

# **Focus Group Results from Mississippi's Uninsured Underrepresented Populations**

**Presented to**

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# **Focus Group Results from Mississippi's Uninsured Underrepresented Populations**

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## **Executive Summary**

In March 2004, Mississippi State University's (MSU) Social Science Research Center (SSRC) was selected to gather and report baseline findings "that describe the characteristics of the uninsured" specifically from underrepresented populations in Mississippi identified as African Americans, Hispanic Americans, Asian Americans, and Native Americans to "develop a comprehensive understanding of the uninsured populations in Mississippi" and "to address cultural issues as they relate to various underrepresented populations." Results of the findings in this report will be combined with findings from other Mississippi research entities to provide a more complete view of the status of uninsured Mississippians for the Health Resources and Services Administration (HRSA) and the Mississippi Division of Medicaid.

Eight focus groups (two per underrepresented group) were conducted using facilitators of the same ethnicity to lead the sessions. Researchers from MSU's SSRC collected data during the months of March and April 2004 at strategic locations within Mississippi, seeking purposeful samples<sup>1</sup> from each population: Philadelphia (for Native Americans, Choctaw), Biloxi (for Asian Americans, Vietnamese), Clarksdale and Indianola (for African Americans), and Morton (for Hispanic Americans).

### ***Overall Findings***<sup>2</sup>

#### **Characteristics of Non-Insured Participants by Population**

<b>Participation</b>	<ul style="list-style-type: none"><li>• Higher representation of Hispanic and Native Americans</li></ul>
<b>Sex</b>	<ul style="list-style-type: none"><li>• More females than males, except for Native Americans (equal)</li></ul>
<b>Age</b>	<ul style="list-style-type: none"><li>• African, Native Americans more evenly represented across age groups</li><li>• Most Hispanics in 31 – 50 group; most Asians in 51 – 70 group</li></ul>
<b>Marital Status</b>	<ul style="list-style-type: none"><li>• Majority of Asian, Hispanic, and Native Americans married</li><li>• One-third African, Native Americans single</li></ul>
<b>Children Under 18</b>	<ul style="list-style-type: none"><li>• High majority of Hispanic Americans have children under 18</li><li>• About half of other groups have children under 18</li></ul>
<b>Education Levels</b>	<ul style="list-style-type: none"><li>• Majority of African, Asian Americans have less than high school education</li><li>• Hispanic, Native Americans more evenly represented across education groups</li></ul>

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<sup>1</sup> Purposeful sampling focuses on gaining insight through "a limited number of cases for examination" and involves studying "information-rich cases in depth and detail to understand and illuminate important cases rather than generalizing from a sample to a population" (Patton, M.Q. *Qualitative Research and Evaluation Methods*, 3<sup>rd</sup> edition, page 563). Decisions about design and methodology were pre-determined by the Mississippi Medicaid State Planning Grants Program.

<sup>2</sup> Participants' characteristics and perceptions *cannot be generalized* as representative of population groups – they provide insights about uninsured individuals within underrepresented population groups who participated in the focus group sessions.

<b>Employment Status</b>	<ul style="list-style-type: none"> <li>• Majority African Americans not employed;</li> <li>• High majority Hispanic, Native Americans employed</li> </ul>
<b>Employment Areas</b>	<ul style="list-style-type: none"> <li>• High majority of Hispanic Americans represented in Labor/Construction</li> <li>• High majority of Native Americans represented in Housekeeping</li> </ul>
<b>Hours Worked Per Week</b>	<ul style="list-style-type: none"> <li>• High majority of Hispanic Americans worked 40 or more hours/week</li> <li>• Half Native Americans worked less than 40 and half worked 40 hours/week</li> <li>• African, Asian Americans worked under 40 hours/week</li> </ul>
<b>Earnings Per Week</b>	<ul style="list-style-type: none"> <li>• High majority Asian and majority of African Americans earned less than \$200/week</li> <li>• High majority Hispanic Americans earned \$200 - \$400/week</li> <li>• Native Americans more equally earning less than \$200 or \$200-\$400/week</li> </ul>
<b>Employer Insurance</b>	<ul style="list-style-type: none"> <li>• High majority Hispanic Americans eligible for employer insurance</li> <li>• Low representation of other groups for eligibility</li> </ul>
<b>Time without Insurance</b>	<ul style="list-style-type: none"> <li>• All groups highly represented in the more than 5 years category</li> <li>• Native Americans more highly represented in the less than 1 year category</li> <li>• Hispanic Americans more highly represented in the 2 – 4 year category</li> </ul>
<b>Medicaid CHIP Application</b>	<ul style="list-style-type: none"> <li>• African Americans more highly represented as applying for Medicaid/CHIP</li> <li>• Hispanic, Native Americans more highly represented as not applying</li> <li>• Asian Americans equally represented as applying and not applying</li> </ul>

## **Perspectives of Health Insurance Issues by Population Groups**

### **A. Importance of Health Insurance**

All groups: health insurance “very important” for self; more important for their children

### **B. Reasons for Health Insurance**

Commonalities

- Main reasons for wanting health insurance: to avoid sickness, maintain good health, financial stability, and avoid bankruptcy. Reasons for not having insurance: lack of money and employment-related issues. Problems experienced: economic difficulties and receiving reduced-quality care. Main worries: not being able to get medical help for an emergency, inability to pay for medical emergencies, need for specialists, and inability to pay for specialized services.

Differences

- African Americans want health insurance to take care of special needs.
- Native Americans want insurance to be able to choose doctor of their preference; pre-existing conditions a reason for not having insurance; worried about obtaining care away from reservation.
- Hispanic Americans want insurance to avoid discrimination; worried about getting into trouble (legal status); reasons for not having insurance: not understanding information from the government or on television.

### **C. Alternatives to Health Insurance**

Commonalities

- Best way to obtain medical services without insurance: go to a hospital/emergency room. Use over-the-counter medications and home remedies when sick. Some from each group had a health check-up within the past year. Unmet needs: vision, dental. Best ways to stay healthy: exercise and proper diet.

## Differences

- African Americans reported varying levels of knowledge about sources of information for health care: although some participants stated they had no knowledge; others mentioned insurance companies, local health centers, and the Internet as sources for health care information. Some “wait out” sicknesses and they believe in prayer and faith for healing. Others use community programs to obtain medical services without insurance. The Hill-Burton Act was discussed and should refer to it when at a hospital. Large majority’s last health check-up was in the past year. Unmet health needs: back, heart, seizure, blood pressure, headache, depression, hernia, stomach. Way to stay healthy: proper medical diagnosis.
- Asian Americans use Catholic Social Services to get information about health insurance, and they go to the local health department or to Coastal Family Services to obtain medical care. Large majority’s last health check-up was ten or more years ago. Declined to answer specifically about unmet health needs, saying topic too personal.
- Hispanic Americans typically felt there were no good sources for health insurance information. Some tend not to go anywhere when sick; for those who do go to a hospital, they avoid private ones. Some said they are able to handle being sick because they are male. Large majority’s last health check-up was within the past two to three years. Unmet health needs: gynecological treatments. Ways to stay healthy: proper clothing, rest, and avoid excesses.
- Native Americans reported that they obtain information about health insurance from people who visit schools and from public media such as mail and television. The Choctaw Health Center is their main way to obtain medical services without insurance; however, some expressed confusion about eligibility for services (mainly based on percent of being Indian). This eligibility requirement was cited as a problem for children who could not prove their percentage because fathers were not signing birth certificates. A large majority of participants had their last health check-up within the past five years. Allergies, arthritis, and chronic pain were mentioned as unmet health care needs.

## **D. Options for Health Insurance**

### Commonalities

- Main reasons for not accepting employer health insurance: not eligible and not having enough money to pay employee portion of benefits. Most expressed willingness to take a job for less pay with health insurance. Mixed responses among all groups regarding eligibility for Medicaid and knowledge about CHIP. All expressed interest in low cost health coverage for children. Needed to obtain insurance: money, including related areas of employment. They would like low- to no-cost Medicaid services.

### Differences

- One of the four African Americans who worked had employers who offered health insurance. Some said they had no knowledge of Medicaid, others said it was for children and pregnant women. All reported some knowledge about CHIP. Faith was mentioned as a source for health insurance.
- One of the seven Asian Americans who worked had employers who offered health insurance. About half had some knowledge about Medicaid, while others did not. All understood one must be a U.S. citizen to qualify. None indicated having heard information about low-cost health coverage for children. Participants want the government to be the source for health insurance.
- All eighteen employed Hispanic Americans who worked had employers who offered health insurance. Main reason for not accepting insurance: would limit options for choice in health care. Some not willing to take a job for less pay because they felt income was already low and meeting only basic needs. Some want to control choice of health provider and costs. The majority indicated they did not know who was eligible for Medicaid, but one stated it was not for “people with no legal papers.” Most understood that children born in the U.S. were eligible for CHIP, depending on family income. Participants want the government to be the source for health coverage.

- Five of the sixteen Native Americans who worked had employers who offered health insurance. Some said young children, low-income families, and pregnant women qualified for Medicaid; others said elderly and disabled qualified. Very few knew about CHIP, but expressed an interest in it. One participant said Medicaid services needed to cover a larger range of incomes, stating “right above the limit is hard.” This group wants an employer to be the source for health coverage.

## **E. Ability and Willingness to Pay for Health Insurance**

### Commonalities

- Indicated willingness to pay something for health insurance, most in the \$20 - \$60 per month range. Similar types of sacrifices to pay a higher amount for insurance: food, limit purchases to necessities. Amounts given as “fair” for co-payments varied, but most estimated increased ranges in this order: doctor visits, prescriptions, then emergency room visits. Difficult to estimate savings with insurance.

### Differences

- African Americans estimated \$10 - \$40 for doctor; \$5 - \$30 for prescriptions; \$10 - \$100 for emergency room.
- Asian Americans had difficult time understanding concept of “co-payment” and did not differentiate amounts for medical services – everything was between \$10 and \$20 or 5% of the bill.
- Most Hispanic Americans used percentages of income as amount willing to pay for insurance: 5% - 10%. Some unable to sacrifice more, while another said this was not a sacrifice because “we would have good service.” Co-payments were expressed as percentages of bill: Doctor, 5% - 10%; prescriptions, 8% - 25%; emergency room, 20% - 30%.
- Some Native Americans spoke of sacrificing personal time: extra work or a second job to pay a higher amount for insurance; others said not eating junk food and choosing between going to school or work. Group had difficulty understanding “co-payment” because they go to the Choctaw Health Center. Some gave figures that may have included both a doctor visit and prescription (\$40 - \$180 and \$500) while some gave estimates closer to the other groups (\$5 - \$25, doctor; \$25 - \$100, emergency room).

## **F. Impact of Being Uninsured**

### Commonalities

- Most would wait between 2 – 3 days or 1 – 2 weeks before seeking medical help. Previous responses described affects of being uninsured on personal health and medical conditions. Difficulty in paying medical bills. They would do whatever is necessary if life-saving surgery were needed.

### Differences

- African Americans reported impacts: not being able to get needed prescriptions or continue treatments, depression, and tension and stress at home. No health services were neglected to save money.
- Asian Americans described impacts in section “C”. To save money, some do not go to the dentist. If life-saving surgery were necessary, they would depend on family for help.
- Hispanic Americans reported impacts: economic (debt) and feelings of discrimination and insecurity. They would not wait to seek medical help for their children. To save money, some do not go to the dentist, get preventive check-ups, vision or specialty care.
- Native Americans felt that the question about impacts of being uninsured did not pertain to them because of the Choctaw Health Center. They would not wait to seek medical help for their children.

## ***Recommendations***

The following recommendations are suggested based on participants' comments and researchers' experiences with the focus groups:

- **Identify and collaborate with organizations that underrepresented populations trust**

Groups reported a need for improved access to information about available health care services. Having a common and trusted source for information may reduce confusion about eligibility issues, feelings of discrimination, and worries about legal status. Researchers identified and worked with trusted individuals and organizations to successfully convene and conduct the focus groups, and participants expressed appreciation for having the opportunity to talk about health issues in this setting.

- **Simplify language regarding and processes for obtaining health care services**

English is a second language for some of these groups; and those who are older may not learn English proficiently. Researchers found that the facilitators used to assist with the focus group sessions for groups whose first language was not English were essential to communicate accurately about health insurance. With many participants stating they need more information about insurance, it is important that the information they do receive is easy to understand. Special attention should be given to avoid medical jargon. Participants also expressed a need for an “easy process for Medicaid.” It should not be assumed that people in these groups understand the “standard” sequence for obtaining the health care they need. For example, one Hispanic American said that he knew what medicine to take and went to a pharmacy to get it but was turned down because he did not have a prescription.

- **Tailor information specifically for issues associated with individual underrepresented populations**

The differences described among populations point to a need for emphasizing and/or clarifying certain issues associated with health insurance. Asian Americans were uncomfortable discussing specific health care needs in a group setting. Native Americans expressed concern for children whose fathers do not sign birth certificates and for obtaining care when away from their home reservation. Hispanic Americans repeatedly expressed feelings of discrimination and insecurity about not understanding “the system” and about concerns for their children’s needs. African Americans were concerned about receiving reduced quality care. All groups expressed concern about obtaining insurance for medical specialists.

- **Respect individuals’ need for self-help**

Most participants indicated a willingness to pay a portion of their medical care and do not want to appear to be asking for free services. Personal financial situations greatly impact their decisions with regard to obtaining health care – many indicated having to choose one among multiple high priority needs to address first. Some expressed concern about avoiding loss of credit and wanted to pay a little at a time.

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## **Introduction**

The Health Resources and Services Administration (HRSA) awarded a State Planning Grant project to the Office of the Government's Division of Medicaid to "1) collect and analyze data that describe the characteristics of the uninsured, 2) design a program to reduce the uninsured through state, federal, and private partnerships, 3) design feasible options for identified populations, and 4) prepare and disseminate reports describing the above."<sup>1</sup> The Mississippi Medicaid State Planning Grants Program will provide a final report of research findings to include actions taken and an analysis of the status of health insurance coverage in the State of Mississippi to the Secretary of the Department of Health and Human Services

Mississippi Institutes of Higher Learning (IHL) affiliates were given the responsibility to collect, analyze, and report data as described above. In March 2004, Mississippi State University's (MSU) Social Science Research Center (SSRC) was selected to gather and report baseline findings "that describe the characteristics of the uninsured" specifically from underrepresented populations in Mississippi identified as African Americans, Hispanic Americans, Asian Americans, and Native Americans to "develop a comprehensive understanding of the uninsured populations in Mississippi" and "to address cultural issues as they relate to various underrepresented populations." The Mississippi Medicaid State Planning Grants Program will use this baseline information to assist in the development of a comprehensive understanding of Mississippi's uninsured as part of an effort "to develop specific plan options." Results of the findings in this report will be combined with findings from other Mississippi research entities to provide a more complete view of the status of uninsured Mississippians.

## **Methodology**

The basic methodology for collecting baseline data describing the characteristics of the uninsured underrepresented populations in Mississippi was provided in the Detailed Project Narrative of the Mississippi Medicaid State Planning Grants proposal. Eight focus groups (two per underrepresented group) were conducted with underrepresented populations to include African Americans, Hispanic Americans, Asian Americans, and Native Americans. The University of Southern Mississippi (USM) provided the focus group guide (see Appendix B). Data from the Underrepresented Population Focus Groups were gathered using traditional "flipchart" facilitation. Minority facilitators assisted with conducting the focus groups. Researchers from MSU's SSRC collected data during the months of March and April 2004 at strategic locations within Mississippi: Philadelphia (for Native Americans), Biloxi (for Asian Americans), Clarksdale and Indianola (for African Americans), and Morton (for Hispanic Americans).

Potential focus group participants were identified through the assistance of local community entities and personnel identified as knowledgeable about and trusted by each underrepresented population group. Targeted announcements were made to members of each of the four underrepresented populations for this study. Focus group participants volunteered their time and information on a voluntary basis and received a \$30.00 Wal-

Mart gift card as an incentive for their participation in the focus groups. Two focus group sessions with up to twenty participants from each ethnic group (for a possible total of forty participants per ethnic group) were held in locations convenient to the targeted audience. For those groups whose first language was not English, a translator was either present to assist the session or conducted the session with the assistance of an MSU SSRC researcher/facilitator. The sessions were tape recorded to ensure that all comments were captured.

Prior to gathering data from the African American, Native American, Asian American, and Hispanic American populations in Mississippi, approval from MSU's Internal Review Board (IRB) was obtained for use of Human Subjects for this study. The format of data gathering (focus group sessions) and the questions to be asked of these individuals were approved prior to conducting this study. Focus group participants read and signed consent forms which are kept in a secured location at the SSRC (see Appendix A for a copy of the consent form). Participants also completed registration forms that asked for demographic and characteristic information which are presented in graph format in Section One of this report (see Appendix C for a copy of the registration form).

### **Methodology Details for Each Underrepresented Population Group**

#### **African American Focus Groups**

The SSRC provided postage paid announcement flyers to community leaders who mailed them to prospective participants prior to the focus groups session being conducted. The Program Director of the Delta Health Partners Healthy Start Initiative assisted with enlistment of community leaders in Clarksdale and Indianola, Mississippi. These community leaders helped enlist focus group participants. The Data Manager with Delta Diamond Healthy Network assisted with the Clarksdale meeting. The Social Worker Case Manager with Delta Health Partners helped solicit people in the Clarksdale area and also agreed to serve as facilitator. Community leaders in the Indianola area who helped solicit participants were associated with the National Caucus and Center for Black Aging Senior Employment Program and with Progress, Inc. The Administrator of the Delta Diamond Healthy Network facilitated the meeting in Indianola, and the Outreach Coordinator with Delta Health Partners acted as scribe. The first of two focus groups consisting of ten African American individuals was held at the Clarksdale Civic Auditorium in Clarksdale, Mississippi on May 11, 2004 in conjunction with a city-wide Health Fair held at the Clarksdale Civic Center. The second session consisting of six African American individuals was held at the Neighborhood Facility Building in Indianola, Mississippi on May 14, 2004.

#### **Asian American Focus Groups**

The SSRC provided project information to the director of Catholic Social and Community Services in Biloxi, Mississippi, who arranged for a Vietnamese-speaking facilitator and scribe. The Catholic Social and Community Services is an organization that is well known along coastal Mississippi as a source that Asian Americans use for

many services. The director also identified qualified individuals and recruited them for the focus group sessions. Both of the focus group sessions consisting of fifteen Asian Americans were held in a classroom at the Catholic Social and Community Services Building in Biloxi, MS on April 27, 2004.

### Hispanic American Focus Groups

The SSRC provided project information to the mayor of Morton, Mississippi, who referred researchers to the Director of the Excel Community & Learning Center in Morton and arranged for a Spanish-speaking facilitator and scribe. The Excel Community & Learning Center, established in 1988, works within the community to provide education, promote community building, encourage community service, and foster healthy lives for families and individuals. Staff of the Center also identified qualified individuals, recruited them, and mailed postage paid flyers to potential participants for the focus group sessions. Two focus group sessions with a total of twenty participants were held at the Excel Community & Learning Center in Morton, Mississippi on March 11<sup>th</sup> and March 12<sup>th</sup>, 2004.

### Native American Focus Groups

The SSRC contacted the Director of Public Information with the Mississippi Band of Choctaw Indians (MBCI) to start the process of obtaining permission and assistance to conduct the focus group sessions with representatives of their tribe. The SSRC was referred to the Associate Commissioner with the Choctaw Gaming Commission (who formally worked for seventeen years as administrator of the Women, Infants, and Children [WIC] program) who assisted with arrangements and facilitated the two focus group meetings. Permission to conduct the focus groups was obtained from the Chief of the MBCI. The facilitator was able to translate in Choctaw for those participants that were Choctaw-speaking only. The two focus groups were held at the Saint Therese Church in Choctaw, Mississippi on September 9, 2004.

The MBCI provides health care for qualifying members of the Choctaw tribe at the Choctaw Health Center through their Choctaw Health Department. Participants for this project were identified as Native Americans who were either not of the qualifying blood percentage to be full members of the Choctaw tribe or who were members of other tribes living away from their home reservations, thereby disqualifying them from complete health coverage through the Choctaw Health Department (see Appendix D for information on the Choctaw Health Department and the Choctaw Health Center).

### Limitations

During the focus group sessions, facilitators and SSRC researchers experienced some difficulties with some participants understanding certain phrases or terms used in the guide (such as “co-payment”) or with participants expressing unwillingness to answer some questions in a group setting because of the questions’ personal nature (for example, a question such as, “What medical conditions, if any, do you or your dependents have

that need a doctor's care?"). There were several questions that asked for information that were similar to other questions, and the contracted facilitators either combined them or referred SSRC facilitators to answers given to previous questions.

### **Presentation of Data**

Data collected from the four underrepresented groups are presented in two sections:

- Characteristics of Non-Insured Groups depicted in graph format; and
- Perspectives of Health Insurance Issues by Non-Insured Groups in descriptive format.

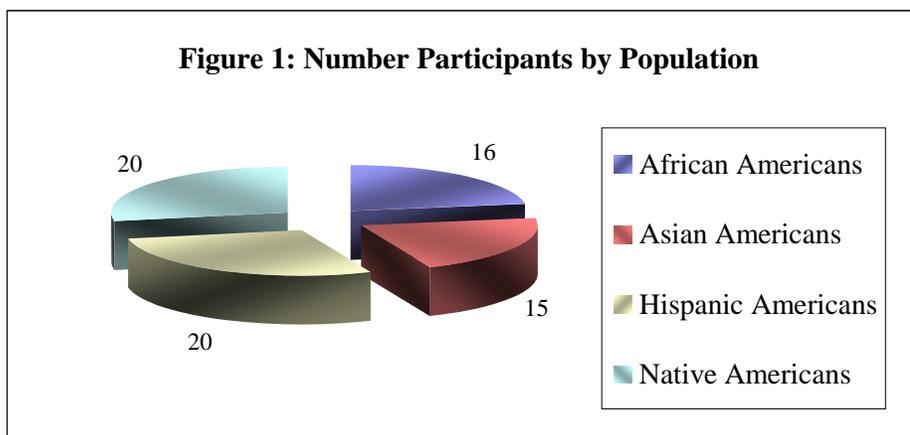
In Section One, participants' characteristics are displayed in thirteen figures that provide self-explanatory descriptive information about each of the underrepresented populations. The graph format of the data also provides a means for comparisons among population groups.

In Section Two, there are a series of questions that provide perspectives of health insurance issues among the underrepresented populations. Responses include both commonalities and differences, with some representative comments from focus group participants provided as examples.

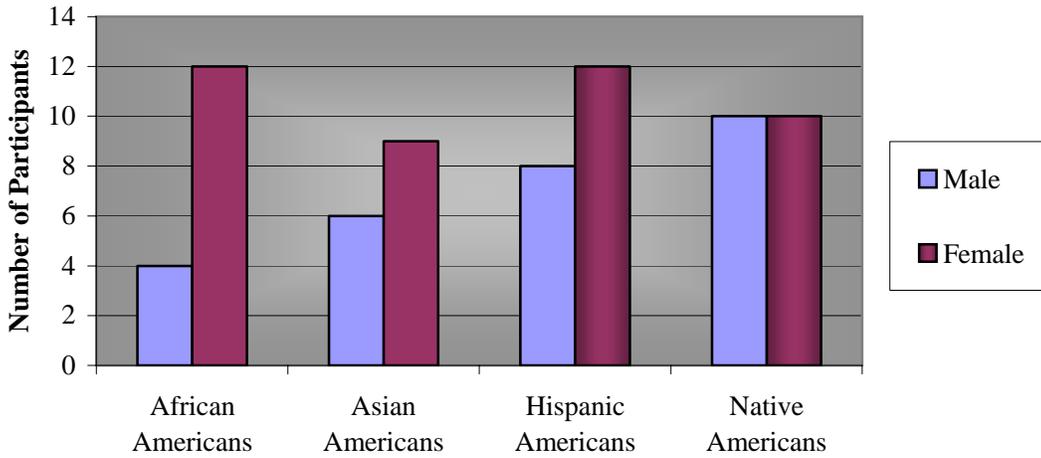
### **Section One: Characteristics of Non-Insured Groups by Populations**

One of the goals of this project was to collect data that described the demographic characteristics of the uninsured. The following thirteen graphs represent data gathered at eight focus group sessions, two sessions with each underrepresented population. These graphs depict data gathered from the registration questionnaire given to each participant prior to the focus group session. The graphs are self-explanatory and provide a means for comparison among population groups.

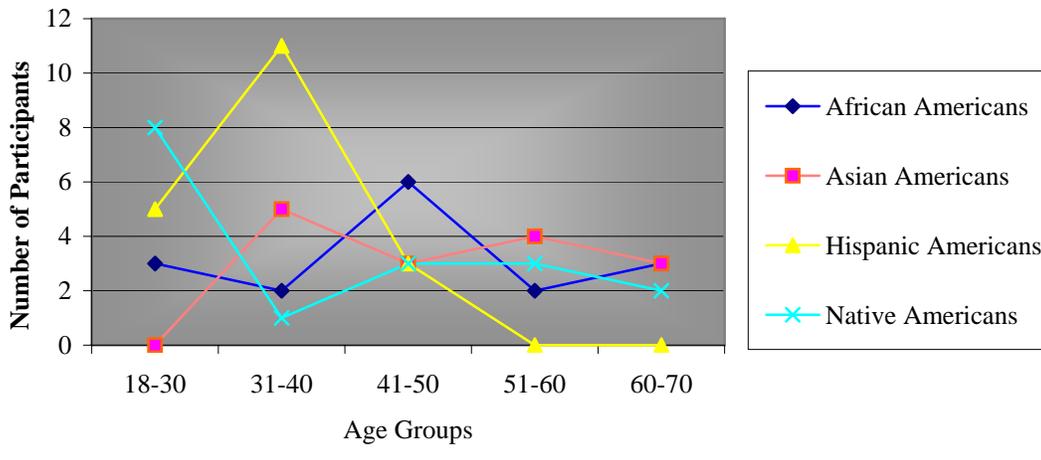
#### **Number of Participants, Gender, and Age**



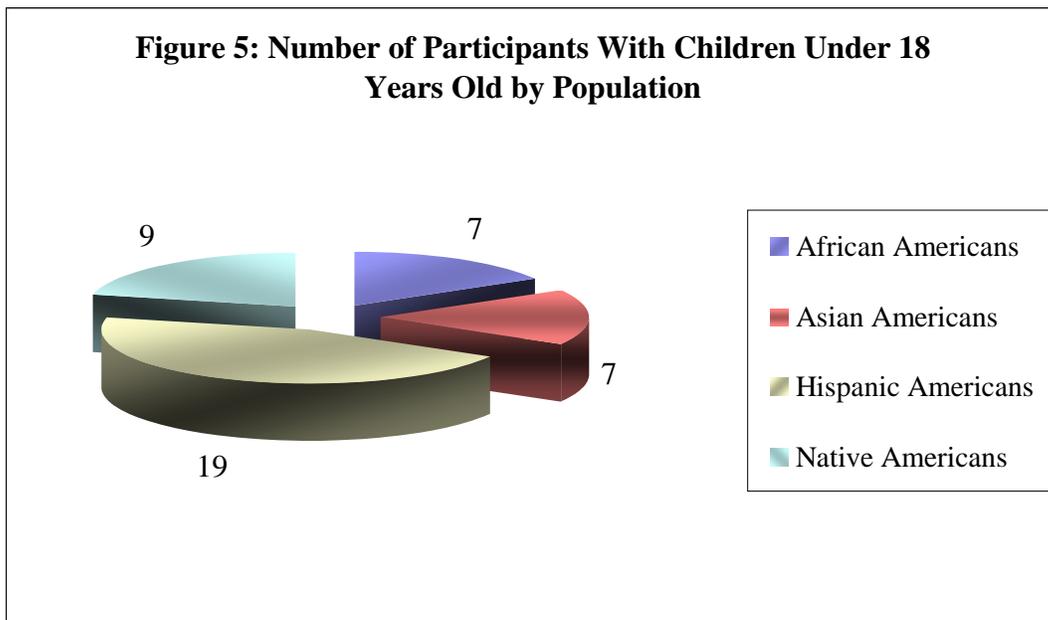
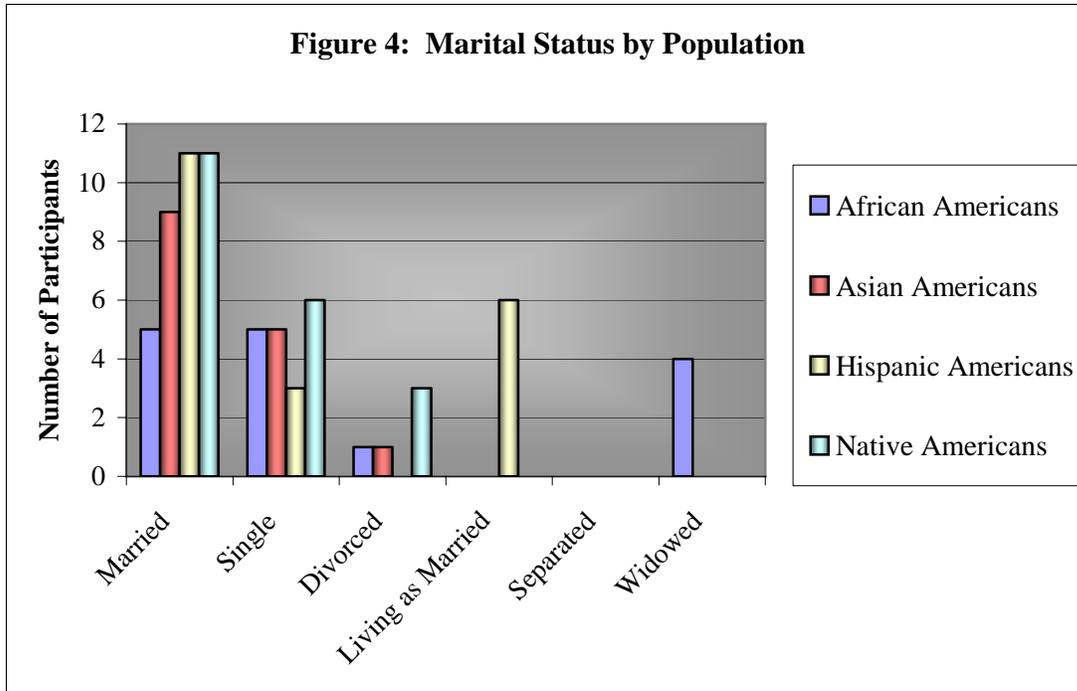
**Figure 2: Gender by Population**



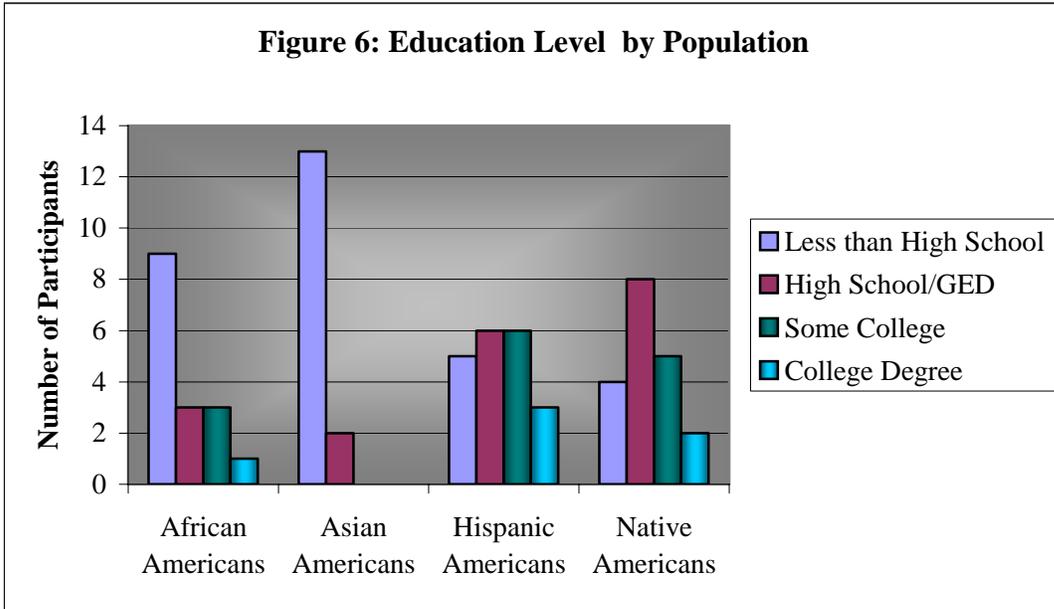
**Figure 3: Age by Population**



Participants' Family and Education Status

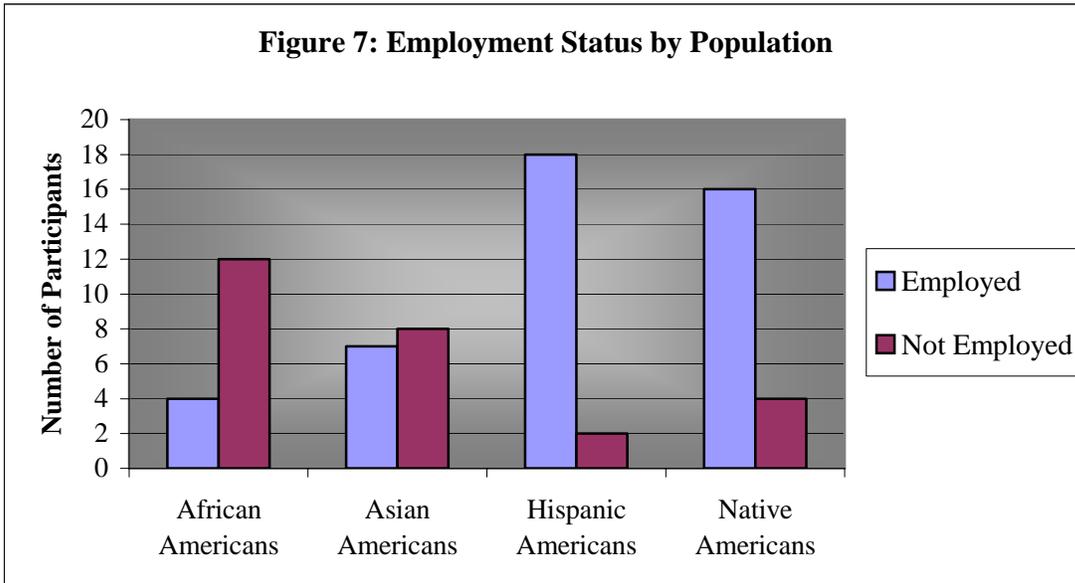


**Figure 6: Education Level by Population**

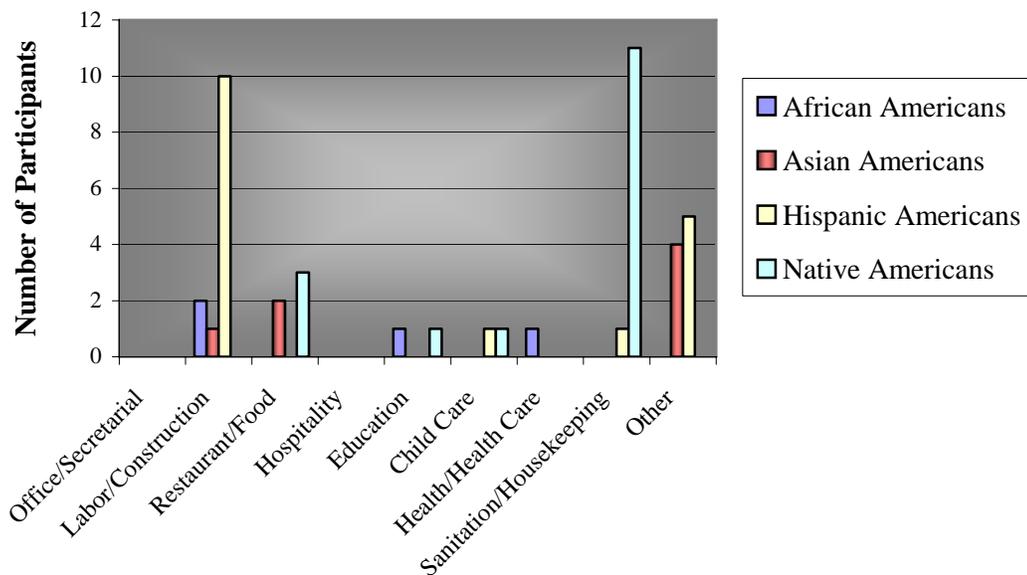


Participants' Employment Status

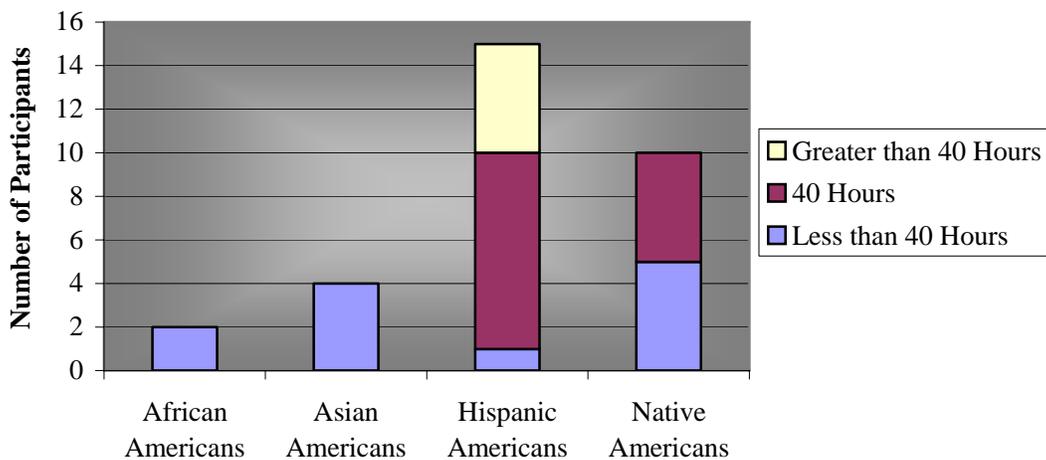
**Figure 7: Employment Status by Population**

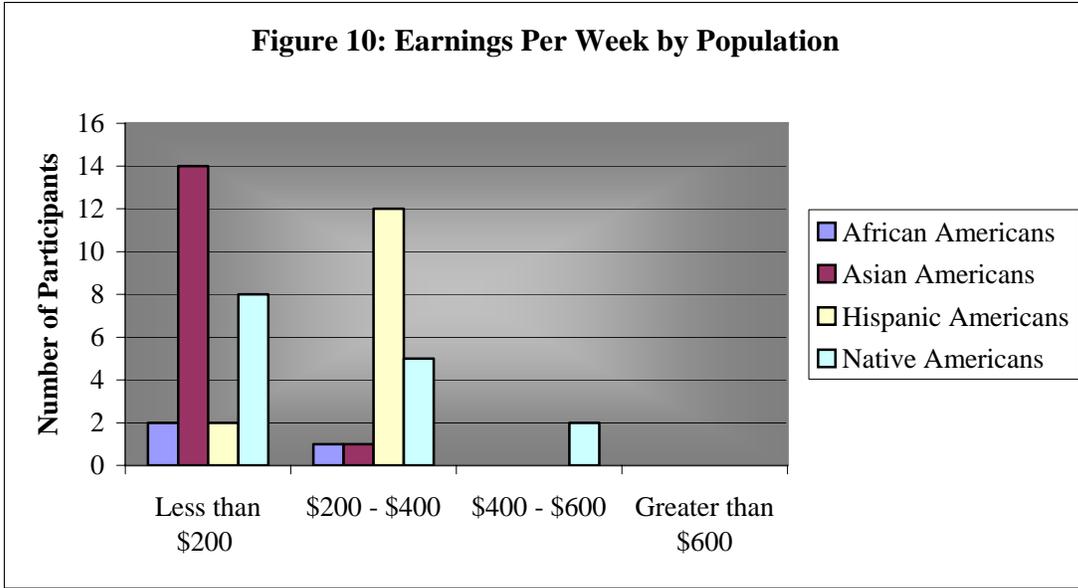


**Figure 8: Employment Area by Population**

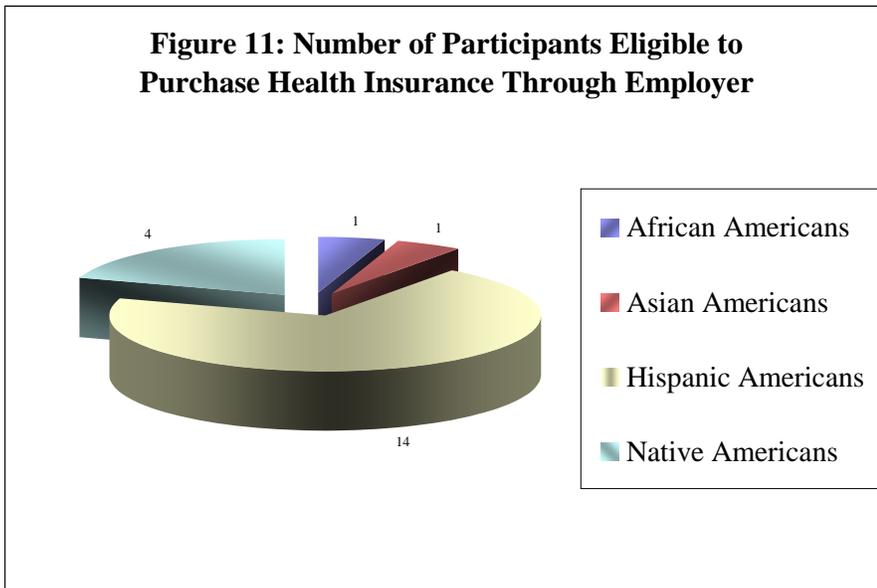


**Figure 9: Work Hours Per Week by Population**

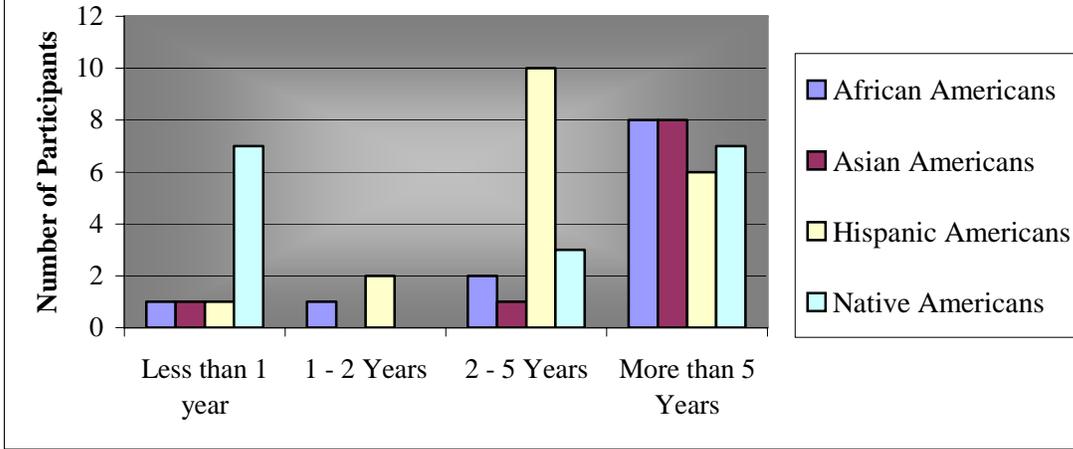




Participants' Health Insurance Status

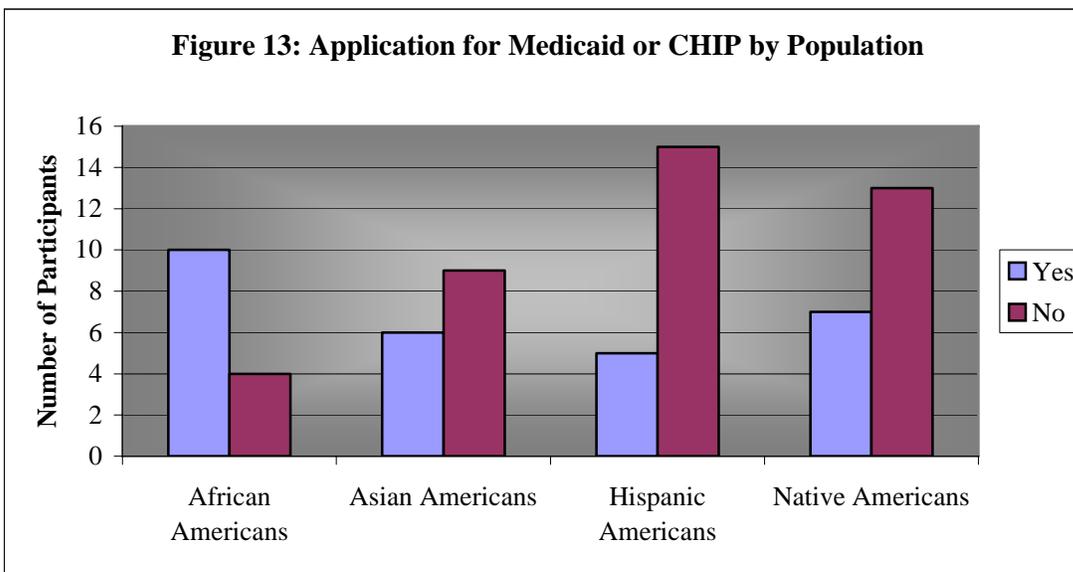


**Figure 12: Length of Time Without Health Insurance by Population**



**Section Two: Perspectives of Health Insurance Issues by Populations**

**Figure 13: Application for Medicaid or CHIP by Population**



To address cultural issues related to various populations with reference to being non-insured, each underrepresented group was asked a series of questions that were given to the MSU SSRC by researchers from the University of Southern Mississippi (USM) and approved by the HRSA Technical Working Group (TWG) (see Appendix B for the Focus Group Guide). Researchers conducted a comparative review of each focus group’s transcript, and a summation of responses follows which provides commonalities and differences among groups’ responses.

## **A) Importance of Health Insurance**

All groups indicated that having health insurance was “very important” for themselves as adults and was even more important for their children. One individual in the African American group explained that had he been diagnosed or educated in preventive health measures when he was younger, such information might have led to the control or possible avoidance of his present health problems (diabetes and high blood pressure). An individual in the Hispanic-American group pointed to the greater likelihood of children having accidents. While the Native American group has the Choctaw Health Center which provides health care for tribal children (see Appendix D for a description of the Health Center provided by the Native American scribe with the approval of the Choctaw Health Center), members in this group expressed concern for those children who did not qualify for health care due to being under the required percentage of Choctaw blood. One tribal member’s comment regarding the greater importance placed on children being insured was representative of the other groups’ feelings: *“I’d rather have my children insured than myself.”*

Several groups expressed concern that lack of health insurance affected their receiving quality care. One African-American participant’s comment explained why most felt this concern:

*I just know that health care insurance is very important ‘cause I have watched it from both ends. I’ve had insurance and I have not had insurance. And when my husband was sick and he had insurance, well they, oh, they cater to every need that you have. But the minute you don’t have it anymore, you can see a total difference in the way they care for you. They just don’t care.*

One participant in the Hispanic American group expressed concern about the impact of a person’s legal status with regard to obtaining health insurance.

## **B) Reasons for Health Insurance**

### Main Reasons for Wanting Health Insurance

Participants were asked for their main reasons for wanting health insurance. Every group expressed a desire similar to “avoid sickness” and for “good health” as said by two Asian-American participants. As one African-American participant explained: *“I know that if I have insurance then I’ll be able to go take regular visits to the doctor to make sure that. . .I’m healthy and I can stay healthy.”*

A number of African American participants said they wanted health insurance as a means to take care of specific health needs such as obtaining medicines, having surgery, and getting medical attention for chronic problems. Several Native American focus group participants said that an important reason for them to have health insurance was so they could choose a doctor of their preference. Financial stability was mentioned by Asian Americans, Native Americans, and Hispanic Americans as important reasons for having

health insurance with expressions such as “*to avoid bankruptcy and financial disaster*” and “*to help pay bills.*” Some Hispanic-Americans considered health insurance as a right and that “*we should not be discriminated against.*”

### Main Reasons for Not Having Health Insurance

All groups listed a lack of money for insurance as well as employment-related reasons such as being unemployed or working part-time or not having worked long enough at a job to qualify for insurance benefits as main reasons for not having health insurance. Hispanic Americans provided additional reasons such as fear of getting into trouble (referencing legal status and lack of social security number) and not understanding information that the government gives them or that they see on television. One Native American participant said that a pre-existing condition prevented her from getting health insurance.

### Problems Experienced as a Result of Being Uninsured

Asian Americans, Native Americans, and Hispanic Americans reported experiencing economic difficulties such as “long-term payments” and credit problems from not being able to pay medical bills. African Americans, Asian Americans, and Native Americans reported feeling they received reduced-quality care or were denied care because of not having insurance.

### Main Worries About Not Being Insured

All groups cited worries about not being able to get medical help should an emergency arise and worried about their inability to pay for a medical emergency. As one African-American participant said, “. . . *if you hadn't got that green card or some kind of insurance or the money up front, they not gonna see you.*”

Another common worry mentioned was the need for a medical specialist and not being able to pay for specialty health care. Being able to pay for services other than general health care was also a concern. One Hispanic American said, “*Lots of Latino children need a dentist, and they can never finish their treatment because they cannot continue to afford it.*” Of concern to Native Americans was obtaining care when away from their home reservation where the Choctaw Health Center provides for their health care needs or when members of another tribe are away from their home reservation and are, therefore, not covered by the Choctaw Health Center.

## C) Alternatives to Health Insurance

### Obtaining Information About Health Insurance

There were more differences than commonalities among responses from the four groups regarding their obtaining information about health insurance. One group of African American participants said they had no knowledge or source of information about health insurance. The other group of African American participants mentioned sources such as insurance companies, local health centers, and the Internet.

The Asian American group was unified with one response for their source of health information: "*Catholic Social Services.*"

One Native American participant said that she received health insurance information while in school from people who would "come around" and tell them about insurance. Others said they got their information from mail received or television advertisements. One participant stated she asked a lawyer "*to see if he can get me higher benefits*" when her health worsened.

Hispanic American participants felt that there were no good sources of health insurance information for them and said there was a need for information centers. One said, ". . . *we are not used to this system.*" The workplace was another source mentioned by an Hispanic American participant for health insurance information, but he added that he did not consider it a good source.

### Best Way to Obtain Medical Services Without Insurance

Participants mentioned several specific sources of medical services available for those without insurance. Asian Americans said they went to the local health department, Coastal Family Services, and St. Vincent de Paul (a low cost/free pharmacy associated with Coastal Family Services). Some Hispanic Americans said they went to the hospital, but one participant warned them not to go to a "private hospital." Others said they did not go anywhere, with one saying, "*There is no better way* [without insurance]." Some African American participants said they would go to the emergency room [at a hospital], especially if it were for their child. Other African American participants made comments that were similar to those of the Hispanic American participants – they do not go anywhere, they "wait out" the sickness.

One member of the African American group provided some valuable information to the other participants who did not know of choices for medical services for the uninsured:

*You get with your community activities program. There are a lot in the community you can go to – home opportunities. You can go to the area health center. . . They have [assistance] program in the community that you can get, you know, help.*

Another participant in the African American group informed them that hospitals have charity monies and have information posted in reference to the Hill-Burton Act:<sup>2</sup>

*You say you don't have any money, and you say I want to fall under the Hill-Burton Law. Read that sign. It'll tell you what you can get and what you cannot get. You need to read that. That's how you know what you can get. No hospital can turn you down, no hospital. Don't let 'em tell you that 'cause that's against the law."*

Discussion within the African American group followed on how information on the Hill-Burton Act did not appear highly visible or easily accessible and that emergency room personnel do not share that information with the public. Another participant stated that while she knew the hospital would not turn her down for services, they would not admit her even if the condition was serious enough for admission.

The Choctaw Health Center was the main source cited for medical services for Native American participants, and participants reported some conditions for qualifying for service and reported confusion about who could receive medical services and the type of medical services that are available. One woman said that, "My husband has to go to county hospitals because he's not Choctaw and they won't see him." According to another participant, the Choctaw Health Center will see "...people that show that they are a member of a recognized tribe;" and another said, "they can't turn anyone away." Yet, another said, "they have to be tribal members," and continued, "as long as you're half and above, you can be considered tribal." The discussion continued regarding the care for a child who is a quarter Choctaw and was "really sick and needed a specialist." The response was that the child would not qualify as a tribal member, but that the Choctaw Health Center would,

*... indicate to you that they needed to be seen by a specialist, but the expenses would be yours. And this is where insurance comes in. It's important that you have some insurance. . . .They can see the doctors [at the Choctaw Health Clinic]. They can go to the school [Choctaw school system]. But as far as being health wise, they can't be sent to a specialist. And if they are sent to a specialist, then the cost of that specialist becomes the responsibility of the parent.*

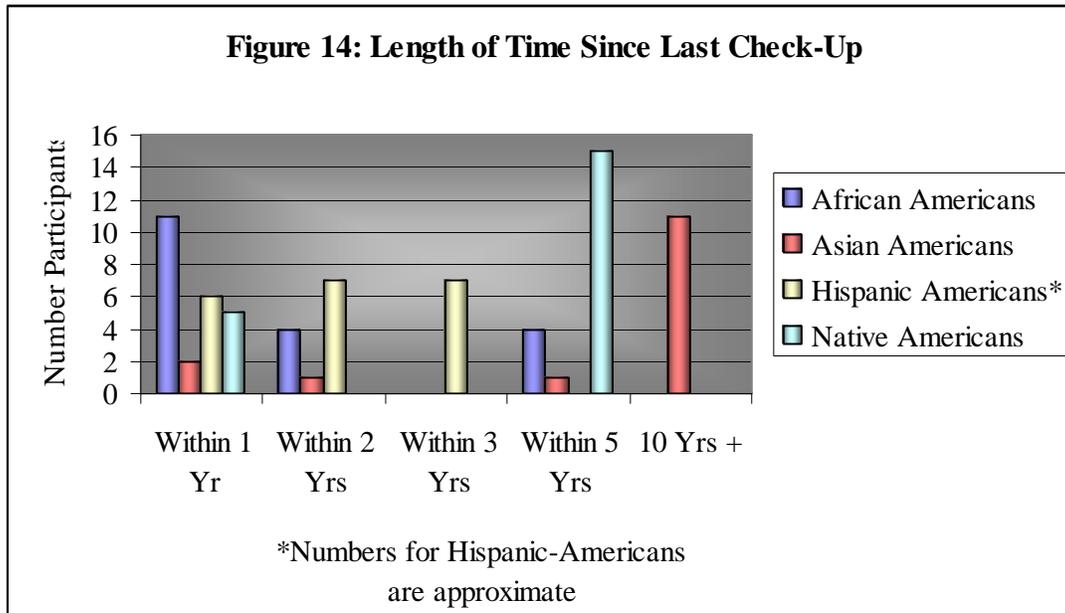
One Native American participant explained that there were some children who could not prove their percent of being Choctaw because there was a problem with fathers not signing their children's birth certificates.

### Actions Taken When Sick

All groups said they relied on over-the-counter medications and home remedies when they or family members became sick. The African American groups provided descriptions of home remedies: heat for pain, garlic powder for high blood pressure, vinegar-soaked plaster for arthritis, mustard for high blood pressure, whisky with lemon and cinnamon for pain and colds, remedies at oriental stores, and prayer and faith for healing. On Hispanic American said, "I am a man, so I can handle it [being sick]."

## Health Check-Ups

The following figure depicts the length of time reported by focus group participants since their last check-up.



## Unmet Health Care Needs

Asian American participants declined to specifically answer the question of, "What unmet health care needs do you and/or your family have" because of the personal nature of responses. They simply stated "*sickness*" and "*need to buy medicines*."

African American participants listed unmet health problems of back, heart, vision, seizure, blood pressure, headache, depression, hernia, and stomach.

Native American participants listed unmet health problems of allergies, teeth, arthritis, chronic pain, and vision.

Hispanic American participants listed unmet health problems of gynecological treatments, dental and vision.

## Keeping Healthy

All groups responded similarly regarding actions they take to keep themselves healthy: exercising and maintaining proper diet. Some responses unique to groups included one African American participant stating that proper diagnosis of health problems was necessary in order to know how to control health problems. Some Hispanic American

participants included the wearing of proper clothing, rest, and avoidance of excesses to maintain health.

## **D) Options for Health Insurance**

### Health Insurance Offered by Employer

Only those participants who were employed could answer the question of, “*Does your employer offer health care insurance?*” For African American and Asian American participants, only one from each group said “yes.” For the Native American participants, five said “yes.” For the Hispanic American participants, all of those who worked said “yes.”

### Reasons for Not Accepting Employer Health Insurance

The main reasons for not accepting employer health insurance reported by participants among all groups were not being eligible for health benefits (ineligible because of working part time or not having worked long enough to qualify) and not having enough money to pay employee portion of benefits. One Hispanic American participant said that he did not accept the insurance because it would limit options for choice in health care. Another Hispanic American participant said, “*When I get offers at work, they tell me they are going to start discounting my income and that I need to wait three months, so I never take it.*”

### Willingness to Take a Job for Less Pay that Offered Health Insurance

All participants from the African American, Asian American, and Native American groups expressed willingness to take a job that paid less but offered health insurance.

Some Hispanic American participants expressed willingness, but others did not, explaining that their income was already low and was meeting only their basic needs. One participant stated, “*I do not want to get paid less. I would rather pay it myself [premium for health insurance] to whoever I want and whatever amount I think I can afford.*”

### Knowledge about Medicaid and CHIP and Interest in CHIP

Among the four underrepresented groups, there were mixed responses regarding knowledge about eligibility for Medicaid and CHIP, with mixed and sometimes seemingly contradictory responses about seeing or hearing about low-cost health coverage for children.

One group of African American participants reported no knowledge about Medicaid eligibility, but some in the other group indicated that Medicaid was for “children” and “pregnant women.” One participant had applied for Medicaid and explained why she was turned down even though her work hours per week varied between fourteen and twenty:

*“They told me I was working and I couldn’t get Medicaid because I was working.”* Both African American groups had participants who reported knowledge about the CHIP program, with more responding affirmatively than did negatively. All participants indicated being interested in signing up for a program that offered low cost health coverage for children; yet, only two participants indicated having heard or seen information about a program like this.

Asian American participants had close to equal numbers who did and did not indicate some knowledge about these programs. Yet, most agreed that they understood one must be a U.S. citizen. All agreed that they would be interested in signing up for a program that provides low cost health coverage for children, but some expressed concern about being able to afford it. None of the Asian American participants indicated having heard or seen information about low cost health coverage for children.

One group of Native American participants listed three types of people they felt would qualify for Medicaid: children ages one to five, low income, and pregnant women. Some participants in the other group of Native Americans said that people with low income or who were elderly or who were disabled would be eligible for Medicaid. One participant said, *“If you’re on certain programs where any type of assistance is given by the state, you’re usually eligible for Medicaid.”* Both groups of Native American participants indicated that nearly everyone did not know about CHIP. (The facilitator provided an explanation). All participants indicated interest in signing up for low cost health coverage for children, with one explaining why she would want this type of insurance even though she had access to the Choctaw Health Center:

*My kids are only a quarter, so they’re not gonna get the full [benefits from the Choctaw Health Center], if they need any specialist, they are not gonna get it here, so I have to have something to back me up in case I need more than just a health encounter.”*

None of the Native American participants indicated having heard or seen information about low cost health coverage for children.

The majority of participants in the Hispanic American group indicated that they did not know who was eligible for Medicaid, but one stated who it was not for: *“not for people with no legal papers.”* The majority of Hispanic American participants indicated that they understood that children who were born in the U.S. were eligible for CHIP depending on the parents’ income. All participants indicated interest in a program that provides low cost health coverage for children, but none indicated that they had seen or heard about a program like this.

### Circumstances to Obtain Health Insurance

A circumstance given by all groups to be able to obtain health insurance involved having the money to pay for it. Some participants offered additional money-related circumstances such as being employed, having a good job, or getting a raise or promotion. One Native American participant said that they would need *“a job that offers*

*it [health insurance].” One Hispanic American participant said that the health insurance had “to guarantee a good service;” while another added that, “they need to be local doctors, so we do not have to travel.”*

#### Offers of Low- to No-Cost Medicaid Services

When asked about their thoughts regarding being offered low- to no-cost Medicaid services, nearly all participants indicated that they would want this. One Native American participant added that it would be good if, *“it covered a bigger range of people. Not just the very low income folks.”* Another in this group continued with that thought, stating: *“right above the limit [income limit for eligibility] is hard.”*

#### Importance of Source of Health Coverage

There were differences in responses among groups regarding whether or not the source of health coverage was important and why or why not.

One African American participant’s statement included the factor of their faith in relying on a source for assistance: *“. . .you got one insurance company that always helps out and that’s the insurance company of God and Jesus Christ. They’re the only ones that we depend on that mostly do better than anybody else.”*

Asian American participants all agreed that they wanted the government to be the source of their health insurance coverage. Hispanic Americans agreed, with one stating: *“if it is from the government, it has reliability, it is stable;”* and another adding, *“if it is from the commercials or institutions we do not know of, I would not feel secure.”*

Native American participants said they preferred their sources of their health coverage to be from their employer or an employee pool or to *“buy it on your own.”* Regarding employer-offered insurance, one participant explained why he felt that was the best source: *“They are trying to attract employees, and that’s one of the ways you attract employees is by benefits so usually they have better insurances then going any other way like pooling or government and Medicaid or anything like that.”* Another participant agreed with the facilitator who spoke about the option of purchasing private insurance through an agent if insurance was available without pre-existing clauses.

### **E) Ability and Willingness to Pay for Health Insurance**

#### Amount Willing to Pay Monthly for Health Insurance

There were wide differences in responses within and among the groups regarding the amount they were willing to pay monthly for health insurance.

African American participants’ responses ranged from *“I can’t afford to pay anything”* to \$40 - \$60 per month. In one African American group, a discussion ensued between the men and women in which some men stated that they could not pay anything or that they

could not pay the amounts suggested by the women, and some women stated that the men could if they tried: *“You could go outside and pick up cans and get \$50 or \$60 a month.”*

Asian American participants indicated they would be willing to pay \$20 - \$100 per month for insurance. This was a similar response from one of the Native American groups who said they would be willing to pay \$20 - \$80 per month. The other Native American group’s response had a much wider range, but with the caveat that *“it depends on the type of coverage:”* \$1 - \$360 per month.

Hispanic American participants spoke of amounts based on percentages of their income, such as 5% to 10% of income. Others indicated a willingness to pay \$20 to \$50 per month. One participant said that, *“it would depend on how many people in the family work.”*

### Sacrifices to Pay a Higher Amount for Health Insurance

Most participants from all groups indicated similar types of sacrifices to be made in order to pay a higher amount for health insurance: food, not purchasing unnecessary items, shopping, entertainment (including gambling), cars, and clothes. One African American participant talked about *“altering lifestyle.”*

Some differences in responses regarding sacrifices to pay higher amounts for health insurance included a comment made by one Native American participant who said that she would *“have to make a choice as to whether you go to school [college] or work.”* A couple of Native American participants spoke of doing extra work or taking a second job. Another offered the idea of giving up *“junk food and go back to the old fashioned, cook it yourself.”* One Hispanic American participant talked about the inability to sacrifice more: *“Single mothers cannot sacrifice anything more than we already do.”* While another from their group did not consider giving up something to purchase health insurance as a “sacrifice” stating, *“It would not be a sacrifice because we would have a good service.”*

### Fair Co-Payments for Medical Services

Asian American participants did not differentiate between their thoughts on fair co-payments for a doctor office visit, a prescription, or an emergency room visit. For all three of these medical services, they suggested \$10, \$20, and 5% of bill. African American participants said fair co-payments for a doctor office visit would be \$10 - \$40; for prescriptions, \$5 - \$30; and for an emergency room visit, \$10 - \$100.

Because some participants in the Native American groups go to the Choctaw Health Center for doctor office visits and prescriptions, one group replied with reference to going to an emergency room in Neshoba County. However, the question was modified so that their answers reflected an amount for the entire service received at the hospital as opposed to a co-payment. Amounts ranged from \$40 - \$180. The other Native American group had participants who suggested co-payments for doctor office visits of \$5 - \$25, but some said that it would depend on the reason for the visit and the type of doctor. In

this group, fair co-payments for prescriptions were mixed with the amounts they were willing to pay for the doctor visit. Fair co-payments for an emergency room visit ranged from \$25 - \$100. (One participant said \$500, but it was not clear if she were referring to the entire cost or for a co-payment.)

Hispanic American participants spoke in terms of percentages regarding fair co-payments for health services. For a doctor visit, 5% - 10% of bill; for prescriptions, 8% - 25%; and for an emergency room visit, 20% - 30%. One from this group stated that, "*I would be willing to pay 50% as long as the visit helps,*" while another countered that he could pay, "*nothing because I would have to be covered completely, it would have to cover 100%.*"

### Money Saved from Having Health Insurance

Most participants found it difficult to estimate the amount of money they would save if they had health insurance. One African American participant explained:

*I can only imagine how much it'd save me because all the tests and things that I need now and the medication that I need that I haven't even been prescribed that I've only been told that I need."*

One Hispanic American participant said, "*I could not say because you never know when accidents will happen.*" While another from this group said, "*Having insurance is one more bill, so it does not really help me to save since it is money that goes out every month.*"

Native American participants had difficulty estimating the amount of money they would save if they had health insurance because the "*Choctaw Health [Center] takes care of the majority of it.*" Another added, "*If it wasn't for the tribe paying for it, I don't know how much I would have had to pay.*"

Some participants offered estimates of savings. Asian American participants estimated monthly savings from \$20 - \$300. Some African American participants offered saving estimates of \$250 - \$4,000. One Native American participant also estimated savings of \$4,000. An Hispanic American participant said, "*If I could pay a 30% [co-payment] then I would save 70%.*" While another Hispanic American participant offered an estimate of 40% - 50% savings or \$10,000 annual savings.

## **F) Impact of Being Uninsured**

### Affects on Use of Health Care Services

There were differences among groups' responses to the question of, "*How has being uninsured affected your use of health care services?*" The Asian American group said that they had already answered this question and referred to section "C" of "Alternatives to Health Insurance." One group of Native American participants agreed with the facilitator that because they go to the Choctaw Health Center regardless of having health insurance, this question did not pertain to them. The other Native American group simply

stated that they either did not go [to receive health services] or only sought services “when you can’t help it.”

African American participants reported a variety of impacts such as not being able to get needed prescriptions, not being able to continue needed treatment, as well as experiencing tension in the home, stress, and depression.

The Hispanic American group reported that not having health insurance has had an economic impact and has affected their use of health care services. One participant stated, “It affects my records since I get in debt with the hospital.” Making a possible reference to an earlier comment about their not understanding this (U.S. health) system, another participant stated, “I know what medicine to take, but when I go to get it and they ask for a prescription, I don’t have one, so there is no way I can get it.” Discrimination and insecurity were reported by others in this ethnic group in reference to not being able to get regular checkups for their children or the medical attention their children need in emergencies.

#### Length of Time Waited Before Seeking Medical Help

Most participants in the groups provided ranges of 2 – 3 days or 1 – 2 weeks regarding the length of time they wait before going to a doctor. One African American stated that he waits until “it’s just uncontrollable.” However, two of the four groups (Hispanic Americans and Native Americans) stated that this waiting period did not apply to their children – they would seek help for their children quickly.

#### Health Care Services Not Sought to Save Money

In reference to specific health care services not received in order to save money, some Asian American participants and some Hispanic American participants said they did not go to the dentist. Other Hispanic American participants added that they did not receive preventive check-ups, vision care, or specialty care (an example given was care for lung cancer). African American participants did not indicate any health services not sought to save money. The majority of Native American participants indicated that this question did not pertain to them because of their use of the Choctaw Health Center. However, one participant stated that he did without physical therapy for an injured ankle, and another participant said that she experienced post-delivery complications for which she did not seek medical attention.

#### Affects of being Uninsured on Personal and Family Health

Responses to this question were similar to responses to the affects of not having insurance on use of health care services. African American participants cited not being able to have regular check-ups or to obtain prescriptions or to have surgery as well as experiencing stress and worry. Hispanic American participants said that not having health insurance affected their health in areas of prevention, prompt treatment for illness, gynecological services, internal disorders (such as ulcer, recurrent heartburn), rehabilitation, and dental

care. Asian Americans as a group responded simply that their “health is worse.” One Native American participant mentioned that mental health care had to be sought outside of the Choctaw Health Center with a referral, but that referrals were given only in “*very, very serious cases*” and that her child needed medical help with Attention Deficit Hyperactivity Disorder (ADHD).

### Medical Conditions Needing Doctor’s Care

African American participants responded that conditions of diabetes, heart problems, spine and joint problems, gout, and arthritis needed a doctor’s care. Some Native American participants also listed diabetes while other added problems with asthma, allergies, broken bones and blood pressure. One Native American participant said, “*I haven’t gone to the doctor. I don’t know. I can just imagine.*”

Asian American participants declined to answer this question as they felt it was too personal for discussion in a group setting.

### Financial Challenges in Paying Medical Bills

All groups expressed difficulty in paying their medical bills, citing loss of credit, long-term payments, and being left “broke.” Several Native American participants stated that there was no problem or that as long as they could pay a little at a time, there was no problem. Some specific financial challenges were offered by participants. One African American participant stated:

*What really got me, now I’m working. . .I owed [hospital name] \$900 and something. I was in the hospital. I owe the [another hospital name] \$1,100 something. [One of the hospitals] garnished my work check, but I was paying the [other] hospital. I was trying to pay one and now I have the other to pay at the same time. No way in the world I can pay ‘em.*

Some Hispanic American participants cited difficulties such as having to “work more hours” and getting “less sleep” and having to use savings to spend on hospital bills. Another stated that, “*I cannot buy all the food I need if I take my children to the doctor.*”

### Actions Taken for Life-Saving Surgery

Nearly all responses to the question of, “What would you do if you or one of your dependents needed life-saving surgery?” included a sense of “doing whatever is necessary.” Some examples of similar statements included using “*every source available*,” “*go into debt*,” “*ask for donations*,” “*beg on streets*,” “*use media to ask public [for help]*,” and “*borrow money*.” Only one group, the Asian American participants, said they would “depend on family members” for help.

One member of the Native American group explained that there was a tribal representative at Anderson Hospital that would help them with meal tickets and a bed if one were staying with someone at the hospital, but that “*you have to be a tribal member.*”

## **G) Other Comments**

Two groups provided additional comments at the end of the focus group sessions. The Asian American participants said they “*need easy process for Medicaid*” and “*need lower rate for health insurance.*”

One Hispanic American participant expressed appreciation for having the “*opportunity to talk about this issue,*” and continued with, “*We do not want to take advantage of anybody, we would pay, but the government should give us an opportunity and help us.*” Another participant also did not want to appear to be asking for free services, “*I would like an insurance that is cheap, I do not ask for anything free.*” Important to several participants was having a source of information about insurance, “*It would be good to organize more programs like this to be aware of health insurance,*” and “*I need more information.*” The issue of health care for immigrant children was mentioned, “*We need priorities for immigrant children; some kind of insurance that won’t affect our family needs.*”

## **APPENDICES**

**Appendix A: Informed Consent for Participation as a Subject in a Research Study**

We would like you to be part of a group to talk about health care issues for you and your family. This study needs comments from people like you to represent your ethnic group's health care issues.

The things that you and others in the group tell us will be put into a report and given to policy makers who make decisions regarding access to healthcare for all Mississippians.

You do not have to answer any questions that you do not want to. You do not have to answer any questions that make you uneasy. You do not have to be part of this group if you do not want to. It is okay for you to leave the group at any time. We will give you a \$30.00 Wal-Mart gift card for being part of this focus group.

Your eligibility for any health benefits is not related to being part of this group or not being part of this group.

We will use a tape recorder so that we do not miss important things that are said.

We will put everyone's comments in a report but no one's name will be in the report. We will not identify you in any way.

If you want to be part of this group, we need you to sign this form to tell us that you want to do this.

These signed forms are for our private records and will be kept in a different place than the recording and written notes of our talk today. If you have any questions about this study, please feel free to contact Georgia Hackney at (662) 325-1895. If you have any questions regarding your rights as a research subject, contact the Institutional Review Board for Protection of Human Subjects in Research at (662) 325-5220

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Investigator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Title of Study: Mississippi Medicaid Underrepresented Population Focus Groups  
Study Site: Biloxi, MS; Philadelphia, MS; Stoneville, MS; and Morton, MS  
Researchers: Ms. Georgia Hackney, Project Manager  
                  Ms. Cherry Sims, Research Associate  
                  Ms. Nilde (Maggie) Dannreuther, Research Associate  
                  Social Science Research Center, Mississippi State University

## **Appendix B: Focus Group Guide for Underrepresented Populations without Insurance**

### **A. Importance of Health Insurance**

1. How important is it for you to have health insurance for yourself and/or your spouse or partner?
2. How important is it for you to have health insurance for your children, if applicable?

### **B. Reasons for Health Insurance**

1. What are the main reasons, if any, that you and your family members want to have health insurance?
2. What are the main reasons that you don't have health insurance?
3. What are the problems you experience as a result of being uninsured?
4. What is your main worry about not being insured?

### **C. Alternatives**

1. Who do you go to, or what source do you use to obtain information about health insurance?
2. What is the best way for you to get medical services without having insurance?
3. What do you do when you or your spouse is sick?
4. What do you do when your child is sick?
5. Have you had a checkup in the last year? In the last two years? In the last five years?
6. Do you or your spouse have any unmet health care needs? What are these needs?
7. Does your child (or do your children) have any unmet health care needs? What are these needs?
8. What kinds of things, if any, do you try at home before you go to the doctor?
9. In what ways, if any, do you try to keep yourself healthy?

#### **D. Options for Insurance**

1. Does your employer offer health care insurance?
2. If your current employer offers insurance, what stopped you from signing up for it?
3. Would you be willing to take a job that offered health insurance, even if it paid less? Why or why not?
4. Do you know who is eligible for the Mississippi Medicaid Program?
5. Do you know who is eligible for the Children's Health Insurance Plan (CHIP)?
6. Would you be interested in signing up for an insurance program that provides low cost health coverage for children? Why or why not?
7. Have you seen or heard any information about a program like this?
8. Under what circumstances would you be able to obtain health insurance?
9. What would you think about being offered low- to no-cost Medicaid services?
10. Is the source of coverage (employer, government, purchasing pool, other) important to you? Why or why not?

#### **E. Ability and Willingness to Pay**

1. At your present level of income, how much would you be willing to pay each month for health insurance?
2. What would you have to sacrifice, if anything, in order to pay a higher amount?
3. In your opinion, how much would be a fair co-payment for a doctor office visit?
4. How much do you think would be a fair co-payment for a prescription?
5. How much do you think would be a fair co-payment for an emergency room visit?
6. How much money, if any, would having health insurance save you?

## **F. Impact of Being Uninsured**

1. How has being uninsured affected your use of health care services?
2. How has being uninsured affected your use of prescription medications?
3. How long do you usually wait before you go to the doctor to see if you'll feel better without having to go to the doctor?
4. What, if any, health care services have you passed up in order to save money?
5. How, if at all, has being uninsured affected your health?
6. If applicable, how has being uninsured affected your family members' health?
7. What medical conditions, if any, do you or your dependents have that need a doctor's care?
8. What financial challenges, if any, have you had paying medical bills in the past?
9. What would you do if you or one of your dependents needed life-saving surgery?

## **G. Other**

1. Is there anything you would like to add to this discussion?

*Thank you for your participation!*

**Appendix C: Focus Group Registration Questionnaire for Underrepresented Populations without Insurance**

<p><b>1. Year of Birth:</b> _____ Year</p>	<p><b>2. Sex:</b> _____M_____F</p>
<p><b>3. Marital Status</b>  <input type="checkbox"/> Married  <input type="checkbox"/> Single  <input type="checkbox"/> Divorced  <input type="checkbox"/> Living as Married  <input type="checkbox"/> Separated  <input type="checkbox"/> Widowed</p>	<p><b>4. Hours Employed per week:</b> _____</p>
<p><b>5. Education Level</b>   <input type="checkbox"/> Less than high school  <input type="checkbox"/> High School Diploma or GED  <input type="checkbox"/> Some college  <input type="checkbox"/> College degree</p>	<p><b>6. Earnings</b>           How much do you earn per week?  <input type="checkbox"/> Less than \$200  <input type="checkbox"/> \$200-\$400  <input type="checkbox"/> \$400-\$600  <input type="checkbox"/> Over \$600</p>
<p><b>7. Type of Employment</b>   <input type="checkbox"/> Office/Secretarial  <input type="checkbox"/> Labor/Construction  <input type="checkbox"/> Restaurant/Food  <input type="checkbox"/> Hospitality  <input type="checkbox"/> Education  <input type="checkbox"/> Child Care  <input type="checkbox"/> Health/Health Care  <input type="checkbox"/> Sanitation/Housekeeping  <input type="checkbox"/> Other</p>	<p><b>8. Employer Health Insurance</b>          Does your employer offer health insurance? _____Y_____N</p>
<p><b>9. Eligibility to Purchase</b>           Are you considered eligible to purchase coverage through your employer? _____Y_____N</p>	<p><b>10. If uninsured, how long have you been uninsured?</b>   <input type="checkbox"/> Less than one year  <input type="checkbox"/> One to two years  <input type="checkbox"/> Two to five years  <input type="checkbox"/> More than five years</p>
<p><b>11. Children</b>           Do you have children under 18 living with you?  <input type="checkbox"/> Y _____N</p>	<p><b>12. Medicaid</b>           Have you ever applied for Medicaid or [CHIP] _____Y_____N</p>

## **Appendix D: Choctaw Health Center** *provided by the Choctaw Health Department*

The mission of Choctaw Health Department is to “raise the health status of the Choctaw people to the highest level possible” and its vision is to “achieve a healthy community through holistic health care services in a culturally sensitive environment, in partnership with satisfied customers, dedicated employers and the Choctaw community.” Through the United States Indian Health Services (IHS) federally recognized tribes allocated federal funds, although these funds are not adequate, to serve the health needs of the Mississippi Band of Choctaw Indians. Funding through IHS needs improvement. To address the issue of unmet needs, the Mississippi Band of Choctaw Indians (MBCI) has allocated a percentage of revenues it has generated to the Choctaw Health Department (CHD) to meet those needs. To gain access to services of the CHD, people must be a member of the MBCI. As a member, health services made available include but are not limited to the following:

- Ambulatory care
- Podiatry
- Inpatient stays
- Emergency services
- Diabetes Management
- Outpatient referrals for mental and behavioral health services
- Contract medical care for those conditions for which tribal members are referred to other medical facilities
- Dental services
- ER Trauma Care
- Medical Supplies and Equipment (e.g., nebulizers for asthma patients, wheelchairs, hospital beds, feeding tubes and bags, patient lifts, prosthetics, portage oxygen to name a few).
- Elective Surgeries

Choctaw Health Center (CHC) also runs three rural clinics that are operated under provisions of the Self-Governance Contract with IHS since 1994. The CHC and the three clinics serve ten counties. The Tribe also funds and staffs a program for mental and behavioral health. The CHD also oversees the Director of the WIC (Special Supplemental Nutrition Program for Women, Infants and Children) a federally funded agency.

Any person accessing clinical services:

- Must be an enrolled member of MBCI and reside in the service area.
- Must be an enrolled member of a federally recognized tribe and reside in the service area and have close social or economic ties with the MBCI.
- Can be a non-Indian pregnant female carrying the child of an eligible member of the MBCI and reside in the contract health care services area.

Other services and programs under the wing of the Choctaw Health Department are the Health Education Center, Environmental Health Services, and Community Health Services. Programs through Community Health Services include:

- Management of the three rural clinics.
- Choctaw Safe-Kids Program.
- Community Injury Prevention.
- STDs/HIV/AIDs, TB and Cancer Prevention Components.

The Tribal Council, whose members are elected officials serving staggering terms, along with the Tribal Chief oversee a series of committees that deal with health, economics, cultural, education, and the welfare of the Choctaw people. They look at present and trending needs, and provide direction for decisions regarding funding and budgetary requirements to address those needs.

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<sup>1</sup> The Mississippi State Planning Grant Proposal to the U.S. Department of Health and Human Services, Dec 05, 2003, Project Abstract.

<sup>2</sup> Originally the “Hospital Survey and Construction Act,” enacted August 13, 1946, with principal bipartisan co-sponsors, Senators Harold Burton (R-Ohio) and Lister Hill (D-Alabama). The “Hill-Burton” Act led to a nationwide hospital-building program, designed to provide the necessary number of staffed hospital beds per 1,000 people throughout the land, regardless of race, color, creed, gender, or ability to pay.