Alaska
HRSA State Planning Grant
Interim Final Report to the Secretary

September 30, 2006

Re: State Planning Grant HRSA-05-035 CFDA # 93.256

Prepared by Health Planning and Systems Development Unit
Office of the Commissioner
Department of Health and Social Services
State of Alaska

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Executive Summary – Alaska SPG Interim Final Report

A summary of the activities conducted under the HRSA grant -- including the State's data collection activities and the policy options selected to increase health insurance coverage in the State -- and recommendations for Federal and State actions to support State efforts to provide health insurance for the remaining uninsured.

Activities conducted with support of the HRSA State Planning Grant to Alaska's Department of Health and Social Services in year one, September 1, 2005 – August 31, 2006 (a no-cost extension was approved for a second year) include:

- Household survey (covering all household members, using BRFSS sample design), being conducted by the Survey Lab of the Division of Public Health through an interagency agreement.
- Employer survey (stratified sample by size of firm, being conducted by Department of Labor and Workforce Analysis Research and Analysis Branch through an interagency agreement).
- Focus group work with populations of concern – minority populations, seasonal occupations, part time workers, low income working families, etc. (with University of Alaska Institute for Social and Economic Research). An important topic for focus groups is the concept of "health insurance coverage" since the perceptions and values associated with insurance vs. access are expected to be diverse
- Key informant interviews with business roundtable members, Alaska Native Tribal health care providers, military and VA, minority advocates, non-profit organizations, small firm employers, policy analysts, and others being identified. (To be completed in year two.)
- Analysis of existing survey, administrative and demographic data including Census 2000 socio-economic and occupational data, County Business Patterns, Current Population Survey, Medical Expenditure Panel Survey (MEPS), 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, 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. Participation in SHADAC conference calls is included.
- Economic analysis of trends and impacts of the uninsured on Alaska's health care costs and cost-shifting (planning initiated in year one; study to be accomplished year two).
- Actuarial analysis of options considered for recommendation (planning initiated in year one; study to be accomplished year two).
- Dissemination of information to stakeholders about the data gathering and research projects, and about initiatives in other states and research and demonstrations.
- Forum discussions of options to recommend for consideration and action, with presentations of relevant preliminary cost analyses.

- Engagement of stakeholders in all stages of the exploration of the data and alternative strategies.

The project goals in Alaska are to do necessary data gathering to provide insight into the complexities of health insurance coverage, and to identify options for making affordable health insurance available to Alaskans currently uninsured. Collaboration with stakeholders and with partners within state government is considered critical to success. Federal demonstration funds are not expected to be available for implementation, so follow-up will depend upon buy-in and commitment within the state framework.

Alaska's resident population (664,000 in 2005) and its many seasonal workers who come for oil field work, tourism related jobs, fishing and fish processing, and other jobs face major challenges in obtaining health care and health insurance. Nearly 18 percent of the population is uninsured as defined by the Current Population Survey – a figure that has wavered but changed little in the past decade. One quarter of the resident population lives in small communities (fewer than 2500 people) geographically isolated from each other and from the "urban"' hub communities that have health care facilities, in this frontier state with 1.1 persons per square mile. One in five Alaskans is Alaska Native and has access to Tribally managed health services, although physician and hospital services may be far removed from the village. However this type of "coverage" is not considered insurance because of lack of portability. Many Alaska Natives are enrolled in Medicaid or covered by military or private health coverage. The elderly population eligible for Medicare is only six percent of the population, compared with about 15 percent nationally.

The unusual characteristics of Alaska's demography, economy, geography, and health care system present unique challenges to providing health care and insurance options in the state. These factors also make it challenging to obtain reliable information about the population and its needs. The combination of quantitative analyses (with careful attention to sample design, and to the limitations of small numbers, increased cell phone use, and heterogeneity of the population) and qualitative analyses demonstrated by other states is welcomed as being likely to provide the most comprehensive in-depth picture of the current status of health insurance coverage, and of the factors affecting access to, availability and cost of health insurance to different segments of the population.

Projected results in relation to goals of the project include :

- Statutory and regulatory changes that may be recommended.
- Clearer picture of state of health insurance coverage, barriers, gaps, and perceptions (knowledge base for Medicaid program and state policy makers).
- Baseline data for evaluation of strategies.
- Increased awareness and consensus about potential solutions, strategies, models, agreed-upon principles for action and for decision-making.

Section 1. Uninsured Individuals and Families

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

1.1 What is the overall level of uninsurance in your State?

According to the 2005 CPS, Alaska had the 10th highest uninsured rate in the United States in 2005 with a 3 year average (2003-2005) of 17.8%. The US average for this same time period was 15.7%.

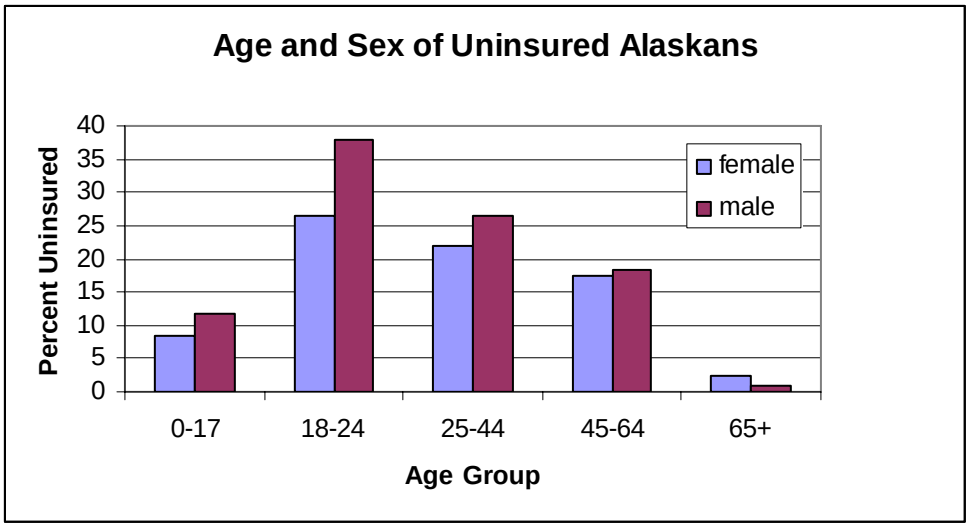
Alaska Uninsured Percentage by Year	
Year	Percent Uninsured
2005	17.7%
2004	16.8%
2003	18.9%
2002	18.7%

1.2 What are the characteristics of the uninsured?

Income: The 2005 CPS reports that about half of all Alaskans living in households with income less than $5,000 per year are uninsured. Nearly one third of those living in households where earnings are between $5,000 and $15,000 are uninsured, almost 25% of those earning between $15,000 and $35,000 are uninsured, just under one-fifth of people living in households earning between $35,000 and $75,000 and nearly 9% of those living in households making over $75,000 are uninsured.

Age: The highest percentage of uninsured are in the 18-24 age group, over 32% of Alaskans in this age group are uninsured according to the 2005 CPS. Over 10% of children under 18 years of age are uninsured, 24.3% of 25-44 year olds are uninsured, 17.8% of 45-64 year olds are uninsured, and just under 2% of the elderly (age 65 and over) are uninsured.

Gender: The 2005 Behavioral Risk Factor Surveillance System (BRFSS) reports 16% of men and 18% of women reported having no health care coverage. According to the 2005 (2003-2005 3-year average) CPS, 16% of females are uninsured and nearly 20% of males are uninsured.



Family composition: The highest percentage of uninsured persons are those from single person families, 28.6% of single persons report being uninsured. The percentage of uninsured living in multiple person families ranges from 12.9-17.4% according to the 2005 CPS.

Health status: The 2005 BRFSS reports on several health status indicators. Nearly one-fourth of persons reporting fair or poor health are uninsured, whereas 15% of those reporting to be in excellent or very good health are uninsured. About 17% of people who report exercising are uninsured and 23% of those who do no physical activity report being uninsured. There were no significant differences in percent uninsured among those who reported binge drinking, asthma, or physical limitations due to health problems; all reported nearly 18%, the statewide uninsured rate. In addition, the Alaska Household Survey on Health Insurance that is currently underway will provide additional results on the question of health status.

Employment status (including seasonal and part-time employment and multiple employers): The 2005 CPS reports 19.3% of employed persons being uninsured and 38.3% of unemployed persons being uninsured. One-fifth of full-time workers are uninsured and nearly 25% of part-time workers are uninsured. More than one-fourth of seasonal workers are uninsured and over 16% of year round workers are uninsured according to the 2005 CPS. Alaska has an unusually high number of seasonal employees, many working in the tourist and fishing industries. Both the Employer and Household surveys currently being conducted are addressing the issues of availability, costs and "take-up" patterns of health benefits for seasonal and part-time workers.

Availability of private coverage (including offered but not accepted): The Alaska Household Survey on Health Insurance is underway at the time of the first year final report. Results will be forthcoming on the question of "availability of private coverage."

Availability of public coverage: Public coverage (using two years' average) is summarized in the following table:

Health Insurance Coverage of Alaskans, 2003-2004
(Medicaid data from CMS/USDHHS Administrative Data,
other data from Current Population Survey, US Bureau of the Census)

Coverage Type	Population	Percent of Population
Employer only	328,460	52%
Individual	25,060	4%
Medicaid	96,000	15%
Medicare	38,020	6%
Other Public	30,430	5%
Uninsured	116,210	18%
Total	634,180	100%

Race/ethnicity: Eighteen percent of Alaska Natives and 17% of non-Natives reported not being covered by any type of health plan according to the 2005 BRFSS. The 2005 CPS reports that 33% of Alaska Natives are uninsured. Just over 15% of whites, 16.1% of Asians and 11.5% of African Americans are uninsured.

Race as a Percent of Total Population and as a Percent of the Uninsured		
Race	Percent of population (AK DOL)	Percent of Uninsured (2005 CPS)
White	71.2%	61.2%
Alaska Native	15.9%	18.6%
Asian	4.6%	5.5%
African American	3.5%	2.2%

Geographic location (as defined by State -- urban/suburban/rural, county-level, etc.): As has been true over the years, the BRFSS for 2004 and 2005 found that the Gulf Coast Region of Alaska (including the Kenai-Peninsula Borough, Kodiak Island Borough, and Valdez-Cordova Census Area (county equivalent areas)) and the "Rural" region (which includes most of northern and southwestern Alaska) have the lowest levels of insurance coverage in the state – roughly 75% compared with 82-83% for the state as a whole. The populations in these regions are mostly in rural/frontier areas where subsistence living (hunting and fishing with low cash economy) and fishing for profit are the main types of employment. Tourism is also an important part of the economy in many of the communities in these areas. The Rural region is also majority Alaska Native population, which has access generally to Alaska Native Tribal health care services. In villages as opposed to subregional and regional centers that have mid-level providers or physicians, the usual care providers are Community Health Aides who are able to provide care under medical supervision which may be reimbursed by Medicaid if the patient is enrolled, but otherwise is not reimbursable by any insurance plan.

Uninsured Alaskans by Region 2005	
Region	Percent Uninsured
Anchorage and vicinity	15%
Gulf Coast	22%
Southeast	18%
Rural	25%
Fairbanks and vicinity	16%

Hypotheses being tested with the household survey and focus groups include the expectation that the rural residents, especially those living in the high tourism and fishing industry areas, will confirm that health insurance is difficult to get and to afford, and that the added barrier of there often being no regular source of physician-level potentially insurance-covered services accounts for much of the lack of insurance coverage in the rural areas.

Although the employer survey underway does not stratify urban and rural firms for the sample, it is expected that the use of firm size strata will ensure a representative sample of rural firms that can be examined for evidence to confirm or reject the expectation of higher coverage in urban areas.

Duration of uninsurance: The Alaska Household Survey on Health Insurance is underway at the time of the first year final report. Results will be forthcoming on the question of "duration of uninsurance."

Other(s): Seasonal and temporary employment arrangements are believed to be a major reason for low insurance coverage in Alaska.

One source of information about who is uninsured is the Employer Survey of 2001 (being replicated with an updated survey tool through the SPG program) which indicated the slight level of coverage by small firms. Of the 44 percent of all firms which are the smallest – with only 1-3 employees -- only a quarter offered health insurance. About one in three firms with 4-9 employees (which accounted for another 30 percent of firms) offered health insurance. Although cost of premiums was the reason given most often for not offering benefits, seasonality and part time work were frequently given as reasons for not offering.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Populations of concern have included minority populations, seasonal occupations, part time workers, low income working families, and others. The Institute of Social and Economic Research (ISER), University of Alaska, Anchorage is currently conducting focus groups under an RSA (interagency agreement) to obtain more information about these populations of concern which include minority populations, seasonal occupations, part time workers, low income working families, and others. The following questions are integrated into the focus group work:

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?
1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?
1.6 Why do uninsured individuals and families disenroll from public programs?
1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?
1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?
1.9 How likely are individuals to be influenced by: Availability of subsidies? Tax credits or other incentives?
1.10 What other barriers besides affordability prevent the purchase of health insurance?
1.11 How are the uninsured getting their medical needs met?
1.12 What are the features of an adequate, barebones benefit package?
1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Focus groups being conducted by the Institute for Social and Economic Research (ISER), University of Alaska, Anchorage are focusing on the qualitative questions regarding the uninsured. Ultimately we believe the focus group information will provide the overall data collection with unique and important findings to further explain the dilemma and needs Alaskans perceive regarding health insurance. We decided to contract with our State affiliated university, University of Alaska, Institute of Social and Economic Research (ISER). This group has extensive knowledge with designing, conducting and evaluating focus groups. Several of the staff has trained with Richard Krueger.

The design and development of the content and mission of the focus groups was done collaboratively with the SPG staff. The SPG Leadership group has been kept aware of the progress and direction as well. The main purpose of this project is to determine, according to the specific group, what health insurance means; how they define health insurance, health benefits; what keep them from having health insurance; what is their view of Medicaid and Denali KidCare and how they would value health insurance. The questions listed in this report have been considered and most will be used in one format or another. In coordination we have set a timeline to conduct a minimum or 12 and a maximum of 21 focus groups. We have divided the State into geographic groups, ethnic groups, employment groups and those who primarily serve the uninsured.

ISER has researched the content and outcome of several other states to use as a model. There will be a questionnaire conducted prior to the start of each focus group to collect such information as age; ethnicity, gender; community; employment status, place of employment; length of employment; existing health insurance and coverage. We anticipate the collection of this specific data will be helpful to formulate the focus group findings into categories for the summary report.

The focus groups will begin in October 2006. Weekly phone conferences are held with ISER and SPG staff to assure timelines are met and the project remains on-target.

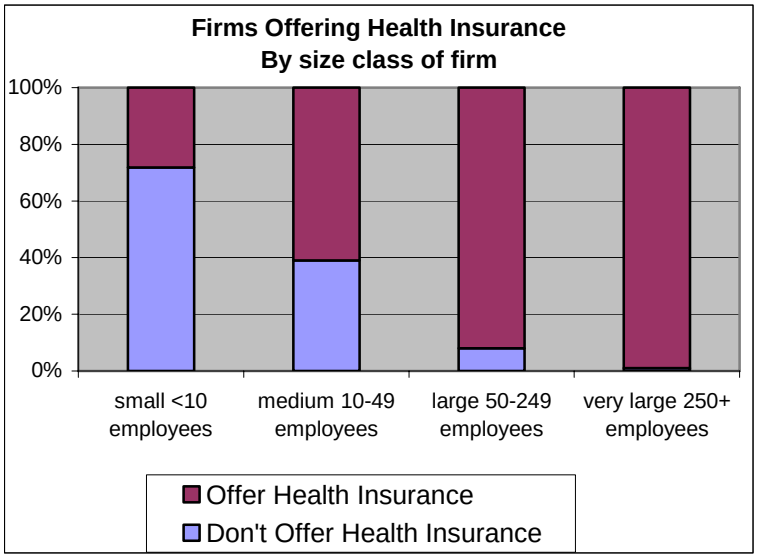
Section 2. Employer-based Coverage

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

*Questions within 2.1 focus on the **quantitative** research work conducted by the State:*

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Employer size (including self-employed): About 26% of Alaskans worked for small firms (those with fewer than 20 employees) in 2000. A 2001 survey of employers' benefit offerings conducted by the Alaska department of labor collected information on health insurance benefits provided by Alaska employers. This survey found that less than one third of small or very small firms (firms with fewer than 10 employees) offered health insurance benefits. Over 60% of medium firms (10-49 employees), 92% of large firms (50-249 employees) and nearly all very large firms (250+ employees) provided health benefits for their employees. A revised survey of employers is being conducted with State Planning Grant funds, to determine if the findings of 2001 still hold or if changes or trends are evident. The survey will also permit more current comparisons with other states' survey results.



Industry sector: In a preliminary analysis of the employers' benefits survey of 2001, industry classification was found not to be a determining factor in whether employers provided health insurance for their employees; firm size was the most significant factor. This will be examined again with the 2006 survey.

Employee income brackets: According to the 2005 CPS (2003-2005 3-year average), over one in four workers earning less than $25,000 per year are uninsured. More than one-fifth of workers earning between $25,000 and $35,000 are uninsured, 13.1% of persons earning between $35,000 and $50,000 are uninsured, 8.6% of workers earning $50,000 to $74,999 per year are uninsured, and 6.8% of those earning $75,000 or more per year are uninsured.

Percent Uninsured by Person Income									
	Person Income								
	none	$1 - $4,999	$5,000 $9,999	$10,000 $14,999	$15,000 $24,999	$25,000 $35,999	$35,000 $49,999	$50,000 $74,999	$75,000 +
Percent Uninsured	15.7%	26.5%	24.4%	25.9%	25.6%	20.9%	13.1%	8.5%	6.7%

Percentage of part-time and seasonal workers: The Institute of Social and Economic Research (ISER), University of Alaska, Anchorage is currently conducting focus groups to obtain information about populations of concern including seasonal occupations and part-time workers. The Employer Survey and Household Survey also address questions specifically to the part time and seasonal employment status to see of a more detailed description of coverage among these workers can be developed. A special study of fishing permit holders is being planned for the second year (with no-cost extension) of the grant project, since this group is a larger sub-set of the seasonal and part time economy than in any other state.

Geographic location: The Employee Benefits Survey of 2001 attempted to stratify for Anchorage versus the rest of the state, but the interpretation of the data for the two regions was compromised by the role Anchorage plays as a "hub" community for the rest of the state, frequency hosting the "central office" of a firm that has most of its employees in rural areas. Although the weighting of the responses had to take into account the location of the office base of operations, analysis pooled the results rather than attempt to examine rural/urban differences.

For those employers offering coverage, please discuss the following:

Cost of policies: The 2001 employer survey did not ask of those offering coverage how much of a problem the cost of policies was. In the focus group with employers and key informant interviews planned for employers, these questions will be asked.

Level of contribution: For full-time employees, about 65% of the employers who provide comprehensive health insurance report paying the full cost of the premium according to the 2001 employer benefits survey. Roughly 34% of employers share the cost of the premium with the employee and less than one percent employers require their full-time employees to pay the full amount.

Percentage of employees offered coverage who participate: The 2006 Employer Survey asks about the "take-up" rate of employees, and the Household Survey asks a set of questions about take-up of offered insurance, and the reasons for not taking up coverage offered if the individual has not signed up. Results of these surveys will be available for the year two final report.

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

In the 2001 Employer Benefits Survey conducted by the Alaska Department of Labor, the most frequent reason given (nearly 47% of respondents) for not providing health benefits was the high cost of premiums.

Reasons for Employer's not offering health benefit coverage	
Percent of Respondents	Reason given
46.7	Premiums too high
10.0	Employee generally covered under other plan
9.0	Employee turnover is too great
5.4	Seasonal or temporary employees
4.4	Employees generally covered by Native Health Service
4.0	Too many low or minimum wage workers
3.5	The firm is too newly established
2.7	Can attract good employees without insurance
2.6	Part-time employees
2.5	Most of our competitors don't offer health insurance
2.3	Administrative hassle of providing health benefits
7.0	Other reason not provided on list

Focus groups being conducted in fall 2006 will include both citizens and employers from diverse backgrounds and industries. These groups will explore the questions of health coverage including many from this report. Key informant interviews with people who work as advocates or who represent interest groups such as small and seasonal employers are also scheduled to take place this fall. We anticipate that the results from these activities will provide more detailed analysis of employer based coverage in Alaska. The "Solving the Health Insurance Dilemma in Alaska" forum to be held December 7, 2006 will engage both large and small employers in discussion of the questions that follow.

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

2.5 What employer and employee groups are most susceptible to crowd-out?

2.6 How likely are employers who do not offer coverage to be influenced by: Expansion/development of purchasing alliances? Individual or employer subsidies? Additional tax incentives?

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Section 3. Health Care Marketplace

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

In the project year, the staff and Leadership Team assembled existing data sources that include past Division of Insurance reports and analyses, Medicaid program analyses and forecasts, utilization data from hospital discharge data and Uniform Data Set reports of Federally-funded community health centers, and health care expenditure reports, all of which inform the project about the health care marketplace. To date the methods for obtaining the marketplace data involve identifying existing reports and data sources. In Year 2, key informant interviews and research efforts will address the questions developed from review of existing reports and consideration of options that may affect the marketplace.

In 2002 the Division of Insurance in the Department of Commerce, Community, and Economic Development contracted with Navigant Consulting to provide an economic analysis of a proposed conversion of Premera Blue Cross from a non-profit service corporation to a for-profit health insurance company.[i] In analyzing the proposed conversion, Navigant analyzed the entire Alaska health insurance market and this is one of the currently available sources of information about the Alaska health care marketplace. The following percentages of Alaskans by type of health insurance coverage were derived from the Navigant data:

Private Insurance	
Self-funded	32%
Insured	23%
Medicaid	13%
Military	8%
Medicare	6%
Uninsured	10%
IHS population w/o private insurance	8%

Most Alaska Natives (about 20% of Alaska's population) have access to health care services through their Tribal health corporation (section 638 of the Public Health Act). Although access to care through these corporations is much better than in most, if not all other states, this access is not health insurance. Health care services are provided only within the State of Alaska, and sometimes only within a specific region of Alaska. In addition there is limited choice regarding provider or care options. Some Alaska natives do have dual coverage with military, VA, and/or employers or other program benefits.

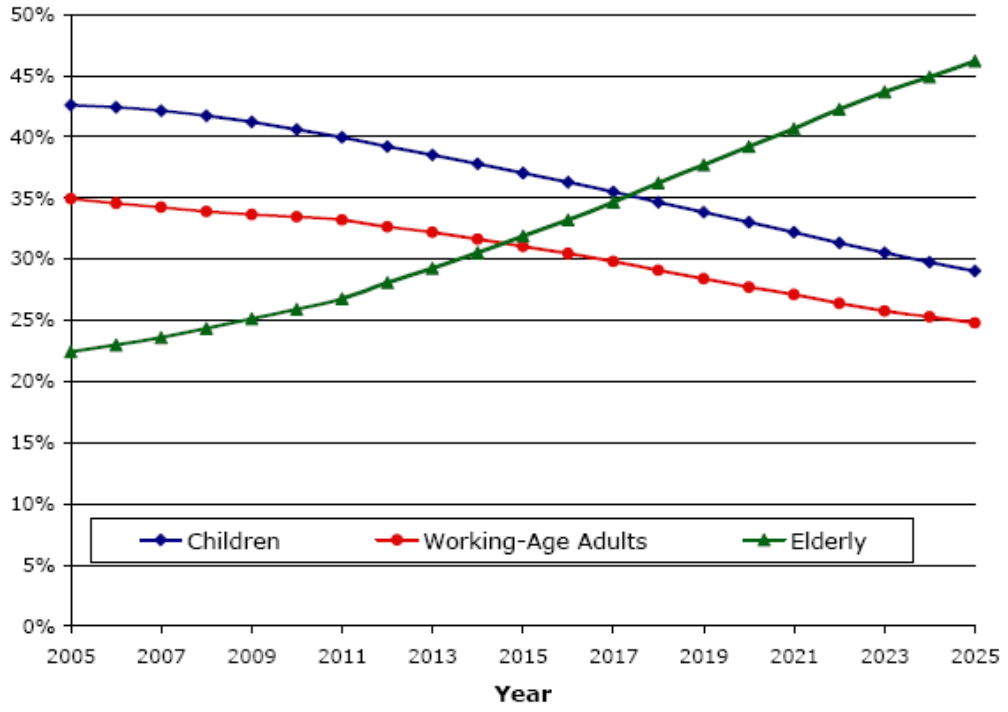
The Division of Insurance, Department of Commerce, Community, and Economic Development regulates the private health insurance market, except for self-funded health plans. The Division compiles data from an annual survey of health insurers that write in Alaska. 2005 survey data shows that about 78% of private (state-regulated) comprehensive health insurance is written by

Premera Blue Cross, the next largest insurer writes about 8%. Only 20 insurers indicated on the 2005 survey that they actively market comprehensive health insurance in Alaska.

A second major study reviewed is the Lewin Group and ECONorthwest report for the Department of Health & Social Services, *Long Term Forecast of Medicaid Enrolment and Spending in Alaska: 2005-2025*, February 2006. The model for forecasting assumed programmatic status quo. Key findings were that the Medicaid program's patient mix and spending will shift to a focus on elderly rather than children. Spending on elderly patients is expected to exceed spending on children in about 2018 (see Figure 1. from the report's executive summary, p. ii), assuming that the elderly population about doubles in that period while the population under age 20 stays about at current levels.

Figure 1: Spending on Elderly will Surpass Spending on Other Age Groups by 2018

Forecasted Proportion of Total Spending on Medicaid Claims by Age Group, 2005-2025



Source: Lewin Group & ECONorthwest analysis of Alaska Department of Health and Social Services data.
Note: Spending projections are on an incurred service basis.

The historical data for recent years (Figure 11, p. 21 of the report) indicated little change in the percent of population enrolled in Medicaid except an increased percentage enrolled for children, where the SCHIP program resulted in an increase from 18% to 31% of children 0-19 enrolled. The increase for children 0-19 which diminished in the last data year reported may reverse as the freeze on the level of household income for SCHIP eligibility takes effect.

The Navigant and Medicaid studies combined with the Division of Insurance and Medicaid Program routine reports provide a basis for comparison with the conditions and trends in health insurance and public program coverage in Alaska compared with other states. With the upcoming economic analyses, and examination of target populations and market niches in other states, the understanding of size and composition of the market segments in Alaska compared with other states will be important.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

Adequate coverage has not yet been defined. The information gathered from the household survey and focus group studies should help to define Alaskans' perception of adequate coverage. Alaska and federal HIPAA laws require health insurers to guarantee issue health insurance coverage to employers. Alaska small employer insurance laws require insurers to offer two health insurance plans that provide a minimum level of benefits. Although these plans are infrequently selected by employers, Alaska small employers with 2-50 employees in the state are guaranteed access to a minimum level of health insurance benefits.

The Alaska Comprehensive Health Insurance Association created under Alaska insurance laws guarantees comprehensive health insurance coverage to individuals that are denied coverage or are offered substantially reduced coverage in the private market due to a medical condition. The Association also guarantees coverage to individuals that meet the eligibility requirements under HIPAA and TAA.

Alaskans with preexisting conditions have access to health insurance either through ACHIA or their employer health plan. Therefore, comprehensive health insurance coverage is available to these Alaskans, but it may not be affordable depending on their level of income. In general, as the cost of health care increases the cost of health insurance increases and become less affordable for many individuals and employers. Insurers in Alaska typically offer several benefit and deductible options with a range of price.

For purposes of the above response comprehensive health insurance coverage means coverage for hospital, medical, and surgical expenses (not supplemental coverage but may include dental and vision benefits that are offered as part of the hospital, medical and surgical coverage.)

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

Comprehensive health insurance is available to individuals and groups in Alaska. A comparison of the benefits offered has not been developed.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

About 60% of the insurance market in Alaska is self-funded. Many of the self-funded plans, including the state employee plans, are administered by insurers. Because the state can not

regulate these plans under state law, state insurance reforms can affect only the 40% of the market that accounts for the insurance purchased by small employers and individuals. Broad based reform would require an ERISA waiver in order to bring in the self-funded employer plans.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

Denali Kid Care was implemented in March 1999 enabling children 18 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. Medicaid Title XIX was expanded at the same time for pregnant women as well. Major outreach efforts resulted in the program enrolling the target number of 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. The upper eligibility level was cut for children in families with incomes $\geq$ 151% FPL under Title XXI and for pregnant women under Title XIX.

About one in five Alaskans is enrolled in Medicaid in the course of a year, and nearly half of births occurring in the state are Medicaid funded. The State Medicaid program accounted for purchase of about $970 million in 2005 including Federal and State matching funds, or about one fifth of total health care spending. Another $180 million are state government costs for employees' and retirees' health insurance, and $233 million were state funds expended for grants, medical education programs, and state psychiatric and correctional facilities. If direct state government expenditures for health care ($787 million in FY2005) and the Federal dollars for Medicaid ($667 million in FY05) are counted as providing a measure of the impact the State has as a purchaser of health care, out of the $5,294 million dollar total for FY05, the State's impact is $1,454 million or 27 percent of the total.[ii]

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

This question cannot be answered with the work undertaken in the first project year. Research in the second year will address this.

3.6 How would universal coverage affect the financial status of health plans and providers?

The effect on health plans cannot be determined until a model for universal coverage is outlined. Effect on providers could be considerable since utilization could be expected to increase. Alaska's recently completed study of physician supply (*Securing an Adequate Supply of Physicians to Meet Alaska's Needs*, September 2006) identifies a shortage compared with the US norm likely to increase, in addition to their being already more profound shortages of medical subspecialties statewide, and of primary care providers in both urban and rural areas. If financial barriers to obtaining health care exist as we believe they do, demand for services would likely increase.

3.7 How did the planning process take safety net providers into account?

Community Health Center staff, the Alaska Primary Care Association, the Alaska Native Tribal Health Consortium, Alaska State Medical Association, and Alaska State Hospital and Nursing Home Association are invited to every public forum and are engaged in a variety of collaborative activities in which the state planning grant effort is described and discussed. They are also being invited to participate and suggest others to participate in focus groups, and include the key informants being invited to contribute.

3.8 How would utilization change with universal coverage?

Utilization of primary care and specialty services would increase, we expect.

3.9 Did you consider the experience of other States with regard to:
Expansions of public coverage?
Public/private partnerships?
Incentives for employers to offer coverage?
Regulation of the marketplace?

These questions have not yet been considered but several states' programs are being presented and discussed during the second year. All of the above types of experience are expected to be addressed.

Section 4. Options for Expanding Coverage

The purpose of this section is to provide specific details about the policy options selected by the State. A number of States have not reached a consensus on a coverage expansion strategy and are not yet in a position to answer the questions included in this section. These States should answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

Not applicable. Alaska's first year State Planning Grant included studies of the uninsured and one set of public forums to discuss barriers to obtaining health insurance. The effort in Year Two (funded by the original award with a twelve-month no-cost extension) will include forums with business leaders and policymakers, and analyses of options the Leadership Team selects for examination. Recommendations regarding options to pursue have not yet been made.

For each option identified, complete questions 4.2 through 4.15 (if relevant to your State's planning process):

Since options have not been identified, questions 4.2-4.15 do not apply.

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

The State has not selected expansion options, but is beginning to provide opportunities for consideration of options.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed, and administrative actions such as waivers), and the remaining challenges.

Not applicable. No policy options have been selected in the first year of the project.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)? Not applicable.

4.19 How will your State address the eligible but not enrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

For the last five years Alaska's SCHIP program Denali KidCare has used an effective regional outreach program to increase enrollment. In addition, the State's Department of Health and Social Services (DHSS) Tribal Program, through the Tribal Initiative which began in 2001, has collaborated with Tribal Health Programs (638 entities) to ensure that Alaska Native beneficiaries who are eligible for Medicaid services and present at Tribal Health facilities, are enrolled and coded appropriately in the Eligibility Information System. This ensures that billing is submitted correctly, in order to obtain 100% Federal reimbursement for Medicaid services and spread Indian Health Service dollars across other non-Medicaid health and non-health areas. It also allows DHSS to spread State of Alaska general fund dollars to Non-Native recipients and Native beneficiaries receiving services in non Tribal Health facilities. A Business Resource Center was established at the Alaska Native Tribal Health Consortium, through matching state grant and ANTHC funds, to pair up with DHSS Tribal Program staff and the DHSS Fiscal Agent to provide training for clerical/billing staff at Tribal health facilities, provide coding services, and to establish procedures and processes that allow for more accurate and effective billing practices.

The State Planning Grant activities have involved collaboration within state government among the Departments in order to identify barriers to appropriate enrollment.

Section 5. Consensus Building Strategies

5.1.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

Alaska's Governor identified the Department of Health and Social Services as the Lead Agency. The Commissioner of H&SS approved appointment of a State Planning Grant Leadership Team composed of high-level representatives of three key cabinet departments: Health & Social Services, Labor & Workforce Development, and Commerce, Community & Economic Development. She invited the Commissioners of the other departments to appoint representatives who would be able to identify experts in their offices to support the project, and who would participate fully in the planning and policy development of the project. The head of the Division of Insurance and her chief actuary have participated regularly on the Leadership Team. The Deputy Commissioner of Labor and Workforce Development has participated, and has engaged his Chief of Research and Analysis on the Leadership Team. DHSS leadership has been provided by the Deputy Commissioner for the Office of Program Review, and the Director of the Division of Public Health. Staff to the project (in the Office of the Commissioner, Health Planning and Systems Development Unit) also staff the Leadership Team. Monthly meetings of the Leadership Team have provided regular opportunities for staff to keep the members well informed about project and have provided guidance and direction to staff regarding data gathering activities and public event planning.

The choice of an internal leadership team structure was made for several reasons: the desire to develop a strong working relationship with the key agencies affected by the issues, the opportunity to streamline the oversight process with shorter, more frequent meetings than would have been possible with a statewide stakeholder group, and the confidence that outside partners and stakeholders could be involved in the process effectively through forums, key informant interviews, and other statewide meetings providing opportunities for reporting and for discussion and input.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

A forum on the uninsured, "Finding a Path to Affordable Health Benefits," was held during "Covering the Uninsured Week" in May 2006. The forum included a panel discussion as well as citizen input addressing the questions of who is uninsured, what keeps workers and employers from getting health insurance, what affects the ability to choose or buy insurance, what geographic, cost and cultural factors influence choices, and what people want for access to care and access to benefits. A diverse selection of public and private constituents were in attendance.

A second forum, "Solving the Health Insurance Dilemma in Alaska," is planned for December 7, 2006. The audience is expected to be business leaders, policy makers, policy analysts, and academics. The first session of the forum will consist of listening to business leaders talk about

the problems they face related to competing for and retaining workers with the lack of affordable health insurance for both employer and employee. The second session will consist listening to other state's talk about their successful initiatives, effective processes and specific reforms. Senator James Leddy (Vermont) will speak on the coalition of business leaders and politicians to develop consensus around core principles and the development of common language for discussing potential solutions. Cathy Schoen (Commonwealth Fund) will speak about the national picture of health insurance and health care reform as well as the Massachusetts model which includes individual and employer mandates. Tentatively, Anthony Rodgers (AZ) will speak about state supported insurance packages for small employers.

The Annual Health Summit provides an additional opportunity for sharing progress and soliciting input from diverse stakeholders, particularly from public health professionals, health care providers, safety net providers, and academic & policy analysts.

University of Alaska's Institute for Social and Economic Research (ISER) has been contracted to conduct focus groups beginning in October 2006 to obtain input from populations of concern – minority populations, seasonal occupations, part-time workers, and low income working families. They are also expected to hold a focus group with small employers in one or more locations. Interaction with ISER has also included discussion of the economics of the health care system and health insurance in Alaska, workforce and infrastructure.

In addition, we are obtaining input from key constituencies through semi annual department meetings with tribal health organizations (mega meeting) and the Policy Academies that Alaska has been participating in include members of the legislature, government officials, health care advocates, and provider representatives.

We will be contracting with an organization to perform key informant interviews with business roundtable members, insurers, non-profit organizations as well as others.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

Major activities in the first year to build public awareness of the issue of lack of insurance, and of the state's project, have included presentations at the annual Alaska Health Summit (December 2005), submission of powerpoint slides on the data related to the problem and to the grant activities to the Health and Social Services Committees of the House and Senate and for budget work through the Department's Assistant Commissioner and the Director of the Division of Public Health, and participation in "Covering the Uninsured Week" in May, 2006, with web postings on the official site for that series of events. The two forums on May 1, 2006, provided opportunities including posters provided at public housing facilities and Municipality of Anchorage offices and community centers, two radio interviews, media releases by the Department, and additional distribution of data to several legislative offices.

The Public Information Office of the Department of Health and Social Services assisted with layout and web publication of materials, including the posters and bookmarks about the Forums that were also widely distributed in Anchorage as a way to alert the general public about the

event. A postcard for submitting comments was distributed at the May Forums, to encourage additional sharing of anecdotal information, questions and concerns with the Leadership Team and project staff.

During the first year of the project, due to delays with hiring project staff and to limited availability of staff in the Public Information Office, only a basic web page about the State Planning Grant was developed, although the page does provide links to informative sites such as SHADAC and the State Coverage Initiatives websites, and to data sources such as the Current Population Survey and state resources.
(http://www.hss.state.ak.us/commissioner/Healthplanning/planningGrant/default.htm)
Powerpoint presentations developed for the project have been posted to the website.

The project anticipates major website development in the continuation year in order to publicize and make available reports from the project's funded surveys, focus groups, interviews and in-depth analyses.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

A variety of health care and insurance reform proposals have been introduced in the State legislature in recent years, and the submissions are expected to increase. The business roundtable Commonwealth North has recently completed devoting a year to studying health care in Alaska, and has established a health care roundtable whose executive director is collaborating with the project to plan the December 2006 Forum with business leaders. News of the State Planning Grant data gathering and policy review information have been provided in each of these settings. Participants have reportedly welcomed the state's commitment to work on the issues. Also, planning for the Alaska Health Summit acknowledged the activities of the program as the sponsoring organization, the Alaska Public Health Association, selected and approved the topic "The Value of the Public's Health" for the 2006 meetings December 4-6. The Summit planners noted the contribution that could be made by the information presented by the SPG project, and accommodated the development of two sessions and a closing keynote address related to the project's data gathering activities and policy discussions.

The Commissioner of DHSS has made public statements and Cabinet remarks, and included information about the project in periodic newsletters. The Commissioner of Commerce, Communities and Economic Development was an active discussant in the first May Forum on the uninsured, expressing great interest in the issues around monitoring health care services. Legislators and several state agencies have requested data. Department staff who deal with budget planning and who review of federal budget decisions about health care have begun to work together because of the information sharing that the project has engendered, so it can be said that the project has improved the shared knowledge base. This should have lasting effects although it is premature to draw conclusions prior to the completion of the project. A new state administration takes office in fall 2006.The final report in September 2007 will be able to report more conclusively on the questions of what proposals may have been initiated, and what might move forward.

Section 6. Lessons Learned and Recommendations to States

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

The Alaska State Planning Grant project has been funded for one year. Many of the projected data collection processes (household survey, forums, employer survey, focus groups, etc.) are underway and should be completed by early spring 2007. We anticipate the qualitative research to have a strong role in identifying stakeholder issues. The Department of Administration, Department of Health and Social Services and the Department of Commerce and Economic Development leadership have expressed interest in the data being collected to help identify coverage expansion alternatives.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

The answer to this question is unknown at this time.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Data collection activities specified in the original application are either underway or should be implemented by summer 2007.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

The input and suggestions of the Leadership Team have been valuable in strengthening the data collection that is underway at this time. They provided major comments in the design of the data collection instruments and in identifying strategies for reaching specific populations of interest, for example, small employers. Suggestions have been provided for reaching special populations including fishing permit holders and school districts, for whom modified survey tools have been designed.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

Since the full array of data collection activities identified in the State Planning Grant awarded in September 2006 are still underway and being planned, other data collection activities that might be needed are unknown. There have been discussions of challenges in understanding issues facing certain employers, such as those self-employed in small businesses. Fishing permit-

holders who employ only a few individuals on a seasonal basis are one of the populations that may warrant a special survey. This supplemental survey may be conducted within the framework of the current project. Discussions of the feasibility of such a survey are underway by the staff and Leadership Team.

The assessment of the economic effects of having a substantial uninsured population will be accomplished in the extension period for the project. It is hoped that the study can be designed to take maximum advantage of other HRSA-funded state projects which have sought to measure these impacts. Technical assistance is being sought from SHADAC and other states with experience in this area. Attention is expected to be given to underinsurance, geographic issues of availability of services, and issues related to Alaska's economy and health care system structure.

Additional research may be needed related to potential effectiveness of implementation strategies in other states that may be pertinent to Alaska's marketplace and population needs. In the final report to HRSA in September 2007 a more complete assessment will be reported.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The answer to this question is unknown at this time.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

The answer to this question is unknown at this time.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The answer to this question is unknown at this time.

6.9 How did your State's political and economic environment change during the course of your grant?

Alaska will have a different Governor after the 2006 fall elections.

6.10 How did your project goals change during the grant period?

At this time, our project goals remain the same generally.

6.11 What will be the next steps of this effort once the grant comes to a close?

The answer to this question is unknown at this time.

Section 7. Recommendations to the Federal Government

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

The answer to this question is unknown at this time.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

The answer to this question is unknown at this time.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

The answer to this question is unknown at this time.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

The answer to this question is unknown at this time.

Section 8. Overall Assessments of SPG Program Activity

The answers to this section will be appropriate at the conclusion of the SPG project in Alaska, in September 2007. Generally speaking, the program activity has attracted interest and attention of stakeholders. Alaska's final project report will provide a comprehensive data summary and will address the questions of this section.

8.1 What is the likely impact of program activities in the near future? What were the major impediments and facilitators for improved outcomes? Include specifics about changes in budgetary environment, changes in political leadership etc.

8.2 What is the state's current view of most feasible expansion options? What direction was deemed most feasible and why?

8.3 What do you foresee to be the sustainability of programs implemented as a result of the SPG program, or the likelihood that programs currently under consideration will be implemented?

8.4 Did your SPG program activity create an impetus to change your state's Medicaid program via a waiver, changes in eligibility or cost-sharing?

8.5 Please describe the realities of state decision-making regarding insurance expansion in terms of things that facilitate and inhibit policy changes.

8.6 Concretely, what was the value of the funding data collection analysis? How were the results used to shape political thinking and build consensus on ways to cover the uninsured? What is the value of data being re-collected and at what frequency?

8.7 In terms of the data collection activities pursued through the SPG grant, are there certain ones you would do differently based on experience?

8.8 How have stakeholder groups evolved over time? In hindsight, what are the central components to putting and keeping together a successful steering committee?

8.9 What activities will be discontinued as a result of the SPG grant coming to a close?

8.10 Highlight specific lessons about potential policy options that could be used by HHS and states to shape future activities.

8.11 Please comment on how helpful the site visit, availability to talk/email with AcademyHealth staff, and general technical assistance of AcademyHealth was to your project?

8.12 Please comment on how helpful the HRSA SPG grantee meetings were to your project?

8.13 Please comment on how helpful the technical assistance from SHADAC was to your project?

8.14 Please comment on how helpful the Arkansas Multi-State Integrated Database System was to your project, (if applicable).

8.15 Please comment on how useful the Agency for Healthcare Research and Quality's technical assistance and survey work (e.g. MEPS-IC) was to your project.

8.16 Please comment on the long-term effect (if any) of your state's SPG program on future efforts to improve coverage via:

- *a. Data collection - e.g. surveys, focus groups, etc.*
- *b. Data analysis – e.g. modeling, actuarial analysis*
- *c. Political understanding/education*
- *d. Approaches and structure for collaboration*

Appendix I: Baseline Information

Population

According to the Alaska Department of Labor, the 2005 population was 663,661.

Number and percentage of uninsured

The percentage of uninsured Alaskans has remained relatively constant over the last five years, with a 3-year rate of 18.1% in 2000 and 17.8% in 2005. Approximately 118,000 people were uninsured in Alaska in 2005.

Average age of population

The Alaska Department of Labor estimates that the median age of Alaska residents in 2005 was 33.4 years old.

Percent of population living in poverty

The 2005 CPS reports 13.7% of Alaskans living in poverty (<125% FPL).

Percent of Alaskans Living in Poverty (2005 CPS)	
FPL	Percent under FPL
100	10.0%
125	13.7%
150	17.5%
200	27.1%

Primary industries

According to the Alaska Department of Labor, the primary industry in Alaska is the service industry with nearly 300,000 workers. Government has the second largest number of workers at a count of nearly 80,000.

Number and percent of employers offering coverage

In a 2001 survey of employer benefits, firm size was the most significant factor for employers providing health benefits. The survey found that less than 1/3 of small (<10 employees) firms provided health benefits, more than 60% of medium sized firms provided benefits to their employees, over 90% of large (50-250 employees) and nearly all of very large (>250 employees) firms offered health benefits.

CPS data indicates that over 18% of all workers were uninsured (2002-2004).

Number and percent of self-insured firms

About 60% of the private health insurance market is self-funded. The Division of Insurance in the Department of Commerce, Community and Economic Development cannot regulate (under ERISA) and does not track this portion of the market.

Payer mix

Nearly 15% of the population is served by Medicaid, 6% by Medicare, about 7% purchase coverage individually, and over 60% have employment based coverage.

Provider competition

The Division of Insurance, Department of Commerce, Community, and Economic Development tracks independent insurers, which makes up about 40% of the insurance market in Alaska. Premera Blue Cross/Blue Shield is the largest independent insurer with 79% of the market; the next largest insurer has about 7% of the market; only five other companies each have over 1% of the comprehensive health insurance market. There are no managed care offerings in Alaska.

Insurance market reforms

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: small group market reforms, the creation of a high-risk pool, and expansions to the Certificate of Need program.

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-insured.

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 Portability 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.

Eligibility for existing coverage programs (Medicaid/SCHIP/other)

Denali KidCare was implemented in March 1999 enabling children 18 and under to be covered by Title XIX/Medicaid even if their families were not enrolled, if family income was below 200% of the Federal poverty guidelines for Alaska. At the same time, Medicaid was expanded for pregnant women. Major outreach efforts resulted in the program enrolling the target number of 11,600 children 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. Current Denali KidCare enrollment of about 10,856 together with poverty level Medicaid child enrollment of 17,541 and children in families on Medicaid (about 36,000 in February 2005) appears to have reduced the rate of uninsured children from about 16% to about 12% in 2003 according to the CPS.

In the early 1990s Alaska kept step with other states with Medicaid expansions for Early and Periodic Screening and Treatment and in 1998 Alaska implemented program changes to provide Medicaid coverage to the working disabled. The expansion allows some working disabled clients to retain Medicaid coverage by disregarding certain amounts of income and resources.

Use of federal waivers

Alaska has an extensive program of home and community based waivers to encourage use of assisted living and home-based options. The Alaska, Division of Senior and Disabilities Services administers four Medicaid 1915(c) waivers. Among the four, people of all ages who meet a nursing facility or ICF/MR level of care can qualify to receive services at home or in other community-based settings outside of institutions. At any given time, over 3,000 Alaskans are receiving home and community-based services in urban and rural communities throughout the state. These services include:

- Respite care
- Environmental Modification
- Adult day care
- Transportation
- Specialized medical equipment and supplies
- Chore services
- Specialized private duty nursing
- Care in an Assisted Living Home
- Home delivered meals
- Habilitation, for people with developmental disabilities

Appendix II: Links to Research Findings and Methodologies

U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement 2005
http://pubdb3.census.gov/macro/032006/health/toc.htm
http://pubdb3.census.gov/macro/032006/pov/toc.htm
http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

U.S. Census Bureau Current Population Survey, Income, Poverty, and Health Insurance Coverage in the United States: 2005
http://www.census.gov/prod/2006pubs/p60-231.pdf

Alaska Behavioral Risk Factor Surveillance System
http://www.hss.state.ak.us/dph/chronic/hsl/brfss/default.htm

Alaska Behavioral Risk factor Survey 2004/2005 Annual Report, *Health Risks in Alaska Among Adults*, Alaska Department of Health & Social Services, June 2006
http://www.hss.state.ak.us/dph/chronic/hsl/brfss/pubs/BRFSS0405.pdf

Employer Benefits Survey (Alaska Departments of Health & Social Services, Labor and Workforce Development, Administration, Community & Economic Development)
http://www.labor.state.ak.us/trends/trendspdf/apr02.pdf

Alaska Population Estimates 2000- 2005**,** Alaska Department of Labor & Workforce Development, Research & Analysis
http://almis.labor.state.ak.us/

Current Employment Statistics, Alaska Department of Labor & Workforce Development, Research & Analysis
http://almis.labor.state.ak.us/

Appendix III: SPG Summary of Policy Options

This section is not applicable at this time.

End Notes

[i] Navigant Consulting, "Report on the economic and market impact on Alaska of the proposed conversion of Premera Blue Cross to a for-profit entity," presented to the Alaska Division of Insurance September 23, 2003.
[ii] Foster, Mark and Goldsmith, Scott, "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research Summary No. 6, March 2006.