BATTELLE STUDY

Nancy

PRELIMINARY SUMMARY COMMENTS: PUBLIC MEETINGS

Alaska Comprehensive Health Care and Financ Study: Battelle Report

January 11-15, 1982

Nome, Fairbanks, Teleconferene Sites, Anchorage, Juneau

1. The challenge is to make the state's health dollars stretch as far as possible by maximizing the federal subsidy.

2. Extension of Medicaid coverage to groups currently covered only under the General Relief Medical Program - G.R.M., would seem to be the most logical and cost effective mechanism for accomplishing this.

3. The state might consider using Medicaid funding to ensure transportation of needy patients to Indian Health facilities where the 100% reimbursement is in effect.

4. If this 100% federal reimbursement policy continues efforts should be made to make sure that the Indian Health clinics in Juneau, Fairbanks, Kodiak, Ketchikan, etc. can recover that 100% reimbursement and that the rural hospitals are retained in Indian Health Service ownership, even if operation has been contracted to a native health corporation or local governments.

5. The two groups to whom I would recommend extending Medicaid coverage are:

   a. Needy families according to the Medicaid income standards with both parents in the home, using any existing insurance as a prior resource. The current policy of linking Medicaid eligibility with AFDC and thereby covering only single parent families has been destructive to family structure in Alaska.

b. The medically needy using a "spend down provision.

6. Additional services to be covered under Medicaid:

a. Physical therapy, occupational therapy and prosthetic devices.

b. Prescription drugs might be included if some agreement could be reached with Indian Health Service to make sure that their current excellent pharmacy service to rural Alaska would continue since it would be difficult to duplicate in the private sector.

c. Institute some cost sharing mechanism such as a $2 per visit copayment, if such a program would not be too difficult to administer.

d. Develop prospective reimbursement system for nursing homes.

7. The above listed suggestions for broadening Medicaid eligibility are contingent upon the accuracy of the statement on pg. 23 that the "freedom of choice" provisions have been narrowed federally so that the state could adopt "cost effective arrangements" that could link eligible natives to certain IHS facilities where 100% reimbursement would be realized, and could also lock overutilizers to a single provider.

8. The Handicapped Children's Program has not even been mentioned in the Battelle report even though it is an important resource for subsidizing medical care for high risk, low income children about whom the Battelle report is concerned.

9. The Battelle report has failed to consider the current Catastrophic Illness Program which also provides coverage for some of the needy "uncovered".

10. In considering the potential state saving by broadening Medicaid eligibility, the saving in these two programs should be considered as well as the savings in GRH funding.

11. In order to provide more comprehensive planning for the Medicaid eligible children, I would recommend that the coordination of the children's portion of the Medicaid program be placed in the Division of Public Health so that a close coordination could be achieved with the EPSDT and HCP Programs that are currently administered by the Division of Public Health. With waiver authority to overrule the "freedom of choice" provision of this would now be possible and would undoubtedly be cost effective for the state.

12. Before unconditionally recommending the extension of Medicaid eligibility is the possible effect of the (federal) cap on Medicaid funding in the state. Specifically, every attempt must be made to exclude the 100% reimbursement to IHS facilities from being included in the Medicaid funding cap.

13. There is an important assumption underlying the entire Health Insurance section that may not be valid, i.e., that the 29,000 uninsured non-Native Alaskans would avail themselves of health insurance if it were offered to them; there has not been enough effort expended in finding out why the uninsured do not have health insurance.

14. There are two groups of people that are apt to be risk takers and accident prone, and for that reason are likely to incur large medical expenses related to accidents both for themselves and for other Alaskan residents. For this reason I would suggest a scheme aimed at subtily mandating insurance coverage for these people, i.e., that proof of both liability and health and accident insurance be mandated prior to issuance of an Alaskan motor vehicle driver's license, including motorcycles.

15. In regard to extending insurance coverage several suggestions:

a. Some form of state sponsored incentive to small businesses to offer health insurance to employees might be a helpful plan, if indeed this is a problem group. However, before designing such a program, I would suggest survey of small businesses in Alaska should be made rather than making the assumption on the basis of nationwide trends that their employees are in need of health insurance. A problem may also exist in cases where the bread winner is self-employed.

b. Some investigation might be made to see whether it would be possible and advantageous to link some health insurance benefits with the collection of Unemployment Insurance in order to cover the temporarily unemployed rather than mandating a complex scheme of exit lags.

c. Rather than devising a statewide insurance plan with a subsidy arrangement that sounds too complex to be administered effectively on a statewide basis with a highly mobile and diverse population, I would suggest that certain homogeneous population groups be encouraged to enter into group plans for their own constituencies. Examples might include:

The Old Believer villages around Katchemak Bay where most of the families are large and the fathers are self-employed fishermen.

Some of the Native Health Corporations, like KANA in the Kodiak area, where medical care is available through the private sector but the Indian Health beneficiary population is resistant to paying for their private care or arranging their own insurance coverage thus rather than instituting a parallel system of free care for the Native population.

16. The Report, on page 125, states that the plan "could include a provision with respect to limiting coverage of pre-existing conditions". One of the problems with many current private

insurance plans is that pre-existing conditions are not covered under GRM, HCP, or Catastrophic plans. It is also hard to see how excluding pre-existing conditions and subsidizing high risk patients are compatible concepts.

17. An effort should be made to educate Alaskans in general and Natives and rural inhabitants in particular about how to utilize health insurance. Currently many Alaskans who do have insurance have very little concept of what services are actually covered, and many of the Natives with coverage through regular employment plans do not even know what company insures them.

18. Providers also need education regarding utilization of insurance. There are cases in which insured individuals have personally pocketed up to $18,000 because providers neglected to secure assignment of benefits. Rural clinics have resisted the bother and paper work necessary to collect from private insurance which, unfortunately, must be done in order to remain economically viable especially when dealing with rural non-Natives a large percentage of whom already have good health insurance coverage through their employment.

19. The Battelle Report has missed the boat regarding "Rural Health Care" although it has pointed out some important facts that, if accurate, may well point the way to a logical evolution of the rural health care problem. Problems are:

    a. The way in which "rural" is defined to include areas such as Kodiak, the Kenai Peninsula, the Mat-Su valley, and the South Eastern cities outside of Juneau and Ketchikan.

    b. The emphasis on the rural non-Native population as being a primary target group. There is an inconsistency in the preoccupation with this group, particularly since the report states on page 178 that all but 2,000 of the 36,500 rural non-Natives live in South and Southeast Alaska and yet does not identify these as being problem areas.

c. The Battelle Report focuses far too much on the rural non-Native population on the great majority of which really does not have much of a 2,000 non-Natives that do live in primarily native areas served by IHS hospitals could be better accommodated if a means could be devised by which the IHS facilities could and would collect health insurance.

d. If contracting management of IHS owned hospitals and clinics to Native Health Corporations or local governments would indeed allow for the recovery of health insurance payments while still allowing collection of 100% federal reimbursement for Medicaid eligible natives, it would appear that this would be the most beneficial type of administrative arrangement for the state to encourage.

e. The unqualified acceptance of the State Health Plan's designation of Level I and Level II communities which in several cases does not fit currently reality. Some of the communities designated as Level II and capable of supporting at least a mid-level practitioner are not assessed by a sufficient population through readily available ground or boat transportation.

f. In designating appropriate staffing for Level II communities, I would suggest a careful review of the medical care history in the communities such as Aniak where over the past 15 years unsuccessful attempts have been made to place a physician, a physician's assistant and a public health nurse. Experience in this particular community emphasizes the fact that a practitioner of facility should not be imposed upon a community without adequate evidence of full community support.

20. Current Indian Health care system and state public health nursing systems should be preserved and built upon. In no way should the services that these systems now provide be circumvented by the Native Health Corporations even though they may assume some of the management functions.

21. Local responsible governments should be involved whenever possible and assumption of health service functions by local governments should be encouraged through a realistic level of state revenue sharing. Local governments should provide a stability that may not exist with the Native Health Corporations. furthermore racial bias would be eliminated if health service were linked to local government.

22. The state should attempt to take maximum advantage of Medicaid funding for coverage of the native population and should also consider covering travel of Medicaid eligible adults to IHS facilities.

23. Maximized private reimbursement should be developed through education as well as through other than direct federal management.

24. Resent the implication that there is a lack of cooperation between the state and the Indian Health Service; for 15 years a close cooperative relationship ha been developed especially in regard to the state public hea'th nursing and Handicapped Children's Program.

25. The state should design an organized and fund a grant program for primary health care facilities in rural areas similar to the currently existing Community Mental Health Center program and the Infant learning grant programs. A specific amount of money shold be allocated for such a program for which interested local governments and/or Native Health Corporations could apply.

26. The state itself should not assume the responsibility for provision of primary medical care as distinguished from the primary prevention health that it now provides for the rural or native population only, but rather should aid local "entities" (what ever they are) to provide facilities and arrange for appropriate medical care provision. By instituting a well designed state sponsored grant or loan program, the state might better and more comprehensively serve rural areas than through the current legislative "Christmas

Tree" approach whereby funds are allocated to communities like Cold Bay in which there is no existing responsible government "entity".

27. There is no mention of the possibility of augmenting the current Catastrophic Illness Program and perhaps allowing for some preauthorization of financial support under that program.

28. There has been no mention of the possibility of developing a mechanism whereby pioneer funds could help to subsidize the care of pioneers, natives and non-Natives in nursing homes.

29. The state should direct its efforts towards maximizing the benefits of the dollars that are already being spent for medical and health care in Alaska rather than spending additional money.

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30. The existing rural health problems are not simply a result of lack of resources but also of a lack of mechanisms for coordinating and allocating existing resources, endorse the establishment of a coordinated planning authority which would include federal and state activities.

31. If the state opts to encourage planning efforts of the Regional Corporations (page 201) in order to expand their perspective and role to encompass the non-native rural population, it should support it financially as that function was one of the first to be dropped with loss in Federal funding.

32. The staffing requirements recommended by South Central Health Planning for Level II are considerably less than recommended by this study and the IHS Resource Allocation Criteria. We have found those criteria to be unusually generous as well as rigid in their adherence to the traditional medical care model. We are concerned that the operational costs of such a staffing configuration would be financially unfeasible.

33. On page 195 and 196 there are several inaccuracies with regard to physician's assistants and nurse practitioners, i.e.,

a. nurse practitioners are licensed under the Nurse Practice Act, not the medical licensing act,

b. nurse practitioners practice on their own license associated with a physician in a collaborative but not supervisory capacity, physician assistants practice on an associated physician's license,

c. the number of currently licensed nurse practitioners is 60.

34. Our support (Health Systems Agency) is given this effort by the State. A great many complex issues have been covered in this study and presented in a clear and concise manner.

35. Page iii - The Alaska Native population is given as 65,000. On page 7, the figure 70,000 is used. Since the IHS figure is 64,047, (1980 census) it would be better to use 65,000.

36. Page 13, A. Medicaid - The last sentence of the introductory paragraph should be modified to explain that the federal government will pay 100% of the Medicaid bill of a Native American in IHS facitilies as a part of non-Medicaid legislation related to improving the health syste: serving Native Americans.

37. Page 170 - The term "rural health authorities" is used several times in the document without being clearly defined. It has the connotation of an enforcement agency. Perhaps "representatives," or something of that nature, would be a better term to use.

38. Page 175 - There are several mistakes in Table XIII-1. The corrections are as follows:

Under Census Areas, add Yukon Koyukuk. Across from this, and under the Community column, add Tanana.

Under the hospital column, please correct these names:

Bethel PHS should b Yukon-Kuskokwim Delta Regional Hospital (PHS)
Kanakanak should be Bristol Bay Regional Hospital (PHS)
Norton Sound should be North Sound Regional.

Under the hospital column, add the following:

Faith	(Glenallen)
Petersburg General	(Petersburg)
Wrangell General	(Wrangell)
Tanana PHS	(Tanana)
Seward General	(Seward)
Kodiak Island	(Kodiak)

39. Are the figures given in the population column for the communities or census areas? This should be designated in the column heading. The population totals of 52,000 in this table conflict with the 57,500 figure of table XIII-3 on page 178, and the narrative on page 177.

40. Page 180, C - Please insert AANHS after Indian Health Service for clarification. It would be better to use the term Native Health Corporations, both here and throughout the document, to distinguish them from the profit Native Regional Corporations.

41. Page 180, #1 - Clarify the first sentence by saying "The AANHS....provides health services to Alaska Natives and non-Native spouses". Please clarify the third sentence by saying, "Use of the AANHS system by non-Natives not eligible for services is very small".

42. Page 182 - Table XIII - 5 does not list data source. All tables in the study should reference the data source.

43. Page 182 - The following breakdown would probably best describe AANHS health program.

- Inpatient Services
- Ambulatory Care Services
  - Medical Care
  - Dental Services
  - Optometry Services
  - Audiology Services
- Community Health Services
  - Public Health Nutrition
  - Mental Health
  - Social Services
  - Health Education
  - Environmental Health Services

Appropriate adjustments would then have to be made in the narrative which follows.

44. Page 183 - a. Please insert the following paragraph which should help to explain the IHS arrangement with Bristol Bay:

"Direct care program funds are a major source of support for the operation of the Bristol Bay Area Hospital by the Bristol Bay Area Health Corporation, under the provisions of P.L. 93-638. See further discussion of P.L. 93-638 programs under Native Corporations on page 186.

In the last sentence, change "Funds for travel have been..." to "Funds for travel are..."

45. Page 183 - b. Move the two sentences beginning "In the future" through "...desire and qualify" to page 186 (2. Native Corporations).

46. Page 184, c. Second paragraph - Add Tanana to the list of hospitals and omit Tanana from the sentence which follows it.

The third sentence should read, "Hospitals and clinics are manned..." Under the Service Unit column,

#3 should be Bristol Bay Area
#4 should be Yukon-Kuskokwim Delta Regional Area
#8 should be Interior Alaska.

Changes should be made on page 185 accordingly.

Please correct the hospital names, see comments for page 175.

47. Page 186 - The first sentence should use Interior Alaska Service Unit not Tanana. The last sentence should read "...Native Corporations to deliver various levels of health care services in the region.

48. Page 198 - The first sentence would be more accurate: "Generally, community health aides are employees of the regional health corporations. CHA's are not employed by the AANHS."

49. CHA's record the names of people to whom they deliver care, including non-Natives; therefore, the available information is more than anecdotal.

50. Suggested rewording for the first factor under Accessibility: "The distinction between what is permitted and what is practiced." (Standard operating procedures are "official".)

51. Page 199 - First paragraph, fourth sentence - This is not true, the third party payers do reimburse fo non-Native medical care.

Second paragraph, First sentence - Insert rural before "non-Natives", insert in remote rural villages before "do not".

52. Page 206 - c. last paragraph - Again, the AANHS is able to collect from private insurers.

53. Page 207 - b. First paragraph, first sentence should read "...government providers for care provided to subscribers who are also eligible for AANHS services (i.e. Alaska Natives and non-Native spouses)."

c. Perhaps the state could work with the Native Health Corporations to develop a model for involving non-Natives on their boards.

54. Page 208 - First paragraph - Because the future funding of HSA's is "hazy", perhaps the best approach would be a coalition of State, HSA, Native Regional Health Corporations and AANHS planners.

55. Appendix 13 - First complete sentence - "Relationship" would be a better word to use than "importance".

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56. In Alaska there are currently 60 Nurse Practitioners authorized to practice. While the educational preparation does vary between certificate programs and programs conferring a Master's Degree, the minimum requirement in Alaska is one (1) academic year of preparation. Because of some of the programs do not lead to an academic degree, requirements for entrance vary and Bachelor of Science in Nursing Degree is not always required. Nurse Practitioners also must be certified by a national certifying body in their speciality area.

57. Nurse Practitioners are authorized under the Nurse Practice Act not the Medical Licensing Act. Nurse Practitioners are licensed Registered Nurses who are authorized to practice acts of medical diagnosis and prescription of medical, therapeutic or corrective measures. The Nurse Practitioner regulations (12 AAC 44.400 to .490) do require a collaborative relationship with a physician. Tihs relationship is a collegial one rather than a supervisory relationship.

58. The Board of Nursing also notes that none of the authorized Advanced Nurse Practitioners are practicing in a hospital setting.

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59. As a citizen of Alaska for only three plus years I have watched with awe and amazement at how the billions of dollars available in this state have been leading many Alaskans to want the State to provide everthing - food, clothing, housing and how even free or subsidized health care. Orrganizations and private individuals are fighting to be the next in line to receive some of this State's wealth. The attitude seems to be: well, if my neighbor or business associate can get dollars for this or that project, why shouldn't I get my share also? This attitude is appalling to me.

60. I was an observer at the Statewide teleconference yesterday to discuss this study, and was shocked that no one presented any concerns about the section of the study discussing implementation of a statewide health insurance program. At the end of the teleconference yesterday my question to myself was: does the average citizen of Alaska really want Alaska to become a socialized state?

61. By implementing either a subsidized health plan for small employers or a statewide health delivery system (which I realize this study is not recommending), you get the same results more people expecting handouts without working for them.

62. I believe my company is representative of small employers in Alaska (9 employees). We are forced to offer health care in order to compete with the State, Federal and Municipal governments for workers. This is not as true in other states. The Battelle study states that nationally 50% of the firms with fewer than 10 employees offer group health. I believe this to be 75% or higher in Alaska. Alaska is not like outside.

63. I believe that implementation of the subsidy program for small employers will cause them to cancel their present policies to obtain "free" money from the State. What's the incentive for them not to! After all, they, like my small company, have other ways to spend the money that goes toward health care premiums for our employees.

64. One question which I had in reviewing the subsidy section was what would happen if the small employer applying and qualifying for the subsidy program suddenly (6 months into the program) had a large increase in business and thus an increase in employees, which would increase his payroll to bring him above the limits to qualify for the subsidy?

65. On of the other areas of concern: the suggestion of exit lags. When the length of unemployment in Alaska is longer for a larger percentage of the unemployed population than it is nationwide (as your study indicates), what is the incentive for the unemployed to really make an effort to get a job when not only do they receive an extremely high weekly unemployment check but now also will get health care benefits for themselves and presumably their families for 6 weeks after they terminate their jobs? Doesn't this encourage some employees to quit their jobs for a paid vacation and paid health care for 6 weeks before looking for another job?

66. Suggestion: a questionnaire to all small employers in Alaska to see how many <u>do</u> offer group health to their employees, the number covered and not covered, the premium, and if not coverage is offered, would they be interested in a state subsidy. Make it short and simple so they will all take the time to respond and maybe even enclose a stamped envelope.

67. Additional observations on the first section of the study pertaining to health care for the needy: First, several of the options suggested would add an unproportionally large cost per eligible for a few to be added to the Medicaid or GRM rolls.

As examples: Option 5, the spend down for GRM, is estimated in the report to annually cost the State $5.8 million for only 550 new coverages. This breaks down to $10,545 per new coverage. Option 1, the spend down for Medicaid, is estimated by the study to cost $12.4 million and adds 1,650 new coverages--a cost of $7,515 per new coverage. It appears other options would cover a greater number of people and at a lesser cost.

Another item in the Needy section which I strongly favor (because of my basic philosophy that one shouldn't ever get something for nothing) is Option 7 - the patient cost sharing. The estimated net savings of $680,000 seems minimal compared to the millions to be expended but I firmly believe it causes the consumer to be more cost conscious and thus reduces unnecessary utilization.

68. The advisory committee's policy guidelines to the Department of Health and Social Services are the following:

POLICY GUIDELINES

The committee agreed to a set of general policy guidelines (listed below) for use in formulating an intial set of options:

1. Cause minimal disruption of the existing health care system.
2. Minimize-direct-state participation in the delivery of health care.
3. Improve the economic efficiency of the health care system, i.e., discourage people from seeking unnecessary health care and include cost containment incentives for third party payers and providers.
4. Yield the greatest improvement in the health status of the state population: i.e., focus on groups which are at highest financial and health risk and are the most needy.

69. A review of the Rural Health section of the Alaska Comprehensive Health Care financing study researched by the Battelle Institute leads me to make the following observations. The thrust of the message in this section states that the State of Alaska seeks to improve "rural health care" in Alaska. However, it states that the problem derives from 91) resources and (2) organizations. It should be noted the IHS has a system in Alaska that has been here for many decades, and it does the job with scarce financial resources. Now, the sttate comes in and says we're going to improve the health of rural Alaskans, and that begs the question of how they are going to improve it. The only way is to provide additional financial resources. My contention is that there is not the politicial will in the State to fund rural Alaskan health systems which serve predominately Alaska natives. It should be noted that the State spent 60 million dollars on sports stadium in Anchorage, and I do not foresee the State providing in excess of 55 million dollars per year for rural health. The IHS system has the organization in place, it is a good one, it merely requires the financial resources to be able to carry out its full program.

70. As to the establishment of rural health authorities. I think this establishes another layer of bureaucracy,k and drains precious financial resources from the operating health entities in Alaska. There is a similar situation in the Indian Health Service Area Office in Anchorage where the program formulation branch does essentially planning activities, and the regional corporations are concerned that this is merely another meaningless bureaucracy in the IHS system. I feel that the State should deal directly with regional corporations, and deny the establishment of rural health authorities.

71. I believe that freestanding regional entities with their own planning systems should take precendence over any centralized rural health authority, or any other type of health planning authority. This would encourage better inter-staff, inter-regional cooperation rather than spending large sums of money on programs that would not be truly cost-effective to the people of rural Alaska.

72. The report states that the State of Alaska and Department of Health & Social Services encourage regional administration and local control of health programs, and they cite the Mauneluk Association assumption of Public Health Nursing program. I fully support the concept of local control, and I urge the State of Alaska to foster the mechanisms by which this can be accomplished by limiting the regulatory and administrative road blocks to such an concept.

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73. Limited funds for Community Health Aide Training represents a real and continuing problem for the rural areas. Reduction of funding to the INdian Health Service is creating major problem in basic training and for inservice training.

74. HEalth Aide Training is available only in three locations: Anchorage, Fairbanks and Bethel. MOre training centers are needed. NOw some of the training is available only once in two years; the Aide often with little or no training; turnover for aides is very high.

75. The 40 clinics mentioned on Page 193 should be reviewed: the selection criteria should be explained and defended.

76. More work is needed with regard to the mid level practitioner.

77. Non emergency travel for medical services should be provided in the rural areas.

78. Possibilities for the native tribal organizations to operate the IHS facilities.

79 Not enough emphasis was given in the report to mental health and alcoholism issues.

80. Certain additional topics should be addressed in the Rural Health section of the report:

Health education in schools;
Local control of health services;
Community responsibility for alcohol problems;
Improved health aide programs;
Improved health planning and resource development efforts.

81. University of Alaska should improve opportunities for health aide training as a university responsibility.

82. Misconception is abroad that the IndianHealth Service is always primary health provider in the rural area.

83. Accessibility to health care was not stressed enough in the report.

84. Medical travel for both emergency and non-emergency needs attention and provisions made for such.

85. Eligibility guidelines should be changed for GR Med and raise income level for elegibility test for medically needy.

86. Benefit suspension by Division of Public Assistance (GR Med /Social Security) after denial and while case is pending appeal

87. Methodology in developing 44,000 not covered pers .s need statement and explanation.

88. Cost sharing, if adopted, would have very wide effect both for public programs and throughout insurance industry: less utilization of services.

89. More information needed on how uninsured persons receive services for medical care.

90. More attention should be given to Catastrophis Illiness program; very important program and very much needed.

91 State should be concerned about those with deep and genuine medical needs and who have not been given services under workmen's compensation programs even though many individuals dropped from workman's compensation benefits are disabeled and have increasingly difficult time in proving their desability to an insurance company representative . Such persons should at the least be targeted for ehlp under the 'medically needy' program.

92. Closer cooperation and coordination needed between the state and the Indian Health Service.

93. Cost sharing would add dignity and respectability to Medicaid and GR Med program if it can be wored out. The treatment of the topic in the report is rather confusing and needs more clarity.

94. The Medicaid and GR Med Program should be combined into a single assistance program for the poor.

95. Long term care, while utilizing a major portion of state medical care funds is not treated very well in the report.

96. The use of the 1976 data should be explained especially as to the adjustments which can be made to make the data valid for consideration at the present time.

97. The Rural Healthsection needs the most work and it should provide more specific options for improvement to be considered by the policy makers.

98. Clinic operational funds support/ source/problems need treatment in the report;

99. telecommunications utilization should be treated;

100. more attention to travel for medical services in rrural areas needed.

101. 'trilal specific" issues from native non profit health organizations should be considered more carefully.

102. the designation of native corporations status of non-profit and profit needs more careful useage.

103. need exists for definition of levels of benefits available from the IndianHealth Service.

104. statement of small use by non-natives of IHS facilities and programs not accurate.

ALASKA COMPREHENSIVE HEALTH CARE FINANCING STUDY

Health Surveillance Coverages

D R A F T

John Middaugh, M.D.
State Epidemiologist
May 6, 1981

Prenatal:

- Complete assessment and counselling on risk factors
- Rubella blood test
- Syphilis and gonorrhea screening
- Hb (blood count)
- Urine analysis
- Blood group Rh type
- Blood pressure

Infants: (birth-17 months)

- Immunizations appropriate for age
- Well baby assessments (4 weeks, 2 months, 4 months, 6 months, 12 months, 18 months)
- Phenylketonuria (PKU) and hypothyroidism screening
- Hb (blood count) once by age 17 months

Children: (18 months-15 years)

- Vision - 2 years, 5 years
- Hearing - 2 years, 5 years
- Immunizations - 18 months, 5 years
- Dental exam - annual

Adults: (16 years and older)

- Blood pressure - annual
- Dental exam - annual
- Immunizations (diphtheria/tetanus every 10 years)
- Breast self-exam instruction - annual
- Mammography - yearly between ages 50-59
- Vision - every 5 years
- Hearing - every 5 years
- Pap cytology - annual when sexually active, then every 3 years after 2 negative exams between ages 20-65
- Stool for blood - annual > 50 y.o.

DS-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

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June 19, 1981

For your information.
J. McGuire

Representative Thelma Buchholdt
Representative Terry Gardiner
Representative Don Clocksin
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representatives Buchholdt, Gardiner and Clocksin:

Your thoughtful response to an editorial in the Anchorage Daily News (May 12th edition entitled "Health Care Plan Can Wait for the Facts") has been read with a great amount of interest. It continues to be encouraging to know that members of the Legislature are addressing with courage and determination the difficult and important problems of health care and health financing for Alaskans. Our department has appreciated the opportunity to work with members of the Legislature and to keep all of the members advised fully as to the status of the assignment given to the Department of Health and Social Services to provide for a study of health care issues including access, financing and other important facets related to health care for the future.

As you know, the work of the Battelle Human Affairs Research Centers has been underway and continues by contract with the Department of Health and Social Services. The need for such a comprehensive, fundamental and basic study of all health care services provided by government and the financing of that health care with implications for the future all have been of deep concern to and under consideration by the department for about three years. With the appropriation by the last session of the Legislature in May of 1980, it was possible for the department to move forward and to provide for the first basic phase of the study during the fiscal year ending June 30, 1981. The cost estimates for FY 1981 were worked out with as much precision as possible and with very close projections. The requirements for the basic research contract with Battelle, expenses of the Advisory Committee's work and other expenses such as printing, related to such a major project were developed for the fiscal year in which the obligations were made, the present fiscal year. The Battelle contract was to be carried out across two fiscal years, 1981 and 1982, for the work envisioned under the project. From the outset, including the departmental preliminary reviews, the development of the Request for Proposals, and finally the contract itself, the department took into account that it was not possible to determine all the data already available from all sources which would assist in the project. For that reason the original contract with Battelle included the following required work provision: (2-4 I.e)

"A description of the types of data not available at present but needed to decide which alternative health care provision and financing approaches would be desirable and feasible for the State of Alaska to pursue, and the cost of obtaining those data."

Those determinations have now been made and the department is able to identify for the first time the additional research that will be needed in order to complete the study as was anticipated all along.

On December 17, 1980 a "Status Report" was sent to every member of the Legislature from the department, detailing the progress of the project as of that date. Battelle contract activities and schedule of the study was detailed in that report. In April of 1981, the department again transmitted materials to every member of the Legislature regarding the status of the project including two basic Interim Reports prepared by Battelle Institute for Human Affairs Research detailing the progress and developments on the study as of April, 1981.

While the department concurs with some of the observations made in your Forum article prepared for the Anchorage Daily News and which appeared on Wednesday, June 17, 1981 under the heading "More Health Care Facts", there are parts of that presentation which could very easily mislead the public and I am sure you would not wish erroneous impressions to grow out of your presentation. For that reason, I would like to make the following observations:

1. Your presentation of the "first phase of the study" as consisting of "documentation about the current state of health care financing in Alaska" is oversimplified, limited and, to that extent, inaccurate. As you will see by referring to the Request for Proposal as well as the contract with the Battelle Institute, Section 2-4 requires work related to at least twenty topics separate even though at times interrelated. While it is true that Battelle has presented, as required, two Interim Reports, they are precisely that and intended to be such Interim Reports. You have indicated in your letter that "Battelle's contribution to current knowledge.....is already done". That statement could seriously mislead legislators and the public. While the first two interim background reports to the Department of Health and Social Services have been completed, that does not mean that the present and continuing work under the contract into the next phase and in FY 1982 will be of no value or unnecessary in order to do the thorough job planned from the beginning.

2. When the Request for Proposal was developed and the contract entered into there was and currently is a very significant and crucial reality faced. It will be found in Section 2-4 Ie of the RFP as set forth above.

   The Interim Reports and further conferences and correspondence with the Battelle Institute have indeed identified requirement for additional facts which as far as we know, and as far as they know, are not available from any source at the present time. Examples of these include but are not limited to the following:

A. Alcoholism Care: Alcoholism has been repeatedly identified as perhaps the major health care problem in Alaska. HB 41 mandates alcoholism treatment benefits in the state employees' health plan, and a number of other states have also mandated such benefits. Alcoholism treatment consumes a significant share of the state health budget. The questions which arise are: Does broad scale private coverage of alcoholism care truly reduce alcoholism? What is the return on the state's current investment in alcoholism care? How significant is the problem that treatment is often available only at sites distant from home - can such programs be successful?

B. Private sector insurance coverage: Knowledge about existing coverage levels for different types of benefits is important to the evaluation of several of the options. The profile generated thus far has relied upon data from the principal insurers, and upon some national level data. While this has been sufficient for interim purposes, much better information could be derived through a scientific sample survey of the coverage offered by employers in this state. This would also permit linking coverage information to characteristics of business and employees, and permit a more thorough analysis than currently existing data would allow of issues which affect employment related health insurance.

C. House Bill 41: HB 41 is a package which combines components of several different options, including a state sponsored plan, mandatory benefits, and expansion of Medicaid. Taken as a package what does HB 41 imply about the demand on health care resources, costs to the state, incentives created for changed private sector behavior? What are the principal implementation issues implied by the bill?

D. Long term care: Long term care is the principal component of Medicaid costs, due primarily to price, since the size of the elderly population is small in Alaska. But during the next 20 years the number of elderly could grow by 125-210% according to the Bureau of the Census projections for Alaska. Furthermore, recent congressional interest has suggested that federal Medicaid contributions for long term care may be capped, even if other elements of the program are not. What does this imply for the State budget? Can the state take steps to try to reduce the bill? What are the problems of integration of the long term care industry, which is principally private and for-profit, with the state's system of Pioneer Home care?

E. Physician distribution: Recent research from RAND has suggested that physician availability in rural areas is improving, purely as a result of market forces. What does this imply for Alaska

with respect to the projected size, specialty mix, and geographic distribution of the physician population? What does it imply for the use of non-physician providers? What have been the recent trends in this area, and to what extent can we expect them to continue?

F. An analysis and evaluation of the present status of native non-profit health corporation assumption of responsibility for health care from Federal Government and from State Government; current and/or potential capacity for assumption of more local control; financial implications both present and and in the future under a greater assumption of local control of health care and financing by the native corporations.

G. A thorough analysis of the possibility under current federal and state programs and the implications of mandating a "cost sharing" or "deductible" provision in the publicly financed health programs.

H. The implications of federal fund reductions for health financing on state options and state budgets as an outgrowth of federal congressional changes and initiatives as well as changing federal policies with regard to Medicaid financing which will be mentioned later.

These additional data gathering projects are included in the work program anticipated as a large part of the requested FY 1982 appropriations for the FY 1982 part of the study. These were not included under the current contract provisions but represent statistics and data anticipated under Section 2-4 I e of the Request for Proposals and the contract.

3. Your letter leaves the impression that the three areas being pursued in the second phase of the project necessarily will become recommendations from the Department of Health and Social Services or the Governor to the State Legislature. That may be the case but it is not necessarily the case. At this stage Battelle and the Department are probing, in as much depth and breadth as possible the problems and possibilities for changes and improvements. The final report of Battelle in December 1981 will indicate to the Department of Health and Social Services the costs and the benefits involved, the values and the limitations. Whether to proceed with the recommending to the Legislature that any or all of the options or alternatives be adopted will be decisions of the Department of Health and Social Services, its broad-based public Advisory Committee, and the executive branch of government. It is anticipated that clear alternatives, undergirded with as factual a base as possible, will be available at the beginning of the next session of the Legislature.

The focus of your letter seems to concentrate on "health care financing in Alaska". That is one emphasis and responsibility of the study. It is by no means limited to that concept. The scope of the study includes: (1) The present health care delivery; (2) The present health care financing systems in

the State of Alaska; (3) Identification of existing potential funding sources; (4) An examination of improvements to the present systems and, (5) Exploration of alternative methods of providing for health care and cost distribution in Alaska; (6) Design proposals for the implementation of potential new systems or methods. I think you will agree that the requirements under the current research and the work yet to be accomplished by December extends far beyond that which is presented in your letter.

4. Your letter leaves the impression that the Battelle study is being extended in time or that Battelle is not providing the originally anticipated information. On the contrary, it is anticipated that the original time schedule will be adhered to with the completion of the study in December of 1981. It is true as we all know that the study is to be carried out within parts of two state fiscal years. The department requested funds in fiscal year 1981, ending this June 30, for the actual obligations made and necessary to carry out certain planning and research for 1981 fiscal year. That budget was submitted and administered related precisely what was anticipated for fiscal year 81. Additional funds are being requested to carry out and to complete the study in fiscal year 1982 as was originally intended. Those funds in 1982 fiscal year, beginning July 1, will be used for: the investigation of the issues not originally forseen in detail but thought to exist as indicated above; the expenses of travel and per diem of departmental personnel attributable to the study and for the statewide Advisory Committee representing a broad spectrum of the public; the expenses connected with holding of public hearings in at least four locations in Alaska between now and December of 1981, as required under the contract and set forth in the Request for Proposals and the incidental costs of the study project such as printing, required telephone and so forth. The fiscal year 1982 phase of the work is extremely important and considered absolutely necessary necessary for the maximum advantage to the State of Alaska for this project. None of the funds requested in the 1982 budget overlap, duplicate, or substitute for the work required by the Battelle Institute within their contract during the FY 1981 budget year and part of their work in the 1982 budget year. Additional payment to Battelle for the 1982 fiscal year will be for those activities beyond the scope of the original contract but which could not be forseen until all the existing and available data could be gathered and analyzed in order to determine what statistics, what data, what facts were not available in usable form from any quarter. You indicate correctly in your letter that "the rest is to pay for more research and documentation".

The Department of Health and Social Services, the Battelle Institute, and the Alaska Comprehensive Health Care and Financing Study Advisory Committee all have been aware of the provisions of House Bill 41. It is acknowledged that in its current version there could be some overlap between the goals and provisions of House Bill 41 and what might emerge from a longer term more fundamental and more extensive study of the facts and data that we believe to be required to arrive at sounder public policy decisions. The Department concurs with the editorial in the Anchorage Daily News to which you refer entitled "Health Care Can Wait for the Facts". Reasons for the agreement are outlined above. In

addition to those facts the following developments are emerging among others on a current basis with a possible strong impact on a re-designed health care and financing policy for the State of Alaska:

1. The U.S. House of Representatives is considering HR 850, an act entitled "National Health Care Reform Act of 1981". That national bill addresses (a) need for structural reforms; (b) specific deficiencies in the present method of delivering and financing health care with problems identified as lack of coordination and continuty of care, excessive government regulation, third party payment system problems, reasonable cost reimbursement, government as third party payer issues, lack of competition. Other congressional initiatives currently underway include a bill to be introduced immediately by Senator John Heinz of Pennsylvania entitled "Competitive Health and Medical Plan Act of 1981". That bill if enacted provides an important alternative in the form of a variation of health maintenance organization which would encourage and stimulate competition among alternative systems of health care delivery. If enacted, it will, or could have, an impact on Alaska. If it is not enacted, some of the strengths and values identified therein should be considered in the process of the final design of a revised system for Alaska. While that bill has specific advantages and relations to the elderly population, it is not limited to the elderly population and the Medicare program.

2. Discussions between the Battelle Institute researchers, myself, and members of the U.S. Department of Health and Human Services' Health Care Finance Administration last week explored in some depth the relative value of the State of Alaska seeking Medicaid waivers in order to retain any reasonable portion of the federal Medicaid funds for Alaska in the event the final design of a program for Alaska, under the comprehensive study, might impact on the Medicaid funding in such a way as to create a potential loss of part of the federal Medicaid funding. The current federal Medicaid initiatives as you know include strong proposals that likely will be enacted soon to put a ceiling on the growth of the Medicaid program within states and limit the rate of growth of that program. The exact Medicaid ceiling decisions of the federal congress are not known at this time but doubtless will come into clear focus, if not finally determined, before January 1982. Those decisions will have strong implications for federal funds available for health care in Alaska as well as new flexibilities in using Medicaid funds within any state. They certainly should be taken into account prior to the enactment of any major or new programs adopted by the Alaska Legislature.

For all of the above reasons, I would urge (1) that the prime sponsors of House Bill 41 and other interested Legislators, await the completion of the Alaska Comprehensive Health Care and Financing Study; (2) strong support to the departmental budget request for the $150,000 needed for adequate financial underpinning for that effort after July 1, 1981; (3) that a fresh look be taken in the new legislative 1982 session with regard to the important issues involved in these public policy questions. The issues surrounding health care and health financing from public funds is of growing concern throughout the nation and within Alaska. As early as three years back, the Department of Health and Social Services did anticipate some of the questions

which have more recently been raised and began then to make provisions for a thorough analysis of the issues involved including health care, health financing, access to care, barriers to care, benefits, coverage and who properly should pay for benefits expected.

The prime sponsors of House Bill 41 are to be congratulated in turning their attention to some of the issues involved in the health care area. The Department is pleased that tne work of the department and the Battelle Institute for Human Affairs Research has been of value to date. We believe that the value level and contribution can strongly be improved and extended following the outcome of the second phase of the work now underway and scheduled for completion in December of 1981.

Sincerely,

Frederick McGinnis

Frederick McGinnis
Deputy Commissioner and
Project Coordinator for the
Alaska Comprehensive Health
Care and Financing Study

We are writing in response to an editorial, "Health care plan can wait for facts," that appeared in the May 12 edition of the Daily News. The thrust of your comment is that passage of HB 41, the health care financing bill, should wait for final publication of a state-funded study of health care financing in Alaska performed by the Battelle Research Center for the Department of Health and Social Services (DHSS). We disagree with your assessment.

We have followed the work of the Battelle study closely this session. The first phase of the study consisted of compiling documentation about the current state of health care financing in Alaska. The report describing this research has already been completed and Battelle plans to do no further work on it. Thus, Battelle's contribution to current knowledge about existing services in the state, and about what services are lacking, is already done. The House has had access to those facts, and has used those facts, in its deliberations over HB 41.

The second phase of the study group's work consists of formulating recommendations to the legislature for action that can be taken to improve health care financing in Alaska. At first, the study group identified 17 options for improvement of health care financing. However, time and funding constraints as well as the availability of needed expertise have narrowed those options down to three.

At the study group's last meeting on May 8, the three options were identified as: (1) a comprehensive state health care plan similar to that embodied in HB 41; (2) improvements in rural health care delivery; and (3) seeking waiver authority from the federal government to consolidate the Medicaid and General Relief Medical (GRM) programs into one plan. Clearly, recommendation 1 coordinates well with HB 41. Recommendations 2 and 3 could easily be enacted in legislation, if indeed legislation is needed, next year. HB 41 already paves the way for recommendation 3 by including most components of the current GRM program in the insurance plan of section 1.

Since we have made a continuous effort to follow Battelle's work, we have be able to take it into account in the design of HB 41. Passage of HB 41 this session would not preclude utilization of information included in the December report and would not require revamping of HB 41. In fact, coverage under the insurance plan called for in section 1 of the bill does not begin until July 1982. This is to give the state time necessary to gear up to offer insurance, and to allow Battelle's findings, and those of other research projects, to be used extensively in implementation of the bill as a whole.

By the way, the state's funding for the Battelle study was not for three years, but only for one year. The Department of Health and Social Services apparently does not plan to finish its work in December though, because it has asked for another $150,000 to continue working with Battelle in FY 82. Despite several inquiries, the legislature was not given any details of the department's plans to spend the $150,000 until (the month of May), even though the request for funding was submitted in January. Much of the money that is sought is to complete payment of items that should have been paid for with the first $170,000. The rest is to pay for more research and documentation, the compilation of which would not conflict with HB 41, but only contingent upon the study's completion.

So much attention has been forced on the insurance portion that we wonder if people know that the bill includes funding for alcoholism treatment of state employees, an attempt to improve the provider reimbursement system for government health care programs, expansion of Medicaid coverage, and a study of how the state can complement Public Health service and Medicare. All of these services are greatly needed to provide more and better health care to Alaskans.

HB 41 does not attempt to take care of every health need of every Alaskan with 100 percent state money. We are attempting instead to assure that 40,000 Alaskans who currently have no health care financing plan are able to afford health crises and provide for their basic health care needs; that more attention be paid to our obvious and collective alcoholism; that comprehensive health care be available to those who are least able to afford it; and that the state consider partial funding of the health needs of rural Alaskans and older Alaskans.

All of these goals should be attained as soon as possible. Any future recommendations of the Battelle study, and the recommendations of others knowledgable of Alaska's health care needs, should be considered. This is not, however, a valid reason to postpone action on some of the problems that can be addressed now.

— Rep. Thelma Buchholdt
— Rep. Terry Gardiner
— Rep. Don Clocksin
Prime sponsors of HB 41

forum

Anchorage Daily News - Wednesday, June 17, 1981

MAY 12, 1981

Anchorage Daily News

Winner, 1976 Pulitzer Prize Gold Medal for Public Service

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Executive Editor

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Managing Editor

Lawrence Fanning, Editor and Publisher 1957 to 1971
Alaska's Only Morning Newspaper • Founded in 1946 by Norman C. Brown

Health care plan can wait for facts

American efforts to develop the finest in health care are the envy of the world; in technology and training our medical community offers abilities that are first rate.

Health care capability does not, however, insure health care delivery. And despite widespread and expensive efforts to provide assistance to all, there still are many citizens who fall between the cracks in the myriad of federal, state and private programs that are available.

In Alaska, estimates indicate at least 10 percent of the population does not have health coverage — a situation that has drawn the attention of legislators concerned over the devastating expense of emergency and long-term services. Like everything else, health care costs more here, and the state House has approved legislation meant to provide the unprotected a state-sponsored option for health coverage.

Such coverage quite properly should be available in a state awash in unprecedented revenues; health care is a basic, quality-of-life issue that concerns everyone at one time or another.

But the House apparently has acted too soon on the initiative. The state already has funded a three-year study into health care financing, the results of which are not due until December. The study presumably will be of great value in determining the best shape of a health care strategy for Alaska. Legislators would do well to wait for it.

Waiting another six months, to be sure, will mean added difficulty for those who suffer misfortune during the interval. But the period will be worthwhile if the delay ultimately results in a plan that is secure, affordable and well-suited to the needs of Alaskans.

Let health care remain on the political agenda until the next legislative session and let it move even higher on that agenda once the necessary information is at hand.

House Research
proposal for interim study

Preventive Health Care

There are many approaches to preventive health care. These can be divided into three general categories: 1) health education and community information programs; 2) screening and early diagnostic programs; 3) alternative treatment programs, usually involving mid-level practitioners. Given the staff time which we have available during the interim, we can address only one of these categories in depth. The second--screening and early diagnostic programs--could be treated most efficiently by our staff. We envision addressing the following questions:

1) What is the relationship between the State's major health problems and preventive health care services?

   - We would identify the state's major health problems and attempt to determine how these problems could be addressed through preventive care. This section would include an overview of the various approaches to preventive care outlined above.

2) What are the primary benefits of screening and early diagnostic programs?

   - This component of the study would address both the health and cost benefits of the early diagnostic programs, e.g., likely effect on health care insurance premiums; possible effects on other state programs.

3) What screening and early diagnostic programs currently operate in the state? Who has access to these programs? How many people have these programs served?

- Programs to be examined would include: Medicaid and the EPSDT program; Public Health Service; Indian Health Service.

4) Are there innovative screening and early diagnostic programs which have been initiated in other states? How are these programs structured and funded? Is there any information available on program effectiveness?

5) How might screening and early diagnostic programs be expanded in Alaska through legislative action?

Any research that we would undertake on the subject of preventive health care would be intended to complement the Battelle study now underway.

Health, Education and Social Services Committee

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

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Alaska State Legislature

Senate

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MEMORANDUM

TO: Charlie Parr

FROM: Rocky Plotnick Weller

DATE: April 30, 1981

RE: The Alaska Comprehensive Health Care Financing Study

You have asked for the current status of the Alaska Comprehensive Health Care Financing Study. I have outlined the study's purpose and schedule below:

I. The study's purpose is to explore health care financing in Alaska, explore alternative means of expanding health care coverage, and improve physical and financial access to health care services.

II. Phase I of the study was completed by Battelle on March 30, 1981. It describes the present methods of public and private health care delivery, access, coverage and financing in Alaska. Also, it presents alternative approaches to reshape health care coverage and financing, and to a lesser extent, delivery and access.

III. The Advisory Committee will meet May 7, 1981 to consider the alternative approaches addressed in Phase I and decide which approaches Battelle should develop.

IV. Phase II will provide a complete plan for implementing and financing each of the alternative approaches selected. The deadline for the

draft is September, 1981.

V. The final document should be completed and submitted to the Department of Health & Social Services, the Governor and the Legislature by December 11, 1981.

ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES

June, 1981

NEWS & VIEWS

Issue No. 7

Battelle Study

Early this year, DHSS contracted with Battelle Human Affairs Research Center, to do a comprehensive year-long study of the delivery and financing of health care in Alaska.

They have delivered two interim reports, the first an analysis of health care resources and financing, and the second, some options for state action.

The analysis found:

- a higher-than-national-average death rate for every age group
- a unique pattern of disease and injury highly related to lifestyle and behavior
- shortages in practitioners and clinics in villages and difficult access to acute care in remote areas
- shortcomings in behavioral health services, emergency medical transportation and village sanitation in some communities

According to the study, the total health care bill in Alaska in 1979 was $480 million, financed 14 percent by state and local government, 31 percent by federal government and 55 percent by the private sector. It found that 44,000 Alaskans, nearly all of them non-Native civilians under the age of 65, have no health care insurance coverage of any kind. For those with coverage, significant gaps in benefits were found for newborn and well baby care, extended care, mental health care, dental care, vision care and hearing care.

The study produced a spectrum of alternative actions the state could take. An advisory committee chose three basic packages which Battelle will study in further detail for a report due September 15.

One package looks at redesigning a health care program for the poor. Actions which Battelle may address include the following:

1. allowing two-parent families to be eligible under current Medicaid/General Relief Medical eligibility
2. making all households eligible if their incomes are less than 150 percent of the federal poverty level guidelines for Alaska
3. withdrawing from Medicaid if restrictions which accompany participation threaten key aspects of the program

A second package includes a state-sponsored comprehensive health insurance plan open to all Alaskans, possibly with subsidized premiums for low income groups not covered by Medicaid. It would be designed to complement private health insurance plans, not replace them.

The third package looks at improved access to health care for rural Alaskans, including coordination of activities of the state, Indian Health Services, Native corporations and the private sector.

The state could choose a combination of actions from all 3 packages.

A final report is scheduled to be in the hands of DHSS, the Governor, legislators and other interested persons by December 15. Deputy Commissioner Frederick McGinnis is coordinating the study project.

Primary Prevention
- Promoting good health
- Elimination of environmental pollution
- Prevention of accidents
- " of occupationally-related disease
- Household safety
- Health education (alcohol, drugs, smoking, exercise, nutrition, sleep).

Secondary Prevention
- screening examinations
- regular exams of children
- Teaching early signs of disease

Tertiary Prevention
- Rehabilitation for chronic illness

Battelle
Human Affairs Research Centers
4000 NE 41st. Street
Seattle, Wash. 98105

Meeting ~~June~~ 15 - Anch.
(coord. - Dept Comm. Fred McGinnis)
[illegible] mtg ——— 378-4668

[illegible] all the work / policy analyses.
[illegible] meeting identified
1 Rural health delivery
2. State health insurance
3 Health care for needy (medicaid / medicare)

— another subject area not known:
[illegible] will be addressed
[illegible] mtg.

[illegible]

[illegible]
1 [illegible] Health Planning
2 [illegible]

[illegible]

[illegible]

[illegible]

[illegible] (State) [illegible] Nursing

[illegible]
[illegible]
[illegible]