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# FISCAL NOTE

STATE OF ALASKA  
1994 LEGISLATIVE SESSION

BILL NO. HB 468

Revision Date: \_\_\_\_\_ Dept. Affected: Administration  
 Title: "An Act extending the termination date of the BRU: Office of the Commissioner  
Citizens' Review Panel for Permanency Planning" Component: Permanency Planning Board  
 Sponsor: Rep. Toohy  
 Requestor: (H) Hes COMPONENT SERIAL NO. 1888

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
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CHANGE IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of current year (FY94) cost: none

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Roberley Waldron, Deputy Commissioner Phone: 258-6117  
 Division: Commissioner's Office Date: \_\_\_\_\_  
 Approved by Commissioner: Nancy Bear Usura Date: 3/4/94  
 Agency: Administration

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Official Business

# Alaska State Legislature

## HOUSE OF REPRESENTATIVES

REPRESENTATIVE CYNTHIA TOOHEY

State Capitol  
Juneau, AK 99801-1182

DISTRICT 13  
SPONSOR STATEMENT

HOUSE BILL 468

### "An Act extending the termination date of the Citizens' Review Panel for Permanency Planning."

House Bill 468 would extend the termination date of the Citizens' Review Panel for Permanency Planning to 1997. This would be in accordance with the recommendation of the Division of Legislative Audit which completed an audit in September of 1993.

The enabling legislation had bi-partisan support and passed both the House and the Senate unanimously in 1990. It established an external citizens' review process in order to ensure that children do not languish in out-of-home placements, but receive the benefits of a permanent home. The goal of the act was to reunite children with their families, but in those cases where reunification was not in the best interest of the child, the process would expeditiously place the child in a secure, permanent home.

DOA originally made a decision not to implement the panels. It has only been in FY94, the year the panels are scheduled to sunset, that DOA is implementing pilot panels in Anchorage, so there is not yet adequate information to analyze the panels' effectiveness. External citizens' reviews have been on-going as a model project only since mid-December of 1993. Although functional for just a short period of time, the panel submitted an annual report to the legislature.

According to the report, public acceptance of the external review process has been excellent. The office has received numerous calls from parents requesting that their child be reviewed by the citizens' review panels. Foster parents have stated they appreciate being a part of the external review process. The office has been able to provide assistance to Native village councils regarding some procedures.

Citizen Review Panels are in existence in 24 states. It has been shown that not only can children spend less time in out-of-home placements, but cost-savings can result. Your support and co-sponsorship would be appreciated. There is a zero fiscal note.

SPONSOR STATEMENT

CG

CITIZEN'S REVIEW PANEL FOR PERMANENCY PLANNING  
ANNUAL REPORT TO THE LEGISLATURE  
JANUARY 1994

STATE OF ALASKA  
WALTER J. HICKEL, GOVERNOR  
DEPARTMENT OF ADMINISTRATION

900 West Fifth Avenue Suite 710 Anchorage, Alaska 99501  
Telephone: 907/258-6104 FAX number: 907/258-1651

CITIZENS' REVIEW PANEL FOR PERMANENCY PLANNING

MISSION STATEMENT

As stated in the findings and purpose section of Alaska Statute 47.10.400, the Citizens' Review Panel for Permanency Planning has a twofold mission:

1. to establish a process to ensure that children do not linger unnecessarily in out-of-home placements; and,
2. to reunite children with their families by advocating for available and appropriate services to promote reunification. or if the reunification is not in the best interest of the child, to ensure that the child is placed in a permanent home as expeditiously as possible.

CITIZENS' REVIEW PANELS FOR PERMANENCY PLANNING  
SUMMARY OF ACTIVITY  
Fiscal Year 94

The Legislature appropriated \$125,000 for FY94 for the Citizens' Review Panels, a program that provides for external reviews of children in out-of-home placement in the interest of determining a permanent placement. Permanent placement could mean unification with family, adoption, emancipation, or extended out-of-home care.

Planning for implementation began prior to the beginning of the fiscal year. Information from other states was gathered and reviewed to find programs that could be tailored to fit Alaska's situation. The final product uses parts from several states. The program is in Anchorage where half of the children in out-of-home care reside. It was designed to be a model program so that expansion could more easily occur should other funding become available. Since reviews will take place only in Anchorage, the administrative members of the state-wide panel became an advisory board. This avoided the necessity of appointing local panels in an area where citizen reviews would not take place and saved time and expenses for travel of the state-wide panel.

Roberley Waldron supervises the program. The Governor's office was asked to appoint twenty or more citizen panelists. Twenty-one members were appointed and currently there are 15 active panelists.

The program has progressed as follows:

- \* The advisory board met several times to plan for implementation.
- \* A contract was negotiated with a social worker-attorney to devise procedures, forms, etc. to meet all state and federal standards.
- \* The list of panelists was received from the Governor's office on October 29, 1993.
- \* An administrative assistant and social worker III were hired in October, a social worker II in November.
- \* Training of panelists was accomplished in November and the list of children to be reviewed was received.
- \* Seventeen children were reviewed in December.
- \* Twenty-six children have been referred for review in January.

Comments from all associated parties regarding the process have been very favorable. The foster parents are particularly pleased to be included. Several calls have been received from parents asking that their child be reviewed by the panel (referrals are received from the court).

Here is a sample statement from a foster parent regarding her participation in the review process: "This is my first opportunity to comment to the review process. One concern I would like to share is the value of keeping the foster parents apprised of the

status of the case plan. (Child's name) lives in our home. She is a member of our family at this point and we love her. We are concerned about her and work to better her future through DFYS. We think of foster parenting as a team effort and appreciate being included in decisions that touch our lives to the core."

A Social worker wrote in her evaluation, "The panel opened up in my mind a potential resource to further explore for this child."

The review process is complex. A great deal of time and effort is spent in gathering information from the Division of Family and Youth Services (DFYS) files and prepared report for the panelists. At times the information is incomplete which is a deterrent to a good review. It takes about three hours to gather material at DFYS, at least two hours to write a summary of the material to be sent to the panels, and the actual citizens' review requires about one and one-half hours. The panelists and staff are extremely conscientious and take their responsibilities very seriously.

At the end of the fiscal year, OMB will review the data from the external reviews and compare with data from DFYS. At that time, it can be better determined what effect the external reviews are having. During the short period in operation, the staff and advisory board have become convinced that the external review could replace some of the reviews currently done by DFYS. They currently have three types of reviews. The citizen reviews meet the federal guidelines and could replace those reviews required by the federal government (Title 4-E). If that should happen, the funding provided by the federal government should follow the review.

# ALASKA STATE LEGISLATURE

## LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit



P. O. Box 113300  
Juneau, AK 99811-3300  
(907) 465-3830  
FAX (907) 465-2347

September 1, 1993

Members of the Legislative Budget  
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

### DEPARTMENT OF ADMINISTRATION CITIZENS' REVIEW PANEL FOR PERMANENCY PLANNING

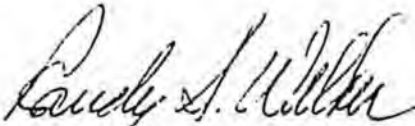
September 1, 1993

Audit Control Number

02-1420-93

The audit reports on whether the Citizens' Review Panel for Permanency Planning (the panel) should continue its existence. Currently AS 44.66.010 has the panel scheduled for termination on June 30, 1994 and provides the panel with a year in which to conclude its affairs. We recommend that the legislature extend the panel's termination date to June 30, 1997 with the provision that sufficient funds be appropriated to allow the pilot project in Anchorage to perform reviews that can be used to evaluate the economic feasibility and rate of success for citizens' reviews.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section of this report.

  
Randy S. Welker, CPA  
Legislative Auditor

## FINDINGS AND RECOMMENDATIONS

### Recommendation No. 1

The legislature should extend the Citizens' Review Panel for Permanency Planning's (the panel's) termination date to June 30, 1997 with the provision that sufficient funds be appropriated to allow the pilot project in Anchorage to perform reviews that can be used to evaluate the economic feasibility and rate of success for citizens' reviews.

Although the enabling legislation for the establishment of citizens' review panels was passed in 1990, the Department of Administration (DOA) originally made a decision to not implement the panels. It has only been in fiscal year 1994, the year the panels are scheduled to sunset, that DOA is implementing pilot panels in one Alaskan city, Anchorage. Because the panels were never established, there are no activities to analyze to determine the panels' effectiveness.

The Department of Health and Social Services (DHSS), Division of Family and Youth Services (DFYS) has been performing permanency planning reviews to meet federal requirements. However, as explained in the Analysis of Public Need section of this report, we do not find DFYS' internal reviews fulfilling the entire objectives of the State's statutes, which establish an external review process. Alaska Statute 47.10, Article 5 specifically creates a Citizens' Review Panel for Permanency Planning and prescribes the duties, appointments, and reporting requirements of the panels.

There also remains a perception among foster care providers, guardians ad litem, court system personnel, and the general public that DFYS' internal reviews do not achieve real permanency planning for children and there continues to be widespread support for citizens' review panels. Because of this perceived need, we believe that the Anchorage pilot project in citizens' panels should be continued until June 1997 to gather data to determine the panels' effectiveness. The pilot project needs to implement a system that meets federal requirements and achieves real permanency planning for children. Effectiveness can be measured by the length of time children remain in foster care and by savings associated with children no longer being part of the foster care system.

If the data from the pilot project shows that citizens' review panels are effective, then decisions need to be made on whether and how to expand the panels to other regions in Alaska. Also, if the citizens' reviews prove to meet federal requirements, DFYS will be able to stop their internal review process and concentrate their resources on case management. DOA should pursue the possibility of receiving federal funding for the activities of the citizens' panels.

## I. OVERVIEW OF REVIEW SYSTEMS

### A. PURPOSE OF FOSTER CARE REVIEW

The purpose of foster care review is to assure that children do not linger unnecessarily in foster care, but rather that they receive the support and benefits of a permanent home. Permanence is defined as a home which holds together during crisis and provides a lasting, trusting, and nurturing environment. The return of the child to the biological family is the ideal permanent goal; however, when this is not possible, the goal becomes to place the child in another stable, permanent home.

### B. IMPORTANCE OF REVIEW SYSTEMS

#### 1. Impact of Foster Care on Children

Children need the stability and support of a permanent home and family in order to grow and flourish; they need the sense of lifelong belonging and continuity that only a permanent home can provide. Children in foster care represent a huge potential loss in both financial and human terms.

It is estimated that almost half a million children pass through state foster care systems in this country every year. In fiscal year 1985, for example, federal government figures show that an average of 108,000 children were in foster care in any given month. The foster care system places a financial burden on U.S. taxpayers that was estimated at \$2 billion. The cost in human potential was- and remains- inestimable, since research indicates a direct correlation between child abuse and neglect and later juvenile delinquency and adult criminality.

When a child is placed in foster care, it is intended to be a short-term solution to an emergency situation. In the past, however, all too often foster care placements resulted in the child being destined to obscurity within the child welfare system. The ideal of assuring a permanent home for every child fell by the wayside while the child was set adrift among different foster families and group homes. The child's vital developmental years were lost, since he was neither free to return home to his natural parents nor eligible to be adopted by a new and permanent family.

Throughout the 1970's, judges, social workers, attorneys and child advocacy groups began to recognize that the U.S. foster care system was failing to respond to the needs of many abused and neglected children and their families. Many children were "adrift" in the system without regular or timely review of their placement. Crowded court calendars and understaffed child welfare agencies were contributing to an increase in the number of children and lengths of time spent in substitute care.

Concern for children lingering unnecessarily in foster care continued to mount throughout the decade. Among solutions proposed by child advocacy organizations were the comprehensive implementation of permanency planning case work and foster care placement monitoring through regular case reviews. A new resource was also identified to help monitor foster care children and to advocate on their behalf: citizen volunteers.

*(from South Carolina which has had a  
citizens review system in place since 1974.*



## ALASKA CHAPTER

## NATIONAL ASSOCIATION OF SOCIAL WORKERS ALASKA CHAPTER

1727 Wickersham Drive  
Anchorage, Alaska 99507  
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FAX (907) 563-4504

Executive Director  
Angela Salerno, ACSW

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Fairbanks

March 8, 1994

Representative Cynthia Toohey  
State Capitol  
Room 104  
Juneau, AK 99801-1182

Dear Representative Toohey:

The Alaska Chapter National Association of Social Workers fully supports HB 468 which would provide for the continuation of the Citizen's Review Panel for permanency planning in Alaska. NASW strongly advocated for the development of this review board, and continues to urge its utilization as a proven method for enhancing the effectiveness of the child protection system. We believe that through this type of review, Alaskan children now growing up in out-of-home care will have a better chance at being reunited with their families, or in finding a permanent adoptive home.

Please feel free to call me with comments or questions.

Sincerely,

Angela M. Salerno, ACSW  
Executive Director, NASW Alaska Chapter

# Alaska Foster Parent Association

---

P.O. Box 142135  
Anchorage, Alaska 99514  
FRANK WASMER, President

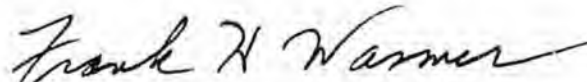
February 25, 1994

The Honorable Cynthia Toohy  
Alaska State Legislature  
P.O. Box V (MS3100)  
Juneau, Alaska 99811

Dear Representative.

We of the Alaska Foster Parent Association wish to express our heartfelt appreciation for your sponsorship of HB 468 extending the termination date of Citizen Review Panels. This process will go far in resolving continuing problems faced by neglected and abused children and the citizens who volunteer as foster parents to care for them.

We support, without qualification, the external review process under Alaska Statute 47.10.400.

  
Frank H. Wasmer



NATIONAL  
ASSOCIATION  
OF FOSTER  
CARE REVIEWERS

190 W. OSTEND STREET, SUITE 201  
BALTIMORE, MARYLAND 21230  
1-800-368-0136

Corinne F. Driver  
Executive Director  
98 Oldchester Road  
Essex Fells, NJ 07021  
201-226-0235

March 7, 1994

Representative Cynthia Toohey  
State Capitol, Room 104  
Juneau, AK 99801

Re: HB468-Citizen Review Panel for Permanency Planning

Dear Representative Toohey:

I am writing in support of the above legislation which would extend the current expiration of citizen review legislation in Alaska until June 30, 1997. NAFCR originally funded a pilot project in Anchorage in 1988, and William Hitchcock, who serves as Children's Court Master in Anchorage, is currently president of NAFCR.

It is my understanding that the implementation of citizen review has only just begun in Anchorage in the latter part of 1993. Extending the life of this legislation will enable that project to serve as a model on which further decisions can be made about funding, organization and support for a more extensive program statewide. In the experience of NAFCR, such model or pilot programs often serve as the blueprint for the design of a system that truly meets the individual state's needs.

In some 24 states across the country, citizen review systems are operating at either the state or local level. We believe that such systems are critically necessary to insure both balance and accountability in the handling of children in foster care. Alaska has a great opportunity to build its system from the base of knowledge already being amassed by the Anchorage program.

Sincerely,

cc: William D. Hitchcock  
President  
NAFCR

**Sec. 47.10.400. Citizens' review panel for permanency planning.** (a) There is created in the Department of Administration the Citizens' Review Panel for Permanency Planning. The state panel consists of five voting members appointed by the governor from among present members of local citizen review panels established under AS 47.10.420. The governor shall appoint at least one voting state panel member from each judicial district. The governor may not appoint a person who has committed a felony or violated AS 11.51.130 or a law with substantially similar elements. The panel also includes the following five nonvoting members who serve ex officio or their designees: the commissioner of health and social services, the director of the office of public advocacy, the attorney general, the public defender appointed under AS 18.85.030, and the chief justice of the Alaska Supreme Court.

(b) Appointed members of the state panel serve at the pleasure of the governor for staggered terms of three years or until their successors are appointed.

(c) The voting members of the state panel shall elect from among the voting members a chair who shall serve for one year. Three voting members of the state panel constitute a quorum for the transaction of business. The panel may not take official action without the affirmative vote of at least three of its members.

(d) Members of the state panel are entitled to reimbursement for actual expenses necessary to perform their duties as state panel members. The reimbursement may not exceed the amount of per diem and expenses authorized for boards and commissions under AS 39.20.180.

(e) The state panel shall meet twice annually. Meetings may take place telephonically.

(f) The state panel may employ a program coordinator who shall serve at the pleasure of the state panel. The program coordinator shall employ staff as necessary to carry out the program coordinator's duties under state panel directives and to provide clerical assistance to local panels. (§ 2 ch 117 SLA 1990)

**Cross references.** — For terms of initial appointees to the review panel, see § 7, ch. 117, SLA 1990 in the Temporary and Special Acts.

**Sec. 47.10.410. Duties of the state panel.** The state panel shall

- (1) by regulation adopt policies and procedures to carry out its duties and to govern the performance of the duties of the local panels established under AS 47.10.420;
- (2) ensure that local panel members receive the minimum level of training necessary to effectively carry out their duties;

A CASE FOR COMPREHENSIVE  
HEALTH CARE REFORM:  
*The Costs of Doing Nothing*



*Prepared by*



AMERICAN ASSOCIATION OF RETIRED PERSONS  
PUBLIC POLICY INSTITUTE

*October 1993*

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*For additional information, please contact:  
Health Team, Public Policy Institute, Division of Legislation and Public Policy,  
AARP, 601 E Street, N.W., Washington, DC 20049 202-434-3890*

# Without health care reform, your family's payment for the nation's health care bill will grow.

The Jones Family

PAY TO THE ORDER OF U.S. Health Care System \$9,377.24



*Bob and Belh Jones*


⑆00 2100 66⑆ 770⑆ 364076⑆ 2121

1993

2000

The Jones Family

PAY TO THE ORDER OF U.S. Health Care System \$16,983.60



*Bob and Belh Jones*

⑆00 2100 66⑆ 770⑆ 364076⑆ 2121

Prepared by AARP Public Policy Institute

SOURCE: HCFA and Bureau of Census. Figures are averages based on total national health expenditures.

## **WITHOUT HEALTH CARE REFORM, YOUR FAMILY'S PAYMENT FOR THE NATION'S HEALTH CARE BILL WILL GROW**

Description: Health care costs have risen dramatically in recent years and are expected to continue on this path under the current health care system. How much does this increase affect Americans' personal pocketbooks? This chart shows that the per-household payment for the nation's health care bill in 1993 is \$9,377. **If Congress and the President do not enact comprehensive health care reform to reduce health care costs, by the year 2000 the payment by each American household is expected to almost double to \$16,983.**

Among the items included in the household payment are health insurance premiums and cost-sharing (i.e., deductibles and coinsurance), bills for health services not covered by insurance, government taxes used for health care programs, lower wages due to rising employer contributions for health insurance, and higher product prices.

Sources: Burner, S.T., Waldo, D.R., and McKusick, D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

U.S. Department of Commerce, Bureau of the Census. "Projections of the Number of Households and Families: 1986 to 2000." Current Population Reports, Series P-25, No. 986.

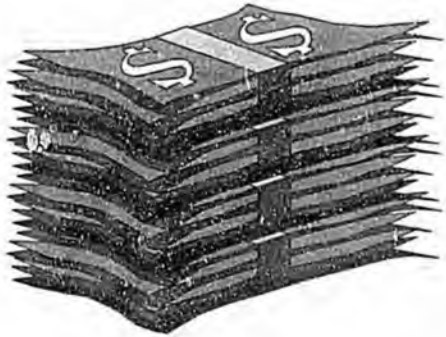
Methods: The per-household health care payment was calculated by dividing total national health expenditures for 1993 and 2000 by the total number of households projected for the same years.

Total national health expenditures, which represent all of the nation's health expenditures, include spending by all sources for personal health care, program administration, net cost of private health insurance, government public health activities, research, and construction of medical facilities. Roughly 90 percent of all health expenditures are for personal health care, which include hospital care, physician and dental services, other professional services, home health care, nursing home care, drugs and other medical non-durables, vision products and other medical durables, and other personal health care.

Series C projections (i.e., projections based on Series C assumptions) were used for the total number of households in 1993 and 2000, as this series produced a 1990 projection that was closest to the actual 1990 population.

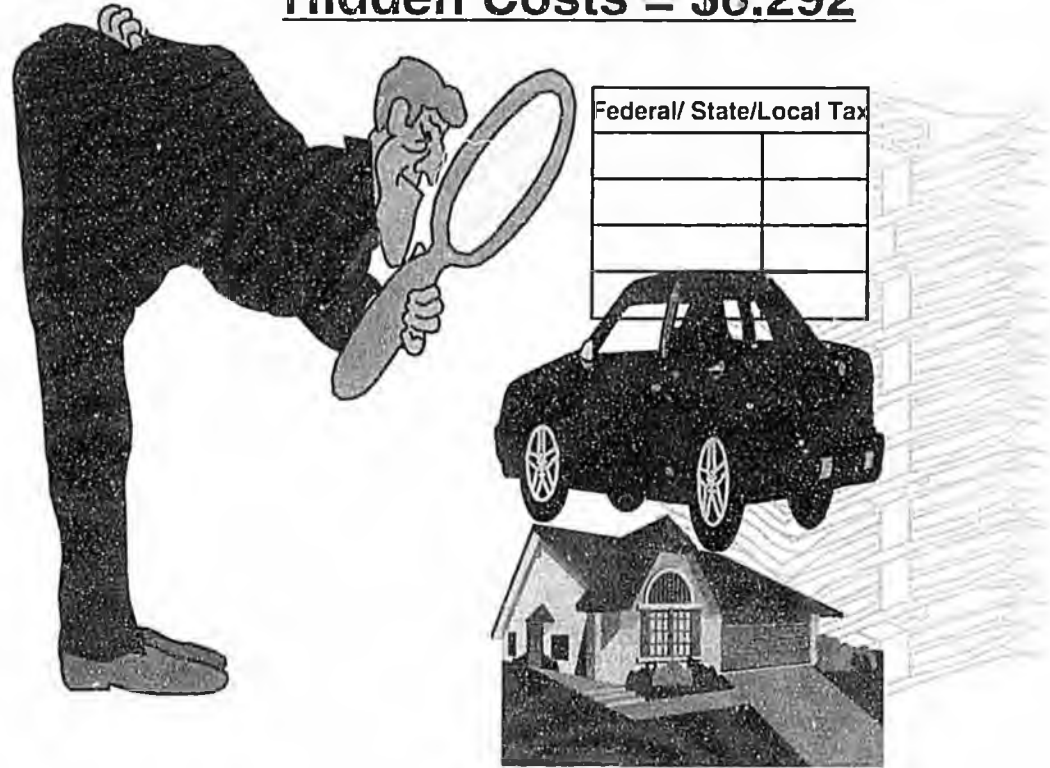
# Hidden costs are a major share of the average family's health care bill in 1993.

Visible Costs = \$3.085



Deductibles and coinsurance  
Uncovered services and goods (e.g., long term care, prescription drugs, mental health)  
Consumer health insurance premiums  
Specific taxes (Medicare Part A)

Hidden Costs = \$6.292



Higher product prices (e.g., automobiles, groceries)  
Lower wages due to employer contributions  
General taxes (e.g., property, sales, income) for public programs (e.g., Medicare Part B, Medicaid, government hospitals)

Prepared by AARP Public Policy Institute

SOURCE: HCFA, HHS, and Bureau of Census. Figures are averages based on total national health expenditures.

## HIDDEN COSTS ARE A MAJOR SHARE OF THE AVERAGE FAMILY'S HEALTH CARE BILL IN 1993

Description: Americans generally are aware of the high health care costs paid directly out of their pockets: these payments include health insurance premiums, coinsurance, deductibles, and bills for uncovered services. However, they may not be aware of all the other *larger yet hidden* ways that households pay for this country's health care. This chart shows that only about one-third of per-household spending on health care in 1993 is for costs that are "visible" to consumers. **Households pay the vast majority of their health care bill -- roughly two-thirds or \$6,292 in 1993 -- through costs that are not as readily apparent but that still come out of their pockets.** "Hidden" costs include the lower wages received because employers have to spend more on health insurance, as well as the higher consumer prices charged by manufacturers seeking to offset their rising health care costs. In addition, federal, state, and local taxes paid by residents are used to help finance government health programs, such as Medicare and Medicaid, and government-sponsored health facilities.

Sources: U. S. Department of Health and Human Services, HHS News, January 29, 1993.

Cowan, C.A. and McDonnel, P.A. "Business, Households and Governments -- Health Spending, 1991." Report of HCFA Office of the Actuary.

Burner, S.T., Waldo, D.R., and McKusick, D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

U.S. Department of Commerce, Bureau of the Census. "Projections of the Number of Households and Families: 1986 to 2000." Current Population Reports, Series P-25, No. 986.

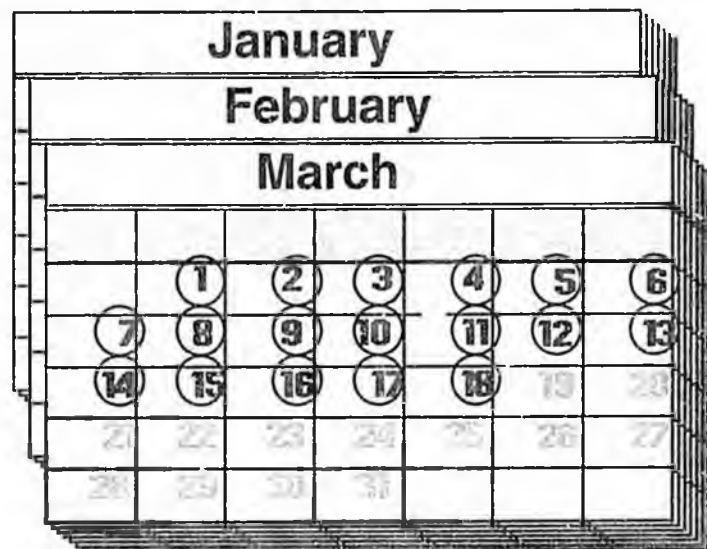
Methods: The percentage of direct vs. indirect spending on health care in 1993 was calculated by applying the actual 1991 percentages for these types of spending to the projection of per-household health care payments in 1993.

Direct spending was defined as including employee contributions to health insurance premiums, premiums for individual policies, Medicare Part B premiums, employee payroll tax and voluntary premiums for Medicare Hospital Insurance (HI) trust fund, and out-of-pocket spending. Indirect spending consisted of employer (both private and government) contributions to health insurance premiums, employer contributions to Medicare HI trust fund, workers' compensation and disability insurance, industrial implant health services, non-patient revenue, research and construction, and federal, state and local health programs.

The per-household health care payment was calculated by dividing total national health expenditures by the total number of households projected for 1993. Total national health expenditures, which represent all of the nation's health expenditures, include spending by all sources for personal health care, program administration, net cost of private health insurance, government public health activities, research and construction of medical facilities. Series C projections (i.e., projections based on Series C assumptions) were used for the total number of households in 1993.

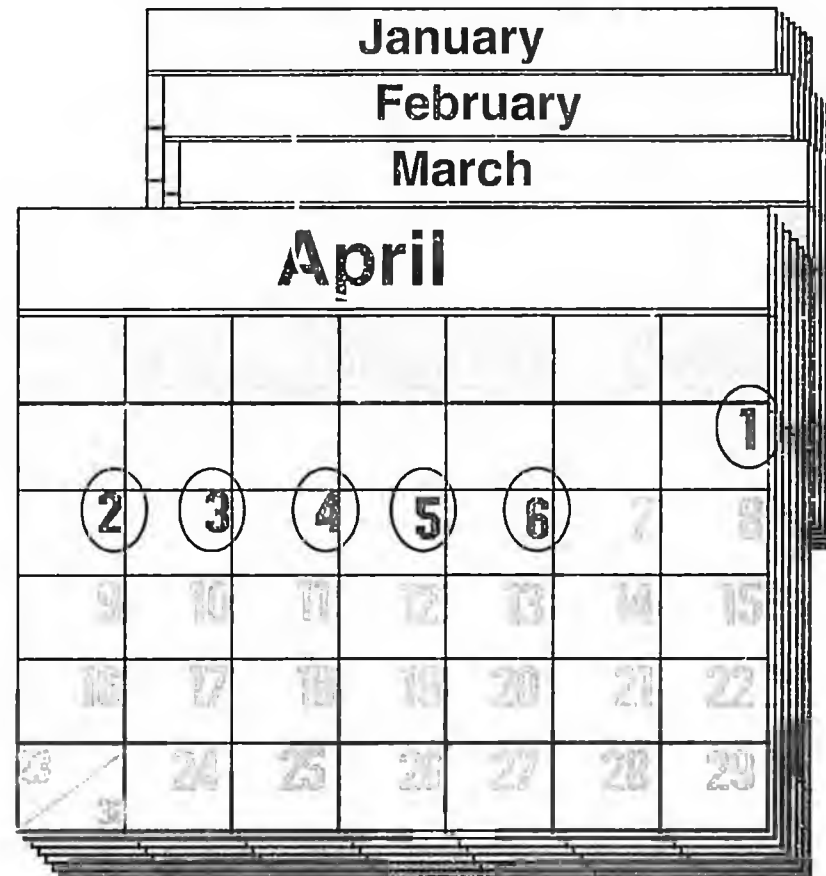
# Without reform, rising health care costs will take three more weeks of your family's income.

1993



77 days

2000



97 days

Prepared by AARP Public Policy Institute  
SOURCES: HCFA, Bureau of Census, and Laurence Meyer Associates.  
Figures are averages based on total national health expenditures.

## **WITHOUT REFORM, RISING HEALTH CARE COSTS WILL TAKE THREE MORE WEEKS OF YOUR FAMILY'S INCOME**

Description: This chart shows that U.S. health care costs are so high that, in 1993, they "consumed" the equivalent of all income from January 1 through March 18, or 77 days worth. **Unless Congress and the President enact comprehensive health care reform, an additional three weeks of household income will be devoted to health care costs by the year 2000.** In that year, it is projected that households will not finish paying their health care bill until April 6, accounting for nearly 100 days worth of household income.

Sources: U.S. Department of Commerce, Bureau of the Census. "Measuring the Effect of Benefits and Taxes on Income and Poverty: 1979-1991." Current Population Reports, Series P-60, No. 182-RD.

Laurence H. Meyer & Associates, Ltd. "Long-Term U.S. Economic Outlook," June 15, 1993.

Burner, S.T., Waldo, D.R., and McKusick, D.R. "National Health Expenditure Projections Through 2030." Health Care Financing Review, Fall 1992, Vol. 14, No. 1.

U.S. Department of Commerce, Bureau of the Census. "Projections of the Number of Households and Families: 1986 to 2000." Current Population Reports, Series P-25, No. 986.

Methods: The number of days worth of income accounted for by household payment for the nation's health care bill was calculated on the basis of 365 days in a year.

Mean household income was defined as before-tax money income including capital gains, government cash transfers, and health insurance supplements. This 1991 figure was inflated at the rate of growth in nominal Gross Domestic Product (GDP) to arrive at a 1993 and 2000 projected income.

The per-household health care payment was calculated by dividing total national health expenditures for each year by the total number of households projected for 1993 and 2000. Total national health expenditures, which represent all of the nation's health expenditures, include spending by all sources for personal health care, program administration, net cost of private health insurance, government public health activities, research, and construction of medical facilities. Series C projections (i.e., projections based on Series C assumptions) were used for the total number of households in 1993 and 2000.

**Without health care reform, what is your risk  
of being uninsured for an entire year in the  
future?**



**1 in 4, if you are single without children.**

**1 in 7, if you are age 30-54.**

**1 in 8, if your head of family works full-time, full-year.**

**1 in 9, if you are a professional services worker.**

**1 in 10, if you are employed by a large firm.**

**Without reform, no one is protected from being  
uninsured.**

Prepared by AARP Public Policy Institute

SOURCE: Employee Benefit Research Institute, 1993. Data are for 1991.

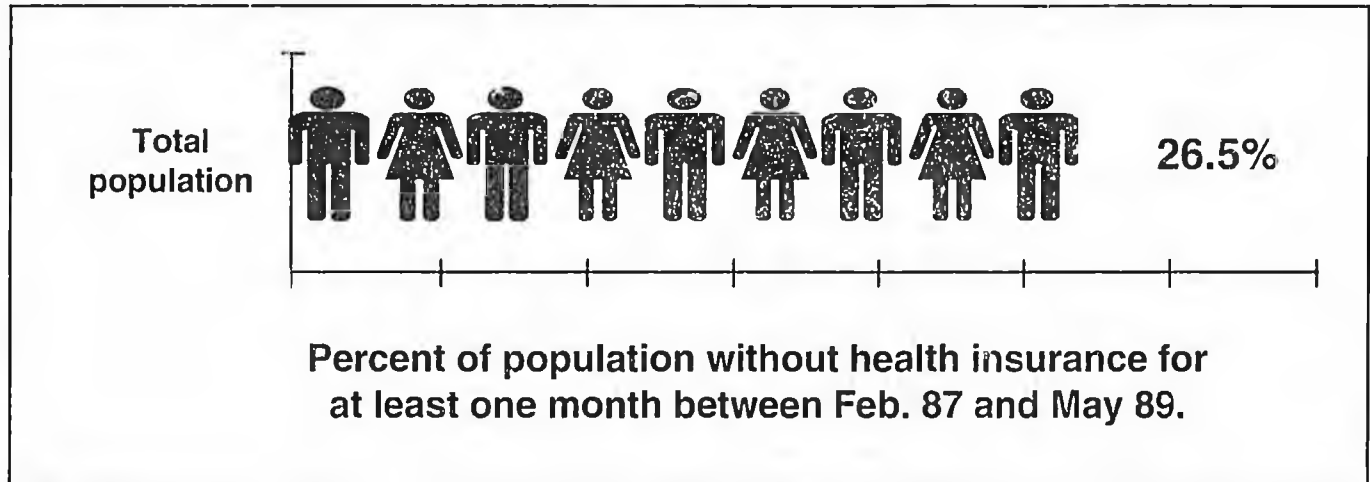
## **WITHOUT HEALTH CARE REFORM, WHAT IS YOUR RISK OF BEING UNINSURED FOR AN ENTIRE YEAR IN THE FUTURE?**

Description: While it is a well-known fact that over 37 million Americans are uninsured, there are widespread misconceptions about the composition of this population. For example, some believe that the uninsured population consists only of the unemployed, the less educated, persons with low income, or single-parent households. Although the risk of being uninsured is greatest among people with these characteristics, the truth is that the average middle-class American is not necessarily protected from a similar fate. The lack of health coverage is more pervasive than most people realize; for example, in 1991, 85 percent of the uninsured belonged to families headed by workers. **Without health care reform, the prospect of being without coverage threatens the security of all individuals, including middle-aged people, persons without children, members of families with a full-time year-round worker, employees of large firms, and people employed in professional services.**

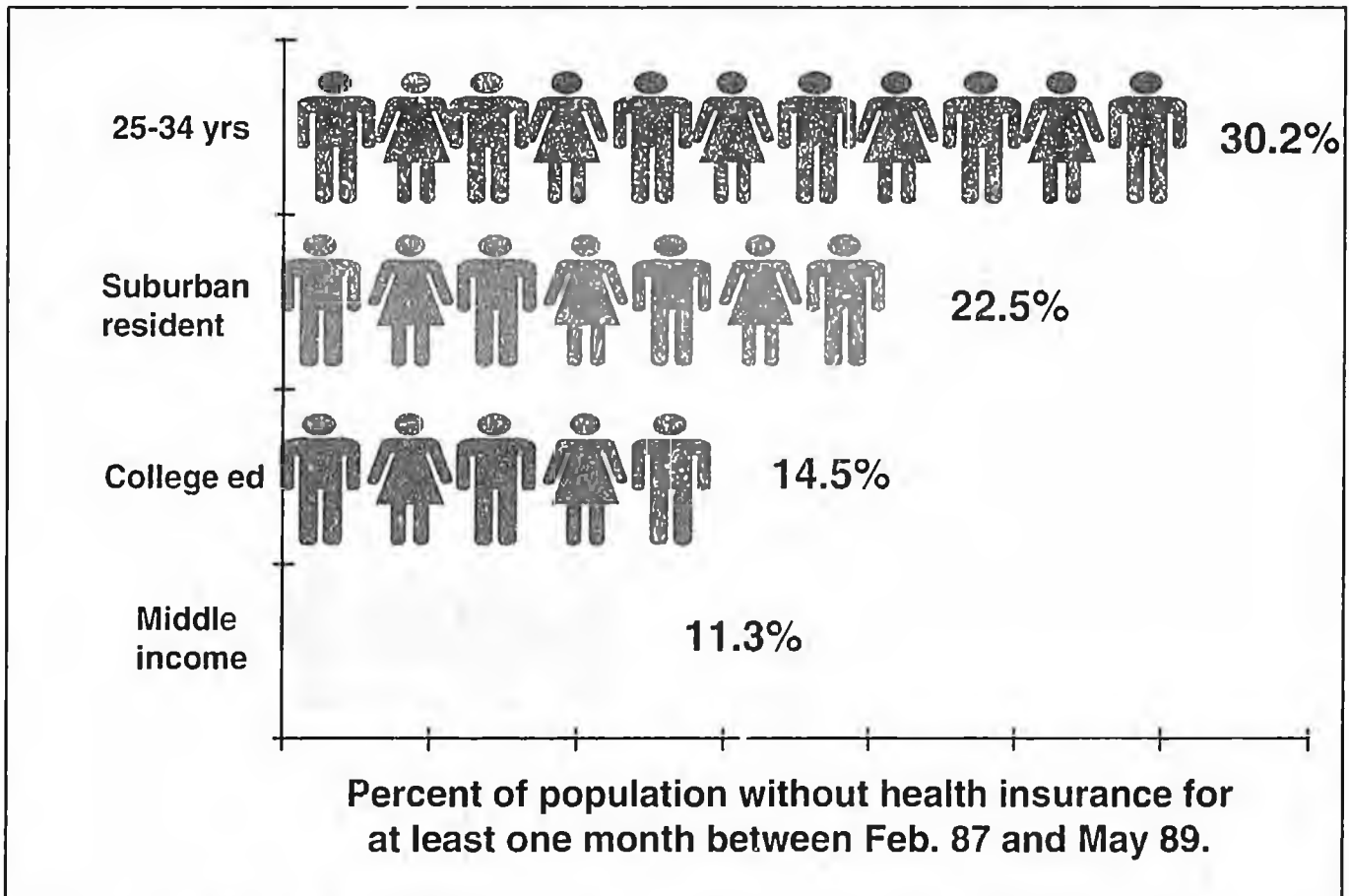
Source: Employee Benefit Research Institute. "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1992 Current Population Survey." Issue Brief Number 133, Special Report 16. Washington, D.C., January 1993.

Methods: The uninsured refers to noninstitutionalized individuals (excluding active duty military workers and members of their families) who were not covered by private health insurance and did not receive publicly financed health assistance. Large firms are defined as those with 500 or more employees.

# Without health care reform, you are at risk of being without health insurance for at least one month. . .



## . . . even if you think you're not!



**WITHOUT HEALTH CARE REFORM, YOU ARE AT RISK OF BEING WITHOUT HEALTH INSURANCE FOR AT LEAST ONE MONTH. . . EVEN IF YOU THINK YOU'RE NOT!**

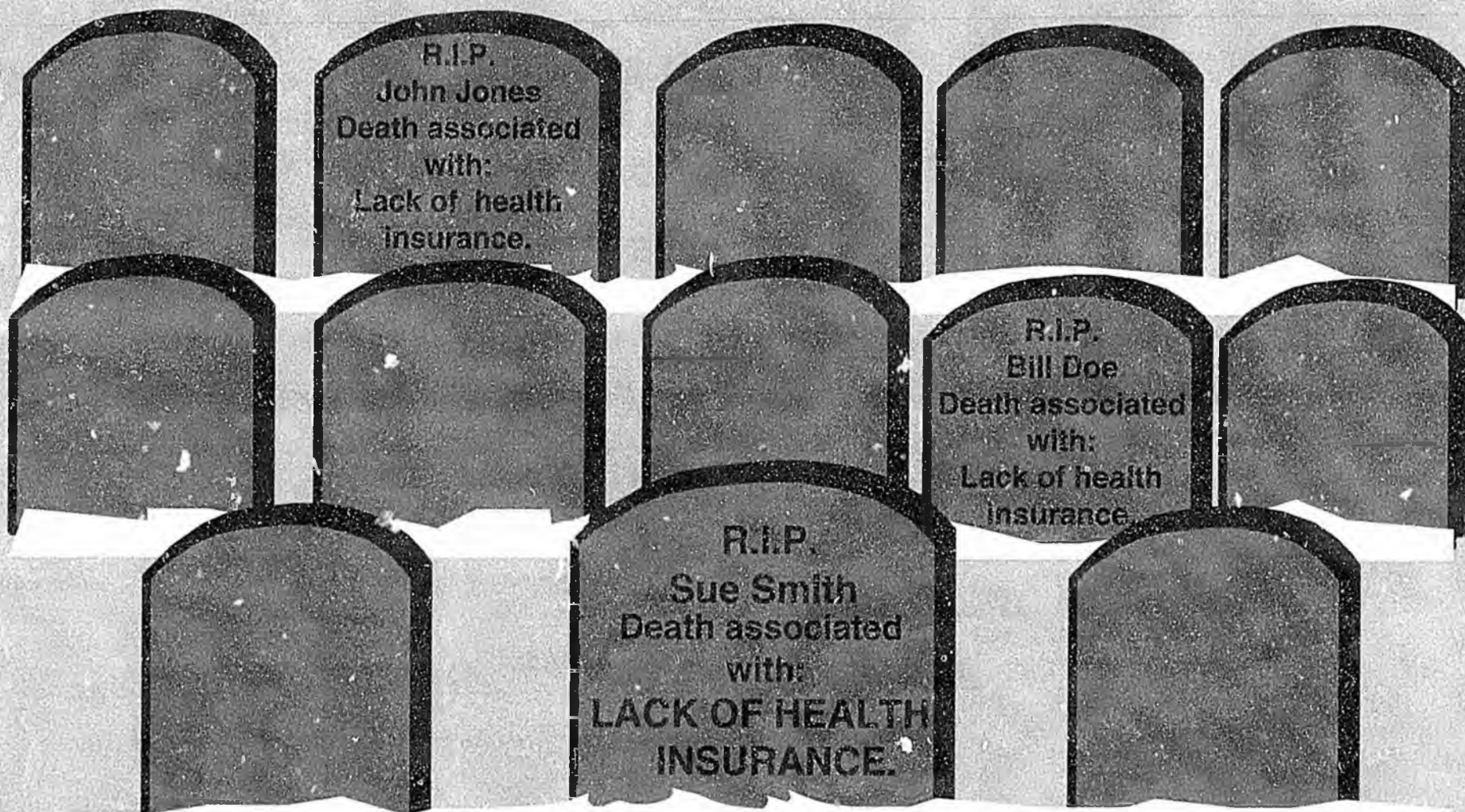
Description: Some individuals lack health insurance for long periods of time, while others experience loss of coverage for one or more months at a time. In fact, while approximately 15 percent of the population typically lacks coverage *throughout* the year, more than one in four Americans lacked health insurance for shorter periods. Between February 1987 and May 1989, 26.5 percent of all persons lacked health insurance for at least one month. **Without health care reform, the risk of being without coverage for at least short periods of time is significant, even for individuals not typically viewed as vulnerable -- those living in the suburbs, those with college educations, middle-income individuals, and people in their late 20s and early 30s, who are likely to have established employment.**

The consequence of being without health insurance for even short periods of time can be dramatic and far-reaching. During one month without health insurance, a woman might discover breast cancer, or fail to discover it because she could not afford the office visit or screening tests. Or, a child could become seriously ill or be injured in an accident. When a family is able to resume coverage after not having had it for a period of time, it may find that insurers impose limitations or exclusions on coverage for conditions or illnesses that were acquired during the period of uninsurance. Without coverage, even for a specific condition, a family may face medical bills that could jeopardize its economic security for years to come.

Source: U.S. Bureau of the Census. Current Population Reports, Series P-70, No. 29, "Health Insurance Coverage: 1987-1990 (Selected Data from the Survey of Income and Program Participation)." U.S. Government Printing Office, Washington, D.C., 1992.

Methods: Middle income is defined as an income-to-poverty ratio of 4 or over.

**Lack of health coverage affects more than money: you face a risk of death 25% higher if you are uninsured than if you are insured.**



## **LACK OF HEALTH COVERAGE AFFECTS MORE THAN MONEY: YOU FACE A RISK OF DEATH 25% HIGHER IF YOU ARE UNINSURED THAN IF YOU ARE INSURED**

Description: There are important advantages associated with having health insurance. For example, insured people pay a smaller proportion of their health care expenses out-of-pocket than do their insured counterparts. They are also less likely to receive inadequate care. It is well established that the lack of health insurance is associated with reduced access to medical care in the form of delayed or forgone care for serious symptoms, fewer physician visits, and a lower use of recommended preventive services; further, health services for the uninsured are usually obtained on an emergency basis.

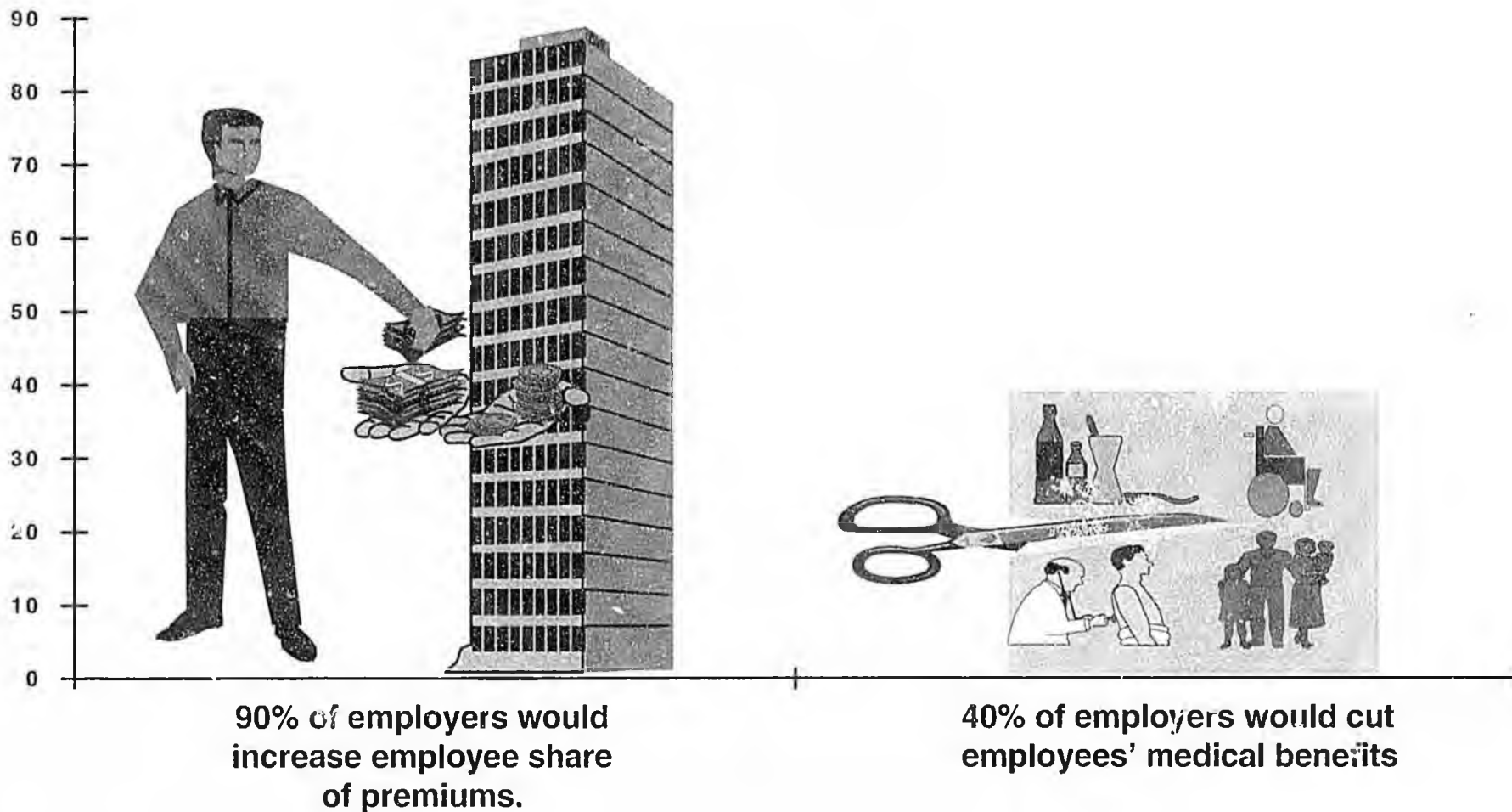
Among those who receive services, the uninsured are more likely than those with insurance to have hospitalizations that might have been avoided and are sicker at the time of hospital admission; they are also less likely to undergo high-cost procedures. In addition, the lack of health insurance has been associated with declines in health and functional status and an increased risk of suffering medical injury from substandard care. **Recent research indicates that the lack of health insurance places an individual at a 25 percent greater risk of subsequent mortality than his or her insured counterpart.** Health care reform is needed to reduce both the financial barriers to receiving health services and the risk of premature death.

Source: Franks, P., Clancy, C.M., and Gold, M.R. "Health Insurance and Mortality: Evidence from a National Cohort." Journal of the American Medical Association, Vol. 270, No. 6, August 11, 1993.

Methods: The relationship between lack of health insurance and risk of subsequent mortality was examined by analyzing data from the National Health and Nutrition Examination Survey Epidemiologic Follow-up Study. Adults older than 25 years who reported being uninsured or privately insured in the first NHANES, a representative cohort of the U.S. population, were followed prospectively from initial interview in 1971 through 1975 until 1987. The analysis adjusted for gender, race, baseline age, education, income, employment status, the presence of morbidity on examination, self-rated health, smoking status, leisure exercise, alcohol consumption, and obesity.

# Without health care reform, employees can expect to pay more in the future for their health benefits and/or receive less in coverage.

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Prepared by AARP Public Policy Institute

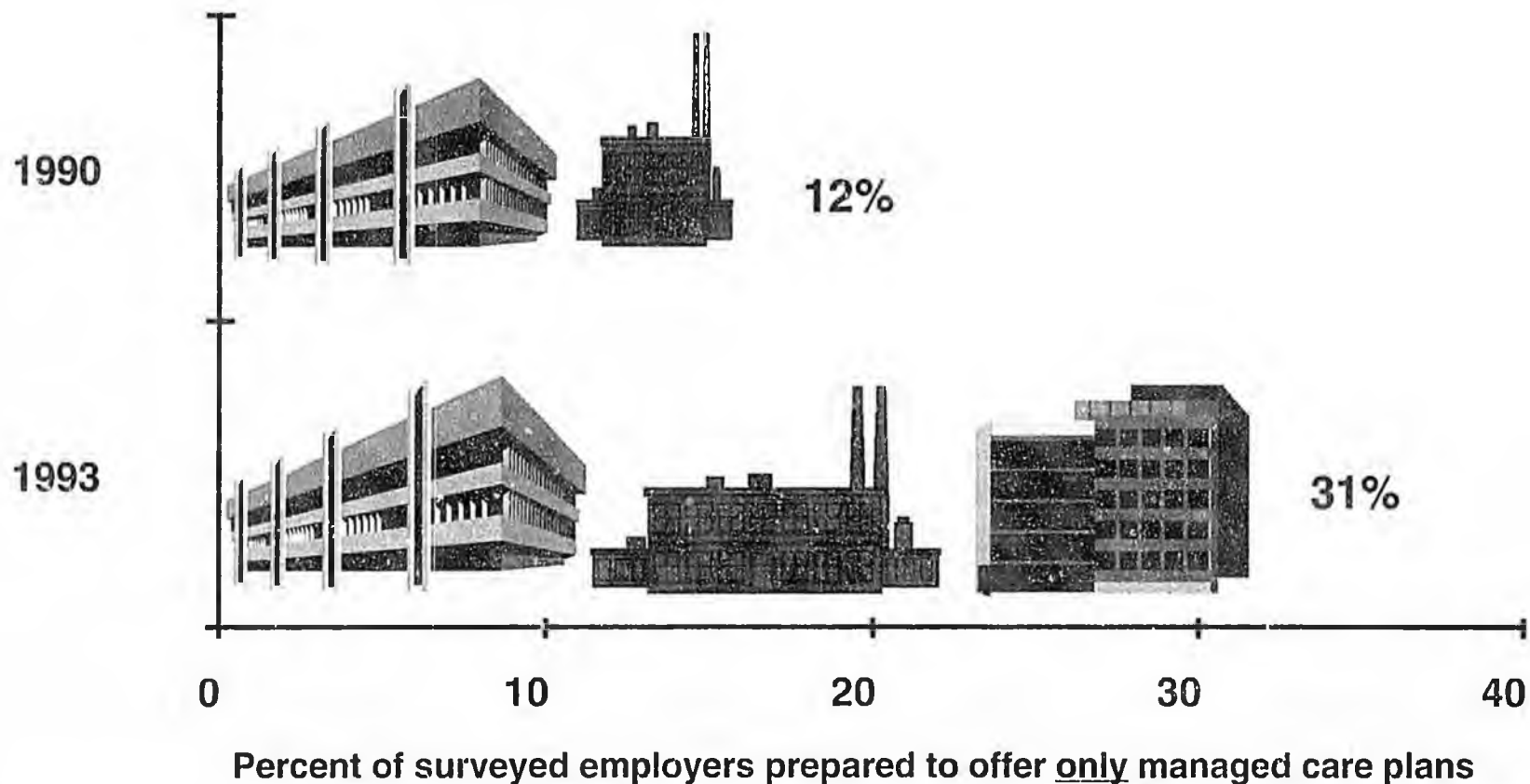
SOURCE: Annual National Executive Poll as presented in Business & Health, July 1993

## **WITHOUT HEALTH CARE REFORM, EMPLOYEES CAN EXPECT TO PAY MORE IN THE FUTURE FOR THEIR HEALTH BENEFITS AND/OR RECEIVE LESS IN COVERAGE**

Description: Along with life insurance and paid time off, medical care is one of the most prevalent employee benefits offered to workers in medium and large establishments. However, Americans, whether working or retired, are now more concerned about their employer-provided health benefits than about any other benefit, including pensions. **Rapidly rising health benefit costs have led employers -- large and small, in the private and public sectors -- to reduce benefits and shift a greater share of the costs onto workers and their families.** In 1991, for the first time since 1979 when the Bureau of Labor Statistics began surveying employee benefits, more workers with medical care coverage contributed to their coverage than did not, both for individual and family coverage. Furthermore, a recently released national poll of business executives found that 90 percent of employers surveyed -- up from 76 percent in 1992 -- would increase their employees' share of premiums if increasing health benefit costs force them to trim their health benefits programs. Additionally, 40 percent of those surveyed -- up from just 16 percent a year earlier -- would cut their employees' medical benefits. Without health care reform, employees are likely to see more of these kinds of changes.

Source: Business & Health, "The Annual National Executive Poll on Health Care Costs and Benefits," July 1993.

**Without health care reform, employees can expect to have their choice of health care plans restricted as employers respond to rising costs.**



Percent of surveyed employers prepared to offer only managed care plans

Prepared by AARP Public Policy Institute

SOURCE: Annual National Executive Poll as presented in Business & Health, July 1993 and April 1990.

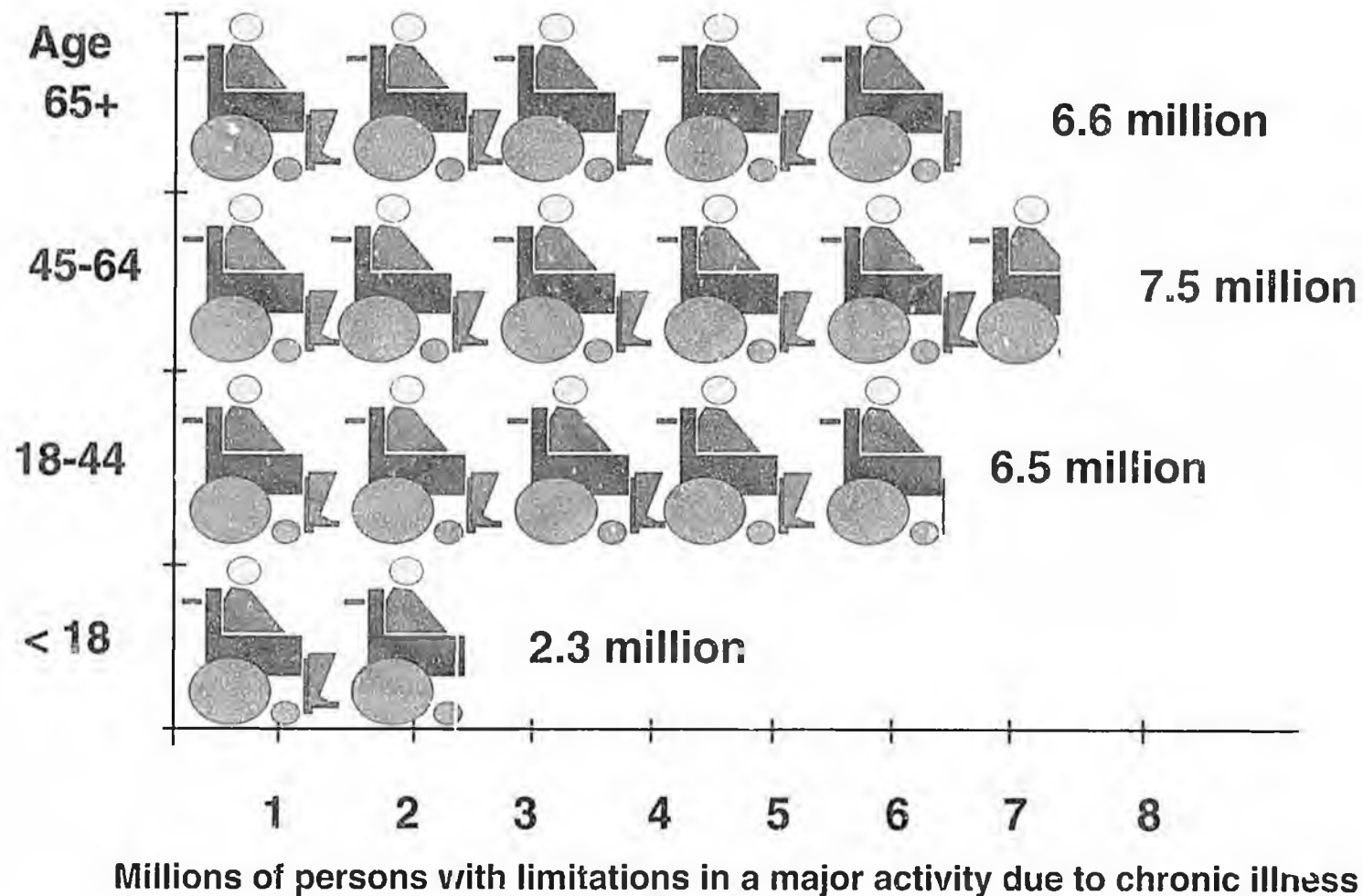
## **WITHOUT HEALTH CARE REFORM, EMPLOYEES CAN EXPECT TO HAVE THEIR CHOICE OF HEALTH CARE PLANS RESTRICTED AS EMPLOYERS RESPOND TO RISING COSTS**

Description: Increasingly, employers are offering managed care options in response to escalating health care costs. According to the Bureau of Labor Statistics (BLS), traditional fee-for-service plans covered two-thirds (67 percent) of medical plan participants in 1991, down from 74 percent in 1988. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) covered about one-sixth each (17 percent and 16 percent, respectively). Earlier, more limited-scope surveys by BLS found that, in 1980, only 2 percent of health plan participants were in HMOs and 98 percent of plan participants were covered by a fee-for-service plan.

Recent evidence indicates that rising costs are increasingly leading employers to introduce benefit changes that may limit employee choice of health insurance plan. **A 1993 survey found that 31 percent of executives would consider dropping traditional insurance and offering only managed care plans in order to trim the cost of health programs -- up from 22 percent in 1992.** Unless an employer offers a point-of-service option (i.e., one that permits employees to decide at the time of service whether to use providers who participate with the plan), workers must often choose between only two or three plans, each with a limited choice of providers. This can mean that longstanding physician-patient relationships are severed, and that workers must pay out of their own pockets to maintain continuity of care.

Source: *Business & Health*, "The Annual National Executive Poll on Health Care Costs and Benefits," July 1993.

**Without reform that includes long-term care, any member of your family may face uncovered expenses due to disability.**



## **WITHOUT REFORM THAT INCLUDES LONG-TERM CARE, ANY MEMBER OF YOUR FAMILY MAY FACE UNCOVERED EXPENSES DUE TO DISABILITY**

Description: The image of long-term care is often associated with nursing homes filled with frail senior citizens with disabilities. **However, individuals of any age can find themselves in need of long-term care services at any time.** In fact, individuals between the ages of 45 and 64 made up the largest group of people in 1990 who were limited in their ability to perform major activities due to chronic illness and therefore at risk of requiring long-term care at some point in their lives, either at home or in a nursing home. Roughly 7.5 million individuals between the ages of 45 and 64 had limitations in a major activity in their daily lives, compared to 6.6 million over the age of 65 and nearly 6.5 million between the ages of 18 and 44. In addition, approximately 2.3 million *children* experienced these limitations in 1990.

Source: Adams, P.F. and Benson, V. "Current Estimates from the National Health Interview Survey." National Center for Health Statistics. Vital and Health Statistics, Series 10, No. 181, 1991.

Methods: The definition of a major activity in the 1990 National Health Interview Survey varies by age: (a) ordinary play for children under age 5, (b) attending school for those aged 5-17, (c) work or keeping house for persons 18-69 years old, and (d) capacity for independent living (the ability to bathe, dress, shop, etc., without needing the help of another person) for those age 70 and older. The purpose of this broad definition is to measure disability in the context of the particular environment and challenges associated with activities at different ages.

**Without reform that includes comprehensive long-term care,  
43% of older people face substantial out-of-pocket costs  
due to nursing home stays.**



**43% of 65-year-olds will use nursing homes  
during their lifetimes.**



**1 out of 2 65-year-old women will use  
nursing homes during their lifetimes.**



**1 out of 3 65-year-old men will use  
nursing homes during their lifetimes.**

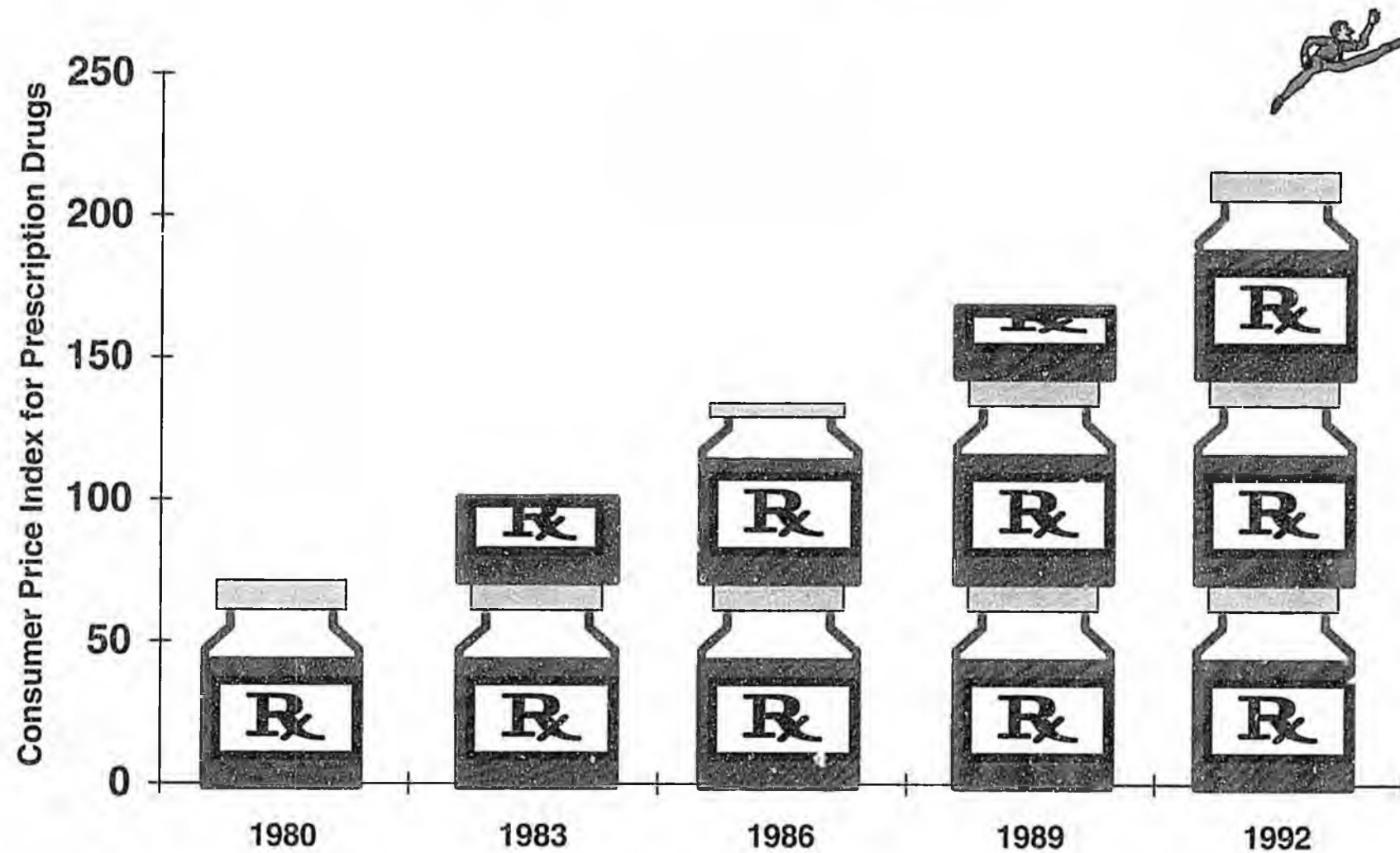
**WITHOUT REFORM THAT INCLUDES COMPREHENSIVE LONG-TERM CARE,  
43% OF OLDER PEOPLE FACE SUBSTANTIAL OUT-OF-POCKET COSTS DUE TO  
NURSING HOME STAYS**

Description: Today, a one-year stay in a nursing home can cost an average of \$30,000 and as high as \$60,000 in some states. **Although 43 percent of persons age 65 in 1990 -- one in two women and one in three men -- will use a nursing home at some point in their lives, without health care reform that includes comprehensive long-term care, few will be able to pay for it without incurring substantial out-of-pocket costs.** Medicare offers very little coverage for long-term care, paying only for post-hospital nursing home stays of limited duration. A relatively small percentage of individuals has private long-term care insurance; this insurance is prohibitively expensive for too many people and may yield few benefits for those who do purchase it. And, while Medicaid covers nursing home care for those without financial resources, it has strict financial eligibility criteria that require individuals to first exhaust most assets and virtually all income. Furthermore, under the current system, long-term care services for those who wish to remain at home or in the community typically must be paid out-of-pocket.

Sources: Kemper, P. and Murtaugh, C.M. "Lifetime use of nursing home care." New England Journal of Medicine, Vol. 324, No. 9, pp. 595-600, 1991.

Methods: Data for this analysis were obtained from the 1986 National Mortality Followback Survey. The next-of-kin of a nationally representative sample of adults who died in 1986 were asked the total amount of time spent in nursing homes by the deceased. These estimates were used to project future nursing home use by persons who were 65 in 1990. The projections were adjusted to account for the effects of increasing life expectancy and the differing composition of the two groups.

Without health care reform, prescription drug prices--which more than doubled in the 1980s--could double again.



## **WITHOUT HEALTH CARE REFORM, PRESCRIPTION DRUG PRICES -- WHICH MORE THAN DOUBLED IN THE 1980s -- COULD DOUBLE AGAIN**

Description: While outpatient prescription drugs are commonly covered under employer-sponsored insurance plans and for Medicaid recipients, the Office of Technology Assessment estimates that 25 to 30 percent of the population still do *not* have health insurance for prescription drugs. Lack of coverage for drugs is a particular problem for older Americans; this population relies more on medications to maintain its health than younger age groups but has substantially less coverage. Medicare, the major insurance program for the elderly, generally does not cover outpatient prescription medicines. Many individuals, particularly older Americans, are denied access to essential -- often life-saving -- medications or are forced to make choices between paying for medications or forgoing other necessities because they cannot afford high prescription drug prices. **Between 1980 and 1990, prescription drug prices rose 151 percent, increasing even more than medical inflation and almost three times as much as general inflation.** This trend in drug prices persisted between 1990 and 1992, when drug prices increased more than medical inflation and nearly three times the rate of general inflation. Without health care reform that includes enforceable cost containment, drug prices will continue to rise at unaffordable rates during the 1990s.

Sources: U.S. Bureau of Labor Statistics, Washington, D.C. [Unpublished data].

U.S. Bureau of the Census, Statistical Abstract of the United States: 1992 (112th edition). Washington, D.C., 1992.

U.S. Bureau of the Census, Statistical Abstract of the United States: 1989 (109th edition). Washington, D.C., 1989.

# Without health care reform, cuts in only public programs lead to higher charges for privately insured patients

When Medicare pays less.....private patients pay more.

Pay to the order of: 2048  
**LOCAL HOSPITAL**  
\$880.00  
*Medicare*  
⑆00 2100 66⑆ 770⑆ 554076⑆ 2121

Pay to the order of: 2048  
**LOCAL HOSPITAL**  
\$1300.00  
*Private Insurance*  
⑆00 2100 66⑆ 770⑆ 554076⑆ 2121



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Prepared by AARP Public Policy Institute  
SOURCE: Congressional Budget Office. Data are for 1991.

## WITHOUT HEALTH CARE REFORM, CUTS IN ONLY PUBLIC PROGRAMS LEAD TO HIGHER CHARGES FOR PRIVATELY INSURED PATIENTS

Description: In response to growing budget deficits in the past several years, Congress has cut public health insurance programs -- Medicare and Medicaid -- without limiting the explosive growth in the rest of the health care system. This fragmented approach has not solved the health care cost problem; rather, it has exacerbated increases in health costs as hospitals have responded since the mid-1980s by charging private patients more. **By 1991, Medicare paid only 88% of the hospital costs of treating Medicare patients (or \$880 per \$1,000 in costs), Medicaid paid only 82% of the cost of treatment, but private insurers and private-pay patients paid 130% of hospital treatment costs (or \$1,300 per \$1,000 in costs).** Looked at another way, Medicare hospital payments were only 68% of what private insurance paid, relative to the cost of treatment, in 1991. Medicaid paid an even lower proportion. This means that employers and workers alike pay what could be considered a health "cost-shifting" tax that increases each time Medicare and Medicaid payments are cut. Without health care reform that provides system-wide limits on costs, hospitals, physicians and other health care providers simply charge privately insured patients more when public insurance programs reduce payments.

Source: Congressional Budget Office, "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals 'Cost Shift'?", May 1993.

Methods: Medicare and private insurance payments are defined as the amount of revenues hospitals receive from each source per \$1,000 in hospital costs associated with treating patients with health coverage from that source.

# Without health care reform, cuts in only public programs affect patient access to physician services.

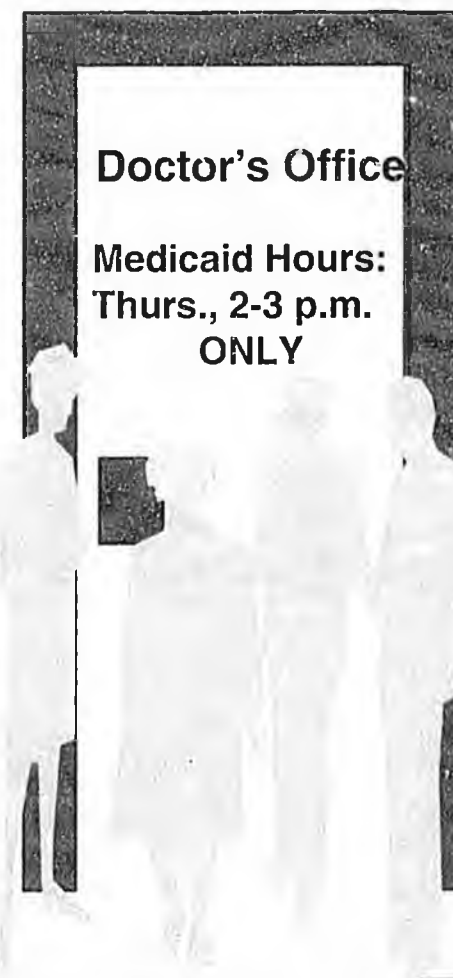


Doctors receive highest payments from privately insured patients.



No longer taking new Medicare patients.

Doctors receive 35% less from Medicare.



Doctors receive 45% less from Medicaid.

## WITHOUT HEALTH CARE REFORM, CUTS IN ONLY PUBLIC PROGRAMS AFFECT PATIENT ACCESS TO PHYSICIAN SERVICES

Description: Under the current health care system, doctors receive higher payments for privately insured patients than for other patients. It is projected that, in 1994, these differences will result in Medicare paying only 65 cents for every dollar that private insurance pays for physician care, and Medicaid paying only 55 cents for every private-pay dollar. **Because payment rate differences make doctors less willing to treat Medicaid and Medicare patients, this growing gap is causing access problems for Medicaid patients and may also be causing problems for Medicare patients.** Widespread evidence indicates that low Medicaid payment levels lead physicians to limit the number of Medicaid patients they treat. Further, in areas where Medicaid fees are lowest, Medicaid patients are less likely to receive care in a physician's office and more likely to get care in outpatient departments, emergency rooms, health clinics, and community and migrant health centers. In addition, Medicare and Medicaid patients are more than twice as likely as privately insured patients to travel more than an hour to their usual source of health care; once at their usual source of medical care, Medicaid patients are almost three times more likely than privately insured patients to wait more than an hour to see a provider. There is also anecdotal evidence that new Medicare patients are having trouble finding doctors who will treat them.

Without health care reform, cuts restricted only to public programs may exacerbate access problems. Health care reform is needed to reduce the variation in payment rates and remove the disincentive to serve Medicare and Medicaid patients.

Source: Physician Payment Review Commission. "Optional Payment Rates for Physicians: An Analysis of Section 402 of H.R. 3626." March 1992.



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