

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672

2199 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

SCOMM

86:7

**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)

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
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

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
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

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
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

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
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

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
American Association of Retired Persons Marie MacKenzie, Health Care Trainer 1620 Crescent 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	
Continuum 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

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
Fairbanks Health Coalition 4454 Chena Hot Springs Road Fairbanks, AK 99712 Ellen Ganley (Coordinator of Fbxs Community 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

BUSINESSES AND BUSINESS-RELATED GROUPS

<u>Name of Organization</u> <u>Contact/Address/Phone</u>	<u>Scheduled</u>	<u>Submitted</u> <u>Written</u> <u>Comments</u>
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.

TIME FOR A CHANGE



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 "pay"—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 some-

MEDICARE FOR ALL AMERICANS

what 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.



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 INOUE 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.

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 be 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 neuromusculoskeletal 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 chiropractic 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.

09/26/92
ACS Letter to Task Force

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 chiropractic 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,

A handwritten signature in dark ink, appearing to read 'D. G. Conners-Allen', written in a cursive style.

Dr. Patricia G. Conners-Allen
Chiropractic Physician
P.O. Box 32439
Juneau, AK 99803
(907) 789-1812



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 to the 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 not 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 illustrate 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 (3000) 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?

Page Two

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

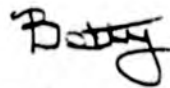
Should the Federal Government provide basic health services directly to the citizens?

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,



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

July 23, 1992

RECEIVED
AUG 04 1992

Division of Administrative Services

LEAGUE IN ACTION

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 falls 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;

Health Care Position Statement

Announced by the LWVUS National Board, April 1993

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 expenditures 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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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.

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 returned 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.

EVLWV 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 LWWUS.

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 Eberman

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)	☒				Minimum basic level of care for all U.S. residents
b)	☒				Health care at an affordable cost to the individual patient
c)	☒				Quality standards of care
d)	☒				Consumer choice in the selection of health care providers
e)		☒			Choice for providers in the selection of type of practice (i.e., traditional single or group practice, HMOs, etc.)
f)	☒				Efficient and economical delivery of care
g)	☒				A reasonable total national expenditure level for health care
h)	☒				Equitable distribution of health care services
i)		☒			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)	☒				Prevention of disease
l)	☒				Health promotion and education
m)	☒				Primary care
n)	☒				Acute care
o)		☒			Long-term care
p)		☒			Mental health care
q)		☒			Dental care
r)		☒			Vision care
s)		☒			Hearing care
t)			☒		Other <u>Extraordinary</u> <u>measures</u>

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)	☒	☐	☐	Requiring insurance companies to use community rating instead of experience rating
v)	☒	☐	☐	Allocating services to medically underserved areas
w)	☒	☐	☐	Providing for training of health care professionals in needed fields of care
x)	☐	☒	☐	Mandating uniform service levels for all publicly funded health care programs
y)	☒	☐	☐	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)	☒	☐	☐	Consumer accountability through deductibles and copayments
bb)	☐	☒	☐	Mandatory second opinion before serious surgery or extensive treatment
cc)	☐	☐	☒	Outcome-based guidelines for providers
dd)	☒	☐	☐	Regional planning for the allocation of personnel, facilities and equipment
ee)	☒	☐	☐	Utilization reviews of treatment
ff)	☒	☐	☐	Establishing maximum level of public reimbursement to providers
gg)	☒	☐	☐	Use of fixed, per capita payments to providers (capitation payments)
hh)	☒	☐	☐	Use of managed care
ii)	☒	☐	☐	Reduction of administrative costs
jj)	☒	☐	☐	Malpractice reform
kk)	☐	☐	☐	Other _____

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)	<u> </u>	<u>✓ </u>	<u> </u>	Ability of patient to pay (from personal resources or from public or private insurance coverage)
mm)	<u> </u>	<u>✓ </u>	<u> </u>	Age of patient
nn)	<u>✓ </u>	<u> </u>	<u> </u>	Urgency of medical condition
oo)	<u> </u>	<u> </u>	<u> </u>	Life expectancy of patient
pp)	<u> </u>	<u> </u>	<u> </u>	Expected outcome of treatment
qq)	<u> </u>	<u> </u>	<u> </u>	Cost of procedure
rr)	<u> </u>	<u> </u>	<u> </u>	Duration of care
ss)	<u> </u>	<u> </u>	<u> </u>	Patient and family wishes
tt)	<u> </u>	<u> </u>	<u> </u>	Quality of life of patient after treatment



LEAGUE OF WOMEN VOTERS

KETCHIKAN GATEWAY BOROUGH
P.O. BOX 8133, 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 of 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 inaccessible 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

7
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.

#

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 and 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 rule 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 Medicare 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, reimbursement 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 reimbursement 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 medicare system is a prime example of this over-utilization. They are able to receive 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 counseling 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 counseling.

The health care reform system 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 AETMA 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 occurrence. "" = factors having moderate impact on rate of occurrence. "X" = factors having greatest impact on rate of occurrence. Circle = represent areas in which interventions should occur, based on criteria of feasibility effect on the health problem, and costs, in relation to benefit	H	C	U	S	C	S	P	L	D	H	P	S	I	I	D
	e	a	n	t	O	S	P	L	D	H	P	S	I	I	D
	a	n	n	r	P	u	n	i	a	m	r	D	m	n	f
	r	c	e	k	D	i	e	v	b	i	n	s	u	c	t
	t	r	n	e		d	m	e	e	c	a		D	d	a
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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	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

(* Primary Sponsors)

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Alaska Chapter, American Association of Social Workers
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Alaska State Veterinary 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 Diabetes 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 Compassion 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.