THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

PUBLIC INPUT:

Written Comments Provided by
Interest Groups

Written Comments Provided by
Individuals

Summary of Eight
Community Meetings/Public Hearings

Results of Two Public
Opinion Surveys

January 1993

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

WRITTEN COMMENTS

Provided by Interest Groups

BRIEF PRESENTATIONS BY INTEREST GROUPS TO THE
HEALTH RESOURCES AND ACCESS TASK FORCE
JULY - OCTOBER 1992

ORGANIZATIONS (OTHER THAN BUSINESSES)

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Aetna Life Insurance Company Reed Stoops (contact) 463-3223 Steven LeBrun (present) Account Consultant P.O. Box 91032 Seattle, WA 98111-9132 206-467-2803	Oct.23,11:40am	
Alaska Academy of Physician Assistants Ron McClellan (contact) 564-4400 ext. 6806 9510 Trinity Circle Eagle River, AK 99577 Mary Durborow, Pres.	Tentatively scheduled; later declined.	
Alaska Association of of Social Workers Dr. Eileen Lally UAA Social Work Dept 3311 Providence Drive Anchorage, Alaska 99508 786-1724, 786-1721 Theresa Tanoury, LCSW (presenter) Chair, Social Action Committee 364-3100 h 586-6938 w 463-5349 fax	Oct. 23, 3:20 pm	X
Alaska Chiropractic Society Dr. Pat Conners-Allen, DC Liaison 2231 N. Jordon Ave. Juneau, AK 99801	Sept. 26, 11:50 am	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Alaska Coalition of Parents Educating for the Disabled and Medically Complex Elaine Hurley, Director P.O. Box 220584 Anchorage,AK 99522-0584 522-1097	Declined; GCHSE will cover.	
Alaska Council of School Administrators 326 Fourth Street, Rm 404 Juneau, AK 99801 Steve McPhetres Executive Director 586-9702	October 23, 4:00 pm.	X
Alaska Dental Society 3400 Spenard Rd, Suite 10 Anchoage, AK 99503 Martha Reinbold (contact) Executive Director 277-4675 274-2960 fax Dr. Julie Robinson, DSS Secretary (present) 880 N Street Anchorage, AK 99501 279-8274	September 26, 2:10 pm	X
Alaska Emergency Medical Services Association 1882 Marika Road Fairbanks, AK 99709 Craig Lewis, President 456-3978 456-3970 fax Ms. Ronnie Sullivan, (presenter) Secretary (Director, Southern Region, EMS Council 6130 Tuttle Place Anchorage, AK 99507 562-6449 563-4721 fax	Oct. 23, 10:40 pm	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Alaska Health Campaign Putt Clark, Organizer 7348 N. Douglas Juneau, AK 99801 456-8172w, 479-4702h until 8/31 586-1251 after 8/31	Request made; later declined.	
Alaska Hospital Council Jim Walsh 745-4813	Left messages; assumed not interested.	
Alaska League of Women Voters Betty Elsner Chair, Health Care Access Study P.O. Box 207 Ester, AK 99725 479-2424 (Jennifer Schmidt, 452-1776w)	July 21, 1:15 pm	X
Alaska Municipal League 217 2nd Avenue Juneau, AK 99801 Kent Swisher Executive Director 586-1325	October 23, 1:50 pm.	
Alaska Native Health Board 1345 Rudakof Circle Suite 206 Anchorage, AK 99508 Anne Walker, Executive Director (contact) 337-0028 337-2001fax Continued, next page	September 26, 3:00 - 3:45 pm	

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
ANHB's orgs to present: Cont., Alaska Native Health Board (1) Bristol Bay Area Health Corporation P.O. Box 130 Dillingham, AK 99576 Robert Clark 800-478-5201 842-9409fax		
(2) Norton Sound Health Corp. P.O. Box 966 Nome, AK 99762 Carolyn Michels 443-3311 443-3139fax		X
(3) Southcentral Foundation 670 West Fireweed Anchorage, Alaska 99503 Darleen Beltz 276-3343 258-5212fax		
Alaska Nurses Association Patty Hong, RN President P.O. Box 321 Girdwood, AK 99587 783-2675	Aug 25, 2:40 pm	X
Alaska Pharmaceutical Association 8251 Pioneer Drive Anchorage, AK 99504 Lynn Rodder (contact) 261-3078 Lori Brown, RPh,(present) President (and) Soldotna Prof. Pharmacy 245 Binkley Street Soldotna, AK 99669 Shirley Coursey, RPh (present) Member HC83 Box 1734 Eagle River, AK 99577	September 26, 11:30 am	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Alaska Public Health Association Denny DeGross, Pres. 2348 Leande Circle Anchorage, AK 99515 344-8824	September 26, 1:50 pm	X
Alaska Public Interest Research Group P.O. Box 101093 Anchorage, AK 99510 Steven Conn, Executive Director 278-3661	September 26, 3:45 pm.	X
Alzheimer's Assoc, Alaska Chapter Mary Troll, Program Development 4450 Cordova Street, Suite 120 Anchorage, AK 99503 561-3313 561-3315fax	July 21, 1:35 pm	
American Academy of Emergency Physicians Dr. Michael Levy, M.D. (present) 20222 Revere Circle Eagle River, AK 99577 696-7386 h 264-1222 w	Oct. 23, 10:40 pm	X
American Academy of Pediatrics, Alaska Chapter Dr. James Nesbitt, MD State Media Spokesperson 4001 Dale Street, Suite 213 Anchorage, AK 99508 562-2944w	Sept. 26, 1:30 pm.	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
American Association of Retired Persons Marie MacKenzie, Health Care Trainer 1620 Cresent Drive Anchorage, AK 99508 562-4895	July 21, 1:55 pm	X
American Physical Therapy Association, Alaska Chapter Avis Hayden (contact) 789-5694 Ms. Pat McAdoo, PT (presenter) President 4660 Reka Drive Anchorage, AK 99508 279-6661	Oct. 23, 11:20 am	X
Anchorage Neighborhood Health Center Dr. Harold Johnston, MD Medical Officer 1217 E. 10th Avenue Anchorage, AK 99501 258-7888	Aug 25, 3:40 pm	
Child Care Connection Mia Oxley Executive Dir. 825 L Street Anchorage, Alaska 99510 279-5024	Oct. 23, 2:10 pm	
Continum of Care Network for Seniors Lillian Wilder, contact Salvation Army Older Alaskans Program 1709 South Bragaw Anchorage, AK 99508 279-7658 (For comments, see Bill Nugent)	Oct. 23, 11:00 am	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Fairbanks Health Coalition 4454 Chena Hotsprings Road Fairbanks, AK 99712 Ellen Ganley (Coordinator of Fbxs Communtiy Health Proj.) 488-2370	Aug. 25, 2:20 pm	X
Governor's Council on Disabilities and Special Education P.O. Box 240249 Anchorage, AK 99524 Mary Elizabeth Rider, Health Planner (contact) 272-2500 272-1134fax Kathy Allelly, Chair (present) Health Committee (and) Laurel Putnam, Member (present) Health Committee	Sept. 26, 2:30 pm	
Green Party Tom Macchia, Co-chair Health Care Task Force P.O. Box 221285 Anchorage, AK 99522-1285 345-1708 562-3835fax	July 21, 2:15 pm	
Kenai Peninsula Borough Health Care Advisory Council 110 South Willow St., Suite 106 Kenai, AK 99611 Stan Steadman, Chair 283-3335	Sept. 26, 11:00 am	X

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Midwives Association of of Alaska Pam Weaver (presenter) P.O. Box 671427 Chugiak, AK 99567 688-2000 h 373-3420 w 376-7847 fax	Oct. 23, 5:10 pm	X
Older Alaskans Commission Connie Sipe Executive Director 465-3250 563-5654 Anch	Left messages; assumed not interested.	
Partners in Action for Teen Health Avis Hayden 12100 Cross Street Juneau, AK 99801 789-5694	Declined.	
Salvation Army Health Care Access Program P.O. Box 70405 Fairbanks, AK 99707 Captain Preston Rider, Commanding Officer, Fairbanks Corps 452-3113 452-6908fax	Aug. 25, 3:20 pm	

BUSINSSES AND BUSINESS-RELATED GROUPS

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Alaska State Chamber of Commerce 217 Second Street Juneau, AK 99801 Jamie Parsons Executive Director 586-2323	Distributed survey rather than making presentation.	
Alyeska Pipeline Service Company 1835 South Bragaw St., MS 536-A Anchorage, Alaska 99512 265-8487 Gordan A. Anderson, CEBS Manager Benefits and Annuitant Affairs	Oct. 23, 3:00 pm	X
Anchorage Chamber of Commerce 441 W. Fifth Ave Anchorage, AK 99501 Carol Heyman, Exec. Director 272-2401 272-4117fax (1) Desiree Pfeffer, owner Golden Office Supply 3111 C Street, Suite 200J Anchorage, AK 99503 563-6003 563-1778 fax (2) Dave Marshall	Oct. 23, 2:30 pm	
Carr Gottstein Foods Company 6411 A Street Anchorage, AK 99518 Eric Tollefsen, Director of Human Resources 563-1961	Contacted; assumed not interested.	

Name of Organization Contact/Address/Phone	Scheduled	Submitted Written Comments
Fairbanks Chamber of Commerce 709 Second Ave. Fairbanks, AK 99701-4475 452-1105 456-1105 fax Margo Goodhew, Ex.Dir.	Scheduled; declined.	
Juneau Chamber of Commerce 124 W. Fifth Street Juneau, AK 99801 Joe Poor Executive Director 586-6420 463-5670fax	October 23. 3:40 pm	
National Bank of Alaska P.O. Box 100600 Anchorage, AK 99510 Kathy Knowles, Executive Vice Pres.	Oct. 23, 1:30 pm	
National Federation of Independent Business Resa Jerrel 9159 Skywood Ln Juneau, AK 99801 789-4278	August 25, 3:00 pm	X

ALASKA CHAPTER
NATIONAL ASSOCIATION OF SOCIAL WORKERS

HEALTH CARE CRISIS: THE NASW SOLUTION

Information to Alaska State Legislature
Health Resources and Access Task Force
October 23, 1992
Anchorage

NATIONAL HEALTH CARE: THE NASW SOLUTION

* A single-payer, publicly financed insurance plan for all Americans.

* Overall federal administration, state responsibility for delivery of health services and payment to providers.

* Benefits:
- Expanded comprehensive benefits
- Long-term and home and community-based care
- Mental health benefits covered on same basis as other health benefits.

* Freedom to choose own provider.

* No longer employer-based coverage.

* Eliminates current patchwork of public and private insurers.

* No consumer cost-sharing, except for limited payment of room and board costs for nursing homes and other residential facilities.

* Payment:
- Annual state health care expenditure budgets
- State acts as single payer for all providers
- Hospitals receive global budget for operating costs
- Purchase of high tech equipment regulated by the state
- Negotiated fee schedules for all practitioners

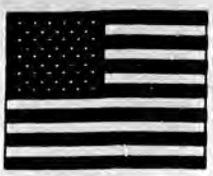
* Financing:
- Financed primarily through federal taxes earmarked for health care
- Additional 6 percent employer payroll tax
- Increases in personal and corporate income taxes
- Increases in alcohol and cigarette taxes
- State contribution based on current health care expenditures and other health factors.

* New taxes replace what people now spend on health care.

WHAT A FAMILY OF FOUR WOULD PAY UNDER THE NASW PLAN

Average Income	Tax Increase Under NASW Plan for Health Care	Spending Under NASW Plan Compared to Current Out-of-Pocket Health Spending
$ 12700	$ 126	$(798)
$ 26800	$ 736	$(716)
$ 39100	$ 1351	$(347)
$ 54000	$ 1963	$ 89
$ 82200	$ 2639	$ 465
$322600	$12799	$9754

NOTE: The use of parentheses indicates a reduction in spending.



MEDICARE FOR ALL AMERICANS

When Dr. James Todd, executive vice president of the American Medical Association, recently met with the editors of CONSUMER REPORTS, we found ourselves in agreement on the need for reforming the U.S. health-care system and even on the principal goals of any reform: universal access to health care, cost control, improved quality of care. Not surprisingly, however, the AMA, hospitals, and insurance companies can envision only those changes that would touch them least.

Doctors want everyone covered by health insurance but reject the idea of limitations on their fees. "The payer has no right to tell providers what they should charge," Todd said. The American Hospital Association wants to eliminate excess hospital capacity, but it opposes proposals for publicly set budgets that might accomplish just that. Insurance companies want to constrain provider fees, but they don't want to lose the right to sell insurance policies or to pick and choose the Americans they're willing to insure. Businesses want their employees covered by health insurance; they just want to pay less of the bill.

Proposals aplenty

All these groups embrace "managed care" techniques, such as health maintenance organizations, as representing the change least likely to disturb business as usual. In theory, managed care can control provider fees and attempt to improve quality of medical care, even if in practice the record has been spotty at best. But managed care does not address the need to make care available to the uninsured or to reduce the administrative waste and complexity inherent in the present system.

Managed care has become big business, with firms competing fiercely to sell employers the latest money-saving tool. One firm told CU that it was looking to its next product—how-to manuals that would help people diagnose their own illnesses.

Other reform proposals acknowledge that more people need insurance coverage, and they would create various mechanisms for accomplishing that end. "Pay or play," the reform backed by some Democrats in the Senate, would require all employers to provide coverage for their workers. If they choose not to "play"—that is, insure their employees—they'd have to pay into a special Government fund that would supply the coverage. That approach appears to be losing support.

The Bush Administration proposes tax credits to help low-income people buy their own insurance. Health insurers back "small group reform" that would make it somewhat easier for small businesses to obtain insurance coverage for their employees; so far, 17 states have passed such laws.

All this tinkering around the edges would add some people now not covered to the private insurance rolls. But, as the profiles of the Americans on pages 580-584 demonstrate, owning an insurance policy does not guarantee access to the care you need or make the care you get affordable.

To cover people that insurance companies still don't want or who are too poor to buy insurance even with tax credits, insurance companies and their political allies propose expanding Medicaid, the joint Federal and state program to provide health care to the poor. Of course, this solution shifts to the taxpayer the full burden of paying for people that private insurers won't accept. Since taxpayers will be reluctant to pay higher taxes at the same time that they must pay higher premiums to cover their own families, Medicaid will lack the budgets needed to reimburse providers fairly. As Hawaii's experience shows, when the public portion of the partnership doesn't pay its share, providers simply charge the private partner more. The Hawaiian experience also shows that Medicaid patients often don't get the care they need because some doctors refuse to accept Medicaid's low reimbursement rates.

The single-payer solution

A single-payer system that draws its inspiration from Canada's is not the best solution for those doctors who are mainly concerned about their own pockets, or for hospitals with ambitions to become major medical centers. It certainly isn't a good solution for health-insurance companies; many of them would go out of business. But it is the best solution for the growing number of consumers shut out of the private-insurance market and the even larger number who have reason to fear their coverage might disappear at any time. Here's why:

1. A single-payer system eliminates the need for private insurance coverage for basic, medically necessary treatment. If the U.S. were to adopt the principles of the Canada Health Act—universality, portability, accessibility, comprehensiveness, and public administration—there would be no need for anyone to buy private insurance policies to cover necessary care. The money currently spent on insurance premiums, and on Government health programs (Medicare, Medicaid, grants to states), could be redirected to make coverage available for everyone under a single, publicly financed insurance plan.

2. A single-payer system furthers the goal of cost-containment by giving a single, influential payer the power to negotiate provider fees and to assure the orderly introduction of technology.

3. A single-payer system allows the payer to experiment with managed-care techniques, collect data, and measure what works and what doesn't.

4. A single-payer system eliminates the cost-shifting to businesses and consumers that results when the Government underpays for medical services. Since a single-payer system covers everyone—young and old, rich and poor—there are no private payers to shift to.

It won't be easy to achieve a single-payer system in the U.S. The health industry has much to lose if such a system is adopted, and it is waging a well-financed war against real reform. Its public-relations campaigns capitalize on distrust of the Government, and on the fear of "socialized medicine."

A model in Medicare

Similar mistrust and fear was used against Medicare before it became law in 1965. Yet the program has been, by most measures, a success.

Today Medicare enjoys strong support from the people it serves, while maintaining remarkably low administrative costs—about 2.5 percent of its total expenditures, compared with 4 to 12 percent for private insurance. To administer Medicare, the Government employs Blue Cross Blue Shield organizations and other insurers, which process patients' claims and pay their bills.

The Medicare system has given all elderly people the security of health insurance, a security they lacked before 1965. But it is not without flaws. Among them are the practice of balance billing, which allows doctors to charge patients more than Medicare pays; the complex payment schemes that both patients and providers must cope with; and the gaps in coverage, which have encouraged a bewildering variety of supplemental policies for the elderly. A strong single payer would have the leverage to correct those problems.

As the U.S. health-care crisis deepens and as the medical insecurity of all consumers becomes more severe, we believe the single-payer approach will make more sense to more people. Then the goals of universal care, cost control, and quality may at long last become a reality.

NASW

National Association of Social Workers

For Immediate Release

Plan Aims to Set the Standard on Health Reform

For Information:
Lucy Sanchez 202/336-8236
Denise Mitchell 202/842-3100

SENATOR INOUYE AND NATION'S SOCIAL WORKERS INTRODUCE MOST COMPREHENSIVE NATIONAL HEALTH CARE LEGISLATION

WASHINGTON, DC, June 9 — A national health care bill introduced today in the U.S. Senate by Senator Daniel Inouye (D-HI) and developed by the National Association of Social Workers (NASW) is the most comprehensive legislative proposal to date, providing greater health and mental health benefits than any other plan.

The National Health Care Act of 1992 would reduce U.S. health administrative costs by 30 percent by setting up a single-payer system in which the government administers health insurance and pays all doctors, hospitals and other health providers.

Of the more than 200 federal legislative proposals dealing with health care, the plan developed by the nation's social workers is one of the few bills that go beyond outlining a financing plan. And it is the only plan that improves service quality and gives mental health parity with physical well being.

"This bill envisions a new way of delivering quality health care services," said Senator Inouye. "It emphasizes the use of health education and prevention programs and makes available preventive and primary care services through care coordination."

"We hope to move the Congress by setting out a model plan for health care delivery in this country," said Mark Battle, executive director of the 140,000-member National Association of Social Workers.

The Inouye/NASW plan, which includes one of the first detailed cost analyses for a universal, single-payer health plan, projects an immediate 3.8 percent increase in health spending to provide all Americans with comprehensive health care. But it would result in significant long-term savings as a result of cost controls, expanded prevention and health promotion efforts and other effects of a healthier population.

The National Health Care Act of 1992 also:

- addresses the need for quality care by assuring that health care reaches into poor and rural areas;

- provides aggressive health prevention and health promotion — allowing people access to health care early in life to enable a healthy start and encourage a healthy lifestyle; and

- deals with issues around service delivery and research overlooked by most other plans — uncovering shortage areas and encouraging treatment for underserved populations.

"Social workers are increasingly helping individuals pick up the pieces when the lack of health coverage has shattered their lives," said Battle. "We believe our proposal would permit every American to receive the same level of comprehensive benefits through the use of a uniform single-payer, cost-effective plan."

The National Association of Social Workers is the world's largest organization of professional social workers, with members in the United States, Puerto Rico, and Europe. Social workers are employed in virtually every health and mental health setting in the country. Nearly two-thirds of NASW members provide health or mental health care service.

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SUMMARY OF S. 2817, THE NATIONAL HEALTH CARE ACT OF 1992

S. 2817, the National Health Care Act of 1992, fundamentally restructures our current health care system. The bill provides universal coverage for high quality and cost-efficient health, mental health, and long-term care through a single-payer national health care system. States have the responsibility to ensure delivery of health services, payment to all providers, and planning in accordance with federal guidelines. Enrollees have the freedom to choose from among a full range of public and private providers, including alternative delivery plans. Private insurance coverage for benefits provided through the national health program would be discontinued.

Eligibility & Enrollment: Coverage is extended to all persons residing in the U.S. Enrollment takes place in the state of primary residence; portability of benefits extends across states.

Benefits: Care coordination, primary prevention and health promotion, outpatient primary care, mental health services, substance abuse treatment and rehabilitation, inpatient and outpatient hospital services (including emergency and trauma care), inpatient and outpatient professional services, laboratory and radiology services, long-term care (including home and community-based services), hospice care, prescription drugs, medical supplies and durable medical equipment, dental care, hearing and speech services, and vision care are covered benefits through the plan.

Cost-sharing: No copayments or deductibles are required for health or mental health services. Consumers would be required to pay a portion of the room and board costs for residential care (the contribution would be capped at 25% of room and board costs and would be waived for low-income individuals).

Service Delivery Improvements: The plan promotes preventive care and adds new health education and health promotion services through a variety of community-based settings. Care coordination is stressed in primary care and is the point of entry for long-term care. The plan encourages the development of new delivery systems, such as the integrated health delivery plan concept, and promotes increased access to health services for underserved communities and populations. The expansion of community-based health and mental health care is encouraged.

Administration: A new federal agency is established to administer the health care program, with policy direction provided by a national health care advisory board representing health care experts and consumers. Medicare, Medicaid, CHAMPUS, FEHBP, and the Department of Veterans' Affairs' health programs would be folded into the plan. A Public Health Services (PHS) Functions and Activities Board would recommend which PHS functions and activities should be incorporated into the new agency and which should remain separate. A National Council on Quality Assurance and Consumer Protection would oversee utilization and quality control. The federal agency would provide the states with an annual global budget for all covered health expenditures. States, in accordance with federal guidelines, would ensure the implementation of all health services, determine the distribution of health care funding, develop and administer a mechanism to reimburse health care providers, work with localities in health planning, implement a quality assurance program, administer a consumer advocacy and information program, and regulate all health care providers and facilities. Federal and state consumer advocacy programs are to be established to administer ombudsman programs, hotlines for complaints, and consumer education and information programs.

Provider Payments: Hospitals will receive a prospective global budget for operating expenses, developed through annual negotiations with the state agency. Separate funds for capital expansion and the purchase of highly-specialized equipment would be subject to approval by the state. Other health care facilities may be paid through a global budget or capitation, as determined by the state. Autonomous health care practitioners will be paid on mandatory assignment and reimbursed on the basis of fee-for-service, according to a negotiated fee schedule. Group practices may choose capitation.

Financing: The program is financed primarily through a federal dedicated tax on personal income and through corporate taxes. Additional sources of revenue include state and federal contributions that approximate the governments' current health expenditures and increases in cigarette and alcohol taxes. All tax increases are earmarked for health care, and all revenues are to be placed in a national health care trust fund. Most individuals would pay less or about the same amount through the tax system for expanded benefits than what they are currently paying through premiums and other out-of-pocket costs.

Financing Plan and Spending Estimates for the
NASW National Health Care Plan

The attached charts represent projected health care costs by revenue source and projected health care spending under the NASW plan for a family of four and for senior citizens. These projections and spending estimates were done by a tax economist with a well-respected accounting firm.

The projected health care spending from different revenue sources and the estimates for health spending for families and senior citizens are based on existing data. The sources for this data are described in the *Explanation of Data Sources and Estimates.*

Projected Health Care Spending By Sector (1991)

This chart shows the revenue sources for the NASW National Health Care Plan. The primary sources are:

Employers

o Imposes 6% payroll tax earmarked for health care
o Maintains current 1.45% health insurance (Medicare) payroll tax (employer share); eliminates the current wage cap
o Increases top corporate income tax rate from 34% to 39% for businesses with more than $75,000 in profits; increase earmarked for health care

Non-elderly Individuals

o Personal income tax increase earmarked for health care; tax rates changed from 15-28-31 to 20-31-39
o Maintains current 1.45% health insurance (Medicare) payroll tax (employee share)

Elderly Individuals

o Personal income tax increase earmarked for health care; tax rates changed from 15-28-31 to 20-31-39
o Medicare Part B premiums plus $25/month for those above 120% of poverty
o Increase tax on the taxable portion of social security benefits from 50% to 85% for those with incomes above $8,000 (individuals)/$16,000 (couples)

State and Local Governments

o Current level of spending for Medicaid and other public programs related to health; plus small increase in contribution

Federal Government

o Current level of spending for federal share of Medicaid, Medicare, other health programs, and employee health insurance

Other Sources

o Increase tax on alcohol ($.45/ounce) and cigarette ($.40/pack) products

The *Projected Health Care Spending By Sector* chart is similar to the one prepared for the Russo bill. In comparing the Russo estimates to those of the NASW plan, it is important to note that the NASW plan calls for $742 billion in health care spending for 1991. This estimate is approximately $76 billion more than the Russo estimate in terms of 1991 dollars. The reason for the differences are: the NASW plan covers more benefits and the NASW cost estimate does not consider reflect as high a level of savings in the first year of implementation as used in the Russo estimate.

Spending Estimates for Families and Senior Citizens

Under the financing scheme for the NASW National Health Care Plan, everyone would eliminate almost all out-of-pocket health care spending, since almost all of their health care needs will covered under this plan. Out-of-pocket health care spending will be replaced, in part, with taxes on personal income, a modest payroll tax, and for seniors a tax on a portion of Social Security benefits and the continuation of a Medicare Part B premium. The tax on alcohol and cigarettes has also been factored in. Our data shows, however, that 80% of all families will spend with the tax increase significantly less or about the same as they now spend on their out-of-pocket health costs, including premiums, copayments, deductibles, and coinsurance. Even families with average incomes of $82,200 will only be paying a tax that reflects a modest increase ($465) over what they now spend out-of-pocket. Only the wealthiest families with incomes over $322,000 will pay considerably more -- as it should be.

Our data for senior citizens shows that 80% of all individuals and 60% of married couples will spend with the tax increase (personal income plus the Social Security tax) and the Medicare Part B premium significantly less or about the same than they now spend on their out-of-pocket health care costs, including premiums, copayments, deductibles, and coinsurance.

We have gotten some preliminary questions concerning the tax estimates for senior citizens in comparison to the family data. Among certain income levels it appears that seniors will be paying more in taxes than families. The difference in the tax estimates between families and seniors reflect different deductions for families as compared to individuals and different rate schedules and deductions allowed between singles and married couples. In addition, it is important to remember that more than any group seniors are gaining the largest new benefit -- coverage for long-term care. The cost of this benefit is considerable, and will result in huge savings in many sectors of the economy and which cannot be adequately calculated.

It is also important to keep in mind that estimating health care spending under a single-payer system is a difficult task, and experts differ widely on how this should be done. There is no question that efforts to calculate spending estimates will change as we refine our methodology. For further information on the sources and the basis for calculating the estimates, see the *Explanation* that accompanies the charts.

January, 1992

Projected Health Care Spending by Sector
(1991 levels; billions of dollars)

Sector	Current	NASW Bill	Change	Explanation
Business	**197**	**239**	**42**	
Employee Health Insurance	144	0	-144	Eliminated
HI Payroll Taxes (Employer Share)	33	194	161	Increase by 6 percentage points, no wage cap
Job Related Medical Costs (Workers Comp)	18	18	0	Retained
In-plant Health Services	2	2	0	Retained
Corporate Income Tax Rate Increase	--	15	15	Top rate up from 34% to 39% for business with more than $75,000 in profits; alternative minimum tax rate up from 20% to 23%
Retiree Health Maintenance of Effort	--	10	10	Maintain current effort
Non-Elderly	**160**	**168**	**8**	
Out of Pocket Payments	87	14	-73	No out-of-pocket expenses for covered services, except for minimum expenses for nursing home care services
HI Taxes (Employee Share)	39	40	1	Current 1.45% retained, extended to all workers
Private Insurance	34	--	-34	Eliminated
Personal Income Tax Rate Increase	--	98	98	20-31-39 rate structure (up from 15-28-31); alternative minimum tax rate up from 24% to 27%
Repeal Medical Deduction	--	2	2	Eliminated
Increase Alcohol & Tobacco Taxes	--	13	13	Increase to $.45/ounce and $.40/pack, respectively

Projected Health Care Spending by Sector (Continued)
(1991 levels; billions of dollars)

Sector	Current	NASW Bill	Change	Explanation
Repeal Child Health Credit	--	1	1	Eliminated
Elderly	**100**	**77**	**-23**	
Out of Pocket Payments	66	14	-51	No out-of-pocket expenses for covered services, except for minimum expenses for nursing home care services
Private Insurance	22	0	-22	Eliminated
Medicare Part B Premiums	12	20	8	Increase of $25/month (above current law premium) for those above 120% of poverty
Added Tax on Social Security Benefits	0	17	17	85% of benefits taxed above incomes of $8,000 (individuals)/$16,000 (couples)
Personal Income Tax Rate Increase	0	23	23	20-31-39 rate structure (up from 15-28-31); alternative minimum tax rate up from 24% to 27%
Repeal Medical Deduction	--	1	1	Eliminated
Alcohol & Tobacco Taxes	--	2	2	Increase to $.45/ounce and $.40/pack respectively
State and Local Government	**108**	**108**	**0**	
Medicaid & Other Public Programs (includes public health)	82	86	4	Small increase in current effort
Employee Health Insurance	22	0	-22	Eliminated
HI Taxes (Employer Share)	4	22	18	All workers covered; rate up 6 pct. points; no wage cap

Projected Health Care Spending by Sector (Continued)
(1991 levels; billions of dollars)

Sector	Current	NASW Bill	Change	Explanation
Other Private (Charity etc)	**20**	**20**	**0**	
Federal Government	**130**	**130**	**0**	
Federal Share of Medicaid	52	--	-52	Eliminated
General Revenue Share of Medicare	35	--	-35	Eliminated
Other Health Programs	33	--	-33	Eliminated
Employee Health Insurance	10	--	-10	Eliminated
Maintain Current Effort	--	130	130	Maintain current effort
Total Health Care Spending (Services & Supplies)	**715**	**742**	**27**	

Note: For basis of calculations, see "Explanation of Data Sources and Estimates"

January, 1992

Changes In Taxes and Average Health Care Spending for a Family of Four Under NASW Plan (1991 Income Levels)

Income Level	Average Income*	Total Out-of-Pocket Health Care Costs Under Present Law	Tax Increase Under NASW Plan**	Change in Average Out-of-Pocket Health Care Costs Under NASW Plan***	Net Change in Cost Under NASW Plan****
Lowest 20 percent	$ 12,700	$1,050	$ 126	$ (924)	$ (798)
Second 20 percent	26,800	1,650	736	(1,452)	(716)
Third 20 percent	39,100	1,930	1,351	(1,698)	(347)
Fourth 20 percent	54,000	2,130	1,963	(1,874)	89
Next 15 percent	82,200	2,470	2,639	(2,174)	465
Next 5 percent	322,600	3,460	12,799	(3,045)	9,754

Notes:
1. All figures are for non-elderly families of four.
2. Figures in parentheses indicate reduction.
3. Out-of-pocket health care costs under present law include premium payments, copayments, deductibles, and coinsurance, but does not include taxes.
4. For basis of calculations, see "Explanation of Data Sources and Estimates"

* Tax and health care cost figures are for families with stated income levels, which are the averages for the portions of the income distribution described in the first column.
** Earmarked for health care spending.
*** Current out-of-pocket costs that will be covered under the NASW plan.
**** Difference between previous two columns.

January, 1992

Changes In Taxes and Average Health Care Spending for Senior Citizens Under NASW Plan (1991 Income Levels)

Single Households

Income Level	Average Income*	Out-of-Pocket Health Care Costs Under Present Law	Tax Increase Under NASW Plan**	Change in Average Out-of-Pocket Health Care Costs Under NASW Plan***	Net Change Under NASW Plan****
Lowest Fifth	$ 4,626	$ 492	$ 27	$(413)	$ (386)
Second Fifth	7,459	775	30	(651)	(621)
Middle Fifth	10,318	926	42	(476)	(434)
Fourth Fifth	15,657	1,094	733	(617)	116
Highest Fifth	35,435	1,165	2,375	(677)	1,698

Married Couples

Income Level	Average Income*	Out-of-Pocket Health Care Costs Under Present Law	Tax Increase Under NASW Plan**	Change In Average Out-of-Pocket Health Care Costs Under NASW Plan***	Net Change Under NASW Plan****
Lowest Fifth	$ 9,798	$1,811	$ 59	$(1,521)	$(1,462)
Second Fifth	17,500	2,910	106	(1,241)	(1,135)
Middle Fifth	25,626	2,957	1,360	(1,281)	79
Fourth Fifth	38,216	3,070	2,400	(1,376)	1,024
Highest Fifth	82,300	3,824	3,857	(2,009)	1,848

Notes:
1. All figures are for individuals age 65 or over.
2. Figures in parentheses indicate reduction.
3. Out-of-pocket health care costs under present law include premium payments, copayments, deductibles, and coinsurance, but does not include taxes.
4. For basis of calculations, see "Explanation of Data Sources and Estimates"

* Tax and health care cost figures are for families with stated income levels, which are the averages for the portions of the income distribution described in the first column.
** Earmarked for health care spending
*** Current out-of-pocket health costs that will be covered under the NASW plan.
**** Difference between previous two columns.

EXPLANATION OF DATA SOURCES AND ESTIMATES

Chart 1 -- Projected Health Care Spending by Sector

The basic data for health spending by sector under present law came from two articles in the Winter,1990 issue of HCFA Review, "National Health Expenditures, 1989" and "The Burden of Health Care Costs: Business, Households, and Governments." The data in these articles is for 1989; for most items, they were inflated to 1991 levels using a general growth factor derived from the Congressional Budget Office (CBO) forecast of 1991 health spending. For Federal spending and tax programs, however, 1991 figures were drawn from the most recent budget documents.

Revenue estimates for the payroll tax and individual and corporate income tax rate increases, and the social security benefit taxation proposal in the NASW package were derived by extrapolating figures presented in the June, 1991 CBO publication, "Selected Spending and Revenue Options." For the payroll tax, the proportions paid by employees, government employers, and private employers were obtained from the above HCFA sources. For the individual income tax, an adjustment was made for the interaction with the benefit taxation proposal. The split between elderly and non-elderly was based on the last published IRS data with this information (Internal Revenue Service, Statistics of Income - 1986, Individual Income Tax Returns, 1989).

Estimates for the excise tax proposals also were based on extrapolations from figures in the CBO publication and on estimates of present law collections published by the Joint Committee on Taxation. The split between elderly and non-elderly was based on population shares of smokers and drinkers from the Statistical Abstract of the United States: 1991 (U.S. Bureau of the Census, Washington, D.C.). Estimates for the repeal of the medical deduction and child health credit were from the Joint Committee on Taxation's tax expenditure pamphlet.

The estimate for the retiree health maintenance of effort provision comes from a Lewin/ICF analysis of Senator Bob Kerrey's bill, the Health USA Act of 1991. The estimate for the part B premium increase comes from the materials prepared to explain the Russo bill, H.R. 1300. The amount of out-of-pocket payments and total health spending under the proposal come from the Center for Health Policy Studies, Cost Analysis of the NASW National Health Care Proposal, 1990, although the latter figure reflects administrative cost savings estimated by NASW.

Chart 2 -- Changes Under NASW Plan in Taxes and Average Health Care Spending, for a Family of Four

The calculations in this chart are based on a spreadsheet model developed by Robert McIntyre, Director, Citizens for Tax Justice, who estimated average income and deductions by type within portions of the income distribution so that income tax liability under present law and the proposal could be calculated. The estimated tax increases

under the proposal also include the effect of the excise tax proposals, as estimated from the distributional data in the June, 1990 CBO publication, Federal Taxation of Tobacco, Alcoholic Beverages, and Motor Fuels.

McIntyre also extrapolated Current Expenditure Survey figures on out-of-pocket health costs by income level to 1991 levels. Figures for savings under the proposal are based on the percentage reduction in out-of-pocket payments shown in Chart 1.

Chart 3 -- Changes Under NASW Plan in Taxes and Average Health Care Spending, for Senior Citizens

Average income by quintile is based on the 1989 figures on p. 1198 of the Ways and Means Committee 1991 Green Book, adjusted for income growth. Tax savings calculations assume that adjusted gross income plus nontaxable social security benefits equal total income; social security amounts were estimated from information in the Green Book. Itemized deductions were assumed to be 15% of income. Excise tax impacts were assumed to be two-thirds of the impact on families of four.

Health cost figures were calculated in the same way as for Chart 2 and reflect the impact of the increase in part B premiums under the proposal.

26 September 1992

Health Resources & Access Task Force
State Capitol
Juneau, AK 99801-1182

Dear Sen. Duncan, Rep. Ellis and members of the Task Force:

My name is Dr. Patricia G. Conners-Allen. I am a Chiropractic Physician in private practice in Juneau. I would like to thank you for the opportunity extended to the Alaska Chiropractic Society to address you today.

As we all know, the cost of health care has risen considerably over the past years and has become a luxury that not all can afford. The statistics indicate that approximately 90,000 Alaskans are uninsured. This scenario presents many facets for this Task Force to review and, therefore, many recommendations to offer.

I would like to make reference to certain areas of the "Guiding Principles" as outlined by your group. Your Preamble specifically states that "Health care costs can best be contained by an educated public, committed to wellness." and that "A basic level of health care will be defined by the task force to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthful lifestyles.". We believe that input from the chiropractic profession will enable you to achieve these goals.

Chiropractic care has been proven to be a cost effective method of treatment for certain neuromusckuloskeletal problems. The role of the chiropractic physician in the realm of preventative injury and rehabilitation has also proven to be one of major importance. The chiropractic physician has extensive training in the arena of biomechanics of the human body and applies said knowledge when dealing with an injury or problem presented. When appropriate, the chiropractor will refer to allied health care providers.

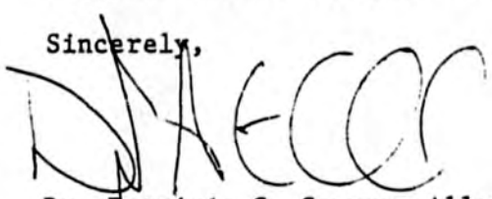
The current health care system in the State of Alaska has prevented the chiropratic physician from offering services that would aid in the cost effectiveness of care by: 1) the arbitrary and capricious workers' compensation regulations, 2) the elimination of chiropractic services from the medicaid program this fiscal year and 3) the lack of inter professional communication. These areas of concern I have mentioned are problematic for my profession when attempting to administer health care and then become a source of increased cost in health care.

According to your reports, out patient utilization patterns have not been focused on since in patient costs are the bulk of health care expenditures. We would suggest that more out patient data be collected and reviewed in order to identify the providers that will aid in establishing cost effective health care parameters.

In summary: We stongly suggest that chiropractic services be reviewed and included in the plan for health care coverage for every Alaskan. When establishing a regulatory and review panel, a representative from the chiropratic community should be appointed to allow input from the chiropractic profession into creating a comprehensive health care plan for Alaskans.

Once again, thank you for this opportunity to speak with you. I would be happy to answer any questions at this time or in the future.

Sincerely,



Dr. Patricia G. Conners-Allen
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Juneau, AK 99803
(907) 789-1812

ACSA

ALASKA ASSOCIATION OF ELEMENTARY SCHOOL PRINCIPALS
ALASKA ASSOCIATION OF SECONDARY SCHOOL PRINCIPALS
ALASKA ASSOCIATION OF SCHOOL ADMINISTRATORS

• ALASKA COUNCIL OF SCHOOL ADMINISTRATORS •
326 Fourth St, Suite 404 Juneau, AK 99801-1101 (907) 586-9702 FAX (907) 586-5879

Testimony via audio-conference

Health Resources and Access Task Force

October 23, 1992

I am Steve McPhetres, Executive Director of The Alaska Council of School Administrators, Representing over 500 school administrators across Alaska. I am pleased to be here this afternoon and to respond to the questions asked in the Sept. Memo " how the current health care system creates problems for us and or what recommendations we have for reforming the health care system.

In preparation for this presentation, we solicited information from school districts across Alaska. The responses represent a large portion of the student body and school personnel in Alaska.

As you know, one of the reasons we and other educational organizations have been lobbying hard for the past six years for an increase in the foundation formula value is because of the continued increase of cost of doing business in schools. One of the major contributors to this increased cost has been in the area of district health care costs.

To give you some examples of that increased cost: Fairbanks have had their insurance costs increased from $4,757,799 in 1989 to $6,559,400 for the district. in Kodiak, their increase in 1991 was 10%, 92-21% and this year 10.56%, in Nome their health care costs increased 15% in Fy91, Fy92-16% and 1993- 18%. Petersburg experiences and increase of 17% in 1992 but did not increase this year because of a negotiated cap on the district's portion Cordova has experienced a 14% increase in cost over the past three years and Alaska Gateway a 17.74% increase.

This is one reason we were so insistent that an increase to the value of

the instructional unit value was so important because the increases were being taken away from the instructional programs to cover this automatic increase.

Districts and employees have assumed cost containment measures. Health benefits are considered a negotiating item and consequently, the cost containment was discussed at the negotiating table. Some districts were able to cap the amount of premium paid by the school district leaving the remainder to be pick-up by the employee. In some cases employees by 25% of the premium. In one district during the negotiations process they ask their carrier to quote premium cost saving should the level of benefits decrease. These types of cost containment items could include an increase in the deductible, reduction of dental or vision benefits or decrease of the percentage amount paid on Major medical charges. Many districts have eliminated double coverage, however, not without creating difficulties with the employee union.

Several districts recommended aggressive pursuit of wellness programs such as exercise and physical fitness for all employees as an incentive for cost containment and possibly be in a position for a better bid price for insurance providers. Others recommended state wide health care plans, and employee participation in premium costs. Some district administrators surveyed felt that increased liability for medical care has a direct impact on the costs so perhaps we need to take a more aggressive look at liability limits. Effort to reduce or limit the rate of increase of medical costs would benefit employers and employees alike. The determination of the level of benefits and the funding of those benefits are best left at the local level.

Collectively, we believe in an affordable health care program for all Alaskans In order for this to occur there will have to be some compromise among the medical profession, insurance providers, attorneys, drug companies and other health care providers. The health of our employees, our children, the parents we work with contribute tot he success the child experiences in school and success in life.

Alaska Dental Society
3400 Spenard Road, Suite 10
Anchorage, Alaska 99503
(907) 277- 4675 • FAX: 274-2960

September 29, 1992

Nancy Cornwell, Project Director
Health Resources & Access Task Force
State Capitol
Juneau, AK 99801-1182

Dear Nancy:

Dr. Robinson asked me to send you this material. It is a transcript of the testimony she presented at Saturday's task force meeting. There is also information about direct reimbursement employee dental benefit plans - published by the American Dental Association.

Thank you for considering dentistry's input in the task force deliberations.

Sincerely,

Martha A. Reinbold
Executive Director
Alaska Dental Society

September 26, 1992 testimony before the Health Resources & Access Task Force

Hello - My name is Julie Robinson. I am a privately practicing dentist in Anchorage and the Secretary of the Alaska Dental Society. I will be president-elect of the society in 1993 and president in 1994.

Organized dentistry has a full agenda and I could spend time discussing our
---manpower shortage problems
---OSHA regulations
---Tort reform or lack thereof
---the continuing anti-amalgam and anti-fluoride campaigns....but, since time is limited, I would like to discuss dental benefits.

Traditional dental insurance, while it affords some patients the opportunity to have dental treatment, it is not without problems. Dentists are increasingly annoyed with companies...delaying and denying claims
...determining appropriateness of treatment
...telling us our fees are above "usual and customary," but <u>not</u> allowing us to examine the data they use to determine a "usual and customary" schedule.
...having exclusions for some treatments
...requesting x-rays and dialogue to justify x-rays

Dentistry has a solution that is simple, cost effective and benefits the employer and the employee.

Nationally, the health care industry is undergoing great change reflecting concerns over the rising cost of health care. Maintenance of the ideals of dentistry:
----freedom of choice
----quality of care, and
----fee for service is of paramount importance to the American Dental Association and its state and local affiliates nationwide.

Today I will present to you an innovative self-funded dental plan - Direct Reimbursement. Preferred by dentistry, Direct Reimbursement provides dental cost assistance to employees while protecting their right to be treated by a dentist of their choice

As an innovative approach to self-funding, Direct Reimbursement offers the flexibility of designing a plan and the simplicity of utilizing it. The design is determined by the employer or plan sponsor. Therefore, it can be tailored to meet the specific needs of the company and its employees.

While the ultimate design of the plan is up to the employer, in its pure form, Direct Reimbursement is a simple process. The employees or covered dependents go to the dentists of their choice, receive the necessary treatment and pay the dentist's fee directly to the dental office. The employee then presents proof of the dental expense to the employer and is reimbursed for all or part of the expense, depending on the benefit levels of the plan.

The level of reimbursement is based on the amount of dental expense not the particular category of treatment received.

A typical plan might reimburse the patient 100% of the first $100 spent annually for dental care, 80% of the next $500 spent, and 50% of the next $1,000 in dental expenses. This schedule would result in a $1,000 annual maximum dental benefit.

The variations on the concept are limited only by the degree of financial commitment the employer is prepared to assume. Many employers, who have no experience with a dental plan offer a modest benefit program to begin with and increase it as experience warrants.

Direct Reimbursement plans may involve some of the features included in traditional insurance plans such as waiting periods, deductibles and the inclusion of dependent coverage.

The reason why Direct Reimbursement works so well is because it recognizes that dental coverage is not insurance in the way that a medical benefit is. Employers, and in some cases employees, pay medical premiums so that they are insured against a catastrophic loss or prolonged illness. Even under a self-funded medical plan, stop-loss coverage is typically used to "insure" against large claims.

Dental plans do not require that type of safeguard because there is no need to insure costs that are predictable. Dental plans are payment assistance plans, designed to assist the employee by paying all or part of the expenses incurred in treatment, not to insure against its occurrence.

When compared to the features of other insurance products, it is clear that dental does not fit the model of an insured risk.

The insurance model is based on covering the insured against a loss from a major incident. The need for dental examinations, cleanings and other treatment is ongoing, not episodic or catastrophic. Such treatment, with the exception of emergencies is planned and scheduled.

In fact, there is only one feature that insurable risks have in common with dental treatment and that is the predictability of its occurrence and therefore the likelihood of its expense. It is this predictability, combined with minimal risk, that makes Direct Reimbursement such a logical design for a dental benefit plan.

In addition to its simplicity and low risk, Direct Reimbursement has many features which result in cost containment for the employer or other plan sponsor. Although the costs are predictable and easy to budget, under Direct Reimbursement there are no fixed premiums: an employer pays only for benefits used. This is an important cost-containment feature in a dental plan since dental care is a traditionally underutilized health benefit. In fact, fewer than 60% of Americans with a dental benefit see a dentist each year.

A Direct Reimbursement design encourages cost containment and careful use of the benefit. Employees view it as a dental benefit account and act as consumers. Employees do not, however, feel the compulsion to use their benefit dollars simply because they are available. Dentistry is usually a service that people seek only when they need it.

Through a Direct Reimbursement plan, an employer can also contain costs by eliminating the extra costs-typically associated with:

...third party profit
...insurance taxes, and
...commissions

The employer can, in fact, gain income from retaining and investing their own reserves.

In addition to its unique cost-containment features, Direct Reimbursement dental plans also have controls over any potential abuse. Like a traditional dental plan, a Direct Reimbursement plan may have built-in co-payments and an annual maximum.

The typical Direct Reimbursement plan with its payment up-front makes the patients more aware of the dentist's total fee and its relation to the treatment they have received. Further, patients have the freedom to choose a dentist whom they feel provides the best treatment and value for their benefit dollar.

An increasing number of employers are enjoying the benefits associated with offering a Direct Reimbursement dental plan. The employer is recognized as the benefactor of the plan. This is especially rewarding in a time when the cost of providing benefits is increasing and when most employees are not aware of the substantial monies an employer spends on those benefits.

One major advantage to employers is the plan's simplicity. This is reflected in a summary plan document which is typically only one page long and which contains no technical language. The benefit, expressed in terms of dollars, is easily read and understood by the employees. This results in less time taken up by explanations and complaints.

In addition, if problems do arise, local dental societies offer peer review services to settle differences between dentists and their patients. Local dental society peer review committees will hear cases involving quality and appropriateness of care and, in some cases, fee disputes. This service is available to Direct Reimbursement as well as insured patients and plan sponsors.

Another advantage to employers who offer a Direct Reimbursement plan is the ease of administration. All of the unnecessary paperwork and administrative details are eliminated along with the resulting increased administrative costs, employee complaints and patient frustration. The simplified plan documents and the streamlined administration reduce the time and paperwork required by the plan administrator. This, in turn, increases employee satisfaction and reduces the transactional costs of offering the benefit.

The employee and other patients also have advantages under a Direct Reimbursement plan. The primary benefit for patients is that they can go to the dentist of their choice and receive benefits for their dental treatment based on their individual needs and not on a contractual arrangement.

Regardless of the type of treatment needed, Direct Reimbursement allows for an equal amount of benefit per employee, since the benefit is expressed in terms of dollars spent.

Employees appreciate that there are no hidden surprises in the amount of coverage allowed for their treatment. The benefit is easily understood and calculated.

Dentists also appreciate a Direct Reimbursement plan since it allows patients to select them based on their ability and expertise rather than on their contractual agreements with third-parties. Direct Reimbursement also allows the dentists to diagnose, prescribe and treat patients based on their best professional judgement, without the influence of third party payers whose concerns may have little to do with quality of care.

The ADA offers assistance to employers interested in implementing a Direct Reimbursement plan. Materials are available to guide the plan sponsor through the steps of designing and enacting a plan. The Association can also help employers and other plan sponsors with an actuarial estimate of their costs under a proposed direct reimbursement dental plan.

Simplicity, Flexibility and Cost Containment - With Direct Reimbursement you **HAVE** a choice.

Direct Reimbursement is an innovative approach to self-funding employee dental benefits. It is strongly supported by the American Dental Association as a cost-effective way to provide a dental plan for employees while protecting their right to be treated by the dentist of their choice.

How it works

One of the most attractive features of a direct reimbursement dental plan is its simplicity of operation. Under a direct reimbursement plan, the employee and covered dependents visit the dentist of their choice, receive the necessary treatment and pay the dentist's bill directly to the dental office. The employee then presents a paid receipt or other proof of payment to the employer and is reimbursed for all or part of the expense, depending on the benefit levels of the plan.

Benefits are simply stated as a maximum dollar limit per year per eligible individual, or a percentage thereof. Reimbursement is based on dollar expenditures rather than on services incurred. Unlike conventional plans, there are typically no exclusions and few if any limitations on specific treatments or services.

Unlike medical costs, dental costs are small enough for an employer to keep the employees involved in selecting the provider, paying their own bills and making sure that the work is satisfactory. In other words, with direct reimbursement the group sponsor is placing the responsibility for the best use of limited dollars available on the employee. Additionally, employees are involved in the cost containment process with cost-sharing provisions such as annual maximums and co-payments.

Flexibility

The details of a direct reimbursement plan may vary widely depending on the level of benefits the employer wishes to provide. Some of the options to be considered in designing the plan include:

- employees only or employees and dependents
- individual or family maximums
- co-payment provisions
- annual benefit maximums
- immediate benefits or a waiting period for eligibility

Several examples of possible direct reimbursement benefit design. ıtrate this flexibility:

Plan A
100% of the first $200 of dental expenses
80% of next $1,000
total annual maximum benefit of $1,000 per individual

Plan B
100% of the first $100 of dental expenses
80% of the next $500
50% of the next $1,000
total annual maximum benefit of $1,000 per individual

Plan C
75% of $1,000 of dental expenses
total annual maximum benefit of $750 per individual

Plan D
50% of $1,000 of dental expenses
total annual maximum benefit of $500 per individual

The variations on the concept are limited only by the degree of financial commitment the employer is prepared to assume. Some employers have begun their plan by offering modest annual maximums to limit initial financial liability. Then, after analyzing a few years' experience with the plan, they often improve the benefit levels based on the past pattern of claim liability.

Administrative considerations

By removing the unnecessary administrative features associated with most dental plans such as detailed claim forms, treatment limits and exclusions, a direct reimbursement plan is generally well-suited for employer self-administration.

The only routine administrative actions are: 1) verifying patient eligibility; 2) calculating the benefit payment; 3) issuing the benefit check; 4) maintaining records of amounts paid to each employee; and 5) educating employees. Documents required to be filed with the federal government such as tax disclosure reports and summary plan descriptions may be prepared as required by qualified in-house staff or outside consultants.

As with all forms of benefit plans, it is suggested that an employer consider retaining the services of an experienced attorney, accountant or benefits consultant in order to establish an appropriate plan design and effective administrative procedures. The employer may also elect to have a third party administer the direct reimbursement plan if desired, realizing that this will add to the cost of the plan.

Available to small groups

Both large and small employers have instituted direct reimbursement programs to assist the employees in meeting the costs of their dental care. Companies with 2 to 18,000 employees have enjoyed cost savings with this type of plan. With direct reimbursement, even a small employer can individualize the plan to suit the needs of the employees while tailoring the benefit provisions to satisfy the company financial and administrative concerns.

Cost considerations

A direct reimbursement dental plan gives the employer immediate control of the level of benefits offered. By including cost-sharing measures in the plan design, the employer is protected against discretionary utilization and wide fluctuations in benefit costs.

Unlike conventional insured programs, where the employer's premium rate frequently is determined by the pooled experience of many groups, the employer's expense for a direct reimbursement program is based only on his own employees' experience. In addition, employer funds that would typically be held in reserve and invested by a third party are held and invested by the employer to generate additional income which may be applied against the cost of the program.

Perhaps the most clearly discernable savings to the employer is in the administrative costs of a direct reimbursement plan. The simplification of claim forms and other extraneous paperwork reduces much of the transactional cost of administration. Further, since a direct reimbursement program is not considered "insurance," there is no state premium tax liability. Finally, a decision to self-administer the program will eliminate the charges usually made by a third party for marketing costs, profit and risk margins.

For more information

One of the most important features of a direct reimbursement plan is the employees' freedom to choose their own dentist without restrictions. This benefits the employer in that there is no legal liability for directing the employee to a particular dentist or clinic for treatment if any problem should arise.

This guide was prepared to provide a brief overview of the direct reimbursement approach to providing dental care benefits. Ultimately, the decision to implement a direct reimbursement program, and the specific details of your plan, is yours. Many state and local dental societies, as well as a number of benefits consultants across the country, are knowledgeable in this area and may be of specific assistance to you. The American Dental Association's Council on Dental Care Programs has a directory of some of the Third Party Administrators in your area who may be able to assist you.

In addition, the Council on Dental Care Programs will provide to interested employers a kit which details a step-by-step process for writing and administering a direct reimbursement plan. If you would like a copy of this kit, or if you have any questions not answered in this guide, the Council staff is available to assist you. Please contact:

American Dental Association
Council on Dental Care Programs
211 East Chicago Avenue
Chicago, Illinois 60611-2678

(312) 440-2746

Kit request form

Yes, I want to tailor my own dental benefit plan. Please send me additional information on how my group may set up a self-funded direct reimbursement dental benefit.

_____
Name

_____
Title

_____
Company or Organization

_____
Address

_____
City, State, Zip Code

( ) _____
Telephone number

_____
Number of Employees

Do you currently have dental coverage? Yes ☐ *No* ☐

Detach at the perforation and mail.

ALASKA EMERGENCY MEDICAL SERVICES ASSOCIATION

CONSIDERATIONS

* Prehospital care, or Emergency Medical Services (EMS), is a large and vital component of the health care system.

* The term "access" has different interpretations as it pertains to the provision of health care.

* The prehospital system understands access to be the ability to contact a responder and have a direct route into the rest of the health care system in case of emergency.

  It includes communications (radios), and quick response by a trained technician. It also includes transportation to the nearest medical facility.

* A major factor impacting the outcome of a critically ill or injured patient is time to definitive care. Initial resuscitation and stabilization by prehospital providers, followed by rapid transport to a higher level of care, is often vital to a positive outcome. It follows then, that efficient operation of an EMS system is essential.

* EMS is a comprehensive system and a member of the health care coalition. 45,000 patients a year enter Alaska's health care system through EMS. We all know that EMS saves lives, but sometimes forget that timely, skilled emergency response and intervention also reduces long term disability and overall health care costs. Those savings impact not only the patient and his family but the insurance industry and, often, the government entity that would have financed long term care.

EMS
An Alaskan tradition:
Neighbor helping neighbor

* Alaska's EMS system is composed predominantly of volunteers. Evaluation of the health care system must not overlook the benefit received from, or the system impact made by volunteer providers. One must also consider the profound disruption to services that will occur should their support decline any further.

* In rural settings, the prehospital provider may be the only individual in town with medical training. The responsibility of that role is substantial. The provider is responder, source of treatment, nurse until transport, and often medevac escort. Weather being what it often is in Alaska, these people sometimes are the only medical care for many hours, and even days.

* Access to well trained personnel, essential equipment and facilities in rural and isolated settings must not be forgotten when rural health care analysis is reviewed. It certainly must not be overlooked if such review could impact on, or cause, a statewide health care reform.

* There are currently 4,325 volunteer EMS providers across the state. Six times as many as physicians living in Alaska; twice as many as registered nurses, including public health nurses, living in Alaska.

* EMS is actively involved in prevention training programs in nearly all communities throughout Alaska. Prudent heart living, CPR, blood pressure and cholesterol checks, child injury prevention, safety belt and helmet use, and programs aimed at reducing drinking and drugs, are commonly taught by those who see those victims first, the community EMTs.

* The EMS system is the lead agency for Alaska's Trauma Register. Given the fact that data seems to be at the heart of many proposals and recommendations, it important that this crucial data collection system should be maintained.

* Access must include a coordinated, widely recognized communications system when help is needed. Universal access is 9-1-1 is important. Many areas of Alaska still do not have that luxury.

* The Alaska EMS system was recently the subject of a formal review process through the National Highway Traffic Safety Administration. This Technical Assistance Team provided a lengthy and valuable evaluation, report and recommendation. Significant in their findings was the need to secure a steady funding base for this vital program.

RECOMMENDATIONS

1. The Alaska State Legislature should fund the Department of Health and Social Services for EMS programs to provide assistance in general and specialized training for rural prehospital and rural hospital based providers. This should include EMS training and continuing education at all EMS levels.

2. The legislature should revisit the issue of dedicated funds and propose, via ballot, the Alaska Constitution be changed to allow for dedicated funding of basic programs.

3. The legislature should ensure continued funding of the Alaska Trauma Register.

4. The legislature should facilitate development of statewide consensus guidelines or standards for specialized facilities such as trauma centers.

5. The administration and the legislature should support, through ongoing and dependable funding, those EMS volunteers and ambulance services serving Alaskans and our visitors.

6. The State of Alaska should fund EMS research and demonstration programs and encourage investigation of EMS problems unique to rural areas and providers.

7. The legislature should revisit EMS statutes and design them to support the cost of an effective volunteer based EMS system.

8. The legislature should establish special funding programs targeting EMS resources to rural areas.

9. The legislature should appoint a special committee to investigate and propose special incentives to sustain Alaska's volunteer provision of emergency medical care. In conjunction, investigate and craft legislation that would encourage volunteer participation in Emergency Medical Services.

10. The legislature and administration should recognize that EMS is an important component of any comprehensive health care system and should be included in all aspects of planning.

NORTON SOUND HEALTH CORPORATION TESTIMONY
SUBMITTED TO THE HEALTH RESOURCES AND ACCESS TASK FORCE
September 26, 1992

Norton Sound Health Corporation serves a region roughly the size of the State of Oregon (25,000 sq. miles), with 15 villages and the City of Nome. Residents must commute by air to access hospital services in Nome. Our hospital is staffed by 6 family practice practitioners - all of whom share a village field schedule. Services of a more specialized nature can be received by travelling to Anchorage - which is 549 air miles or $580 round trip by commercial jetliner.

Because NSHC was never a federally designated Service Unit, nor has its ownership of facilities been with the federal government, we are in the legal position of having to rely on the State Medicaid and Medicare system for reimbursement of costs for eligible beneficiaries -- this differs from other federally owned service units in Alaska. Norton Sound relies on revenues from its IHS contract for Native beneficiaries (this funding level has been based on the historical cost of care for Natives without alternate means of payor i.e. M&M, health insurance, etc.), revenues from billing third party payors for Natives and Non-Natives and more recently revenues derived from operating a Nursing Intermediate care facility to fund our entire operation. Inpatient, Outpatient and Nursing Home Care are located in one facility in Nome. This approach towards a more comprehensive and expanded service delivery system is our best way to reach some level of cost containment for a small rural facility serving such a small population (8000) over a geographically large and isolated area.

Our main concerns regarding the Task Force's work to date are:
1) Is there a commitment to recognize the geographical size of the State, the lack of transportation infrastructure, and the cost of doing any type of business, and the small dispersed population as just plain reality for the State of Alaska -- if so, comparisons to the costs in the lower 48 are like comparing apples to oranges until the state can affect some of these variables. Yes labor costs are higher, yes transportation therefore goods and services are higher, yes facility construction and operation/maintenance costs are higher ---- all these costs are beyond the control of hospitals and must be recognized as such. Also, the population is not there in many sites to meet the criteria of what some may consider to be the "most economical or feasible" yet is the state system going to be designed such that care will not be available to someone just because they live in Nome and not in Anchorage or Fairbanks?

2) We would be concerned as to how the new entity which will oversee cost containment, access and pooling initiatives will fit into the current system-i.e. the Medicaid Rate commission, etc. Will there be rural representation?

3) The same concern goes for a the establishment of a global spending limit---will this be sensitive to the particularly high costs of doing business in Rural Alaska where no alternatives exists for the recipient population?

4) As far as defining 'excess capacity' - this again poses a special problem in areas where no alternatives exist---there are times when our facility exceeds capacity and other times when occupancy is below standards - without alternatives available to the population which are reasonably accessible in terms of distance, time and travel costs, it seems that this again just has to be a reality that we accept within the health delivery system.

5) As a community hospital, and the only available resource to our uninsured population, NSHC has been concerned with non-payment of services as a factor of costs. We would like to submit separate written testimony on this at a later date, especially as it relates to foreign visitors from the Soviet Union who have no available means of payment.

Nancy Cornwell, Project Director
Health Resources And Access Task Force
State Capitol, Juneau AK 99801-1182

Dear Nancy,

In August 1991, at the Tanana Valley Fair, the Tanana Valley League of Women Voters held a strawpoll on several issues. Our Questions on Health Care and the responses tallied follow.

Should health insurance pay for preventive health measures such as prenatal care, well child care, annual physicals, life-style counseling, mammograms and the like?

YES	1073	NO	156
%	87.3		12.6

Should the government be responsible for providing health insurance for those who can't afford to buy it, or who are not covered by their employer?

YES	787	NO	427
%	64.8		35.1

Should the Federal Government provide basic health services directly to the citizens?

YES	732	NO	421
%	63.4		36.5

With only about 1200 voters participating, this is not a very big sample, but it does give a clue about those particular questions.

Thank you for the opportunity to present the views of League in Alaska.

Sincerely,

Betty

Elizabeth F. Elsner, M.D.
Health Study Chair
League of Women Voters
of Alaska

July 23, 1992

League *Adopts*

The diagnosis is in. The League of Women Voters supports stringent cost-control measures in the health care industry, universal access to health care and a standard definition of what constitutes basic quality care for Americans. With a position on health care policy now in place, League members will begin lobbying Congress and state legislatures in support of fundamental reform of the nation's health care system.

Grounds for Consensus

The LWVUS position represents the culmination of the first phase of a two-year study of health care financing and delivery in the United States. It was reached after six months of thoughtful analysis, discussion and member agreement. Some 30,000 League members in 821 Leagues in all 50 states took part in the decision making.

"The League's involvement in this issue is prime evidence that mainstream Americans are very concerned about this country's health care crisis," League President Susan S. Lederman said. "Our current health care system is unsustainable. Citizens want their leaders to end the partisan posturing and get on to the practical solutions to this pressing national problem."

Support for universal access was nearly unanimous within the League. Ninety-nine percent of participating Leagues said that a basic level of quality care should be available to every U.S. resident. Among the other findings:

- 96 percent said that *efficient and economical delivery* of care should be a high priority.
- 94 percent said that providing health care at an *affordable* cost should be a high priority.
- 91 percent agreed that *equitable distribution* of health care should be a high priority.

In the controversial cost-control area, the Leagues endorsed strong measures:

- More than two-thirds called for *independent review* of treatments.
- Nearly three-quarters said that consumers should be responsible for paying *deductibles* and making copayments.
- Three-fifths said that *managed care* should be used.
- Three-fifths said that ensuring a reasonable national *total for health care expenditures* should be a high priority.
- 94 percent supported regional planning for *allocation of personnel, facilities and equipment.*
- 96 percent believed that excessive *administrative costs* must be curtailed.

"The League's thoughtful process and careful study led to a sound conclusion that cost control and universal access are necessary components of a health care system that works," said Mary Ellen Barry, LWV board member and chair of the League's national health care study.

The League position defines "universal access" as a health care system guaranteeing that all U.S. residents will receive quality health care, regardless of their ability to pay. In other areas, the League supports malpractice reform, better geographic allocation of medical resources, training for health care professionals and establishing insurance pools for small businesses and organizations.

A Political Issue

The League position comes at a pivotal time when health care reform is gaining momentum in Washington. While the League will not endorse or oppose any legislation as a whole until the second phase of the health care study is completed in 1993, League members will use the position to evaluate the merits of the major proposals being advanced in Congress and by the President.

"For millions of Americans, health care is too expensive or unavailable," Lederman said. "We can no longer manage with our makeshift system. It fails too many Americans. It is time for Congress to vote for fundamental reform."

Dozens of health care initiatives have been proposed in Washington, with most following one of three approaches:

- single payer — similar to the Canadian model where government is the sole source of health insurance;
- play-or-pay — where employers provide employees and their families with health insurance or pay a tax to fund a government program that provides coverage to the uninsured;

[redacted]

Health Care Position Statement

Announced by the LWVUS National Board, April 1992

GOALS

The League of Women Voters of the United States believes that a minimum basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology and a reasonable total national expenditure level for health care.

MINIMUM BASIC LEVEL OF QUALITY CARE

Every U.S. resident should have access to a minimum basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority.

EQUITY ISSUES

The League believes that health care services could be more equitably distributed by:

- allocating medical resources to underserved areas,
- providing for training health care professionals in needed fields of care,
- standardizing basic levels of service for publicly funded health care programs,
- requiring insurance plans to use community rating instead of experience rating,
- establishing insurance pools for small businesses and organizations.

COST CONTROL

The League believes that efficient and economical delivery of care can be enhanced by such cost-control methods as:

- the reduction of administrative costs,
- regional planning for the allocation of personnel, facilities and equipment,
- the establishment of maximum levels of public reimbursement to providers,
- malpractice reform,
- the use of managed care,
- utilization reviews of treatment,
- mandatory second opinions before surgery or extensive treatment,
- consumer accountability through deductibles and copayments.

ALLOCATION OF RESOURCES TO INDIVIDUALS

The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

- incremental reform of the current system.

In the House, the Ways and Means Committee and the Energy and Commerce Committee are seeking to move legislation quickly. Senate leaders also would like to move quickly. However, the number of competing reform proposals and the lack of consensus on such a complex, politically charged issue could make passage of fundamental health care reform legislation more likely in 1993.

WHAT YOU CAN DO

Urge elected officials at all levels to work for a system of health care providing universal access to a basic level of quality care and stringent cost controls in the health care industry. Tell the President that his proposals are insufficient because they don't provide for universal coverage and tough cost controls. ■

AND NOW PHASE TWO...

The national board has recommended an extension of the second phase of the League's two-year comprehensive health care study into the next biennium for final decision by delegates to the League's national convention in June. The second phase will examine financing and administration issues. Look for important study information and a direct member-agreement report form in the September/October issue of *The National Voter*. ■

LEAGUE OF WOMEN VOTERS OF THE UNITED STATES
HEALTH CARE POSITION STATEMENT

GOALS

The League of Women Voters of the United States believes that a minimum basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology and a reasonable total national expenditure level for health care.

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Every U.S. resident should have access to a minimum basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority.

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The League believes that health care services could be more equitably distributed by:

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* standardizing basic levels of service for publicly funded health care programs,
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* establishing insurance pools for small businesses and organizations.

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ALLOCATION OF RESOURCES TO INDIVIDUALS

The League believes that the ability of a patient to pay for services should not be a consideration in the allocation of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

This position is based on Phase 1 of the League's study of the U.S. health care system. Phase 2 of the health care study, which will conclude in January 1993, will address issues of financing and administration.

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HEALTH CARE STUDY REPORT January 24, 1992

In Anchorage the members have studied and will reach consensus by mailing in the questionnaire which was published in their Voter, to be retuned by January 31, 1992. Blanche Stephens attended the third meeting of the State Health Care and Access Task Force. Pat Redmond was at the presentation of Hawaii's health care system by Dr. John Lewin, Director of the Hawaii Department of Health and is sharing information from that.

Kenai held its consensus meeting January 18, 1992 at a brunch at Marge Hays home. There had been numerous articles on the issues published in the Kenai Voter.

In Sitka, Ruth McKenzie shared information she had obtained at work at the hospital with four active members of that league. They will reach consensus before the deadline February 10, 1992.

Connie Monroe reported that Juneau League had a forum attended by 40 people, although only 6 League members turned in consensus forms before leaving. AARP, the Juneau schools and retired teachers had helped involve the public. Speakers included Sen. Duncan, who chairs the Legislative Health Resource Task Force, Dr. Patricia Collins-Allen, a health care consultant, and Deputy Commissioner of Health and Social Services, J. Livey. Betsy Brenneman of the local PBS station moderated the meeting.

Ketchikan studied the health care issues with a talk on the Canadian system by Dr. Peter Rice, and by viewing videos of the subject moderated by Walter Cronkite and Dr. C.Everett Koop. They used two meetings to reach consensus on the issues and had a good turn-out of seven to nine members at each meeting.

TVLWV held its consensus meeting on November 9, 1991. Fourteen members addressed the questionnaire after a year of meetings and study on the issues. The board approved the consensus and comments collated by Ruth Benson and sent to LWVUS.

National League will analyze the responses from local leagues, formulate a position, and present it for adoption to their board next spring, when it will be announced. Phase II will start in August with articles on health care policy in National Voter.

Betty Elsman

5

HEALTH CARE STUDY CONSENSUS REPORT

Anchorage: Committee members attended meetings of the Older Persons Action Group, the Health Care Resources and Access Task Force, and a lecture by John Lewin on Hawaii's Health Care System. Consensus questions were distributed to members via their newsletter.

Ketchikan: Held two meetings to come to consensus on health care with 7 and 9 members attending. Their comments are attached.

Juneau: Members took part in a forum, described in the attached sheet. Some members answered a questionnaire at the forum, others received them by mail to return. Nine members participated.

Kenai: The January meeting was held to reach consensus on the Health Study questions. A guest speaker, Jerry Near, is an insurance businessman, presently serving on borough and statewide committees looking into an alternative insurance program. He blamed ineptness of insurance companies for the fact that those who need insurance most are being left out. He discussed suggestions such as standardizing forms, credits for non-smokers and others with healthy life-style habits.

Sitka: No report on consensus, but they did meet in small groups to discuss the issue.

Tanana Valley: Met in November to reach consensus after several meetings on the issue. 15 members participated.
TVLWV felt that a minimum basic level of care for all U.S. residents, with quality standards of care, choice of type of practice for providers, efficient economical delivery of care, and a reasonable total national expenditure level for health care were all high priority.
Minimum basic care should include prevention of disease, health promotion and education and primary care as highest priority. Acute care, longterm care that encourages home care,and mental health care were considered high priority. Dental, vision and hearing care were given lower priority, but these and mental health should be stressed in Prevention and Health Education.
We agreed on most of question III, but advocated a universal tax paid Health and Illness Care. We did not reach consensus on community rating vs. experience rating for insurance companies.
On question IV, cost control methods, we agreed on all but aa) and gg), but urged enforcement of regional planning and establishment of maximum level of public reimbursement to providers if universally applied.
In V, criteria for rationing health care should not include ability of patient to pay, nor age nor life expectancy of the patient. We agreed that urgency of medical condition, expected outcome of treatment, cost of procedure, duration of care, patient and family wishes, and quality of patient's life after treatment should be taken into account.

LWV of Ketchikan

State: AK File #: AK 082

CONSENSUS QUESTIONS

I. What should the goals of health care policy in the United States include?

(Check "High Priority," "Lower Priority," "Not a Priority," or "No Consensus" for each item in Question I, according to the value your League places on that goal. It is permissible to choose "High Priority," "Lower Priority," etc. for as many as necessary.)

	High Priority	Lower Priority	Not A Priority	No Consensus	
a)	x				Minimum basic level of care for all U.S. residents
b)	x				Health care at an affordable cost to the individual patient
c)	x				Quality standards of care
d)	x				Consumer choice in the selection of health care providers
e)		x			Choice for providers in the selection of type of practice (i.e., traditional single or group practice, HMOs, etc.)
f)	x				Efficient and economical delivery of care
g)	x				A reasonable total national expenditure level for health care
h)	x				Equitable distribution of health care services
i)		x			Advancement of medical research and technology
j)					Other

II. If a goal of U.S. health care policy is a minimum basic level of care for all U.S. residents, what should that minimum basic level include?

(Check "High Priority," "Lower Priority," "Not a Priority," or "No Consensus" for each item in Question II, according to the value your League places on that choice. It is permissible to choose "High Priority," "Lower Priority," etc. for as many as necessary.)

	High Priority	Lower Priority	Not A Priority	No Consensus	
k)	x				Prevention of disease
l)	x				Health promotion and education
m)	x				Primary care
n)	x				Acute care
o)		x			Long-term care
p)		x			Mental health care
q)		x			Dental care
r)		x			Vision care
s)		x			Hearing care
t)			x		Other ~~Extraordinary measures~~

LWV of Ketchikan

State: AK File #: AK 082

III. If a goal of U.S. health care policy is equitable distribution of health care services, what would contribute to achieving this goal?

(Check "Agree," "Disagree," or "No Consensus" for each. It is permissible to agree or disagree with more than one item.)

	Agree	Disagree	No Consensus	
u)	x			Requiring insurance companies to use community rating instead of experience rating
v)	x			Allocating services to medically underserved areas
w)	x			Providing for training of health care professionals in needed fields of care
x)		x		Mandating uniform service levels for all publicly funded health care programs
y)	x			Providing for insurance pools for small businesses and organizations.
z)				Other

IV. If a goal of U.S. health care policy is efficient and economical delivery of care, which of the following cost control methods would contribute to achieving this goal?

(Check "Agree," "Disagree," or "No Consensus" for each. It is permissible to agree or disagree with more than one method.)

	Agree	Disagree	No Consensus	
aa)	x			Consumer accountability through deductibles and copayments
bb)		x		Mandatory second opinion before serious surgery or extensive treatment
cc)			x	Outcome-based guidelines for providers
dd)	x			Regional planning for the allocation of personnel, facilities and equipment
ee)	x			Utilization reviews of treatment
ff)	x			Establishing maximum level of public reimbursement to providers
gg)	x			Use of fixed, per capita payments to providers (capitation payments)
hh)	x			Use of managed care
ii)	x			Reduction of administrative costs
jj)	x			Malpractice reform
kk)				Other

LWV of Ketchikan

State: AK File #: AK 082

V. In a health care system with limited resources, what criteria should be used in allocating or "rationing" health care services for individuals in need of care?

(Check "Agree," "Disagree," or "No Consensus" for each. It is permissible to agree or disagree with more than one criterion.)

	Agree	Disagree	No Consensus	
ll)		✓		Ability of patient to pay (from personal resources or from public or private insurance coverage)
mm)		✓		Age of patient
nn)	✓			Urgency of medical condition
oo)	✓			Life expectancy of patient
pp)	✓			Expected outcome of treatment
qq)	✓			Cost of procedure
rr)				Duration of care
ss)	✓			Patient and family wishes
tt)	✓			Quality of life of patient after treatment

LEAGUE OF WOMEN VOTERS
KETCHIKAN GATEWAY BOROUGH
P.O. BOX 6133, KETCHIKAN, ALASKA 99901

LWV-Ketchikan believed the top priority for health care was a focus on preventive health care, health promotion and education. It was felt that while change would be slow, behavior modification toward valuing healthful living versus crisis intervention would occur.

I.

***Affordable health care** - there should be a balance between health care being perceived as a right and/or a privilege. Suggestions were made to have consumers pay a percentage of their care based on income. This would contribute to a sense of ownership or responsibility that would encourage monitoring of health care and costs. Present public health systems have a "request for payment" process that does prorate charges with the client allowed to have free care. Other countries have instituted minimal charges equivalent to $.50 and feel that instills some dignity to the system rather than being a handout.*

***Quality standards of care** - Peer review boards of health care professionals already exist with citizen members participating. It seems necessary to extend these board duties to evaluate what health services can reasonably be expected in small or isolated communities, duplicated in urban areas with a view to instituting long term philosophical beliefs regarding health care.*

***Consumer choice** - HMO's limit choice. Universal health care similar to Canada's allows choice but a universal, same salary doesn't address specialty liabilities, geographic costs.*

***Provider choice in the selection of types of practice** - Multiple types of practices contribute to administrative costs. We would envision the government building clinics and paying salaries to employees, including physicians. Incentive programs do need to be addressed to encourage provider "ownership" of the system. Health education costs would need to be subsidized to encourage physician participation.*

***Efficient and economical delivery of care** - must be by local review determining community need for special equipment, appropriate diagnostic procedures.*

***Advancement or medical research and technology** - research was encouraged but technology advancements were lower priority.*

II.

***Long term care** - more options needed such as funding for foster home for disabled or elderly adults.*

***Other** - Extraordinary measures such as orthodontia, in vitro fertilization were viewed as not a priority. One member mentioned that in England, people suffering a myocardial infarction are not kept in the intensive care unit for 10 days as is commonly done in the U.S. This is a time of high recurrences but over a six month time, the English survival rate is similar to the U.S. Difficult cost effectiveness issues such as this need to be addressed. Oregon seems to be the leading state in this area.*

III.

Community vs. experience rating - Would broaden the rating pool but would need to define community, i.e., like businesses or lifestyles, not necessarily geographic locality. We would recommend this be defined state by state, not nationally.

Medically underserved areas - We recommend a return to the old Health Systems Agency utilization review to monitor providers and equipment use in all locales. Allowing forgiveness of education costs in return for service to under served areas would encourage provider compliance with controlled costs.

Professional training - Allied health professional training encouraged to cut costs and increase access to care in rural areas. Equitable reimbursement for care would need to be assured. Funding for health professional education must be reinstated focusing on minority groups.

Mandated uniform service levels - We agree with the concept of uniform levels of care but acknowledge limitations of sites and provider resources. The term "mandated" is unrealistic; uniform care would have to be minimally developed to allow individual adaptation.

Insurance Pools - Need to make it easier to apply, i.e., young adults need a pool to cover them for transition time when they're not in school. High risk individuals will continue to need coverage.

IV.

aa) Consumer accountability - Suggest a basic level of care free, the first $500-1000/family with co-payment beyond that. This would encourage consumer participation in cost containment and activism in health issues.

bb) Mandatory second opinion - Suggest mass screening cursory review by an agency that determines the need for second opinion. Procedures needing a second opinion would be specified. Quality review of clinics may be needed.

ff and gg) Some provision for exceptions needs to be made.

hh) Managed health care with consumer choice or participation.

Health Resources and Access Task Force

Remarks
Patricia Hong
President, Alaska Nurses Association

August 25, 1992

Thank you for the opportunity to bring to the Task Force the fundamental principles found in Nursing's Agenda for Health Care Reform. As you know, organized nursing has created a document which outlines what the profession believes must occur for any health care reform program to be truly effective in meeting the health care needs of all citizens and residents. I have distributed copies of the Executive Summary to each of you; members of the Alaska Legislature have previously received a copy of the entire document, and other members of the Task Force are invited to request their own copy by calling the Alaska Nurses Association office at 274-0827.

I've been asked to discuss "how the current health care system creates problems for ..[nursing's].. interests" and/or "what recommendations ..[nursing].. has for reforming the health care system". In addition, I will address whether the task force's guiding principles conform with those contained within "Nursing's Agenda for Health Care Reform".

First, let me address the current health care system and how it impacts nursing's "interests". Nurses have been, and will continue to be advocates for the recipients of whatever health care system exists. Our primary interest in health care is the consumer: access to adequate and appropriate health care for that consumer, and the quality of health enjoyed by that consumer. The current health care

system is filled with inequities and inadequacies, the effects of which nurses have seen firsthand. Nurses work with individuals who have not known the benefits of preventive health care, and who, even if they had known of those benefits, could not have afforded to pay for preventive services. Nurses work with adolescents who, because of lack of education about health and life skills, engage in activities that prove to be dangerous to even their very lives. Nurses care for children who are malnourished and in need of nutritional education. Every day, nurses care for individuals who, because they had not been active participants in making decisions about their own health care, now suffer health problems that could have been made less severe or avoided completely if adequate health promotion and disease prevention had been available.

The American Nurses' Association works to lead the way in bringing the nursing profession together on the issue of health care reform. "Nursing's Agenda for Health Care Reform" is a document built around four principles:

I. **ALL CITIZENS AND LEGAL RESIDENTS OF THE UNITED STATES MUST HAVE EQUITABLE ACCESS TO BASIC HEALTH CARE BENEFITS AND SERVICES.**

II. **HEALTH AND HEALTH CARE SERVICES MUST BE IMPROVED THROUGH A RESTRUCTURED SYSTEM WHICH FOCUSES ON CONSUMERS, PROMOTES HEALTH, AND OFFERS NECESSARY AND EFFECTIVE SERVICES USING APPROPRIATE PROVIDERS, SETTINGS AND DELIVERY ARRANGEMENTS.**

III. FINANCING FOR BASIC HEALTH BENEFITS AND SERVICES MUST BE EQUITABLE, AFFORDABLE AND INCLUDE CONTRIBUTIONS BY INDIVIDUALS, EMPLOYERS, AND GOVERNMENT.

IV. THE COSTS OF HEALTH SERVICES MUST BE MADE MORE PREDICTABLE, AND MOTIVATIONS FOR COST-EFFECTIVE BEHAVIORS MUST BE ENHANCED.

In comparing the Guiding Principles adopted by the Task Force to the those upon which nursing's agenda is based, the following points must be emphasized:

1. Nursing's Agenda for Health Care Reform is the first document supported by the American Nurses' Association that outlines a policy position regarding financing recommendations for health care reform. While this document does call for a "play-or-pay" approach utilizing a mix of public and private plans, ANA welcomes any opportunity to participate in discussions that center around a single payor concept. The nursing profession proposes that a phase-in strategy be used in implementing health care reform, and calls for provision of basic health services to the most vulnerable populations first -- all pregnant women, infants, and children under 6.

2. A key factor within the four principles outlined by the nursing profession is an emphasis on health promotion. While the task force has identified health and safety education as important,

these are only strategies that are used in promoting health. The concept of health promotion provides a much broader perspective, leading to changes in patterns of living. Health education is but one method that can be used to achieve health promotion. For example, educating individuals about the use of seatbelts is well within the realm of health education, but is only one part of the campaign to change behavior in the general population. Laws mandating seatbelt use is another strategy that Alaska has used to protect the public health against the leading cause of injury in the state. Another example is the goal of reducing cigarette smoking in adolescents (and, in the long run, the entire population) -- one strategy to achieving this goal is to increase education about the effect of smoking, and another strategy is to do what the Legislature has done this past session -- require that vending machines that sell cigarettes be placed in areas unaccessible to adolescents. Multiple strategies are necessary in achieving health promotion because each one affects different groups of consumers.

3. The task force must emphasize equitable access to care, and must emphasize that there be a core of essential services provided by the full range of health care providers and available to every citizen and legal resident. Barriers to equal care would include geographic as well as economic inequities.

4. . While the task force has identified the need for preventive and primary care, incentives for healthful lifestyles, I believe that

there must also be more focus on the concept of self-care and consumer involvement in decisions regarding health care.

5. The nursing profession believes that health care reform must address the growing need for long-term and chronic care in this country. The concept of restorative care must be explored, in addition to the concept of providing coverage for long-term care services of short duration. Nursing calls for development of an innovative mix of private and public financing arrangement. Creative options to help pay for long-term and chronic care must be explored -- long-term care insurance, new savings incentives through federal tax preferences, and personal home equity conversion -- allowing individuals to continue to retain the same personal responsibility for their long-term care needs as they have for their general health. Let me emphasize here, however, that the nursing profession does not ignore those individuals who do not have resources and would need public assistance to ensure adequate long-term care -- these individuals must and will receive necessary care.

6. In the area of cost containment, nursing believes that health care costs must be more predictable. Several mechanisms can and should be used to hold costs down:

   - state and local review bodies to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement for

providers.

- utilizing the full range of qualified health professionals. Alaska is a leader in this area, resulting in improved access to care.

- utilizing multi-disciplinary clinical practice guidelines. These guidelines, based on outcome research, will help to eliminate wasteful and unnecessary services.

- requiring managed care for those enrolled in the public plan, and encouraging participation in private plans. The goal should be to retain maximum possible consumer choice and value those services that address health and preventive care.

- case management services to integrate, coordinate, and advocate for those individuals who require complex services. A variety of health care professionals would be used to provide this service, which would result in less fragmented care and a more holistic approach.

7. The nursing profession will be relentless in its call for equal and universal access to health care. It's not enough to simply expand services -- the same basic health care services must be available to all, including the uninsured. For health to be a

priority in individuals' lives, it must become one of what nursing calls activities of daily living -- it must be available in convenient locations such as schools, community centers, the workplace. Preventive services, including health education, screening, immunizations, prenatal care, well-child care, must be easily accessible and cost nothing at the point of service. The cost savings of preventive services has been well documented -- a $10 savings for every $1 spent on prenatal care, and a $3 savings for every $1 spent on immunizations.

The members of the task force are to be commended for the work that has already been accomplished -- Alaska can and should be a leader in health care reform. The nursing profession urges you to consider emphasis in the following areas:

- long-term and chronic care
- community-based health care with a focus on the consumer
- rural health needs

I've just received a press release from the Robert Wood Johnson Foundation identifying those states who have been awarded up to $8.4 million to develop health care reform plans. I would recommend that the task force monitor these states, as there are many proposals that are similar to those contained in the interim recommendations.

Thank you for this opportunity to speak on behalf of the nursing profession -- I would be happy to entertain any questions.

NEWS FROM:
THE ROBERT WOOD JOHNSON FOUNDATION

FOR MORE INFORMATION, CONTACT:
Marc S. Kaplan
Direct News Line: (609) 243-5937

EMBARGOED FOR RELEASE: MONDAY, AUGUST 3, 1992, 11:30 A.M.

TWELVE STATES AWARDED MORE THAN EIGHT MILLION DOLLARS TO FINANCE HEALTH CARE REFORMS

Broad Spectrum of Plans to Reduce Cost, Increase Access To Be Tested

PRINCETON, N.J. -- Twelve states have been granted up to $8.4 million to develop a wide range of plans to expand health insurance coverage and contain costs, as part of the Robert Wood Johnson Foundation's $25.5 million national program, State Initiatives in Health Care Financing Reform.

The 12 grantee states are: Arkansas, Colorado, Florida, Iowa, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington.

The two-year development grants will assist states in testing many of the ideas and options now being considered as strategies for national health care reform.

"State governments are being challenged to do what the federal government up to now has been unable to do: implement health care reform," commented Steven A. Schroeder M.D., president of the Princeton-based Robert Wood Johnson Foundation, in announcing the awards.

"The intent of the program is not only to help states develop new ideas and test models for reform, but for federal policymakers

(more)

to learn from these state-based experiments when they redesign national health policy," he said.

While all the funded proposals share the ultimate goal of expanding access to health care, they span the political and theoretical spectrum of health care reform strategies, including individual health accounts, managed competition, play-or-pay mandates on employers, and single-payer systems.

Some highlights of the funded proposals include:

* Three states propose to establish single payer or regulated multiple-payer systems.

* Four states will explore the use of establishing dollar limits or targets that will limit total expenditures for health care services annually, or paid to a provider.

* Four states propose to develop a play-or-pay mechanism in which all employers would provide basic coverage to their employees, or pay into a state insurance pool.

* Six states intend to create a state insurance plan or to subsidize health insurance products that target special populations, such as small businesses or children.

* Four states propose to develop uniform claims processing and billing systems for insurance.

A total of 35 proposals were received by the foundation and reviewed by an independent national advisory committee comprised of experts in the field of health care financing and delivery.

(more)

Following the first phase of the program in which the twelve grantees will use their funds to develop their proposed reforms, they will then be eligible to apply for up to three years of additional funding to support the implementation of their efforts.

To assist grantees in assessing their options, analyzing data, and understanding the legal and regulatory issues involved in reform, specialized technical assistance and consulting services will be supplied by the National Governors' Association, the Alpha Center, acting as the national program office, together with RAND and the Urban Institute, helping states with their analytical needs.

"We have made these funds available to the states to encourage them to go as far as they can to improve access and to control costs," added Dr. Schroeder. "Historically, states have paved the way for a number of new national policies, and in many ways they will be testing the reality of health care reform strategies."

The Robert Wood Johnson Foundation is the nation's largest philanthropy devoted exclusively to health care, having awarded more than a billion dollars in grants since its founding in 1972.

"The Foundation will continue to work at both the national and state levels to stimulate fair, affordable health care for every American," Dr. Schroeder concluded.

# # #

Nursing's Agenda for Health Care Reform

EXECUTIVE SUMMARY

America's nurses have long supported our nation's efforts to create a health care system that assures access, quality, and services at affordable costs. This document presents nursing's agenda for immediate health care reform. We call for a basic "core" of essential health care services to be available to everyone. We call for a restructured health care system that will focus on the consumers and their health, with services to be delivered in familiar, convenient sites, such as schools, workplaces, and homes. We call for a shift from the predominant focus on illness and cure to an orientation toward wellness and care. The basic components of nursing's "core of care" include:

- A restructured health care system which:
  - Enhances consumer access to services by delivering primary health care in community-based settings.
  - Fosters consumer responsibility for personal health, self care, and informed decision making in selecting health care services.
  - Facilitates utilization of the most cost-effective providers and therapeutic options in the most appropriate settings.

- A federally-defined standard package of essential health care services available to all citizens and residents of the United States, provided and financed through an integration of public and private plans and sources:
  - A public plan, based on federal guidelines and eligibility requirements, will provide coverage for the poor and create the opportunity for small businesses and individuals, particularly those at risk because of preexisting conditions an those potentially medically indigent, to buy into the plan.
  - A private plan will offer, at a minimum, the nationally standardized package of essential services. This standard package could be enriched as a benefit of employment or individuals could purchase additional services if they so choose. If employers do not offer private coverage, they must pay into the public plan for their employees.

- A phase-in of essential services, in order to be fiscally responsible:
  - Coverage of pregnant women and children is critical. This first step represents a cost-effective investment in the future health and prosperity of the nation.
  - One early step will be to design services specifically to assist vulnerable populations who have had limited access to our nation's health care system. A "Healthstart Plan" is proposed to improve the health status of these individuals.

- Planned change to anticipate health service needs that correlate with changing national demographics.

- Steps to reduce health care costs include:
  - Required usage of managed care in the public plan and encouraged in private plans.
  - Incentives for consumers and providers to utilize managed care arrangements.
  - Controlled growth of the health care system through planning and prudent resource allocation.
  - Incentives for consumers and providers to be more cost efficient in exercising health care options.
  - Development of health care policies based on effectiveness and outcomes research.
  - Assurance of direct access to a full range of qualified providers.
  - Elimination of unnecessary bureaucratic controls and administrative procedures.

- Case management will be required for those with continuing health care needs. Case management will reduce the fragmentation of the present system, promote consumers' active participation in decisions about their health, and create an advocate on their behalf.

- Provisions for long-term care, which include:
  - Public and private funding for services of short duration to prevent personal impoverishment.
  - Public funding for extended care if consumer resources are exhausted.
  - Emphasis on the consumers' responsibility to financially plan for their long-term care needs, including new personal financial alternatives and strengthened private insurance arrangements.

- Insurance reforms to assure improved access to coverage, including affordable premiums, reinsurance pools for catastrophic coverage, and other steps to protect both insurers and individuals against excessive costs.

- Access to services assured by no payment at the point of service and elimination of balance billing in both public and private plans.

- Establishment of public/private sector review -- operating under federal guidelines and including payers, providers, and consumers -- to determine resource allocation, cost reduction approaches, allowable insurance premiums, and fair and consistent reimbursement levels for providers. This review would progress in a climate sensitive to ethical issues.

Additional resources will be required to accomplish this plan. While significant dollars can be obtained through restructuring and other strategies, responsibility for any new funds must be shared by individuals, employers, and government, phased in over several years to minimize the impact.

Comments from Lori Brown, AK Pharmaceutical Association, Sept. 26, 1992

On behalf of the Alaska Pharmaceutical Association, I would like to thank you for allowing us this time to speak. I work as a retail pharmacist, hospital pharmacists and nursing home consultant pharmacist in Soldotna. My name is Lori Brown and I am a health care provider as well as a health care recipient. My employer provides insurance for me, I am one of the lucky ones..

I am here today to try to assist you in understanding the pharmacists role in the health care system: For the past several months Mr. X comes in weekly for a prescription for injectable and oral pain medications and anti-nausea tablets. These medications are for his wife who is dying of cancer. He treats her himself at home to cut down costs. He is covered by insurance, but his wife is not. His out of pocket bill for drugs alone is $250.00 weekly. A single asthma patient may spend 300 to 400 dollars monthly on their medications. Without these medications, their chances of being hospitalized increases.

These situations are not exceptions, they are becoming the norm. Not only are there a significant amount of Alaskan's uninsured, but many are underinsured where strict stipulations are put on recipients when they need coverage the most. Others are even losing the coverage they have had for years due to insurance carrier changes, employer bankruptcy or "seasonal" employment. In this vast picture of Health Care Cost problems, Pharmacy plays a major role.

In 1990 the country's overall health care costs increased 12.3 percent, while the cost of the prescription drug component rose 23 percent. Of that 23 percent increase, 15 percent was due to price increases. Figures for 1991 showed prescription drug benefits rising at more than double the rate of overall health costs. Hospital/surgical/medical costs are still the largest component of employer-funded health care packages, but when employers start analyzing the numbers in the packages,the numbers in the pharmacy component leap out at them. And, as prescription prices increased, dispensing fees remained flat.

Pharmacy is now going to take a pro-active approach.
Pharmacy has been left out of almost all of the proposals made federally as well as throughout the various state's that have tried to tackle the Health Care problem. Pharmacy was left out of the Medicaire program. This has been a major problem. The life savings of an elderly person can be gobbled up in drug costs alone, in a short period of time if they have no pharmaceutical coverage.

Global Budgeting is necessary and we must have a unified cost system, as well as a means to contain costs. We also must have standardization. When looking at reimbursement in pharmacy you must consider that in the past, reimbursment for pharmaceuticals has been minimal. The previous third party reimbursement systems are not going to be tolerated anymore. Pharmacies maintain a

tremendous inventory, with only a small return, not to mention the time and paper work that goes into filing a claim. And many of the claims filed are never reimbursed. In our profession, it is difficult to deny someone a life-saving product. When the pharmacy is not paid, we not only lose our profit, or means for business, but we also lose the cost of the drug we dispensed which can be astronomical.

Most payers today still view pharmaceuticals as commodities. This is something we need to change. Pharmacists, in conjunction with selected authorities need to differentiate between the pharmaceutical commodity and the pharmaceutical services pharmacists provide. Then they need to convince payers that overall program costs can be better managed by taking advantage of pharmacists' skills and services. A tremendous amount of research needs to be done on pharmacy reimbursment with pharmacists before any reimbursement system is approved. Pharmacists must have a hand in this.

Utilization is another issue which must be addressed. It appears that when some people have insurance, they begin to overutilize or spend where they otherwise wouldn't. The medicaide system is a prime example of this over-utilization. They are able to recieve prescriptions that an uninsured or underinsured may not be able to afford. We must be ready to face over-utilization and be sure the doctors prescribe conservatively.

The National Pharmacy Associations are concerned. The American Pharmaceutical Association and the National Association of Retail Pharmacists are concerned that in this process of Health Care Reform, that choice will be ignored. Currently, even within the State of Alaska, many pharmacists are losing a great amount of business to out-of state pharmacies, HMO's and other providers. We need to consider this when deciding how pharmaceuticals are handled in a new health care system. When you remove choice, you remove competition and health care costs are more likely to sky-rocket. Please keep our money within our state. Any Health Care reform system should recognize the role of the pharmacist and include payment for product and services provided. Our counceling has never been reimbursed. Pharmacists are now demanding to be reimbursed for their skill and knowledge.

The American Society of Hospital Pharmacists are concerned about any health care system that would impede the progression of the delivery of pharmaceutical care. Reimbursement for pharmaceutical services should not be associated with issues of the profitability of pharmaceutical manufacturers, but instead, based on the value of the services provided by the pharmacist. Technological progression must remain.

American Society of Consultant Pharmacists feel that the reform system should recognize the pharmacists role in optimizing patient drug treatment, including patient counseling. And the pharmacists must take responsibility for therapeutic outcomes of the patient. In the Canadian Health Care system, drug benefits are included as part of the health insurance coverage. Physicians make the therapeutic choice and the pharmacists makes the product choice through the use of a formulary .

Several National Pharmacy Associations are in the process of writing position papers on Health Care Reform. For your information APHA is publishing their position paper in the next few months in Pharmacy Times. I hope you will read it.
True managed care should encompass three broad areas: ensuring appropriate therapy, achieving the desired outcome, and delivering the most effective care. In true managed care, you are not just managing price, you are managing the overall cost by applying quality. Quality care is cost effective care. Most payers don't understand that high quality pharmacy services can save them money in the long run. All of us need to demonstrate that quality services can make a real difference to the bottom line. Non-compliance in pharmacy creates about 1.7% of the nation's total health care costs, which translates into $8 billion or $9 billion in wasted health care resources. (Strandberg) That's hundreds of millions of dollars in wasted health care resources in the State of Alaska alone, due to non-compliance.

Medications, when taken correctly as prescribed by a doctor, and dispensed and counceled by a pharmacist, can save money.

Example: a ulcer patient may spend anywhere from $75-300 monthly on medications. This is a small price to pay, compared to the alternative of hospitalization and surgery. Heart patients may spend hundreds of dollars on medication monthly. But, the cost of hospitalization of a single heart attack victim is astounding, and the patient will likely have to take more medication after surgery, than if they'd taken preventative medications. Prevention is an issue we need to consider.

We need to begin to look to the pharmacist as a key element in health care reform. We are the final health care professional that the patient has contact with. We are in the position to stress the importance of drug compliance and be sure the patient is aware of why they need to take their medications as well as be aware of side-effects and drug interactions. When factored in, any problem resulting in drug problems results in increased cost. Pharmacists have 5-6 years of intensive schooling, as well as continuing education updates. We are the experts on pharmaceuticals. USE OUR SERVICES, DON'T LEAVE US OUT.

It is important that pharmacists are included in your plan for health care reform. Pharmaceuticals are a part of the rising costs of health care. By part I mean, through pharmacy, we may be able to reduce the spending by many individuals , insurance companies, and medicaid with decreased hospitalization, drug compliancy and couceling.

The health care reform systen and how pharmacy fits in is too large a topic to speak on in 10 minutes. But, I do hope that I have stressed the importance of our involvement in your future plans. The health care problem is not the fault of one specific group, not the insurance companies, the doctors, the hospitals, or the pharmacies. It is an intertwining of many problems within these groups and society.

I believe Karen Marcey would like to speak for a few minutes now.....Then questions may be directed to Karen, Shirley Coursey or myself.

****

I would like to add that Linda Hamm's testimony, when speaking of AETNA in relation to contracting with pharmacies like Pay N Save, Carrs and Longs, was not the feelings of the association. Instead I believe it was the feelings from her personal point of view as a chain pharmacist. The Alaska Pharmaceutical Association is concerned that if pharmaceuticals are contracted out within the state, that independent pharmacies are included. Most of these large chain pharmacies are Seattle based. Contracting with them alone would still cause dollars to be sent out-of-state. This is an issue that needs to be addressed and I hope you will contact the independent pharmacists as well as the chains. Our Association will be of any help to you if needed. Thank You.

Alaska Pharmaceutical Association
Lori A. Brown, President
245 Binkley Street
Soldotna, Alaska 99669

Please send me a copy of the Guiding Principles and the Final Report.

ALPHA PRESENTATION TO THE HEALTH RESOURCES AND ACCESS TASK FORCE, SEPTEMBER 26, 1992

1. ALPHA believes that the core functions of public health; of assessment, policy development, and assurance are the State's basic responsibility (see statement on State's obligation)

2. ALPHA, therefore, supports the statement submitted to the Task Force by Dr. Nakamura, on September 25th. It is critical that we understand why people get sick and why they die. To focus exclusively upon access and medical financing issues is to miss the mark dramatically. (see enclosure on contributing factors on rates of occurrence)

3. ALPHA continues to be committed to the pursuit of a rational, comprehensive, statewide health planning process as described in the Alaska Health Summit Resolution (see resolution; and recommendation to the Commissioner)

- Good data is critical to the administration of state public health programs as well as to any efforts at reform of the medical services industry.

- It would be a mistake to commit to any medical financing system until the data collection and analysis have been done.

4.. ALPHA very much appreciates the good work that has been done by the Health Resources and Access Task Force. However, ALPHA is concerned that the process of education through which the Task Force has traveled will end when the Task Force comes to its end. A major recommendation of the Alaska Health Summit was that the discussion about these complex issues needs to be taken out to our public, something like was done in Oregon, prior to their adoption of major health care reforms. It is ALPHA's belief that the Task Force, or some form of it, must continue. The investigative work has been done. Now it is time to take these findings to the people for their consideration. The Task Force can yet serve a critical role as "guide" and "counselor" in that process.

5. While the Task Force recommendations do not conform to the American Public Health Association recommendations in every

particular, ALPHA acknowledges the need that the states will have to craft a systems of health and medical services which meet the needs of each.

THE OBLIGATION OF STATES ON THE MATTER OF THE PUBLIC'S HEALTH

Adopted by the Alaska Public Health Association Board of Directors, September 12, 1992

(The) states are and must be the central force in public health. They bear primary public sector responsibility for health. (The) public health duties of states should include the following:

- assessment of health needs within the state based on statewide data collection;
- assurance of an adequate statutory base for health activities in the state;
- establishment of statewide health objectives, delegating power to localities as appropriate and holding them accountable;
- assurance of appropriate organized statewide effort to develop and maintain requisite personal, educational, and environmental health services; provision of access to necessary services; and solution of problems inimical to health;
- guarantee of a minimum set of essential health services; and
- support of local service capacity, especially when disparities in local ability to raise revenue and/or administer programs require subsidies, technical assistance, or direct action by the state to achieve adequate levels.

From *The Future of Public Health*, 1988, The Institute of Medicine:

PREFERRED* INTERVENTIONS TO REDUCE RATE OF OCCURRENCE OF HEALTH PROBLEMS

Preferred based on feasibility, cost effectiveness, effect on health problem. "0" = factors having least impact on rate of occurance. "" = factors having moderate impact on rate of occurance. "X" = factors having greatest impact on rate of occurance. Circle = represent areas in which interventions should occur, based on criteria of feasibility effect on the health problem, and costs, in relation to benefit	Heart	Cancer	Unintent. Inj.	Stroke	COPD	Suicide	Pneumonia & Flu	Liver-Cirrhosis	Diabetes II	Homicide	Perinatal Cond.	STDs	Immun. Disease	Infectious Hep.	Dental Disease.
PUBLIC HEALTH SYSTEM: ***INDIVIDUAL - COMMUNITY BASED*** ***HEALTH PROMOTION - PREVENTION***															
ENVIRONMENT (outside individual) PHYSICAL: air, water, housing, noise, waste, radiation, roads	0	*	*	0	*	0	*	0	0	0	0	0	0	(X)	*
SOCIAL: cultural forces, marketing and advertising, legal sanctions	*	*	(*)	*	(*)	(X)	0	(X)	*	(X)	*	*	(*)	*	X
LIFESTYLE Decisions made by individuals	(X)	(*)	(X)	(X)	(X)	X	*	(X)	(X)	X	(X)	(X)	(X)	(X)	(X)
PUBLIC HEALTH SYSTEM - ***MEDICAL CARE SYSTEM BLEND***															
DETECTION - EARLY PRIMARY CARE Immunization, presymptomatic screening	*	(X)	0	*	*	0	(X)	0	*	0	(X)	(*)	(X)	*	(*)
MEDICAL CARE SYSTEM															
DIAGNOSIS AND TREATMENT	*	*	*	*	*	0	(*)	0	*	0	*	*	*	*	*

ALASKA HEALTH SUMMIT: 1992:

RESOLUTION May 1, 1992

1. Whereas: Current health systems planning in Alaska is weak, fragmented and contributes to a lack of consistent direction in the public and private health system, and;

2. Whereas: The existing health system is characterized by lack of coordination among its parts, particularly across disciplines, contributing to factionalization and inefficiency in the system, and;

3. Whereas: The overall economic condition in Alaska is likely to worsen, and the competition for limited resources will likely increase, and;

4. Whereas: The lack of coherent direction, lack of coordination, together with the anticipated decrease in resources threatens to cause serious decay of the public and private care system, and;

5. Whereas: The State of Alaska, by virtue of its constitutional obligation to represent all the people of Alaska, is in the position to provide the necessary leadership in issues affecting the health and well-being of all the people of Alaska, and;

6. Whereas: An overwhelming majority of the Alaska Health Summit attendees, on April 30, 1992, strongly expressed the need for a functioning, comprehensive state-wide health planning system and process to promote greater coherence, coordination, and efficiency for Alaska's health system, and;

7. Whereas: An overwhelming majority of the Alaska Health Summit attendees on April 30, 1992, strongly expressed the need for the convening of a meeting to discuss all appropriate options for reinstituting a state-wide health planning capability, and;

8. Therefore be it resolved: that the Alaska Health Summit, 1992 requests that the Commissioner of Health and Social Services convene a meeting for the purpose of developing an appropriate health planning system for the State of Alaska, and;

9: Be it further resolved: that the representation to that meeting include but not be limited to: health service consumers, providers, (military, Veterans Affairs, private, governmental) and elements which reflect purchasers of care

(such as employers), urban and rural representatives, minorities, Alaska Natives, and labor unions.

William Dann, Alaska Health Summit Chairman

Dennis P. DeGross, Chair for the Resolution

ALASKA SUMMIT SPONSORS AND CO-SPONSORS

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Alaska State Veternary Association
Alaska Public Health Associationn*
Alaska State Nutrition Committee *
Alaska Health Education Consortium *
American Association of Retired Persons *
American Society of Safety Engineers *
American Society for Circumpolar Health
Alaska State Hospital and Nursing Home Association
Eleventh Air Force, Elemendorf Medical Center
Health Resources and Access Task Force, State of Alaska
Humana Hospital
Municipality of Anchorage, Department of Health and Human Services *
Providence Hospital *
Rural Alaska Health Professions Foundation (RAHEC), UAF *
School of Nursing and Health Sciences, UAA *

OTHER AGENCIES ACTIVELY INVOLVED IN THE ALASKA HEALTH SUMMIT

AFL-CIO
Alaska Health Care Coalition
Alaska Community Health Aides Association
Alaska Emergency Medical Services Council
Alaska Green Party
Alaska Home Economists Association
Alaska Medical Records Association
Alaskan Aids Assistance Association
Alaska Cancer Society
American Diebetes Association
American Heart Association
Arctic Investigative Program, National Center for Infectious Diseases, Center for Disease Control
Bristol Bay Area Health Corporation, Dillingham
Copper River Native Association, Copper River
Our Lady of Compasion Care Center, Anchorage
North Slope Borough Health and Social Services Department
Norton Sound Health Corporation, Nome
Professional Growth Systems Inc.
Southern Region Emergency Medical Services, Anchorage
Southeast Alaska Regional Health Corporation, Juneau/Sitka
Tanana Chiefs Conference, Inc., Fairbanks
The North Pacific Rim
United States Department of Veterans Affairs
Yukon-Kuskokwim Health Corporation, Bethel

PRIMARY THEMES AND RECOMMENDATIONS FROM THE PLENARY SESSIONS "ALASKA HEALTH SUMMIT: 1992"

General Comments

The "Alaska Health Summit" drew approximately 420 health professionals, government representatives and others. More than 50 organizations were involved with the "Summit", of whom 23 were actively engaged in planning and support roles. There were 101 sessions, of which 88 were concurrent sessions on the afternoons of April 29 and 30.

Major Themes:

1. The State of Alaska doesn't know where it is going on the question of health, we don't have clear policies; we don't coordinate very well, and we don't have data to show what we need to do.

2. Poverty, education, racism and culture must be taken into account when considering how to improve public health.

Recommendations

1. Alaska needs a comprehensive, state-wide health planning process that will bring important "stake-holders" to the table, and that will generate reliable data. Such a planning process would incorporate, not replace, planning efforts underway by the Division of Public Health (Healthy People 2000 National Objectives) and by the Health Resources and Access Task Force

2. The "forward momentum" provided by the "Summit" needs to be sustained by:

   a. Vigorous follow-up on the "sign-up" sheets to assist the State in meeting Year 2000 Health Objectives.
   b. Active participation in ALPHA to provide leadership in developing a public awareness process.
   c. Enervate the Alaska Health Network - get more of the necessary "players to the table" (public safety, education, environmental, Alaska Natives, Legislators, etc.).
   d. Press the Legislature and the Governor to implement a statewide health planning process.

3 The Health Community has a moral and ethical responsibility to speak out on bad or inadequate public health policy as it relates to education, literacy, poverty and the distribution of wealth, and criminal justice ("War on Drugs").

4. The Health Community must press for broad public involvement on the important health issues confronting Alaska. Specifically, the discussion of access to health services and medical care needs to become a "road show" and taken to the people. There was discussion of ALPHA developing a Public Awareness package to use in local public workshops statewide.

5. Existing state health statutes need to be reviewed for possible application (resurrection?) in the current situation.

6. The public needs to be urged to consider self taxation that is more consistent with the experience of other states as a means providing necessary health services and medical access to its citizens. There was some discussion of a specific, income related "health tax" (would require amendment to State Constitution).

7. Local communities need to be responsible and involved in planning and executing their own health standards and services. A Community Development approach needs to be considered by government agencies providing funds for programs.

8. Increase participation of Alaska Natives and their organizations in these kinds of conferences.

9. Educate the public about the effects of uninsured and under-insured on health care costs and present it in a language that everyone can understand.

10. Consider a single group health insurance policy for the State of Alaska.

11. Require that all health insurance policies cover preventive services (such as well baby services).

12. Promote "global budgeting" and "community rating" in any plan for medical services that we in Alaska consider adopting.

NOTE: A document which summarized the 90 Concurrent Sessions of April 29 and 30 was produced and distributed to "Summit" participants on Friday morning, May 1. For information call Denny DeGross, 344-8824

EXERPT FROM ALPHA COMMUNICATION TO COMMISSIONER MALA,
October 6, 1992

The ALPHA Board, in its discussions, acknowledged that there may be no statutory basis for the kind of planning effort that is needed and that was recommended by the Summit Resolution. The Board also noted that a comprehensive state-wide planning apparatus must necessarily include state health programs which reside outside your department's sole responsibility. The Board also noted that the medical care industry, and federal health programs must also be parties to a comprehensive state health planning process.

With those aspects noted, the ALPHA Board believes it would be helpful to the process for you to take the following actions:

> Convene a meeting of a work group of modest size (30 - 40), representing the various interests outlined in the Summit Resolution. This meeting would most advantageously occur sometime shortly after the Data Conference (Nov. 2, 3) so as to take advantage of the most recent understanding of our data needs.
>
> In order to prepare for this meeting, your department might wish to examine existing, currently active, state statutes for their relevance as authorizing statutory basis for health planning. Second, with assistance from other departments, your department should identify the most obvious and troublesome data gaps for presentation at the work meeting.

The purpose of the work-meeting would be to further delineate the data gaps, review health planning statutes of other states and prepare a draft bill on health planning in preparation for introduction to the Legislature in the Spring. This effort should carefully weigh the final products of the Health Resources and Access Task Force, so as to incorporate into our outcomes, whatever of those products are deemed appropriate. (Please see enclosed)

For our part, ALPHA will pledge to assist in getting key players to the work meeting. Additionally, the ALPHA Board will commit to participating on a planning/steering committee for the purpose of planning the work meeting.

ALPHA DISCUSSION OF HEALTH REFORM ISSUES

1. ALPHA strongly supports cost containment efforts- Cost containment in the medical care industry is a central issue. A good deal of the health care expenditure increases in Alaska relate to the lack of cost management efforts (state employee insurance and Medicaid, control of self-interested insurance industry).

2. There is a lack of competition among providers in Alaska. They can often charge higher fees because the only alternative for patients is to seek care outside the community, which often involves air fare.

3. Several major factors driving national health care expenditures may not be as relevant in Alaska. Some research articles point to high-tech medicine and the aging of the population as major contributors to the U.S. health care system. Alaska has relatively little high-tech in the state, with the exception of Anchorage, although there is increased pressure to offer more in other communities, in attempts to capture more dollars in local facilities. Further, Alaska is the second youngest state in the U.S. We have relatively few adults over the age of 65 or the even higher risk group of 85+ years. Although this certainly a future problem as the state ages and programs like the Longevity Bonus, Pioneer's Homes, PFD, property tax exclusions, etc, have allowed more elderly to remain in the state and has attracted immigration of some elderly from other states

4. It is enlightening that the most common reasons for inpatient care in Alaska are related to labor and delivery.

5. ALPHA suspects that the percent of uninsured in Alaska may be smaller, if not less significant than has been reported nationwide. This is owing largely to the high percentage of military and dependents, as well as to the high percentage of Native people who are "covered" by the Indian Health Service. Many of the uninsured in Alaska may be those employed in the seafood processing mining and lumber industries, many of whom are only seasonal residents of the state. A program to address these workers will be very difficult to administer, and may be of questionable "interest" to Alaska, since it may provide incentive for these individuals to get their health care needs met while they are seasonally employed in Alaska.

6. High costs in Alaska, it seems to us, are influenced by the following factors:

Alaska's geography: providing health care services in non-metropolitan, often remote areas and the higher cost of living in Alaska create higher health care costs.

Little competition between providers: outside the Anchorage area, there is relatively little competition between health care providers. Since providers can set their own fees and there is little control over fee setting with the exception of facilities, provider fees are generally much higher, sometimes more than double, what providers charge in the rest of the country. Further, there is little incentive to shop around for lower fees outside the local community, as it involves transportation costs not usually covered by health financing agencies when services are available locally.

For a state with a small population, we have all the complexity of any state health system. The private health care system is a major provider, but IHS, the Native non-profit health agencies, the military, the VA, and state programs add as much, if not more, complexity to Alaska's system as is present elsewhere.

There is very little in the way of regulatory control of our health care industry. Data collection and reporting is not much above minimum levels, program evaluation for cost effectiveness is almost non-existent, and the state has exerted very little authority at controlling health care cost through utilization controls, setting reimbursement rates, and educating consumers outside the state's Medicaid program about how to "shop around".

In the same way that utilization and provider fees increased when private insurance was fully paid by employers, Alaska's health care system continues to expand because of the lack of motivation to control costs.

Facilities were built in areas where it is now unlikely that there exists an adequate local revenue base to continue to maintain them. It wasn't an issue then, because small hospitals used to do more than they are now allowed to do. The oil money kept them going for awhile. But that is over, so what do we do? Do we close some of them down?

The State, as a major employer, has not implemented a rational and adequate co-payment system for its employees (since full costs at or below Usual, Customary, or Reasonable fees are paid by the State's Insurance and SBS systems). There may also be inadequate utilization control in the State's Medicaid program. Increased utilization of that program may be generated by consumers demanding more services. Or, some providers may simply be increasing services for reasons as yet not understood.

7. If radical changes in the system are deemed necessary, ALPHA would support the 13 points offered by the American Public Health Association. However, ALPHA would specifically support the idea of global budgeting. ALPHA has not had an opportunity to internally debate the efficacy of a single payer system of "pay of play" options.

8. Some of the problem of increasing costs may be approached without making radical changes in the system:

Expand financing of trasportation for medical reasons and regionalize services. If the service region is outside Alaska, so be it. This is not an area we should worry about capturing all the revenue in Alaska for the purpose of creating economic diversity in employment. We really are concerned about the quality and cost-effectiveness of care. Quality and cost-effectiveness are often achieved by centralizing medical services, especially for high-tech procedures. Further, it is often a dis-service to the patient to offer a service locally, since, for some procedures, doing a small volume of procedures translates into poor patient outcomes and it often restricts financing for travel to the regional facility. Further, if there is poor patient outcomes, future malpractice claims may be moved against municipal governments, as well as against providers.

Standardization of claim forms: multiple claims forms creates the need for additional clerical staff to process claims.

Work for better coordination between federal, Native, non-profit, state and private providers to avoid duplication of services.

Get greater control of provider fees, in both inpatient and outpatient settings.

Offer reasonable alternatives to consumers for medical care. Avoid inappropriate use of ER rooms by making lower, less costly mid-level services available.

Teach consumers to "shop around"

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9/26/92

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AKPIRG
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Prepared Testimony for Presentation to the Health Resources and Access Task Force by Alaska Public Interest Research Group.
September 26, 1992

Task Force Members:

Alaska Public Interest Research Group, a 6,000 member non-profit research and consumer advocacy group has been asked to address " what recommendations AkPIRG has for reforming the health care system" and "how the current health care system creates problems for our organization's interests."

We have decided to focus on our comments directly on the Health Care Reform Final Recommendations to the Governor and the Legislature, adopted March 14, 1992.
AkPIRG applauds the decision to endorse a single payor system by the Health Resources and Access Task Force. It is in that spirit of appreciation that we hope you will examine these comments and distribute them to all interested parties. They are intended to spark renewed debate and begin a process of serious public examination of this important subject.

A. Global budgeting in the sense that it is commonly used, as in Canada, can only work if there is a single payor system. The most efficient single payor system is operated by the public sector. Nowhere in the final recommendations does it state categorically that Alaska will become the single health insuror, and that private health insurance will be abolished. If private health insurance is simply to be funneled through a new state agency, this is really no better than the current system in terms of wasted private insurance overhead and administrative costs.

In Canada physicians with negotiated fees simply do more procedures to amass the income they desire. What will prevent that under this system?

A key issue is WHO will be on the authority/commission that regulates rates and other important features of Alaska's heath care system? It should not be a hegemony of health care providers and others with a financial interest in the health care system.Consumers and others from grass roots organizations must have a very significant and central role in this all important regulatory body, and all of their work must be public and open to public scrutiny and review.

If medical care prices are not frozen the first year, or rolled back to the previous year immediately after this legislation is enacted, health care entrepreneurs will massively increase prices

in anticipation of regulation years down the road. Additional data collection will be important and useful.

B. Regulation of Utilization Review Agents is extremely important since they are totally unregulated nationally. Health care consumers should be a central part of the board or other mechanism established to regulate UR agents.

C. Authority to review rates filed by health insurers. We understand that legislation to do this was killed by a massive lobbying effort of the health insurance industry. This legislation would be a very important step. This demonstrated political power will certainly be used to kill other key aspects of the Task Force recommendations without work to organize grassroots support for this legislation.

D. Small Group Market Reform has generally been a failure ascross the country as a means of expanding access. State initiatives along these same lines have been ignored by the targeted small businesses.

E. State High-Risk Pool Enacted by Law. While such pools have been implemented in many states across the county, they have been of very limited effectiveness because either the premiums are too high to help all but the wealthy, or the state rapidly runs out of funds to subsidize pool insurance.

F. Community rating/minimizing medical underwriting. If you contemplate a private health insurance system, then the concepts of community rating and the minimization of medical underwriting are laudable goals. The point, of course, is to abolish private health insurance and eliminate the need altogether for medical underwriting and individual payment for coverage.

G. State incentives. These are only necessary if premiums are paid by all to private health insurers, guaranteeing inequality of access. In the case of a single public payor financed by progressive taxation, there is obviously no need to offer " state incentives."

F. Pay -or-play approach is a very bad idea for a number of reasons. It builds upon the flawed historical approach of providing health care at the place of employment. It knocks out small business and favors big business. It short changes retired people, the unemployed and all those not associated with a workplace. It is administratively far more difficult than progressive taxation to finance a single payor. It keeps the private insurance industry and guarantees its stranglehold on the inequities of health care.

H. Medical malpractice insurance. There is little research evidence that the Task Force's approach on this issue will in any way result in the lowering of medical malpractice payments, but it is very likely to take away the civil liberties of a class of people. Furthermore, it will encourage those phsycians who apparently engage in malpractice to continue doing so. If we are to encourage reform in this area, we must abolish the old boy peer review networks enjoyed by physicians and their licensing boards and replace them with predominantly consumer review boards. Since the malpractice premiums would need to be rigidly controlled and companies forced to follow actuarial and not cash flow accounting, a better idea might be to have the state take over malpractice insurance.

I. Health Planning/Certificate of Need. While this is an excellent idea,once again there must be a predominance of people on the regulating board who are not health care providers, and who otherwise have no conflict of interest. Furthermore, the regulating body must have the legal teeth to implement what they recommend.

Further commentary:

Health care reform in Alaska will confront problems that are not yet seriously acknowledged, problems that will challenge the state under any implemented system.

The future of the Indian Health Care System, even as an inadequate, ultimate safety net for indigenous peoples, both rural and urban, who do not otherwise qualify for medical care will be seriously challenged, both by falling Federal support for Indian health programs and, ironically, by the state's persistent legal challenge to the legal concept of tribal sovereignty. This irrational attack on the proposition that underlies continual Congressional support of a Federal program for native peoples in Alaska will also seriously impact programs delivered by regional nonprofit health organizations who depend on this same source of funds.

As to unmet needs which will generate massive health problems in the future, one need look no further than the just completed newspaper series on water and sewage problems in Alaska native villages to anticipate epidemics that will flow from the bush to urban Alaska. Finally, the persistent failure of Federal agencies to disclose historical contamination of Alaska lands and wildlife has been coupled with the serious misinterpretation of health data that has concealed generational afflictions caused, not by life styles, but by enviornmental poisoning of the lands, water and wildlife. The recent rediscovery of a radioactive dump is but the first indication of this vile legacy long buried in IHS data and

long misinterpreted or ignored because the victims are predominantly native people served by the IHS.

Although its charge may be otherwise, the Health Resources and Access Task Force should look carefully at these "time bombs" and direct its considered expertise to remediation that will force Federal acknowledgement of this serious problem and redirect state energy to consumer protection and not to attacks on the legal proposition of tribalism that now requires Federal support of a supplementary managed health system.That system of Indian health care must be seriously expanded and improved.

Thank you for this opportunity to begin what is hoped will be public discussion and debate on health care reform.

Stephen Conn
Executive Director

Dr. Lawrence D. Weiss, AkPIRG Health Reform Volunteer Consultant

STATEMENT

of the

ALASKA CHAPTER
of the
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

to the

STATE OF ALASKA
HEALTH RESOURCE AND ACCESS
TASK FORCE

Presented by

Michael Levy M.D.
President, Alaska Chapt
American College of Emergency Physicians

RE: Providing Adequate Health Coverage
for the Uninsured and Underinsured

October 23, 1992

Executive Summary

*Emergency departments are the safety net for many of the uninsured and underinsured but are being jeopardized by the burden of uncompensated care. For many the emergency department is their only source of care, and their entryway into the health care system.

*A 1986 study for the American College of Emergency Physicians showed that on average 31% of the care provided by emergency physicians was uncompensated care.

*Federal policy requirements imposed on emergency departments have increased their responsibilities to fill the gaps in the health services delivery system by mandating a medical screening examination and stabilization of emergency medical conditions. At the same time there has been a decrease in the payment for these services, further straining the resources of the providers and hospitals.

*COBRA laws impose civil penalties for transferring patients who are unstable or become unstable, making it undesirable to transfer patients with entitlements to their providing facility (e.g. military/native).

*Administrative requirements continue to add cost to the service.

*Emergency physicians are treating sicker patients as outpatients who require follow-up care which an emergency department cannot adequately provide.

*Patients cannot be expected to have the medical sophistication to be able to differentiate an urgent from an emergent medical condition. Payment systems based retrospectively on the discharge diagnosis are unfair to both the patient and the provider of the care.

*The Access to Health Care Coalition, consisting of twenty-one physician organizations believe that the preferred approach to assure access to needed health care is one that builds upon the strengths of public/private system of insurance and contains the following:

-employers should be required to provide health insurance to their employees and dependents with appropriate cost-sharing;

-Medicaid must be both expanded and substantially improved, including the enactment of minimum eligibility and benefit levels and incentives to enhance provider participation;

-For those not eligible for employer-based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost-sharing on a sliding scale;

-Health insurance whether public or private should provide access to basic physical and mental health benefits

EMERGENCY MEDICINE[1]

Emergency Medicine is a relatively new specialty, first recognized and credentialed in 1979. Residencies were established as were educational and performance goals for the new specialty. The need for the establishment of this new specialty was the increasing complexity of medicine in general, and the emergency department (ED) in particular. EDs have undergone a complete transformation from the "emergency rooms" of old: those "rooms" in a hospital that a nurse would bring the occasional patient who was too sick to go see their own doctor. Such a person would be attended by the "doctor of the day" who would be called at his office and have to leave his scheduled patients to take care of the emergency. Sometimes, there were full time doctors in the emergency rooms but they were likely a retiree or a moonlighting resident. Similarly, the nurses in this setting were unlikely to be specially trained for its rigors. Things have changed.

Emergency medicine is now a specialty requiring the successful completion of an approved Emergency Medicine residency for the opportunity to sit for the certification exam in Emergency Medicine. The American College of Emergency Physicians (ACEP) represents 13,600 emergency physicians nationwide and 47 Alaskan emergency physicians. We, along with our co-workers in emergency nursing, meet the need for prompt treatment of patients with bona fide emergencies regardless of a patient's ability to pay. ACEP believes that quality emergency care is a fundamental individual right and should be available to all who seek it. In

addition, EDs often serve as the entryway to the entire health system for uninsured patients, because alternative treatment sites may be in short supply or even unavailable in the community.

It is important that policy makers understand the crucial role that emergency medicine provides to the health care system. We are quite literally the safety net for the whole system.

THE UNINSURED AND EMERGENCY MEDICINE

Emergency physicians are among those who have had to respond most directly to the problems of the uninsured. No other physician is available 24hours a day for unscheduled care. A 1984-1985 survey conducted by the National Opinion Research Center for the Health Care Financing Administration found that uninsured patients accounted for 19 percent of the visits to the emergency physicians. Another survey conducted by Mathematica Policy Research, Inc., for ACEP in 1986 found that on average, 31 percent of the care provided by emergency physicians was uncompensated care. This, on average, is three times more free care than a typical private practitioner could provide.

State and federal policy requirement imposed on EDs have increased the responsibilities of emergency physicians and EDs to fill gaps in the health services delivery system. In 1986, Congress required that every patient presenting with complaints to a hospital ED be given an appropriate screening examination. The goal of a screening examination is to

determine whether the inidividual has an emergency medical condition or is in active labor. The law further requires that patients found to have emergency medical conditions or to be in active labor must be provided necessary medical treatment within the hospital's capability to stabilize their condition.

Such laws simply codify what emergency physicians already do. We have dedicated ourselves to emergency care for our patients and happily provide services to all who present to our departments. These laws do put constraints upon us and our ability to serve as "gatekeeper" to the health care system. Furthermore, we believe that physicians should provide a portion of uncompensated care to serve the interests of the patients and the community. However, may come a point when expenses outstrip returns and this has led to closure of EDs nationwide.

Therefore, EDs are the only entities mandated by federal law to provide care to all who need it. Patients come to our doors knowing they will receive care regardless of their ability to pay. Legislators must begin to understand that we represent the only source of health care for many Americans, and that we as physicians are very concerned about our ability to continue to provide these needed services when one-third of our patients have no source of payment.

EMERGENCY DEPARTMENTS AND EMERGENCIES

EDs provide 24hour access to emergency care. In addition to the skills of

the doctors and nurses, this requires immediate access to laboratory studies, Xrays, CT scans etc. It is both technology-intensive and labor-intensive and consequently it is often more expensive than other facets of hospital-based health care. We believe that our patients have a basic right to the highest quality emergency care and it is always provided without prior evidence of ability to pay.

We believe that technologies, therapies and pharmaceuticals should be proven efficacious. We support the need for research to better define the effect on outcome of our technologies and techniques.

EMERGENCY DEPARTMENTS AND NON-EMERGENCIES

Emergencies must be self-defined by the patient. It is unrealistic to presume that those who seek emergency care will have the sophistication to differentiate between, for example chest pain due to a muscular strain versus that caused by a heart attack.

A portion of all ED visits are by low income persons and those without health insurance who use EDs for non-emergency care. However, patients determine whether they are in need of emergency care, and should not be discouraged from pursuing the care which they deem most appropriate.

We physicians are not able to accurately diagnose by casual perusal. There are myriad conditions that seem benign at first sight which can in fact be serious. As a simple example, consider the twisted ankle. Is it an

emergency? If it is only a mild sprain then, frankly, it probably requires little expert care. If it is a severe sprain or a fracture it most certainly should receive immediate attention. In reality we usually do not know until we've taken a good history, done an exam and, sometimes, reviewed the Xrays.

Is a sore throat an emergency? Many times it is simply due to a virus and physicians have little to offer. Other times it could represent an immediately life-threatening condition such as an abscess, epiglottitis or even diphtheria. We simply do not know until we have done a proper history and exam.

The "art" of medicine, I.e. clinical experience and judgement, has also taught us to look especially carefully at patients who present to our EDs with what seem to be minor complaints. The patient often has a good sense for the underlying severity of a condition.

So, we are obliged professionally and ethically to see all patients who come to the ED. Federal laws extend further stipulations. It should also be realized that we are under great pressure from malpractice attorneys to leave no possibility of a bad outcome in any patient with whom we have had any interaction. We are liable for acts of omission as well as commission.

Alaska has a number of peculiarities in the delivery of health care related to our size and sparse population.

I practice in Anchorage and receive frequent calls from midlevel practitioners and health aids at outlying sites who have questions about patient management or are notifying me of a patient transfer. Given the level of their training, I often receive individuals who in fact do not have a medical emergency but have been shipped to Anchorage at an odd hour by someone who thought that they did. Clearly, these inidviduals have to be treated in the ED and arrangements made for their follow-up (often quite a challenge). Those who do not understand this environment might simply look at the patient's complaint and eventual diagnosis and deem it an inappropriate emergency visit, but if one understands our environs it becomes obvious that no other options existed.

EDs frequently care for individuals who are entitled to free care at other facilities, yet come to the ED for evaluation of problems of varying severity; many times they have already been seen for the same complaint at their place of entitled care (it is eventually revealed) and are essentially looking for a second opinion. They are rightfully using health care benefits that they possess but to an extent it seems to represent a duplication of services. More often than not, though, in my experience, these folks are accessing the system in the only way that they know how and are earnest in trying to find out more about a given affliction. For whatever reasons, they distrust their entitlement provider and the ED, to them, represents a setting where they can get care that they trust.

EDUCATION AND SELF-HELP

A long term goal of health policy should be health promotion and disease prevention. Alaska ranks first or second in the nation as the "least healthy" places to live. This is in part due to dangerous industries but also has something to do with our similar placement in per capita tobacco and alcohol consumption. Trauma due to acts of violence has been shown to be a recurrent "illness" for a certain segment of the population who make repeated trips to EDs for treatment. By and large this group eventually dies at an early age as a result of trauma. We must make efforts to interrupt this cycle. Young mothers lacking a support structure frequently bring their children to the ED for evaluation at the first signs of minor illness and without having tried usual home measures. Better health education would save ED visits and also boost the parents' confidence and self-image.

USER TAX

Alcohol is involved in at least 50% of the injuries seen at most EDs. It also results in an astounding drain on ED resources in the form of inebriated individuals brought to EDs for evaluation. Cigarette abuse leads to frequent ED visits for respiratory ailments and eventually to visits related to cancer. "Sin" taxes could be levied and the revenues applied to defray the cost of their consequences.

Certificate of Need

Duplication of expensive resources is to be avoided. Yet, in Anchorage alone, a new hospital is being built and another is being planned. This seems to be the most egregious excess but has received no mention. For example, the new native hospital will have an ED, yet it is virtually next door to Providence Hospital which has in place a large, modern ED.

MALPRACTICE

The current predatory malpractice environment leads to increased health care expenses due to high premiums and defensive medical practices. Emergency physician's malpractice premiums are among the highest in medicine. We are literally forced by the threat of avaricious attorneys to order needless, expensive test. Malpractice litigation reform is clearly needed.

ADMINISTRATIVE

Estimates vary but it is clear that our administrative burden is expensive.

<u>ACEP SUPPORTS THE FOLLOWING CONCEPTS</u>

- Utilizing the traditional approach of employer based insurance, employers should be required to provide health insurance to their employees and dependents with appropriate cost-sharing by employees. Recognizing the potential financial burden this could impose on certain small businesses, provisions should

be included which would ameliorate the impact of this requirement such as tax relief, subsidies, phased-in implementation, risk pools and other reforms which would make insurance more available and affordable.

- Medicaid must be both expanded and substantially improved including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation. Due to uneven eligibility criteria and benefit levels across the states, the current medicaid program covers fewer than 42% of Americans with incomes below 100% of the poverty level.

- For those who are not eligible for employer-based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost sharing on a sliding scale premium basis.

- Health insurance programs, whether public or private, should provide access to basic health benefits.

- Medical malpractice reform must be enacted, including limitations on non-economic damages, the use of alternative dispute resolutions, reductions in contingency fees, , etc.

- Health insurance reform should be enacted,elimination of pre-existing conditions,community rather than experiential rating,et

- Reductions in administrative cost through the use of universal form, etc. should be accomplished.

- Technology and pharmaceuticals should be assessed for efficacy and cost effectiveness

- Health promotion, disease prevention, education and research should be enhanced.

- Increased use of managed care system and /or the principles of managed care is acceptable so long as the need of emergency medicine in providing quality emergency care are not deterred, i.e., timely authorization of services, mandatory screening exams, transfer guidelines, etc. Stong federal oversight would be needed.

[1]Portions of this document are taken from the ACEP and AMA 7/23/90 statement to the US Senate Subcommitte on Health for Families and the Uninsured

HEALTH RESOURCES & ACCESS TASK FORCE
PRESENTATION
Dr. James Nesbitt, MD
September 26, 1992

The interest of the Alaska Chapter of the American Academy of Pediatrics is to improve health care availability for the children of Alaska.

Every day pediatricians in Alaska see children whose parents cannot afford proper medications because of lack of health insurance. They are not eligible for Medicaid because one parent works, but their income is so low they cannot afford to properly care for their children's medical needs out-of-pocket. Their employer does not provide dependent coverage or if it does, the coverage does not provide for immunizations, preventive care, medications, routine lab work or care of pre-existing conditions. Yesterday I saw a two and one-half year old child with Vitamin D dependent rickets whose mother had delayed bringing him back for follow up for a year and a half because she had no health insurance due to her husband's company going bankrupt. She felt she could not afford the X-rays, lab work and medications I had told her the child needed a year and a half ago. This child is now going to need additional X-rays, lab work and longer time on treatment with a less likely chance of success because of the delay in treatment.

I am often forced to prescribe a less effective antibiotic because a parent cannot afford the more effective and more expensive one. This often leads to additional office visits, more expensive medication and less chance of success in the long run.

Access to health care in Alaska is limited for the most part by lack of health insurance.

<u>What recommendations does the Alaska Chapter of the AAP have for reforming the health care system?</u>

Nationally, the AAP supports HR 3393, the Matsui Bill, "Children's and Pregnant Women's Health Insurance Act of 1991".

1) It would cover all children through age 21 and all pregnant women.

2) It is a pay or play system: Employers provide either a

qualified insurance package for dependents or they will pay a payroll tax to the State-Administered Insurance Fund. The states will administer the SAIF through private insurance companies. Insurers, whether contracting with the state or with an employer, will be required to provide a standard benefit package.

3) There will be three baskets of benefits:
   Preventive
   Primary/Major medical
   Extended/Major medical

4) Financing:
   a) Money which now goes for Medicaid.
   b) Employer payroll tax (3.2%) for those employers not providing the standard benefit package.
   c) Employee payroll tax (1.0%) for those not covered by their employer.
   d) Premiums.

This will establish a one class system of medical care.

Cost Containment - Cost Sharing (Premiums, Deductibles, and Coinsurance

The emphasis on preventive care and administrative saving due to uniform benefits will contain costs. Coordinated care in the Extended Major medical package will also control costs.

Insurance Reform:

1) Pre-existing condition exclusions will be prohibited.

2) Guaranteed issue and renewability of coverage for any small business regardless of health or risk status will be required.

3) Community rating will be required.

4) A minimum benefit standard will be established.

Physician/Hospital Payment

Resource-based relative value scale (RBRVS) for pediatric and obstetric services will be established.

What are the benefits for Alaska of such a system?

1) It has the benefits that children need. It places an emphasis on preventive health care and provides age-appropriate and comprehensive services for children. The focus on preventive care will reduce the need for more expensive emergency room care.

2) It establishes a one-class system of care and requires uniform benefits.

3) It is doable. It builds on the employer-based system of private insurance. It provides affordable health insurance for all dependents and eliminates pre-existing condition clauses in insurance.

4) It replaces the portion of the Medicaid program currently serving children and pregnant women with private insurance, thus eliminating the increasing medicaid mandates from Congress.

5) Insurance reform will make health care coverage more affordable for small businesses.

6) Cost-sharing and the use of care coordination will also help contain costs.

7) There will be a limit on the payroll tax, so business will know in advance their annual cost for employee health insurance and not be faced with rapidly increasing unknown costs.

8) Businesses will have the cost-effective option of providing insurance for their full-time workers and paying the tax for their part-time workers.

9) The removal of pre-existing condition exclusions will allow employees more freedom in job selection.

10) Children's health care is cost effective and relatively inexpensive and the payoff is substantial:

   a) $1 for immunizations saves $10 in future medical costs.
   b) $1 for prenatal care saves $3.
   c) $1 for early prevention and intervention saves $4.75 in costs for remedial education, welfare and crime down the road.

11) Providing access to health care to all children now will help assure that Alaska will have the healthy work force which is essential to the productivity and financial stability of the state in the future.

American Academy of Pediatrics, Alaska Chapter

ACADEMY-BACKED LEGISLATION

THE CHILDREN'S AND PREGNANT WOMEN'S HEALTH INSURANCE ACT OF 1991
Rep. Robert Matsui (D-CA) H.R. 3393

Introduced September 24, 1991

ELIGIBILITY:
All children through age 21 and pregnant women will be eligible for the program. This will extend coverage to more than 12 million children and 500,000 pregnant women who currently lack insurance, and will eliminate the underinsurance problem.

STRUCTURE:
Play or pay system. Employers will either provide a qualified insurance package for dependents or they will pay a payroll tax to the State Administered Insurance Fund (SAIF). The states will administer the SAIF through private insurance companies. Insurers, whether contracting with the state or with an employer, will be required to provide a standard benefit package.

BENEFITS:
Three baskets of benefits. (AAP benefit package and schedule)
Preventive – child preventive (routine visits, routine lab tests and immunizations), prenatal, newborn, family planning, child abuse assessment and preventive dental. Primary/Major medical – hospital services, inpatient and outpatient physician care for acute and chronic conditions, diagnostic tests, acute dental care, ambulance, durable medical equipment, corrective glasses and lenses, hearing aids and prescription drugs. Extended/Major medical – mental health, substance abuse services, treatment of developmental and learning disabilities (excludes educational component), speech, orthodontia, occupational and physical therapy, hospice, respite, short-term skilled nursing care and nutritional assessment and counseling.

FINANCING:
Financing will be through existing sources (previously allocated for Medicaid), the employer payroll tax (3.2%) for those not providing the standard benefit package, the employee payroll tax (1.0%) for those not covered by their employer and premiums. General revenue will be needed to cover subsidies to low-income workers and corporate tax revenue loss. A one-class system of medical care will be established by replacing, with private insurance through the SAIF, the portion of the Medicaid program currently serving children and pregnant women and by requiring uniform benefits.

COST CONTAINMENT:
Cost sharing (premiums, deductibles and coinsurance), emphasis on preventive care and administrative savings due to uniform benefits will contain costs. Coordinated care in the third basket will also control costs.

INSURANCE REFORM:
Preexisting condition exclusions will be prohibited. Guaranteed issue and renewability of coverage for any small business regardless of health or risk status will be required. Community rating will be required. A minimum benefit standard will be established.

PHYSICIAN / HOSPITAL PAYMENT:
The bill will establish a resource-based relative value scale (RBRVS) for pediatric and obstetric services. It will require the Secretary of Health and Human Services (HHS) to establish a national advisory committee composed of pediatricians, family physicians, obstetricians and experts on and advocates for maternal and child health. The national advisory committee will advise the Secretary of HHS on appropriate payment amounts (including the conversion factor) and all factors that influence the adequacy of health funding for children and pregnant women (such as quality of care and distribution of services).

HOW CHILDREN FARE:
All children will have financial access to the AAP recommended benefits.

TABLE 2—COST-SHARING STRUCTURE — STATE FUND

Family Income Level (Expressed as a percentage of the Federal Poverty Level)	Annual Premium Share	Annual Deductible	Coinsurance		
			Category 1: Preventive Benefits	Category 2: Primary/Major Medical Benefits	Category 3: Extended/Major Medical Benefits
200% or More	Variable Up to 25% of Cost of Plan Not to Exceed $458*	$200	No Deductible or Coinsurance Regardless of Income Level	20%	30%
150% - 200%		$150		15%	22.5%
133% - 150%		$50		10%	15%
Less than 133%	None	None	None	None	None

Note: A catastrophic cap of 10% of family income to a maximum of $3,000 per family or $1,000 per beneficiary limits out-of-pocket expenditures.

No insurer will be allowed to exclude coverage of any preexisting condition. States will enact rules for insurance companies based on federal regulations. The Secretary of Health and Human Services will guide development of these federal regulations.

SHARED FUNDING

Individuals, the private sector, and state and federal governments will share in funding the system. The federal government will apportion funds from these sources to the states on the basis of the projected number and age of the beneficiaries enrolled in the state plan. Employers will be required to provide an insurance package with specified benefits for dependents and pregnant employees, or pay a 3.17 percent tax* on the wages of all employees, up to the Social Security wage base. This requirement will apply equally to employers who currently offer limited coverage for dependents, who offer no dependent coverage or who offer no employee health insurance.

The above requirement may present a hardship to small employers who have been unable to purchase group insurance either because of cost or unavailability. Health insurance reforms will be required to guarantee the availability of insurance to all small groups and to set equitable premium rates for all purchasers within the same geographic area. Tax deductions and tax credits are also viable options.

The share of a dependent's premium paid by the employee must be no more than the share that the employee pays for his or her own premium, and in any case, may not exceed 25 percent of the total premium. Payroll taxes and premium rates will be adjusted to ensure that adequate funds are generated to purchase private health insurance. Federal and state contributions, payroll taxes and premiums can be adjusted for inflation.

* All tax and cost estimates are based on 1988 data.

The state administered insurance fund will be financed from three sources:

- federal and state Medicaid funds currently allocated to children and pregnant women;
- employer payroll taxes; and
- premiums.

Family premiums and cost sharing for some services will be determined by family income.

▶ COST SHARING

Cost sharing includes deductibles and coinsurance which is a fixed percentage of the total cost of care. Cost sharing will not apply for preventive care, regardless of income of participants.

Families participating in the SAIFs, with incomes below 133 percent of the federal poverty level, will be exempt from premiums. The annual premium for state-contracted private insurance for a family with income over 200 percent of the federal poverty level will be $458 per family*. Families with incomes between 133 and 200 percent of the poverty level will have their coinsurance and deductibles determined on a sliding scale. Coinsurance for primary/major medical services will be 20 percent, and for extended/major medical (care coordinated) services will be 30 percent for families with incomes above 200 percent of the poverty level. (See table 2.)

Based on national standards, states will determine eligibility for subsidies for state fund participants. Provisions are included for timely review of income status should family income change substantially during the year.

Families whose dependents receive insurance through an employer will pay a $200 deductible. Coinsurance for primary/major medical will be 20 percent and 30 percent for extended/major medical services. (See table 3.)

* All tax and cost estimates are based on 1989 data.

TABLE 3—COST-SHARING STRUCTURE EMPLOYER BASED INSURANCE

Annual Premium Share	Annual Deductible	Coinsurance		
		Category 1: Preventive Benefits	Category 2: Primary/Major Medical Benefits	Category 3: Extended/Major Medical Benefits
Variable Up to 25% of Cost of Plan	$200	No Deductible or Coinsurance Regardless of Income Level	20%	30%

Note: A catastrophic cap of 10% of family income to a maximum of $3,000 per family or $1,000 per beneficiary limits out-of-pocket expenditures.

Uninsured Children: The Facts

- Seventeen percent of American children under the age of 21 -- approximately 12.4 million -- have no health insurance, either private or public. Tens of millions more children have insurance which does not cover routine preventive care, including immunizations. (Employee Benefit Research Institute (EBRI), Washington, DC)

- Anyone can become uninsured, regardless of age, income or employment status. But the major reason for the growing number of uninsured persons is the decline in dependent coverage by employers. The current system is not treating children and pregnant women fairly. (*A Call For Action*. Final Report of the U.S. Bipartisan Commission on Comprehensive Health Care)

- A September 1991 New York Times/CBS Poll revealed that 29 percent of Americans reported that they or a family member were without health insurance some time in the last year, with 20 percent reporting their household had been seriously hurt by medical bills.

- Seven out of eight uninsured children live in families where at least one parent works. Often, parents are covered by health insurance from their employers, but their children are not. (EBRI)

- Sixty-five percent of uninsured children live in families whose income is above the federal poverty line ($14,000 for family of four). Thirty percent of uninsured children live in families whose income is more than 200 percent of the federal poverty line. (EBRI)

- Children's medical care needs and consequently their utilization of services are very different from those of adults. Yet, the benefits offered by most private health insurance plans are designed to cover an adult pattern of utilization, i.e., inpatient care and high cost procedures. (EBRI)

- America spends 12 percent of its GNP on health care, but only .08 percent of that budget is spent on preventive health care. Access to age-appropriate, preventive and comprehensive primary health care is critical to the well-being of our children and adolescents. (*Our Children's Future: Health Care*, Joycelyn Elders, M.D., Feb. 1990)

- More than seven million U.S. women aged 21-45 have no insurance, public or private. Many others are uninsured for maternity and delivery services. (EBRI)

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- Compared with other nations, an alarming percentage of babies born in the U.S. die before their first birthday. The U.S. lags behind 21 nations in infant mortality and 20 nations in child mortality. (Source: U.S. Department of Maternal and Child Health) Infant mortality data not only report how many of our babies die before the age of one; these data are also widely recognized as important indicators of the overall health of our children. (*A Call for Action*)

- Every $1 spent on early prevention and intervention can save $4.75 in costs associated with remedial education, welfare and crime down the road. (*A Proper Inheritance: Investing in the Self-sufficiency of Poor Families*, 1989)

- For every $1 spent on all childhood immunizations, $10 is saved in future medical costs. (U.S. House of Representatives Select Committee on Children, Youth and Families)

January 1992

Key Access Messages

Following are some of the key messages that should be conveyed in your presentations on the access to health care issue:

- For humanitarian, economical and political reasons, it makes sense to begin revamping our health care system by meeting the needs of children and pregnant women first.

- It may be years before all Americans have access to quality medical care, but the needs of our nation's most vulnerable population -- children -- can and should be addressed now.

- We all bear the costs of care for children and pregnant women who have no health insurance. We pay in taxes, higher hospital bills and runaway insurance premiums. We're usually paying for the care of the uninsured in crisis situations that might have been averted if access to preventive care were universal.

- The health care access problem is getting worse, not better. The number of uninsured children has been growing steadily since 1980.

- Lack of insurance is not a problem only for low-income families. More than half of uninsured children live in two-parent families where at least one parent is employed full time and earning an income above the federal poverty line.

- In light of current government budget constraints, we must set new priorities for health care spending -- away from *sick care* and toward preventive care.

- Children's preventive health care is cost-effective and relatively inexpensive, and the payoff is substantial.

- Kids who don't get early and prompt care get sicker, making their health care more costly. Pregnant women who lack prenatal care have babies who are less healthy and who often require intensive and expensive care.

- Providing access to health care to all children now will help assure that America in the 21st century will have the healthy workforce which is essential to the productivity, security and defense of our nation.

Answers for Business

"Ensuring a healthy, well-educated next generation is our best and perhaps only way of guaranteeing future national security. At the very least, we should start now by providing all pregnant women and newborns with a basic health insurance plan."

David Packard, Chairman, Hewlett-Packard Co.

"More and more of our nation's children are arriving at school woefully unprepared ... They are deprived of an education because they are deprived of the health care that would make them physically, emotionally and intellectually ready to learn."

Keith Geiger, President, National Education Association

Owners of small and large businesses are particularly concerned about the effect of the current health care crisis on their business and their employees. Following are some reasons why business leaders should support H.R. 3393.

- Currently health care costs are unfairly distributed among businesses since some provide health insurance while others do not. H.R. 3393 will alleviate this unfair distribution by involving all businesses in the provision of health insurance.

- This bill includes cost controls that will help restrain runaway medical costs.

- H.R. 3393 utilizes community rating, which requires that an insurance company charges all small employer health plans with similar benefits in the same community the same rate. This will make the cost of health insurance more affordable for small businesses.

- Under the plan, insurers will be required to offer coverage to all small employers in a community if they offer it to one. Additionally, each small employer health plan is guaranteed to be renewed. This guaranteed issuance and renewability will make the health insurance market more stable for those companies who have high-risk employees.

- H.R. 3393's four-year phase-in will give businesses a chance to adapt their systems and budgets to be in compliance.

- There will be a limit on the payroll tax, so businesses will know in advance their annual cost for employee health insurance and will not be faced with rapidly increasing, unknown costs.

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- The employer payroll contribution is tax deductible for businesses.

- Businesses will have the cost-effective option of providing insurance for their full-time workers and paying the tax for their part-time workers.

- The removal of preexisting condition exclusions will allow employees more freedom in job selection.

Why Support H.R. 3393?

- **H.R. 3393 has the benefits that children need.** Unlike many universal health care reform proposals, the basic benefit package included in H.R. 3393 places an emphasis on preventive health care, and provides age-appropriate and comprehensive services for children.

- **H.R. 3393 establishes a one-class system of care.** A one-class system of care will be established by replacing, with private insurance, the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform benefits.

- **H.R. 3393 is doable.** Rather than cause a major disruption in our current health care system, H.R. 3393 builds on the employer-based system of private insurance. It replaces the portion of the Medicaid program currently serving children and pregnant women with private insurance. It provides affordable health insurance for all dependents and eliminates preexisting condition clauses in insurance.

- **H.R. 3393 is less expensive.** Because H.R. 3393 deals only with children and pregnant women, it will cost less than other health care reform proposals that attempt to cover the whole population. H.R. 3393 will provide Congress with experience, much as a demonstration project would, for larger, universal, health care reform proposals.

- **H.R. 3393 can help our children now.** Through this legislation, we can act now to protect our most vulnerable population, children, while the debate over universal access (which may take years) continues. Our children cannot and should not have to wait for essential health care.

- **H.R. 3393 is a "first step."** Support for H.R. 3393 does not preclude support for a universal access plan. H.R. 3393 represents action that Congress can take now (a first step) as it works towards implementation of a universal plan. H.R. 3393 can be expanded in the future to cover the entire population once Congress agrees on a universal package.

- **H.R. 3393 is politically feasible.** Due to the fact that H.R. 3393 helps children and is less expensive than other proposals, politicians can take action to protect a particularly vulnerable population and not "break the bank" in the process.

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Is H.R. 3393 Practical and Can We Afford It?

- **H.R. 3393 makes good economic sense.**
  - For the federal government, it will cost less than other universal health care reform proposals currently pending.
  - For states, it eliminates the increasing Medicaid mandates from Congress.
  - The focus on preventive care will reduce the need for more expensive emergency room care.
  - Insurance reform will make health care coverage more affordable for small businesses.
  - Cost-sharing and the use of care coordination will also help contain costs.
  - For physicians and other providers, it decreases complex billing procedures, inadequate reimbursement and cost shifting.

HEALTH CARE AMERICA

Meeting America's Health Care Needs

AARP's Draft Proposal For Health Care Reform

AARP

Stock # D14720

Health Care America Proposal Highlights

Health Care America is AARP's draft proposal for a comprehensive health care system that provides health and long-term care coverage for all individuals. The cornerstone of the plan is MEDICARD, a single health insurance access card. The card guarantees each user — regardless of age, income or job status — high-quality health coverage through a strengthened, improved and expanded Medicare program or through private employer-based coverage that meets the same standards for coverage, benefits, quality and cost-containment. Long-term care coverage is available to all individuals through the new Medicare program.

Health Care America - An Overview

- The new program is easy to use and understand. All one needs to obtain health services is his or her MEDICARD. The card assures access to a full range of benefits, including hospital and doctor care, preventive care, outpatient prescription drugs and long-term care.
- It controls costs. It also standardizes doctor and hospital payment rates, and limits prescription drug prices. The proposal establishes spending targets at both the national and state levels. Its streamlined billing system cuts down on administrative expenses.
- It includes what most people don't have — long-term care coverage in the home, in the community and in the nursing home. It places limits on long-term care costs to the individual. People with disabilities can get help with their daily activities if they live at home or in the community. If they need nursing home care, that's also covered. Out-of-pocket payments for these services are limited so that long-term care is affordable.
- It preserves our freedom of choice. We can select our own doctors — just as we do today.
- It promotes preventive care. There is no charge for such preventive measures as physical check-ups, prenatal and well-baby care, pap smears, immunizations and other services that help ensure good health.
- It provides comprehensive benefits for all. Everyone automatically is covered, regardless of age, employment status or income. No individual can be denied coverage on the basis of a pre-existing condition.

Why We Need To Take Action

America's health care system is in deep trouble. While some of us enjoy the highest standard of medical technology and life-saving procedures in the world, many of us can't afford basic health services. The system is unfair and grossly inefficient. National spending on health care continues to soar even as millions go without health coverage. Millions more are unable to afford needed long-term care. It is a crisis we can no longer ignore.

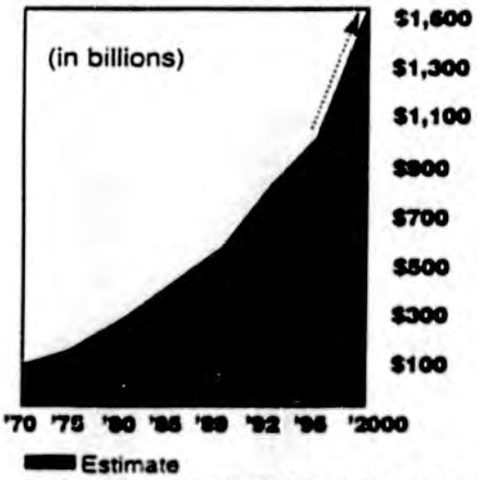
Consider these facts:

- Our annual health care spending is expected to rise from $800 billion in 1992 to $1 trillion by 1995, according to government projections. Unless we reform our health care system, that figure will nearly double — to $1.6 trillion — by

the year 2000. The average per person spending on health care will soar from $2,566 in 1990 to more than $5,700 in the year 2000.

- The cost of health care is rising two to three times faster than general inflation. In other words, two to three times faster than most people's incomes. Our incomes are rapidly losing ground to our health care bills. Employers are being forced to cut back on hiring and pensions and other benefits. The high cost of health care is placing America at a competitive disadvantage in the world marketplace.
- An estimated 36 million Americans do not have health care coverage. Two-thirds of these are workers and their dependents. Almost 10 million children under age 18 have no coverage.
- On average, nursing home care costs $30,000 per year, much of which is paid by the nursing home resident or his or her family. Residents often use up their savings to pay for their care. Long-term care services in the home and the community are frequently unavailable or unaffordable for those who need them.

National Health Care Expenditures



Source: Health Care Financing Administration, 1990

Reforming our health care system has become a national priority. The truth is, we can't afford not to. AARP has responded to this challenge by developing Health Care America, a draft proposal that controls cost, guarantees quality of care, and provides comprehensive benefits for all.

Where AARP Stands

For more than three decades, AARP has taken a leadership role on issues of health and long-term care. AARP stands firmly for a health care system that provides high-quality, affordable health and long-term care for all. Health Care America achieves that goal. We recognize that no matter which approach to health care reform our nation adopts we will all face difficult decisions on how to pay for a new system and how our care is provided.

Health Care America reflects the Association's strong commitment to improving the quality of life for all generations. The need for a better system of health and long-term care is so great that it overrides what some may view as AARP's organizational self-interest. Although AARP derives considerable revenue from providing health insurance to members, the Association will gladly forego every penny of it in exchange for a national health care system that guarantees universal access to quality care, real cost containment, and a way to pay for care that is broad-based and fair.

Health Care America: A "Blended" Plan

We call this a "blended" plan. That's because it takes the best elements from several different approaches to health care reform along with our best ideas and "blends" them into one highly efficient plan. Our planning was guided by the following goals. The new system must:

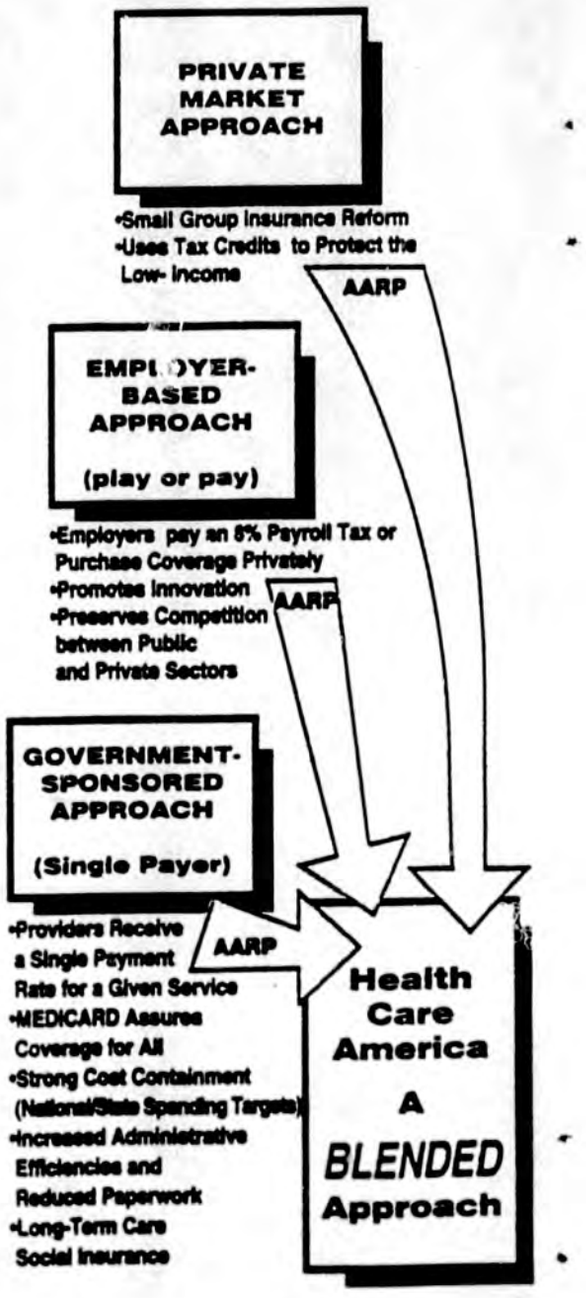
- control costs
- cover everyone
- ensure quality
- provide a comprehensive set of benefits, including long-term care
- ensure fair and equitable financing

The proposal's cornerstone is MEDICARD, a single health insurance card that guarantees access to the full range of coverage, from hospitalization, physician services, and nursing home care to preventive health services and outpatient prescription drugs.

Coverage is available to <u>everyone</u> through the new expanded and strengthened Medicare program. The program is built on the strengths of the existing Medicare program but makes improvements in its benefits, cost containment and administration. Employers can enroll their workers in Medicare or instead pay privately for their medical benefits, that is for their hospital, doctor, lab, X-ray, preventive services, etc. However, benefits provided privately must be as good as or better than those provided through the new Medicare program.

Either way, you can no longer be denied coverage on the basis of a condition you already have, such

How Health Care America "Blends" Approaches



as diabetes or heart disease. Everyone automatically is eligible for coverage of health and long-term care services.

The proposal's benefits fall into two categories: 1) doctor, hospital and other medical and preventive care services; and 2) long-term care.

Doctor, Hospital, and Other Medical and Preventive Care

This includes health services that help prevent disease; medical care given for short-term or temporary illnesses; emergency care; accidents or hospitalizations; and prescription drugs. For most families, direct out-of-pocket expenses for health care will be less than they pay today.

What the Plan Covers:

- Hospital and other inpatient services
- Physician and surgical outpatient services
- X-ray and laboratory services
- Both inpatient and outpatient mental health care
- Preventive care such as periodic check-ups, mammography, pap smears, colorectal tests, prostate cancer screening, prenatal and well-baby care, dental/vision/hearing screening services
- Dental/vision/hearing treatment for all children and low-income adults
- Outpatient prescription drugs

HEALTH CARE AMERICA'S MEDICAL CARE COVERAGE At-A-Glance

KEY POINTS	HOW MUCH YOU WOULD PAY
Annual Deductible Single/Family	$200/$400
Annual Out-of-Pocket Limit Single/Family	$1500/$3000
Hospital Services Inpatient	0% coinsurance
Physician & Surgical Outpatient Services	10% coinsurance
X-ray and Laboratory	10% coinsurance
Mental Health •Inpatient •Outpatient	 0% coinsurance 10% coinsurance
Preventive (e.g., Check-ups Immunizations, Mammography, Pap Smears, Colorectal and Prostate Cancer Screening)	No deductible 0% coinsurance
Prenatal and Well-Baby Care	No deductible 0% coinsurance
Prescription Drugs	10% coinsurance
Premiums: •For those in the new Medicare	 $50 mo. / $600 year
•For those with employer-based coverage	Up to 20% of total premium

What You Pay for Medical and Preventive Care:

- Deductibles. A single person would pay the first $200 of medical costs per year before the insurance kicks in; a family would pay the first $400.
- Coinsurance (or copayments). The plan pays 100 percent of preventive care such as checkups and immunizations. You pay 10 percent of most other services, including prescription drugs, X-ray and laboratory services, and outpatient mental health care. There is no coinsurance for inpatient hospital care and hospice care.
- Prescription medication is provided. The plan covers all but 10 percent of the cost of outpatient prescription drugs.
- Your risk is limited. Yearly, no one would pay more out of their own pocket than $1,500 per person or $3,000 per family in deductible and coinsurance amounts.
- Premiums. Individuals and families enrolled in the new Medicare program would pay a monthly premium of $50 per adult and $25 for family coverage, regardless of how many children are in a family. So, a family of four (2 adults and 2 children) would pay $125 per month under the plan. Individuals receiving medical coverage through an employer could be asked to pay up to 20 percent of the private premium costs.
- Low-income people would be protected. The poor would pay no premiums, deductibles or coinsurance. Other low-income individuals or families would be eligible for assistance with their out-of-pocket health costs.
- Taxes. (See "How We Pay For The Proposal," page 16.)

Long-Term Care

Long-term care services would be covered for people with chronic conditions or disabilities (both physical and mental, e.g., Alzheimer's Disease) who need assistance in their daily lives.

Millions of Americans — in fact, almost all Americans — now have virtually no protection from the financial costs of long-term care. This will become an increasing problem as our population ages. By the year 2000, nearly 9 million Americans will need long-term care, up from about 7 million in 1988.

This is a particularly critical issue for those who will need nursing home care and their family caregivers. On average, nursing home care currently costs $30,000 per year. Nationally, about half of nursing home costs are paid by the nursing home resident or his or her family. People currently have to use up their savings and become poor before getting help with their nursing home costs through the Medicaid program.

Health Care America offers what other plans don't — a comprehensive and affordable set of long-term care protections. The goal is to help people remain independent and at home for as long as possible. The same MEDICARD that ensures access to physicians' services, clinics and hospitals also guarantees coverage of long-term care services for everyone through the new Medicare program.

The plan covers care provided in the home, in the community and in the nursing home. It supports

AARP'S LONG-TERM CARE COVERAGE At-a-Glance

Coverage through the new Medicare Program	Persons of all ages with serious disabilities or impairments.
Benefits	Home and community-based services, including respite and adult day care. Nursing home care.
Cost-Sharing	
•Deductible	None
•Coinsurance	20% for home and community-based services. Room and board co-payment for nursing home care (not to exceed $962 per month in 1993).
Financial Protection	Income-related caps on out-of-pocket costs. No asset test.
Administration	National public program administered as part of Medicare. States contract with care coordinating agencies which determine a person's need for services.

the efforts of families to care for their own. Again, everyone — regardless of age, income or employment status — will be eligible for long-term care services if they need them. In all settings, services are made available at a reduced cost to those persons with lower incomes.

What the Plan Covers:

- The plan provides long-term care in the most appropriate setting. A "care" coordinator, such as a nurse or social worker, works with you, your doctor, and your family to determine if you need long-term care and, if so, which setting would be best for your needs.
- Home and community services. If you are able to stay at home, the plan will cover services to support the informal help you receive from family and friends. These services might include personal or nursing care, homemaker services, adult day care, respite care for family members, transportation or minor home adaptations.
- Nursing home care. If you or a loved one needs to be in a nursing home, this will be arranged by your care coordinator, such as a nurse or social worker.
- Quality long-term care. Quality will be assured through extensive monitoring. For example, your care coordinator will help make sure that the services you receive are of the highest quality. All providers of long-term care services will be certified and licensed. An expanded advocate service for residents will also monitor the quality of care in nursing homes or in your home or community.

What You Pay for Long-Term Care:

Home and Community Services

- The plan will pay for 80 percent of the cost of home and community services with no deductible. You or your family will pay the remaining 20 percent up to an annual limit of $1,500 per person or $3,000 per family. Studies show that more than three out of four older persons who receive such long-term care services under Health Care America will pay $460 a year or less.
- Annual out-of-pocket spending caps for those with both medical and home or community long-term care expenses will be limited to $1,800 per individual or no more than $3,600 per family.
- Persons with incomes below the poverty level will pay nothing for their care. Others with low incomes will receive assistance in paying providers for their share of care. Out-of-pocket spending for home- and community-based care is capped for all individuals.
- States will determine the prices for home and community services through a competitive bidding process.
- People would not have to "spend down" or use up their savings and become poor in order to qualify for care, as is the case under Medicaid today.

Nursing Home Services

- If you need to be in a nursing home, the plan will provide coverage for your entire stay. You will not have to use up your savings before receiving coverage, nor will you need to pay a deductible.

- You will need to pay a certain amount for room and board The amount you pay is related to your income up to a specified limit. For example, a resident with an annual income of $12,000 will pay $150 a month in 1993. A single resident with an annual income of $24,000 will pay $550 a month. No one will pay more than $962 a month (an amount representing about 35 percent of the average cost of nursing home care in 1993).
- All nursing home residents will be able to keep a monthly $100 personal needs allowance, regardless of income.
- Married nursing home residents will be able to protect $1,790 per month of their own income to support their spouses. Additional income could be protected to support other dependents or to pay high housing costs.
- Your care is covered based on a plan worked out in consultation with a nurse, social worker or other care coordinator. States will set the rates paid by your care coordinator for nursing home care.

Use of the System by the *Patient* and the *Provider* under Health Care America

1. You will receive a MEDICARD to use when visiting your doctor or other health care professional. The card enables you to receive the full range of covered health care services.

2. With MEDICARD, your health provider gains access to a computerized system that bills either Medicare or your private insurer for the health services you received.

3. Your doctor or other health provider receives full payment from either the new Medicare or from your private insurer. Medicare or the insurer bills you for your share, if any, on a monthly basis.

4. If you need long-term care, your card enables you to contact a care coordinator, such as a nurse or social worker. This person will help you determine the type of care required. He or she will then authorize the services you need to maintain your independence at home or help obtain admission to a nursing home, if that becomes necessary.

What The Plan Costs

Many people believe that the $800 billion spent on health care in 1992 is more than enough to pay for a new health care system. While we can drastically reduce the waste in our current system and save money, the savings won't pay for everything we need to add.

AARP estimates that it will take $112 billion in new taxes to provide comprehensive health and long-term care to all individuals. However, increased taxes will be offset significantly by reductions in how much we pay for insurance premiums, deductibles, coinsurance and other out-of-pocket costs for health care. Taking these factors into consideration, the true added cost of Health Care America is closer to $22 billion in the first year, with savings achieved in following years.

What do we get in return? Everyone — children, the employed, retired, and unemployed — will have full access to high-quality health and long-term care services. The 36 million Americans who have no insurance today will be covered.

As a nation and as individuals, we will have far greater control over our health spending. Workers will no longer have to worry about losing their health coverage if they lose or change their jobs. Chronically ill or disabled persons won't have to spend all their hard-earned savings to pay for long-term care or worry about paying for the medicine their doctors prescribe.

If we do nothing, we will still end up spending more and more for a fragmented system that leaves millions of people without access to health and long-term care.

What You Pay for Long-Term Care:

Home and Community Services

- The plan will pay for 80 percent of the cost of home and community services with no deductible. You or your family will pay the remaining 20 percent up to an annual limit of $1,500 per person or $3,000 per family. Studies show that more than three out of four older persons who receive such long-term care services under Health Care America will pay $460 a year or less.
- Annual out-of-pocket spending caps for those with both medical and home or community long-term care expenses will be limited to $1,800 per individual or no more than $3,600 per family.
- Persons with incomes below the poverty level will pay nothing for their care. Others with low incomes will receive assistance in paying providers for their share of care. Out-of-pocket spending for home- and community-based care is capped for all individuals.
- States will determine the prices for home and community services through a competitive bidding process.
- People would not have to "spend down" or use up their savings and become poor in order to qualify for care, as is the case under Medicaid today.

Nursing Home Services

- If you need to be in a nursing home, the plan will provide coverage for your entire stay. You will not have to use up your savings before receiving coverage, nor will you need to pay a deductible.

- You will need to pay a certain amount for room and board. The amount you pay is related to your income up to a specified limit. For example, a resident with an annual income of $12,000 will pay $150 a month in 1993. A single resident with an annual income of $24,000 will pay $550 a month. No one will pay more than $962 a month (an amount representing about 35 percent of the average cost of nursing home care in 1993).
- All nursing home residents will be able to keep a monthly $100 personal needs allowance, regardless of income.
- Married nursing home residents will be able to protect $1,790 per month of their own income to support their spouses. Additional income could be protected to support other dependents or to pay high housing costs.
- Your care is covered based on a plan worked out in consultation with a nurse, social worker or other care coordinator. States will set the rates paid by your care coordinator for nursing home care.

How We Pay For The Proposal

Health care costs today are covered by three general sources:

- Taxes on individuals and businesses (federal, state and local)
- Premiums paid by employers
- Premiums and out-of-pocket payments by individuals

Health Care America attempts to make the way in which we pay for our total health care system more fair and efficient.

Health Care America provides much more health care coverage and reduces out-of-pocket expenses for most people. For many, it also lowers premiums. On a national scale, the plan provides the first real means to limit increases in our yearly health care costs, producing billions in savings over the next few years and beyond.

However, like any plan that provides comprehensive care for all, Health Care America will require funding tradeoffs. Existing revenues dedicated to health care, as well as an increase in taxes, will be necessary to pay for the increased services, benefits and expanded coverage in the new Medicare program. A number of sources would be used to pay for the new Medicare program:

- Existing state and federal funding for health care programs would continue.
- An 8 percent payroll tax would be paid by employers who enroll their workers in the new Medicare program. This would be waived for employers who provide equivalent or better health care coverage to their workers and workers' dependents. Special provisions would protect new and low-wage businesses from the transitional burden of this tax.
- Premiums of $50 per month would be paid by adults enrolled in the new Medicare program. Families would pay an additional $25 per month for children. The maximum family premium would be $125 per month.

The remaining money would come from new tax revenues, mostly from <u>one</u> of the following:

- A special 3 percent national income tax.

  Under the national income tax, income includes: adjusted gross income, total Social Security benefits, tax exempt interest and contributions to IRA/Keogh/401K plans.

  The first $15,000 of yearly income per person or $20,000 per couple is exempt from the tax. A couple with $30,000 in income would pay a tax of $300 per year.

<u>OR</u>

- A 5 percent tax on consumption called a "value added tax."

  This tax is like a sales tax. It is commonly used by democracies throughout the world to help pay for health care. It would be added to the price of all goods and services, except food, housing, and medical care. The tax would be refunded for

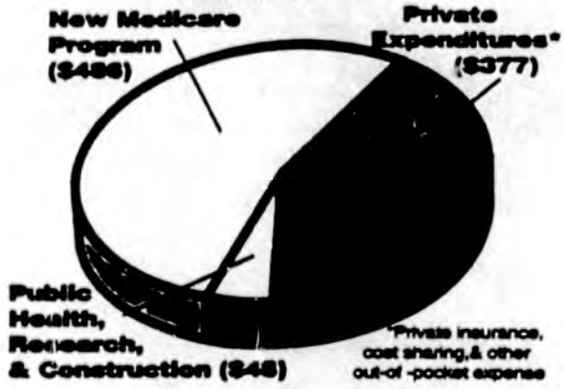
those with low incomes who file for a tax credit on their income tax return. A couple with $30,000 in income that spends $10,000 on covered goods and services would pay $500.

Additional Tax Revenue Sources

The balance of the necessary funding would come from the following sources:

- Increased "sin" taxes on alcohol and tobacco. These would be doubled, reflecting the health costs to society associated with tobacco and alcohol use.
- A 5 percent surtax on existing corporate income tax. This compensates for the plan's substantial savings to many employers who would have greatly reduced costs for retiree health benefits and other health care services.
- Higher estate taxes on estates over $2.5 million. Estate tax rates would be brought back to pre-1981 levels to help finance the estate protection features of the long-term care protections.

SYSTEM COSTS UNDER HEALTH CARE AMERICA (1993)
(In Billions)



Total Health Care Spending ($911)

Source: Lewin/ICF HBSM

Proposal Advantages: A Summary

- It's easy to use and understand. Each of us receives a MEDICARD to present to health care providers. Benefits cover hospitalization, physician services and mental health care, as well as outpatient prescription drugs and preventive and long-term care. All services are itemized on a single, easily understood monthly statement.
- It controls cost. For the first time, our national health care system would operate on a spending plan. Spending targets are set at the national and state levels, and rates of growth in health care spending are limited. The proposal standardizes fees charged by doctors, hospitals and nursing homes. It strictly limits prescription drug prices, and it reforms our medical malpractice insurance so that physicians no longer would feel they need to order unnecessary medical procedures to protect themselves.
- It is far more efficient. Streamlined administration, the use of standardized forms, and electronic billing eliminate much of the nightmarish complexity and paperwork of today's health care system. They also reduce costs.
- It provides comprehensive benefits for all. Everyone is eligible for coverage regardless of age, employment status or income. The welfare-based Medicaid program is abolished and low-income protections are provided without stigmatizing recipients.
- It preserves our freedom of choice. We can continue to select our own doctors, hospitals and other health providers.
- It provides comprehensive long-term care. Services can be provided in the home, in the community, and in the nursing home. It also places limits on out-of-pocket, long-term-care expenses so that no one need go broke as they do under the current Medicaid program.
- It covers outpatient prescription drugs. You pay only 10 percent out of pocket for your prescriptions.
- It protects the already-sick. No one can be excluded from coverage on the basis of a "pre-existing" medical condition such as diabetes or heart disease.
- It greatly reduces out-of-pocket spending. It covers 100 percent of preventive care costs. It eliminates coinsurance payments for inpatient hospital care and hospice care. The proposal also sets annual limits on out-of-pocket spending for medical care services. Supplemental insurance for medical care is no longer necessary because the benefits are so comprehensive.
- It places new emphasis on preventive care. By diagnosing and treating small problems early, we can prevent costly illnesses, and even unnecessary deaths.
- It provides children with total health services. The plan includes dental, vision, and hearing screening *and* treatment for *all* children.
- It strengthens vital health research and quality assurance programs. The plan provides for continued improvements in our technology and in the quality of our health services by increasing funding for research in biomedical treatment and outcomes of care.
- It gives employers a choice. Rather than enroll employees and their dependents in the new

Medicare program, employers can choose to provide private coverage, just as long as it is as good as or better than Medicare coverage. This promotes innovation and maintains an important standard of comparison for Medicare. (Note: Employers are not required to contribute toward the cost of long-term care coverage for their employees and the dependents of employees. Long-term care services are covered through the new Medicare program.)

How The Proposal Was Drafted

Health Care America was drafted in response to requests from members that the Association play a vital role in reforming our nation's fragmented system of health and long-term care. It was built on the principles for health care reform already adopted by AARP's Board of Directors. Health Care America is a draft proposal only, and will not be finalized until we fully review it with our members and hear back from them.

Prior to drafting Health Care America, AARP conducted more than 25 public hearings. At those sessions, thousands of AARP members and the general public heard the testimony of health experts and voiced their own views on health care reform. The Association gathered feedback from hundreds of AARP community forums, focus groups and opinion polls and fielded thousands of letters from concerned citizens. AARP also studied other national health care proposals, the health care systems of other countries, and innovative health programs across America.

As a result, AARP's volunteer leadership asked the all-volunteer National Legislative Council to develop a plan for health care reform that meets the needs of its members and the general public.

Health Care America reflects the Association's current best thinking on how to address the crisis in our health care system. The draft proposal is meant to inform our members about potential solutions while providing an opportunity for discussion, debate, and plan modifications. We recognize that this is not the only way to reform our nation's health care system, but it is a specific detailed attempt to spell out a comprehensive and effective proposal. AARP seeks your active participation in this process.

Where We Go From Here

Health Care America is a draft proposal *only*. AARP will take no action on it until we fully hear from our members. In coming months, there will be many opportunities for members to let us know what they think about the proposal through hearings, community forums, surveys and more. AARP's volunteer National Legislative Council will take this member feedback and incorporate it into a revised plan in early 1993. The Board of Directors then has the final authority and responsibility to decide whether or not to formally propose the revised plan to the President and Congress.

We also will continue to evaluate other plans and proposals using our health care reform principles. We realize that there may be several ways to achieve the goals set forth in the principles. Health

Care America blends the best ideas of several plans. Because many members expressed interest in a single-payer plan, AARP studied ways to convert its proposal to a single-payer plan. A description of Health Care America as a single payer plan is included in the Appendix at the end of this brochure.

AARP recognizes that any comprehensive health care reform proposal will be controversial. Debate is fundamental to our society's democratic process. By providing this draft plan, AARP is hopeful that it will move the difficult debate about health care reform closer to resolution.

What You Can Do

- Become informed. Read articles on health and long-term care issues in your local newspaper, in national magazines, and in AARP publications. Watch TV programs on the issues. Learn about specific problems with health and long-term care that affect people in your community.
- Get involved. Attend local programs on health care reform — and on Health Care America in particular. Call your local AARP chapter or unit to find out when a program is scheduled. Write your legislative representatives and candidates for public office to learn their position on health care reform.

Reforming America's health care system is *everyone's* concern.

If you are interested in more information on AARP's Health Care Campaign or have comments on Health Care America, write to:

Bob Sell, Chairman
AARP National Legislative Council
601 E Street, NW
Washington, DC 20049

Appendix

Health Care America As a Single-Payer Plan

Health Care America as it is currently proposed is a "blended" plan. That means it includes and expands upon some of the best features of other proposals. These range from private-sector approaches (such as tax credits), to employer-based approaches ("play or pay"), to government-based approaches (single-payer).

Before recommending the "blended" approach, AARP's National Legislative Council (NLC) spent considerable time debating its merits versus those of other approaches — in particular, the single-payer approach.

Under a strict single-payer approach, health care coverage is provided through the federal government. The role of private insurers is greatly reduced in such a system.

Health Care America could be converted to a single-payer plan by eliminating the private insurance option for employers. The result would be a much larger public program that would cost the government about $670 billion, rather than $486 billion. The difference would be made up, in part, by everyone paying their premiums into the public program. In addition, all employers

would pay a 5 percent payroll tax into the public program. If cost-sharing and premiums were eliminated in the conversion of Health Care America to a single-payer approach, taxes would have to be raised to make up the lost revenues.

Under Health Care America as a single-payer plan, every individual would still be issued a single MEDICARD to gain access to the full range of health and long-term care services. The benefits described previously would remain the same.

The single-payer approach has two basic merits. It is simple to understand and use, and it would yield greater administrative cost savings.

In considering what to recommend to our members, NLC members questioned whether or not the federal government should be the exclusive source of coverage in a new health care system. They were not convinced that we, as a nation, are willing to so radically restructure the way health care coverage is provided and paid for in the U.S. Concerns also were expressed about how a single-payer system might affect our economy, if it produced sudden and major shifts in the distribution of health care financing. Would we retain the kind of competition in the health care system that fosters medical advances? And, would the public accept the additional taxes which would be necessary under most single-payer approaches?

Based on these considerations, the NLC recommended taking the draft "blended" proposal to AARP's membership for discussion and debate. At the same time, it also recommended that the Association describe what Health Care America might look like as a single-payer system to give AARP members another option for discussion and debate. For additional information on Health Care America as a single-payer plan, please write to:

AARP National Legislative Council
601 E Street, N.W.
Washington, D.C. 20049

HEALTH CARE AMERICA DRAFT PROPOSAL FEEDBACK

AARP wants to know how you feel about its Health Care America draft health care reform proposal. Please answer **each** of the following questions by checking the box that most closely represents your view. Return the completed questionnaire to:

AARP/Health Care America Feedback,
601 E Street, N.W.
Washington, D.C. 20049.

1. Based on what you know, how well do you understand AARP's Health Care America draft proposal - the "blended" plan?

☐ Very well ☐ Fairly well ☐ Only a little ☐ Not at all

2. What do you think about each of the following features of the plan?	**Very Good**	**Good**	**Neutral**	**Poor**	**Very Poor**	**Don't Know**
A Medicard that eliminates almost all paperwork.	☐	☐	☐	☐	☐	☐
Guaranteed health care coverage for everyone.	☐	☐	☐	☐	☐	☐
Protections for low-income people.	☐	☐	☐	☐	☐	☐
Coverage of at least two-thirds of nursing home costs - even more for people with low and moderate incomes.	☐	☐	☐	☐	☐	☐
Coverage of 80% of long term care costs at home or in the community.	☐	☐	☐	☐	☐	☐
Income and asset protection for nursing home residents and their spouses.	☐	☐	☐	☐	☐	☐
Care coordinator (e.g., nurse or social worker) to help persons in finding long term care services they need.	☐	☐	☐	☐	☐	☐
Employers have to cover their workers or pay a tax to enroll them in the expanded public program.	☐	☐	☐	☐	☐	☐
Cost controls including pre-set payment amounts for doctors and hospitals.	☐	☐	☐	☐	☐	☐
90% coverage of prescription drug and doctor costs.	☐	☐	☐	☐	☐	☐
100% coverage of preventive service and vision, hearing, and dental screening.	☐	☐	☐	☐	☐	☐
The amount you would pay out of your pocket (deductibles and co-payments) for medical expenses like hospital/doctor's fees, lab tests, etc.	☐	☐	☐	☐	☐	☐
Annual limit on what you pay out of pocket for all doctor, hospital, and other medical care ($1500 per person, $3000 per family)	☐	☐	☐	☐	☐	☐
A monthly premium of $50 for each adult with a maximum of $125 for a couple with children ($75 for a single parent with children).	☐	☐	☐	☐	☐	☐

3. Thinking about both the coverage offered by this plan and the costs, how does this plan compare with your current coverage?

☐ Much better
☐ Somewhat better
☐ About the same
☐ Somewhat worse
☐ Much worse
☐ Don't know

4. It is estimated that the Health Care America plan would cost the government $112 billion MORE in 1993 for health care. AARP suggests two different tax options to raise most of the needed revenue. Which one of the following options would you prefer?

☐ A special 3% tax on all yearly income (including all Soc.Sec., tax-exempt bond income, etc.) above $15,000 for a single person ($20,000 for a couple).

☐ A 5% tax on consumption of goods and services (except food, housing and medical care) - a value-added tax.

☐ I could NOT support either of these

☐ I COULD support either of these

☐ Don't know

5. AARP's Health Care America proposal can be structured in two different ways. Which do you prefer?

☐ The "blended" version of the Health Care America proposal which provides coverage either through employer-provided private insurance or an expanded Medicare program.

☐ The "single-payer" version which provides coverage for everyone through an expanded Medicare program.

☐ Neither of these. ☐ Don't know

6. After member input and possible modification, if AARP proposes the Health Care America plan, or one like it, to Congress, how would you feel about it?

Strongly favor	Somewhat favor	Somewhat oppose	Strongly oppose	Don't know
☐	☐	☐	☐	☐

7. The Health Care America plan proposed by AARP is only ONE way that health care might be reformed in this country. Which ONE of the following do YOU think is BEST?

☐ Health Care America, AARP's "blended" proposal.

☐ a plan that's completely sponsored by the government - a "single-payer" plan.

☐ a plan that requires all businesses to provide insurance coverage for their employees or pay into a public program - a "play or pay" plan.

☐ the system of health care that we have now

☐ the system we have now with some insurance reform and government vouchers or tax credits to help the uninsured buy insurance

☐ some other plan (please describe briefly):_____

_____

8. Any Additional Comments?

9. Where did you receive this questionnaire?

☐ AARP Chapter meeting ☐ Brochure/mail

☐ Community Forum (City_____State_____Date_____)

☐ Other (Specify_____)

INFORMATION ABOUT YOU:

10. Gender:
☐ Male
☐ Female

11. Age:
☐ Under 50
☐ 50 - 64
☐ 65 or older

12. Are you an AARP member?
☐ Yes
☐ No

13. Education:
☐ Less than high school
☐ High school graduate
☐ Some college
☐ College graduate

14. Employment Status:
☐ Retired
☐ Working Full time
☐ Working Part time
☐ Homemaker

15. Are you an AARP Chapter or an NRTA unit member?
☐ No, neither
☐ AARP chapter member
☐ NRTA unit member

Thank you very much for spending the time to share your opinions with us. D14769 (4/29/92)

HEALTH CARE REFORM

PHYSICAL THERAPY AGENDA

The American Physical Therapy Association shares the concerns of citizens of the United States, political leaders, and health care providers regarding the need to make health services available to all citizens of the United States. Physical therapists are concerned not only as members of society, but also as health care deliverers in a profession whose focus is rehabilitation and maximizing function. The following statements provide a basis upon which physical therapists believe all Health Care Reform should be based.

I. COST CONTAINMENT

The American Physical Therapy Association believes that society has not participated fully in a debate that establishes what percentage of the gross national product should go to health services on the one hand, or what level of service is required or necessitated by society on the other. This debate must occur prior to establishing explicit cost containment measures. It is clear that various proposals provide for cost sharing and provide this through managed care. We as a profession support cost containment and savings, but believe the debate on how to accomplish this should include not only consideration of equal access to care for all while maximizing the efficiency of the system, but also how to maintain high quality care delivery and how to promote quality of life.

II. PREVENTION AND WELLNESS

Prevention of occupational injuries is a focus of both the federal government and industry. Low back injury is the leading musculoskeletal disorder in the United States. Of the musculoskeletal disorders, back injuries are the most frequent and costly. Disorders of the back and spine are the third leading cause of impairment in the United States with costs associated with back injuries amounting to $14 billion per year as of 1984. The single largest category of back injury is classified as a sprain or a strain; this accounts for 85 percent of the claims for back injury compensation. Preventive services, such as those that can and should prevent back injury, must

Health Care Reform should also promote concepts of wellness. Prevention and the focus on wellness should be targeted to individuals of all ages and should include general education as well as specific instruction in relation to specific activities or problems. Such programs would include: prenatal care, patterns of exercise and the benefits of exercise for various populations including the aging, prevention of low back or neck problems, industrial disability prevention, and education regarding addictions to substances deemed unhealthy.

III. LONG TERM DISEASE/DISABILITY

Maintaining persons with lifelong diseases or disabilities is critical to the individuals involved, to society, and to the government. The ability to provide these individuals with ongoing care that alleviates the necessity for hospitalization, decreases the length of each hospitalization, and maintains maximum function should be paramount to any Health Care Reform package.

Health Care Reform should not decrease or stop ongoing treatment that can decrease the number of hospital days or the need for hospitalization altogether. Individuals who would require ongoing care include those with degenerative musculoskeletal disorders, pulmonary diseases, cardiac diseases, and neuromuscular diseases. Many individuals with these diseases have an ongoing deterioration of function, but through close monitoring and ongoing programs (much of which can be done at home by the individuals themselves with periodic visits to or by appropriate care givers) can greatly improve or maintain quality of life and decrease costs to society from expensive hospitalizations or emergency interventions.

IV. ENTRY TO CARE

Traditional medical models require the physician to be the mode of entry into the health care system. This is not cost-effective in many situations. Health Care Reform must allow other health care professionals to be the point of entry. Those professionals should include nurses and physical therapists.

V. ENVIRONMENTS OF CARE

A. Acute Care

All individuals should have access to acute intervention, whether received through an office visit, an emergency room visit, or elective entry into a hospital. Health Care Reform must move toward more established guidelines to determine when to discontinue services when the services are no longer beneficial or of assistance to a patient. This is important across the spectrum of the health care delivery system, whether it is for the individual who has low back pain and has been receiving services or whether the individual is terminally ill and on mechanical support systems.

B. Rehabilitation

Rehabilitation should be available whether it occurs in an outpatient setting, in an acute care facility, in a rehabilitation facility, or in a freestanding service such as a physical therapy service. Rehabilitation should return the individual to the highest functional level so that the individual may contribute to society at an optimum level. The benefits of enabling individuals to return to optimal function in relation to jobs and personal lives will aid in decreasing the cost of health care as well as provide positive personal financial resources to families and society.

C. Long-Term Care

Health Care Reform must direct greater attention to the availability of long-term care, including access to and the provision of rehabilitative services in a rehabilitation facility, care in a nursing home, or care at home with the appropriate personnel provided. This care should be part of services offered and should allow a patient to receive appropriate long-term care without requiring large individual expenditures. The effectiveness of long-term care should be evaluated to delineate who benefits from these services and in which setting.

D Community Care

Initiation and acceptance of community care under any Health Care Reform proposal is mandatory to provide for cost-cutting in terms of expeditious discharges from acute care, rehabilitation facilities, and nursing home facilities. Community care that is reimbursable will facilitate patient function, thereby decreasing the need for more extensive intervention at a later date.

VI. HEALTH CARE DELIVERY MODES

Health Care Reform should assure that small practices or individual health care providers are part of the health services system. The individual practitioner has long been a valuable contributor to the delivery of health services in the United States. The ability to maintain or provide care through a single or individual practice or a small group practice facilitates the delivery of services in less accessible and rural areas and often allows the delivery of services on an individual, caring basis. Health Care Reform should maximize efficiency of care, but not at the expense of disallowing or not providing reimbursement for services delivered by a solo or small group practice.

VII. RESEARCH EFFORTS

Health Care Reform must facilitate the coordination of education, research, and health care delivery. Research dollars must be available for effectiveness studies, thereby allowing the evaluation of outcomes with various modes of intervention (patient outcome oriented research). Health Care Reform should not so restrict services as to eliminate the focus on performing research and attempts to evaluate variations in service settings. Society's health care needs will continue to change over time and research must continue to address, study, and recognize these changes. If Health Care Reform is excessively restrictive or directive in terms of how health services should be delivered, this will not only impinge on future valuable research, but also impinge on who is attracted to the health care professions. We agree with health care analysts

that the scientifically inquisitive individual will not be attracted to health care professions and invaluable future scientific investigations will be lost if health care delivery is so directive as to hinder innovative care.

VIII. EDUCATION

Health Care Reform should account for and provide support for educating clinicians in the fields where there are shortages of clinicians. Without adequate numbers of clinicians, any Health Care Reform will not be able to ensure quality and/or access to care because of an inadequate supply of health care practitioners. Educational support should be available on a broad basis and should include attracting individuals from minorities and from culturally divers backgrounds. Support must extend beyond the traditional "doctor" titles.

Those professions that are experiencing a shortage of faculty and of needed clinicians must receive support to:

a. Allow individuals to obtain appropriate academic credentials in their field of study.

b. Increase the flow of individuals into the system to allow for adequate numbers to care for patients. This may require funding to attempt unusual or untraditional educational modes of entry.

October 21, 1992

The Honorable James Duncan
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Duncan and Task Force Members,

Thank you for the opportunity to present to you today. I am Bill Nugent representing a group of seniors and senior service providers who are working together as the **Anchorage Senior Care Network.** We are concerned about the limitations of access to long term care services and payment for the care. Over the past year we have collaborated with the Older Alaskans Commission and the Department of Health and Social Services in the development of Medicaid waivers under Project CHOICE (Community and Home Options to Institutional Care for Everyone). Our goal is to see the development of a consumer-directed system of long term care in Anchorage and Alaska, one founded in least-restrictive environment and appropriate, cost-effective care.

We have developed a critical issues paper which I have enclosed in your copies of this presentation. There are many similarities to the Task Force's guiding principles.

At this time I would like to highlight three critical health systems concerns of our group.

1. The State's Medicaid system and the new proposed Project CHOICE waivers deny access to care for people with Alzheimer Disease or other related dementias (ADRD). Currently, in order to receive services a person must meet a definition of "medical necessity," a condition involving a major medical complication. For example, a person may be unable to communicate, make decisions about their well-being, or even feed themselves, yet they are ineligible for services that would provide 24 hour supervision and care. Many states have addressed this issue by including activities of daily living in their admission criteria--Alaska has continued to refuse to do that or even recognize ADRD as a disease.

2. Project CHOICE waivers and options must be adequately funded and staffed. Currently our state system of care relies too heavily on nursing home placements and does not provide safe, adequate options for other residential and community

based services. As our senior population continues to grow dramatically, it will be necessary to develop a broader array of services for the Medicaid and non-Medicaid populations alike.

3. The cost of long term care services and the mechanisms for access to those services must be considered as an integral part of health care cost and access reform. The senior population is the fastest growing group, both in Alaska and the United States. Seniors comprise a large constituency; they are major consumers of health care, and a large portion of our healthcare dollars is spent for care of the elderly. As you reconsider your interim recommendations, we urge you to include that portion of the population 65 and older as well as the health care system serving them.

We appreciate the opportunity to discuss these issues directly with you. We would be happy to answer any questions on these comments or on the critical issues paper. Thank you for your time.

Sincerely,

Bill Nugent
Anchorage Senior Care Network

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LONG TERM CARE CONTINUUM IN ANCHORAGE

Critical Issue Areas

ACCESS

- Many people do not know how and where to access the services they need; there is no visible, coordinated long term care continuum in Anchorage.
- Accessing long term care services with different eligibility criteria and program limitations can often be a confusing, exhausting task for the older person or caregiver.
- Eligibility for many long term care services is based on age and medical need, rather than level of functional need.
- Financial circumstances may limit or exclude access to some of the services in the long term care continuum.

SERVICES

- There is an extreme scarcity of residential supported living arrangements (adult foster care, senior group homes, residential care, and assisted living) for persons whose needs can no longer be met at home but who do not require the level of care provided in a nursing home.
- More community based support services (eg.,respite, adult day care, in-home care, minor home repair/maintenance) are needed to help older persons stay at home.

INTEGRATING MECHANISMS

- Because of the variety of funding for services, Anchorage does not have a system to coordinate services in the continuum of care.
- Care management is underfunded and can only oversee care for individuals who have little or no support and complex needs.

Fairbanks Community Health Project
Project Overview

The Fairbanks Health and Social Services Commission, through the City of Fairbanks, received a $50,000 planning grant in August 1991 from the UAF Rural Alaska Health Education Center (RAHEC) and the Alaska Department of Health and Social Services.

The Fairbanks Community Health Project was a year long examination of the health of the community and the factors affecting access to the local health care system. The goals of the project were to:

- Examine the health status of the citizens of Fairbanks and the health service resources available.
- Involve health service providers and consumers in a public process that will identify issues and highlight health care needs. This process culminated in community forums held in May, 1992.
- Establish the Fairbanks Health Coalition to guide the planning process, develop recommendations for the future, and carry forward the plan developed through this project. Coalition membership includes service providers, consumers, advocates and local government representatives.
- Publish a final report/plan which will include recommendations resulting from the project.

The project is guided by the City Health and Social Services Commission and has undertaken a wide range of activities during the past year. Activities include:

WORK GROUPS: As a first step in the process, work groups were formed to identify problems and issues important to the community. Work groups for Medical/Dental Services, Allied Services, Mental Health and Addiction Services, and Alternative Health Services were formed in October and met monthly through January. The work groups were facilitated by members of the League of Women Voters, who designed a group process for identifying problems and generating solutions. Over one hundred people, most of whom were service providers, were involved in the work group process. A summary of the issues and solutions generated by the groups is attached. The solutions will be refined and advanced by Health Coalition committees.

FAIRBANKS HEALTH COALITION: The Fairbanks Health Coalition was organized in February. The 21 members of the coalition represent health care providers and consumers, state and local government, and the major health care systems in Fairbanks. Members of work groups were nominated to the Coalition by their work group. At least one representative from each group is a consumer.

The Coalition meets monthly and recently developed the following draft mission statement:

The purpose of the Fairbanks Health Coalition is to provide a forum for community centered planning and to promote local involvement and ownership of the health care system in the Fairbanks North Star Borough.

The specific purposes of the Coalition are:

- To promote wellness through public education and advocacy.
- To provide a community voice in administrative, legislative, and judicial actions as they relate to the health of the community and the local provision of health services.
- To identify the health service needs of the community and to plan for meeting those needs.
- To periodically monitor the results of planning.
- To facilitate communication and cooperation between health care providers, people who use health services, and community policy makers.
- To promote cooperation between health care providers in the community.
- To communicate and cooperate with other community and state health promotion and planning organizations.

COMMUNITY HEALTH FORUMS: In order to assure that a truly "public" or "consumer" perspective was incorporated into the planning process, the Health Coalition held a series of community health forums during May. Forums were facilitated by members of the League of Women Voters and moderated by local government representatives. Forum topics and moderators were as follows:

- **Family Health**, moderated by Jim Hayes, Fairbanks City Council.
- **Mental Health and Substance Abuse**, moderated by Bob Coghill, FNSB Borough Assembly.
- **Health and Aging**, moderated by Lowell Purcell, Fairbanks City Council.
- **The Government's Role in Health Care**, moderated by Fairbanks Mayor Wayne Nelson,Fairbanks North Star Borough Mayor Jim Sampson, and North Pole Mayor Lute Cunningham.

Public response to the forums was very low even though extensive advertising was done in the newspaper and on radio and television. The best turnout was for the **Government's Role in Health Care** forum, where discussion centered on which governmental entity should have health and social service powers. Most of those in attendance were service providers.

COMMUNITY HEALTH SURVEY: A community health survey was conducted during April and May. More than 700 Fairbanksans completed surveys. Most responded to the survey at the Fairbanks Health Fair on April 17 and 18. Other survey sites included the Fairbanks Health Center, the Fairbanks Chiropractic Clinic, A Birth

Place (a mid-wifery clinic), the Senior Center, the Alaska Department of Labor Unemployment Office, and at health project forums held in May. The purpose of the survey was to look at how people use health services in relation to how they pay for services.

WHAT HAVE WE LEARNED? Although this project is on-going and still in the process of collecting information on local issues and solutions, a number of issues have appeared consistently throughout the process. They are:

- **Cost of Services:** The cost of care is the greatest barrier to access to health services. People who do not have insurance or who do not qualify for Medicaid can not afford adequate care.

- **Medicaid:** Medicaid is an all or nothing situation - people qualify for everything or nothing. Single people between the ages of 18 and 65 can not qualify unless they are pregnant or have a disability. The application for Public Assistance and Medicaid is cumbersome. Once a person is determined eligible, the care options are often limited to treatment of acute conditions.

- **Physician/Patient Relationships:** Patients need more time to talk to physicians, to discuss tests, prescriptions and the patient's condition. Physicians rarely make referrals to alternative health services or to allied services, like home health or homemaker services. People also are unhappy with having to wait weeks or months for appointments and not being able to get appointments during their non-work hours.

- **Funding of Services:** Community fund raising and support for services should always be sought first - communities should decide what they will support. The issue of who should have health and social services powers, the city or borough, should be explored.

- **Health Education:** Health education and disease prevention information is not easy to find. Information should be available throughout the borough and region, and include materials appropriate to people of other cultures and non-readers. Information should be available on all kinds of health services, including alternative care options.

CURRENT AND FUTURE ACTIVITIES: The Fairbanks Health Coalition is continuing to meet each month. Activities planned for the next year include:

- **Advocating for Transfer of Health and Social Services Powers to the Borough** - The Coalition is working with the Arctic Alliance for People to promote the passage of a borough ordinance mandating an areawide vote on whether the borough should assume health and social services powers. The current goal is to get the question on the October ballot.

- **Candidates Forum** - The Coalition is co-sponsoring candidate forums for local and state candidates with the Arctic Alliance. The candidate forum for local races is scheduled for September 21 and the forum for state candidates is October 13. The Coalition is developing a list of questions that will be asked of the candidates by the League of Women Voters moderators.

- **Developing Special Interest Committees** - The Coalition is forming four committees which will focus on different parts of the health care system. The committees are Medical/Dental Services, In-Home Services, Alternative Health Services, and Mental Health and Addiction Services. Committees will include non-Coalition members, including former members of work groups, and will work towards developing solutions to the issues identified earlier.

- **Pursuing Funding for a Section 330 Community Health Center** - Discussion between the Coalition and community health care providers on the feasibility of seeking funds through Section 330 of the Public Health Service Act began in March. If there is support from the community, an application will be submitted in the Spring of 1993.

•••DRAFT•••

Fairbanks Community Health Project

Community Health Survey

As a part of the Fairbanks Community Health Project, a community health survey was conducted in Fairbanks during April and May, 1992. More than 700 Fairbanksans completed surveys. Most responded to the survey at the Fairbanks Health Fair on April 17 and 18. Other survey sites included the Fairbanks Health Center, the Fairbanks Chiropractic Clinic, A Birth Place (a mid-wifery clinic), the Senior Center, the Alaska Department of Labor Unemployment Office, and at health project forums held in May.

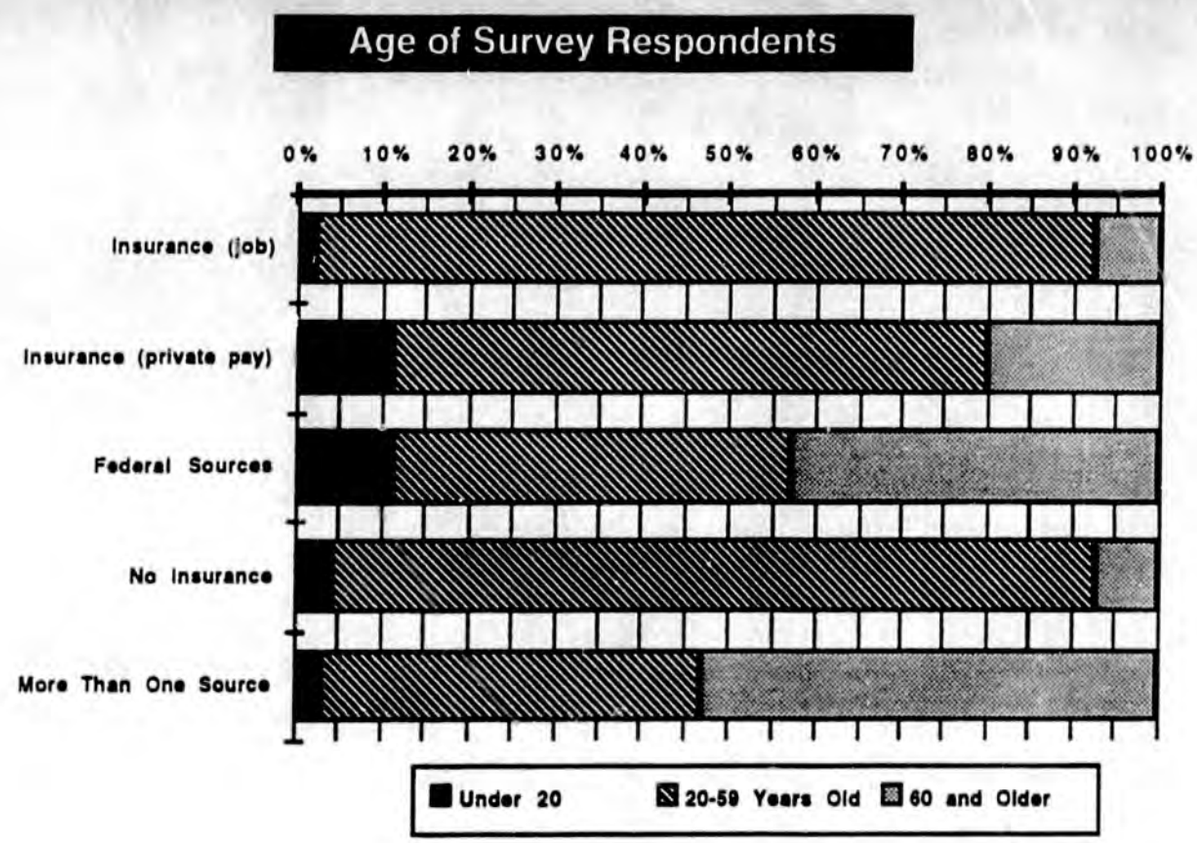
The sample for the survey is not random so that the assumptions that can be drawn are somewhat limited. However, the purpose of the survey was to look at how people use health services in relation to how they pay for services. Survey respondents were grouped by source of payment for health services, including those with 1) insurance through a job, 2) private pay insurance, 3) federal sources, including Medicaid, Medicare, Indian Health Service, CHAMPUS and VA, 4) no insurance and 5) multiple payment sources, usually Medicare plus another payer.

People were also asked to rate their health and the quality of health care in Fairbanks, whether they had sought health care outside the community, and if they had ever delayed seeking health care because they were afraid of the cost.

Sample Overview: The 703 people surveyed reported their primary payment source for health care as follows:

Payment Source	Number	%
Insurance (job)	347	49.4%
Insurance (private pay)	36	5.1%
Federal Sources	63	9.0%
No Insurance	137	19.5%
More Than One Source	99	14.1%
No Response or Other	21	3.0%

More women completed survey forms, with 62.4% or 439 of the respondents being women and 36.7% (258) men. Six individuals were unknown. The mean age varied by payment group. The youngest group, with an average age of 39, was those who had no health insurance. Respondents who had more than one source of payment were the oldest group, with an average age of 55. Most of these individuals appear to be older Alaskans who supplement Medicare with private insurance or other payment sources.



Health Services Used in the Past 12 Months: Respondents reported using a wide variety of health services. The type of care sought most often was cleaning and preventive dental care (49.2% of sample). The next most frequently used types of health care were family practice (48.2%), general dental services (34.3%), optometry and glasses (34.1%) and obstetrics/gynecology (22.5%).

Of those who listed a payment source, people with insurance through a job were the most frequent users of health services of almost every kind. People who paid for health care through private pay insurance and those who had no insurance were the least likely to have used health services. This is particularly true for dental services. Sixty-four percent (64%) of those insured through a job visited a dentist for cleaning or preventive care during the past year. Only 29% of those without insurance used the same service. Similarly, while 41.8% of those with insurance through a job received general dental care this year, only 24.1% of those without insurance and 22.2% of those with private pay insurance used these services.

People with insurance through a job also used a wider variety of health services than people in the other payment groups. They reported using an average of 3.2 different health services during the past year. Those with more than one payment source used an average 2.8 services, followed by people using federal sources (2.7 services) and those who pay for their own insurance (2.5 services). Respondents who do not have health insurance or another payment source used an average of 2.4 health services in the past twelve months.

Use of Health Services in Past 12 Months

Percentage of Respondents Reporting Visits to Health Care Providers

Health Service	All Respondents	Insurance (Job)	Insurance (Priv.Pay)	Federal Sources	No Insurance	More Than 1 Source
Medical Services:						
• *Family Practice*	48.5	53.3	36.1	44.4	43.1	51.5
• *Obstetrics/Gynecology*	22.5	27.1	13.9	19.0	19.7	14.1
• *Other Specialty*	10.4	9.5	5.6	11.1	11.7	13.1
Dental Services:						
• *Cleaning/Preventive*	49.2	64.0	44.4	38.1	29.2	40.4
• *General Dental Services*	34.3	41.8	22.2	31.7	24.1	32.3
• *Orthodontics*	4.6	3.5	5.6	4.8	5.8	7.1
Hospital Emergency Room	15.6	14.4	16.7	17.5	16.1	18.2
Alcohol/Drug Counseling	1.0	1.4	0	1.6	0	1.0
Optometry/Glasses	34.1	38.6	36.1	38.1	21.2	34.3
Mental Health Counseling	6.0	5.5	5.6	6.3	8.0	5.1
Chiropractic Services	19.8	25.1	5.6	19.0	13.1	18.2
Midwifery	2.4	1.4	5.6	0	4.4	4.0
Acupuncture/Acupressure	5.3	4.6	8.3	1.6	5.1	9.1
Naturopathic Medicine	6.7	7.2	11.1	4.8	6.6	6.1
Home Health Services	<1.0	<1.0	0	3.2	<1.0	1.0
Respite Services	<1.0	<1.0	0	0	<1.0	0
Hospice Services	<1.0	1.4	2.8	0	0	0
Fairbanks Health Center:						
• *Well Child Clinic*	3.6	2.9	2.8	3.2	5.1	5.1
• *PHN Home Visits*	<1.0	<1.0	2.8	3.2	0	0
• *Family Planning*	3.4	1.7	5.6	7.9	4.4	3.0
• *Immunizations*	7.8	6.6	8.3	6.3	8.0	14.1
• *Other Center Services*	4.4	2.3	8.3	4.8	8.8	4.0
Other	3.6	3.2	0	3.2	5.1	1.0

National studies report that women who do not have health insurance often delay prenatal care until late in their pregnancies. Although respondents were not directly asked about prenatal care, the data indicate that this may also be the case in this survey sample. The average ages of respondents who have health insurance through a job and those without any health insurance are nearly the same (40 and 39, respectively). Almost half of the women (45.9%) with insurance through a job sought out OB/GYN services during the last 12 months while only 27.8% of those without insurance received similar services. While it is not possible to directly relate this data to prenatal care, women without insurance are less likely to receive regular examinations and realted prevention services.

Another women's health service respondents were asked about was mid-wife services. When considered together with OB/GYN services, the pattern of use remains the same.

For women between 16 and 40 years old, 55.1% of those with insurance through a job had received OB/GYN or mid-wife services in the past year while 36.2% of the women without insurance received similar services. Older women (41 and older) sought out service less often than younger women, with 35.7% of the women with insurance and 15.4% of the women without insurance seeking services in the past year.

Use of Women's Health Services by Age Group

Women's Health Services	Insurance (Job)			No Insurance		
	# of Women	16 - 40 Yrs Old	41 and Older	# of Women	16 - 40 Yrs Old	41 and Older
Women in Payment Groups	**205**	107	98	**97**	58	39
Women's Health Services:						
OB/GYN	**92**	54	38	**26**	16	10
Mid-Wife	**3**	3	0	**5**	4	1
Both	**2**	2	0	**1**	1	0
Services Total	**97**	59	38	**32**	21	11
% in Age Group Using Women's Health Services	**47.3%**	55.1%	35.7%	**33.0%**	36.2%	15.4%

How Do You Rate Your Health? Most survey respondents rated their health excellent or good. More than ninety percent (92.5%) of the people with insurance through their workplace reported that their health was excellent or good. The next most healthy group was those with private pay insurance (91.6%), followed by people whose health care is supported by federal sources (85.8%), those without insurance (82.5%), and those with more than one payment source (78.7%). It is not surprising that those with more than one source are the least healthy since they are significantly older than the other groups. However, it is interesting that the youngest payment group, those without insurance, report excellent or good health significantly less often than the payment group closest to them in age, respondents who have health insurance through a job.

How Do You Rate Health Care in Fairbanks? Most people responding to the survey (77.4%) rated health care in Fairbanks as excellent or good. Those with private pay insurance were the most satisfied, with 91.6% rating care as excellent or good. People with insurance through their job were the next most satisfied (81.8%), followed by those with more than one payment source (76.7%) and those with federal payment sources (71.5%). Individuals who do not have insurance were the least satisfied, with 69.3% rating health care in Fairbanks as excellent or good.

Have You Sought Health Care Outside the Fairbanks Community?

Almost a third (32.1%) of the survey respondents received health care from providers outside the Fairbanks community in the past five years. People who have more than one source of payment for health care were the most likely (43.4%) to seek care elsewhere. One third (33.3%) of those with federal payment sources received care outside the community, followed by 30.6% of the respondents with private pay insurance and 29.9% of those with no insurance. People with insurance through a job were the least likely (29.4%) to have sought care elsewhere.

Reasons for Seeking Care Outside Fairbanks

Reasons for Seeking Health Care Outside Fairbanks	All Respondents	Insurance (Job)	Insurance (Priv.Pay)	Federal Sources	No Insurance	More Than 1 Source
Specialized Care Not Available in Fairbanks	16.4	15.7	18.2	14.4	7.3	30.2
Better Quality Care Available Elsewhere	4.4	6.9	0	9.5	0	2.3
Health Care Costs Less Elsewhere	25.2	30.4	9.1	9.5	36.6	16.3
Wanted to Receive Care Closer to Family	5.3	3.9	18.2	4.8	7.3	2.3
Other or More Than One Reasons	45.2	40.3	54.6	57.1	46.3	46.5
No Response	3.5	2.9	0	4.8	2.4	2.3

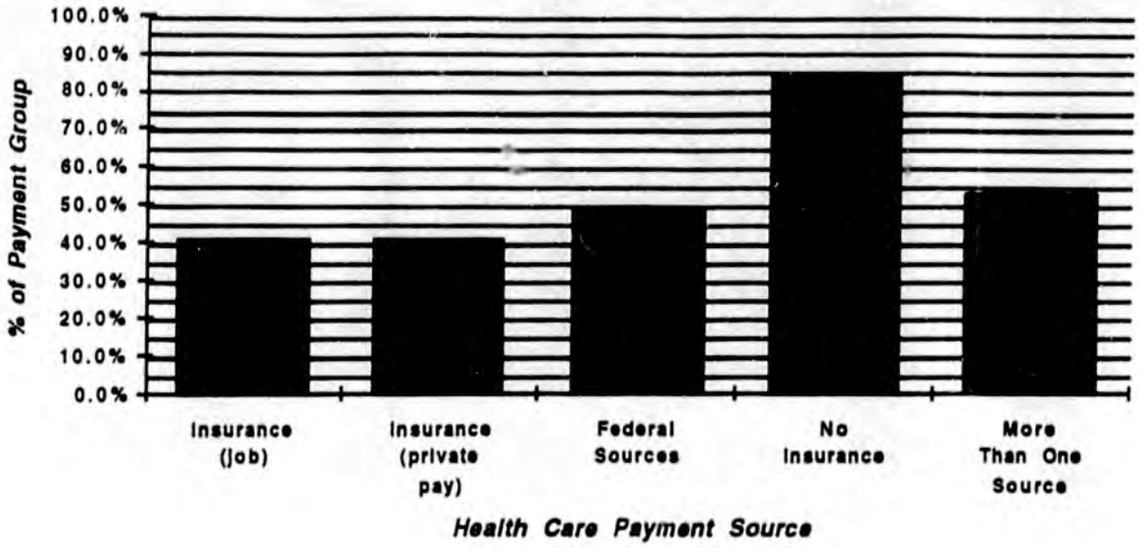
Have You Delayed Health Care Because of Cost? Survey respondents who had no health insurance were more than twice as likely to have delayed seeking health care because of the cost than people with insurance through their job or private pay insurance (84.7% compared to 40.6% and 40.5% respectively). Approximately half of those with federal payment sources (48.5%) and those with more than one source (52.5%) reported that they have delayed seeking care.

Conclusions: A number of conclusions can be drawn from data. The discussion of findings is accompanied by quotes from respondents' answers to the open-ended question, "What is the most serious problem you experience in getting health care?" Each quote is followed by the sex, age and location where the survey was completed.

> **"I married my husband for his health insurance. I could not go to a dentist or eye doctor (for glasses) prior to that and got other care either from the Fairbanks Health Center or if I thought I absolutely had to have medical care.**
>
> **Woman, 42 - Health Forum**

People Who Have Delayed Health Care Because of the Cost

By Health Care Payment Source



"During my second pregnancy, I didn't seek prenatal care until my third trimester after an initial evaluation. We just couldn't afford to have care. When you don't have health insurance, it is so frustrating to know that there are health care professionals out there, but we can't get care because we don't have the money."

Woman, 38 - Fairbanks Health Center

The cost of health care is the most important barrier experienced by survey respondents. The effects of this barrier can be seen throughout the data. People who have no insurance and pay cash for care are the most significantly impacted. They use most health care services less often than other payment groups The greatest disparity is in the use of preventive health care services, such as dental cleaning/preventive services and women's health services (OB/GYN, midwifery). People who do not have health insurance rate their health status lower than other groups. They also rate the quality of local health care lower, which is not surprising considering their lack of access to care. Respondents in this group were also twice as likely to have delayed seeking health care because of cost. The long-term implications of lower health status, lack of preventive care and delaying care will be felt in the need for more expensive acute care in the future.

"The cost of medical attention is astronomical. This cancels the opportunity for preventive medicine for my family, as well as many others. I am a single parent with two children."

Woman, 44 - Fairbanks Senior Center

The cost of health care is an issue for all payment groups. A number of respondents noted that paying insurance deductibles or co-payments is often a problem. While people who had no insurance were the most likely to have delayed care because of cost (84.7%), it is interesting to note that almost half of people with insurance, either through a job (40.6%) or private pay (40.5%), also delayed seeking care.

"Even with insurance, the cost of medical care is so high that I still measure whether or not can do without the treatment."

Woman, 28 - Midwifery Clinic

"Health care is too expensive. I have insurance but I still can't afford what I need (considering the deductible and 20% I must pay and my insurance company's refusal to pay Alaskan rate for services). I need a couple of thousand dollars worth of dental care right now but my insurance will only pay 50%, so I can't do it. This lack of care now may result in serious problems later (like the loss of a bunch of teeth). Society winds up paying in situations like that, and the state and the feds pay more for serious problems later than they would for preventive care now."

Woman, 28 - Fairbanks Health Fair

Nearly a third of the people responding to the survey (32.1%) reported that they had sought health care outside the community in the past five years. The follow-up question on why they chose to look elsewhere for services was inconclusive. It is apparent that there are many reasons, including the need for specialized care and the cost of services in Fairbanks. This question merits further study to determine the reasons for and the solutions to this problem, and to gauge the economic impact on the Fairbanks health care service system.

FAIRBANKS COMMUNITY HEALTH PROJECT
Issues and Solutions
WORK GROUPS - November, 1991 - January, 1992

ISSUES	*SOLUTIONS*
A. **COST OF SERVICES:** The cost of care is the greatest barrier to access of health services. People who do not have insurance or qualify for Medicaid can not afford adequate care. This is an especially critical issue for people with chronic conditions or chronic mental health problems.	- Standardize insurance forms to reduce processing time - Encourage insurance companies and Medicaid to reimburse a wider variety of services including alternative health care, psychological services, and home health care - Tort reform to control malpractice costs - physicians might order fewer tests and procedures, lowering costs - Sliding fee scales developed and advertised (professional groups) - Increase the number of mental health providers that can be reimbursed by third party payors - Expand Salvation Army Medical/Dental Care Access Program to include similar pro bono efforts in medical specialty services, alternative health providers, and mental health services, i.e targeted clinics - work through local professional organizations - Encourage networking between small businesses to form larger groups for health insurance coverage - Increase availability of health care services for people without insurance to reduce the use of the emergency room at the hospital for primary care - Greater prescription and use of generic drugs - Insurance companies should be required to provide an insurance pool for people who are "uninsurable" or have "pre-existing conditions"
B. **MEDICAID:** Medicaid is an all or nothing situation - people qualify for everything or nothing. Single people between the ages of 18 and 65 can not qualify unless they are pregnant or have a disability. The application for Public Assistance and Medicaid is cumbersome and, once a person is determined eligible, many of the care options are limited to treatment of acute conditions.	- Medicaid should be expanded to cover other services, i.e. prevention services, psychologist and counselors, alternative health care services, and home health care - Incentives for providers to accept Medicaid, i.e. reduce paperwork required, find other ways to simplify process - Advocate for adequate funding in state Medicaid budget - shortfalls mean some services are not available until the beginning of the next budget year - The state Medicaid program should allow a person to 'spend down' to meet Medicaid financial requirements - Medicaid application process should be streamlined - difficult to understand and lengthy - Find ways to increase Medicaid recipient compliance and/or responsibility for showing up for appointments, perhaps a token payment for services

ISSUES	SOLUTIONS
C. **PHYSICIAN-PATIENT RELATIONSHIPS:** Patients need more time to talk to physicians, to discuss tests, prescriptions and the patient's condition. Physicians rarely make referrals to alternative health services or to allied services, like home health or homemaker services. Patients believe that malpractice suits would be less likely if physician-patient relationships improved.	- Provide professional organizations (physicians, dentists, nurses) with information on in-home, alternative and mental health services in community - Patient education on how to take responsibility for health care and to better communicate individual needs to physicians
D. **CASE MANAGEMENT:** There is little coordination of case management. Some people have more than one case manager, which is confusing for the patient and often puts providers in conflicting positions.	- Local "clearinghouse" for services to work with individual agency case managers and to provide information on pro bono services around the community - Establish a centralized information and referral source
E. **HEALTH EDUCATION:** Health education and disease prevention information is not easy to find. Information should be available throughout the borough and region, and include materials appropriate to people of other cultures and non-readers. Information should be available on all kinds of health services, including alternative care options.	- Weekly column in the Fairbanks Daily News Miner - Hire marketing expert to develop community education campaign - Use local theater and dance groups to reach adults and children - Involve UAF journalism and broadcasting department in developing community health education campaign - Work with university to develop a Public Health Education degree - encourage existing programs (i.e. the Addictions School) to include prevention in their courses - Include information on alternative health service options in public health education campaigns - School health education should include information on alternative health care options - Medical continuing education opportunities should be well publicized and open to the public
F. **FUNDING FOR SERVICES:** Funding for new and existing services is not adequate.	- FNSB should take on health and social services powers to administer borough-wide services - Community fund raising or support for services should always be sought first - communities can make decisions about what they will support - Look first to community associations, like civic organizations or churches, to solve community problems
G. **FAIRBANKS HEALTH CENTER:** Public health services are currently provided in sub-standard facilities scattered throughout town.	- Consolidate state public health programs in offices that provide adequate space and equipment for services - Need agreement on the new health center site

ISSUES	SOLUTIONS
H **INFORMATION RESOURCES:** Better coordination is needed between in-state research and information resources (ex.. UAA - Alaska Health Sciences Library) and programs and policy makers.	- Organize regular community resource information days
I. **MEDICAL AND ALTERNATIVE HEALTH CARE :** Medical care providers have negative attitudes about alternative health care services and providers. This makes it difficult for patients to be referred to alternative health care services. Without a referral, a patient can not get insurance coverage for the care. There is a lack of networking between the medical and alternative health care communities. The doors to continuing education opportunities are often closed to providers outside the medical care system.	- Encourage insurance companies and Medicaid to reimburse alternative health care - Alternative health providers should be certified or licensed - Open medical continuing education classes to alternative health care providers as a way to begin a dialogue between the provider communities - Alternative health care providers should organize to identify concerns, produce materials, and do public education
J **RELATIONSHIP BETWEEN RESEARCHERS, PROGRAMS, AND POLICY MAKERS:** The funding of services is often based on what was funded in the past rather than on information on what works best. Policy makers, including boards and commissions, should be up to date on current research and trends in the field.	- Program funding should be done through zero-based budgeting to encourage thorough review of current research and trends - Use community needs assessments to fund services people need rather than what programs want to provide - Service agencies and groups must advocate for well informed board and commission members
K. **SERVICES FOR PEOPLE WITH PERSONALITY DISORDERS:** In-patient and out-patient care for people falling between crisis and chronic is not available, especially for people without insurance.	- Expand services to people with mental health problems which are not chronic or expand definition of chronic mental illness
L. **COMMUNITY HEALTH:** The community needs a greater focus on optimal health and wellness. People are generally not concerned about health until they are sick.	- Media campaign - "A healthy community is a more productive community" - A healthy community will require free or low cost preventive and acute services for people who can't afford them - Fairbanks is an aging community - we need to plan now for our future - Need to plan for the long term needs alcohol and drug exposed children
M **PREVENTIVE HEALTH CARE:** Preventive health care services are usually not covered by insurance or Medicaid. Preventive care is especially lacking for women	- All women should be guaranteed prenatal services, either through Medicaid or state services
N **TRANSPORTATION:** Transportation was cited as a problem by all service providers. Lack of transportation is a major access problem for many people, especially older Alaskans and people with disabilities.	- Increase hours and capacity of Van Tran - Coordinate the use of agency vans for picking up people around town when not in use by the individual programs

Tom Macchia ,Co-Chair
Health Care Committee
Green Party Of Alaska

July, 22 1992
Health Resource and Access Task Force

Dear Task Force Members,

On behalf of The Green Party, thank you for the opportunity to testify before your task force. As I said in testimony the straw vote taken in your Monday July 21st meeting makes me feel hopeful.

I had conversations with a few of the Task Force members after our testimony that expanded on my comment regarding a stronger consumer input. I encourage you to think in terms of using the upcoming teleconferences as an opportunity to create community consumer health committees which I hope will provide grass-roots input to the Task Force and act as advocates for the plan the Task force puts forward. Creating a sense of ownership in the plan by the citizens of Alaska will give us the pressure group we will need to carry it through. In addition it will set a precedent for a feature that I hope will be included in any comprehensive reform package, strong consumer participation. It has been my experience, in counseling and in other health work, that people, especially Alaskans feel most comfortable with change when they feel in control of the circumstances. Also some of the most valuable lessons I've learned in medicine have been from frank feedback from my patients.

With regard to a question that was asked about surveying on health care in Alaska I will fax the results of a 1990 question we ,inserted in a political survey. It showed support for "guaranteed comprehensive health care for all Alaskans, regardless of income or health status."

Again thank you for the chance to provide some input. I'm looking forward to seeing you all in August.

Sincerely,

Tom Macchia

Tom Macchia
Green Party Health Care Co-Chair

From: Tom Macchia
ph: 907 562 6299
fax: 562 3835

To: Nancy Cornwell
2 pages
ph: 465 2933
fax: 465 3234

ask*

Marketing and Research Group

August 27, 1990

FOR IMMEDIATE RELEASE

Sample size - 825 random proportioned telephone interviews with adults head of household 19 years or older. THe survey was taken betwenn March 20 and April 20, 1990 for a variety of clients. The overall margin of error was approximately ±3.5%.

Question:

How do you feel about guaranteed comprehensive health care for all Alaskans, regardless of income or health status?

Strongly for	34.3%
Somewhat for	37.2
Not sure/Don't know	5.2
Somewhat against	13.0
Strongly against	10.4

Respondents had clear feelings one or the other acout this question.

Of male respondents, 64.5% supported the concept and 77.3% of women interviewed supported it.

Only 34.5% of those strongly supporting this idea were men; 65.5% were women opposing this idea 63.9% were men and only 36.1% were women.

Women were least undecided with only 33.2% indicating unsure whereas 56.6% of men felt likewise.

Opinions were generally distributed evenly over age of respondents; there was no statistical significance.

P.O. Box 100752, Anchorage, AK 99510 (907) 562-1275 Telex: 9102504754 ASK INFO

Kenai Peninsula Borough
Economic Development District (Alaska)
Health Plan Development Project

OVERVIEW

The Kenai Peninsula Borough, Alaska is located south of Anchorage, encompassing over 25,000 square miles with a population of over 40,000 people. In November, 1991, the Borough Assembly passed a resolution establishing the 30 member Health Care Advisory Council and requesting the Kenai Peninsula Borough Economic Development District (EDD) to administer the work of the Council. Since January, 1992, the Council has been aggressively pursuing a course to accomplish its mission:

> SUBMIT A REPORT TO THE BOROUGH ASSEMBLY MAKING FINDINGS AND RECOMMENDATIONS AS TO OPTIONS FOR THE ESTABLISHMENT OF A BOROUGH-WIDE INSURANCE PROGRAM WHICH WOULD MAKE AFFORDABLE HEALTH INSURANCE AVAILABLE TO ALL RESIDENTS AND THEREBY INCREASE ACCESS AND UTILIZATION OF THE LOCAL HEALTH CARE SYSTEM.

Kenai Peninsula Borough residents are concerned about the accessibility and rising costs of health care. This concern is particularly acute for low income residents and the many workers in high risk, seasonal, small business occupations. The expectation that the state or federal governments will act to establish a program to meet the needs of those who cannot afford insurance is not being realized as lawmakers continued to be mired in debate between competing interests.

Over the past several months the Council's members have worked in committees and sub-committees defining elements of the proposed plan to be revealed in a workshop on October 16-17, 1992, in Kenai, Alaska. The day and a half workshop provides an opportunity for in-depth discussion of plan elements as reviewed by chosen experts in the area of funding, delivery of health services, benefits design, organization of structure, and implementation and management.

REGIONAL ECONOMIC ISSUES

The leadership in this project ~~forms~~ stems from a recognition of the following issues:

1) Surveys of local entrepreneurs show the cost of employee insurance high on the list of barriers to business development.

2) Local governments are faced with either reducing direct government services or raising taxes to meet the rising costs of public employee insurance benefits.

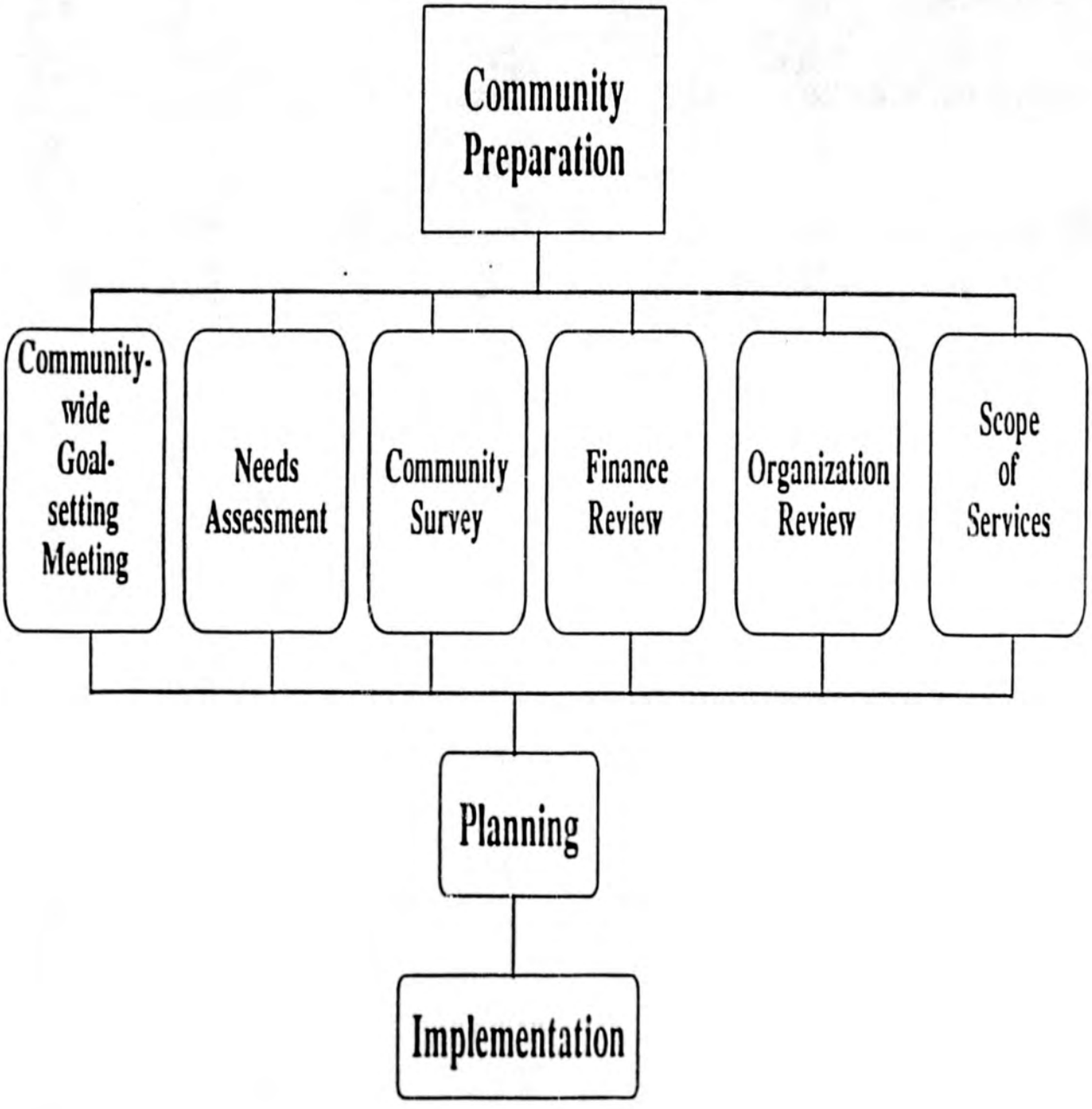
3) Annually millions of dollars in insurance premiums which could be used locally are exported (estimated in excess of $25 million) to Outside based insurance companies.

4) A significant percent of health care to local residents is provided outside of the area, leaving local facilities operating in efficiently at levels substantially under capacity.

5) The health care costs of the uninsured are, in part, passed on to public agencies, employers, and all citizens.

Figure 1

CHSD Phases



Council: Studies ways to pay for plan

Continued from page 1

thing," council member Rich Underkofler said.

Among the possible mechanisms the funding committee is looking at to pay for the plan are: tax subsidies, such as sales tax, property tax, severance tax, income tax, and so-called "sin" taxes; block grants from the state; private foundation funding; premiums, including subsidized premiums for the poor; and "cost containment" measures to lower the prices people pay for medical care.

A benefit design committee is discussing what services should be covered, ranging from pre-natal care to prescription drugs to optional vision and dental care.

The committee has also talked about "deductibles," the amount patients pay before insurance kicks in, ranging from $100 to $1,000; making the deductible lower for preventive care procedures, like dental exams; and paying a greater percentage of costs for people who use borough doctors.

The committee has suggested requiring residents to live in the borough a year before becoming eligible for the plan and using things like property ownership, driver's license and voter registration to prove that residency.

A health services delivery committee is looking at ways to coordinate health and social services so all factors contributing to an illness or injury, for instance, alcoholism or domestic violence, are addressed, rather than just the medical ailment.

An implementation committee is looking at whether to implement the plan in partnership with an insurance company or in-house, how to avoid overloading it with high claims initially, how to market the plan, what kind of data system would be needed and other issues.

'I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them.'

—Stan Steadman, executive director of the Economic Development District

The organizational structure committee is looking at what kind of governmental body should be set up to run a borough health plan.

The committees will further refine their ideas by the next council meeting, Golden said.

A group of experts who have been invited to an October conference will tell them whether the concepts they've proposed seem workable, Steadman said.

"We set up the conference as a way to obtain outside peer review of what we were doing, so we weren't operating in a vacuum," he said.

In the next few months, the council will also be hiring an actuary, a person whose work is to calculate risks and premiums for insurance, to put some numbers to the concepts it's coming up with.

"People keep saying 'how much will this cost,' and we can't answer that until we come up with a plan and have an actuary determine rates," Steadman said.

Underkofler remarked at the last council meeting that he had heard some physicians are apprehensive about what the council is doing.

Dr. James Zirul said it's true some doctors are nervous because organizations that have sprung up in the Lower 48 to control costs — like preferred provider organizations and health maintenance organizations — have buried physicians in paperwork, compromised patient care and made it is difficult for doctors to pay their overhead costs. Zirul is one of several health care providers on the council.

What the council is trying to do here is very different from approaches that have been tried elsewhere, he said, and no one knows yet whether it will work.

Steadman said the project manager for the council was in Homer this week meeting with physicians there. Council representatives have had meetings with doctors on the staff of the three hospitals within the borough, he said.

"What we're telling them is we're striving for a better system to provide health care and we recognize that they are a key, integral part to that being accomplished, and we're looking for their input to be sure their interests are represented."

Some doctors are hopeful that the council can come up with something better than the system now in place.

Dr. Lynn Carlson, who operates a family practice clinic in Nikiski, said many of his patients fall into that category of people who are neither able to afford insurance nor eligible for Medicaid. He is hoping the council may be able to find a better way to provide care to them.

"I'm thinking that a locally run health system would be better than a federally run" system, Carlson said.

"I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them," Steadman said.

It's too early to know yet bottom line things like how much such a plan could cost people in premiums and taxes, what they would get in benefits and how it would affect the medical establishment.

The council's timeline calls for it to go before borough voters at the October 1993 municipal election. It would have to receive Borough Assembly scrutiny before it could even be placed on the ballot.

KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL
WORK PROGRAM

(for prior track consult revised draft of March 23, 1992)

July - Education Committee and Steering Committee approved survey.

July - Kenai Peninsula Health Care Survey Pilot Testing

July 13 - Full Council Workshop. Dr. Bruce Amundson CHSD Model presentation. Dave Ford, plan organizational alternatives. Council initiates the work of health care plan development. Issues development groups organize around five key areas: Funding, Benefits Design, Implementation and Plan Management, Organizational Structure and Health Services Delivery.

Issues development groups meet to prepare draft issues statements.

August 7 - Full Council Meeting. Standing committees report as well as issues development groups. Decision on alternate date for fall conference which has become more of a fall workshop. The potential still exists for a full conference in the spring.

September 11 - Full Council Meeting. Discuss final drafts of issues statements for inclusion in the work shop packet material. Other operations issues. Approve form of a "Request for Proposal" for a third party consultant to assist with the demographic, coverage, actuarial, financial and management components of the health insurance plan. The RFP Selection Committee is the Steering Committee.

The scope of the consultant's services should include these tasks:

Design a model "community based" health insurance program based on issues development resolves by the council through their "expert" advisors in the October work shop. Specifics should include but are not limited to:

- Prediction of annual expenses of the program
- Classification of program expenses to be retained or deferred by excess insurance or a reserve fund
- Allocation of expenses between various sources of revenue

October 8 - PFP Selection Committee review proposals and select with approval of the Steering Committee.

Kenai Peninsula Borough

Health Care Advisory Council

Kenai Peninsula Borough Economic Development District, Inc. 110 S. Willow St., Suite 106 Kenai, Alaska 99611 (907) 283-3335 Fax: (907) 283-3913

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Health Care

on the

Kenai Peninsula

A COMMUNITY SURVEY

NOTE: This survey is conducted by the Kenai Peninsula Borough Health Care Advisory Council as part of an evaluation of medical care within our borough. This survey invites you to have an impact on medical care in your community. Please return the completed survey as soon as possible.

The survey asks you to answer questions about "your community." Consider all of the Kenai Peninsula to be your community, unless a particular question says otherwise. Do not consider areas outside the Peninsula to be part of your community.

1. List the age and circle the sex of the members of your household including yourself.
M=*male* F=*female*

	AGE	SEX	AGE	SEX	AGE	SEX
First, yourself:	____	M F	____	M F	____	M F
	____	M F	____	M F	____	M F
	____	M F	____	M F	____	M F
	____	M F	____	M F	*List any others in margin*	

In the following questions, the term "household" will mean all the people you have just listed. If questions are individualized, answer for yourself.

2. Have members of your household *ever* been hospitalized (stayed in hospital overnight) in any of the following Kenai Peninsula Borough Hospitals? *Circle all that apply.*

   a) Seward
   b) Soldotna
   c) Homer
   d) None of these

3. How many times have members of your household been hospitalized (overnight stay) during the ***past two years*** in each of the following places? *Do not count hospitalizations occurring before you lived in this community.*

   List number, or put a zero when none:

   a) Seward ____
   b) Soldotna ____
   c) Homer ____
   d) Anchorage ____
   e) Other ____
   Where?_____

4. If you were to be hospitalized tomorrow, where would you go? _____

5. **If household members were hospitalized outside of the Kenai Peninsula Borough** during the ***past two years***, why were non-Peninsula hospitals used? *Please indicate whether each of the following were reasons for non-local hospital use:*

Circle 1 or 2 for each reason:

		YES, A REASON	NOT A REASON
a)	Services not provided locally	1	2
b)	Quality of services better elsewhere	1	2
c)	Services cheaper elsewhere	1	2
d)	Referred by local physician	1	2
e)	Referred by non-local physician	1	2
f)	Non-local hospital easier to get to	1	2
g)	More privacy at non-local hospital	1	2
h)	College student away at school	1	2
i)	If Other, please specify: _____		

6. How would you rate the hospital you named in Question 4 in each of the following categories? *Circle one answer for each category:*

		EXCELLENT	GOOD	FAIR	POOR	
a)	Overall quality of care	1	2	3	4	Don't know
b)	Physician care	1	2	3	4	Don't know
c)	Nursing care	1	2	3	4	Don't know
d)	Reasonableness of charges	1	2	3	4	Don't know
e)	Staff concern/compassion	1	2	3	4	Don't know
f)	Building cleanliness/condition	1	2	3	4	Don't know
g)	Emergency room care	1	2	3	4	Don't know
h)	Food services	1	2	3	4	Don't know
i)	Billing and financial services	1	2	3	4	Don't know
j)	Outpatient services (lab, x-ray, physical therapy, etc.)	1	2	3	4	Don't know
k)	Patient input into care program	1	2	3	4	Don't know

7. How do you feel about the number of different types of health services (physical therapy, x-ray, etc.) provided by Kenai Peninsula Borough Hospitals? *Circle one answer.*

1) SHOULD INCREASE
2) STAY ABOUT THE SAME
3) SHOULD DECREASE
4) DON'T KNOW WHAT SERVICES ARE AVAILABLE

8. If you were hospitalized tomorrow, who do you think would pay for the majority of the bill? *Circle one answer.*

1) SELF-PAY
2) MEDICARE (Includes supplemental policy) (OVER AGE 65)
3) MEDICAID (PUBLIC ASSISTANCE)
4) FISHERMAN'S FUND
5) PRIVATE INSURANCE (including employer plans)
6) ALASKA NATIVE HEALTH
7) VA
8) OTHER - please specify:_____

9. If you selected #5 in question 8, what is your total out-of-pocket monthly premium payment for everyone in your household (not including deductibles)? $_____

10. Do you feel that you have adequate, satisfactory health insurance? *Circle one answer.*

1) YES
2) NO

11. **If no**, why not? *Circle one answer.*
    1) CAN'T AFFORD IT
    2) CAN'T GET INSURANCE DUE TO HEALTH PROBLEMS
    3) SELF-INSURE (pay your own bills)

12. Do you feel that physicians and hospitals on the Peninsula would help you arrange a payment schedule for medical bills if needed?
    1) YES 2) NO 3) DON'T KNOW

13. How important is it that all three Peninsula Hospitals remain open? *Circle one answer.*

1) VERY IMPORTANT 2) SOMEWHAT IMPORTANT 3) NOT IMPORTANT

14. How many medical care visits have members of your household made during the ***past yea.*** In each of the following places? *Do not count hospital inpatient visits or visits occurring before you lived in this community. If you saw both a physician and a nurse, midwife or physician assistant in the same visit, count it as a physician visit. List a number on each line.*

	Physician Visits	Visits to Nurse Practitioners, Public Health Nurses, Midwives, and Physician Assistants.
a) Kenai-N. Kenai	____	____
b) Soldotna-Sterling-Kasilof-Ninilchik	____	____
c) Homer-Anchor Point-Seldovia	____	____
d) Seward-Moose Pass	____	____
e) Anchorage	____	____
f) Seattle	____	____
g) Other	____	____
If other, where?	_____	_____

15. During the ***past year***, did members of your household visit a non-physician health care provider (dentist, nurse practitioner, chiropractor, etc.) outside of the Peninsula?

1) YES →
2) NO

16. If yes, what types of non-local providers were seen?

_____

_____

_____

17. Did household members visit ***physicians*** in places other than the Kenai Peninsula during the past two years?

1) YES; if so, please go to 18 and 19.
2) NO

18. Why did household members visit physicians outside the community? *For each reason, circle 1 or 2:*

	Yes, a reason	Not a reason
a) Services/specialty not provided locally	1	2
b) Quality of services better elsewhere	1	2
c) Services cheaper elsewhere	1	2
d) Referred by local physician	1	2
e) Referred by non-local physician	1	2
f) Takes too long to get appointment with local physician	1	2
g) Non-local providers easier to get to	1	2
h) More privacy with non-local providers	1	2
i) Wait in office to see local physician too long	1	2

j) Other—why?_____

19. Please list the physician specialties seen outside your community, (cardiologist, gynecologist, etc.):

_____

_____

_____

20. How would you rate each of the following aspects of the overall physician care provided in your community? *Circle one answer for each category.*

		EXCELLENT	GOOD	FAIR	POOR	
a)	Quality of medical treatment	1	2	3	4	Don't know
b)	Concern/compassion for patient	1	2	3	4	Don't know
c)	Reasonableness of charges	1	2	3	4	Don't know
d)	Competence of support staffs	1	2	3	4	Don't know
e)	Night and weekend care availability	1	2	3	4	Don't know
f)	Ability to get appointment quickly	1	2	3	4	Don't know
g)	Ability to see MD promptly at scheduled hour	1	2	3	4	Don't know

21. Do you have a personal physician who you expect to care for most of your medical care needs? *Circle one answer.*

1) YES
2) NO

22. **If yes**, where do you see your personal physician? *Circle one answer.*

1) Kenai-N. Kenai
2) Soldotna-Sterling-Kasilof-Ninilchik
3) Homer-Anchor Point-Seldovia
4) Seward-Moose Pass
5) Anchorage
6) Seattle
7) Other

23. How satisfied are you with the care you get from your personal physician ? *Circle one answer.*

1) VERY SATISFIED
2) SOMEWHAT SATISFIED
3) INDIFFERENT
4) SOMEWHAT DISSATISFIED
5) VERY DISSATISFIED

24. How satisfied are you with each of the following aspects of health care in your community? *Circle one answer in each row:*

		Very Satisfied	Somewhat Satisfied	Indifferent	Somewhat Dissatisfied	Very Dissatisfied	
a)	Hospital	1	2	3	4	5	Don't know
b)	Emergency room	1	2	3	4	5	Don't know
c)	Physicians	1	2	3	4	5	Don't know
d)	Public health services	1	2	3	4	5	Don't know
e)	Dental services	1	2	3	4	5	Don't know
f)	Pharmacy services	1	2	3	4	5	Don't know
g)	Eye Care services	1	2	3	4	5	Don't know
h)	Ambulance service	1	2	3	4	5	Don't know
i)	Counseling/mental health	1	2	3	4	5	Don't know
j)	Drug/alcohol treatment	1	2	3	4	5	Don't know
k)	Hospice care	1	2	3	4	5	Don't know
l)	Nursing home care	1	2	3	4	5	Don't know
m)	Chiropractic care	1	2	3	4	5	Don't know
n)	Homeopath/Naturopath	1	2	3	4	5	Don't know
o)	Midwives/Nurse practitioners	1	2	3	4	5	Don't know
p)	Physical/occupational therapy	1	2	3	4	5	Don't know
q)	Home health services	1	2	3	4	5	Don't know
r)	Village Health Clinic	1	2	3	4	5	Don't know
s)	Outpatient surgery	1	2	3	4	5	Don't know

25. Where would you seek care for each of the following health care needs?
Circle one place in each row, and complete blank if other location:

a)	Cancer treatment	Soldotna	Homer	Seward	Anchorage	Seattle	_____
b)	Broken arm	Soldotna	Homer	Seward	Anchorage	Seattle	_____
c)	Pregnancy/delivery	Soldotna	Homer	Seward	Anchorage	Seattle	_____
d)	Pneumonia hospitalization	Soldotna	Homer	Seward	Anchorage	Seattle	_____
e)	Knee surgery	Soldotna	Homer	Seward	Anchorage	Seattle	_____

26. How do you rate your knowledge of the health services that are available in your community? *Circle one answer.*

1) EXCELLENT
2) GOOD
3) FAIR
4) POOR

We're almost done! The following few questons are of a more personal nature, but are equally important to our survey (and, of course, will be kept strictly confidential). Please answer them and then mail the survey today!

27. What is your zip code? _____

28. Approximately how far do you live from your local Hospital and how long does it take you to get there?

_____*miles* _____*minutes*

29. How long have you lived in this community?

_____*years*

30. Which of the following best describes your yearly total household income? *Circle one answer.*

1) less than $5,000
2) $ 5,000 - $ 9,999
3) $10,000 - $14,999
4) $15,000 - $ 24,999
5) $25,000 - $49,999
6) $50,000 or more

31. Which of the following best describes your racial or ethnic identification? *Circle one answer.*

1) BLACK
2) CHICANO OR HISPANIC
3) NATIVE AMERICAN (American Indian, Eskimo, Aleut)
4) WHITE
5) ASIAN OR PACIFIC ISLANDER
6) OTHER (*Please specify*): _____

32. What is your marital status? *Circle one answer.*

1) SINGLE
2) MARRIED
3) SEPARATED OR DIVORCED
4) WIDOWED

36. How would you rate your health on a scale from 1 to 10, with 1 being very poor and 10 being excellent? *Circle one answer.*

1 2 3 4 5 6 7 8 9 10

37. If you travel outside of the Kenai Peninsula for medical care, how often do you shop for consumer goods (household, medications, automotive products, etc.) on the same trip? *Circle one answer.*

1) ALWAYS
2) OCCASIONALLY
3) NEVER
4) DOES NOT APPLY

38. Would you be willing to pay local taxes to support a Kenai Peninsula Borough Health Care Plan that would subsidize your care from local providers for all the residents in the community? *Circle one answer.*

1) YES
2) NO

39. If you answered YES to question 38, which form of taxation would you prefer? *Circle one answer.*

1) PROPERTY TAX
2) SALES TAX
3) SEVERANCE TAX ON RESOURCES (FISH, TIMBER, COAL, ETC.)
4) OTHER (*Please specify*)

40. What do you feel is the most important health care problem in your community?

KENAI PENINSULA BOROUGH
HEALTH CARE ADVISORY COUNCIL
Revised Survey Instrument Time Line

May 18-22	Draft # 1 survey instrument
May 26	Send draft with meeting packet for full council review June 4
June 4	Review, amend by full council; draft #2
June 23	Education Committee consider and approve: -Amended survey instrument -Amended time line for survey work -Instrument distribution, tabulation and analysis -Pilot testing plan
July	Pilot testing of survey instrument: July 1-6 Mail test survey with cover letter to health care providers, others July 6 Seward General Hospital Board of Directors (7:00 PM) July 23 Central Peninsula Hospital Service Area Board (5:30 PM) South Peninsula Hospital Service Area Board (6:00 PM) July 29 Kenai Chamber of Commerce (Noon) Final survey instrument, begin survey publicity Publicity activities: *Radio talk shows in Homer, Seward and Kenai-Soldotna *Media release to local papers *Radio PSA's - 30 second sound bite *Newspaper guest editorials: Dr. Bruce Amundson and committee members
Aug 1-14	Develop alternative sources for data base from which to construct sampling frame
Aug 17-27	Sampling frame construction by Idaho State University, transport survey to Alaska for bulk mail.
Aug 28	Surveys in mail, continue publicity
Sept 24	Close out receipt of surveys for data entry purposes
Sept 24-31	Data entry (estimated 1,000 surveys)
Oct 1-14	Data analysis and preparation of draft report
Oct 15	Final Report
Oct 16-17	Health Care Work Shop

General Information

Purpose - A workshop for the Kenai Peninsula Borough Health Care Advisory Council, Health care service providers, local government officials and citizens to further define a health care plan for Kenai Peninsula Borough residents.

Invited Experts - **Dr. John Coombs**, Vice President, Medical Affairs, Tacoma General Hospital; **Cindy Rice**, Sound Care Manager, Kitsap Physicians Service, Bremerton, Washington; **Dennis P. Degross**, Health Planner, Community Health Services Development Project, University of Alaska, Fairbanks; **Jack Brandt**, NCAS Northwest, Seattle; **Dr. Bruce Amundson**, Private Rural Health Consultant, Seattle; **Amy Hagopian**, Associate Director, University of Washington, Department of Family Medicine, Seattle; **David Ford**, Private Health Benefits Consultant, Seattle; **Cheryl Schott**, Executive Director, Group Health Cooperative of Puget Sound, Seattle.

Transportation - ERA, SouthCentral Air, and Markair Express all serve Kenai from Anchorage and Homer. Currently Alaska Airlines (with ERA Commuter) and Markair (with Markair Express) offer roundtrip Seattle/Kenai fares of $380 if tickets are purchased prior to Sept. 30 (Saturday night stay).

Housing & Workshop Site - The workshop housing and site is the Kenai Merit Inn, 260 South Willow, Kenai, AK; telephone is 907-283-6131; Fax is 907-283-6090. When making reservations say you are attending the HCAC Workshop for a special $55 rate; single or double occupancy.

Sponsors - Kenai Peninsula Borough Health Care Advisory Council through Kenai Peninsula Borough Economic Development District; funding support from Community Health Services Project Development Grant.

Conference Agenda

Friday, October 16, 1992

3:00PM - 5:00PM	Welcome and Introduction of HCAC Project - Stan Steadman, HCAC Chair; Local and National Significance of Plan- Dr. Bruce Amundson, Project Consultant
5:30PM - 7:00PM	Reception (included in registration)
7:00PM - 9:00PM	Public Forum: Community Health Care Plan and Survey Results- Stan Steadman; Bruce Amundson; and Amy Hagopian, University of Washington (no fee to attend)

Saturday, October 17, 1992

8:00AM- 9:30AM	Continental Breakfast; Presentation of HCAC Plan Draft & Development Team Reports on Funding, Benefits Design, Implementation & Management, Delivery of Health Services, Organizational Structure
10:00AM- 2:00PM	Breakout Sessions for Plan Development teams to work with faculty experts. Lunch break will vary with group needs (box lunch provided)
2:00PM- 5:00PM	Report of teams and draft plan refinements; wrap-up; next moves: political action, schedule of community forums, publicity, work assignments

Registration

Name _____

Title _____

Company _____

Address _____

City _____ State___Zip_____

Telephone _____Fax_____

Payment Information

Registration fee is **$25.00**, which includes reception, continental breakfast, and box lunch. Pay by check (payable to EDD) if registering by mail, check or cash if registering at the door. Conference attendance will be limited, so make reservations. Send registration to:

EDD
110 So. Willow St., Suite 106
Kenai, Alaska, 99611
Tel. (907)283-3335; Fax (907)283-3913

Early Arrivals

A tour beginning at 9:00 AM on Friday, October 16th, of the Kenai-Soldotna area will be available for out-of-towners arriving early. Please check the box if interested.

Early Arrival Tour ☐

See you on the Kenai!

Kenai Peninsula Borough

Health Care Advisory Council

Kenai Peninsula Borough Economic Development District, Inc. 110 S. Willow St., Suite 106 Kenai, Alaska 99611 (907) 283-3335 Fax: (907) 283-3913

KENAI PENINSULA BOROUGH
HEALTH CARE ADVISORY COUNCIL

Lottie Bogard
Sterling

Margaret French
Homer

Dr. Vickey Hodnik, DDS
Homer

Mike Lockwood
Soldotna

Robert Roth
Kenai

Ray Zagorski
Soldotna

Karen Moore
Soldotna

George Carnahan
Kenai

James Krasnansky
Seward

Dick Swarner
Soldotna

Jeanne Berger, M.A., PHN
Hope

Dr. Jon Godfrey, DC
Homer

Dr. John Kobylarz, DDS
Soldotna

Dr. James Zirul, DO
Soldotna

Linda Hutchings
Soldotna

Emery Thibodeau
Kenai

Jon McMichael
Soldotna

Burt Anderson
Homer

Rich Underkofler
Soldotna

Brenda O'Brien
Seward

Jerry Near
Soldotna

Mike Pate
Homer

Ken Hepner
Sterling

Judy Charpentier
Kenai

Jim Heim
Soldotna

Bonnie Heimbuch
Soldotna

Ross Kendall
Nikiski

Marion Nelson
Nikiski

EX-OFFICIO MEMBERS

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Soldotna, Alaska 99669

Kathleen (Kathy) Scott, Proj. Mgr.
K. Scott & Assoc., Inc.
Box 2488
Kenai, Alaska 99611

Kenai Peninsula Borough
Economic Development District (Alaska)
Health Plan Development Project

OVERVIEW

The Kenai Peninsula Borough, Alaska is located south of Anchorage, encompassing over 25,000 square miles with a population of over 40,000 people. In November, 1991, the Borough Assembly passed a resolution establishing the 30 member Health Care Advisory Council and requesting the Kenai Peninsula Borough Economic Development District (EDD) to administer the work of the Council. Since January, 1992, the Council has been aggressively pursuing a course to accomplish its mission:

> SUBMIT A REPORT TO THE BOROUGH ASSEMBLY MAKING FINDINGS AND RECOMMENDATIONS AS TO OPTIONS FOR THE ESTABLISHMENT OF A BOROUGH-WIDE INSURANCE PROGRAM WHICH WOULD MAKE AFFORDABLE HEALTH INSURANCE AVAILABLE TO ALL RESIDENTS AND THEREBY INCREASE ACCESS AND UTILIZATION OF THE LOCAL HEALTH CARE SYSTEM.

Kenai Peninsula Borough residents are concerned about the accessibility and rising costs of health care. This concern is particularly acute for low income residents and the many workers in high risk, seasonal, small business occupations. The expectation that the state or federal governments will act to establish a program to meet the needs of those who cannot afford insurance is not being realized as lawmakers continued to be mired in debate between competing interests.

Over the past several months the Council's members have worked in committees and sub-committees defining elements of the proposed plan to be revealed in a workshop on October 16-17, 1992, in Kenai, Alaska. The day and a half workshop provides an opportunity for in-depth discussion of plan elements as reviewed by chosen experts in the area of funding, delivery of health services, benefits design, organization of structure, and implementation and management.

REGIONAL ECONOMIC ISSUES

The leadership in this project stems from a recognition of the following issues:

1) Surveys of local entrepreneurs show the cost of employee insurance high on the list of barriers to business development.

2) Local governments are faced with either reducing direct government services or raising taxes to meet the rising costs of public employee insurance benefits.

3) Annually millions of dollars in insurance premiums which could be used locally are exported (estimated in excess of $25 million) to Outside based insurance companies.

4) A significant percent of health care to local residents is provided outside of the area, leaving local facilities operating in efficiently at levels substantially under capacity.

5) The health care costs of the uninsured are, in part, passed on to public agencies, employers, and all citizens.

APPROACH

In conjunction with a $47,000 grant received from the state funded Community Health Services Development Project (CHSD), the Council has implemented the CHSD Model developed by the WAMI Rural Health Research Center (see attachment) in the analysis and development of a borough-wide health care plan. The following four phases are envisioned by the model and have been implemented by the Council:

1) Preparation - A core group of community and health system leaders brought the request for official sanction and participation in the project to the Borough Assembly. In November, 1991, the Assembly established the 30 member Health Care Advisory Council, requested the Borough Mayor to select Council members, and requested the EDD to service as the project administrator. Since January, 1992, the Council has been discharging its responsibilities under the leadership of three committees: steering, planning, and education. Through the EDD, a consultant project manager, Kathy Scott, and a project advisor, Dr. Bruce Amundson, were hired.

2) Analysis - Identification and discussion of the concerns of Council members, analysis of existing health data, and investigation of innovative health care systems across the United States and Canada occupied the first several months of the Council's efforts. In mid-summer, 1991, the Council undertook preparation of a borough-wide, random community survey evaluating the health care system within the borough with the assistance of the Institute of Rural Health Studies, Idaho State University, and the University of Washington School of Medicine . Also, the Council surveyed Alaska and Seattle, Washington, hospitals to determine the location and type of care provided ouutside of the local area to Kenai Peninsula Borough residents. Both surveys were still in progress as of September, 1992.

3) Planning/Development - By mid-summer, 1992, the Council turned its focus to developing the specifics of a health care plan. Five issue groups were organized to work on various plan elements: funding, benefit design, implementation and plan management, organizational structure, and health services delivery. The work of these groups will be revealed in a workshop, October 16-17, in Kenai. At that time an invited panel of experts will assist with plan refinements. Then, with a draft plan in place, an actuarial firm will be hired to determine costs and prices.

4) Implementation - This phase will begin when the Council feels confident in proceeding with public review of a draft plan. According to the schedule under which the council is working, the draft will go to public review prior to a fall, 1993, referendum election on whether necessary public powers should be adopted to enable full plan implementation.

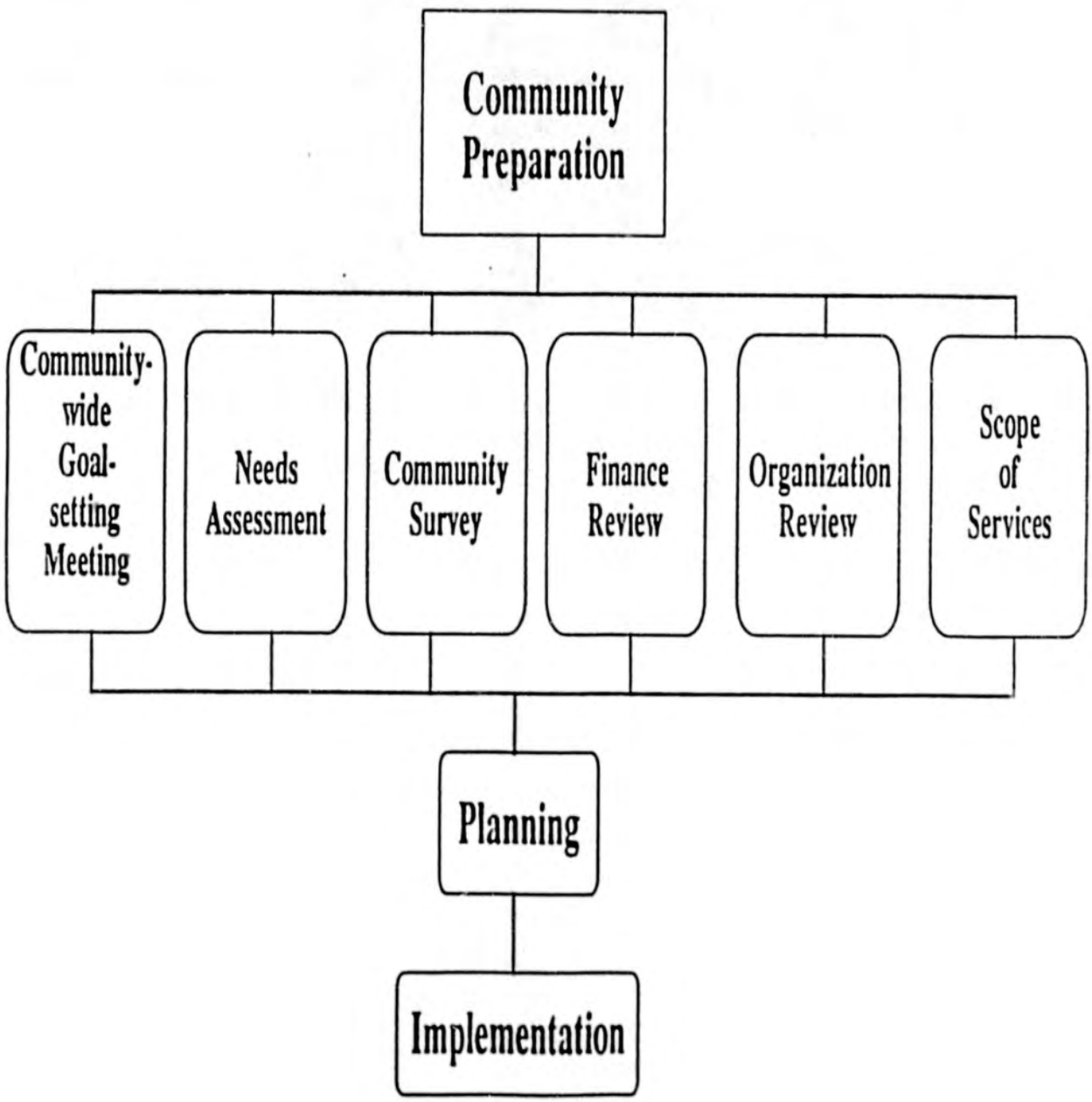
VISION

Many of the basic resources to accomplish this project are available locally (i.e. leadership, public involvement, data). However, the Council will look to participation of other agencies, organizations, and foundations for resources beneficial to project accomplishment.

The presentation of this concept at state and national conferences has sparked keen interest. The inclusion of all jurisdiction residents in a locally administered plan and the linking of health costs to economic development objectives are unique, and the success of this project is seen as having far reaching importance in dealing with this critical issue.

Figure 1

CHSD Phases



Health care panel wins award for innovation

By CATHY BROWN
Peninsula Clarion

8/13/92

The Kenai Peninsula Borough Health Care Advisory Council, which is in the midst of coming up with a possible boroughwide health plan, has garnered an "innovation award" for the borough Economic Development District, EDD Executive Director Stan Steadman said.

As administrator of the health council, the EDD has won a National Innovation Award from the National Association for Development Organizations.

The award not only provides recognition of the council's work, it also may help it gather financial support, Steadman said.

"I think it gives us visibility," he said. "With that kind of recognition, it strengthens our position in seeking grants, in seeking participation in the program from federal, state and private funding sources."

The 30-member health council was established last winter by the Borough Assembly to investigate the feasibility of a boroughwide health program.

The idea is that by pulling borough residents into one large insurance pool, the borough may be able to make health care more affordable for all residents.

The EDD also sees the council as a way to keep insurance and health care dollars in the community.

The council spent much of first half of the year educating itself about factors driving the cost of care and the cost of health insurance and looking at plans other states have adopted to try to deal with the problem.

It is now beginning to visualize what a borough health plan might look like. Five committees are coming up with ideas for benefits, funding, organizational structure, implementation and delivery of health services.

They met last week to talk about what they've come up with, but won't have firm recommendations until a Sept. 11 meeting, said Bonnie Golden, administrative assistant to Borough Mayor Don Gilman.

"This is still brainstorming, looking at alternatives, looking at the pros and cons of every-

See COUNCIL, page 16

Council: Studies ways to pay for plan

Continued from page 1

thing," council member Rich Underkofler said.

Among the possible mechanisms the funding committee is looking at to pay for the plan are: tax subsidies, such as sales tax, property tax, severance tax, income tax, and so-called "sin" taxes; block grants from the state; private foundation funding; premiums, including subsidized premiums for the poor; and "cost containment" measures to lower the prices people pay for medical care.

A benefit design committee is discussing what services should be covered, ranging from pre-natal care to prescription drugs to optional vision and dental care.

The committee has also talked about "deductibles," the amount patients pay before insurance kicks in, ranging from $100 to $1,000; making the deductible lower for preventive care procedures, like dental exams; and paying a greater percentage of costs for people who use borough doctors.

The committee has suggested requiring residents to live in the borough a year before becoming eligible for the plan and using things like property ownership, driver's license and voter registration to prove that residency.

A health services delivery committee is looking at ways to coordinate health and social services so all factors contributing to an illness or injury, for instance, alcoholism or domestic violence, are addressed, rather than just the medical ailment.

An implementation committee is looking at whether to implement the plan in partnership with an insurance company or in-house, how to avoid overloading it with high claims initially, how to market the plan, what kind of data system would be needed and other issues.

'I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them.'

—Stan Steadman, executive director of the Economic Development District

The organizational structure committee is looking at what kind of governmental body should be set up to run a borough health plan.

The committees will further refine their ideas by the next council meeting, Golden said.

A group of experts who have been invited to an October conference will tell them whether the concepts they've proposed seem workable, Steadman said.

"We set up the conference as a way to obtain outside peer review of what we were doing, so we weren't operating in a vacuum," he said.

In the next few months, the council will also be hiring an actuary, a person whose work is to calculate risks and premiums for insurance, to put some numbers to the concepts it's coming up with.

"People keep saying 'how much will this cost,' and we can't answer that until we come up with a plan and have an actuary determine rates," Steadman said.

Underkofler remarked at the last council meeting that he had heard some physicians are apprehensive about what the council is doing.

Dr. James Zirul said it's true some doctors are nervous because organizations that have sprung up in the Lower 48 to control costs — like preferred provider organizations and health maintenance organizations — have buried physicians in paperwork, compromised patient care and made it is difficult for doctors to pay their overhead costs. Zirul is one of several health care providers on the council.

What the council is trying to do here is very different from approaches that have been tried elsewhere, he said, and no one knows yet whether it will work.

Steadman said the project manager for the council was in Homer this week meeting with physicians there. Council representatives have had meetings with doctors on the staff of the three hospitals within the borough, he said.

"What we're telling them is we're striving for a better system to provide health care and we recognize that they are a key, integral part to that being accomplished, and we're looking for their input to be sure their interests are represented."

Some doctors are hopeful that the council can come up with something better than the system now in place.

Dr. Lynn Carlson, who operates a family practice clinic in Nikiski, said many of his patients fall into that category of people who are neither able to afford insurance nor eligible for Medicaid. He is hoping the council may be able to find a better way to provide care to them.

"I'm thinking that a locally run health system would be better than a federally run" system, Carlson said.

"I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them," Steadman said.

It's too early to know yet bottom line things like how much such a plan could cost people in premiums and taxes, what they would get in benefits and how it would affect the medical establishment.

The council's timeline calls for it to go before borough voters at the October 1993 municipal election. It would have to receive Borough Assembly scrutiny before it could even be placed on the ballot.

KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL
WORK PROGRAM

(for prior track consult revised draft of March 23, 1992)

July - Education Committee and Steering Committee approved survey.

July - Kenai Peninsula Health Care Survey Pilot Testing

July 13 - Full Council Workshop. Dr. Bruce Amundson CHSD Model presentation. Dave Ford, plan organizational alternatives. Council initiates the work of health care plan development. Issues development groups organize around five key areas: Funding, Benefits Design, Implementation and Plan Management, Organizational Structure and Health Services Delivery.

Issues development groups meet to prepare draft issues statements.

August 7 - Full Council Meeting. Standing committees report as well as issues development groups. Decision on alternate date for fall conference which has become more of a fall workshop. The potential still exists for a full conference in the spring.

September 11 - Full Council Meeting. Discuss final drafts of issues statements for inclusion in the work shop packet material. Other operations issues. Approve form of a "Request for Proposal" for a third party consultant to assist with the demographic, coverage, actuarial, financial and management components of the health insurance plan. The RFP Selection Committee is the Steering Committee.

The scope of the consultant's services should include these tasks:

Design a model "community based" health insurance program based on issues development resolves by the council through their "expert" advisors in the October work shop. Specifics should include but are not limited to:

- Prediction of annual expenses of the program
- Classification of program expenses to be retained or deferred by excess insurance or a reserve fund
- Allocation of expenses between various sources of revenue

October 8 - RFP Selection Committee review proposals and select with approval of the Steering Committee.

October 16-17 - Full Council Work Shop with "faculty" experts to refine elements of the proposed health care plan. (See work shop outline for detail).

November 6 - Full Council or Steering Committee consider and approve interim report of Health Care Advisory Council in preparation for presentation to the Borough Assembly at their November 17 Meeting. Extension of time from Borough Assembly for life of Health Care Advisory Council occurs at same meeting.

- Secure remainder of funding needed for the project. Potential sources of additional funding may be: the Borough hospitals, a grant from the American Hospital Association, a grant from the Kellogg Foundation, another state grant, etc.

Authorize consultant to proceed.

1993

February 4 - Due date for the first draft of the consultant's report.

Revisit the assumptions. Adjust demographics, coverage, services and/or allocation of program expenses between the various sources of operating revenue (as appropriate) to make the cost consistent with what residents should be willing to pay for the health insurance program.

Introduction of state and local legislation necessary to amend existing laws to give KPB explicit authority (or exemption from existing law) to implement a community based health insurance program subject to the approval of a majority of the borough's voters.

April 1 - Due date for second draft of consultant's report. Give policy guides as appropriate for final revisions to the report.

May 6 - Submit final report to the Borough Assembly making findings and recommendations for the establishment of a Borough-wide insurance program which would make affordable health insurance available to all residents and thereby increase access to and utilization of the local health care system.

June 1 - Assembly introduces an ordinance which would provide the Borough with authority to implement the program subject to approval of the voters at the October regular election.

October 7 - Voters decide whether to approve or reject a proposition to enable implementation of the program.

Midwives Association of Alaska
October 23, 1992

MIDWIFERY CARE IS A VIABLE OPTION

I. Midwifery in Alaska

A. Midwives Association of Alaska

1. Membership
2. Registry requirements (fashioned after N.M. licensing requirements)
3. Direct-entry Midwives -- combination of apprenticeship and academics (degree programs available)
4. Affiliation with national association -- the Midwives Alliance of North America

II. National Focus on Midwifery

A. Carnegie-Sponsored meetings
- ACNM: American College of Midwives
- MANA: Midwives Alliance of N. America
- Consumers

1. Decisions:
   a. Nursing not necessary prerequisite to midwifery
   b. Core competency more important than specific pathways of learning
   c. National testing standards adopted

B. Credentialing in other states

C. Reimbursements in other states.

III. Comments

A. Financial Access to System

1. Medicaid -- licensing should make a difference
2. Private insurance -- approximately 60% pay currently -- will improve with licensing

B. Quality of Care

1. Social support of woman and her family

2. Education

3. Continuity of care throughout

4. Midwives spend approximately 50-60 hours with a woman for prenatal, labor and delivery, postnatal care and education which translates into:

   a. improved infant and maternal health
   b. improved mother and baby relationship
   c. breast feeding success
   d. less abandonment and neglect

C. Cost Effectiveness

1. A cost comparison was done in the six areas of the state where members of the registry of the Midwives Association of Alaska practice; that is Juneau, Soldotna, Fairbanks, Palmer, Anchorage and Cordova. Their fees were compared with the combined fees of doctors (family practice and obstetricians averaged) and hospitals for perinatal care including a normal vaginal delivery without complications or interventions when the mother spends 24 hours or less in the hospital.

2. The average cost of midwifery care was **$1,850.00**. The average cost for doctor/hospital care was **$4,100.00**.

3. Please note additional enclosures including FACT SHEETS prepared by the Midwives Association of Washington State for additional information.

IV. Summary

Midwifery care **is a viable option** for low-risk women. Low income women are presently denied this option of choice which would potentially translate into savings of many health care dollars.

Thank you for the opportunity of addressing this task force.

Prepared by: Pam Weaver (907) 688-2000.

Dollars and Sense: Midwifery Care Is Cost-Effective Care

Midwifery Fact Sheet

- Professional fees of midwives are lower than those of physicians: in 1988 they averaged $1450, while physician charges for comparable care averaged $2100.[1] Additionally, midwifery fees have not increased at the same rate as physician fees in recent years.

- Midwives use fewer expensive technologies to provide safe care. Consequently, patient charges, including length of hospital stay, are significantly lower. Comparisons of midwifery care and physician care, including one study of the same population of patients in the same hospital,[2] have shown that midwives have equally good outcomes, while using fewer interventions.[3,4]

- Midwifery care is preventive care. Midwives spend time to provide education, information and social support to their clients. All of these factors have been cited as significant contributors to reducing adverse outcomes, especially prematurity and low birthweight.[5,6]

- Midwives have far fewer malpractice claims filed against them than do physicians. In a survey conducted by the American College of Nurse-Midwives, 9.6% of nurse-midwives said they had been named in a suit.[7] The American College of Obstetricians and Gynecologists' national survey of 1985 revealed that 73% of obstetricians had been sued at least once.[8]

- Because midwives are sued less frequently than physicians, their malpractice insurance premiums cost less. In 1987 the average premium for a physician delivering babies was $37,000; for a midwife, malpractice insurance cost $3,500.[9] This difference greatly contributes to the lower cost of midwifery care.

- Midwives offer a choice of birth setting. Out-of-hospital births, either at home or in a licensed birth center, offer the low-risk, healthy woman a safe option at considerable savings. The cost of an out-of-hospital birth is 50% to 70% less than a hospital birth.[1] Recognizing these substantial savings in health dollars, several private health insurance plans now encourage midwife-attended out-of-hospital birth by reimbursing 100% of these charges, while hospital delivery is reimbursed at 80%.[10] Similarly, the state's Medicaid program reimburses for delivery in a licensed birth center.[11]

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Birth Outside the Hospital

Midwifery Fact Sheet

Trends in birth setting

● In 1940, 50% of births in this country took place at home, with a doctor or midwife in attendance. By 1960, birth had been moved almost exclusively into the hospital. During the 1970's, a notable increase in out-of-hospital births signaled a new debate among consumers and health professionals on the appropriate place for labor and birth.

Today, approximately 1% of American families choose to give birth outside the hospital: in Washington State, this proportion is about 2.5%. These families choose home birth, or delivery in a free-standing birth center (not a hospital facility) licensed by Washington State's Department of Health. The majority of out-of-hospital births, in Washington as well as throughout the United States, are attended by midwives.

Reasons for out-of-hospital birth

● Why do families choose out-of-hospital birth? A number of consistent themes emerge from the literature including:

- increased control over the childbirth experience;
- avoidance of unnecessary medical routines and interventions;
- continuous care by a known and supportive birth attendant;
- labor and delivery among loved ones and in familiar surroundings;
- avoidance of the high cost of hospitalization.

Safety: What the Studies Say

● For most people concerned with childbirth, a central issue is safety. What do we know about the relative risks of childbirth in various settings? Studies reporting outcomes from well-organized out-of-hospital birth practices, both in the U.S. and abroad, show very low rates of adverse outcomes for mothers and infants. Holland, for example, where 35% of deliveries take place in the home, has one of the lowest perinatal mortality rates in the world. There is no evidence that birth in the hospital is safest for women at low medical risk.[1,2]

Some early reports on outcomes of out-of-hospital births were misleading because they compared hospital and non-hospital births without determining whether these births were planned and/or attended by a qualified person. In other words, late miscarriages, premature births, taxi cab deliveries, and other unexpected out-of-hospital births were included in the outcome data.[3,4]

Other studies which considered these factors found that the neonatal mortality rates of the planned out-of-hospital births with a qualified attendant averaged 4/1000, below the national rate, while for the unplanned groups the rates averaged 97/1000.[5,6,7]

In controlled studies, those births planned to occur outside the hospital with midwives in attendance were associated with lower rates of obstetrical interventions than births planned to occur in the hospital with physicians and other care providers. In some studies, planned out-of-hospital births also had lower rates of complications than the hospital births.[8,9,10]

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Several authors have estimated that the probability of an emergent complication arising during an out-of-hospital labor, in a well-screened, healthy population of women, in which the loss of time in transit to a hospital could increase the risk of an adverse outcome, would be less than 1 in 1,000.[1,11,12]

Midwifery Practice Ensures Safety

Midwives attending out-of-hospital births ensure optimum safety for their clients by:

- Accepting into care only women who have no pre-existing medical conditions, who want to have natural labor and birth (without medical interventions or pain medication) and who are experiencing a normal pregnancy;
- Providing comprehensive prenatal care that includes on-going screening for complications, education, support and personal attention;
- Ensuring continuous, one-to-one care during labor, carefully monitoring the progress of labor, and maternal/fetal condition;
- Maintaining the skills and equipment needed for treating emergent and unexpected conditions, such as hemorrhage or neonatal resuscitation;
- Establishing consultation and referral relationships with obstetricians and pediatricians who can provide hospital treatment if indicated.

In summary, an out-of hospital birth that is planned, with a well-trained attendant, is a safe, satisfying, and economical choice.

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What do international experts say about midwifery?

"...I came to see that midwifery wasn't just a way of substituting cheaper obstetrical care for the poor and deprived...I discovered that the countries with the lowest infant mortality rates in the world also had medical care systems in which the whole of normal obstetrical practice was carried on by midwives."

George A. Silver, M.D.
Professor Emeritus of Public Health, Yale University

Source: The Next Fifty Years of Nurse-Midwifery Education, Maternity Center Association, New York, 1983, page 66.

"...there is evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the U.S. one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation."

Marsden G. Wagner, M.D.
Maternal and Child Health Officer for the European Region, World Health Organization

Source: "Infant Mortality in Europe: Implications for the United States: Statement to the National Commission to Prevent Infant Mortality", *Journal of Public Health Policy*, Winter 1988:473-484.

"Midwifery provides a balance between the family and medical perspectives on birth. To negotiate and balance the different meanings and perspectives of birth within the health care system, it is essential for midwives to have a legitimate and powerful role within the system. Midwifery should be powerful enough to influence both the nature and delivery of services. This, I believe, would greatly enhance maternity care, which ultimately is the crux of the matter...the safe, loving and skilled care of women, their babies and their families at one of the most important points of life...birth."

Lesley Page
Director of Midwifery, Oxfordshire, England

Source: "The midwife's role in modern health care" in *The Midwife Challenge*, Sheila Kitzinger, ed. Pandora: London, 1988, page 259-260.

"The midwife must be able to advise the expectant mother, give her moral support, to make her enthusiastic for a natural childbirth, and above all, to supervise her in such a way that all minor and major abnormalities are recognized or at least suspected as early as possible. I am convinced that she is able to do this as well as a doctor, and very often better...Without the presence and acceptance of the midwife obstetrics becomes aggressive, technologic, and inhuman."

G. J. Kloosterman, M.D.
Former President, International Federation of Obstetricians and Gynecologists

Source: "The Midwife: Her Task and Responsibility in a Technologic World" in *The Five Standards for Safe Childbearing*, David Stewart, ed. NAPSAC International: Marble Hill, Missouri, 1981, pages 157-158.

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Crisis in Maternity Care: The Problem

Midwifery Fact Sheet

● *The United States presently ties for last place in infant mortality rates among all industrialized countries in the world.*

Low birthweight (and prematurity) is the leading cause of infant death, and the single largest contributor to death in the neonatal period (birth to 28 days). Since 1980, there has been no reduction in the incidence of low birthweight in the United States.

● *The United States stands alone among 75 industrialized and developing countries in its failure to ensure basic health and social services needed during pregnancy, childbirth and infancy.*

The most effective prenatal interventions have been shown to be social, not medical. Programs that provide all women with assistance in nutrition and lifestyle changes, and that provide personal attention improve the health of mothers and babies.

● *Maternity care costs have increased at an alarming rate, partly due to increased use of expensive technologies and surgical procedures.*

An uncomplicated physician-attended delivery in a Seattle area hospital now costs $5000; with interventions, this cost is driven much higher. Nearly one-fourth of all births are cesarean sections (which cost two to three times more than vaginal births). This rate is two times higher than the maximum rate considered acceptable according to World Health Organization recommendations. It is estimated that in 1986, this excess in cesarean births cost the United States over 1 billion dollars.

● *In 1988, 13% of women giving birth in our state did not receive adequate prenatal care.*

Early and continuous prenatal care reduces the incidence of complicated births, particularly low birthweight: for every $1 invested in preventive prenatal care, more than $3 can be saved in expensive curative care. Today, at least half of Washington's 39 counties are considered "distressed areas" because too many women are receiving inadequate prenatal care. Yet, while the need increases, there has been a sharp decline in physicians providing obstetric care, particularly to poor women.

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Midwifery Care: Part of the Solution

- ***Professional midwifery care in the United States has been associated with reduced rates of low birthweight and neonatal mortality.***

This is true not only in "low risk" populations, but also among low income women who, as a group, are at higher risk for these problems.[1-6]

- ***Midwives provide quality prenatal care that is especially effective for women who are at risk for having a low birthweight infant because of social and economic factors.***

Since midwives provide more time, education and personal care, these clients are more likely to keep their prenatal appointments, follow recommendations and feel more satisfied with the care they receive.[4,7]

- ***Women cared for by midwives have lower rates of obstetrical interventions, with no compromise in maternal or infant outcomes.***

A variety of studies have shown that midwifery care can reduce the cesarean section rate, the need for analgesia and anesthesia during labor, the use of episiotomy and the length of hospital stay.[3,8,9]

- ***Midwives can provide accessible care to underserved populations.***

Training opportunities available in Washington have contributed significantly to the steady increase of midwives in the state over the past ten years. These midwives report that the majority of their clients are low income women.[10] The Midwives' Association of Washington State is committed to assisting in the placement of midwives in underserved communities.

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Landmark Decision for British Homebirth & Midwifery

by Marjorie Tew

Marjorie Tew was an academic in the field of research statistics at Nottingham University when she stumbled into the subject of safety in childbirth. In 1975, she was teaching students at the university's medical school how much they could find out about various diseases from the available official statistics, and she assigned a group of them to look at how increased hospitalization of birth had affected infant and maternal mortality. She was very surprised to discover, as a result of these epidemiological exercises, that the relevant statistics did not seem to support the widely accepted hypothesis that the institutionalization of birth was responsible for the decline in infant and maternal mortality. Once she had written up her discovery, she was dismayed to find that medical journals were not interested in publishing her work. Finally, in 1977, her first article was published, and she began to receive support from the many British midwives and doctors who were aware of the problems caused by overuse of technology in childbirth. Her book, Safer Childbirth? A Critical History of Maternity Care, *was published by Chapman and Hall in 1990.*

Safer Childbirth? *made a powerful case that Britain's move to total hospitalization of birth had not been made on scientific grounds and that the previous system of maternity care that allowed women to have options about the kind of maternity care they received was, in fact, safer.*

Now it appears that policy planners in Britain have looked at the evidence presented by Marjorie Tew and others and have decided there is merit to her argument. Here are her reactions to the newly issued Report on Maternity Services made by the Health Committee of the House of Commons. — IMG

This non- party Committee, made up of eleven Members of Parliament with Chairman Nicholas Winterton MP (Member of Parliament), took a year to make an in- depth survey of the current British Maternity Services. Its enquiry, instigated by one of its members, Audrey Wise MP, was begun in February 1991 by giving an open, widely advertised invitation to all concerned, whether as providers or users of the service, to make written submissions describing their views and it received around 450 of these, many long and detailed. In addition it was made aware of relevant books and articles already published. Besides digesting this written material, the Committee called many representatives of professional bodies and consumer organizations to give oral evidence at the House of Commons and to answer the questions raised by the Committee members. It broadened its understanding of the problems by visiting a sample of maternity hospitals and clinics, not only in the United Kingdom, but also in Sweden and Holland, countries noted for the high quality and good results of their maternity service and, in the case of Holland, for its uniqueness in providing for over 30 percent of births to take place in the mother's home and for independent midwives to take sole responsibility for the delivery of over 40 percent of babies whether in hospital or at home. To assist in evaluating the accumulating evidence, the Committee had the advice of six expert advisors, but whereas in all previous official inquiries, the dominant expert advisors had been obstetricians or uncritical supporters of the obstetrician's philosophy that childbirth is a pathological condition, the dangers of of which can be avoided only by obstetric management, this time only two of the six advisors were obstetricians, while two were midwives, one was a pediatrician and one a general practitioner.

In March 1992 the Committee produced a lengthy report (1) of its findings, ending with a list of its 34 conclusions and 66 recommendations. Many of these are relevant only to practical arrangements or management issues within the United Kingdom, but some of universal relevance to the organization of maternity care in all countries. These are reproduced at the end of this report in the hope that, coming as they do from a detailed and unbiased survey of a wide range of evidence on the same issues as cause concern in other countries, they will furnish convincing arguments to assist groups there in their campaigns to secure reforms in their own maternity services.

The Report deserves to stand as a landmark in the history of maternity care world wide.

The Report of a Parliamentary Committee does not have the force of law, but government departments are usually influenced by its recommendations. If the implementation of any of the recommendations of this Committee would require a change in the

law there is a good chance that appropriate legislation would in due course be put before Parliament and, if approved, enacted. Most of the recommendations for change, however, would be more likely to affect policies and administrative arrangements at central and local levels and would be subjects for discussion and agreement between all the parties concerned.

The relative strengths of these bodies in arguing their case in the light of the Committee's recommendations will determine the extent to which the changes will be implemented. The Report deserves to stand as a landmark in the history of maternity care world wide.

For the first time in any such inquiry, paramount importance has been given to organizing the maternity service so that it best serves the physical and psychological needs of the mother and baby. The human interests of the service receivers are given precedence over the professional interests of the service providers, except in the respects where the evidence has clearly shown that these are not in conflict.

Given this changed attitude, as will be obvious from the extracted material that follows, the Report's main recommendations strike at the heart of the official policy of the Department of Health, which since 1970 has been to provide for all births to take place in consultant obstetric hospitals, of which the larger hospitals equipped with more facilities for technological interventions have been progressively favored. But it has never been illegal to give birth in any other place, in particular in the mother's home. Nevertheless, as a result of professional persuasion or, through a variety of tactics, of keeping birthing mothers from realizing that they did have a choice, 96 percent of all births in England and Wales in 1989 took place in obstetric hospitals, with less than 2 percent in small maternity units and only 1 percent at home. If the recommended changes are to be implemented, there will have to be revolutionary changes in the provisions for maternity care, with revolutionary implications for the current providers of care, unfavorable for those whose professional interests are best promoted by the existing system, favorable for those whose professional interests have been demoted by the existing system. As would be expected, these latter have welcomed the Report with great enthusiasm, as have the consumer groups who have campaigned for reform, but there has not yet been time for the medical establishment to express its considered reaction and to indicate what steps they may take to facilitate or obstruct the implementation of the recommendations.

On a personal note, I am gratified that the evidence assembled in my book *Safer Childbirth? A Critical History of Maternity Care* (2), together with that put forward in my written submission and oral testimony, carried some weight in influencing the Committee's deliberations and conclusions.

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Selected Conclusions and Recommendations with Universal Relevance

from a Report on Britain's Maternity Services by the House of Commons Health Committee

On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouragement all women to give birth in hospitals cannot be justified on grounds of safety. *(paragraph 33)*

Given the absence of conclusive evidence, it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions. *(paragraph 33)*

We conclude that there is a strong desire among women for the provision of continuity of care throughout pregnancy and childbirth and that the majority of them regard midwives as the group best placed and equipped to provide this. *(paragraph 49)*

We conclude that the choices of a home birth or birth in small maternity units are options which have been substantially withdrawn from the majority of women in this country. For most women, there is no choice. This does not appear to be in accordance with their wishes. *(paragraph 86)*

We conclude until such time as there is more detailed and accurate research about such interventions as epidurals, episiotomies, cesarean sections, electronic fetal monitoring, instrumental delivery and induction of labor, women need to be given a choice on the basis of existing information rather than having to undergo such interventions as routine. *(paragraph 96)*

The evidence we have received suggests that the importance of continuity of care needs underlining very heavily for the professionals who are involved in delivering the maternity services of the National Health Service. Many still demonstrate an insufficient awareness of its prominence among the criteria which women use to judge the quality of the care they have received. Nor have they yet done nearly enough to respond in practical terms to the call by women to be involved as full partners in the decisions made about their care. *(paragraph 191)*

We believe that the discussions we have heard about the case of providing continuity of care and the enabling of women to control their own pregnancies and deliveries have been far too heavily influenced by territorial disputes between the professionals concerned for control of the women whom they are supposed to be helping. *(paragraph 191)*

We are persuaded that the present imposition of a rigid pattern of frequent antenatal is not grounded in any good scientific base, and there is no evidence that such a pattern is medically necessary. The identified needs of women for information and support during pregnancy can be met

more effectively than happens at present. There is widespread agreement that this requires a more flexible system which is based in the community, not in the hospital. The present system of shared care between hospitals and the community should, by and large, be abandoned. Hospitals are not the appropriate place to care for healthy women. *[paragraph 208]*

We conclude that there is an established need for the professionals involved in the maternity services to address the issue of providing women with a wider choice of place of birth and to consider ways of organizing services to support that choice. More immediately there is a need to establish ways of providing a choice of a less medicalized pattern of intrapartum care, whatever the setting. *[paragraph 230]*

We are not persuaded by the evidence we have received that the current organization of the maternity services for intrapartum care has yet succeeded in resolving the conflicts between different philosophies of care. In the oral evidence presented to us there was a clear indication of the potential for a damaging demarcation dispute between the professional groups over how labor should be supervised. *[paragraph 232]*

We conclude that there is universal agreement between all involved in maternity care that an increase in the level of breast-feeding is desirable. *[paragraph 255]*

We recommend that geographically-based follow- up of intensive care survivors, especially VLBW (Very Low Birth Weight) infants, should be regionally organized and supervised by Regional Perinatal Advisory Committees. The results should be made widely available so that the outcome of intensive care is clearly known. *[paragraph 290]*

We recommend that the policy of closing small rural maternity units on presumptive grounds of safety should be abandoned forthwith....We recommend that in considering any appeal against the closure of such a unit, the Secretary of State should make a presumption against closure unless the case is overwhelming, since we believe that there is a shift in attitude towards maternity care which can only be met by maintaining such units as a realistically available option. *[paragraph 312]*

We recommend that a hospital delivery unit should: afford privacy; look like a normal room rather than be reminiscent of an operating theater; enable refreshments to be available for the woman and her partner or companions; ensure the feasibility of the woman being "in control" of her labor. All case notes should contain the woman's wishes for her labor; enable the woman to take up those positions in which she is most comfortable; enable the woman to have with her a midwife she has been able to form a relationship with during her pregnancy. *[paragraph 328]*

We recommend that the Department of Health vigorously pursue the establishment of best practice models of team midwifery care. *[paragraph 339]*

We recommend that the Department of Health take steps to impress upon all GP (general practitioners) their duty to facilitate the wishes of women, especially in their choice of place of birth and their right to midwifery only care. *[paragraph 349]*

We recommend that it be a duty placed upon all GP practices to have in place arrangements for women to have home confinement with GP cover or midwife-only cover if they so desire. *[paragraph 349]*

We recommend that, in the area of postnatal care above all others, attention must be turned away from a medical model of care to a woman-centered approach which takes full account of their social needs. *[paragraph 383]*

We recommend that Ministers, when considering the resources of the maternity services, give urgent attention to filling gaps in our knowledge of the true costs of the current pattern pattern of delivery of maternity care. *[paragraph 420]*

We recommend that the funding for the MRC (Medical Research Council) should be sufficient to support a full research program relevant to the maternity services. *[paragraph 425]*

We recommend that all maternity services be obliged to publish figures relating to operative intervention and stillbirth and neonatal mortality rates over the previous five years, and to make these figures available to women booking with that service. *[paragraph 435]*

We recommend as a matter of priority, that the Department of Health funds the establishment of extensive pilot schemes in the establishment of midwife- managed maternity units within or adjacent to acute hospitals. We further recommend funding of an extensive program of establishing small team midwifery care using community-based clinics. *[paragraph 440]*

Summer 1992 Issue

The Birth Gazette

Florida Celebrates Passage of Midwifery Act!

By Jackie Casanova

This year, supporters of direct entry midwifery in Florida have a major reason for celebration with the passage of the Midwifery Practice Act. Florida is now in a position to share its experience and to offer hope to midwifery supporters in other states where there is no direct entry training and licensure.

On March 12, Florida legislators passed a law which sets guidelines for the training and licensing of midwives. This law even provides Medicaid reimbursement to licensed midwives for prenatal and postpartum care and says that any hospital receiving public funds must also provide clinical experience to midwifery students!

There was a strong grassroots movement that brought the needs of the family the legislative attention it deserved. In 1990, the Florida Senate Health Care Committee mandated a study on the issue of midwifery in response to consumer demands for safe birth options with midwives in settings other than hospitals. Other public concerns were lack of access to care for pregnant mothers, decreasing numbers of practitioners providing maternity care and the high rate of cesarean sections in the state.

The study concluded that it was safe and cost effective to train and license midwives to meet these needs and also recommended that Medicaid pay for care provided by a licensed midwife.

Many people who have been waiting in the wings to open schools or to enter them are now working to get the ball rolling — again! Other states pushing for similar legislation should be aware of what supporters of midwifery in Florida learned the hard way: sunset review can mean losing everything. This isn't the first time Florida has been in a position to regulate direct entry midwifery.

In 1982, Florida took a progressive step by passing the Midwifery Practice Act (F.S. 467), which allowed midwives to become licensed after a three year program of academic and clinical training. Two Florida schools opened their doors in January of 1984. However, on the last day of the 1984 legislative session, when the law was up for sunset review, it was politically sabotaged by a physician legislator. He added an amendment which restricted applicants for state licensure to only those who were currently enrolled in the schools.

It has now been ten years since the original legislation came to pass. What we have learned in Florida is that if you aren't politically savvy, the rug can be pulled out from under you. An article in **The Birth Gazette** (Volume 6, Number 3) on Sharon Wells gives a detailed history of the women and work that created the first direct entry schools in Florida. Now, ten years later, we are about to re-create the wheel — hopefully for the last time. When the current legislation comes up for review in the year 2002, it is probable that Florida will be leading the nation by example in providing a full range of safe, affordable birthing options to our families.

Jackie Casanova has been a supporter of licensed midwifery since attending her first birth at a birth center eight years ago. At the time, she was in her final semester of Public Relations at the University of Florida's College of Journalism and published a feature story and photos on the birth. Since then she has published many stories related to midwifery, which she plans to compile in a public relations handbook for achieving direct entry midwifery state by state.

FROM MOTHERING MAGAZINE FALL/WINTER 1992

Becoming a Midwife in the Nineties

Shortages in maternity care exist in rural counties and inner cities alike. And midwives are the obvious, and acknowledged, solution to the crisis.

Rahima Baldwin

The acceptance of midwives and the demand for midwifery care are increasing at such a dramatic pace that the nineties promises to be an especially exciting time for aspiring and practicing midwives. Just as no one could have foreseen how rapidly the Berlin Wall would come down or the Communist bloc would disintegrate, so five years ago, no one could have predicted how different the attitude toward midwifery would be today.

Suddenly, in the past two years, the United States has witnessed a growing recognition that more trained midwives are needed to meet the burgeoning need for cost-effective maternity care. Lowering the infant mortality rate has finally become a national priority; at the same time, however, malpractice insurance rates have created a doctor shortage in obstetrics, and skyrocketing fees have placed maternity care beyond the reach of families without insurance. Shortages in maternity care exist in rural counties and inner cities alike. And midwives are the obvious, and acknowledged, solution to the crisis.

To meet the challenge, midwifery groups such as the American College of Nurse-Midwives (ACNM) and the Midwives' Alliance of North America (MANA) have undergone internal changes and have begun communicating in a series of meetings sponsored by the Carnegie Foundation. Here, certified nurse-midwives (CNMs), direct-entry midwives, and consumers have been exploring together the need for—and the implications of—training *thousands* of new midwives.

What Is a Midwife?

Among the most promising developments emerging from the Carnegie-sponsored meetings is a new consensus on what it means to be a midwife. In this regard, two historic shifts in attitude have occurred. One resulted in a mutual agreement that a degree in nursing is not necessarily a prerequisite for being a good midwife. The second led to an agreement that "core competencies" are more important than "pathways of learning." This means that a woman may be considered a midwife by a broad segment of society (legislatures and insurance companies, for

example) if she can demonstrate certain knowledge, skills, and abilities regardless of where she learned them—whether in school or through apprenticeship with another midwife.

It was a triumphant moment for midwifery when, on June 9, 1991, the Interorganizational Work-Group on Midwifery issued a statement signed by all the delegates—six chosen by the ACNM, six by MANA, and six consumer advocates—acknowledging that a "professional midwife" could be prepared for practice "through a variety of educational routes that have been approved by the American College of Nurse-Midwives (ACNM) or the Midwives' Alliance of North America (MANA)" and that she "practices in accord with MANA or ACNM standards."

A third historic change occurred at a meeting held in September 1991. Here, the Interorganizational Work-Group accepted a statement on "The Grand Midwife," recommending that any midwife in the United States who practiced under local regulation prior to 1965 be allowed to return to practice if she so desires, and that all midwifery training programs utilize the expertise and knowledge of these Grand Midwives. No longer written off as "granny midwives," these direct-entry practitioners are finally approaching the recognition they deserve from the nation's major midwifery organizations.

What about women who choose not to take the registry exams—specifically, those who prefer to be granted the title "midwife" by the community of women whom they serve, or those who think of themselves as "traditional midwives" and have no desire to work within the confines of the current healthcare system? Many participants at MANA's October 1991 conference expressed the conviction that these women's rights to be called a midwife and to practice the art of midwifery need to be safeguarded while their sister midwives are moving toward greater acceptance as "professional midwives."

Participants emphasized, moreover, that MANA is an organization for *all* midwives, whether they call themselves certified nurse-midwives, direct-entry midwives, community midwives, Christian midwives, shamanic midwives, or anything else. It is the right of birthing women to choose who will serve them, with disclosure statements forming the basis of informed choice.

Educational Developments

In response to the national demand for more trained midwives, numerous organizations are both creating new educational options and expanding on those already in existence. The ACNM has added a community-based training program for nurses who want to become CNMs. The Community-based Nurse-Midwifery Education Program (CNEP), which allows nurses to do their midwifery training through a two-year program *while remaining in their own communities*, hopes to train 10,000 nurse-midwives by the year 2000. This past year alone, the program has enrolled as many students as the other 27 nurse-midwifery training programs combined. The key is that nurses may do most of their coursework at home through "modules" and their clinical work with a "preceptor"—a local nurse-midwife prac-

In response to the national demand for more trained midwives, numerous organizations are both creating new educational options and expanding on those already in existence.

ticing in a hospital or birth center—thus enabling many women with families or job obligations to complete their training and receive certification.

The ACNM is also exploring accreditation and certification standards for direct-entry professional midwifery programs, and investigating ways to help foreign-trained midwives become certified to practice in the United States. In addition, the organization voted to add a module on homebirth to each nurse-midwifery training program.

MANA has been wrestling with educational issues as well. It has stood firmly for the validity of the apprenticeship model, and has been probing the question of which core competencies are truly central to midwifery. In addition, the National Registry Board, which MANA mandated in 1989, has developed an exam to test entry-level midwifery knowledge. The exam is being given throughout the country, and any midwife who passes it may call herself a "North American Registry Board Licensed Midwife."

Direct-entry training programs, which have been in existence for a number of years, are actively seeking recognition through junior colleges, college accreditation programs, and the ACNM. The Seattle Midwifery School, for example, having trained direct-entry midwives for many years, was approved by the ACNM Division of Accreditation to offer a nurse-midwifery pathway in affiliation with a local university. And a program developed by the New Mexico Midwives Association and the Northern New Mexico Midwifery Center has been recognized by the New Mexico Commission of Higher Education as a degree-granting institution now known as the National College of Midwifery. The college offers associate, bachelor's, master's, and doctorate degrees in midwifery. In addition, a Midwifery Education Accreditation Council has been formed, with the goal of establishing an accreditation body for direct-entry midwifery educational programs so that they can receive national recognition just as nursing programs now do.

The Legislative Climate

Each state has its own regulations regarding the practice of midwifery. As a result, the nation remains a checkerboard of opportunity and repression. On the positive side, licensed direct-entry midwives in New Mexico and Washington can now receive Medicaid reimbursement for their services. Furthermore, legislation decriminalizing midwifery and establishing various guidelines for its practice is pending in many states.

On the downside, Illinois has declared pregnancy a "condition," implying that unlicensed direct-entry midwives who "treat it" are committing a criminal offense. Cases against midwives are pending in Georgia, California, and other states. Moreover, direct-entry midwives in most states are not eligible for reimbursement by insurance companies, which adds further constraints to the challenge of earning a living as a direct-entry midwife.

Amid today's rapidly changing conditions, it is impossible to predict what the future will bring. One thing's for sure, the country needs midwives. Clearly, midwifery has "grown up" over the past 20 years, as evidenced in both the increasing professionalism of direct-entry midwives and the acceptance of certified nurse-midwives into hospitals, where they are getting excellent results, even in high-risk populations. Midwives are becoming more assertive about sharing their knowledge, and more politically savvy. In addition, midwives are being called upon to serve as primary healthcare providers for pregnant women.

While the options for midwifery training and practice are likely to increase dramatically over the next five years, the path toward full acceptance of midwifery may involve setbacks—simply because old ideas, institutions, and special-interest groups are notoriously resistant to change. Even so, the decade of the nineties promises to be an exciting time to be working toward better births for all women.

For More Information

Midwifery Organizations

American College of Nurse-Midwives
1522 K Street NW, Suite 1000
Washington, DC 20005
202-289-0171

Community-based Nurse-Midwifery Education Program
PO Box 529
Hyden, KY 41749

Midwives' Alliance of North America
PO Box 1121
Bristol, VA 24203

Seattle Midwifery School
2524 16th Avenue South
Seattle, WA 98144
206-322-8834

Additional Resources

For information on the National Registry Exam, write to North American Registry of Midwives, PO Box 13, Linn, WV 26384.

For information on the National College of Midwifery, the Midwifery Education Accreditation Council, or the National Coalition of Midwifery Educators, contact Elizabeth Gilmore, National College of Midwifery, Drawer SSS, Taos, NM 87571.

For a discussion of the legislative regulations in each state, along with useful addresses, request a copy of *Midwifery and the Law* ($19.95) from *Mothering*, PO Box 1690, Santa Fe, NM 87504.

For a list of direct-entry midwifery training programs, state midwifery organizations, and midwifery journals, request a copy of the seven-page pamphlet *Becoming a Midwife* ($1 in cash) from Informed Homebirth, PO Box 3675, Ann Arbor, MI 48106.

For more information on midwifery, see the following articles in past issues of *Mothering*: "*Mothering* Interviews the Taos Midwives," no. 20; "Midwives United: The Midwives Alliance of North America," no. 24; "Confessions of a Restrained Midwife," no. 27; "Midwife," no. 33; and "The History of Midwifery in the United States," no. 34.

Rahima Baldwin *is a practicing midwife and codirector of the Garden of Life Birth Center. She is founder of Informed Homebirth, an author, and mother of Seth (13), Faith (16), and Jasmine (12). Rahima lives with her husband, Agaj Dancy, and their children in Ann Arbor, Michigan.*

Health Resources and Access Task Force

October 23, 1992

Submitted by: Gordon A. Anderson, CEBS
Manager, Benefits and Annuitant Affairs
Alyeska Pipeline Service Company
Anchorage, Alaska

Senator Jim Duncan, Representative Johnny Ellis, and task force members. I am Gordon Anderson, Manager, Benefits and Annuitant Affairs for Alyeska Pipeline Service Company. I am pleased to be able to speak to you today.

Alyeska is a company with our entire operations located in this great state. We have approximately 1,300 employees working and living in remote and urban areas, participating in and supporting each community. Our employees and their families use the health care system available in Alaska and are supported by benefits plans which the company provides. At present, we anticipate 1992 claim payments of $4.2 million.

As you are aware, we have been asked to comment upon several items dealing with problems created by the health care system, recommendations we might have for reforming the system and lastly how the Task Force's guiding principles support or conflict with our view of health care reform.

First let me comment upon the current system and how it impacts our organization.

Health care costs have skyrocketed over the past 20 years, much faster than the general rate of inflation. We have all contributed to some degree in this cost escalation through fee-for-service plans and state mandated coverage's. The current system is a well meaning process for providing health care coverage which has gotten out of control. Though state mandated coverages in Alaska are minimal, the costs of health care in this state are higher than the national average as acknowledged by the interim report of the Task Force. This has an impact on public and private employers as well as on employees.

Alyeska has always shared the cost of coverage with employees. This means that increasing prices affect the company's and employees' finances. Our premium for employee and family coverage was $98.00 in 1979 and is $448.36 today, approximately five times the 1979 rate. Because we are "insured" and have the means to pay, we are affected in the cost transfer mechanism whereby hospitals and other providers reallocate the cost of uninsured care

to patients with coverage. Health care costs represent a larger portion of our employee overall expenses than previously and are of great concern to our employees. Alyeska has attempted to react to changing events and we have since 1989 had a program of managed care . This has stemmed temporarily the rate of coverage increases.

Second, I will briefly outline the recommendations I would propose for health care reform. These are similar to many proposals which have already been discussed. It is the implementation of these items which require tough political and ethical decisions by all who are involved in the management or delivery of health care.

Overall a combination of governmental programs and private sector programs should be developed to coordinate the allocation of resources to health care. This is more suitable to the culture of this country than purely governmental programs.

Under this system the uninsured and underinsured could be covered by a modified Medicare/Medicaid system of basic and catastrophic care. The uninsured suffer virtually no access and the underinsured suffer exposure to catastrophic loss. The conflicting and confusing regulations from multiple federal and state agencies should be simplified to decrease confusion and paperwork. Individuals should be able to buy into a health care program whether it be government or private. However, this solution for the governmental portion will not be easy in Alaska given the projected state deficit predicted by a recent paper issued by the Institute of Social and Economic Research.

— Market based reforms are preferable to universally mandated or administered government coverage. Governmental systems tend to bureaucratize the process, generate excess controls and stifle innovation. The market system is not without risk but it does encourage innovation and allows employers who cover the majority of insured persons, the flexibility of tailoring plans to fit the financial strength of each company.

— Small employers should be allowed access to controlled pools wherein their employee base combines with other small employers to form a larger premium base over which claim risk is spread and coverage can be obtained at reasonable cost.

— Legislation inhibiting managed care should be reasonable, uninfluenced by special interest groups and limited in order to allow non provider interaction with the hospital/physician providers.

— Facilitate the development of community coalitions of health care consumers for the analysis of health care costs, the utilization of resources including sophisticated technology within each community and the dissemination of pricing information to the consumer. The utilization of technology resources may involve the creation of satellite facilities for immediate care which refer patients to an acute care facility .

— Facilitate "Outcomes" research to determine the relationship between the level of health care or treatment and the quality of the result.

— Revise the medical malpractice system via Tort reform. Alaska has recently taken some steps in this direction but more needs to be done.

— Integrate the worker's compensation provisions of care into the overall system of non work related health care.

Lastly, in answer to the question, "do the guiding principles of the Task Force support or conflict with our recommendations for change", I offer these comments.

Access	-	Individuals should have access to basic health care for early detection and treatment. The private sector may differ on the level of primary care and coverage for catastrophic and terminal illness.
Financing	-	The desire to have individuals wherein possible share in the cost of coverage is consistent with our philosophy practiced with our own employees. The private sector may differ on how the state should collect revenues to finance governmental coverage's.
Cost Containment General	-	We find no disagreement with the committee's basic approach. Simplicity where possible will reduce cost and improve the application of care.

NFIB Alaska

National Federation of
Independent Business

PRESENTATION

TO

HEALTH RESOURCES AND ACCESS TASK FORCE

AUGUST 25, 1992

PROBLEMS AND SUGGESTIONS FOR REFORM
OF THE HEALTH CARE SYSTEM

State Office
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The Guardian of
Small Business

Chairman, members of the Committee, my name is Resa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. On behalf of our 4,730 small business owners, I appreciate the opportunity to share with you some of the problems small business owners face in attempting to obtain and retain health insurance coverage and to offer some solutions.

Since the early 1980's NFIB Foundation surveys have revealed that small business owners consider the cost and availability of health insurance a serious problem. Surveys were conducted in 1990 and 1992 and again, business owners characterized health insurance as their number one problem.

Further surveys also have found that small business owners want to offer health insurance as a fringe benefit out of both a sense of family obligation and competitive necessity.

PROBLEMS

* Cost/Profitability

The ability of the small business owner to provide insurance is influenced by the high costs of premiums and profitability of the business. I have given to staff a very interesting research paper that shows there is a direct tie between business profitability and a business providing employee health insurance. Exhibit 1 shows the data creates an almost stair-like pattern. The graph shows that as the income of a business rises the propensity for small employers to provide employee health insurance rises as well.

For many small business the skyrocketing annual premium increases, small profit margins and restricted cash flow all contribute to the increasing difficulty small business owners have in purchasing health insurance. If the cost of purchasing or continuing to provide health insurance continues increasing, small business owners will be forced to increase employee contributions, cut benefits, or in some cased drop coverage altogether.

Small business are most severely impacted by:

* Adverse selection
* Demographics of the work force
* Higher employee turnover resulting in unpredictable participation rates
* Lack of expertise and clout in purchasing plans

By virtue of their size, small businesses have very little access to cost containment mechanisms available to large firms such as

self-insurance. Being unable to obtain the benefits of self-insurance they must:

* Comply with expensive state mandates

* Pay state premium taxes

* Shoulder a larger portion of the carrier's administrative expenses

Under the present tax structure only 25 percent of health insurance premiums are deductible. I know you can not do anything about the Federal tax structure. I would encourage you to recommend to the Legislature that they pass a Resolution asking Congress to raise the deduction from 25 to 100 percent. Raising the tax deduction will encourage many uninsured self-employed to purchase health insurance not only for themselves, but for their many employees.

SMALL BUSINESS MARKET REFORM

Last week I gave to staff detailed suggestions from National NFIB and the Healthcare Equity Action League. Briefly those documents state that effective small market health insurance reform should include:

* Lower the cost of health care coverage by eliminating state health insurance benefit mandates and allowing the insurance industry to develop affordable basic benefit packages.

* Permitting small business to form health insurance purchasing groups.

* Restricting the preexisting condition limitation.

* Instituting the use of rating bands.

* Guaranteeing the issuance of health insurance policies.

* Guaranteeing renewal of health Insurance policies.

* Establishing risk pools.

* Promoting managed care and utilization review.

* Educating health care consumers.

* Reforming medical malpractice laws.

* Simplifying health insurance administrative costs.

Thank you for the opportunity to outline some of the

problems small businesses face and offer some solutions. NFIB/Alaska has supported and will continue to support any legislation that will help make voluntary, privately administered health insurance more available and affordable for small businesses.

NFIB

National Federation of
Independent Business

NFIB VIEW ON SMALL MARKET REFORM

Since the early 1980's small business owners have been saying that the cost and availability of health insurance are serious problems. Today, health insurance ranks twice as high as the second most important concern of small business, which is federal taxation of business income. The most critical obstacle they face in obtaining health insurance is cost or affordability.

Small business owners demand reform of a health insurance system that is broken and out of control. They want a return to free market principles to ensure the availability, affordability, renewability and portability of health insurance for themselves and their employees. The changes needed to bring this about are part of a proposed package referred to as small market health insurance reform. Some elements of this package will increase cost, others will reduce them. Taken as a whole it will make health insurance more affordable for small business.

NFIB believes that effective small market health insurance reform should include:

* Preempting state health insurance benefit mandates and allowing the insurance industry to develop affordable basic benefit packages.

Currently all states mandate that certain types of treatments are covered by insurance policies. Combined nationwide, there are over 900 state mandates. These mandates cumulatively can raise the cost of health insurance by more than 30 percent. According to the National Center for Policy Analysis, as many as 8.5 million Americans have been priced out of the health insurance market by costly mandates. All of these are in smaller businesses that cannot afford to self-insure.

The key to finding affordable insurance is creating competitive low-cost basic policies that can be marketed nationally so that newer or less profitable firms can afford to purchase a minimum level of coverage for their employees.

Problems Addressed: Accessibility and affordability.

* Permitting small business to form health insurance purchasing groups.

Allowing small firms to band together to self-insure

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The Guardian of
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has proven to be a very effective way of providing affordable and manageable health care coverage. Purchasing groups reduce the administrative and medical costs of providing health insurance through economies of scale and risk sharing. Purchasing groups will bring the cost of coverage to a level that more Main Street firms can afford.

Problems Addressed: Accessibility and affordability.

* Enacting legislation to permit self-employed business owners (sole proprietors, partnerships or s-corporations) to deduct the full cost of the purchase of health insurance (100% deductibility).

The self-employed business owner should have the same tax deduction for health insurance as do big businesses. Increasing the deduction for health insurance premiums for the self-employed from 25 to 100 percent will level this playing field and enable many of the 4.8 million uninsured self-employed to purchase health insurance not only for themselves, but for their nearly five million employees.

Problems Addressed: Affordability

* Restricting the Preexisting Condition Limitation.

Pre-existing condition clauses typically exclude certain health conditions from being covered and reimbursed through insurance from a period of six months to as long as two years. Pre-existing condition restrictions should not be used if a person has previously been insured. This will enable employees with medical conditions to change jobs without fear of losing their health insurance.

Problems Addressed: Accessibility and portability

* Instituting Use of Rating Bands

Current insurance industry rating practices have resulted in serious price fluctuations for small businesses. Carefully crafted rating bands will enable small firms to predict future premium costs. These bands should allow for a 20 percent variance between blocks of business and not more than 1.5 times the lowest premium for the first three years within the business block.

Problems Addressed: Affordability and stability

* Guaranteeing the Issuance of Health Insurance Policies

Insurers often seek to insure the healthiest groups of individuals and drop coverage for those requesting reimbursement for high medical costs. Adverse selection

must be addressed by guaranteeing small business access to affordable health insurance. The insurance industry should be required to issue a policy to any business that wants to obtain coverage.

Problems Addressed: Accessibility

* Guaranteeing Renewal of Health Insurance Policies

Insurance companies should not be permitted to cancel a policy unless the policy holder is grossly negligent in paying premiums or is engaged in fraudulent activities. Limiting the variation in premium increases and prohibiting increased rates or cancellation based on health status will significantly stabilize the health insurance market for small firms.

Problems Addressed: Accessibility and affordability

* Establishing Risk Pools

High risk individuals, while making up a small percent of the population, can drive up health insurance costs for everyone. The cost of providing coverage for this group must be spread through risk pooling.

Problems Addressed: Accessibility, affordability and stability

* Promoting Managed Care and Utilization Review

The use of coordinated care systems can lead to lower costs and better quality care. Managed care and utilization review foster competition which are clear means by which to control costs. State anti-managed care provisions must be preempted.

Problems Addressed: Cost containment, quality of care, and affordability

* Educating Healthcare Consumers

Consumer information and education would instill personal accountability in the system and reduce deceptive or aggressive rating practices and defensive medicine. Beneficiaries should be given information on provider fees, treatment protocols and quality of care. Patients must be encouraged to question providers' fees and practices and should be able to select and refuse treatment. Cost sharing through higher deductibles and copayments will force a patient to assess the cost and medical necessity of each visit.

Problems Addressed: Cost containment, quality of care, and affordability

* Reforming Medical Malpractice Laws

Effective medical malpractice tort reform, which includes the elimination of the collateral source rule, uniform statute of limitations, caps on damages, as well as the use of practice guidelines as a defense would reduce not only malpractice premiums and doctors' fees but would curb the expensive practice of defensive medicine.

Problems Addressed: Affordability, cost containment, and accessibility

* Simplifying Health Insurance Administrative Costs

Paperwork reduction must be a part of any healthcare reform. Developing uniform claims for both private and public payers and establishing electronic data interchange (i.e. electronic billing, enrollment, and purchasing) will significantly reduce the cost of administering health insurance.

Problems Addressed: Affordability

* Conducting Outcomes Research

Research must be conducted on the effectiveness of new technologies and drugs, the results of which must be shared with patients to allow them to knowingly participate in their medical treatment.

Problems Addressed: Affordability, cost containment, and quality of care

* Summation

The health insurance market cannot remain dysfunctional. Implementation of these reforms will help bring predictability and competition to the market which will significantly drive down the cost of providing health insurance and thereby give access to insurance for many of the uninsured.

The National Federation of Independent Business is the nation's largest small business advocacy organization, representing more than 550,000 small and independent business owners nation-wide.

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

The Healthcare Equity Action League: Its Recommendations and Membership

The Healthcare Equity Action League (HEAL) seeks to reform the nation's health care system so Americans can obtain health insurance, afford to pay for it and not lose it when they need it most. HEAL looks to accomplish its goals by building on the best of the current health care system and making those aspects accessible and affordable to people currently left out. It does not favor scrapping the current system for unworkable, costly government-imposed controls.

HEAL is a large and diverse group. More than 400 companies and organizations representing 1 million employers and 35 million employees are members of HEAL. They are small and large businesses, corporations, associations, health care providers and insurers. They are united around a set of proposals for which there is already a broad consensus — proposals that can and should be enacted now.

The positive steps HEAL is proposing would reform the health care system while maintaining its basic structure. These practical steps would help make the best of the private health care system available and affordable to more Americans and keep it available to those who are in danger of becoming uninsured.

In addition, HEAL's proposals have broad, bipartisan political support and could be enacted now to bring quick relief to the problem of health care accessibility and cost. They include the following:

- Significantly lower the cost of health care coverage by eliminating more than 1,000 state rules mandating many specific and costly provisions. These provisions, which in some cases require businesses to pay for hair transplants, acupuncture and in vitro fertilization, inflate the cost of coverage.
- Pre-empt state laws that restrict managed care health plans. This would allow the insurer to monitor costs, treatments and practices to assure better care and further reduce premium costs.
- Allow small businesses to deduct 100 percent of their health insurance premiums. Currently, incorporated businesses may deduct 100 percent, but many small business owners and the self-employed are only allowed a 25 percent deduction. By changing the tax code to allow full deductability for all businesses, smaller companies would have an incentive to obtain or expand health insurance.

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- Reform insurance underwriting to prohibit the denial of claims for pre-existing conditions once an individual has been covered or when an employee changes jobs or files claims.

  This proposal also would provide for "portable" coverage that would enable employees to maintain eligibility, even when they change jobs. This would enable working Americans to make career decisions based on factors other than the availability of health care benefits.

- Reform medical malpractice laws to reduce the use of costly and unnecessary tests and treatments ordered to avert malpractice claims.

- Empower consumers and encourage personal responsibility. Patients need timely, reliable information on fees, physician practices and protocols as well as treatments and their outcomes in order to be effective participants in their own health care — and to stimulate a market-driven health care system. Wellness education also is needed to help contain future health care costs.

- Bring health care costs under control by pursuing innovative purchasing and managed care techniques. Health care providers must be part of the solution to escalating health care costs.

HEAL was formed to combat the idea that the nation's health care problems can only be solved by totally restructuring the system. HEAL rejects national health insurance and so-called "play or pay" mandated coverage programs as proposed solutions.

For example, under the "play or pay" option, all employers would be forced to provide health insurance to employees or pay a tax. HEAL contends that the tax increase needed to finance either of these plans would place unreasonable financial burdens on taxpayers and small business, possibly costing employees their jobs or driving small firms out of business.

In addition, HEAL believes the resulting system would not improve the quality of health care. Instead, it's quite likely a national health insurance program administered by a federal bureaucracy would diminish the quality of care by having the government decide how much health care patients can receive and when they can receive it.

Instead, HEAL proposes a better way — one that is attainable, preserves jobs, delivers quality care and provides life-long security of coverage at a reasonable cost.

6/52

The NFIB Foundation

An Affiliate of
National Federation of
Independent Business

TAXES BASED ON THE INABILITY TO PAY: ANOTHER EFFECT OF "PLAY OR PAY"

Mandatory employer provision of employee health insurance is a tax levied on those least able to pay. Whether the tax is direct ("pay" option) or indirect ("play" option) depends on an employer's choice. But in either case, the effect is the same -- a large, new tax liability that must be paid principally by those who can least afford to do so. That is true whether one assumes the new tax burden falls on employees through lower wages and fewer employment opportunities, or on employers who will forego earnings to pay it. Unfortunately, the negative redistribution effects of "play or pay" have gone largely unnoticed in the current debate, mocking the re-distribution concerns lying at the political heart of the vigorous debate over the so-called middle income tax cut and various other issues.

It is well-known that working Americans without employer spon-sored health insurance usually fall near the bottom of the income scale. If one believes that these low income Americans would ef-fectively pay the full cost of their health insurance under "play or pay," as do most economists, then the proposal is by definition regressive. The reason is that the proposal for all intents and purposes levys a substantial tax increase ($2,000 - $3,000 a year) almost exclusively on the working poor and near-poor. However, if one believes that employers will absorb the increase by reducing their income, as do many social activists, then regressivity may not be an issue.

The following paragraphs demonstrate that one's belief about who ultimately pays the cost of a "play or pay" health insurance program is irrelevant to the regressivity discussion. They show that even if employers do absorb program costs, or even a fraction of their costs, "play or pay" remains a highly regressive approach to resolution of the health insurance coverage problem.

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Business Profitability and Employee Health Insurance

A direct tie exists between business profitability and the provision of employee health insurance. Owners who take more out of their businesses in the form of salary, earnings, draw, etc., are more likely to provide employee health insurance, while those who take out less income are less likely to do so. In fact, a 1989 survey conducted by The NFIB Foundation found that over 90 percent of those taking more than $70,000 out of the business in the prior year provided employee health insurance.[1] Just a third of those who took $20,000 or less out of the business did so.

Exhibit 1 presents the direct relationship between income from the business and provision of employee health insurance. The data create an almost stair-like pattern. As business income rises in $10,000 increments, the propensity for small employers to provide employee health insurance rises as well. In other words, where businesses are relatively profitable, small business owners tend to provide health insurance as an employee benefit. Where businesses are marginally profitable, small business owners tend not to.

"Play or pay" demands that all employers not currently providing employee health insurance make a significant financial contribution to the health care costs of their employees. But who is not now providing health insurance? Those drawing comparatively little from the business are the ones usually not providing the benefit. Therefore, if one believes that employers will bear the cost of a "play or pay" program, the burden absorbed by employers primarily will fall on the group least able to afford it. Under these circumstances, the financing system of "play or pay" is regressive.

Critical observers might question the validity of the self-reported income figures used to make the association found on Exhibit 1. They might also wonder about the bar on Exhibit 1 labeled "N/A," noting that only 61 percent of the "N/A" group provided employee health insurance. Those observers could reasonably ask how large this group of respondents was and where did its members fall on the "take-out" scale. The short answers to these two questions are that a check within the survey indicates that the income data are reliable and that the "N/A" group reflected the distribution of the income data across the reporting population. The following section addresses those data reliability questions. Readers not wishing to review these data nuances should skip the section and proceed to the section on owner income and business size.

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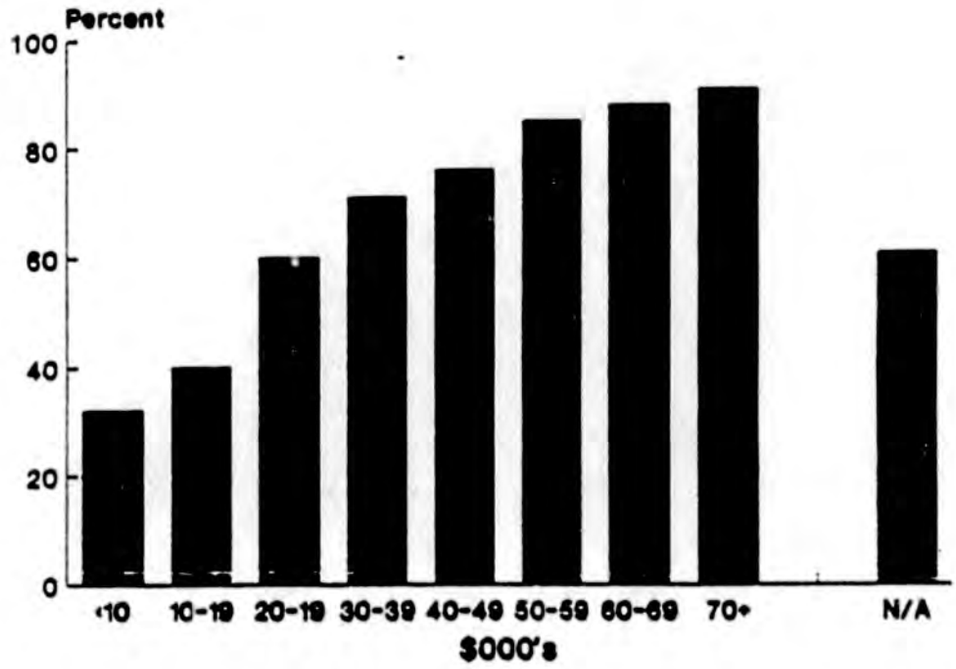
[1]Hall, Charles P., and Kudor, John M., *Small Business and Health Care: Results of a Survey*, The NFIB Foundation: Washington, D.C., 1990.

Check on the Reliability of Income Data

The income question ("About how much did you take out [salary, draw, earnings, etc.] of your business last year?") appeared at the very end of the survey. It provided respondents possible answers in $10,000 increments up to $70,000. In addition, the query offered a "Prefer Not To Answer" option. These broad ranges were designed to provide respondents with a degree of comfort in reporting a private matter that narrower ranges or actual dollars figures would not have. As it was, 19 percent chose the "Prefer Not To Answer" option and five percent left the question blank.

Exhibit 1
SMALL BUSINESS OWNER "TAKE-OUT" AND THE
PROPENSITY TO PROVIDE EMPLOYEE HEALTH INSURANCE

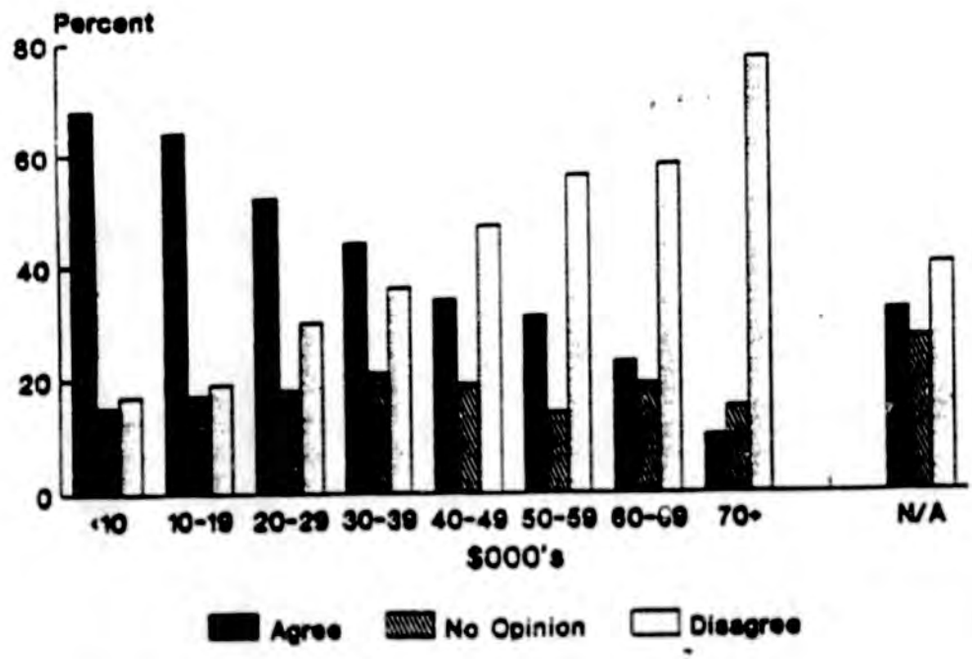


A check on the income inquiry was included earlier in the survey. It was designed to uncover similar, though not identical, data, and to provide a comparative point for the income question. The check query posed the following proposition, "I could earn more working for someone else than in this business." Respondents could answer on a five point scale ranging from "Strongly Agree" to "Strongly Disagree." Factors such as personal opportunity costs, newness of the business, etc., would affect agreement or disagreement with the proposition. However, financial success of the business should be the most prominent factor in the assessment.

Note the close relationship exhibited on Exhibit 2 between the belief that an owner could earn more elsewhere and low take-out, i.e., earnings. More than 2/3's of those reporting take-out of $10,000 or less agreed that they could earn more elsewhere. At the other end of the scale, over 3/4's of those reporting take-out of $70,000 or more did not believe they could earn more elsewhere. The chart's bars are, in fact, almost symmetrically positioned. As income rises, the percent disagreeing rises and the percent agreeing falls. As income falls, the opposite occurs. The correlation between the answers to both questions is very high. Moreover, the point where more begin to disagree with the proposition than agree with it comes at $40,000, just about the point of median family income for a family headed by someone with above average education and in their 40's. As a result, the data are mutually reenforcing and suggest reasonable reporting accuracy.

Twenty-four (24) percent of survey respondents failed to answer the "take-out," i.e., income, question. This group conceivably could be loaded with owners doing very well, yet providing employee health insurance infrequently. On the other hand, it could be loaded with those who are not doing well, yet offering insurance far in excess of their means. One way to address the issue is to cross-reference (cross-tab) the check question with the 24 percent who didn't answer the income question. If a comparatively large percentage of the non-respondents disagreed with the notion that

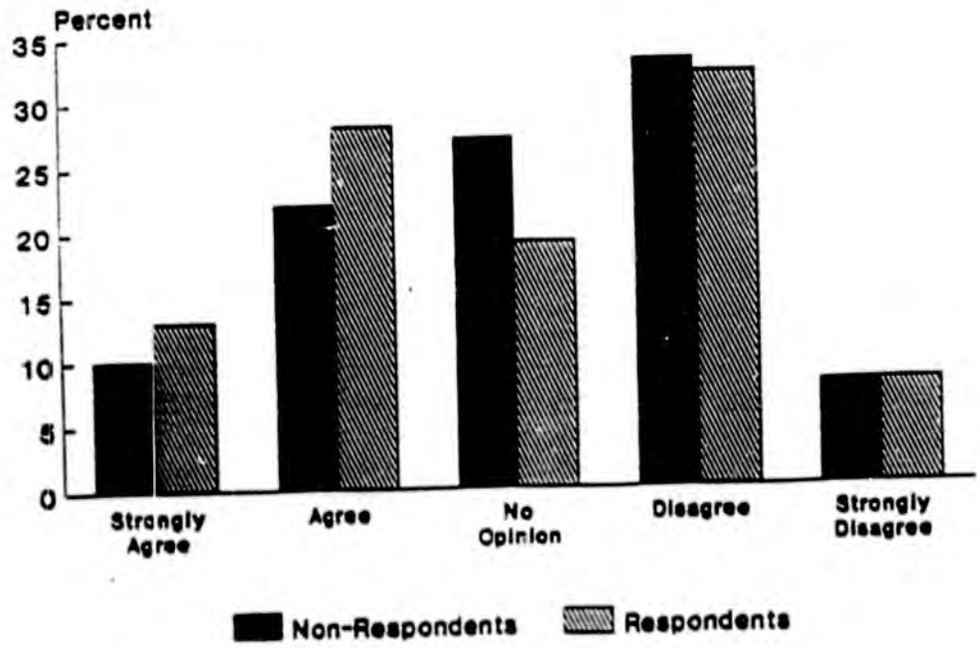
Exhibit 2
AGREEMENT WITH THE PROPOSITION THAT "I COULD EARN MORE WORKING FOR SOMEONE ELSE THAN IN THIS BUSINESS BY REPORTED 1989 BUSINESS TAKE-OUT



they could earn more elsewhere, then we might conclude the group is heavily (and disproportionately) populated by those doing well. The opposite would also be true.

Exhibit 3 demonstrates remarkably little difference as measured by the check question between those who answered the income question and those who did not. The two populations are the same for all intents and purposes. The small difference that did exist suggested that non-respondents do somewhat better than respondents. At the same time, non-respondents did not offer insurance as often as did respondents (63 percent versus 60 percent). The cumulative effect is to modestly reduce the slope of the increases in insurance provision as take-out rises. In other words, small business owners with relatively low take-outs are somewhat more likely to provide employee health insurance than the data on Exhibit 1 suggest. The opposite is also true. Yet, the fundamental relationship is unchanged. Those doing comparatively well exhibit a high propensity to provide employee health insurance, while those with doing comparatively poorly exhibit a high propensity to provide none.

Exhibit 3
RESPONDENT AND NON-RESPONDENT TO THE INCOME SURVEY QUESTION
BY AGREEMENT/DISAGREEMENT WITH THE PROPOSITION THAT THEY
COULD EARN MORE WORKING ELSEWHERE



Owner Income and Business Size

W. David Helms, President of the Alpha Foundation, a Washington-based health research and consulting organization, observed that the health insurance coverage "problem is with the very small employer, or the micro-employer," i.e., businesses with less than 10 employees.[2] He noted that half of the employed uninsured could be found in firms of less than 10 employees and another 18 percent in firms of 10-24. How does this phenomenon relate to an employer's financial capacity to provide employee health insurance benefits?

The smallest employers not only are the ones who least often provide employee health insurance, they are also the ones who take least out of their firms. Examine exhibit 4. It presents owner take-out by size of firm. Note the employee size of business Helms identified as the "problem." Forty-five percent of those who owned firms with 1-4 employees reported taking-out less than $20,000 in 1988. That percentage falls almost by half when moving to the next largest size classification, i.e., the 5-9 employee group. Still almost one in four took less than $20,000 out of their businesses. The percentage of those who took out less than that amount falls rapidly as the businesses size increases. The opposite occurs as well. Relatively few owners of businesses employing 1-4 people took $60,000 or more out of the business. The same is true of those owning businesses with 5-9 employees, but the percentage rises along with firm size.

The data presented in Exhibit 4 provide corroborating evidence of the blatantly regressive nature of the "play or pay" proposal under the assumption that employers ultimately absorb the cost. We already know that the proposal is regressive if the employee ultimately aborbs the cost. But, if "play or pay" is also regressive when the employer absorbs the cost, shouldn't those people sensitive to the concerns of the less-fortunate be appalled at the scheme? It would seem so. Yet, many are not. How can that inconsistency be resolved?

A Regressive Tax or a Simple Premium?

An argument can be made for "play or pay" recognizing that the financing mechanism is regressive. The argument runs that those paying the bills, i.e., the formerly uninsured, effectively are also those receiving the benefits. Thus, the tax is really not a tax at all. It is merely a premium paid for health insurance, and good social policy requires that everyone have health insurance. Regressivity is not an issue under these circumstances.

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[2]W. David Helms, "Experiments with Incentives for the Smallest Employers," *Rescuing American Health Care: Market Rx's*, The NFIB Foundation: Washington, 1991, p. 50.

Exhibit 4
OWNER TAKE-OUT BY EMPLOYEE SIZE OF BUSINESS

Employee Size of Bus	% of Total Population	Income from Business <$20	$20-39	$40-59	$60+
1-4	52	45	36	12	7
5-9	23	24	40	23	14
10-19	13	15	38	25	22
20-49	8	10	24	26	40
50+	4	4	15	16	65

Population totals from SBA data, 1991

That argument is supported by the nearly five million people who purchase non-group health insurance with under $15,000 in annual income, or the nearly ten million who purchase it with less than $30,000.[3] This group manages to purchase health insurance on modest incomes. Others can as well. Add tax credits for the very poor and some real progress can be made on the non-coverage problem.

If that argument were to be made, no reason exists for small employers, those most effected by "play or pay," to be included in the process. Conventional wisdom holds that small employers bring group economies to their uninsured employees if nothing else. There is some truth to that argument. But we also know small business owners already pay substantially more for the same coverage than do larger insured units. The participation of the small employer, therefore, serves to raise the premium for the low-income insured by requiring the employee's participation in a small rather than a large group. It would be much simpler, fairer and cheaper to fashion large purchasing groups, by-passing small employers, and eliminating the need for a "play or pay" scheme.

Conclusion

Most economists argue that employee benefits are paid by employees in the form of lower wages and less employment. That means health insurance provided under "pay or play" would be financed by the people that would receive coverage. Thus, the working poor and near-poor would receive the benefit, but they also would pay the bill. A strong argument can be made for that position -- those who

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[3]Helms, *op cit.*

receive benefits should pay for them. Yet, it is precisely because the poor and near-poor usually cannot pay for their insurance given other financial demands that a coverage problem exists.

Adding a significant financial burden to the working poor and near-poor bothers many people. But even if employers ultimately bore the cost of health insurance, nothing would change. A serious regressivity problem would remain. Small employers who do not provide employee health insurance are also the ones who take comparatively little out of their businesses. They, too, are often part of the working poor or near-poor. To tax them to provide the health insurance for other members of the working poor or near-poor makes no more sense than simply requiring the poor to purchase insurance. In fact, it makes less sense because the marginal employer would usually have to absorb the costs of more than one person/family, making the tax all that more severe.

Most "play or pay" proposals do incorporate tax credits or subsidies of a similar nature. Those credits are intended to ameliorate some of the most egregious regressivity inherent in the "play or pay" approach. But, to increase the credits sufficiently to eliminate, or nearly eliminate, regressivity abandons "play or pay" as an approach. To purge the credits puts an extreme burden on the working poor or near-poor whether they be employees or employers. Thus, the inclusion of credits in "play or pay" legislation primarily functions to acknowledge and underscore its liabilities.

"Play or pay" is an ill-devised approach to the health insurance coverage problem. The plan proposes a huge new tax. And, the huge new tax would be apportioned on the <u>inability</u> to pay. There are better ways to finance health care.

GENERAL INSURANCE

ANNUITY SPECIALISTS

FINANCIAL DIVERSIFIED SERVICES INC.

FAX TRANSMITTAL COVER SHEET

NAME OF SENDER A.L. TAMAGNI, SR.

DATE January 13, 1992 TIME ~~2:10 PM~~

NAME OF RECEIVER Ms. Risa Jerrell

COMPANY Nat'l Fedeation of Independant Business

CITY & STATE Juneau, Alaska FAX # (907)789-3433

COMMENTS:

FINANCIAL DIVERSIFIED SERVICES, INC.
Annuities and General Insurance

These are in addition to the letter for review

A. L. TAMAGNI SR.

Phone: 907-562-3938
Fax: 907-562-1366
Home: 907-349-1736

1205 East International Airport Road
Suite 205
Anchorage, Alaska 99518

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Alaskan's For Liability Reform

January 13, 1992

Ms. Risa Jerrell
Nat'l Federation of Independant Business
9159 Skywood Lane
Juneau, AK 99801

Dear Ms. Jerrell:

I am enclosing herein the pertinent data in regards to the Insurance Commissioner's report for the year 1990, which outlines the amount of funds collected by the State of Alaska on the Sale of Insurance from within the State. The rates are broken out on the Premium Tax Rates page, and the amounts are on the second page, Revenue Appropriations and Expenditures for 1940-1990.

The amount of funds to run the Division of Insurance for the period of 1990 was 1.9 million dollars, yet the legislature saw fit to charge consumers who bought insurance taxes in excess of 22 million dollars, in addition to Agents, Brokers, and carrier fees in excess of 2.1 million dollars.

The premium taxes are a sales tax under the rhetorical phrase of Premium Taxes.

The legislature chose to exempt themselves and all other state employees from this action with passage of 21.209.210(I), which pertains to all State employee benefits under Statute 39.30.

I believe that it would be a good position for the State Chamber to ask for equal treatment.

In the event you may have any questions on this, feel free to call me at any time.

Very Truly Yours,

Al Tamagni, Sr.

P.O. Box 201668
Anchorage, Alaska 99520
Phone: 561-6250

PREMIUM TAXES

The taxation on Health Insurance Policies by the State of Alaska is divided into 2 categorizes:
All Domestic and Foreign Insurers (Alaska Statutes 21.09.210(b)(1) - 2.7%. This is calculated by taking Total Premiums paid minus dividends and refunds equals the amount taxes times 2.7%. Regular Insurance Companies

Hospital and Medical Services Corp(Alaska Statutes 21.09.210(b)(2) - 6% This is calculated by taking total premiums minus claims paid equals the amount taxes times 6%, Blue Cross.

WHAT IS A PREMIUM TAX

A premium tax is a tax collected from the purchasers of Insurance by Insurance Companies and paid to the State of Alaska. It should be more rightfully know as an Insurance Sales Tax.

STATE EMPLOYEES

In legislation introduced in the 1988-1989 Legislative Session Jim Duncan from Juneau Added Sections to Alaska Statutes 21.09.210 (i) on exhibit A-2 which excluded taxes on premiums purchased on contracts by the State under Chapter 39.80 Insurance and Supplemental Employee Benefits, which includes all participating legislators etc.

As a result of this action State Employees, legislators and certain vendors under 39.80.090 (7),(8)(9)(10)(11)(12) that purchased insurance and additional coverages, were exempt from this tax.

The question is one of fairness to all, should there be a sales tax on Health, Disability and Life Insurance. If the answer is no then everyone should be exempt. If the answer is yes, then there should be no exceptions.

Chapter 27. Pay Plan for State Employees.

Section
11. Salary schedule

Sec. 39.27.011. Salary schedule. (a) The following monthly basic salary schedule is approved as the pay plan for classified and partially exempt employees in the executive branch of the state government who are not members of a collective bargaining unit established under the authority of the Public Employment Relations Act and employees of the legislature under AS 24.10 and AS 24.20:

Range No.	Step A	Step B	Step C	Step D	Step E	Step F
05	1504	1546	1591	1635	1683	1728
06	1591	1636	1683	1728	1778	1830
07	1683	1728	1778	1830	1887	1945
08	1778	1830	1887	1945	2001	2064
09	1887	1945	2001	2064	2131	2191
10	2001	2064	2131	2191	2258	2327
11	2131	2191	2258	2327	2405	2480
12	2258	2327	2405	2480	2565	2652
13	2405	2480	2565	2652	2746	2845
14	2565	2652	2746	2845	2945	3057
15	2745	2845	2945	3057	3166	3276
16	2945	3057	3166	3276	3394	3516
17	3166	3276	3394	3516	3637	3762
18	3394	3616	3637	3762	3885	4032
19	3637	3762	3885	4032	4155	4310
20	3885	4032	4155	4310	4442	4605
21	4155	4310	4442	4605	4750	4921
22	4442	4605	4750	4921	5084	5270
23	4750	4921	5084	5270	5446	5650
24	5084	5270	5446	5650	5841	6039
25	5446	5650	5841	6039	6252	6497
26	5650	5841	6039	6262	6497	6731
27	5841	6039	6262	6497	6731	6987
28	6039	6262	6497	6731	6987	7230
29	6262	6497	6731	6987	7230	7485
30	6497	6731	6987	7230	7485	7749

(b) *[Repealed, § 38 ch 3 SLA 1980.]*

(c) If a state officer or employee is appointed a deputy department head or a division director and, at the time of appointment, the officer or employee is receiving a salary higher than that set for the position to which appointment has been made, the officer or employee is entitled to continue receiving the higher salary. This subsection does not apply to the salary of a person appointed to a position of deputy department head or a division director.

(d) The commissioner of administration shall adopt the r... required under AS 22.05.140(d), AS 22.07.090(e), AS 22.10.1... AS 22.15.220(e). The regulations relate to the internal manag... state agencies and their adoption is not subject to the Admin... Procedure Act (AS 44.62). The regulations shall be publishe... Alaska Administrative Register and Code for informational pu...

(§ 12 ch 148 SLA 1976; am § 1 ch 92 SLA 1977; am §§ 1, 10 ... SLA 1978; am §§ 1, 16, 30, 31, 38 ch 3 SLA 1980; am § 1 ch. 50 ... 1982; am § 1 ch 83 SLA 1983; am § 4 ch 87 SLA 1985; am § 7 ch ... SLA 1987; am § 1 ch 46 SLA 1990; am §§ 9, 10 ch 19 SLA 19...

Cross references. — For applicability of the salary schedule in (a) of this section to employees of the judicial and legislative branches, and to employees of the executive branch not otherwise covered by this section, see § 2, ch. 46, SLA 1990 and § 11, ch. 19, SLA 1991 in the Temporary and Special Acts, for compensation of certain employees of the University of Alaska, see § 3, ch. 46, SLA 1990 and § 13, ch. 19, SLA 1991 in the Temporary and Special Acts.

Effect of amendments. — The 19... amendment, effective May 11, 1990, r... wrote subsection (a).

The 1991 amendment, effective June 7, 1991, rewrote subsection (a) and added subsection (d).

Editor's notes. — Section 4, ch. 46, SLA 1990 provides: "This Act is retroactive to January 1, 1990."

Section 13, ch. 19, SLA 1991 provides: "This Act is retroactive to January 1, 1991."

Chapter 30. Insurance and Supplemental Employee Benefits.

Article
2. Group Life and Health Insurance (§§ 39.30.090 — 39.30.096)
4. Supplemental Employee Contribution Withdrawal from Social Security (§§ 39.30.150, 39.30.153, 39.30.160, 39.30.162)

Article 2. Group Life and Health Insurance.

Section
90. Procurement of group insurance
96. Group health and life benefits fund

Section
96. [Repealed]

Sec. 39.30.090. Procurement of group insurance. (a) The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.25.168, AS 22.26.090, AS 39.35.535 or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance,

surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance.

(2) Each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration.

(3) A governmental unit may participate under a group policy if

(A) its governing body adopts a resolution authorizing participation, and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing.

(4) The Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from any insurer authorized to transact business in the state under AS 21.09 and AS 21.90, or from a health maintenance organization authorized to operate in this state under AS 21.86.

(5) The Department of Administration shall make available bid specifications for desired insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available on or before July 1, 1965, and at least once every succeeding five years. The lowest responsible bid submitted by an insurance carrier with adequate servicing facilities shall govern selection of a carrier under this section.

(6) If the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees.

(7) A person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit.

(8) A person electing to have insurance under (7) of this subsection shall pay the cost of this insurance.

(9) For each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half.

(10) A person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section. The level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age,

survivors, and disability insurance program. A person electing to have insurance under this paragraph shall pay the cost of the insurance. The commissioner of administration shall adopt regulations implementing this paragraph.

(11) A person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care insurance for that person and eligible dependents under this section. A person who elects insurance under this paragraph shall pay the cost of the insurance premium. The commissioner of administration shall adopt regulations to implement this paragraph.

(12) Each licensee holding a current operating agreement for a vending facility under AS 23.15.010 — 23.15.210 shall be covered by the group policy that applies to governmental units other than the state.

(b) In this section

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee; and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a municipality, school district, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts and health maintenance organizations. (§§ 1, 2 ch 151 SLA 1955; am § 1 ch 168 SLA 1959; am §§ 1, 2 ch 105 SLA 1965; am § 1 ch 70 SLA 1968; am § 66 ch 69 SLA 1970; am § 1 ch 123 SLA 1970; am § 1 ch 159 SLA 1972; am §§ 1, 2 ch 46 SLA 1973; am §§ 13, 14 ch 47 SLA 1974; am §§ 2, 3 ch 27 SLA 1976; am § 2 ch 86 SLA 1977; am § 39 ch 177 SLA 1978; am § 1 ch 55 SLA 1979; am § 1 ch 62 SLA 1981; am § 37 ch 137 SLA 1982; am § 1 ch 46 SLA 1984; am §§ 13, 14 ch 87 SLA 1986; am § 2 ch 38 SLA 1990; am §§ 2, 3 ch 95 SLA 1990)

Effect of amendments. — The first 1990 amendment inserted "or persons entitled to coverage under AS 23.15.136" in the introductory paragraph of subsection (a) and added paragraph (a)(12).

The second 1990 amendment, effective June 8, 1990, added the provisions relating to AS 21.86 in paragraph (a)(4) and added "and health maintenance organizations" at the end of paragraph (b)(3).

Sec. 39.30.095. Group health and life benefits fund. (a) The commissioner of administration shall establish the group health and life benefits fund as a special account in the general fund to provide for group life and health insurance under AS 39.30.090 and 39.30.160. The commissioner shall maintain accounts and records for the fund. The fund consists of employer contributions, employee contributions

of insurance in this state may be suspended by the director if the annual statement has not been filed by March 1.

(f) In addition to the requirements of (a) of this section, a domestic insurer shall file its annual statement with the National Association of Insurance Commissioners by the due date established by the association, and shall pay the applicable filing fee. An insurer that fails to comply with this subsection is subject to the penalties specified in (e) of this section, calculated from the filing and fee due date established by the National Association of Insurance Commissioners. (§ 1 ch 120 SLA 1966; am § 1 ch 149 SLA 1984; am § 7 ch 26 SLA 1985; am §§ 17, 18 ch 50 SLA 1990)

Effect of amendments. — The 1990 amendment, effective May 16, 1990, rewrote the second sentence and added the present third sentence in subsection (a) and added subsection (f).

Sec. 21.09.205. Quarterly statement. (a) The director may require an insurer to file quarterly financial statements. If required, the statements must follow for a given quarter the reporting format specified in the quarterly financial statement blank form and instructions most recently approved by the National Association of Insurance Commissioners.

(b) A quarterly financial statement, if required, is due 60 days after the end of the quarter to which it applies.

(c) An insurer shall pay to the division $100 for each day the insurer fails to file the quarterly statement in the form required or within the time established in (b) of this section. (§ 19 ch 50 SLA 1990)

Sec. 21.09.210. Tax. (a) Each authorized insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall file with the director, before March 2 in each year, a report of all insurance business written or contracted in the state (with proper proportionate allocation of premium for the property, subjects, or risks in the state insured under policies or contracts covering property, subjects, or risks located or resident in more than one state) during the preceding year ending December 31. The report must show

(1) the amounts paid policyholders on losses;

(2) the total direct premium income including policy membership and other fees, premiums paid by application of dividends, refunds, savings coupon, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance whether designated a premium or otherwise;

(3) the amounts paid policyholders as returned premiums;

(4) the amounts paid policyholders as dividends.

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director annually before April 1, and is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 per cent;

(2) for hospital and medical service corporations, six per cent of their gross premiums less claims paid.

(c) *[Repealed, § 48 ch 29 SLA 1987.]*

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, before April 1 of each year, pay to the director a tax of three-quarters of one per cent on its gross underwriting profit. The gross underwriting profit is computed by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance), on wet marine and transportation insurance contracts, the net losses paid (i.e., gross losses paid, less salvage and recoveries on reinsurance ceded) during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit shall not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts.

(e) Payment to the director by an insurer of the tax upon its premiums required by this section shall be in lieu of all other taxes imposed by the state upon premiums, franchise, privilege, or other taxes measured by income of the insurer commencing with the taxable year beginning January 1, 1967.

(f) The state hereby pre-empts the field of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses, and fees upon insurers and their general agents, agents, and representatives as such; and on the intangible property of insurers or agents; and all political subdivisions of agencies in the state, including home rule boroughs or cities, are prohibited from imposing or levying upon insurers, or upon their general agents,

agents, and representatives as such, any tax, license, or fee. However, that this subsection shall not be construed as prohibiting the imposition by political subdivisions of taxes upon real and tangible personal property of insurers and their general agents, agents, and representatives.

(g) The director may suspend or revoke the certificate of authority of an insurer that fails to pay its taxes as required under this section.

(h) The provisions of this section do not apply to title insurance companies. A premium tax on title insurance companies shall be levied in accordance with the provisions of AS 21.66.110.

(i) Premiums paid by the state for insurance policies and contracts purchased under the provisions of AS 39.30 are exempt from taxation under this section. An insurer may not include the tax imposed under this section in a premium charged on an insurance policy or contract purchased by the state under the provisions of AS 39.30. An insurer may claim the exemption on forms provided by the division of insurance. (§ 1 ch 120 SLA 1966; am § 29 ch 137 SLA 1982; am § 1 ch 118 SLA 1986; am § 41 ch 14 SLA 1987; am §§ 1, 48 ch 29 SLA 1987; am § 1 ch 23 SLA 1989)

Effect of amendments. — The first 1987 amendment, effective May 30, 1987, deleted "except as provided in AS 21.89.360(c)" preceding "is computed at the rate" near the introductory language of subsection (b).

The second 1987 amendment in subsection (c) inserted "that has filed with the director, before July 1, 1987, for approval to organize" and "not more than" preceding "five years" and added "or until June 30, 1987, whichever occurs first" at the end of the subsection and repealed subsection (e), July 1, 1989.

The 1989 amendment, effective May 9, 1989, in subsection (i), added the present second sentence and substituted "An insurer may claim the exemption" for "Claims for exemption shall be made" at the beginning of the last sentence.

Editor's notes. — Section 2, ch. 118, SLA 1986 provides that the tax rates in (b) of this section, as amended by § 1, ch. 118, SLA 1986, apply "to the tax due by April 1, 1987 for the tax year beginning January 1, 1986 and to the tax due for subsequent tax years."

Section 2, ch. 23, SLA 1989 provides that this section is retroactive to January 1, 1989.

NOTES TO DECISIONS

Constitutionality. — Subsection (h), prior to the 1986 amendment of this section, violated the equal protection clauses of both the Alaska and federal constitutions because it imposed a higher tax on foreign insurance companies than on domestic insurance companies, a discrimination which lacked any legitimate state purpose. Principal Mut. Life Ins. Co. v State, Div. of Ins., 736 P.2d 1023 (Alaska 1986).

The purpose of excluding "insurance businesses" from the coverage of AS 43.70.080(a) of the Alaska Business License Act by virtue of the definition in AS 43.70.110(1) is apparently to avoid taxing these businesses twice, since insurers are subject to a premiums tax imposed by this section. Northern Adjusters, Inc. v Department of Revenue, 677 P.2d 265 (Alaska 1984).

Secs. 21.09.220 — 21.09.240. Resident agent's counter signature exception; affidavit requirement. [Repealed, § 2 ch 41 SLA 1984.

Sec. 21.09.250. Prohibited acts. An insurer doing business in this state may not make, write, place, or cause to be made, written, or placed in this state a policy, duplicate policy, or contract of insurance of any kind or character, or general or floating policy upon persons or property resident, situated, or located in this state, from or through a broker, agent, general agent, surplus line broker, or person who has not secured a license in this state. An insurer may not pay a commission or any form of remuneration to a person, firm, or organization for the writing or placing of insurance coverage in this state unless that person, firm, or organization holds a license issued by the director. (§ 1 ch 120 SLA 1966; am § 2 ch 29 SLA 1987)

Effect of amendments. — The 1987 amendment inserted "general agent" in the first sentence and made minor punctuation change throughout the section.

Sec. 21.09.260. Violations — Penalties. An insurer that the director determines, following an appropriate hearing as provided in AS 21.06.170 — 21.06.230, has violated the provisions of AS 21.09.250 is subject to a civil penalty of not more than $2,500 for each violation. The director may suspend or revoke the license of the insurer for a violation of AS 21.09.250, but violation does not invalidate the insurance contract. (§ 1 ch 120 SLA 1966; am § 1 ch 41 SLA 1984; am § 2 ch 149 SLA 1984)

Sec. 21.09.270. Retaliation. (a) If, under the laws of another state or foreign country, taxes, licenses, and other fees, in the aggregate, and fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Alaska insurers, or upon their agents or representatives, that are in excess of the taxes, licenses, and other fees, in the aggregate, or that are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon their agents or representatives, of another state or country under the statutes of this state, as long as the laws of the other state or country continue in force or are applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kinds shall be imposed by the director upon the insurers, or upon their agents or representatives, of the other state or country doing business or seeking to do business in this state. A tax, license or other fee or other obligation imposed by a city, county, or other political subdivision or agency of another state or country on Alaska insurers or their agents or representatives shall be considered

ALASKA PREMIUM TAX RATES

ADMITTED (AS 21.09.210)	PERCENT
Domestic and Foreign Insurers (AS 21.09.210(b)(1)) (Total Direct Premiums — Dividends/Refunds)	2.7%
Hospital and Medical Service Corp (AS 21.09.210(b)(2)) (Gross Premiums — Claims Paid)	6%
Wet Marine and Transportation Insurance (AS 21.09.210(d)) (Gross Underwriting Profit)	¾ of 1%
Title Insurers (AS 21.66.110) (Gross Premium)	1%
SURPLUS LINES	
Casualty Insurance (AS 21.09.210(b)(1)) (Total Direct Premiums — Dividends/Refunds)	2.7%
Marine Insurance (Except Wet Marine) (AS 21.34.900(12)) (Total Direct Premiums — Dividends/Refunds)	2.7%
Wet Marine Insurance (AS 21.34.900(12)) (Gross Premiums — Taxed under AS 21.33.055)	¾ of 1%
Filing Fee — All Lines (AS 21.34.190) (Gross — Returned Premiums)	1%
UNAUTHORIZED (AS 21.33.055)	
Casualty Insurance (Gross Premiums)	3%
Marine, Wet Marine & Transportation Insurance (Gross Premiums)	¾ of 1%
SELF-PROCURED (AS 21.33.061)	
All Lines (Except Marine Insurance) (Gross Premiums)	3%
Marine, Wet Marine & Transportation Insurance (Gross Premiums)	¾ of 1%

Revenue, Appropriations and Expenditures
Fiscal Years 1940 — 1990

Year	Fees	Taxes	Receipts	Appropriation	Expenditure
1940	4,769	27,274	32,043		
1950	26,620	162,035	188,655		
6/30/60	80,204	857,211	937,415	42,400	
6/30/70	171,114	2,561,761	2,732,875		156,449
6/30/80	536,297	10,435,773	10,972,070		735,816
6/30/81	654,757	10,618,190	11,272,947		862,700
6/30/82	686,689	12,530,175	13,216,864		913,000
6/30/83	801,034	13,842,732	14,643,766	976,000	
6/30/84	833,710	16,172,775	17,006,485	991,600	
6/30/85	876,059	17,504,733	18,380,792		791,000
6/30/86	1,641,244	21,285,325	22,926,569	1,082,000	1,052,674
6/30/87	1,411,122	23,659,248	25,100,370	964,700	933,720
6/30/88	1,763,899	23,847,174*	25,611,073	1,306,300	1,281,651
6/30/89	1,773,062	19,391,389*	21,164,431	1,626,000	1,605,097
6/30/90	2,159,787	22,691,760	24,851,547	1,960,600	1,936,555

*Taxes collected as of 6/30/88 were overstated by a $1,698,261 refund that was not processed until December 1988. Accordingly, taxes as of 6/30/89 are understated by the amount of the refund. The corrected 6/30/88 tax figure is $22,148,913 and for 6/30/89, $21,089,650.

Total Premiums Written
1950-1989
($000)

Year	Property & Casualty	Disability	Life	Title	Surplus & Self-Procured	Total
1950	6,732	238	1,104	19	1,575	9,668
1960	20,701	3,605	6,679	357	2,812	34,154
1970	62,045	19,539	21,987	2,001	7,621	113,193
1980	243,067	99,440	75,608	8,064	52,509	478,688
1985	562,034	193,166	117,927	16,283	66,715	956,125
1986	618,059	191,478	132,021	15,915	84,508	1,041,981
1987	588,850	144,444	127,956	11,020	72,652	944,922
1988	568,604	170,598	120,649	10,010	52,353	922,214
1989	601,003	203,154	111,360	13,450	54,874	983,841

WRITTEN COMMENTS

Provided by Individuals

We MUST put more into preventive health care, and also reimburse alternative methods of treatment. We must learn from other countries, where health care costs less, is available to all, where the illness and death rates are lower.

If the borough could come up with such a plan, we would be a pace setter for the nation.

Martha Ellen Anderson
4020 Primrose
Kenai, Ak 99611

October 25, 1992

Alaska Legislature Health Resources
and Access Task Force
State Capitol
Juneau, AK 99801-1182

Dear Task Force:

Our yearly income is between $60,000 and $100,000 a year. I have a individual Blue Cross Health Insurance Plan that covers me and my 2 children. I have a $1,000 deductible per person and pay $270 bi-monthly. My husband buys his own private health plan from Central States through payroll deductions of $70 a month; he also has a $1,000 deductible per each separate medical incident each year. Our concerns are as follows:

1. Every man, woman and child is entitled to health care.

2. For the birth of my first child, I had maternity coverage through my Blue Cross policy. I had an emergency C-section and Blue Cross paid for 80% of the cost. Soon after, however, Blue Cross sent me a letter and said I was no longer covered for maternity benefits. (I still had to pay the same premium.) My second child was also a C-Section and we paid over $10,000 out of pocket expenses.

3. When we do fulfill our deductibles, and bills are sent in Blue Cross will only pay 80% of what they felt the medical charge should have been.

4. This year we tried to put my husband on my Blue Cross policy and he filled out a detailed

medical history for Blue Cross. They sent back a nice letter saying they would be happy to insure him except for all his "pre-existing conditions" . Insurance companies should not be allowed to "exempt" anyone.

5. My family receives excellent, but expensive, medical care, simply because we are lucky enough to afford it. A uninsured woman I know can only afford going to the neighborhood health clinic where she can pay a sliding fee for only the very basic of services. When she or her children need a specialist, because she is uninsured, the doctors will refuse to she her without cash up front. It is humiliating to her to try to BEG for medical care for her family and this makes me furious.

6. Ideally health care reform should mean the extinction of the health insurance industry. The insurance company's goal is profit, not human lives.

7. If the insurance industry is kept, all their "dirty tricks" have to be done away with completely.

8. I would gladly give up my permanent fund check or pay state income taxes for a reformed health care system.

Thank you for your time and consideration.

Sincerely,

Susan Bergerson

Susan Bergerson
2830 Legacy Drive
Anchorage, AK 99516

my Concerns –

– Feels at employer responsible for providing health care. How is paid by government and insurances. Our income is below threshold for the government for payments of these. Patients Pelosi utilize emergency departments more than their primary care they are treated without insurance. We need to recognize the needs and design a plan for universal participate. No matter what system, we design and plan for there who will not be able to pay.

– Insurance companies do penalize individuals for misuse of the system medication of treatments. Should incentives as a good motivation for cost controls.

– Provider duplication of services offered. Should there improved coordination between hospitals. Private like VA. Public health and private systems.

– Increase utilization of outpatient services rather than inpatient stays. Less costly.

– Tools and resources created for the elderly. Allowing them to remain in their home as long as

Thank you

Christine Spencer
4866 Mills Dr Anthony 7350

[illegible] the health care system. Persons on Medicaid will begin to come to the E R for very minor problems such as "I have a stomach ache" or "my child removed" or they have a cold or a very tiny laceration. All of these minor problems could be handled more appropriately elsewhere than the E R but they don't OK I've got coupons!" At great price to taxpayers I know that is big news, I am praying for it. Some will bring the entire family with a sniffle - something you or I who know we'd have to pay the entire bill for would never come in for. It's almost like a social outing for them.

Others come demand to have their prescriptions filled "I have no money!" yet it seems they have enough for their cigarettes!!

There are people where the paramedics because they have no vein and a tape or tied off arm. Many are able bodied but have no intention of finding work. It is very sad to let someone else take care of them. I think that these people should have to pay a certain amount every month for their coupons and a set amount up front for each E R visit as they do think twice before coming in for trivial things.

Also we are seeing folks coming up here from other states because our welfare benefits are better! These folks are really obscene in their use of and veterans of working the system.

We need to quit coddling hopeless cases and folks that don't want to be. The health care system has gone way overboard in trying to accommodate and will never have a good quality of life again. Most of this is driven due to the lawyers & their litigation-happy ways. Something must be done to curb that.

Adopt China's system & anyone who has more than 2 children has to pay a big penalty for each additional child instead of getting paid more for each child.

Some believe that their own hospital with free care. They should not also be given Medicaid so they can use other hospitals as well as they can pay for them twice. If they want to carry insurance, then fine. Then they can choose where they want to go.

All persons on Medicaid should have their premiums deducted from their state check in order to help cover their Medicaid benefits.

CVT-C

they are not automatically encouraged to have benefits thru any
the way at all now they are encouraged to not work & get out the
hand & say "Here me". We need to get enabling them & get off.
It is more cost effective & this would raise their self esteem.
Have recipients of welfare do public service for several hours or weeks so
that they feel more like they are earning it, not just given it.

Many of my co-workers have the same concerns as Dottie well.

Our own health insurance has changed tremendously since the working
here in 1980. At first the hospital paid all the premiums. Now, every
year we have to pay a more & more & the benefits are less and less
it is very frustrating!! Also we are told where we have to go & not
have to see to get the most from our insurance.

Sincerely,

Diane Hoto

ALASKA PHARMACEUTICAL ASSOCIATION

Box 10-1185 Anchorage, Alaska 99510

October 29, 1992

Alaska State Legislature
Health Resources & Access Task Force
State Capitol
Juneau, Alaska 99801-1182

Dear Health Care Task Force:

Thank you for allowing me to speak on behalf of the Alaska Pharmaceutical Association at the September meeting. Tom Hodel and I attended the Kenai Peninsula Borough meeting on October 17th and were impressed with the work being done. We are still not aware of any proposals on how pharmaceuticals should be handled with the health care reform. Tom and I would like to share with your task force the proposal we are recommending locally for prescription coverage and we hope it will be seriously considered. We have worked with many third party prescription billing and believe our recommendations to be most effective in dealing with prescription coverage.

Choice is a primary concern of pharmacists, as it is with physicians. We are definitely OPPOSED to bidding or contracting out. Competition must remain to prevent a "corner on the market" which may ultimately result in increased prices. We feel that with a co-pay, the patient will shop for the lowest price and the best service. If a patient is forced to use a particular pharmacy they may not want to be a part of the program.

We believe a "menu" choice is necessary for prescription coverage. For many, a program without prescription coverage would be worthless. However, we feel that this extra benefit should be "paid" for. Otherwise, the program would probably not sustain the high cost of drugs. A menu also allows those who prefer to pay "out of pocket" to do so. We suggest an added dollar value of $25.00 to $50.00 monthly, and/or a separate prescription deductible be added to the premium. If a menu was not set up and prescriptions were included in your program, we feel the tremendous financial impact on your program could be devastating. (A single terminal patient may spend thousands of dollars monthly in prescriptions alone.) Also, it may not be feasible to the program for a policy holder to opt for the prescription benefit at any time during coverage, by paying the extra coverage.

We feel a co-pay is essential. This helps prevent over-utilization which is a major problem with patients receiving their medications "free" such as medicaid patients. We recommend an 80% coverage by plan and 20% coverage by enrollee. This would encourage patients to "shop around" for best price and service. Also, having a 20% co-pay would encourage use of generic brand. We do not believe that a different co-pay should be mandatory for generic. Patients seem to dislike the fact that they are forced to get generic. Patients will opt for generic when 20% is paid because they will save money.

We feel that the following recommendation would be most effective in your plan:

1. Quantities should be limited to a 34 day supply or 100 doses, whichever is greater. This would decrease any waste that may be created if the patients drug is changed or discontinued.

2. The plan should include all medications requiring a prescription and it should include, (but not limit to) insulin, insulin syringes, blood test strips, blood glucose monitoring machines, urine test strips and lancets.

3. Smoking cessation products, such as patches and gum should be a covered item. Though these items are expensive, they will ultimately decrease medical costs. (Some newer programs make the patient pay initially, and if after a year they have not started smoking again, the insurance program will rebate part or all of the cost of their prescription.)

4. Anorexics or anti-obesity products should be excluded.

5. Oral contraceptives and diaphragms should be covered.

6. Durable medical equipment (crutches, commodes, walkers etc.) should be covered but ONLY when ordered on a prescription form by a physician.

We hope that you will seriously consider our proposal when deicing how pharmacy will fit into your proposed program. Thank you and Tom or I will be glad to help you in any way.

Yours truly,

Lori A. Brown

Lori A. Brown
Pharmacist, President AKPHA

Anchorage!

"See Us In a New Light"

Because I wished to leave early, I didn't indicate a desire to testify. However, if I had I would have applauded the Task Force's efforts in this regard. I do feel a concern about the possible of increases in Alaska — the difficulty of small businesses to afford coverage for employees — and the current cost of less than one. There are other concerns as well. I do appreciate that the Task Force has pinpointed the right place for health care reform. Their efforts will be circulated by American Assn. of Retired Persons. There are some very good points in the plan.

Betty Carlson
Acting State Director
AARP

Anchorage! Convention & Visitors Bureau
1600 A Street, Suite 200 • Anchorage, AK 99501-5147 • (907) 276-4118
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Box 2871
Sitka, Alaska 99835
October 19, 1992

Senator Jim Duncan
Health Resources and Access Task Force
State Capitol
Juneau, Alaska

Dear Senator Duncan:

I have mulled over the discussion at the recent teleconference here in Sitka, and read the Task Force's Report and write today to give my thoughts.

It would have been well for me to have read your Report before I attended the hearing. I had no idea what issues to raise for I did not know what direction the committee had taken. I know we have awful communications difficulties in Alaska, but in this instance there was a lot of interest in the subject and I think people would have prepared for the hearing had they had access to the Report, and it might hae been worth the trouble to get it distirbuted beforehand. (Putting a copy at the local library and noting in the pubicity that it is there might suffice.)

Speaking of publicity, the Sitka AARP did quite a bit of publicity for the hearing.

My concerns about the medical care system have to do with rather small pieces of it. Though there is no doubt we need a global, systemic approach, it is not too late in the planning process to think about pieces of the system, analyze the problem in terms of its parts. Possibly, we can improve the general situation by making small, incremental changes. Such small changes might hae a more general effect. Small changes that work would serve to encourage the planners and I submit that concerned people could use some success, some encouragement.

I have followed your work in Juneau a little, as much as I could in the newspapers, and have been impressed with your creativity. If I make no other point today, I would like to encourage you to continue to be creative and innovative. I still think that Alaska with its small population eager to tackle new project, to dream impossible dreams, could set precedent for the country. I am discouraged with the way things go in Juneau but want to send a message from one citizen that I admire and support your efforts.

Oregon has tackled health care problems creatively and I would hope we use what it has learned in our studies.

It looks to me like the way Medicare is administered has had a great effect on raising care costs.

I have had some years experience with home health services and I am stunned with the amount of paperwork medicare demands and how

that eats up nursing time, raising costs.

It seems that the prices for services are in fact set by Medicare. What medicare will reimburse is what is the charge period. But medicare reimburses not only for the actual cost of the care but for the cost of doing all that medicare administrative stuff.

Medicare, and other insurance, seems to structure the business practices of the offices of hospitals and doctors. Billing is done for medicare and insurance and good accounts receivables practice cannot be carried out.

You must hear all over that patients cannot understand their billings, cannot deal with them like they deal with other payables. I tried to deal with the hospital about bills for my elderly father. I had invoices and payment notices all over my desk and was unable to sort them out and decide what I owed the hospital. Billings are done by encounter, not by patient. I wrote and asked for a statement, showing invoices and payments, saying that we were prepared to pay the balance due immediately. I never got a reply from the hospital. It has been a couple of years now and I can just assume that we don't owe them anything. If it is that difficult to get a statement out, we can imagine the state of the receivables.

These very receivables seem to demand a lot of work. The business office staffs appear to grow before my eyes.

Given the methods used, there is nothing that patients can do to help with billings because they are not allowed. I found this out in an incident at Bartlett in Juneau. I got a little fracture, waited until doctor's offices were open and called for an appointment with an orthopedist. I was refused an appointment because any fracture is an emergency and I must go to the emergency room. I was forced to go to the emergency room. There I was asked to sign an assignment of insurance proceeds to the hospital. I refused to do this, saying that I would pay the charges myself and deal with my insurance myself. (It was a small injury and I don't feel claims should be made for little things and I might have decided not to file.) The hospital said it was the policy to refuse care to anyone who would not sign the assignment! My rejoinder that I would pay cash for the service did not help. I felt at that point that it was not in the interest of the hospital to share its billing with me and about then I really wanted to see it. No one would believe at that point that it was my concern about rising costs that motivated me, but I perservered and signed the assignment but paid the charges for the visit, opting to be reimbursed by the hospital when the insurance paid the hospital. The costs for that little cast were over $500. Had I gone to a doctor's office, I can't believe it would have cost more than $100.

I complained to Blue Cross administration in Seattle, and learned that Blue Cross is owned by the hospitals in whose interest it is

to have high charges and as a policy holder I had no standing to intervene.

I have an idea that it would be fruitful to look carefully at accounts receivable practices generally in the medical care business, that there may be lots to learn and maybe some direction to be gained. There might be a possibility that the State could work with the medicare intermediary for Alaska for some reform just here.

I am surprised to see that people seem to want insurance to cover all medical care costs. People seem to think that someone else should pay for all prescriptions, every doctor visit etc. That seems silly to me, for generally we all can pay for the services we buy from any source, and it is extraordinary expenses that we buy insurance for. (I, by the way, had no problem getting health insurance for just myself since I would accept a high deductible.)

Since it is apparently the case that the best is for people to have medical care paid for in advance, that puts me in mind of an HMO. I have long wondered if Alaska couldn't organize a State HMO, organizing the current physicians into a prepaid group practice.

On the subject of general cost containment, is it not time that the Indian Health Service and the State work together? I know it is very difficult but if the Legislature put enough pressure on DHSS and IHS they would have to cooperate. Maybe.

One last thought, and this is about long term care. I operate an adult foster care home here in Sitka. I see that people who are in nursing home can be well served in a situation of this sort at great savings in cost. I doubt that the population that would have its needs met here is very large, but every little bit helps. The State is just impossible with these institutions. It has made it difficult in many ways. I am not willing to take State clients and have not signed the contract with DHSS. If DHSS supported this type of service, and it could in many ways at little cost, it would help some with costs generally--and the worst cost of all, long term care. If it would help, I would be willing to share my facts and understanding with you.

I hope my thoughts are some little help to you in your work. I offer them primarily because I laud your work and think that all of us who think it is worthwhile should try to help in any small measure.

Very truly yours,

Judy Christianson, RN

HAWKA
GLASS
STUDIO

25 OCT 1982

Both my husband and myself are independent Studio artists. Currently we pay £2000/00 per year for very medical - a 70 fully policy that excludes dental, eye, yearly OB/Gyn. It is for "Catastrophic" illness only and covers us in our studio. This is a bit much... as we have to pay out of pocket and fund health care costs are extremely expensive and to may be overlooked (preventive medicine) as we do not have the funds. We must be interested in a "pool" concept for individuals and small business owners... If I can help please do not hesitate to contact me —

Cynthia Jarboe - England

P.S. I hold an MSW. (Master of Social Work)

Elizabeth M Dahl
1400 "D" Street
Anchorage, AK 99501
(907) 277-6277

November 21, 1992

Health Resources and Access Task Force
Alaska State Legislature
Juneau, AK 99801-1182

Dear Task Force,

I am very concerned about the rising costs of health care and the lack of a national or state health care plan that ensures all citizens access to affordable, basic health care. I am a 31 year old, lifelong Alaskan, who has not had the luxury of being covered by a health care plan via the workplace. For seven years I went without any coverage at all. Fearing financial ruin due to escalating health care costs, I obtained a private policy in March 1990. My monthly premium, with a $500.00 deductible, was $54.68. Today my premium is $98.15. My premium was increased four times in twenty-four months. For certain I can expect more increases. I would also like to mention that this insurance policy contains three riders of excluded coverage for pre-existing conditions.

Three weeks ago I went to Providence Hospital's Emergency Room with abdominal pain. I had an ovarian cyst - cost $700.00. Two hundred dollars of that expense will not be covered by my insurance. I have reached the point where I am no longer getting proper medical attention because 1.) I can not afford it and 2.) I do not have access to affordable, comprehensive insurance. The most desirable solution would be to have a National Health Insurance plan, but it is my opinion that the crisis is so severe that we can no longer wait for the Federal Government to take action. Instead the State of Alaska should begin to address and remedy the problems NOW. Please don't just "study" this issue, formulate a viable plan such as the State of Hawaii's plan, and implement it. Alaska's population is small enough that it should be possible to form a decent insurance pool for those who have no coverage. Please try to do more than recommend a solution (s), be the catalyst for real change!

Sincerely,

Elizabeth M Dahl

Elizabeth M Dahl

October 28, 1992

Alaska Legislature Health Resources
and Access Task Force
State Capitol
Juneau, AK 99801-1182

To Whom It Concerns:

There is an issue that the State of Alaska needs to address in order to keep health costs in line with the overall cost of living.
At this time approximately 50% of physicians in the State have office staff (RN, phlebotomist or medical technician) draw blood and collect other specimens needed for laboratory tests, send the specimen(s) to a reference laboratory for testing and charge a substantial fee for that service. A cap should be placed on the handling fee and/or phlebotomy fee for the sample collected ($10-$15) and the laboratory test fee should be billed as the listed fee the reference laboratory would routinely charge the patient in that area. The physician is currently unlimited by law in marking up the cost of the laboratory test in order to pad his/her income in the practice of patient care. Ideally, the laboratory or other ancillary medical service provider should bill directly for services provided.
Enclosed is a copy of Oregon Senate Bill 705 which addresses this very issue.

Sincerely,

Nancy O. Davis

Nancy O. Davis
17508 Toakoana Way
Eagle River, AK 99577
Phone # 694-3556

Terri

OREGON LEGISLATIVE ASSEMBLY–1979 Regular Session

A-Engrossed

Senate Bill 705

Ordered by the Senate June 11
(Including Amendments by Senate June 11)

Sponsored by Senator BURBIDGE

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Prohibits mark up, commission, or profit by *[physician]* practitioner authorized by law to order laboratory testing for services rendered by independent persons or laboratories. Requires *[physicians]* practitioner to provide itemized billings to patients. Makes failure to comply grounds for disciplinary action.

A BILL FOR AN ACT

Relating to health care.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) Any person authorized by law to order laboratory testing may charge a reasonable fee for all laboratory and other specialized testing performed by the practitioner or by a person in the practitioner's employ. In addition, the practitioner is entitled to charge a reasonable fee for collecting and preparing specimens to be sent to independent persons or laboratories for testing, and for the preparation of the billing to the patient for the test. However, a practitioner shall not mark up, or charge a commission or make a profit on services rendered by an independent person or laboratory.

(2) A practitioner shall prepare an itemized billing, indicating the charges for each service rendered to the patient. Any services rendered to the patient that were performed by persons other than those in the direct employ of the practitioner and the charges therefor shall be indicated separately on the patient's bill.

(3) Failure to comply with the requirements of this section shall be considered to be unprofessional conduct and may be subject to disciplinary action by the appropriate licensing board.

(4) As used in this section, "practitioner" means a person licensed to practice medicine, dentistry, naturopathy, chiropractic or optometry or a nurse practitioner.

NOTE: Matter in bold face in an amended section is new; matter *[italic and brackets]* is existing law to be omitted; complete new sections begin with SECTION.

HOUSE AMENDMENTS TO PRINTED A-ENGROSSED SENATE BILL 705

By COMMITTEE ON HUMAN RESOURCES

June 28

(No change in Measure Summary)

In line 16 of the printed A-engrossed bill, delete the first comma and insert "or" and delete "or optometry" and before "a" insert "to be".

Trish,

Sorry this took so long – hope its not too late. Not all of it is pertinent to your needs. Probably but I used this to "express."

- 2 more things

Problem: MD's over ordering (for whatever reason – legal +/or acuity indicator which ~~makes~~ allows them to charge more for fees. The other part of this is many MD's do not follow up on labs. This happens to my husband frequently (3 V), + I know of many incidents personally – not from ED. One was a cancer pt. that should have received chemo, a biopsy needing further V's. MD's must be held accountable if they are going to order these.

Here are examples of policies that are questionable – Books, toys etc in Hospitals – a policy has to be in the Books to clean after each pt. Do Private Pediatricians do the same, do toy stores where all kinds of kids go (even sick), Check & clean – i.e. not sure it is always realistic.

Lorayne Embretson
2760 Chandalar Dr
Anch, AK 99504 337-1771

I would like to know the
o/o age return on the
questionaire — are you basing it on
Arch. Population?

IDEA'S TO HELP

Take a % of the permanent fund dividend each individual gets and put it in a health care "bank account" for them to use when they need it for health care.

← Very Last Resort measure, as government cannot manage money!

More neighborhood health clinic's to care for Medicaid pt's so abuse of the ED stops ED's then should refuse non-emergent patient's.

TAX Alcohol---to fund treatment for alcohol related health problems - Clitmroe - ALL programs for ETOH Rehab Should be supported totally By Alcohol tax.

Tax cigarettes to fund treatment for COPD etc. (related problems).

Look at the Oregon plan and consider rationing.

Promote more preventative care.

Hospitals work more closely together to share resources and not duplicate services.

Decreasing dollar Bennefits for people on Public Assistance programs when they have another Child. Use motivation we ALL understand and is immediate/tangible.

~~Base~~

Have nurses work as 'Interns or fellows' with the Legislature to Assist with Health Care planning. Nurses are the most objective as they are the patient Advocate and most do not depend on direct dollar payment from the patient.

Better Use of Home Health vs Institutions. for elderly.

Problem:
Insurance billing system so complex it is impossible for laypersons to check on billings and misc. items.

DRUG & EQUIPMENT VENDORS & REPS

Somehow control the middle man profit margin if everyone else is controlled. These guys have terrific markups.

Drug reps "secure" a MD's interest in a drug by giving samples thus pts. are often put on that drug when indeed that sample drug may not even be the best drug for the patient nor the most cost effective.

MAKE IT ILLEGAL for drug reps to give food, clothing, note pads,paper, $80.00 pens and anything else to MDs etc. Samples should be purchased by the MD. at a reduced cost if nec. These "gifts" the reps give are often expensive and only run the cost up for those of us who pay as we do not get the samples since we are the paying customer. Baby food & formula should be allowed to be used as samples. I've heard that trips to exotic places have even been used to get MDs to use certain drugs.

Medical equipment is often over priced-ie item has simple assembly w/ a few dollars worth of supplies wires etc-literally charge thousands of dollars for it since there may not be many suppliers.

Eliminate pre existing conditions that ins impose. Unable to move from job to job -It is an unfair judgement. alcohol and tobacco cause more problems that are never disclosed than most ie-diabetics. Compliant diabetics take better care of themselves than the general public and do well as do heart pts. The amount of alcohol induced injuries that go unoticed by workers comp,ins cos, employers is incredible-as is cigarette abuse. TAX these items heavily so they are self sustaining programs. If this cannot be done set up state owned liquor stores to recoup the dollars from the sales.

Eliminate the ceiling imposed by insurance companies--where is the ceiling on medicaid and other government programs.

FIND a way to ACTIVELY STOP medicaid/medicare fraud and prosecute these people/MDs(whatever) hard!!! I think the Fed gov. is not being honest w/ their fraud statistics. Recently an article asked why so many professional would do this-the answer was simple it said-"greed" by MDs. This and other evidence seems to point to the medical field attracking a person who is motivated by money-often as a sole motivator. I'm not sure what can be done but I do think it has to be addressed because MDs wil be competing for medical dollars even more so in the future.

RULES & REGULATIONS & QI are necessary but some are just plain overkill and the inspections of hospitals are perhaps too much. Private MDs are not governed by the same set of standard as hospitals but they may be doing the exact same procedure. Who inspects Privvate MD offices to be sure they clean things etc. -perhaps the licensing bd does do this and I am unaware of it.

WHY are insurance companies/employees allowed to dictate where I seek my

medical care but medicaid pts can go anywhere. Insured people have many more limitations than the medicaid category. Once again the use of emergency areas for routine things-"it doesn't matter, I have medicaid insurance."!!!!Some actually think it is just that. Why are medicaid people allowed to transfer or move about from state to state freely and get medicaid--insured people cannot. THE PROBLEM IS MEDICAID(and people on government programs) now have more freedom than paying insurance carriers and the insurance carrier is paying for them both!!!!

TEENAGE pregnancy-offer FREE ANYTHING-bith control including implants to medicaid recipiants and welfare mothers and fathers. Again use the decreasing dollar for each born child and they will get the message. People who have to pay their own bills limit their # of children because of a sense of responsibility. People collect gov. monies must be taught accountability somehow--I really feel money is understandable-it may take one or two decreases to catch on. SOLUTIONS to this--hold parents accountable in a dollar amount for uninsured pregnancies--it may at least get people talking and communication going-even if it is only a low dollar amount-its the accountability. I heard Wisconsin was going to try this system. Set up creative programs--I mean really creative!!to try to enhance the lives of underpriviledged girls (esp girls) starting at age 7-10 yrs old. If these girls are not 'caught' by 10 yrs old they are looking for all the wrong things in all the wrong places. . . . . And then comes the pregnancy and babies w/ drug addictions and no job and more welfare and more babies and more welfare and more babies and on and on and the cycle is started.

COntract special MDs /clinics for medicaid pts to use so fees/payment are controlled more easily just as our private insurances dictate where we can go and our employers contract for the best deals-so should medicaid. Fine them if they abuse emergency department or other parts of the system or take away coupons.

ENCOURAGE male recipients to have vasectomies and offer them for free through gov payment. Insist mothers to name fathers to receive free medical care and do "education" w/ the father. Make them do public service if they are not working, if working make them pay something for the medical care of the child.

The questionnaire is too basic ? its real value. It goes without saying every..one should be concerned about these issues. Perhaps it was to investigate how much education was necessay to the public. Thanks for listening.

Waste of Medical Care and Rationing Medical Care / Resources

I think we are at a point in history where something has to be done to control people who cannot control their own abuses. Medical resources are like the earth - they are not limitless.

Examples - Habitual drug abuser who comes many times a week to ED after cocaine abuse. Has specialized mental health consultation but fails to follow up for the daytime appts.

Mother of 5 comes to Emergency for Detox / Cocaine Abuse and is 3 months Pregnant and on medicaid. Decrease her dollar amount w/ each child. Allow reporting of drug abuse + follow up appropriately - drugs are illegal but police can never be involved - fear of drug abusers not seeking medical care. Also Detox clearance is such a simple exam yet these people almost always get this done in EDs.

Alcoholic comes in found unresponsive, Blood Alcohol is very high too high to send to sleep off. Patient is allowed to sleep in Emergency dept. 6-12 hrs., requires checking since he is in the dept. which increases the cost. The alcoholic who is too drunk for sleep off runs up a $500 ±1,000 Emergency Bill This is a daily event — these things are not just happening at the native hospital — its all of them in sum.

I think if people can't comply they should be put in homes where limits are set for them. We do them no favors by allowing the destructive behavior to continue. Set up more housing but stress for more self sufficiency - grow their own food, own cooking, cleaning etc to keep cost down. These habitual waste tax players money - next will have non-compliant drug resistant TB pts. — what are we going to do to get them to comply. We need a plan + we need it NOW!

CONCERNS REGARDING HEALTH CARE IN ALASKA

Abuse of Medicaid -- using the emergency department as a clinic. People on medicaid with multiple children/dependents. It Becomes a "Way of Life."

Native patients using Medicaid and using hospital other than ANHS especially since they are covered 100% at that institution.

There are 4 hospitals in the Anchorage bowl and there seems to be poor sharing of resources, more attention needs to be taken when hospitals ask for certificate of need.

Some MD's in Alaska have been overcharging, as evidence by what insurance will pay. Those of us who pay for this, indirectly pay for those that don't as the over charging compensates for this

MD's have to much power in Alaska, it seems when specific issues come up between the hospital and the MD's the hospitals back down.

There seems to be an overall waste of resources. Example why is a patient with AIDS and Dying of AIDS being dialysised 3 times a week? Why are the elderly who have living wills and have expressed a wish for no treatment being put on ventilators at the families wishes? (Because MD's are afraid of being sued and will follow family wishes before that of the patient).

Local hospitals need to stop paying for MD Quality Assurance data collection and education etc. MD's make enough money that they can pay for their own. AND they are not employee's of the hospital's.

- Doctors office - Have Sick leave/vacation pl. who have sore throats, minor finger injuries et Because they don't have a vacation and they don't pay. Pvt. Insurance + self pay don't pay

Health Care Issues - Comments

① The middle class is concerned about prices! We have to pay + then be reimbursed (usually 80% or less). The underinsured who make too much to be on medicaid are really in a financial bind. We get calls all the time from pts. who we've referred ~~for~~ to MD's in the community who require payment up front - these people either have to return to the E.D. or go thru a long, frustrating process trying to find an MD who will take payments (NOT MANY AROUND!) NOT all MD's take medicaid pts, either.

② Pts on general relief or medicaid have little or no comprehension of medical costs. We often receive the answer - it doesn't matter what the cost - "I'm on medicaid". ~~Receive~~ It's the underinsured pts and pts who have insurance, but little ready cash who are hurting in this system.

(3) The medicare / social security system is very complecated to deal with. My Mother, who was a dialysis pt had to hire a service to review her bills & submit for payment to soc sec & medicare + her medigap insurance. She would get dunning notices from various agencies because of slow payment by soc. sec. or medicare + she would pay out of her own pocket even though she was covered because she was so intimidated by the wording on the late Bills.

(4) The fees the private MD's charge are outrageous. Despite high insurance payments + overhead — they still make tremendous profits.

(5) More money should be spent on prevention of disease + trauma. Too much is spent of costly ICU days during the last days of illness - even on patients of no hope of recovery - AIDS in terminal stages, elderly pts & end-stage disease

Alaska Legislature Health
Resources & Access Task Force
State Capitol
Juneau, AK 99801-1182

October 26, 1992

The attached questionnaire, from the Anch. Daily News, was completed by me as a 65 year old covered by Medicare; a recent condition. However, for the 10 years prior to becoming 65, I had no health care insurance coverage.

Actually, health resources & access can't be treated and improved without consideration of security (protection from mental & financial destruction). Besides access to adequate health care; 1. the poor want not to be permanently relegated to a lifetime of poverty they can never get out of, due to acquiring an insurmountable medical bill, 2. the middle aged economically middle class family fears a medical catastrophe that will wipe out their savings and put them hopelessly in debt, and 3. the retired do not want their lifelong work toward a comfortable retirement destroyed.

In trying to improve financial access to health care, I hope the emphasis will be on requiring all to participate in early, minor and entry costs while protecting everyone from overwhelming financial destruction of individuals and families. Less first dollar coverage; more protection from financial ruin.

Ron Hammett

Ron Hammett
3512 Stanford Drv.
Anchorage, AK 99508
Ph. 279-2339

DEA # _____

JAMES M. NESBITT, JR., M.D.
GERRY J. SCHRIEVER, M.D.
ELIZABETH HATTON, M.D.
DANIEL TULIP, M.D.
THE CHILDREN'S CLINIC
SUITE 213
4001 DALE STREET
ANCHORAGE, AK 99508
562-2944

NAME _____

ADDRESS _____ DATE _____

℞ I am a pediatrician and
I believe we need a single
payer system.
There are many physicians
who are in favor of
more radical reform
than the state or
national AMA would
suggest

☐ Label

Refill _____ times PRN NR

☐ Dispense As Written

☐ Substitution Allowed

_____ M.D.

12/08/90 0301-K11088372

Alaska Legislature Health Resources and Access Task Force
State Capitol
Juneau, AK 99801-1182

I feel two areas need to be addressed in regards to health care/health care system.

First, it is my understanding that several states have enacted a "guarantee issue" law, to the best of my knowledge Alaska has not. I feel that this would at a minimum allow companies the flexibility of change in insurance carriers rather than being locked into an existing carrier and existing carrier noncompetitive price increases. This would also avoid possible problems associated with a general denial based on an underwriting review.

Second, I feel that tort reform is an area that can be substantially reviewed and modified to cut rising cost increases. Individuals can be held responsible for their actions. I strongly feel that no solution to the current aids problem (either preventative or after the fact) will be invented or developed for market as long as there remains a liability with the developer.

Thomas J. Hebnes
2321 Sues Way
Anchorage, AK 99516

Hrdlicka Chiropractic Clinic
413 CEDAR STREET
KODIAK, ALASKA 99615
(907) 486-4042

October 23, 1992

Mr. Cliff Davidson
P. O. Box 746
Kodiak, AK 99615

RE: Health Care Tash Force

Dear Cliff:

I understand that I recently missed my opportunity to speak at a teleconference for recommending for reforming the health care system. I would like to inform you of my thoughts and I would like you to forward this letter to the Health Care Task Force as I don't know their address.

The present health care delivery system is not a health care system but a "symptom, sickness and disease care system." Consequently, health and wellness are not addressed. Suppression of symptoms, sickness and disease is the sole focus. ignoring the fundamental underlying cause which is poor health to begin with.

The vital issue is not how to treat disease but how to stay well in the first place. This simple philosophy needs to be implemented at the state and national level.

The cost of sickness and disease to society, to the economy and to the gross national product is a menace that could be transformed into a value of abundant health.

This can be achieved by giving school courses on nutrition, exercise, meditation, relaxation, chiropractic, massage therapy, body work and all of the emerging professions that facilitate well-being.

A natural educational health and wellness campaign needs to be established promoting responsible healthy habits and life styles.

Incentive to activily engage in fitness and wellness programs could be given in the private sector as well as at the federal, state and local levels to all employees.

Funding and grants need to be given toward investigating and researching the matrix of health, the life style and belief system of people who are symptom-free and who have no technologically detectable pathologies. We must include regular wellness care as "medically necessary."

Chiropractic care must be a choice and part of the national health care plan as it is the largest drugless health profession in the world rendering a service that facilitates health in sick people as well as in people who are completely free of tymptoms or diagnosable pathologies.

A Life, Health and Wellness Department needs to be created at the federal, state and local levels.

As a result of such measures and policies, the health of America could be rebuilt over a few generations to lead the world into a new era of positive constructive lifesyltes. Health and Wellness politics may not be popular, but it is the future.

Thank you. I hope and trust that all's well with you and yours.

Yours for better health, naturally,

Keith L. Hediger, D.C.

10-27-92

I have M.S. I haven't been diagnosed w/ the disease but have so many of the symptoms I feel sure of my "home diagnosis".
I can't be diagnosed because I live in fear that my insurance rates will soar & I will be unable to receive other insurance in the future. The insurance industry has a computer bank that they check out new applicant before assigning insurance. Once flagged you are penalized for life.
My insurance has become too costly & next month I will have to do w/out As other diseases (fatal) can mimic M.S. I am endangering my life daily & the financial future of my family.
No one should have to live in this fear that grows daily.

Helpless

730 Park Av
Ketchikan, Ak
10-16-92

Health Resources & Access Task Force
State Capitol
Juneau, Alaska

Dear Project Director,

The Alaskan health care system throughout is in need of great changes. We are spending fortunes on insurance premiums and bedside health care and can only see costs escalating in the future. Where is the stopping point? Where can we go to receive a responsible physical check-up & necessary treatments if needed?

In S.E. Alaska, it's far better to go to Seattle for medical reasons than waste time & money on a visit to a doctor here. In fact, the doctors send bills even when they haven't seen a patient. Imagine that!

Entirely too much money was given by legislature to erect Ketchikan Gen. Hospital. Nobody can 'run' it effectively and its sad news for those who go there for treatment. And many millions more are destined to be invested there before the

building is completed. Its a waste of resources & money.

Only a few people in Ketchikan can afford to pay for services rendered while being a patient- the costs are unreal. Services are meager.

We need a change in services offered, cost containment and availibility & access

Let's begin to be responsible & treat patients with sincerity & honesty and I believe lots of problems will be solved.

Please enter this statement for the Community meeting on health care system. I couldn't attend the teleconference.

Sincerely,

Carmen Salum

III

Here are some reasons why we need improvement and immediate changes in Health Care for Alaska:

1. Following my husband's recent Cardiac arrest and hospitalization our honest providers tried to collect fees a second time by sending the identical bill, but changing the doctors name. Of course, it didn't fly - its aggravating to see people in the public trust become so greedy & selfish.

2. Patients are treated for various reasons & never realizing the serious consequences of the wrong diagnosis - but the scene is duplicated time & again An anorism was being treated as a rheumatism affliction.

2. My husband's bill for Care & hospitalization in ~~March~~ February never arrived till the end of July, making it difficult for us to know what obligations we had. The insurance company made an overpayment due to poor timing in billing - but Ketchikan General Hospital found it difficult to admit the overpayment was received & it became necessary to demand

the repayment. This is how the public is treated. If folks are honest - there's no way to survive with this system of extreme high costs + cheating.

4. Mothers have been sent home, after delivering a child, with the complete placenta still intact. Talk about barbarians - names are available if you desire!

5. Changes must be made, there's room for improvement, in services provided and costs involved

The end.

730 Fork Ave
Ketchikan, Ak.
10-16-92

Aetna
Seattle, Wa.

Dear Sir,

Enclosed are a complete set of statements and initial eye exam report.

I really need a responsible solution from Aetna. A complete exam included measuring sight distance and any probable eye problems.

Medicare did provide $9.50 which certainly does not cover the expenses.

Please recalculate this bill.

Sincerely,
Carmen Kaplan
574-09-2228

to

Alaska Legislative task force on health care

I do believe we should look at what the state of Hawii is doing and other states and sources of information and experience. Your task force has probably done that.

I think we should strive for a national plan, at the same time a national plan may evolve from efforts by state government. I understand the state of Minnesota is progressive in facing up to health care concerns.

My wife and I are both covered by Medicare and our co insurance is Aetna state Group. We are very fortunate! two of our children have good health care coverage and those do not and serious sickness would devastate them economically. I know there are many other young people in some precarious health insurance

situation.

I and my wife would accept higher medicare and co-insurance premiums and/or deductibles if it would help advance the realization of health care for all citizens and at the same time hold down cost and even lower cost.

We believe everyone should pay some of the cost of their health care except for those obviously incapable of doing so. People who are wealthy and those with higher incomes should pay higher premiums and deductibles than the lower bracket income people.

thank you.

Edward F. and Susie Luebenthal
HC 67 Box 70
Anchor Point AK
99556

10/24

Our particular need is for a system that would provide insurance against catastrophic health expenses that could be afforded by young people.

I also support basic health insurance for ~~all~~ those that don't have it already. The Federal Govt. Employees Health Ins. program works pretty well.

Janice McCabe

1326 K, Anc.
99501

3236 W. 30TH AVE
ANCHORAGE AK
99517

ALASKA LEGISLATIVE HEALTH
RESOURCES AND ACCESS TASK FORCE,
STATE CAPITOL
JUNEAU AK 99801-1182

I am fortunate that I have fair to good benefits (health insurance) through my employer, at a reasonable cost., however I feel this is going to be harder to come by in the near future as small businesses and part-time/seasonal workers will find it nearly impossible to find ~~health~~ adequate health insurance at affordable rates. The two ~~cost~~ descriptions will continue to drift apart as a reasonable definition. I partly blame the Medical delivery companys, drug companys, insurance companys, and the legislators who have been influenced to support their cause. If all citizens were made to pay a small, reasonable, state health insurance premium, and laws were passed to allow only inflation based increases in medical costs, then those without employer provided heath insurance would be covered by the state net, or possibly the employer also could pay a fee, based on the number of workers (DO NOT EXCLUDE SEASONAL OR PART-TIME)

I believe, over time (lets start thinking over the long term) a system could be in place that could be a model for other states, and possibly the federal government. There has to be some losers somebody has to pay, of course, but if the long-term is considered, no one sector should be unreasonably hurt. There is a high degree of waste on paperwork, excessive costs for medicine, unnecessary treatments and operations, and too much gouging by unscrupulous M.D's

over the long term, weeding out these conditions should go a long way to lowering the costs of insurance and medical treatments.

One has to come to a conclusion or two before this program or one like it could work.

1. Is affordable health care to be elevated to a "right" as a citizen?
2. Should the medical profession/providers move "profit" out of the supreme position it now holds, and drift back a little to the old and revered ethnic of Hippocrates?

— we can go to war over oil, support murdering dictators, win a 50 year cold war, feed and support starving poor people in untold numbers of countries around the world, spend billions on pork-barrel politics, billions more on space exploration ..... lets just take half of what we waste taxpayers money with on the above and other fat programs, and take care of our house first, our health first, our education first. Given this attitude, and a chance, over time, I feel we could have a healthy Alaskan and American population, and maybe once again be an example to the world instead of the policeman, and world welfare provider we have become. There comes a time for statesmen to draw a line, that time is now.

Jean Voth
P.O. Box 113
Nenana, AK 99760
(907) 832 5802

October 26, 1992

Alaska Legislative Health Resources & Access Task Force
State Capitol
Juneau, AK 99801-1182

Dear Task Force Members,

This letter is in response to the questions which you asked the public to respond to in the Sunday, October 25 "Anchorage Daily News". I am writing this because I am concerned about Health care and I do want to share my concerns with you. You see, I am unable to answer your questions as published because they were directed toward people who have some health insurance coverage.

I am one of many Alaskans who have no health insurance. I have a partner who is in private business who cannot afford health insurance. I am unemployed and have been without insurance for over two years. My two children are without insurance also.

We all have medical conditions which should be treated, but we can not afford to go to the doctor. Our lives are challenged often by this fact. A major or emergency illness would be catastrophic to us.

Alaska needs universal health coverage for all. A national plan would be most beneficial to Alaskans and other Americans. Your task force should take care to remember the 100% uninsured. Task Force

HC 33 [illegible]
Health Resource Task Force   Wasilla, Alaska [illegible]
State Capitol
Juneau Alaska 99?4

The middle of October there was a meeting concerning health care in Wasilla chaired by your group I am told. I was unable to attend.

I wish to state the health care used to be very good. The workers (care givers) were courteous, gentle, lovely people. They still are - however under the new plan now tendered by the State their wages have been cut by about 4.0/hr while the charge to the client has more than doubled. This is a very disturbing trend. I understood this was a program to aid weak, incapacitated people young or old - not one to rob them. If this is a program to make a profit for the State on this class of people [illegible] - The price I am asked to pay is outlandish and no gain to those who give the care.

This must be removed.

Sincerely

Beulah Wilson

October 25, 1992
Carol M. Owens
8014 East 2nd. ave.
Anch. Alaska 99504

RE: Health Insurance

In 1979 my daughter and son-in-law were expecting their first child. My daughter was unable to work, she wasn't physically strong enough, she did try. Our son-in-law was making just enough money to pay for essentials.

The state welfare system declined their request for medical coverage, claiming our son-in-laws income was too high, he wasn't making more than $6.00 per hour.

We families were unable to help financially.

Our daughter and son-in-law were lucky to find a doctor who let them make monthly payments

I was informed that Providence Hospital would help. This help isn't advertised. Providence charges according to income. Providence paid all of the hospital bill.

I would like to see help from the state of Alaska.

Sincerely Carol M. Owens

AK 99508

Dear Ser Madam

I work in the emergency room at Providence on night shift; I feel there is no problem with access to medical care, I feel too many ineligible people are receiving medicaid; there is no system of restriction! pt walks in demanding inappropriate care, the provider is unable to deny these demands eg. calling and using ambulance for "bladder pain" eg. Natives who don't want to wait at anmc! eg. I want my ears cleaned out now! eg. rash

not only that we have an entire generation ignorant of basic healthy awareness of body and health..

Just wanted to give you my 2c worth

Sincerely

Esther Peters RN

Oct. 28 1992

To Whom It May Concern

I am a retired teacher living in Alaska and am very concerned about insurance coverage and medical costs. About 2 months ago Blue Cross raised their premium for dental/vision coverage from $242 every 3 months up to $410. every 3 months. What a huge jump! I will no longer be able to afford the payments, but I don't want to be without the insurance either. As I have 2 school age children, who need dental care, and I need to wear glasses.

I was also enrolled in the States long term care program with my husband, but have dropped that also to save money.

I am very grateful for the 80% Major Medical insurance that we receive from the state as a retiree, because I wouldn't be able to afford it if I had to pay.

Something needs to be done to curtail medical costs and jumps in insurance premiums so the average Alaskan can afford insurance and medical care.

Thank you for your attention.

Carol Phillips

10/29/92

Medical care is the ultimate political plaything. The concept of having a spectrum of quality vs cost is drowned by the emotional nature of the issue. Healing oneself or a loved one becomes the goal with money no object. Unfortunately somebody must pick up the tab. A free market approach whereby individuals must make the hard decision for themselves is the only workable way. Most people care in any and most people are healthy. Catastrophic illness is the exception. Government by its very nature is inherently corrupt. For it to be allowed to expand its role in yet another sphere of activity would not be wise. For it to tamper with such an important issue as human lives would be a tragedy. A prosperous economy to provide ample employment; a free market to provide an abundance of choice, & the freedom to decide individually the issue of quality/cost; & the resulting abundance of private love and charity is the answer. Nobody can simply remove pain & effort. But the political process can only waste what few resources are available leaving the alleged beneficiaries doomed forever more to deal with unresponsive & uncaring bureaucracy.

Sincerely

P.S. I write this as I sit & wait in yet another govt. office.

Tom Ralloff
203-8001

10/26/92

Mark A. Rinehart
4026 E 8th Ave. #
Anchorage, AK
99508

Alaska Legislature Health Resources
And Access Task Force
State Capitol
Juneau, AK. 99801

Dear Folks:

Enclosed is a health care survey form which appeared in the Editorial Section of the Sun. 10/25/92 Anch. Daily Newspaper. Please consider my responses in regards to your review of Alaska's health care system.

COMMENTS ⇒

#3. Not the role of Gov't. (state, local or Nat'l.).

#4 This should be in the realm of Employer/employee interactions.

Additional Comment ⇒ The only beneficiaries of this reform will be the public sector employees + managers. I don't want to subsidize their fringe benefits!!

However, if you must tinker with the system, then you should follow the common sense initiated by the reformers in the State of Oregon. To implement/follow any other plan other than the Oregon Plan is sheer financial suicide!!

Of course, the most appropriate plan of action would be to enforce and promote individual responsibility for medical contingencies. In a society lacking a tax structure, positive reform should occur with implementation of regulations which WILL REDUCE medical ~~&~~ and dental insurance premiums.

Make insurance affordable and I believe the greater majority of individuals will respond positively and become insured. For the others, irresponsibility has a price! I care not to carry their burden. Thank you

Nick A. Rice

Dec. 21, 1996

Dear Health Risk Force

I am one of the many who have fallen through the cracks when it comes to medical coverage. When I was employed at a small day care I was uninsured & in need of medical assistance. All of my (meager) wages was being spent on medical needs. I was unable to purchase needed medications & had to postpone treatment.

I couldn't get insurance coverage b/c couldn't find a company that would insure our small group. Because of my medical situation I eventually became uninsurable. My ongoing problems left me too much of a "high risk". The few companies that considered me as a client were useless to me. My insurance policy would have had numerous exclusions. In fact, there is little that would be covered.

As my health declined I wasn't as able to work. Even when

My resources were quite limited, I was not eligible for state assistance. Because I didn't fit the ~~[illegible]~~ state's criteria (elderly, single parent, or suffering from the "recognized & approved disabilities) I couldn't receive any help.

In the mean time, I had applied for Social Security Disability. I was denied & had to appeal 3 times. During this time, I was struggling immensly. My physical situation and the financial stress it provoked left me overwhelmed. Unable to work, financially strapped, denied medical care, I felt backed against the wall.

The constant hassles concerning medical coverage were overwhelming. My credit was scarred - as I was unable to continue minimal payments. I was left to survive & contemplated suicide - repeatedly.

Ive just been allotted Social Security Disability. Having been placed on Adult Public Assistance

I'm now receiving Medicaid. I'm able to get needed prescriptions & address my physical problems. I am ~~cancer~~, not out of the "dark" yet. My new disease requires special care. I am constantly fighting to have my needs met. Though Alaskan physicians have requested certain treatments - I'm told that Medicaid will not cover such treatment. This still leaves me in a dilemma. I'm grateful for the period when I did not have to decide between medication & utility bill or doctor's advise vs vehicle insurance.

I'm still left in a tough spot. I wish there were more treatment choices available - that would be covered. Preventative & alternative treatments (pain clinic, chiropractic care, naturopathy, hypnosis, homeopathy) might be helpful in my situation. I can't tell however, because I'm unable to cover such treatments.

The state of AK is willing
to ~~hospit~~ pay for
various tests
hospital stays
Medications
travel (including flights
to Anchorage when no assistance
was available if I drove to & from)
surgery & many other
"acceptable" treatments. This is a
great expense to the people of AK
Though my disease isn't
common - & can't be easily treated
~~In fact~~ questionable treatments
are denied. In fact specialists
are apt to treating the symptoms
& doubtful of solving the root
of the problem. I'm left to try
experimental drugs (which have
not worked in the past). With
these given facts - I'm still denied
options that could improve my
lifestyle.

Hopefully this task force
will be able to address the
issues at hand. I'd like to

attention payed to the ones that are slipping through the cracks. I'd like to see help available for the low income person who can't afford insurance... I'd like to see medical coverage available for the "high risk people. Treatment centers should be available to those in need of the system.

Thank you very much for your efforts in this matter. I'd also like to thank you for allowing me to express my opinions. You have my support & best wishes while tackling this ~~[illegible]~~ complicated situation.

Sincerely,

Cindy Rae Schoolcraft

Rt. 1 Box 94-A

Yoakum, Texas

77995

(h) 707-283-5771

Miss Beverlee Schnable
P.O. Box 494
Hoonah, AK 99829-0494
October 3, 1992

Honorable Don Young
House of Representatives
2331 Rayburn House Office Building
Washington, D.C. 20515-0201

Dear Honorable Young:

PLEASE HELP ME TO UNDERSTAND!!!!!!!!!!

What is your definition of Native American and Alaskan Native? Is there a difference? This is not a trick question.... Trust me I am a voter.

I was a bit annoyed when I read the last letter you sent your constituents. My question is; How can you give free services when the Native American already have free medical coverage?!?!

I understand that they have a hospital in Anchorage and another in Sitka, although I hear this one is not the best. Am I also to understand that you are updating the hospital in Kotzebue for $62 million and also building a new one in Anchorage for $70 million?!? Can't the N.A. utilize Humana or Providence Hospitals if the need arises? I do not begrudge anyone of anything, but their are some low income white people who do not have the privilege of getting free medical when a medical emergency comes along. I was refused medical coverage by Public Assistance, General Relief Medical. I earned $319.97 the month of July and I am only allowed to earn $300.00, because I was over the allotted amount I was refused G.R.M. I went to the Hoonah Health Center for severe pain in my left flank. The first time I went was July 12. I was given a urine test and found out I had a kidney infection, so I was given antibiotics for 10 days. I had the pain in the back for about 3 to 4 weeks before I went to the clinic, but I did not have the money to go so I put it off. By the time the pain set in it was pretty bad. On the 11th I had severe pains again with no let up, so I went to the clinic once again. This time the pain was worse than the first time. The health aide called Mt. Edgecumbe and Dr. Kreiss told her what to do. It was apparent that I had a kidney stone as well as an infection. I was given an I.V., a pain shot and penicillin through the I.V. I was advised by Dr. Kreiss to go to Bartlett the next day to see my doctor. I flew to Juneau on the 12th at 11:00 AM, because there was no ferry. My doctor, Dr. Palmer, was out of town, so I went to the emergency room. I had blood and urine tests done and a lot of x-rays, plus a mini exam. They found out that I had a severe kidney infection and several kidney stones. They gave me the strongest antibiotics that can be taken, which cost me $86.00, plus Tylonol 3 for the pain. I felt okay on Monday so I flew home. I had an attack of pain and went to

the clinic for a shot of Talwin at 12:30PM Tuesday the 13th. At about 3:15 PM the pain had not let up, so I called the clinic and they said they could not do anything else for me, and I should go to Juneau. I flew to Juneau again on the 4PM flight, and I cried most of the way due to the pain. I got to Bartlett around 4:45PM. By this time I was in pain for 5-1/2 hours with no let up. I was given 20 mgs of Demerol every half hour for 2 hours and I still felt the pain. After the second shot Dr. Vaught came in to see me and said that I was in such bad shape that I should be hospitalized, and said considering I did not have insurance he could not admit me. I was flabbergasted to put it mildly. He said I should have been on an I.V. with mega doses of antibiotics for the night. I was not able to keep food down all day. I have an ileostomy and dehydrate very quickly, because I do not have my large intestines, due to cancer of the colon and rectum. I left the hospital with the same pain I had when I went in and had to pay for the E.R. and the doctor. I was given a shot for nausea and pain pills, and sent on my way. I was so groggy I hardly made it to the waiting room. I believe if I was a native I would have been flown to Mt. Edgecumbe immediately with no questions asked. Please help me to understand why the N.A need another hospital all their own? My suggestion would be to allow the low income white people who have medical emergencies and very little state aide utilize the N.A. hospitals?

I pay taxes and some of it goes to women who kill their babies by having abortions, and many other nationalities to have the privilege of free medical coverage. I've read in studies that most women who have abortions are married and only 2 to 5%, because of rape or incest. There is something wrong with the **SYSTEM**. I had surgery July 1991 and Hill Burton paid the hospital bill, thank God for that, but I had to pay $1,200.00 out of my pocket. I still owe $525.00 on a part time job. I do get unemployment checks, but it does not go very far with all the medical I owe. I am very frugal with my money. I have to be.

In reading the "Rural Alaska Newsletter, Summer, 1992," Indian Health Care Task Force, I can go along with 1, 2, and 3. There are several hospitals and new clinics. 4, 5, 7, and 8 they already have free, so how can you give them more free coverage? It does not compute!!!!!!!!!!!!!!!!!!!!!!!!!!

I thought we were out of the "Dark Ages." Slavery has been over for many years, but black people still hold on to so much bitterness against the white folk. There are many other nationalities that we so freely help and we have many of our own who have needs too, especially low income whites. I had nothing to do with slavery. The blacks and Native American say we owe them!! What do we owe them? and why? Haven't we paid our dues? I believe giving people things free i.e. medical, welfare, food stamps, etc. only encourages those on the programs to remain lazy. I have heard many times, "Why work when I can make more on welfare with a lot

less hassle. "This is not the way to build self-esteem. It causes old wounds to continue to fester. I sure do agree with raising the minimum wage. Why work for $4.65 when you can get a whole lot more on welfare. I can agree with that logic, but it does not seem right. I believe if the minimum wage was higher and welfare lower, it might encourage those on welfare to work at least part time. I hear the natives accuse the white people of taking their jobs. I have talked with several store owners who hire the native and most of the time they do not do their jobs thus getting fired. Then they holler discrimination. What a farce. There are jobs that I cannot get because the federal government has a stipulation on the job description, i.e. Equal Opportunity Employer, native preference. That one really confuses me. I put in an application to manage the apartment building where I live and was hired, but was told that T.&H. made a mistake and posted the wrong job description and they had to re-advertise it. Then I was told I did not have the job, although I was more qualified and was the oldest of those who applied, but there was one factor that remained, I was not native and H.U.D requires that a native be hired. Another confusing situation. I see this as reverse discrimination.

Doctors and hospitals really bleed the public especially those who have insurance. One time I was overcharged, $250.00, so I called the hospital and told them I did not have that service while I was in the hospital and they told me, "Don't worry the G.R.M. program will cover it and besides we probably did some other service and did not charge you." **Fat chance** of that happening. I have talked to other people that this has happened to, in the same amount, and they were told the same thing. This is why I like Canada's socialized medicine plan. This way everyone would be treated equal and there would be no discrimination.

I need a physical once a year for cancer follow up. I have paid for them for the past 8 years, but this time I cannot afford to, because I need to have an upper G.I. and small intestinal series done. I had surgery, June 17, 1982, and had my colon and rectum removed due to cancer. I had proctocolectomy for Familial adenomatous polyposis (Gardners Syndrome) with cancer of the rectum. It was advised by Dr. Guy Kratzer that I have stomach and small bowel x-ray as an essential part of my follow up. I cannot afford to let my health go any longer. I have a spur on my left heel, which is very painful, but I live with it because there is not much else I can do about it at this time. I was given several anti-inflammatories, which did help for several days than the pain began again. These can get spendy, but they do not dissolve the spur, and the pain goes on. Why not solve the problem rather than put a big band-aide on it. I am very rarely sick or need medical attention, and I pay whenever I can. I was fired from my last job at the end of March. This is the letter I received from the Labor Board. "It has not been established that there was misconduct in connection with your work. You were discharged for reasons that do not constitute willful misconduct in connection with your work.

Benefits are therefore allowed beginning 04-05-92." I was refused a check one week because I went to a friends funeral in Juneau. I was refused G.R.M. in July because I earned $19.97 over the allotted amount $300.00. Public Assistance seem to consider your earnings on the gross amount. There is about 20% taken out each pay. It appears what I pay out, i.e. rent, the medical bills I owe, Ostomy supplies I need every week amount to about $6.50 a week, food, shoes, clothes (rarely) thank God for Salvation Army, and the vitamins I take to maintain, etc.... Dr. Palmers office called First Health to get approval for me to have the x-rays done and they told them, the only way I would get help is if I was in the hospital over night. Dr. Palmer would have to justify my being in over night. Everyone has their hand in the pot.

As I stated before I have an exam once a year and this year I need more than just an exam. In 1980 my mother passed away due to cancer (G.S.) my brother (45) (G.S.) in 1982, my father had 80% of his stomach removed due to cancer and he passed away in 1984 due to a massive heart attack. He had many problems with high blood pressure and was on medication for a while. My sister passed away in 1989 (G.S.) and she was in the hospital, bed ridden, for 4 months. Another brother had surgery (G.S.) in March 1991 and had 18" of his large intestines removed and found out he has a recurrence and needs to have surgery again. Yes, I've had a clean bill of health for 10 years, and I thank God for that, but my mother had a clean bill of health for 27 years. So you never know. I was going to buy insurance years ago, but the only way they would cover me is if I had a recurrence of cancer. **Why wait until this happens?!?!?** Another factor, I am considered high risk and the premium I had to pay was horrendous. I had 3 hernia operations in 4 years, so I cannot lift anything over 35#. When I do too much lifting my insides hurt for several days. I am not handicapped, but I am limited to what I can do. I am between a rock and a hard place. I am supposed to have an upper G.I. and small bowel series every 3 to 5 years and it has been 7 years. Considering my families history I would like to have the x-rays the end of September. What happened to the old expression, **An ounce of prevention is worth a pound of cure."** Oh, on top of it all I have a tooth that is severely cracked and chipped and I know I will need a crown for it to the tune of $400.00 to $500.00. Oh well one day it will get taken care of. I have had problems with high blood pressure and went to the clinic twice a week for several months. They advised me to take medication for it, but I declined, because of the added expense. I do not like the idea of putting all those chemicals in my body. I believe in getting to the root of the problem. This I did.

I heard of a couple who get money from the Kake Corporation and get food stamps every month. Their are people who have insurance and what the insurance does not cover Public Assistance does. This is mind boggling to me!?!?!?!?!? I ask for help once every five years and it is hard or nigh impossible to get. Yes, I am very

grateful for the help I have received. My blood boils when I hear young girls talk about getting pregnant so they can get away from home and get on welfare. The government encourages them to be dishonest. Look at the fraud that has been shown on "20/20" and "60 Minutes." They cannot all be lying. There **has** to be a better balance. I read that Fish and Wildlife will be getting $120.00 more a day perdiem for travel. That must be nice. I went to Anchorage about 7 years ago and was allowed $34.00 perdiem. I had to stay at the "Black Angus" a rough part of Anchorage and was stalked twice, plus I had a drunk who wanted to join me for dinner and when I told him I preferred to eat alone he became nasty and walked away. I hear that the perdiem has not improved too much. This is sad. I checked out other places, but I did not have the money to pay more and for food....I called a friend and his mother found another place for me to stay. It was with a friend of hers. I did not get much sleep that night, and I put the chair up against the door and there were several knocks on my door. I sure did a lot of praying that night. I am very glad that I have friends that I can stay with when I go to Juneau. I do not believe too many government officials have such a problem. It must be nice. They do not cut down on their travels, plus most of you could afford to pay some out of your pockets. How many governors and senators refuse a pay raise? How often do they get one? Some women are on welfare and have live in boyfriends who have full time employment. The way they beat the system is not to tell Public Assistance about it or they say the boyfriend does not live there all the time. When a N.A. has to go to Mt. Edgecumbe for medical reasons, but it is not considered an emergency why don't they take the ferry which $44.00 round trip verses flying which is $245.00 round trip? Yes, flying is much faster, but why not help save money where we can.. Again I have heard I don't have to pay for it. It is even more when a parent has to escort a child, $367.50.. Many children grow up as welfare kids and this is all they know, so they follow suit. There has to be a way to teach them that they have other options. It is their mentality, because they do not see their parent (s) work. This is, in part, what I mean when I say they are spoiled. Their are whites who are in the same boat.

I am totally against abortions. It is killing no matter what anyone may say. Yes, we are all entitled to our opinion. If a woman wants to have an abortion, it is her business, but I **strongly disapprove of using my tax dollars.** There are soooooooo many forms of birth control. Yes, they are not all full proof. I agree with choice , but it should be made before the couple decides to have intercourse. If we continue to aide abortions we give the message to the young girls that it is okay. I believe we could curve the abortions that are done if the women who have them had to pay for them. Maybe they would be more careful. Using abortion as birth control is not the way to go. What is wrong with abstinence? So many, "consenting adults" (married, but not to each other commit adultery these days. How can they teach their children respect? Most "consenting adults" give the message it is okay to sin for a

season. and we wonder why the United States is in such bad shape. God has blessed us in spite of our sins and we continue to lie, cheat, steal, commit adultery, murder and it does not seem to phase some of us. I can assure you God will not turn His head forever. There is a Judgment day.

I get angry when I hear so many people blaming so much of our countries problems on the president. From what I have heard on the T.V. and read in the papers their are more Democrats in office and the president **does not** have the run of the government. I get tired of hearing the Democrats degrade the Republicans and vice versa.. How can we teach our children to respect others when you government officials are so blatant and disrespectful to each other. We all have dirty laundry, but we do not have to use it against each other. Maybe what is said is partially true, but why use it at election time? To me it is a cheap trick and anyone who does it will not get my vote!?!? Why can't the parties work together for the betterment of the people. What happened to the expression, "Of the people, for the people and by the people." I hear of the people and by the people, but I think for the people got lost in the shuffle. Why do I have to vote all Republican or all Democrat? I believe it is the signs of the times. As the Bible reads, In the end times there will be wars and rumors of wars. Earthquakes in divers places (and I believe we can add hurricanes). So much money is spent on saving the animals and the environment than to help people. Anything to get a vote. Let's get our **PRIORITIES** in order. Then I believe we will see the blessings again.

I agree, there are no pat answers, but we can learn to work together rather than be at odds all the time. Each party is like Ford they think they have a better idea. Learn to listen when someone has something to say rather than just wait for the man on the floor to shut up so you can get your two cents in.

I have been told that I should become a politician, but I do not think so. I am too honest and do not want to get old before my time.

The above things I have shared with you are from my own experiences and not hear say. This is why I am writing this to you. I will be sending copies of this letter to other people. Some are politicians like yourself. I sat quiet too long, but no more.

Sincerely yours,

Beverlee Schnable

Miss Beverlee Schnable

INDIAN HEALTH CARE TASK FORCE

I was asked to join the Congressional Indian Health Care Task Force. This group's interest is improving health care for Native Americans. This year, we have been busy reauthorizing the Indian Health Care Improvement Act. This law provides for the following:

1) A program encouraging young natives to pursue medical careers

2) A scholarship program for native students

3) A special nursing program

4) A catastrophic health emergency fund

5) Diabetes, dental and mental health programs

6) New hospitals and clinics

7) Assistance for Natives in getting medicare/medicaid benefits

8) Alcohol and drug abuse programs

I am looking forward to the work I will do on this task force to improve health care for all Alaska Natives.

If you are having any problems with the Federal Government, please contact one of Congressman Don Young's offices:

222 W. 7th Ave., Box 3
Anchorage, 99513-7595
271-5978

Federal Building, #401
Juneau, 99802-1247
586-7400

130 Trading Bay Road, #350
Kenai, 99611
283-5808

101 12th Ave., Box 10
Fairbanks, 99701-6275
456-0210

109 Main Street
Ketchikan, 99901-6842
225-6880

2331 Rayburn HOB
Washington, D.C. 20515
(202) 225-5765

Congress of the United States
House of Representatives
Washington, DC 20515

OFFICIAL BUSINESS

Don Young
M.C.

POSTAL CUSTOMER

MISS BEVERLEE SCHNABLE

Earnings June, July, and August $1,350.00

Medical - $1,608.00

Travel to Juneau for doctors appointments and to the emergency room at Bartlett Memorial Hospital $150.00.

Pharmacy - $119.05 (Meds for kidney stones and infection.)

Supplies for my ileostomy - $78.00.

Hoonah Health Center $72.50.

What I owe for the surgery I had last year - $475.00.

My rent to T.H.R.H.A. (Low Income Housing) $222.00.

This is not all that I owe, but you get the idea.

The figures above are fairly accurate, - especially the medical ones.

JUNEAU
DIVISION OF PUBLIC ASST
811 W 12TH ST 2ND FLOOR
JUNEAU AK 99801
(907) 465-3551
(1-800) 478-3551

STATE OF ALASKA
DIVISION OF PUBLIC ASSISTANCE

CASE NUMBER: 05079118
CASELOAD ID: 111021

MAILING DATE: 09/16/92

BEVERLEE SCHNABLE
PO BOX 494
HOONAH AK 99829

GRM DENIAL

DEAR BEVERLEE SCHNABLE

YOUR APPLICATION FOR GENERAL RELIEF MEDICAL BENEFITS RECEIVED ON SEPT.9,1992 HAS BEEN DENIED FOR THE REASONS LISTED BELOW:

REASON(S) : REQUESTED SERVICES ARE COVERED BY THE GM PROGRAM. MUST HAVE INPATIENT HOSPITAL SERVICES.

PLEASE READ THE BACK OF THIS NOTICE FOR ADDITIONAL INFORMATION REGARDING YOUR RIGHTS AND RESPONSIBILITIES.

IF YOU HAVE ANY QUESTIONS REGARDING THIS ACTION, PLEASE FEEL FREE TO CONTACT ME.

THIS ACTION IS BASED ON GR/GRM MANUAL SECTION 600.

AREA CODE 215
433-8181

GUY L. KRATZER, M.D., P.C.
1447 HAMILTON STREET
ALLENTOWN, PENNSYLVANIA 18102

PRACTICE LIMITED TO
DISEASES OF THE RECTUM AND COLON

OFFICE HOURS
BY APPOINTMENT

August 3, 1992

Miss Beverlee A. Schnable
Box 494
Hoonah, Alaska 99829

Diagnostic Radiology

Miss Beverlee A. Schnable had proctocolectomy for Familial adenomatous polyposis (Gardner Syndrome) with cancer of the rectum 6/17/82 and must have stomach and small bowel x-ray as an essential part of her follow-up.

Thank you.

Sincerely,

Guy L. Kratzer, M.D., P.C.

An ounce of Prevention is worth a pound of cure.
↑
AMEN

Dr. Kratzer did my major surgery 10 years ago, and has been our families doctor for at least 35 years.

Beverlee Schnable
8-27-92

SCHNABLE, BEVERLEE
BOX 494
HOONAH, AK
99829

DESCRIPTION	REV CODE	UNITS	TOTAL CHARGES
OFFICE/OP VISIT, EST, L 90050	510	1	52.50
RX-MOTRIN 400 MG	250	1	20.00
TOTAL AMOUNT	001	2	72.50

→ I saw the P.A. for a 5 min visit

Hoonah Health Clinic

Mt. Edgecumbe

Sitka

(S.E.A.R.H.C.)

Please
Return This Statement
With Your Check.
Thank You

PAYER	REL INFO	ASG BEN	DEDUCTIBLE	CO-INSURANCE	EST. RESPONSIBILITY	PRIOR PAYMENTS	EST. AMOUNT DUE
SELF PAY	Y	Y			72.50	0.00	72.50

DUE FROM PATIENT ▶

INSURED'S NAME	SEX	P.REL	CERT.-SSN-HIC.-ID. NO.	GROUP NAME	INSURANCE GROUP NO.
SCHNABLE, BEVERLEE	F	01			

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

PATIENT COPY

PATIENT'S NAME Beverly Schnabel

MAILING ADDRESS _____

PHONE: Home _____ Work _____

Patient's Date of Birth _____

Are you covered by:

☐ VA ☐ Medicare

☐ Workers' Compensation ☐ Medicaid

☐ Private Insurance (like Aetna, Blue Cross, etc.)

* Patients with private insurance are responsible for filing their own claims.

10301 Glacier Highway
Juneau, Alaska 99801
Phone (907) 789-2910
IRS 92-0087060

S

☐ DR. MIKE FRANKLIN

☒ DR. KIM SMITH

☐ DR. WILLIAM COLE

☐ DR. ERIC OLSEN

☐ LARRY DePUTE P.A.-C.

X

PATIENT ACCT. # 8974 RM. # _____

SURGERY				INJECTIONS				Culture/Misc.				Elbow	73070		
I&D	10060			Therapeutic Inj	90782			Urine Culture/Sens.	87184			Lumbar Spine	72110		
Excise Lesion	114.....			Soft Tissue Inj	20550			Culture, Throat	87060			Wrist	73110		
Size:				DPT	90701			Strep Screen	86171			Hand	73130		
Suture Laceration	12.....			DT	90702			Wet Mount	87220			Finger	73140		
Length:				Flu	90724			Spec. Collection	99000			Pelvis/Hip	72170/73500		
Location:				Hep B	90731			Venipuncture	36415			Knee	73560		
Hyfrecator	17100			HIB	90737			OUTSIDE LAB				Ankle	73610		
Cryo	17340			OPV	90712			PSA	86229			Foot	73630		
Bx Cervix	57500			PPD	86580			Pap Smear	88150	—		OFFICE VISITS			
Cast Procedure	2.....			Tine Test	86585			Culture, GC	87070			New Pt. Level I	99201		
Cast Materials	99070			Allergy (one)	95115			Chlamydia	86999			NP Level II	99202		
I&D Hemorrhoid	46320			Allergy (mult.)	95117			HIV	86312			NP Level III	99203		
Path Specimen	88305			Chemo Push Inj	96408			Chem Panel, T4, HDL	80050,1			NP Level IV	99204		
Spec Path	88305.1	78		Chemo Infusion	96410			Chem Panel, Basic	80050			NP Level V	99205		
				OFFICE LAB				Coronary Risk	80062			Est Pt Level I	99211		
SPECIAL PROCEDURES				Hemogram	85024/85021			Glucose, Plasma	82947			EP Level II	99212		
Flex Sig	45330			Diff	85007			Liver Function	80058			EP Level III	99213		
Sig w/Bx	45331			Hgb	85018			Prothrombin Time	85610			EP Level IV	99214		
EKG Trac	93000			Hct	85014			Renal Eval	80073			EP Level V	99215		
EKG 1 Lead	93040			WBC	85048			Thyroid Screen	80070			Child PE new/est			
Vitalor	94160			Platelet Ct.	85560			Hypothyroid Profile	80070,2			School PE new/est			
Endo Bx	58100			ESR	85650			X-RAY				Sports PE new/est			
Treadmill	93015			Monospot	86300			Sinus	70210			Women's Annual new/est			
Audiogram	92551			Glucose, Whole Bld	82947			Cervical Spine	72050			Phys. Exam new/est			
IUD Insert	58300			Pregnancy, Urine	84702			Shoulder	73020			FAA new/est			
Vasectomy	55250			Urinalysis	81000			Chest IV/2V	71010/71020			Phone Consult Brief	99920		

ADDITIONAL LAB WORK:

TEST:	CPT:	$	TEST:	CPT:	$
TEST:	CPT:	$	TEST:	CPT:	$

INSTRUCTIONS:

OUTSIDE LAB AND X-RAY

Pt. pd. $28.00 on 7/27

TOTAL CHARGE: 78.00

METHOD OF PAYMENT:

Cash Check Other

DIAGNOSIS: renal calculi 592.0

GENERAL	ICDA	Drug Dependence	304	Ischemic Heart Dis	414.9	GENITO-URINARY		Edema	782.3
Breast Mass	611.72	Sleep Disorder	780.50	Peripheral Vas Dis	440	Abnormal Pap	788.0	Impetigo	684
Contraception	V25.09	Smoking Habit	305	Syncope	780.2	Amenorrhea	626.0	Scabies	133.0
Contraception	V25.2	NERVOUS SYSTEM		Varicose Veins	454.9	Chlamydia	078.8	Seborrheic Derm	690
Family Hst Probs	Y87	Dizziness	780.4			Dysf Uterine Bleed	626.8	Urticaria/Hives	708.9
Fatigue	780.7	Headache NS	784.0	RESPIRATORY		Dysmenorrhea	625.3	Warts	078.1
Fever	780.6	Migraine HA	346.9	Asthma	493.90	Enuresis	788.3		
Pain in Limb	787.1	Seizure Disorder	780.3	Bronchitis Acute	466.0	Menopausal Symp	627.2	MUSCULOSKELETAL	
Social/Fam Probs	Y13	Somatic Symptoms	306.9	Cough	786.2	Pelvic Inflam Dis	614.9	Joint Pain	719.40
Weight Loss	783.2	Tension HA	307.81	Dyspnea	786.09	Prostatitis	601.9	Low Back Pain	724.2
Well Adult	V700	SENSE ORGANS		Emphysema	492.8	Renal Failure	788	Low Back Strain	846.9
Well Baby/Child	V202	Serous Otitis	381.01	Influenza	487.1	Urethritis NS	597.80	Tendonitis	726
INFECTIOUS DISEASE		Eustan Tb Dysf.	381.81	Pharyngitis	462	UTI	599.0	Rheumatoid Arth	714.0
Hepatitis	070.1	Allgc Rhinitis	477.9	Pleurisy	511.0	Vaginitis/Gard	622.10	Shoulder Syndrome	717
Mono	075	Cerumen Impaction	387.1	Pneumonia	486	Vaginitis/Trich	131.01	Synovitis/Bursitis	727
ENDO/HEME		Conjunctivitis	372.30	Sinusitis	473.9	Vaginitis/Yeast	112.1	Degen Joint Dis	715.9
Anemia/Iron Def	280.9	Otitis Externa	380.1	URI Unspecified	465.9	BPH	600	Lesion:	
Diabetes Mellitus	250.00	Otitis Media	382.9	DIGESTIVE		PREGNANCY/PUERPERIUM			
Fluid Prob	276.9	CIRCULATORY DISEASE		Abdominal Pain	789.0	Pregnancy	V22.2	INJURIES	
Hypertension	244	Abnormal EKG	794.31	Constipation	564.0	Mastitis	611.0	Abrasion	958.3
Lipid Disorder	272	Atrial Fib/Flutter	427.3	Diverticl	562.9			Burn	949.0
Lymphadenopathy	785.6	Cerebrovasc Dis	438	Duodenal Ulcer	532.9	SKIN & SUBCUTAN		Contusion	924.9
Overweight	278.0	Chest Pain	786.50	Gastroenteritis	558.9	Acne	706.1	Foreign Body	959
PSYCHOLOGICAL		Ectopic Beats	427.60	GI Bleeding	578.9	Cutaneous Abscess	682.9	Fracture	829.0
Alcohol Abuse	303.0	Heart Failure	428.0	Hemorrhoids	455.6	Dermatophytosis	110.9	Laceration	870.0
Anxiety	300.0	Heart Murmur	427.5	Nausea/Vomiting	787.0	Diaper Dermatitis	691.0	Sprain	848
Depression	311	Hypertension	401.9	Pepsia Dis	536.9	Eczema/Atop Derm	692.9		

White—Patient Yellow—Insurance Pink—Office

STATEMENT

(907) 586-1005 ID NO. 541625207

NO.	PATIENT NAME	PROCEDURE	SURGERY DATE	CODES CPT #	MODIFYING FACTORS ANES STAT	MODIFYING FACTORS OTHER
1	BEVERLEE SCHNABLE	EXC ABD LIPOMA	07/19/91	00800	P1	99112

NO.	ANESTHESIA TIME START	ANESTHESIA TIME END	BASIC UNITS	TIME UNITS	MODIFIER UNITS	TOTAL UNITS	UNIT CHARGE	ANESTHESIA CHARGE	PAID TO DATE	PAY CODE	LATE CHARGES	TOTAL DUE
1	0750	0905	3	5	2	10	$36	$360.00	$210.00	S	$0.00	$150.00

THANK YOU FOR YOUR PAYMENT(S).

PAY CODES: I INSURANCE
S SELF PAYMENT
O OTHER

A LATE CHARGE OF 1½% WILL BE ADDED EACH MONTH AFTER 60 DAYS

STATEMENT

WILLIAM M. PALMER, M.D., P.C.
Surgeon
3268 HOSPITAL DR., SUITE E
JUNEAU, ALASKA 99801
PHONE: 907-586-1895

ck# 450 2-17-92 50.00

Beverlee Schnable
Box 494
Hoonah, AK. 99829-0494

276L

DATE	REFERENCE	DESCRIPTION	CHARGES	CREDITS PAYMENTS	CREDITS ADJ.	CURRENT BALANCE
		BALANCE FORWARD				
5/28/90	-26508	OV	87 -	45 -		42 -
10/1/90		RCA		12 -		30 -
11/1/90		RDA		10 -		20 -
12/3/90	27094	OV 90050	52 -	10 -		62 -
1/2/91		RDA		12 -		50 -
4/1/91		RDA		20 -		30 -
5/10/91		RDA		10 -		20 -
6/1/91		RCA pt		10 -		10 -
7/2/91		RDA - pt		10 -		0
7/15/91	2473	Pre-op	136 -			136 -
7/22/91	28476	OV	NC			136 -
7/19/91	28541	S 11406	474 -			610 -
		RCA (not paid) no letter		25 -		585 -
8/30/91		RCA pt		20 -		565 -
9/5/91	29054	OV	NC			565 -
9/26/91		RDA		20 -		545 -
11/22/91		RCA		45 -		500 -

PAY 'n SAVE

8745 OLD GLACIER HWY.
JUNEAU, AK 99801

789-0908
For Refills Call

Pay 'n Save Pharmacies. Nearby when you need us.

Rx 425076 Dr. VAUGHT, RON
BEVERLEE SCHNABLE
BOX 494
HOONAH AK 99829
907-945-3450
TAKE 1-2=TABLETS EVERY 4
HOURS AS NEEDED FOR PAIN

ACETAMIN/CODEINE 30MG
ALIGEN 00405-0008-03
10 TABS 1 REFILL
ORIG : 7/12/92 N
NOW 7/12/92
NEARBY WHEN YOU
NEED US .....

PRICE $6.99 PAY $6.99

SAVE FOR INSURANCE AND TAX RECORDS

PAY 'n SAVE

8745 OLD GLACIER HWY.
JUNEAU, AK 99801

789-0908
For Refills Call

Pay 'n Save Pharmacies. Nearby when you need us.

Rx 425075 Dr. VAUGHT, RON
BEVERLEE SCHNABLE
BOX 494
HOONAH AK 99829
907-945-3450
TAKE 1-2=TABLETS TWICE DAILY
FOR 14 DAYS

CIPRO 500MG
MILES 00026-8513-51
28 TABS NO REFILLS
ORIG 7/12/92 N
NOW 7/12/92
NEARBY WHEN YOU
NEED US .....

PRICE $86.39 PAY $86.39

SAVE FOR INSURANCE AND TAX RECORDS

SALES DRAFT
AMERICAN EXPRESS

Retain this copy for statement verification

CARDHOLDER COPY

Qty	Code	Description	Price	Amount
		KY		23.98

7-12-92 1258 X

Owner's License or Service Number 7/12/92 Date Owner's Init. 614

Sub Total
Sales Tax
Tocar 23.98

MEM. HOSPITAL
PITAL DRIVE
AK. 99801

2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
041151	7115643	131

5 SC/SS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9
079	920118538	020009	HSC2CP	

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
SCHNABLE, BEVERLEE			P.O. BOX 494	HOONAH, AK.		99829

12 BIRTH DATE	13 SEX	14 MS	15 ADMISSION DATE	16 HR.	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV.D	24 M-C D	25 C-I.D	26 L-A.D	27
01-18-44	F	S	07-15-92	21	1	7			01	07-15-92	07-15-92					

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE CD	FROM	THROUGH

34

SCHNABLE, BEVERLEE
P.O. BOX 494
HOONAH, AK. 99829

CONDITION CODES	BLOOD RECORD (PINTS)				44 SP PROG.	45	
35	36	37	38	39	40 PURN	41 REPL	42 NOT RP	43 OLD			207340937

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54 NON-COV	55	56
PHARMACY	250		1790			
LABORATORY	300		5905			
EMERGENCY SERVICE	450		6925			
PRO FEE/ER	981		10000			
-- TOTAL CHARGES --	001		28620			

APPROVED OMB NO. 0938-0279

T MEM. HOSPITAL
SPITAL DRIVE
AK. 99801
(907) 586-2611

2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
041151	7115494	131

5 SC/SS PROV NO	6 FEDERAL TAX NO	7 MEDICARE NO	8 MEDICAID NO	9
079	920118538	020009	HSC2CP	

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP
SCHNABLE, BEVERLEE			P.O. BOX 494	HOONAH, AK.		99829

12 BIRTH DATE	13 SEX	14 MS	15 ADMISSION DATE	16 HR.	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV.D	24 M-C D	25 C-I.D	26 L-A.D	27
01-18-44	F	S	07-12-92	11	1	7			01	07-12-92	07-12-92					

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE CD	FROM	THROUGH

34

SCHNABLE, BEVERLEE
P.O. BOX 494
HOONAH, AK. 99829

CONDITION CODES	BLOOD RECORD (PINTS)				44 SP PROG.	45	
35	36	37	38	39	40 PURN	41 REPL	42 NOT RP	43 OLD			207340937

46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT

50 DESCRIPTION	51 R. CODE	52 S. UNITS	53 TOTAL CHARGES	54 NON-COV	55	56
PHARMACY	250		1600			
PHARMACY-RADIOLOGY	255		3120			
MED-SUP SUPPLIES	270		250			
LABORATORY	300		17035			
EX X-RAY	320		1975C			
EMERGENCY SERVICE	450		8075			
PRO FEE/ER	981					
-- TOTAL CHARGES --	CC1		68958			

THIS COPY NOT FOR INSURANCE USE

UB-82 HCFA-1450

PATIENT COPY

Return By 4/23
(Date)

Alaska Department of Labor
Employment Security Division

MEDICAL REPORT

Notice to Claimant: In order to make a decision regarding your eligibility for unemployment insurance benefits, we need the medical information on this form. This form is to be completed by your physician. If there is no physician in your community, it may be completed by the Public Health Nurse or other official able to verify your health or physicial condition.

Physician: The individual below has reported an illness, injury or disability which may affect his/her eligibility for unemployment insurance. Your cooperation in verifying this individual's condition is appreciated.

Name	Social Security Number
Beverlee Schnable	207-34-0937

For the period from _____ to _____ please furnish the following information:

1. Beginning date of illness, ~~injury or disability~~	2. Nature of illness, ~~injury or disability~~
May 1981	Gardners Syndrome Ileostomy done for Colonic Cancer

3. Date patient was no longer able to work	4. Did you advise the patient to quit work?	5. Did you advise the patient to move to a different area?
NA	☐ Yes ☐ No	☐ Yes ☒ No

6. Did you advise the patient to change occupations?	If Yes, what type of work did you recommend?
☐ Yes ☐ No	

7. Date patient is able to work full-time	8. Are there any limitations or restrictions pertaining to the work the patient can perform?	If Yes, please describe nature of limitations
Now	☒ Yes ☐ No	See below.

9. Was individual hospitalized? ☐ Yes ☐ No	If so, give dates
	From: _____ To: _____

Remarks: This patient has had multiple abdominal wall hernias resulting from the surgery she had for her cancer — She has required prosthetic (artificial mesh) material placed in the abdominal wall for reinforcement. She is obviously at greater risk than her neighbor for a recurrent hernia. It would be best if she could limit her lifting to 50 lbs or less

Signature William M. Palmer MD Date 4/21/82

Local Office Address	Please type, stamp or print below physician's name and complete mailing address
Alaska Benefits Unit Mail Claims Section PO Box 25511 Juneau, AK 99802	WILLIAM M. PALMER, M.D. SURGEON 3288 HOSPITAL DR. SUITE E JUNEAU, ALASKA 99801 907 586-1668

07-230-018 (10/87)

Hoonah, Ak. 99829

To whom it may concern:

Bernice Schaible has been seen at this clinic 6-16, 6-30, 8-14, 8-17-95 for various conditions. Each visit her Lt Heel pain was discussed. X-ray 6-30 showed a small spur. The pain did not respond to Motrin 800 mg TID. taken for. Baker, or Indocin 50 mgm taken TID x 1 wk.

I have advised her & pick Care with an orthopedist for this. There is also the possible need for Surgery in the future if she does not respond to antiinflammable medication.

Thank you.

John Ables PA
Tribal Health Clinic

November 6, 1992

Alaska Legislature Health Resources and Access Task Force,
State Capitol
Juneau, AK 998011-1182

Dear Sir,

The Health Task Forces recommendations are worth careful consideration. My family has been effected by the health care crises. Health care insurance companies consider my mother 'high risk' and 'uninsurable'. Of my mothers five daughters, two of us have health insurance. The cost of health care prohibits routine health visits, therefore my families health care suffers. I can only hope that my family will not be affected by a illness before a comprehensive and affordable health care can be provided to them.

My family is typical. I have been a nurse for ten years and am appalled at the financial ruin that takes place because of the lack of affordable health care. It is not just financial ruin that occurs, the horrible thing I see is the lack of preventative care that could save a substantial amount of human lives.

Health care reform is an meaningful issue to me. There are several important points I would like to make regarding the Task Force Recommendations.

1) The wording should be changed from physicians to *qualified health care providers*. Physicians are not the only ones providing health care in Alaska. There are nurse practitioners, midwives, as well as others that give excellent health care in the Alaskan community. The mid-level practitioners should be recognized for the excellent health care they provide. The wording of *qualified health care providers* is critical when legislatures look to the task force for their recommendations. Financial reimbursement as well as other important issues rest on using the proper terminology used in legislature bills.

2) I was disappointed to see the emphasis on illness. Health prevention for low-income pregnant women falls short in the goal of community health prevention. Reams of literature show health prevention save a tremendous amount of money and lives. Please re-evaluate the health task focus, *prevention*, not illness should be your emphasis.

3) There are no cost containment recommendations. I realize this is a unpopular suggestion. Cost containment is critical if Alaska's

escalating health care costs are going to be stopped. Literature supports that regulation passed without a cost containment policy is useless at stopping the rapidly rising health care costs.

4) Your report did an excellent job in identifying the overgrowth of the Alaskan hospitals. Instituting a certificate of need sounds like it would work but in actuality does little in solving the problem. The certificate of need regulation does not control the increase in capital expenditures and operating costs. Furthermore hospitals have found ways around the certificate of need process, making it an ineffective tool at decreasing the cost of health care. (Study done by Saldever and Bice. *Nursing Economics*, 1985, Vol. 3, No 2, by Lanis Hicks).

5) There are 6000 nurses in Alaska. Nurses are patient advocates, one should be assigned to the board. I recognize Sister Donna's contribution but her primary responsibility is that of a hospital administrator. The appointed nurse should be active in the profession of nursing, such as a mid-level practitioner or a university nursing professor. There are several nurses that would be honored at being able to contribute to the movement to improving the health care in Alaska.

6) I was surprised at seeing in the Final Recommendation to the Governor endorsing tort reform. If it was researched, the results was not mentioned in Appendix or the Legislature report. You need to reveal the impact of law suits on hospitals and qualified health providers in Alaska prior to making recommendations regarding tort reform to the Governor.

7) Community rating insurance is an excellent idea.

Please keep me informed of the Task Forces activities. I would like to see comprehensive health care for all Alaskans. I realize there will be an increase tax burden associated with this change. We must modify the current system. We can not afford the high cost of health care which excludes people and inadequately covers others. I wish to thank you for allowing me to contribute to this important issue.

Sincerely,

Patty M. Scott

Patty M. Scott
P.O. Box 241246
Anchorage, AK 99524-1246

889 Lancaster Dr
Anchorage, AK 99503

Other concerns regarding health care in Alaska:

1. It appears that there are different charges for people with insurance and those without by health care providers.

2. Medication - increasing costs. 100 pills cost $88.00 in 1988. The charges now for the same medication is up to $118.00

3. Doctors and dentists are over the allowable amount permitted by insurance companies.

4. Provide for more liberal allowances for alternative health care providers.

5. More liberal allowances for in home health care.

6. Malpractice lawsuits need to be addressed.

7. Look at other programs that are in place and seem to be working Example Rochester, New York.

Shirley + Donald Seppi

11-14-93

Alaska Legislature Health
Resources and Access Committee
State Capitol
Juneau AK 99801-1182

Dear Sirs:

Please consider the following suggestion:

- Investigate the feasibility of a universal catastrophic health insurance, funded through a portion of the permanent fund dividend. This insurance would kick in after $5,000 or $10,000. It would replace a portion of the Medicaid payments and should lower the "good Samaritan" portion of medical fees and the cost for individual health insurance.

Thank you

Sarah Scheirman

24 October 1992

Health Resources & Access Task Force
State Capital
Juneau, Alaska 99801-1182

Dear Sir,

Since missing the teleconference date for public comment from the rural interior portion of Alaska on health reform, I wish to add my suggestions via correspondence to your report. I do want to congratulate you on the time and effort you have spent gathering your information about the health services in Alaska. I do hope you will seriously consider additional aspects as presented from your public comment hearings..

From my 50 years of experience in delivering health services with 46 of these years in Alaska and 32 in rural areas, I would like to cover two major areas of recommendation for your report.

I. DELIVERY OF SERVICES.

A. The topic for your report is *Health* yet your material is almost exclusively about *ILLNESS*. The major focus needs to be on the consumer rather than physicians and hospitals. We are never going to make a dent in reducing health costs and improving health until we start putting our major emphasis on promotion of health or wellness rather than treating illnesses. HOW?

1. Pay for primary health services at the community level wherever the consumer is comfortable - at work, in the school for the whole family and even in churches, rather than paying for excess hospital beds and equipment.

2. Provide immediate and early attention to vulnerable populations for early treatment, thus eliminating major costs for full blown treatments. Though we have excellent, expensive medical intervention for serious conditions, many could have been prevented or treated earlier at less costs and discomfort of the consumer. Fully fund home health care - look at the excellent results of groups i.e. *Hospice*.

3. Increase direct access to the whole range of qualified health providers, not just physicians. The consumer is well protected as the State of Alaska already licenses these providers and states specifically what they can do. Dr. Wilson alluded to this in his report included in your January 11, 1992 interim report. I have

been told that the average annual salary of a medical doctor is $169,000 and for a nurse $27,000, but I do not have the figures for other qualified health providers.

4. Promote consumers responsibility for self care through education and rewarding healthy life styles. The opportunities available in the schools for health education are under utilized - Why aren't the two state departments (Health & S.S. and Education) not working closely together? Who has ever supported the many requests for mandatory health education K-12 with qualified teachers? Health education needs to be promoted for all Alaskans regardless of age, stressing the individuals responsibility to care for themselves..

5. Promote the excellent available wellness programs for state employees, private companies, etc.

II, FUNDING HEALTH SERVICES.

A. You have made an excellent start with your ideas on health insurance for ALL Alaskans.

1. Besides the present private plans, we need to establish a public plan which includes the poor and buy-in's for small businesses and individuals with no workplace access. In our small rural community, 90% of the non-senior population without Medicaid coverage, have no health insurance. Most are seasonal workers with families or have small businesses but cannot afford to buy the insurance.

2. Need to have a catastrophic cap. After a basic amount is paid by the private persons insurance, the public plan pays the rest for catastrophic conditions. Our son has had diabetes for 25 years. Due to an accident which developed into osteomyelitis of the foot, he was given the choice of being dropped from his employers health insurance or loosing his job, as the companies health insurance rates had been raised so much due to his medical expenses.

3. Health insurances in the state need to include long term care for the chronically ill - children as well as seniors. They should also be required provide a uniform insurance form, accept all persons even with pre-existing health conditions, and permit individuals to carry their insurance from one work place to another. Many folks are frozen in one job and are afraid to accept other employment opportunities for fear of losing their health insurance.

B. I do not believe that TORT is the big problem which you have stated. It is reported that 8% of the physicians cause 82% of the injuries, thus it should be the responsibility of the medical boards to better police their peers.

C. To assist in funding the public health insurance plan, CHIPRA had a good idea in recommending health insurance coverage be mandatory for any Alaskan who wants a dividend check.

I am sorry this has become such a lengthy document, but I have given a lot of study to possible health reforms needed in our state. Let's make wellness and health promotion the key words.

Sincerely,

Elva R. Scott

Elva R. Scott, R.N., B.S., MEd.
AARP Health Coordinator
P. O. Box 56
Eagle City, Alaska 99738

GUY STENBER
HC31 SR5202
WASILLA AK
99657
PH - 376-4308

DEAR SIR'S

THE ALASKAN HEALTH CARE SYSTEM NEEDS TO BE COMPLETELY REBUILT,

WITH INDIVIDUALS HAVE NO EQUALITY WHEN IT COMES TO THE GOVERNMENT STATE WORKERS GET OR PEOPLE ON WELFARE OR NATIVES

THERE IS A HOSPITAL BEING BUILT IN ANCHORAGE THAT LIMITS ACCESS TO A RACE OF PEOPLE, NATIVES

SOLUTIONS

TAKE ALL STATE GOVERNMENT EMPLOYEES, OFFER TO TAKE OVER WELFARE FROM THE FEDERAL GOVERNMENT FOR THE PRICE THEY ARE NOW PAYING, HAVE A INCOME TAX FOR EVERYBODY ELSE SLIDING SCALE DEPENDANT ON TAX RETURN, REGULATE HOSPITAL CHARGES STATE WIDE, FUNNEL ALL INCOME TO PERMANANT FUND, FUNNEL ALL PAYMENTS FROM PERMANANT FUND, BALANCE BOOKS YEARLY

THE PROBLEM WITH THIS SOLUTION IS IT WILL CUT LAWYERS OUT OF MAKING MORE MONEY AND INSURANCE COMPANIES. THE CHOICE IS CLEAR A SOLUTION FOR EVERYBODY OR MORE INEQUITY

REMEMBER PRIVATE CITIZENS WORK AS HARD AS GOVERNMENT EMPLOYEE'S BUT DO NOT HAVE THE FINANCIAL RESOURCES ~~TO~~ TO GET THE SAME COVERAGE

I DO NOT FILL OUT YOUR SURVEY BECAUSE IT INCLUDES GOVERNMENT WORKERS WHO HAVE TAX FREE 100 PERCENT COVERAGE WHO ~~WOULD~~ WILL DISTORT THE SURVEY'S FINDINGS

THANK YOU

[illegible]
P. O. Box 2010
Nenana, Alaska 99811
October 27, 1992

Health Resources Task Force
State Capitol
Juneau, Alaska 99801-1101

Attn: Nancy Colwell

Dear Nancy,

I listened in on the recent teleconference put on by your task force. It was very interesting and a lot of people had valuable input. As a consequence of the conference Representative Mike Navarre and Jerry Near sent out a letter asking that the questionnaire be returned, they also requested further input via letter if we wished to do so. While I didn't get a questionnaire I would like to offer the following observation.

Since Alaska is a very large and diverse State any overall, or all encompassing, health program is bound to be inefficient and cumbersome. For example the administration of the Indian Health Program in a native village is bound to be different than in a larger town or city, as will the Public Health Nursing function, Home Health programs and etc.. I believe that each political district should plan and/or administer its own health care system in a way that best suits that particular area, this way health plans will not be fragmented, emphasis can be put on prevention and early intervention and providers can better interact with each other. To do this a plan would have to be formulated, the present funding mechanisms identified and a way made to [illegible] the present funding to the proposed plan. Allocations would be on a [illegible] basis for the various areas.

Here on the Kenai Peninsula we have been working on a comprehensive health insurance program that is intended to provide access to the health care system for all residents of the Kenai Peninsula Borough. We have not finalized the program yet but during our last workession funding data for outpatient health programs were put together by Dr. Steve Amundson, a consultant from the Fred Hutchinson Cancer Center in Seattle. I have attached a copy of the Kenai Peninsula Borough Health Care Expenditures as put together by Dr. Amundson for your review. In this study he identifies six sources of expenditures for health care on the peninsula, these six sources total over $127 million dollars, this breaks down to over $600.00 per month per family or over $251.00 per month per individual based on our population of 41,000 people and 16,000 families. If we could turn these health care expenditures into revenue for a Comprehensive Health Care Plan for the Kenai Peninsula Borough what a nice plan we could have.

Can you and your task force think of a way?

Sincerely,

Emery Thibodeau

Emery Thibodeau

Borough Health Care Expenditures (Approx.)

Data from multiple sources; most = 1991; includes recent Community Survey(U.W.) payor information

Medicare: actual expenditures, 1991, from HCFA	$7,080,000
Medicaid: currently 1,867 eligibles; total based on state capitated average	5,670,000
Private insurance: estimate half of the 51% with private insurance, or 7,125 households; ave monthly premium - $300	25,650,000
Government insurance, local and state: estimate 50% of the 51% of households with private insurance, or 7,125; ave. monthly premium - $370/month	31,650,000
Out of Pocket: national estimates = 20% of health care costs	20,000,000
State-funded services (P.H., M.H., D.D., Alcohol/Drug, etc.); state figures	35,000,000
Total:	$125,050,000

* Does not include expenditures for CHAMPUS, Fisherman's Fund, Indian Health Service

Borough population: 40,800

Average expenditure/person: $3,065 (including the approximately 7,300 (18%) with no health insurance

(The estimate of $111,000,000 based simply on the total expenditures in Alaska times the percent of the Borough population is probably a significant under-estimate.)

Bruce Amundson, M.D.

October 19, 1992

Ms. Nancy Cornwell
Project Director
Alaska State Legislature
Health Resources and Access Task Force
Juneau, AK 99801-1182

RE: Task Force continuation support options

Dear Nancy:

Thank you for the time spent with Prent Gazaway and me discussing future options to continue the work of the Task Force beyond its expiry date. During the past several weeks, I also have had the opportunity to briefly discuss my interest in the future work of Task Force and access to its documents, tapes and other materials with Dr. Rod Wilson, Mr. Jerry Near and Ms. Trish O'Gorman.

There appears to be genuine interest amongst the health care and university communities in Anchorage to continue the work of the Task Force. I am very pleased with the initial response of these colleagues, and their willingness to explore the various concepts in detail.

In particular, there is an expressed interest in the prospective federally-mandated, state or municipally-based health programming and cost-containment authorities proposed by at least one presidential candidate. Apparently, if such a "health care marshal plan" is effected, organizations like the Task Force may benefit. Your thoughts and observations on that possibility would be appreciated.

At this point, my sense is that a full-time, PhD-level health economist would be "nice but not necessary" as on-campus support from the University of Alaska Anchorage. As you pointed out, the Economics Department, the School of Business, and The Institute of Social and Economic Research (ISER) continue to be reluctant to pick up on-going administration of the Task Force without a PhD-level health services or health insurance economist onboard. However, I am confident they will continue to be available on a "job shop" basis to do other work, much like ISER does for Larry Bartlett now.

My observation is that high-quality health economics work-ups are available from the University of Washington, University of British Columbia and University of Victoria, as well as private firms with respected small-populations experience. The Task Force could continue to operated quite effectively, and utilize this type of economic analysis support for the next year or so. Of course, the "wild card" of a major federal initiative to grant blanket ERISA waivers and mandate the states and municipalities to quickly

set-up universal-access plans would certainly change that timing.

Another concept came up while talking with friends visiting for the Alaska Federation of Natives convention last week. They pointed out that the regional health boards/authorities could become involved if approached, as well as members of the Alaska Municipal League, the Association of Village Council Presidents, and similar organizations.

Still another approach could be a spin-off of the work being done by the Kenai Peninsula Borough Economic Development District. There approach makes a lot of sense, and may present some ideal opportunities, depending on the outcome of the November presidential election.

Whatever the continuing form and composition of the Task Force may be, there is little doubt that overall administrative coordination and clerical support will continue to be necessary. The services provided by your good office will be a tough act to follow in any case. However, I am confident some creative organizational and funding strategies can be worked out.

Nancy, I hope these preliminary thoughts will be helpful to you and the members of the Task Force. Perhaps we could again revisit some of these concepts during your next trip to Anchorage.

Please don't hesitate to contact me as necessary concerning any aspect of the Task Force and its outstanding work toward improving access to health care resources in Alaska.

Sincerely,

Greg S. Thies
C/O University of Alaska
School of Nursing and
Health Sciences
Health Science Resource
Center
3211 Providence Dr.
Anchorage, AK 99508
(907) 786-1294 (HSRC)
(907) 786-1211 (FAX)
UAA VAX: ATGST

P.S. I HAVE A 27 YR. LONG. ASBESTOSIS, ASTHMA, DAMAGED LUNG CONDITION, CONTRACTED IN A CHICAGO WAR PLANT WHERE WE PUT TOGETHER THE PRATT-WHITNEY 18 CYLINDER RADIAL ENGINE FOR THE B-29, 54 PER FORTRESS ENGINE.

I WAS EXPOSED TO ASBESTOS WHICH LAY IN PILES ON TABLES (NOT IN MY DEPT.) THE FEDERAL GOVT. KNEW (SEE NEW YORKER MAGAZINE JUNE, 1985 ISSUES -2) BUT NO WORKERS KNEW, AS I WAS 19 AT THE TIME & INHERITED A ROBUST, "PEASANT" HEALTHY BODY FROM WEST VIRGINIA ANCESTORS, I HAPPEN TO BE "STILL ALIVE, AFTER A FASHION" — MY DRUGS AND X-RAYS & CHECK-UPS RUN OVER $300.- A MONTH. HAVE BEEN RUSHED TO FLORENCE HOSP. 4-5 TIMES IN A

HYPERVENTILATION STATE AND HAVE PAID THESE BILLS WITH SELF PAYMENT - EXCEPT 1, FOR WHICH I REC'D HELP FROM THE FORMER "CATASTROPHIC ILLNESS" FUND WHICH I UNDERSTAND NO LONGER EXISTS (HAVE NOT BEEN HOSPITALIZED SINCE GETTING ON MEDICARE)

MY LIFE AND ANY ACTIVITIES IS CURTAILED TO A POINT OF A HANDICAPPED INVALID DUE TO THIS CONDITION - I AM A 32 YR. ALASKAN AND DID 25 YEARS OF VOLUNTEER WORK - I HAVE NOT REC'D ANY HELP FROM FEDERAL GOVT.

THIS IS A VERY CONCISE DISCRIPTION

I RECEIVE THE $250.- MO. SENIOR LONGEVITY CHECK - IF THEY CURTAIL IT - I WILL HAPPILY SELL-OUT AND LEAVE ALASKA + NO REGRETS EITHER -

GLORIA S. THOMPSON
2435 CLEMENT DR.
ANCH. 99515
345-2076

Dear Editor:

The problem of long term health care is causing desperate situations for many people. Consider the inequitable costs in the following three situations, concerning the Smiths who were middle income, the Joneses who were rich, and the Johnsons who were poor.

Mr. and Mrs. Smith came to Alaska 35 years ago and both taught school, retiring in 1980. They owned a house worth $75,000 and a car worth $5,000. They had other assets in land and $50,000 in a savings account. Their monthly state pensions amount to $3,000.

The wealthy Joneses came to Alaska 17 years ago and he worked for a private company. They own a house worth $300,000 and a car worth $30,000. They have substantial savings "hidden" in a daughter's name. Mr. Jones' private pension of $5,000 per month is paid into a trust which pays them $1,200 per month.

The Johnsons also came to Alaska 17 years ago and have lived on his modest income of $20,000 per year.

Then all three men had debilitating strokes which required long term nursing care. Mr. Smith and Mr. Jones are in Our Lady of Compassion in Anchorage where the cost of care is $8,000 per month. Mr. Johnson is in the Pioneer Home where the cost to him is $800/month

Since Mr. and Mrs. Johnson were over 65 and had been in Alaska over 15 years, they had moved into the Pioneer Home where the destitute are given preference. When he had his stroke he was moved into the full-care unit of the Home and the cost of his care is largely provided by the State of Alaska.

Now we come to the point of this story. Medicaid pays Our Lady of Compassion for well-to-do Mr. Jones' care. Mrs. Jones lives in her $300.000 home, drives her $30.000 car, and lives off her private "hidden" income; all of which her daughter will inherit.

On the other hand, Mrs. Smith has had to pay over their monthly pensions to the private nursing home, deplete their savings, sell their old house and car and their land to pay for two years of care for Mr. Smith. Because his monthly income exceeds $1,266 per month he can never qualify for Medicaid in Alaska. Mrs. Smith is bankrupt, destitute and homeless. Although she taught school for 25 years and saved her money, she has nothing tangible to show for it. Mrs. Jones and Mrs. Johnson, who did not work outside the home, however, have been taken care of by the system.

If you are rich or poor, you are taken care of, but if you are of the middle class who funded the system, you are out of luck. As Reuben Haines put it with his Chilkoot Charlie's slogan, "we cheat the other guy and pass the savings on to you." Mrs. Smith is the "other guy" who was cheated to pass the savings on to "poor" Mrs. Johnson and "rich" Mrs. Jones.

There is no moral to this story. It is all immoral.

B Turner
Beatrice
Wasilla

SUMMARY OF EIGHT COMMUNITY MEETINGS/PUBLIC HEARINGS

SUMMARY OF COMMENTS MADE AT THE
JUNEAU COMMUNITY MEETING AND SOUTHEAST TELECONFERENCE
OCTOBER 12, 1992

Senator Jim Duncan, Co-chair
Dr. Rodman Wilson, Co-chair

JUNEAU

#1-A
193

Justine Muench, consumer and nurse, spoke to the problems of lack of preventive services, physician availability, and long-term care. She cited the problem that Medicare does not cover preventive services. She recommended the health care system focus on the consumer and not the provider or insurance industry. She urged the task force to include the following items in a benefit package offered to state residents and implement it using a phased-in approach, beginning with pregnant women and children, prenatal care, preventive services, discounts for participants who control unhealthy lifestyles, primary care, out-patient surgery, homecare, hospice, long-term care of short duration, rehabilitation services to prevent institutionalization, and dental care which would include screening and cleaning. Justine requested that insurance reform legislation include affordable premiums and fair and consistent reimbursement levels. She also stated she had read CHIPRA and wanted to see the malpractice issue handled separately, since CHIPRA only addresses malpractice for doctors.

352

Linda Giannino, consumer, cited the need and benefit of preventive services and the failure by insurance companies to reimburse for these services.

SITKA
389

James Burris, an AARP member, testified in support of AARP's "Health Care America" plan.

450

John Shaffer, consumer and AARP member, expressed concern for the high cost of health care and health insurance. He cited a 20% increase in premiums in one year. He urged the task force to make insurance affordable and available.

PETERSBURG
501

Gary Grandy, Administrator of Petersburg Hospital, voiced his concern regarding federally funded hospitals competing with private hospitals. He suggested a possible change in the present federal policies (i.e., IHS patients can only stay at a private hospital 3 days, then the patient must be moved to an IHS-funded facility in Anchorage or Sitka). He recommended a system similar to Medicaid, where private hospitals could provide services and be reimbursed by the federal government in this case, IHS. He also expressed concern over the lack of available health insurance, and suggested the task force look at a 50/50 program where half of the funding for policies for the uninsured be paid out of the permanent fund and half by the State.

KETCHIKAN
569

Erma Mead, a consumer, cited several problems including the high cost of medical care, slow reimbursement process for Medicare recipients, extensive testing spurred on by defensive medicine and the high cost of medical malpractice premiums. She suggested that one claim form be used for all medical care.

JUNEAU
I-B
588

Betty Stidolph, small business owner, spoke to both the lack of available and high cost of health insurance. She expressed her concern for the small business owner who cannot afford to offer insurance to employees. She addressed the adverse impact of losing trained employees to the State or other large organizations who are able to afford health insurance. She also shared her family's experience concerning their loss of insurance when it was discovered that her husband had a condition which made him uninsurable. She urged the task force to implement a program which would emphasize preventive services and incentives for reducing utilization.

WRANGELL
502

Laureen McGee, nurse and consumer, cited several problems with the Medicare program including no preventive services or dental care reimbursement, and the number and complexity of forms. She also shared her experience in contacting Medicare representatives (took her 3 days and the representatives were uncooperative).

SITKA
457

Dick Wilson, consumer and member of the Alliance for the Mentally Ill, urged the task force to include preventive services in the benefit plan, especially for prenatal care. He explained that some forms of mental illness are linked to iron deficiencies. He was concerned by the lack of physicians in rural communities. He further urged that early intervention programs be part of the health plan the task force recommends.

KETCHIKAN
359

Lois Gordon, member of AARP, gave a brief presentation on "Health Care America", the national health care plan AARP is proposing.

317

Karen Peterson, a seasonal worker, explained that she does not have medical insurance and has not for two years. She cannot afford the high premiums. She suggests an option to purchase insurance through the State with premiums on an income/sliding scale basis with the Permanent Fund Dividend paying for a portion.

SUMMARY OF COMMENTS MADE AT THE
MAT-SU COMMUNITY MEETING AND TELECONFERENCE
GLENNALLEN, VALDEZ AND CORDOVA
OCTOBER 13, 1992

Senator Jay Kerttula, Co-Chair
Dr. Rodman Wilson, Co-Chair

WASILLA

Marjorie Campbell, consumer and worker in the health care field, expressed her concerns regarding expensive medical equipment and the practice of defensive medicine. She feels they are large contributors to the high cost of medical care. She told of a friend's experiences and their eventual move to Canada for medical treatment. She urged support for prenatal services, and the use of the Permanent Fund Dividend in funding health insurance.

Bea Turner, a retired teacher, shared her personal dilemma concerning long-term care. Her husband has Parkinson's Disease, and is still living at home. She is his primary caregiver, but has some assistance from friends. She wishes to keep her husband at home as long as possible, but fears the day will come when she will no longer be able to care for him. The waiting list to get into the Pioneer's Home is very long, and the monthly cost of placing her husband in a nursing home is exorbitant -- $8,000 - $9,000 per month. She would be required to exhaust all of their savings, and give up their car, home and any other assets before her husband could receive any help from Medicaid. She urged the task force to support AARP's "Health Care America" Plan.

CORDOVA

Brian Gilbert, Administrator of the Cordova Hospital, voiced his concern about the high cost of health care and health insurance. He expressed concerns regarding federally funded hospitals (IHS) competing with private hospitals, and the concept of health care rationing.

VALDEZ

Dan Moeller, Administrator of Valdez hospital, spoke to the problems of high medical costs (citing one incident of a patient being charged $10,000 for less than 24 hours hospital stay) and health insurance. He testified in support of universal health care.

SUMMARY OF COMMENTS MADE AT THE
DELTA JUNCTION, TOK, AND NENANA TELECONFERENCE
OCTOBER 14, 1992

Rep. Mark Boyer, Co-Chair
Karen Perdue, Co-Chair

DELTA JUNCTION

Janice Templin-Weller, a part-time public health nurse, described the impact that low funding levels from the Department of Health and Social Services has on her clients (i.e. lack of privacy in her office (space donated by the senior citizen group), and lack of phone access). Janice further addressed the access problems residents have saying a large portion of the community are either seasonal workers or self-employed and delay treatment because they lack health insurance, and in many cases, must travel to Fairbanks for treatment. If affordable health insurance were available, she believes, many would purchase it, particularly those with children.

TOK

Penny Pfeffer, a public health nurse, spoke to access problems. She stated many residents delay medical care because they must travel to Fairbanks for care, and they lack health insurance. If affordable health insurance were available, she believes many would purchase it, particularly those with children. Penny also expressed concern about the lack of emergency medical services.

SUMMARY OF COMMENTS MADE AT THE
KOTZEBUE, NOME, AND BETHEL TELECONFERENCE
OCTOBER 15, 1992

Dr. Rodman Wilson, Co-Chair
Trish O'Gorman, Co-Chair

BETHEL

Joan Hamilton, a consumer and IHS beneficiary, stated her concern for non-Natives who have no insurance coverage. She has insurance coverage through her employer for herself, and has purchased insurance for her son because she prefers to have continuity in health care, which is not available through IHS. Joan urged the task force to support preventive services. She also expressed concern regarding the slow reimbursement rate from insurance companies, and questioned the necessity of such complicated forms. She proposed that insurance companies streamline their claim forms.

KOTZEBUE

Arlys Loew, a public health nurse, testified that the health practitioner system is working very well in the villages. However, she stated access is reduced because of high travel and hotel accommodation costs. IHS pays for only one-way airplane ticket and hotel accommodations are the patient's responsibility. As a result, many delay treatment. She urged the task force to support healthy lifestyles and preventive services.

SUMMARY OF COMMENTS MADE AT THE
SOLDOTNA/KENAI, HOMER AND SEWARD
COMMUNITY MEETING AND TELECONFERENCE
OCTOBER 19, 1992

Rep. Mike Navarre, Co-Chair
Jerry Near, Co-Chair

SEWARD

Judy Aravis, a nurse, expressed her concern about the high cost of medical care and health insurance. She is in support of a pay-or-play system and preventive services. She further stated she feels it is an individual's responsibility to provide for their own care, but feels some subsidies may be necessary for pregnant women and children.

Sue Clifton, a consumer, shared her experiences with and without health insurance over the years. She urged the task force to support preventive services, low-income subsidies for pregnant women and children, and community rating. She also expressed her concern for the high cost of medical care and the high cost and lack of available health insurance. She also advocated for malpractice reform including a clear and convincing evidence clause. Sue stated it has been cheaper to pay for hospital bills than health insurance premiums.

HOMER

James Hood, testified in support of alternative medical treatment for consumers, and a single payer system.

George Plagenz, a consumer and commercial fisherman, urged the task force to act now and not to wait for the federal government to address the high cost of medical care and health insurance. He supported dedication of funds and feels the public is ready for that kind of a change in the system.

HOMER

Patricia Boily, a health care worker, expressed her concern about the high cost of medical care and health insurance. She further voiced her concern that a select few get health coverage and recommends the State provide health coverage to all Alaskans as soon as possible.

Jeanne Berger, a health care provider, testified that there are no preventive resources available. She urged support of programs which would have facilities and staff available to provide health education, nutritional counseling (particularly for pregnant women and diabetics) preventive services, and health care for pregnant women and children.

Cindy Rae Schoolcroft, a consumer, who has experienced chronic health problems and is now disabled, shared her concern about the lack of available health insurance due to pre-existing conditions. She further expressed support for patient's choice of alternative medicine.

SUMMARY OF COMMENTS MADE AT THE
FAIRBANKS COMMUNITY MEETING
OCTOBER 20, 1992

Rep. Mark Boyer, Co-Chair
Dr. David Mather, Co-Chair
Karen Perdue, Co-Chair

FAIRBANKS

Teresa Lyons, President of the Fairbanks Association of Critical Care Nurses, testified in support of fundamental health care reform. She further stated that the reform package should include health care for all Alaskans, and in particular, should address long-term care, prenatal care, basic services, and tort reform.

Anne Harrison, a nurse, spoke in support of the "Nurses Agenda for Health Care Reform", and urged support of a basic health care package. She expressed concerns regarding the pharmaceutical industry's exploitative practices. She urged the task force to support legislation which would empower the consumer.

Phyllis Hunsucker, testified in support of comprehensive health care reform. She stated she is concerned about the high cost of medical care and health insurance premiums.

Dr. Roger Harding, a pathologist at Fairbanks Hospital, expressed his views on the high cost of health insurance, and the necessity for individuals to be personally responsible. He went on to say that Medicare should be available only for those who need it.

Margaret Soden, a pharmacist who works for a small employer, testified that pharmaceutical companies are making outrageous profits. She cited problems with the obtaining insurance, including high premiums, the lack of availability in many cases, and underwriting practices. She expressed support for the Oregon plan, and urged the task force to support a benefit plan for all Alaskans.

Cedar Dvorin, a social worker, urged the task force to consider the National Association of Social Workers' plan. She is in support of a single payer system, but feels it is an individual's responsibility to contribute. She added that the Permanent Fund Dividend could provide a portion of the funding. She also urged the task force to support preventive services and drug and alcoholism treatment.

Patrick Shier, a labor negotiator for the State, testified he believes everyone is responsible for the current health care crisis. He urged all the parties to come to the table, particularly the insurance industry.

Terria Sorensen, a consumer and small business employee with no insurance coverage, expressed concern at the high cost of health care and health insurance. She is worried that should a family member become seriously ill, they would loose their home. Terria added she would be willing to contribute to purchasing health insurance if any affordable plans were available.

Marlene Leak, pediatrist, cited problems with the current system including exclusions for pre-existing conditions on health insurance policies. She opposes government involvement and the pay-or-play system. She supports tax breaks for preventive care, and the creation of pools where the premiums could be invested and later used for the individual's health care needs.

Herb Melchior, a consumer, stated there needs to be massive behavioral changes, providers need to offer better information to patients, and alternative health care should be available.

Mike Mayberry, President-elect of Staff Council for the University of Alaska, testified the University's costs for health insurance is rising dramatically. They are looking at some strategies to control costs and increasing co-payments.

Anita Bush, a critical care nurse and part-time instructor at the University, cited many have mentioned the Oregon plan and reluctantly admitted that it includes rationing. She states that what we now have is rationing, and the criteria is "your ability to pay". She is opposed to the pay-or-play approach. She expressed concern about the profound shortage of nurses, and urged the task force to look at mid-level health care providers as a large part of the solution to the access problem.

Anne Swift, a nurse, cited prevention as a major factor in reducing costs. She went on to say many people delay medical treatment and end up at the emergency room because they do not have a doctor or insurance coverage.

Wendy Rae, health care worker, testified that medical malpractice premiums and the cost of medical supplies are outrageously expensive.

Mary Giuchici, a consumer without health insurance, stated that physicians prescribe unnecessary tests, particularly if a patient has health insurance. She further stated the costs of pharmaceuticals are so much higher for humans than animals, and specifically cited the identical medication for animals are sold at a fraction of the cost.

Linda Holbert, previously employed by the Department of Health and Social Services and presently employed in the health insurance field, stated that technology has outpaced our ability to pay for it. She urged the task force to reallocate how we spend our health care dollars, with particular emphasis on prevention and prenatal care.

SUMMARY OF COMMENTS MADE AT THE
KODIAK, DILLINGHAM, AND UNALASKA
OCTOBER 21, 1992

Rep. Mike Navarre, Co-chair
Jerry Near, Co-Chair

KODIAK

Ed Meyers, Administrator of Kodiak Island Hospital, testified in support of the task force's recommendations and legislation introduced last session. He also supported universal access. He commented on the increasing problem of uncompensated care. He further stated that although their hospital is a regional hub, they are not equipped to deal with many of the medical emergencies that arise.

UNALASKA

Mike Barber, health board member, believes there is a lot of overcharging on the part of the hospitals and requests someone investigate it. He shared a personal experience of having to get a second CAT scan because someone got a finger print on the first one. He also spoke to the problems of pre-existing conditions exclusions in health insurance policies, and the practice of defensive medicine in connection with medical malpractice.

Amiee Kniaziowski, rural resident, spoke to the problems of living in a very isolated community that has no doctor. She went on to say the community does have a non-profit clinic, with a mid-level practitioner. The clinic provides health care for all the communities around Unalaska. Although they deal with major trauma, their ability to handle it is limited. She asked what kind of access rural Alaska can expect from the recommendations of the task force, and further asked that someone from the task force come to Unalaska to see the conditions they work under.

KODIAK

Harry Felton, a physicians assistant at Kodiak Island Medical Center, spoke to the shortage of health care providers in Kodiak.

Janet Burts, a consumer, Multiple Sclerosis patient, and ex-employee of a large self-insured business was laid-off when she became pregnant and was diagnosed with Multiple Sclerosis. She shared her experience with trying to get health insurance, and being turned down. She already has excessive medical bills and expects more in the future. She is currently on a COBRA policy which will expire in October. She fears it may be necessary to divorce her husband and go on welfare in order to be covered by Medicaid. She spoke in support of insurance pools where an individual could pay on a sliding scale according to their income.

Ed Barrington, President of the Alaska Chiropractic Society, spoke in support of including chiropractic treatment in the benefit package. He stated chiropractic services are no longer covered by workers compensation, or Medicare.

David Wolfe, a full-time temporary employee of the federal government (receives no medical benefits), stated he has been unable to obtain medical insurance due to a pre-existing condition (diabetes).

Tim Feller, Green Party candidate, spoke in support of community rating, and making a state health insurance pool available to all state residents. He went on to say that those who could not afford the premiums could have a portion paid by their Permanent Fund Dividend. He also urged the task force to contact Louise Tate of the Yukon Territory concerning their health system.

Tom Suthard, spoke in support of universal access, citing that all Alaskans should have access to medical care as Alaska Natives do. He supported the idea of using one half of the Permanent Fund Dividend for medical coverage and one half for an education fund.

James Joiner, a student who has no health insurance, testified that he has delayed medical treatment because of the high cost of care and insurance premiums. He urged the task force to support more mid-level health care practitioners (nurses, physicians assistants, and nurse practitioners) by developing an incentive based program.

Greg Rupert, a nursing student, spoke to the need for individuals to have more choices/responsibility for their medical care, and preventive medicine. He also advocates that more mid-level practitioners be available.

SUMMARY OF COMMENTS MADE AT THE
ANCHORAGE COMMUNITY MEETING
OCTOBER 22, 1992

Rep. Johnny Ellis, Co-Chair
Dr. Rodman Wilson, Co-Chair

Patty Hong, President of the Alaska Nurses Association, testified in favor of the "Nurses' Agenda for Health Care Reform", restructuring of prevention and health promotion programs. She cited the lack of available health insurance as a large problem.

Michael Brogan, a consumer who is self employed, mentioned the problem of excessive fraud in the present system, saying many have boats and snowmachines, but no health insurance for their children. He is opposed to universal access, and is in favor of targeted access for pregnant women and children, and low income individuals.

Daltrice Boehmer, a consumer, spoke to the problems of access for Medicare recipients (i.e. finding a doctor to accept her as a patient). She also spoke in support of alternate forms of medical treatment (including chiropractic and mid-wifery), incentives for healthy lifestyles, and more individual control over the kind of medical treatment covered by insurance.

Lucille Clark, a consumer, testified in support of alternative forms of medicine including vitamin and mineral therapy. She spoke to the problems of the high cost of medical care and health insurance premiums, adding that insurance companies practice discrimination against the aged. She also sees cost-shifting as a great problem, saying she paid $1004 for two stitches in her hand, and asserted that it was a result of other patients not paying for their care.

Dr. Robert Rowen, a physician, stated the present system is not working because it is designed to suppress symptoms, not to heal or prevent illness. He asserted that pharmaceutical companies are only interested in the profits. He spoke in support of preventive medicine and healthful lifestyles and added that there should be some incentives for those who practice it.

Lillian Wilder, a senior citizen, cited that serious cutbacks in the Department of Health and Social Services budget have impacted the elderly. She spoke in support of home health aides making visits when home deliveries of meals are made in order to regularly monitor the health of those that are home-bound.

Bill Cannon, a retired miner, spoke in support of preventive medicine, incentives for those who practice healthy lifestyles, and a voluntary plan which individuals could contribute a portion of their Permanent Fund Dividend for health insurance.

RESULTS OF TWO PUBLIC OPINION SURVEYS

CITIZEN SURVEY:

Summary Results of Citizen Survey,

Survey Results from the Community Meetings/Public Hearings,

Survey Results from the Anchorage Daily News Editorial,

Survey Results from the Anchorage Neighborhood Health Center,

Survey Results from the Anchorage Rescue Mission, and

Survey Results from Bean's Cafe

BUSINESS SURVEY:

Survey Results from Alaskan Businesses

The Task Force circulated two surveys asking Alaskans to express their confidence in and concerns about our current health care system. One survey was designed for the general public, the second for business representatives.

Four hundred and sixty-two (462) general public or "citizen" surveys were returned to the Task Force. They included 124 from our community meetings/public hearings, 243 from the Anchorage Daily News (who put the survey in their editorial column), 79 from the Anchorage Neighborhood Health Center, 6 from the Anchorage Rescue Mission, and 10 from Bean's Cafe. The summary results of the entire 462 surveys are reported in this appendix as well as, separate reports for each of the different sources.

The business survey was distributed at the Alaska State Chamber of Commerce meeting. Thirty surveys were returned. Those survey results are reported separately.

Obviously, the survey results were not generated using a random method, but nonetheless, they did give the Task Force some indication of the confidence and concerns Alaskans have about our health care system.

Surveys were distributed between October and November 1992.

SUMMARY RESULTS OF CITIZEN SURVEY

Four hundred and sixty-two surveys were returned to the task force from the Anchorage Daily News editorial, Anchorage Neighborhood Health Center, Anchorage Rescue Mission, Bean's Cafe, and community meetings and teleconferences. The following results include the number of responses for each question and percent of respondents for each question.

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (450 responded to the question)

   11% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (50 responses)

   60% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (269 responses)

   28% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (126 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (425 responded to the question)

      46% A great deal (197 responses)
      36% Quite a lot (152 responses)
      19% Not much (80 responses)
       4% Not at all (15 responses)
       0% Not sure (2 response)

   b. That you will have to pay a much larger premium for your current health care plan (439 responded to the question)

      40% A great deal (175 responses)
      35% Quite a lot (152 responses)
      19% Not much (82 responses)
       4% Not at all (18 responses)
       3% Not sure (12 response)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (458 responded to the question)

47% A great deal (215 responses)
38% Quite a lot (174 responses)
13% Not much (58 responses)
1% Not at all (6 responses)
1% Not sure (5 responses)

d. Losing health insurance coverage which you have now (425 responded to the question)

38% A great deal (160 responses)
29% Quite a lot (123 responses)
22% Not much (95 responses)
8% Not at all (35 responses)
3% Not sure (12 responses)

e. That the benefits under your current health care plan will be cut back substantially (425 responded to the question)

38% A great deal (160 responses)
37% Quite a lot (159 responses)
19% Not much (79 responses)
4% Not at all (16 responses)
3% Not sure (14 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (440 responded to the question)

94% Agree (415) 6% Disagree (25)

b. Ensuring access to basic health services for all Alaskans? (430 responded to the question)

96% Agree (413) 4% Disagree (17)

4. How important an issue should the reform of Alaska's health care system be for state officials? (447 responded to the question)

21% Single most important issue (93)
76% One of several important issues (341)
3% Not at all important (13)

5. Do you currently have health care coverage? (440 responded to the question)

85% Yes (375) 15% No (65)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (354 responded to the question)

67% Yes (237) 33% No (117)

If you answered yes, who are those persons? (Based on 237 "yes" responses)

63% Your child (149 responses)
47% Your parent (111 responses)
42% A sibling (99 responses)
48% Your spouse (113 responses)

7. Are you a health care provider or employed in the health care field? (381 responded to the question)

27% Yes (102) 73% No (279)

SURVEY RESULTS
COMMUNITY MEETINGS AND PUBLIC HEARINGS

One hundred and twenty-four surveys were returned to the task force from the community meetings and teleconferences. The following results include the number of responses for each question and percent of respondents for each question.

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (118 responded to the question)

   4% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (5 responses)

   69% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (82 responses)

   26% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (31 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (112 responded to the question)

      42% A great deal (47 responses)
      38% Quite a lot (43 responses)
      17% Not much (19 responses)
       2% Not at all (2 responses)
       1% Not sure (1 response)

   b. That you will have to pay a much larger premium for your current health care plan (121 responded to the question)

      30% A great deal (36 responses)
      48% Quite a lot (58 responses)
      19% Not much (23 responses)
       2% Not at all (3 responses)
       1% Not sure (1 response)

   c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (122 responded to the question)

      37% A great deal (45 responses)
      51% Quite a lot (62 responses)
      12% Not much (15 responses)

d. Losing health insurance coverage which you have now (118 responded to the question)

33% A great deal (39 responses)
36% Quite a lot (42 responses)
23% Not much (27 responses)
6% Not at all (7 responses)
3% Not sure (3 responses)

e. That the benefits under your current health care plan will be cut back substantially (121 responded to the question)

32% A great deal (39 responses)
45% Quite a lot (55 responses)
20% Not much (24 responses)
2% Not sure (3 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (116 responded to the question)

97% Agree (112) 3% Disagree (4)

b. Ensuring access to basic health services for all Alaskans? (119 responded to the question)

98% Agree (117) 2% Disagree (2)

4. How important an issue should the reform of Alaska's health care system be for state officials? (118 responded to the question)

21% Single most important issue (25)
78% One of several important issues (92)
1% Not at all important (1)

5. Do you currently have health care coverage? (120 responded to the question)

84% Yes (101) 16% No (19)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (99 responded to the question)

69% Yes (68) 31% No (31)

If you answered yes, who are those persons? (Based on 68 "yes" responses)

57% Your child (39 responses)
47% Your parent (32 responses)
40% A sibling (27 responses)
41% Your spouse (28 responses)

7. Are you a health care provider or employed in the health care field? (107 responded to the question)

23% Yes (25) 77% No (82)

SURVEYS RESULTS FROM
ANCHORAGE DAILY NEWS EDITORIAL
OCTOBER 25, 1992

Results from the 243 Anchorage Daily News surveys returned to the task force are as follows:

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (237 responded to the question)

   9% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (22 responses)

   55% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (131 responses)

   35% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (84 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (241 responded to the question)

      44% A great deal (105 responses)
      37% Quite a lot (90 responses)
      16% Not much (38 responses)
       3% Not at all (8 responses)

   b. That you will have to pay a much larger premium for your current health care plan (231 responded to the question)

      48% A great deal (112 responses)
      30% Quite a lot (69 responses)
      18% Not much (41 responses)
       2% Not at all (5 responses)
       2% Not sure (4 responses)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (242 responded to the question)

54% A great deal (131 responses)
32% Quite a lot (78 responses)
12% Not much (29 responses)
1% Not at all (3 responses)
.5% Not sure (1 responses)

d. Losing health insurance coverage which you have now (220 responded to the question)

44% A great deal (97 responses)
25% Quite a lot (56 responses)
21% Not much (47 responses)
8% Not at all (18 responses)
1% Not sure (2 responses)

e. That the benefits under your current health care plan will be cut back substantially (222 responded to the question)

44% A great deal (98 responses)
33% Quite a lot (73 responses)
19% Not much (43 responses)
2% Not at all (4 responses)
2% Not sure (4 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (235 responded to the question)

93% Agree (219) 7% Disagree (16)

b. Ensuring access to basic health services for all Alaskans? (220 responded to the question)

95% Agree (209) 5% Disagree (11)

4. How important an issue should the reform of Alaska's health care system be for state officials? (238 responded to the question)

21% Single most important issue (51)
75% One of several important issues (178)
4% Not at all important (9)

5. Do you currently have health care coverage? (225 responded to the question)

92% Yes (208) 8% No (17)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (168 responded to the question)

62% Yes (104) 38% No (64)

If you answered yes, who are those persons? (Based on 104 who answered yes to the question)

69% Your child (72)
47% Your parent (49)
46% A sibling (48)
47% Your spouse (49)

7. Are you a health care provider or employed in the health care field? (180 responded to the question)

24% Yes (43) 76% No (137)

SURVEY RESULTS FROM
ANCHORAGE NEIGHBORHOOD HEALTH CENTER

Results from the 79 surveys returned to the task force from the Anchorage Neighborhood Health Center are as follows:

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (76 responded to the question)

   28% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (21 responses)

   64% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (49 responses)

   8% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (6 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (56 responded to the question)

      66% A great deal (37 responses)
      29% Quite a lot (16 responses)
      38% Not much (21 responses)
      4% Not at all (2 responses)
      2% Not sure (1 response)

   b. That you will have to pay a much larger premium for your current health care plan (71 responded to the question)

      28% A great deal (20 responses)
      30% Quite a lot (21 responses)
      21% Not much (15 responses)
      13% Not at all (9 responses)
      8% Not sure (6 responses)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (78 responded to the question)

40% A great deal (31 responses)
37% Quite a lot (29 responses)
17% Not much (13 responses)
3% Not at all (2 responses)
4% Not sure (3 responses)

d. Losing health insurance coverage which you have now (71 responded to the question)

30% A great deal (21 responses)
25% Quite a lot (18 responses)
24% Not much (17 responses)
11% Not at all (8 responses)
10% Not sure (7 responses)

e. That the benefits under your current health care plan will be cut back substantially (67 responded to the question)

30% A great deal (20 responses)
36% Quite a lot (24 responses)
18% Not much (12 responses)
9% Not at all (6 responses)
7% Not sure (5 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (76 responded to the question)

93% Agree (71) 7% Disagree (5)

b. Ensuring access to basic health services for all Alaskans? (77 responded to the question)

96% Agree (74) 4% Disagree (3)

4. How important an issue should the reform of Alaska's health care system be for state officials? (77 responded to the question)

17% Single most important issue (13)
79% One of several important issues (61)
4% Not at all important (3)

5. Do you currently have health care coverage? (79 responded to the question)

67% Yes (53) 33% No (26)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (73 responded to the question)

75% Yes (55) 25% No (18)

If you answered yes, who are those persons? (Based on 55 who answered yes to the question)

58% Your child (32)
44% Your parent (24)
40% A sibling (22)
56% Your spouse (31)

7. Are you a health care provider or employed in the health care field? (78 responded to the question)

41% Yes (32) 59% No (46)

SURVEY RESULTS FROM
ANCHORAGE RESCUE MISSION

Results from the 6 surveys returned to the task force from the Anchorage Rescue Mission are as follows:

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (4 responded to the question)

   0% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (0 responses)

   100% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (4 responses)

   0% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (0 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (6 responded to the question)

      50% A great deal (3 responses)
      17% Quite a lot (1 responses)
      17% Not much (1 responses)
      17% Not at all (1 responses)

   b. That you will have to pay a much larger premium for your current health care plan (6 responded to the question)

      50% A great deal (3 responses)
      17% Quite a lot (1 responses)
      33% Not much (2 responses)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (6 responded to the question)

67% A great deal (4 responses)
33% Quite a lot (2 responses)

d. Losing health insurance coverage which you have now (6 responded to the question)

17% A great deal (1 responses)
50% Quite a lot (3 responses)
17% Not much (1 responses)
17% Not at all (1 responses)

e. That the benefits under your current health care plan will be cut back substantially (6 responded to the question)

17% A great deal (1 responses)
50% Quite a lot (3 responses)
0% Not much (0 responses)
33% Not at all (2 responses)
2% Not sure (4 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (4 responded to the question)

100% Agree (4) 0% Disagree (0)

b. Ensuring access to basic health services for all Alaskans? (6 responded to the question)

100% Agree (6) 0% Disagree (0)

4. How important an issue should the reform of Alaska's health care system be for state officials? (6 responded to the question)

0% Single most important issue (0)
100% One of several important issues (6)
0% Not at all important (0)

5. Do you currently have health care coverage? (6 responded to the question)

67% Yes (4) 33% No (2)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (6 responded to the question)

83% Yes (5) 17% No (1)

If you answered yes, who are those persons? (Based on 5 who answered yes to the question)

60% Your child (3)
17% Your parent (1)
0% A sibling (0)
33% Your spouse (2)

7. Are you a health care provider or employed in the health care field? (6 responded to the question)

0% Yes (0) 100% No (6)

SURVEY RESULTS FROM
BEAN'S CAFE

Results from the 10 surveys returned to the task force from Bean's Cafe are as follows:

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (10 responded to the question)

   20% Responded that on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better. (2 responses)

   30% Responded that there are some good things in our health system, but fundamental changes are needed to make it work better. (3 responses)

   50% Responded that the Alaskan health care system has so much wrong with it that we need to completely rebuild it. (5 responses)

2. To what extent do you worry about the following problems?

   a. Having to pay very expensive medical bills which are not covered by health insurance (10 responded to the question)

      50% A great deal (5 responses)
      20% Quite a lot (2 responses)
      10% Not much (1 responses)
      20% Not at all (2 responses)

   b. That you will have to pay a much larger premium for your current health care plan (10 responded to the question)

      40% A great deal (4 responses)
      30% Quite a lot (3 responses)
      10% Not much (1 responses)
      10% Not at all (1 response)
      10% Not sure (1 response)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (10 responded to the question)

40% A great deal (4 responses)
30% Quite a lot (3 responses)
10% Not much (1 response)
10% Not at all (1 response)
10% Not sure (1 response)

d. Losing health insurance coverage which you have now (10 responded to the question)

20% A great deal (2 responses)
40% Quite a lot (4 responses)
30% Not much (3 responses)
10% Not at all (1 responses)

e. That the benefits under your current health care plan will be cut back substantially (9 responded to the question)

33% A great deal (3 responses)
44% Quite a lot (4 responses)
0% Not much (0 responses)
11% Not at all (1 responses)
11% Not sure (1 responses)

3. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state government should play a more active role in:

a. Controlling rising health care costs? (9 responded to the question)

100% Agree (9) 0% Disagree (0)

b. Ensuring access to basic health services for all Alaskans? (8 responded to the question)

88% Agree (7) 12% Disagree (1)

4. How important an issue should the reform of Alaska's health care system be for state officials? (8 responded to the question)

50% Single most important issue (4)
50% One of several important issues (4)
0% Not at all important (0)

5. Do you currently have health care coverage? (10 responded to the question)

90% Yes (9) 10% No (1)

6. In a medical emergency, would you feel financially responsible to help pay the medical bills of some family member who currently does not have health insurance? (8 responded to the question)

63% Yes (5) 38% No (3)

If you answered yes, who are those persons? (Based on 5 who answered yes to the question)

60% Your child (3)
100% Your parent (5)
100% A sibling (5)
60% Your spouse (3)

7. Are you a health care provider or employed in the health care field? (10 responded to the question)

20% Yes (2) 80% No (8)

SURVEY RESULTS FROM ALASKAN BUSINESSES

Thirty-three surveys were returned to the Health Resources and Access Task Force on Business' Views on the current health care system. The following results include the number of responses for each question and percent of respondents for each question.

1. Which of the following statements comes closest to expressing your overall view of the health care system in Alaska? (30 responded to the question)

   37% On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better (11 responses)

   47% There are some good things in our health care system, but fundamental changes are needed to make it work better (14 responses)

   17% The Alaskan health care system has so much wrong with it that we need to completely rebuild it (5 responses)

2. Do you currently have health care coverage? (32 responded to the question)

   97% Yes (31 responses) 3% No (1 response)

3. Do you provide health care coverage to your full-time workers? (28 responded to the question)

   79% Yes (22 responses) 21% No (6 responses)

4. To what extent do you or your workers worry about the following problems? (Please check the appropriate item, indicating the degree to which your are concerned about each.)

   a. Having to pay very expensive medical bills which are not covered by health insurance (29 responded to the question)

   31% A Great Deal (9 responses)
   14% Quite A Lot (4 responses)
   48% Not Much (14 responses)
   7% Not At All (2 responses)

b. That you will have to pay a much larger premium for your current health care plan (31 responded to the question)

29% A Great Deal (9 responses)
32% Quite A Lot (10 responses)
29% Not Much (9 responses)
10% Not At All (3 responses)

c. That your out-of-pocket costs for medical bills will increase rapidly over the next few years (30 responded to the question)

40% A Great Deal (12 responses)
30% Quite A Lot (9 responses)
30% Not Much (9 responses)
0% Not At All (0 responses)

d. Losing health insurance coverage which you have now (29 responded to the question)

24% A Great Deal (7 responses)
34% Quite A Lot (10 responses)
24% Not Much (7 responses)
17% Not At All (5 responses)

e. That the benefits under your current health care plan will be cut back substantially (28 responded to the question)

21% A Great Deal (6 responses)
57% Quite A Lot (16 responses)
18% Not Much (5 responses)
4% Not At All (1 responses)

5. If you do not provide health care coverage for your full-time workers, have you ever tried to get coverage and (answer both a and b)

a. been denied coverage because of the type of work you do? (11 responded to the question)

0% Yes (0 responses) 100% No (11 responses)

b. been denied coverage because of the health status of your workers or their dependents (10 responded to the question)

20% Yes (2 responses) 80% No (8 responses)

c. been offered coverage but at a very high rate that was unaffordable to you. (10 responded to the question)

40% Yes (4 responses) 60% No (6 responses)

6. Please indicate below whether you agree that, in the absence of national health care reform, the Alaska state Government should play a more active role in:

	Agree	Disagree
a. Controlling rising health care costs? (29 responded)	79% (23)	21% (6)
b. Ensuring access to basic health services for all Alaskans? (28 responded)	57% (16)	43% (12)

7. How important an issue should the reform of Alaska's health care system be for state officials? (Please check one) (30 responded to the question)

0% Single most important issue (0 responses)

77% One of several important issues (23 responses)

23% Not at all important (7 responses)

8. a. Are you a health care provider or employed in the health care field? (28 responded to the question)

4% Yes (1 responses) 96% No (27 responses)

b. Are you employed in the health care field? (31 responded to the question)

3% Yes (1 response) 97% No (30 responses)

GUIDING PRINCIPLES

For each of the following guiding principles, please tell us whether you agree or disagree with each principle.

1. All Alaskans should have access to timely, appropriate, and adequate health care without regard to personal financial means. (Please check one.) (30 responded to the question)

   23% Strongly Agree (7 responses)
   40% Somewhat Agree (12 responses)
   20% Slightly Opposed (6 responses)
   17% Very Opposed (5 responses)

2. A basic level of health care should include prevention, primary care, early diagnosis and treatment and incentives for healthful lifestyles. (Please check one.) (29 responded to the question)

   41% Strongly Agree (12 responses)
   41% Somewhat Agree (12 responses)
   7% Slightly Opposed (2 responses)
   10% Very Opposed (3 responses)

3. All Alaskans have a responsibility to obtain and pay for adequate health care for themselves and their dependents. It is the responsibility of society at large to adequately finance care for those unable to pay. (Please check one) (27 responded to the question)

   15% Strongly Agree (4 responses)
   33% Somewhat Agree (9 responses)
   33% Slightly Opposed (9 responses)
   19% Very Opposed (5 responses)

4. Responsibility for the financing of care should be equitably distributed among payers. (Please check one.) (28 responded to the question)

   25% Strongly Agree (7 responses)
   36% Somewhat Agree (10 responses)
   25% Slightly Opposed (7 responses)
   14% Very Opposed (4 responses)

10. Individuals should have an informed and reasonable choice in selecting health care providers. However, they may be restricted to certain providers in cases where such arrangements are more cost-effective. (Please check one.) (28 responded to the question)

29% Strongly Agree (8)
46% Somewhat Agree (13)
7% Slightly Opposed (2)
18% Very Opposed (5)

11. Systems to maintain and expand access and control costs should be as simple to administer as possible. (Please check one.) (28 responded to the question)

86% Strongly Agree (24)
11% Somewhat Agree (3)
0% Slightly Opposed (0)
4% Very Oppose (1)

12. Design of programs should be sensitive to cultures and community needs, including the special problems in rural areas of access and availability of providers. (Please check one.) (26 responded to the question)

27% Strongly Agree (7)
58% Somewhat Agree (15)
12% Slightly Opposed (3)
4% Very Opposed (1)

13. A public health system based on the core functions of assessment, policy development, and assurance of essential public health services must be established and maintained as the foundation of an effective health program for Alaska. (Please check one.) (28 responded to the question)

14% Strongly Agree (4)
43% Somewhat Agree (12)
29% Slightly Opposed (8)
14% Very Opposed (4)

5. Health care costs can be extended to everyone only if overall costs are contained. Duplicate coverage should be avoided. (Please check one.) (28 responded to the question)

54% Strongly Agree (15)
36% Somewhat Agree (10)
7% Slightly Opposed (2)
4% Very Opposed (1)

6. Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay. (Please check one.) (26 responded to the question)

12% Strongly Agree (3)
62% Somewhat Agree (16)
12% Slightly Opposed (3)
15% Very Opposed (4)

7. Health care should be provided in the most efficient and cost effective manner and location and may include contractual arrangements for patient management and utilization controls. (Please check one.) (28 responded to the question)

50% Strongly Agree (14)
36% Somewhat Agree (10)
7% Slightly Opposed (2)
7% Very Opposed (2)

8. Payments to providers should be reasonable and fair. (Please check one.) (29 responded to the question)

72% Strongly Agree (21)
24% Somewhat Agree (7)
0% Slightly Opposed (0)
3% Very Opposed (1)

9. Health services based on disease prevention, health promotion, and health protection must be promoted as a major influence on cost containment. (Please check one.) (28 responded to the question)

43% Strongly Agree (12)
50% Somewhat Agree (14)
4% Slightly Opposed (1)
4% Very Opposed (1)

10. Individuals should have an informed and reasonable choice in selecting health care providers. However, they may be restricted to certain providers in cases where such arrangements are more cost-effective. (Please check one.) (28 responded to the question)

29% Strongly Agree (8)
46% Somewhat Agree (13)
7% Slightly Opposed (2)
18% Very Opposed (5)

11. Systems to maintain and expand access and control costs should be as simple to administer as possible. (Please check one.) (28 responded to the question)

86% Strongly Agree (24)
11% Somewhat Agree (3)
0% Slightly Opposed (0)
4% Very Oppose (1)

12. Design of programs should be sensitive to cultures and community needs, including the special problems in rural areas of access and availability of providers. (Please check one.) (26 responded to the question)

27% Strongly Agree (7)
58% Somewhat Agree (15)
12% Slightly Opposed (3)
4% Very Opposed (1)

13. A public health system based on the core functions of assessment, policy development, and assurance of essential public health services must be established and maintained as the foundation of an effective health program for Alaska. (Please check one.) (28 responded to the question)

14% Strongly Agree (4)
43% Somewhat Agree (12)
29% Slightly Opposed (8)
14% Very Opposed (4)