and administrative support staff. Committed leadership roles (5% FTE in-kind effort each) by Deputy Commissioner of DHSS & Medicaid Director	Project management staff selected, roles defined, project system quantified & timeline set in place.
2. Finalize composition & roles of SPG Leadership Team & Statewide Advisory Group.	Oct. 05	DHSS Project Team; Principal Investigator; Project Director; Commissioners of Depts. of Labor, Administration, Commerce-Community-Economic Development (Div. of Insurance) provide SPG Leadership Team designees to Commissioner of DHSS (lead agency)	Composition of SPG Leadership Team & Statewide Advisory Group finalized; 3 to 4 meetings anticipated, initial meeting scheduled & held. Solicit input on methodology for refinement of employer benefit offerings analysis, household survey, focus groups & key informant interviews, economic impact analysis, Alaska Native tribal system role & issues, strategic planning & recommendation development.	Agenda set, short-term goals identified in written format for each group.
3. Convene task groups with	Oct. 05	DHSS Project	SPG Leadership Team & Statewide	Agenda, minutes & written

internal & external partners. Finalize detailed work plan with SPG Leadership Team, Statewide Advisory Group & Project Team.		Team, Statewide Advisory Group; PI, Project Director, Project Coordinator	Advisory Group defines goals, roles & approves work plan.	work plan compiled from convened teams. Timelines set.
4. Identify & acquire previous Alaska data pertaining to the uninsured.	Current - Oct. 05	Project Team; Research Manager	Locate & recognize previous Alaska data, studies & reports on the uninsured.	Written reports compiled showing source, outcome & foundation or need for data collection.
5. SPG Project Team conducts monthly meetings. Provides staff support to SPG Leadership Team & Statewide Advisory Group to meet goals & objectives.	Oct. – Aug. 05	DHSS Project Team; Project Director; Project Coordinator	Reviews tasks, timelines, project goals & objectives. Verify that each group's timeline is met; report to SPG Leadership Team which has representation & authority with agency partners	Compile & organize reports, agendas, & minutes from each group on a monthly basis.
6. Select contractors & vendors via procurement & interagency agreements under state procedures, for each project component. (Some specific processes are described below for certain activities, as relevant)	Project Period Sept. 05 – August 06	SPG Leadership Team; Budget/contract manager	Budget/contract manager will work with SPG Leadership Team to resolve administrative barriers & ensure cooperation of agency offices	Timely completion & processing of specifications, requests, agreements or contracts
7. Prepare and submit quarterly reports, financial reports, financial status reports as needed	Project period as required	Project Director; Budget/Contract manager	Required reports	Reports submitted in timely fashion
8. Routinely evaluate progress in light of timelines and program objectives.	Project Period	Project Director, SPG Project staff	Monthly reports to SPG Leadership Team; SPG Leadership Team can expedite problem-solving in order to keep project moving effectively on schedule.	Document process and outcomes for monthly meetings of SPG Leadership Team, and to provide basis for final report to HRSA on activities, barriers, and accomplishments

Task I.B Construct & implement data collection strategy, methodology & timeline				
Action Steps	**Time-table**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Develop final research plan & methodology for presentation to SPG Leadership Team & Statewide Advisory Group; implement with any necessary refinements by selecting qualified researchers (see #4 below)(following state DHSS procurement procedures &/or interagency agreement procedures)	Sept. – Oct. 05	DHSS Project Team, SPG Leadership Team (LT); consultants (SHADAC to be consulted, potential contractor); Research Manager	Detailed work plan for surveys & research protocols; outline of report to HRSA presented to Statewide Advisory Group (SAG) first meeting; decisions made by LT & SAG regarding specific special studies/white papers on economic impact of lack of insurance on (a) Alaska's economy, (b) state expenditures (Medicaid, other), & (c) health care providers. SHADAC has offered consultation regarding model projects from SPG states.	Research & work plan approved by Statewide Advisory Group by mid-October 2005. RFPs distributed to qualified researchers for special studies as approved by SAG, by Oct. 30. (University, state agencies, private research & policy groups may propose.)
2. Identify key strata & variables to meet the purposes for data collection for proposed project elements: - Household survey - Employer survey - Focus Groups - Key Informant Interviews	Sept. – Nov. 05	DHSS Project Team, key state partners in Div. of Insurance & DOL; contractors; Research Manager	Strata & grouping variables will be consistent across project components to facilitate integrated analysis	A written accepted set of common variables & definitions designed & used throughout the project.
3. Compile existing relevant data from multiple sources, consistent with needs for economic & actuarial analysis regarding current & potential impacts of policies, & consistent with methodology (#1). Solicit data from Alaska State Hospital and Nursing Home Association	Nov. 05– Jan. 06	DHSS Project Team; contractor(s)	Analytic files assembled & organized. Consider using actuarial &/or economics consultants. (Medicaid claims data (DHSS STARS files), Medicare (Area Resource File, HRSA BHPr, &/or CMS or First Health if it can be	Data organized in a format for analysis.

members regarding charity care experience; request information from physicians, dentists, and other health care providers regarding charity care, bad debt or other write-offs, & obtain Anchorage Access to Care Coalition Voluntary Health Care Network reports.			provided), hospital discharge data (DHSS files), tribal administrative data (RPMS/I), Census 2000 income & public program participation data, etc., & AK DOL population estimates & projections that may be needed for rates, subgroup estimates & projections, actuarial or demographic).	
4. Select contractors/ consultants & interagency experts for economic analysis. (In-state resources include University of Alaska Institute for Social and Economic Research and private research organizations with extensive in-state track records)	Oct.-Nov. 05	DHSS Project Team; Budget/contract manager	Clear statement of purpose for economic impact analysis developed with LT & SAG, developed by Project Team. Solicitation per DHSS administrative procedures. Appropriate candidates reviewed by proposal evaluation committee.	Contracts or interagency agreements in place with defined scope of work.
5. Oversee economic analysis work	Nov 05 – July-06	DHSS Project Team; Research Manager	Progress reports & final report; Discussions with Statewide Advisory group about methods & findings, & implications.	Minutes of bi-monthly meetings with consultants on progress; final report.

II. Collection & analysis of primary data

Task II.A Conduct Household survey				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1 Work with other states & SHADAC to identify reliable & useful questions for comparison with other states' data & to answer Alaska-specific research questions. Review & consider best practices of other states.	Nov. 05	DHSS Project Team; Research Manager	Consolidated State Core Survey (CSCS) tool used as base, selected state added questions selected to meet needs for measuring Alaska-specific concerns re seasonality of coverage & employment, regional differences in offerings by employers, type & size of firm variables.	Survey tool designed & sampling frame determined. (Sample size & sampling frame are expected to be same as BRFSS, to enable comparison with BRFSS results).
2. Solicit contract/interagency agreement for household survey with final design specifications for scope of work, including sampling frame & content of household survey.	Oct. – Nov. 05	DHSS Project Team, Contractor, Budget/Contract Manager	Contractor identified. Oversight established & methods & deliverables clarified with contractor.	Contract or interagency agreement signed & approved in timely fashion.
3. Conduct household survey. Expected to use BRFSS sample design for 2500 households, with oversampling of rural/Alaska Native, all household members to be tabulated (approx 7500 individuals).	Nov. 05 – Mar. 06	Contractor	Survey completed by contractor. Contractor will provide monthly progress report on surveys completed, response rate, & time per survey.	Data file available to Project Team by end of March 2006, with appropriate analytical weights.
4. Construct analytic file, & analyze data.	April – May 06	DHSS Project Team, Contractor, Research Manager, RAIII	Detailed analytical tables & summary results reported to SPG Leadership Team & Statewide Advisory Group. SHADAC guidelines for abstracting HRSA-required data will be used.	Written report & analysis completed & presented to SPG Leadership Team, SPG Project Team & Statewide Advisory Group.

Task II.B Conduct employer survey				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Review previous Alaska survey results (including 2005 pilot survey) & tools & other state's tools & sampling designs to plan follow-up survey; do additional analysis of past survey results.	Sept. 05	DHSS project Team, SPG Leadership Team; Research Analyst	Additional analysis of existing data (1992, 2001, 2005); evaluation of design & question content with SHADAC consultation, in light of specific Alaska issues (seasonal jobs, part time employment, limited insurance products to purchase).	Analysis plan approved by Statewide Advisory Group at initial meeting. (October)
2. Design survey to address specific SPG needs, both HRSA requested items & Alaska SPG project goals, using an interdepartmental survey planning team; as appropriate solicit input from ANTHC, University, & business roundtable (Commonwealth North, &/or Chamber of Commerce)	Sept. – Oct. 05	DHSS Project Team with AK DOL, Div of Insurance (DCED) & DOA	Improved design with appropriate sampling plan & tool for survey. Key research questions identified related to Alaska issues will be used in the sampling plan & survey tool.	Survey plan & key research questions approved by Statewide Advisory Group at initial meeting. (October)
3. Select contractor/interagency agreement for survey &/or analysis for employer benefit offerings, stratified to allow for comparison with prior Alaska surveys for small & large employers, examining Anchorage-based vs. rest of the state employers, Tribal area & Tribal employer concerns.	Oct. – Nov. 05	DHSS project team; SPG Leadership Team; Contractor; Budget/contract Manager	Scope of work & specifications completed; proposal evaluation committee (PEC) selected if needed for contractor selection &/or interagency agreement developed. Consideration will be given to supplemental survey using web-based surveyor tool to get attitudes, opinions & preferences of employers (this tool not likely useful for questions that require data look-up).	Contract or interagency agreement done in timely fashion (following state procurement procedures).
4. Survey implemented.	Dec. 05 – Mar. 06	Contractor; Oversight by Project Team, Research Manager	Tentatively 80% response rate target; mail out/mail back with phone follow-up expected.	Reports to Research Coordinator & Employer Survey Team (interagency group) monthly on progress & response rate
5. Analyze data.	April – June 06	Contractor, Research	Data file provided to Research Coordinator; contractor provides	Preliminary analysis & final report completed in timely

		Analyst	preliminary results for review & comment showing weighting procedures to Employer Survey Team; contractor provides completed report meeting HRSA reporting requirements & specific project requirements.	fashion.
6. Prepare written report.	May – Jun. 06	Contractor; reviewed by Res. Manager	Comprehensive written report, showing results of survey; publication to web & hard copy as determined by project.	Distribution of final report to LT & Statewide Advisory Group.

Task II.C Conduct key informant interviews				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Form a Key Informant Work Group of project staff, agency representatives & other partners (especially Tribal health partners, employer representative, another minority special population representative) to advise & assist in this activity.	Sept. – Oct. 05	SPG Leadership Team (includes interagency partners), Project Team	Key Informant Work Group has clear "charge" to look into the economic or financial, cultural, geographic, & other factors/barriers hypothesized to determine health insurance product availability, cost, & take-up rates. Opinions about potential solutions may be sought. Work Group will have the expertise to advise how best to ask the questions to get valid answers.	Key Informant Work Group charge & composition approved by SAG at October meeting.
2. Identify, select and contact key informants with significant information regarding uninsured in Alaska. This will complement the employer survey & household survey to address reasons for identified clusters of uninsured such as workers not taking up insurance offerings. Identify insurers to provide insight into cost factors, market reform suggestions from their perspective, and industry standards or criteria for	First Quarter	Project Director, Research Manager, Key Informant Work Group	Key informants tentatively selected to include: - Insurance carriers - Alaska Association of Health Underwriters (provide advice/ consultation to small employers) - Tribal organizations (Alaska Native Tribal Health Consortium) - State Department of Labor - State Division of Insurance - State Department of Communities & Economic Development	Matrix established of key informants by organization & individuals to assure full representation, by December. A written tracking & measurement system set.

risk pools. Use key informant interviews to help frame questions for further study through economic assessments & analysis of administrative data on outreach, experience with "crowd-out" and information available on that topic, and entitlement and dual coverage issues (Tribal, military, VA, etc.).. Estimated number: 30 key informant interviews. Several questions for the final report to HRSA will be included, such as why uninsured individuals and families do not participate in public programs or employer sponsored coverage for which they are eligible, awareness of programs and subsidies, why employers decide to offer or limit coverage, and likely responses to subsidies, incentives, group purchasing options, etc.			- State Department of Administration - Alaska State Hospital & Nursing Home Association - Anchorage Access to Care Coalition & Voluntary Network - Representatives selected to represent at-risk groups of individuals (e.g., Hispanic, Samoan, Korean, & Filipino communities), small business, non-profits, seasonal employers, others to be defined.	
3. Develop semi-structured key informant interview tool reviewing best practices from SPG states; select/add questions as necessary to meet Alaska specific concerns. Ask for example about importance of barriers such as distance/cost of accessing care, availability of services in a frontier state (delivery system and geographic factors), and available choices. Get opinions on acceptable options for public/private sector, current barriers, cost-sharing methods and	Oct. – Nov. 05	Project Team, Contractor	Key research questions identified & formulated to be useful for Alaska in the focus group activity, &/or survey tools for employers & households.	Key Informant tool/ questions developed; scope of work, timeline, and work plan developed and implemented for the conduct of key informant interviews by project staff directly or as participant observers with contractors/University or interagency collaborators

trends (co-pays, premiums), delivery system issues, perceptions regarding high risk groups, and specifics regarding the relevance of Alaska's exceptionally seasonal economic activity.				
4. Conduct Key Informant Surveys (estimated 30) as identified by the Project Team (with input from LT & SAG)	Nov. 05 - Jan. 06	DHSS Project Team, Contractor	Survey completed	Progress reports; Data file submitted to Project Team
5. Construct analytic file, & analyze data for next step. Consideration given to methods for sharing data with SHADAC & other SPG states.	Mar. – Apr. 06	DHSS Project Team, Contractor	Data compiled in written & tabulated format for quantitative and qualitative analysis; summaries written including commentary useful to planning process	Analysis completed & written report shared with SPG Leadership Team, Project Team & Statewide Advisory Group.
6. Prepare summary report using all data sources.	May – Jun. 06	DHSS Project Team, Contractor	Results compiled in a written format.	Distribution of findings/final report to LT, Project Team & Statewide Advisory Group.

Task II.D Conduct Focus Groups				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Develop specifications & work plan/criteria for focus groups related to the uninsured throughout Alaska. Utilize lessons learned from other states, specifically those who have similar issues (Hawaii – tourism; New Mexico – American Indian; Texas – large geography).	Sept. 05	Project team; a Focus Group Work Group may be formed to advise this activity	Consultation with SHADAC & SPG state reports will help guide decision-making re (1) specifications re research questions to be addressed via focus groups, (2) focus group composition, (3) guidelines for focus group activity, (4) criteria for contractor selection, (5) training for focus group activity if this is determined to be a need.	Written plan developed to communicate with each focus group. Written tracking system set. Statewide Advisory Group approves scope of work & methods in October.
2. Select contractor to conduct focus groups.	Oct. – Nov. 05	Project coordinator	Organization selected to conduct Alaska focus groups.	Contract executed with qualified organization.

3. Develop framework for focus group selection process, & complete focus group guides.	Dec. 05	Project team, work group, Contractor	Key research questions identified & formulated to be useful for Alaska in the sampling plan & survey instruments.	Focus group guides finalized & approved by project team.
4. If needed & approved, conduct focus group training at Alaska Public Health Institute to enhance Alaska capacity.	April 06	DHSS Project team; consultant trainer; Project Coordinator	Focus group strategy has been underutilized in Alaska in part due to limited expertise available instate. Tribal, Hispanic organization, behavioral health, public health & other partners may all be interested in training which could enhance available resources for the SPG work & follow-up	Training provided to 15 or more individuals from partner organizations; some of the trainees are utilized in the spring/summer focus group work for the SPG project.
5. Conduct focus groups as identified by Project Team with input from work group of the Statewide Advisory Group. Focus groups may include: Alaska Native groups (rural, urban separately with questions about migration, employment, income, subsistence, & access to care as they affect insurance availability & acceptance), rural, regional, disabled, seasonal worker, Hispanic, Samoan, Filipino, "Old Russian Believers" & potentially other ethnic subgroups.	Jan. – June 06	Contractor; Research Manager; Project Director	Formulate & conduct at least 12 focus groups throughout the state; Multi-season span of time is required to reach selected target groups including seasonal tourism & fisheries workers. Multiple focus groups may be needed for the target groups to be sure to obtain sufficient input for the project. This is an area requiring additional planning but will be done with expert advice from SHADAC and other states.	Interim reports as focus groups are completed; Final results summarized in a written report to SAG
6. Prepare Report.	May – July 06	Contractor, Project Team	Results from focus groups provided in a clear written report. Integrated into report to HRSA. Findings to be considered by the SAG for its deliberation of options to address uninsurance: which potential remedies may address needs of each group?	Final report distributed to LT & Statewide Advisory Group (SAG) for deliberations of decision-making by the SAG for recommendations to HRSA, DHSS, Governor & Legislature.

III. Compile, analyze & report secondary data

Task III.A. Research from other States & from previous Alaska studies				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Compile literature, review other SPG state reports, SHADAC reports, Turning Point, Kaiser Family Foundation, Commonwealth Fund & other reports on the uninsured & on strategies for making affordable health insurance available.	Current – Oct. 05; additional work for each SAG meeting	DHSS Project team	Summary of best practices & lessons learned from states, especially those which have similar issues. (Hawaii – tourism; New Mexico – American Indian; Texas – large geography). Identify which instruments for study & for addressing needs have been found to be most helpful.	SAG is able to review pros & cons from other states' experiences & experiments, to use in planning the Alaska SPG project & in selecting options for proposed implementation.
2. Conduct telephone meetings with representatives from selected states.	Current – on-going	Project Team	Find support, models or contacts, which may be beneficial in the success of this project in Alaska.	Opportunities & systems identified to expedite SPG project in Alaska – data collection strategies & evaluation of interventions
3. Summarize findings from other State initiatives.	Current – on-going	Project Team, SPG Leadership Team	Compile findings & models in a matrix, which are most related to Alaska issues.	Report distributed to Statewide Advisory Group.
4. Compile/analyze previous AK studies & reports, which have relevance to Alaskan's uninsured & effective strategies. Examples: - SCHIP & Medicaid - CPS analyses (DHSS) - Medical Care Cost & Expenditure Reports responding to legislative requests (including health care reform initiatives) - Health Caucus of Alaska Legislature (reports to the Caucus, other documents) - Dept of Labor reports	Current – March 05	Project team; potential contractors	Comprehensive review of results of studies & efforts to address problems in providing health insurance can be accomplished by this project. University or other expert involvement in compile the relevant data into a written format & summarize what is relevant to the SPG questions & goals will be examined, with interagency agreements or contracts. These will be among the special reports or "white papers" to be published as part of this project.	SPG Leadership Team & Statewide Advisory Group have opportunity to use a comprehensive review of past efforts & available data for Alaska by mid-year meeting (March). Contracts of interagency agreements executed as needed for accomplishment of one or several components for the overall summary document/compendium &

- Workforce Development Project (2002) - Foraker Group project for non-profits (2004)				executive summary.

Task III.B. Conduct economic analysis				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Develop specifications for an economic impact analysis needed to evaluate (a) economic impact of the uninsured in Alaska, & (b) economic impact of potential strategies for intervention based on experience elsewhere.	Nov. 05	DHSS Project Team, LT; an "economic advisory work group" may be used.	Identify contractor to conduct data analyses. This could be one or more "white papers" due to the need to examine two different questions, each of which could be a major project.	Invitation to bid for contractor(s) completed.
2. Review & select contractor to do economic analysis.	Nov. – Dec. 05	SPG Project Team	Economic analysis is compiled in a clear written format, per expectations & required timeframe.	Contract(s) signed.
3. Alaska specific issues are clarified for economic analysis related to the uninsured in Alaska to include such areas as: - employment patterns - economy/industries - geography (distance, distribution of providers) - Tribal systems - market trends - seasonality	Jan-June 06	SPG Project Team, Research Manager; Consultant(s)	Final economic assumptions formulated to be combined with other data for final analysis; develop a model to help policy-makers understand the feasibility & relative impact of different strategies such as assisting in purchase of insurance for working uninsured; changing Medicaid eligibility or otherwise enhancing Medicaid program (e.g., waivers); requiring employer offerings of basic insurance; expanding or enhancing the risk pool for the non-working uninsured & other hard to insure individuals; incentivising programs for hard-to-insure groups such as the disabled, or other options.	Data analysis & models are reported to Project Team, LT & Statewide Advisory Group for use in the final report & in recommendations to Governor, Legislature & stakeholders.

Task III.C Evaluate implications of data analysis				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Present analysis from all studies, both past & current.	May – July 06	SPG Project Team; SPG Leadership Team	Identification of uninsured; considerations of options to address the problem of uninsurance with pros & cons listed based on findings.	Findings & options presented to Statewide Advisory Group in written format for consideration.

IV. Planning for the uninsured

Task IV.A Develop preliminary strategies for health coverage for the uninsured				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Identify preliminary strategies & their feasibility through an analytical process, for covering the uninsured. (Healthy Alaskans 2010 target: 5% vs. 19% in 2000 uninsured.) Consider (based on data collected) the feasibility & likely cost & benefit of modifying Medicaid eligibility or benefits or state plan, providing incentives or infrastructure for pooling risk, sharing premium costs in selected situations, etc. to meet needs of different sub-groups of the popu-lation. Identify which strategies are likely to meet the needs of which groups & how much.	June 06	SPG Project Team; SPG Leadership Team	Identify strategies to meet the needs for each target group so that the goal of covering the uninsured might be accomplished: consider processes, systems & studies other states have used to avoid planning failures. Determine of policies or programs have been effective in periods of economic/employment growth or in periods of downturn; consider robust solutions for an environment like Alaska's socio-economic & demographic situation. SHADAC consultation is expected to be of great value in this process.	Contact initiated with at least 3 other states to review their process or system to address the documented needs, & experience to date; lessons learned are summarized for SAG to consider in making its findings & recommendations.
2. Research value of, & identify specific tasks for, utilizing economist or actuary, by conferring with other	January 06 (contract for	Project Coordinator; economic	Identify actuaries or economists, as other states recommend, who can develop a report from data collected on the	Contract with economist &/or actuary developed; SAG has opportunity at mid-

states &/or SHADAC, determining lessons learned.	January-May 06 if desired)	analysis work group (subcommittee or designees of the Leader-ship Team or the SAG) may be needed	uninsured in Alaska, & Alaska health care cost information & other data as required, using selected strategies that may be considered for recommendation, to estimate potential costs; ensure that assumptions & alternatives are clearly defined & explained.	year meeting to be informed & to review analysis approach; SAG will take analysis into account in its final deliberations
3. Develop a report based on professional analysis of actuary or economist data showing feasibility & risks for insurance for those currently uninsured.	Aug. 06	Project Team, SPG Leadership Team, Contractor	Comprehensive report developed showing cost, risk, opportunities, feasibility & benchmarks of the uninsured in Alaska, & alternative strategies	Final report shared by SPG Leadership Team SAG with the partner agency Commissioners with the Governor, Legislature, Tribal entities, & the public.
4. Develop a proposal showing aggregate cost analysis for uninsured.	Aug. 06	DHSS Project Team, Contractor	Cost impact analysis developed	Written impact statement developed.
5. Design list of options for comprehensive, coordinated plan for covering the uninsured with recommendations.	Aug. 06	DHSS Project Team; Contractor	Plan options and cost impact statements developed; use economic and/or actuarial consultation as needed	Written plan and impact statement developed for Statewide Advisory Group.
6. Convene meetings and hold public hearings to present findings and to analyze and prioritize action plan strategies	June-Aug. 06	Principal Investigator; Proj Director; Leadership Team and partners	Developing consensus regarding strategies that are feasible, acceptable, desirable	Summaries of meetings are available for final deliberations of Statewide Advisory Group for its recommendations
7. Convene dialog with Commissioners, Governor, legislature (Health & Social Services Committees of House and Senate), statewide stakeholder organizations to analyze and prioritize strategies	June-Aug 06	SPG Leadership Team; Principal Investigator; Proj. Director	Emerging acceptance of a set of actions that will be coordinated and comprehensive to cover the uninsured	Priorities, basis of consensus and recommendations can be summarized in final plan
7. Create a report which the State of Alaska legislative body, insurers, insurance carriers, employers, unions	Aug. 06	DHSS, SPG Leadership Team,	A greater awareness of the uninsured in Alaska.	A comprehensive plan can be developed to improve the availability of insurance to

& other agencies can understand the financial & integrated conclusions of the SPG & its findings.		Statewide Advisory Group		those groups identified who have no insurance in Alaska.

V. Report to HRSA

Task V. A. Participate in Nationwide SPG Program and Provide Required Reports				
Action Steps	**Timetable**	**Responsible Agency or Person**	**Anticipated Results**	**Evaluation/Measurement**
1. Key Alaska representative attends HRSA quarterly meetings.	Quarterly	Project Director	Build a broader awareness of national issues around the uninsured.	Attendance at meeting.
2. Correspond with SPG projects in other states, participate in conference calls	Project period	DHSS Project Team	Integration of other states' experience into Alaska planning; sharing of information with all partners as reality check and to inspire consideration of new concepts	Periodic summaries of findings are distributed to partners and used in reports
3. Provide required financial reports and final FSR	Quarterly & Oct. 06	Proj. Director, Budget/contract Manager	DHSS tracking system and project management plan will comply with grant requirements	Reports submitted in timely fashion
4. Final written report sent to HRSA, distributed to in-state and out-of-state interested parties and posted to website.	Oct. 06	DHSS Project Team; Project Director	Final written report of entire project showing the findings & suggested proposals.	Final report shared with the Governor, Commissioner of Health & Social Services, Commissioner of Labor, Director of Division of Insurance, Tribal entities, the public, HRSA, Legislatures, & other identified stakeholders.

X. 4.C. Governance: Management, Accounting, and Governance Structure of the Project.

C.1. Governance

Structure:

The Department of Health and Social Services (DHSS) will be the lead organization for coordinating the State Planning Grant project. The DHSS Project Team will be comprised of staff in the Health Planning and Systems Development Unit in the Office of the Commissioner, DHSS. In-kind support for the project will be provided by Deputy Commissioner, Anthony Lombardo; State Medicaid Director, Jerry Fuller, and Medicaid Analyst Barbara Hale. The Commissioner of the Department of Health and Social Services, Joel Gilbertson, will be providing policy leadership and has signatory authority and responsibility for the grant. He and the Deputy Commissioner will be providing the linkages to the other state agency departments, Department of Labor, Division of Insurance, Department of Administration, and the legislature as needed for project implementation and long range planning.

We anticipate forming three workgroups: the DHSS Project Team; the SPG Leadership Team; and the Statewide Advisory Group. The DHSS Project Team will be comprised of the staff who are managing and carrying out the day to day activities of the grant. The SPG Leadership Team will be comprised of the leaders of the state agencies involved in the project, including DHSS, Department of Labor, Division of Insurance, and Department of Administration. This team will provide guidance and decision-making regarding strategies and policies that will analyzed and proposed to address the uninsured. The Statewide Advisory Group will be comprised of representatives from DHSS, other state agencies, statewide organizations and stakeholders that have a demonstrated interest and knowledge of issues related to the uninsured. These groups will be responsible for reviewing the findings from the primary and secondary data analysis,

Project personnel:

Key project personnel include the Principal Investigator (.1 FTE), Project Director (.5 FTE); Research Manager (.25 FTE), Project Coordinator (.5 FTE), Budget/Contract Manager (.25 FTE), Research Analyst (1.0 FTE), Administrative Clerk (1.0 FTE), and College Intern (.1 FTE). Most of the staff members are existing personnel in the Health Planning and Systems Development Unit within the Office of the Commissioner, Department of Health and Social Services. These staff members work on various HRSA and other federally funded grants and contracts. We have the flexibility and the need to have additional personnel costs covered by the State Planning Grant. This section should identify key project personnel and the amount of time they will devote to the project. Brief biographic sketches of the project director and key project personnel describing their qualifications are included in the Section v. Budget Justification of this application.

Funds from the State Planning Grant will not supplant any state covered salaries or projects.

C.2. Grant Monitoring Plan and Reports to the Department.

Monitoring Plan:

The State Planning Grant Project Director and the Principal Investigator will have primary responsibility for assuring that Alaska's State Planning Grant is managed effectively and efficiently. The Project Director will convene the DHSS Project Team at least monthly and will have responsibility for supervising the work of project staff. Timelines specified in the Project Workplan will be assessed and monitored. The Project Coordinator will assist the Project Director in convening the Leadership Team and Statewide Advisory Group.

The Alaska Department of Health and Social Services has established regulations, policies and procedures for grant and contract procurement. These procedures specify advertising, bidding, reviewing, awarding, reporting and payments of grants and contracts. Contractors are held accountable for the quality and production of their work based on these regulations and procedures.

Monthly meetings will be held with the Deputy Commissioner and Medicaid Director to assure that the State Planning Grant project is meeting expectations of the Department of Health and Social Services management. Meetings will be conducted with the Commissioner as needed to brief him on the project's progress and findings to date. These meetings will be essential in assuring that the project is on task and that the project's activities are leading toward findings and outcomes that meet agency expectations. This step is expected to increase the likelihood of identifying outcome insurance coverage strategies that have acceptance and can be implemented.

Report to the U.S. Department of Health and Human Services:

The Commissioner of the Alaska Department of Health & Social Services in conjunction with the Commissioners from Department of Labor and Workforce Development, Department of Commerce, Community and Economic Development Division of Insurance and the Department of Administration will be responsible for interaction with the Governor and Governor's Office staff, to foster analysis and adoption of strategies in the final report.

Within 30 days after the end of the State Planning Grant project period, the Department of Health and Social Services will submit a report of findings and strategies to the US Department of Health and Human Services. The report will follow the format specified by HRSA, USDHHS and will incorporate the broad range of activities planned by the Alaska State Planning Grant committees. As requested, the final report will include key data elements such as the total number of uninsured in Alaska and their characteristics.

The State Planning Grant Final Report will include a description of the various strategies identified through out the project to expand health insurance coverage for the uninsured. We will maintain communication with the HRSA State Planning Grant Project Officer to assure that the project report we prepare are consistent with expectations. We already have begun contacting other states and anticipate expanding this contact when funded in order to gain and share knowledge, tools and strategies.