

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672

2200 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Teach consumers to "shop around"

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9/26/92

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ALASKA PUBLIC INTEREST RESEARCH GROUP

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

Task Force Members:

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

We have decided to focus on our comments directly on the Health Care Reform Final Recommendations to the Governor and the Legislature, adopted March 14, 1992.

AkPIRG applauds the decision to endorse a single payor system by the Health Resources and Access Task Force. It is in that spirit of appreciation that we hope you will examine these comments and distribute them to all interested parties. They are intended to spark renewed debate and begin a process of serious public examination of this important subject.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Further commentary:

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

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

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

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

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

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

Stephen Conn
Executive Director

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

STATEMENT
of the
ALASKA CHAPTER
of the
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

to the
STATE OF ALASKA
HEALTH RESOURCE AND ACCESS
TASK FORCE

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

RE: Providing Adequate Health Coverage
for the Uninsured and Underinsured

October 23, 1992

Executive Summary

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

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

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

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

*Administrative requirements continue to add cost to the service.

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

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

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

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

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

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

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

EMERGENCY MEDICINE¹

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

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

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

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

THE UNINSURED AND EMERGENCY MEDICINE

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

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

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

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

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

EMERGENCY DEPARTMENTS AND EMERGENCIES

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

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

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

EMERGENCY DEPARTMENTS AND NON-EMERGENCIES

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

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

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

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

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

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

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

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

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

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

EDUCATION AND SELF-HELP

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

USER TAX

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

Certificate of Need

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

MALPRACTICE

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

ADMINISTRATIVE

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

ACEP SUPPORTS THE FOLLOWING CONCEPTS

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

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

- Medicaid must be both expanded and substantially improved including the enactment of minimum eligibility and benefit levels, and incentives to enhance provider participation. Due to uneven eligibility criteria and benefit levels across the states, the current medicaid program covers fewer than 42% of Americans with incomes below 100% of the poverty level.
- For those who are not eligible for employer-based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost sharing on a sliding scale premium basis.
- Health insurance programs, whether public or private, should provide access to basic health benefits.
- Medical malpractice reform must be enacted, including limitations on non-economic damages, the use of alternative dispute resolutions, reductions in contingency fees, , etc.
- Health insurance reform should be enacted,elimination of pre-existing conditions,community rather than experiential rating,et

- Reductions in administrative cost through the use of universal form, etc. should be accomplished.
- Technology and pharmaceuticals should be assessed for efficacy and cost effectiveness
- Health promotion, disease prevention, education and research should be enhanced.
- Increased use of managed care system and /or the principles of managed care is acceptable so long as the need of emergency medicine in providing quality emergency care are not deterred, i.e., timely authorization of services, mandatory screening exams, transfer guidelines, etc. Strong federal oversight would be needed.

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

HEALTH RESOURCES & ACCESS TASK FORCE
PRESENTATION

Dr. James Nesbitt, MD
September 26, 1992

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

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

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

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

What recommendations does the Alaska Chapter of the AAP have for reforming the health care system?

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

- 1) It would cover all children through age 21 and all pregnant women.
- 2) It is a pay or play system: Employers provide either a

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

- 3) There will be three baskets of benefits:
 - Preventive
 - Primary/Major medical
 - Extended/Major medical
- 4) Financing:
 - a) Money which now goes for Medicaid.
 - b) Employer payroll tax (3.2%) for those employers not providing the standard benefit package.
 - c) Employee payroll tax (1.0%) for those not covered by their employer.
 - d) Premiums.

This will establish a one class system of medical care.

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

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

Insurance Reform:

- 1) Pre-existing condition exclusions will be prohibited.
- 2) Guaranteed issue and renewability of coverage for any small business regardless of health or risk status will be required.
- 3) Community rating will be required.
- 4) A minimum benefit standard will be established.

Physician/Hospital Payment

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

What are the benefits for Alaska of such a system?

- 1) It has the benefits that children need. It places an emphasis on preventive health care and provides age-appropriate and comprehensive services for children. The focus on preventive care will reduce the need for more expensive emergency room care.
- 2) It establishes a one-class system of care and requires uniform benefits.
- 3) It is doable. It builds on the employer-based system of private insurance. It provides affordable health insurance for all dependents and eliminates pre-existing condition clauses in insurance.
- 4) It replaces the portion of the Medicaid program currently serving children and pregnant women with private insurance, thus eliminating the increasing medicaid mandates from Congress.
- 5) Insurance reform will make health care coverage more affordable for small businesses.
- 6) Cost-sharing and the use of care coordination will also help contain costs.
- 7) There will be a limit on the payroll tax, so business will know in advance their annual cost for employee health insurance and not be faced with rapidly increasing unknown costs.
- 8) Businesses will have the cost-effective option of providing insurance for their full-time workers and paying the tax for their part-time workers.
- 9) The removal of pre-existing condition exclusions will allow employees more freedom in job selection.
- 10) Children's health care is cost effective and relatively inexpensive and the payoff is substantial:
 - a) \$1 for immunizations saves \$10 in future medical costs.
 - b) \$1 for prenatal care saves \$3.
 - c) \$1 for early prevention and intervention saves \$4.75 in costs for remedial education, welfare and crime down the road.
- 11) Providing access to health care to all children now will help assure that Alaska will have the healthy work force which is essential to the productivity and financial stability of the state in the future.



**THE CHILDREN'S AND PREGNANT WOMEN'S
HEALTH INSURANCE ACT OF 1991
Rep. Robert Matsui (D-CA) H.R. 3393
Introduced September 24, 1991**

ELIGIBILITY:

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

STRUCTURE:

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

BENEFITS:

Three baskets of benefits. (AAP benefit package and schedule)

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

FINANCING:

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

COST CONTAINMENT:

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

INSURANCE REFORM:

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

PHYSICIAN / HOSPITAL PAYMENT:

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

HOW CHILDREN FARE:

All children will have financial access to the AAP recommended benefits.

TABLE 2—COST-SHARING STRUCTURE STATE FUND

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

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

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

SHARED FUNDING

Individuals, the private sector, and state and federal governments will share in funding the system. The federal government will apportion funds from these sources to the states on the basis of the projected number and age of the beneficiaries enrolled in the state plan. Employers will be required to provide an insurance package with specified benefits for

dependents and pregnant employees, or pay a 3.17 percent tax* on the wages of all employees, up to the Social Security wage base. This requirement will apply equally to employers who currently offer limited coverage for dependents, who offer no dependent coverage or who offer no employee health insurance.

The above requirement may present a hardship to small employers who have been unable to purchase group insurance either because of cost or unavailability. Health insurance reforms will be required to guarantee the availability of insurance to all small groups and to set equitable premium rates for all purchasers within the

same geographic area. Tax deductions and tax credits are also viable options.

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

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

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

- ① federal and state Medicaid funds currently allocated to children and pregnant women;
- ② employer payroll taxes; and
- ③ premiums.

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

► COST SHARING

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

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

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

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

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

TABLE 3—COST-SHARING STRUCTURE		EMPLOYER BASED INSURANCE		
Annual Premium Share	Annual Deductible	Coinsurance		
		Category 1: Preventive Benefits	Category 2: Primary/Major Medical Benefits	Category 3: Extended/Major Medical Benefits
Variable Up to 25% of Cost of Plan	\$200	No Deductible or Coinsurance Regardless of Income Level	20%	30%

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

Uninsured Children: The Facts

- Seventeen percent of American children under the age of 21 -- approximately 12.4 million -- have no health insurance, either private or public. Tens of millions more children have insurance which does not cover routine preventive care, including immunizations. (Employee Benefit Research Institute (EBRI), Washington, DC)
- Anyone can become uninsured, regardless of age, income or employment status. But the major reason for the growing number of uninsured persons is the decline in dependent coverage by employers. The current system is not treating children and pregnant women fairly. (*A Call For Action*. Final Report of the U.S. Bipartisan Commission on Comprehensive Health Care)
- A September 1991 New York Times/CBS Poll revealed that 29 percent of Americans reported that they or a family member were without health insurance some time in the last year, with 20 percent reporting their household had been seriously hurt by medical bills.
- Seven out of eight uninsured children live in families where at least one parent works. Often, parents are covered by health insurance from their employers, but their children are not. (EBRI)
- Sixty-five percent of uninsured children live in families whose income is above the federal poverty line (\$14,000 for family of four). Thirty percent of uninsured children live in families whose income is more than 200 percent of the federal poverty line. (EBRI)
- Children's medical care needs and consequently their utilization of services are very different from those of adults. Yet, the benefits offered by most private health insurance plans are designed to cover an adult pattern of utilization, i.e., inpatient care and high cost procedures. (EBRI)
- America spends 12 percent of its GNP on health care, but only .08 percent of that budget is spent on preventive health care. Access to age-appropriate, preventive and comprehensive primary health care is critical to the well-being of our children and adolescents. (*Our Children's Future: Health Care*, Joycelyn Elders, M.D., Feb. 1990)
- More than seven million U.S. women aged 21-45 have no insurance, public or private. Many others are uninsured for maternity and delivery services. (EBRI)

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Children first...

- Compared with other nations, an alarming percentage of babies born in the U.S. die before their first birthday. The U.S. lags behind 21 nations in infant mortality and 20 nations in child mortality. (Source: U.S. Department of Maternal and Child Health) Infant mortality data not only report how many of our babies die before the age of one; these data are also widely recognized as important indicators of the overall health of our children. (*A Call for Action*)
- Every \$1 spent on early prevention and intervention can save \$4.75 in costs associated with remedial education, welfare and crime down the road. (*A Proper Inheritance: Investing in the Self-sufficiency of Poor Families*, 1989)
- For every \$1 spent on all childhood immunizations, \$10 is saved in future medical costs. (U.S. House of Representatives Select Committee on Children, Youth and Families)

January 1992

Key Access Messages

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

- For humanitarian, economical and political reasons, it makes sense to begin revamping our health care system by meeting the needs of children and pregnant women first.
- It may be years before all Americans have access to quality medical care, but the needs of our nation's most vulnerable population -- children -- can and should be addressed now.
- We all bear the costs of care for children and pregnant women who have no health insurance. We pay in taxes, higher hospital bills and runaway insurance premiums. We're usually paying for the care of the uninsured in crisis situations that might have been averted if access to preventive care were universal.
- The health care access problem is getting worse, not better. The number of uninsured children has been growing steadily since 1980.
- Lack of insurance is not a problem only for low-income families. More than half of uninsured children live in two-parent families where at least one parent is employed full time and earning an income above the federal poverty line.
- In light of current government budget constraints, we must set new priorities for health care spending -- away from *sick care* and toward preventive care.
- Children's preventive health care is cost-effective and relatively inexpensive, and the payoff is substantial.
- Kids who don't get early and prompt care get sicker, making their health care more costly. Pregnant women who lack prenatal care have babies who are less healthy and who often require intensive and expensive care.
- Providing access to health care to all children now will help assure that America in the 21st century will have the healthy workforce which is essential to the productivity, security and defense of our nation.

Children first...

Answers for Business

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

David Packard, Chairman, Hewlett-Packard Co.

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

Keith Geiger, President, National Education Association

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

- Currently health care costs are unfairly distributed among businesses since some provide health insurance while others do not. H.R. 3393 will alleviate this unfair distribution by involving all businesses in the provision of health insurance.
- This bill includes cost controls that will help restrain runaway medical costs.
- H.R. 3393 utilizes community rating, which requires that an insurance company charges all small employer health plans with similar benefits in the same community the same rate. This will make the cost of health insurance more affordable for small businesses.
- Under the plan, insurers will be required to offer coverage to all small employers in a community if they offer it to one. Additionally, each small employer health plan is guaranteed to be renewed. This guaranteed issuance and renewability will make the health insurance market more stable for those companies who have high-risk employees.
- H.R. 3393's four-year phase-in will give businesses a chance to adapt their systems and budgets to be in compliance.
- There will be a limit on the payroll tax, so businesses will know in advance their annual cost for employee health insurance and will not be faced with rapidly increasing, unknown costs.

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Children first...

- The employer payroll contribution is tax deductible for businesses.
- Businesses will have the cost-effective option of providing insurance for their full-time workers and paying the tax for their part-time workers.
- The removal of preexisting condition exclusions will allow employees more freedom in job selection.

Why Support H.R. 3393?

- **H.R. 3393 has the benefits that children need.** Unlike many universal health care reform proposals, the basic benefit package included in H.R. 3393 places an emphasis on preventive health care, and provides age-appropriate and comprehensive services for children.
- **H.R. 3393 establishes a one-class system of care.** A one-class system of care will be established by replacing, with private insurance, the portion of the Medicaid program currently serving children and pregnant women, and by requiring uniform benefits.
- **H.R. 3393 is doable.** Rather than cause a major disruption in our current health care system, H.R. 3393 builds on the employer-based system of private insurance. It replaces the portion of the Medicaid program currently serving children and pregnant women with private insurance. It provides affordable health insurance for all dependents and eliminates preexisting condition clauses in insurance.
- **H.R. 3393 is less expensive.** Because H.R. 3393 deals only with children and pregnant women, it will cost less than other health care reform proposals that attempt to cover the whole population. H.R. 3393 will provide Congress with experience, much as a demonstration project would, for larger, universal, health care reform proposals.
- **H.R. 3393 can help our children now.** Through this legislation, we can act now to protect our most vulnerable population, children, while the debate over universal access (which may take years) continues. Our children cannot and should not have to wait for essential health care.
- **H.R. 3393 is a "first step."** Support for H.R. 3393 does not preclude support for a universal access plan. H.R. 3393 represents action that Congress can take now (a first step) as it works towards implementation of a universal plan. H.R. 3393 can be expanded in the future to cover the entire population once Congress agrees on a universal package.
- **H.R. 3393 is politically feasible.** Due to the fact that H.R. 3393 helps children and is less expensive than other proposals, politicians can take action to protect a particularly vulnerable population and not "break the bank" in the process.

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Children first...

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

■ H.R. 3393 makes good economic sense.

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

HEALTH CARE AMERICA

*Meeting America's
Health Care Needs*



*AARP's Draft Proposal
For Health Care Reform*

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Stock # D14720

AARP
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Health Care America Proposal Highlights

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

Health Care America - An Overview

- The new program is easy to use and understand. All one needs to obtain health services is his or her MEDICARD. The card assures access to a full range of benefits, including hospital and doctor care, preventive care, outpatient prescription drugs and long-term care.
- It controls costs. It also standardizes doctor and hospital payment rates, and limits prescription drug prices. The proposal establishes spending targets at both the national and state levels. Its streamlined billing system cuts down on administrative expenses.
- It includes what most people don't have — long-term care coverage in the home, in the community and in the nursing home. It places limits on long-term care costs to the individual. People with disabilities can get help with their daily

activities if they live at home or in the community. If they need nursing home care, that's also covered. Out-of-pocket payments for these services are limited so that long-term care is affordable.

- It preserves our freedom of choice. We can select our own doctors — just as we do today.
- It promotes preventive care. There is no charge for such preventive measures as physical check-ups, prenatal and well-baby care, pap smears, immunizations and other services that help ensure good health.
- It provides comprehensive benefits for all. Everyone automatically is covered, regardless of age, employment status or income. No individual can be denied coverage on the basis of a pre-existing condition.

Why We Need To Take Action

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

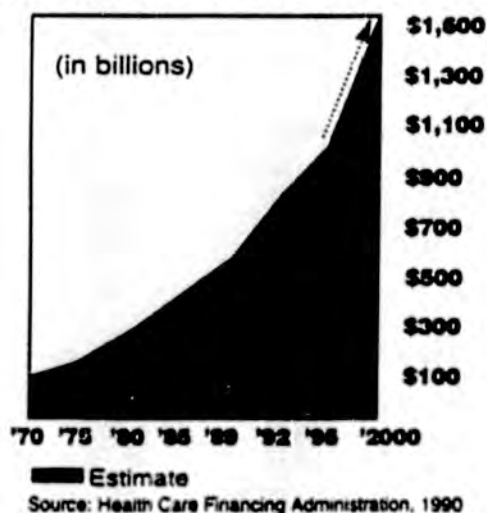
Consider these facts:

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

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

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

National Health Care Expenditures



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

Where AARP Stands

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

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

Health Care America: A "Blended" Plan

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

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

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

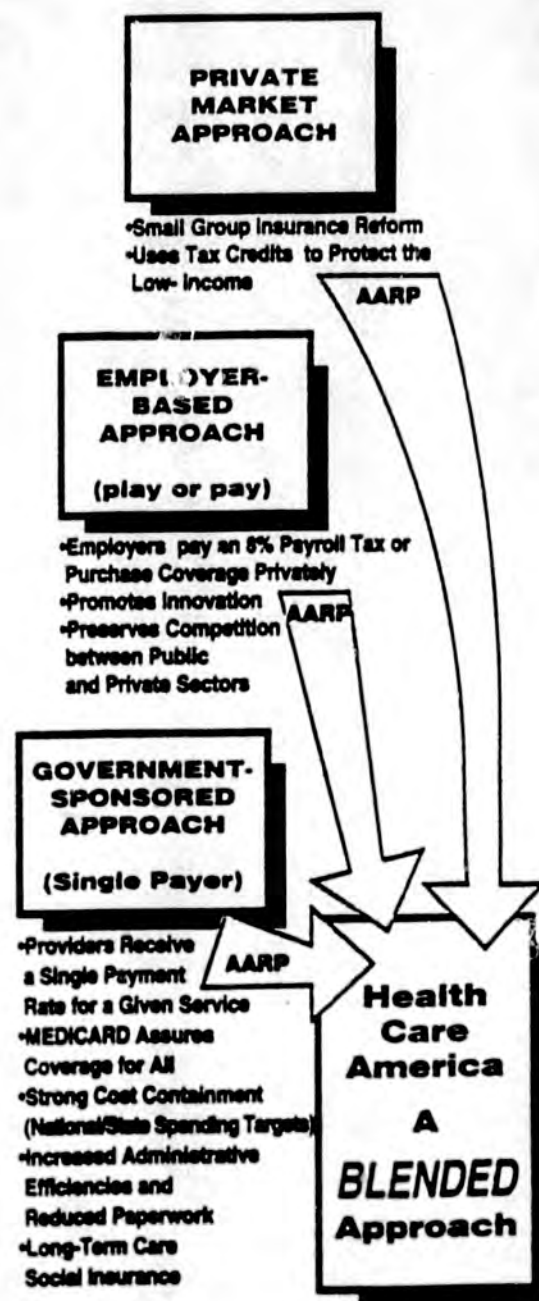
Coverage is available to everyone through the new expanded and strengthened Medicare program.

The program is built on the strengths of the existing Medicare program but makes improvements in its benefits, cost containment and administration.

Employers can enroll their workers in Medicare or instead pay privately for their medical benefits, that is for their hospital, doctor, lab, X-ray, preventive services, etc. However, benefits provided privately must be as good as or better than those provided through the new Medicare program.

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

How Health Care America "Blends" Approaches



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

The proposal's benefits fall into two categories:

1) doctor, hospital and other medical and preventive care services; and 2) long-term care.

Doctor, Hospital, and Other Medical and Preventive Care

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

What the Plan Covers:

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

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

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

What You Pay for Medical and Preventive Care:

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

Long-Term Care

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

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

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

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

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

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

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

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

What the Plan Covers:

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

What You Pay for Long-Term Care:

Home and Community Services

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

Nursing Home Services

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

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

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



1. You will receive a MEDICARD to use when visiting your doctor or other health care professional. The card enables you to receive the full range of covered health care services.
2. With MEDICARD, your health provider gains access to a computerized system that bills either Medicare or your private insurer for the health services you received.
3. Your doctor or other health provider receives full payment from either the new Medicare or from your private insurer. Medicare or the insurer bills you for your share, if any, on a monthly basis.
4. If you need long-term care, your card enables you to contact a care coordinator, such as a nurse or social worker. This person will help you determine the type of care required. He or she will then authorize the services you need to maintain your independence at home or help obtain admission to a nursing home, if that becomes necessary.

What The Plan Costs

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

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

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

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

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

What You Pay for Long-Term Care:

Home and Community Services

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

Nursing Home Services

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

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

How We Pay For The Proposal

Health care costs today are covered by three general sources:

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

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

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

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

- Existing state and federal funding for health care programs would continue.
- An 8 percent payroll tax would be paid by employers who enroll their workers in the new Medicare program. This would be waived for

employers who provide equivalent or better health care coverage to their workers and workers' dependents. Special provisions would protect new and low-wage businesses from the transitional burden of this tax.

- Premiums of \$50 per month would be paid by adults enrolled in the new Medicare program. Families would pay an additional \$25 per month for children. The maximum family premium would be \$125 per month.

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

- A special 3 percent national income tax.

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

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

OR

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

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

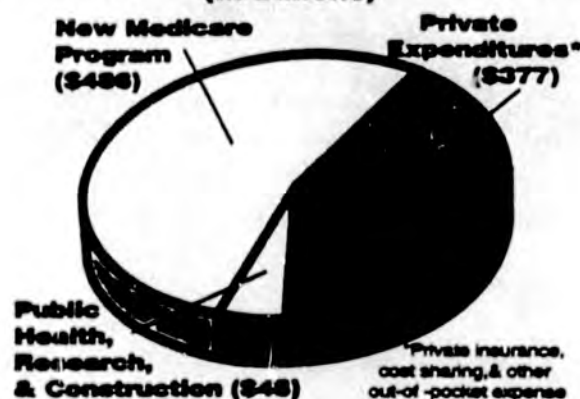
those with low incomes who file for a tax credit on their income tax return. A couple with \$30,000 in income that spends \$10,000 on covered goods and services would pay \$500.

Additional Tax Revenue Sources

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

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

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



**Total Health Care Spending
(\$911)**

Source: Levin/ICF HBSM

Proposal Advantages: A Summary

- It's easy to use and understand. Each of us receives a MEDICARD to present to health care providers. Benefits cover hospitalization, physician services and mental health care, as well as outpatient prescription drugs and preventive and long-term care. All services are itemized on a single, easily understood monthly statement.
- It controls cost. For the first time, our national health care system would operate on a spending plan. Spending targets are set at the national and state levels, and rates of growth in health care spending are limited. The proposal standardizes fees charged by doctors, hospitals and nursing homes. It strictly limits prescription drug prices, and it reforms our medical malpractice insurance so that physicians no longer would feel they need to order unnecessary medical procedures to protect themselves.
- It is far more efficient. Streamlined administration, the use of standardized forms, and electronic billing eliminate much of the nightmarish complexity and paperwork of today's health care system. They also reduce costs.
- It provides comprehensive benefits for all. Everyone is eligible for coverage regardless of age, employment status or income. The welfare-based Medicaid program is abolished and low-income protections are provided without stigmatizing recipients.
- It preserves our freedom of choice. We can continue to select our own doctors, hospitals and other health providers.
- It provides comprehensive long-term care. Services can be provided in the home, in the

community, and in the nursing home. It also places limits on out-of-pocket, long-term-care expenses so that no one need go broke as they do under the current Medicaid program.

- It covers outpatient prescription drugs. You pay only 10 percent out of pocket for your prescriptions.
- It protects the already-sick. No one can be excluded from coverage on the basis of a "pre-existing" medical condition such as diabetes or heart disease.
- It greatly reduces out-of-pocket spending. It covers 100 percent of preventive care costs. It eliminates coinsurance payments for inpatient hospital care and hospice care. The proposal also sets annual limits on out-of-pocket spending for medical care services. Supplemental insurance for medical care is no longer necessary because the benefits are so comprehensive.
- It places new emphasis on preventive care. By diagnosing and treating small problems early, we can prevent costly illnesses, and even unnecessary deaths.
- It provides children with total health services. The plan includes dental, vision, and hearing screening and treatment for all children.
- It strengthens vital health research and quality assurance programs. The plan provides for continued improvements in our technology and in the quality of our health services by increasing funding for research in biomedical treatment and outcomes of care.
- It gives employers a choice. Rather than enroll employees and their dependents in the new

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

How The Proposal Was Drafted

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

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

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

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

Where We Go From Here

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

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

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

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

What You Can Do

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

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

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

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

Appendix

Health Care America As a Single-Payer Plan

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

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

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

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

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

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

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

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

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

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

HEALTH CARE AMERICA DRAFT PROPOSAL FEEDBACK

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

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

1. Based on what you know, how well do you understand AARP's Health Care America draft proposal - the "blended" plan?
- ☐ Very well ☐ Fairly well ☐ Only a little ☐ Not at all

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

3. Thinking about both the coverage offered by this plan and the costs, how does this plan compare with your current coverage?
- ☐ Much better
☐ Somewhat better
☐ About the same
☐ Somewhat worse
☐ Much worse
☐ Don't know

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

- ☐ A special 3% tax on all yearly income (including all Soc. Sec., tax-exempt bond income, etc.) above \$15,000 for a single person (\$20,000 for a couple).
- ☐ A 5% tax on consumption of goods and services (except food, housing and medical care) - a value-added tax.
- ☐ I could **NOT** support either of these
- ☐ I **COULD** support either of these
- ☐ Don't know

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

- ☐ The "blended" version of the Health Care America proposal which provides coverage either through employer-provided private insurance or an expanded Medicare program.
- ☐ The "single-payer" version which provides coverage for everyone through an expanded Medicare program.
- ☐ Neither of these. ☐ Don't know

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

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

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

- ☐ Health Care America, AARP's "blended" proposal.
- ☐ a plan that's completely sponsored by the government - a "single-payer" plan.
- ☐ a plan that requires all businesses to provide insurance coverage for their employees or pay into a public program - a "pay or pay" plan.
- ☐ the system of health care that we have now
- ☐ the system we have now with some insurance reform and government vouchers or tax credits to help the uninsured buy insurance
- ☐ some other plan (please describe briefly): _____

8. Any Additional Comments?

9. Where did you receive this questionnaire?

- ☐ AARP Chapter meeting ☐ Brochure/mail
- ☐ Community Forum (City _____ State _____ Date _____)
- ☐ Other (Specify _____)

INFORMATION ABOUT YOU:

10. Gender:

- ☐ Male
☐ Female

11. Age:

- ☐ Under 50
☐ 50 - 64
☐ 65 or older

12. Are you an AARP member?

- ☐ Yes
☐ No

13. Education:

- ☐ Less than high school
☐ High school graduate
☐ Some college
☐ College graduate

14. Employment Status:

- ☐ Retired
☐ Working Full time
☐ Working Part time
☐ Homemaker

15. Are you an AARP Chapter or an NRTA unit member?

- ☐ No, neither
☐ AARP chapter member
☐ NRTA unit member

HEALTH CARE REFORM
PHYSICAL THERAPY AGENDA

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

I. COST CONTAINMENT

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

II. PREVENTION AND WELLNESS

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

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

III. LONG TERM DISEASE/DISABILITY

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

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

IV. ENTRY TO CARE

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

V. ENVIRONMENTS OF CARE

A. Acute Care

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

B. Rehabilitation

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

C. Long-Term Care

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

D. Community Care

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

VI. HEALTH CARE DELIVERY MODES

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

VII. RESEARCH EFFORTS

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

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

VIII. EDUCATION

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

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

- a. Allow individuals to obtain appropriate academic credentials in their field of study.
- b. Increase the flow of individuals into the system to allow for adequate numbers to care for patients. This may require funding to attempt unusual or untraditional educational modes of entry.

October 21, 1992

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

Dear Senator Duncan and Task Force Members,

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

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

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

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

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

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

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

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

Sincerely,



Bill Nugent
Anchorage Senior Care Network

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LONG TERM CARE CONTINUUM IN ANCHORAGE

Critical Issue Areas

ACCESS

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

SERVICES

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

INTEGRATING MECHANISMS

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

Fairbanks Community Health Project Project Overview

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

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

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

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

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

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

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

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

The specific purposes of the Coalition are:

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

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

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

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

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

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

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

- **Cost of Services:** The cost of care is the greatest barrier to access to health services. People who do not have insurance or who do not qualify for Medicaid can not afford adequate care.
- **Medicaid:** Medicaid is an all or nothing situation - people qualify for everything or nothing. Single people between the ages of 18 and 65 can not qualify unless they are pregnant or have a disability. The application for Public Assistance and Medicaid is cumbersome. Once a person is determined eligible, the care options are often limited to treatment of acute conditions.
- **Physician/Patient Relationships:** Patients need more time to talk to physicians, to discuss tests, prescriptions and the patient's condition. Physicians rarely make referrals to alternative health services or to allied services, like home health or homemaker services. People also are unhappy with having to wait weeks or months for appointments and not being able to get appointments during their non-work hours.
- **Funding of Services:** Community fund raising and support for services should always be sought first - communities should decide what they will support. The issue of who should have health and social services powers, the city or borough, should be explored.
- **Health Education:** Health education and disease prevention information is not easy to find. Information should be available throughout the borough and region, and include materials appropriate to people of other cultures and non-readers. Information should be available on all kinds of health services, including alternative care options.

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

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

- **Candidates Forum** - The Coalition is co-sponsoring candidate forums for local and state candidates with the Arctic Alliance. The candidate forum for local races is scheduled for September 21 and the forum for state candidates is October 13. The Coalition is developing a list of questions that will be asked of the candidates by the League of Women Voters moderators.
- **Developing Special Interest Committees** - The Coalition is forming four committees which will focus on different parts of the health care system. The committees are Medical/Dental Services, In-Home Services, Alternative Health Services, and Mental Health and Addiction Services. Committees will include non-Coalition members, including former members of work groups, and will work towards developing solutions to the issues identified earlier.
- **Pursuing Funding for a Section 330 Community Health Center** - Discussion between the Coalition and community health care providers on the feasibility of seeking funds through Section 330 of the Public Health Service Act began in March. If there is support from the community, an application will be submitted in the Spring of 1993.

...DRAFT...
Fairbanks Community Health Project
Community Health Survey

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

The sample for the survey is not random so that the assumptions that can be drawn are somewhat limited. However, the purpose of the survey was to look at how people use health services in relation to how they pay for services. Survey respondents were grouped by source of payment for health services, including those with 1) insurance through a job, 2) private pay insurance, 3) federal sources, including Medicaid, Medicare, Indian Health Service, CHAMPUS and VA, 4) no insurance and 5) multiple payment sources, usually Medicare plus another payer.

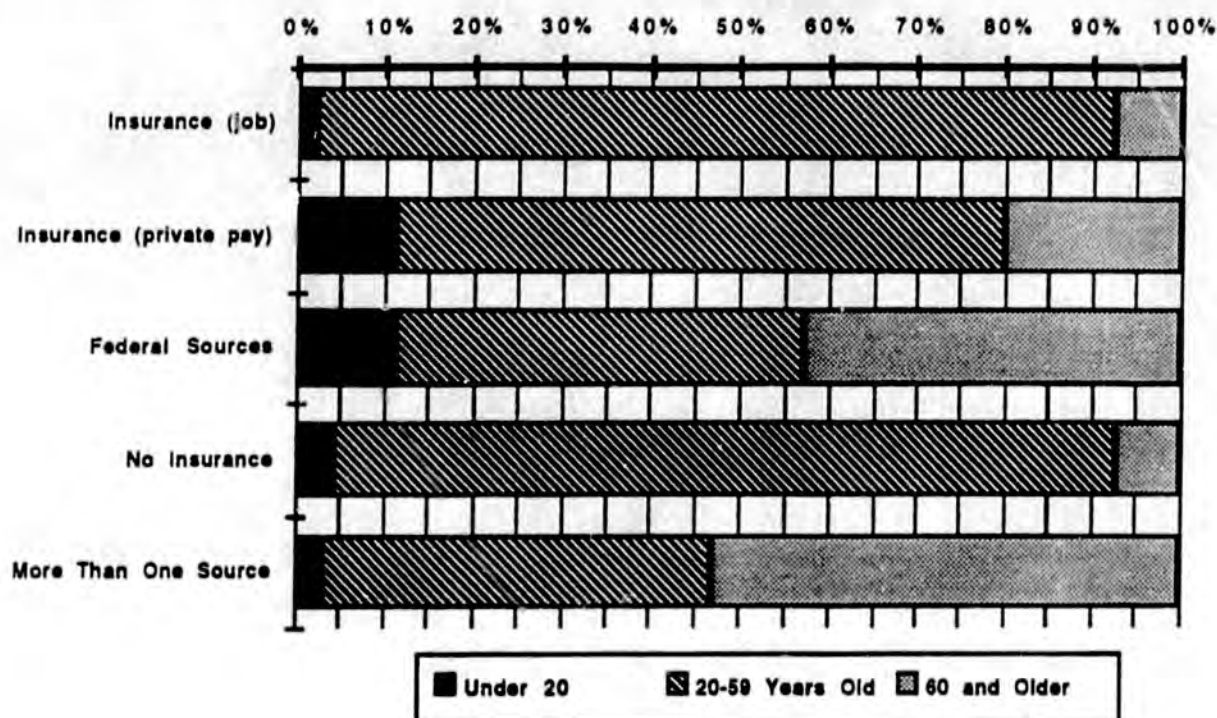
People were also asked to rate their health and the quality of health care in Fairbanks, whether they had sought health care outside the community, and if they had ever delayed seeking health care because they were afraid of the cost.

Sample Overview: The 703 people surveyed reported their primary payment source for health care as follows:

Payment Source	Number	%
Insurance (job)	347	49.4%
Insurance (private pay)	36	5.1%
Federal Sources	63	9.0%
No Insurance	137	19.5%
More Than One Source	99	14.1%
No Response or Other	21	3.0%

More women completed survey forms, with 62.4% or 439 of the respondents being women and 36.7% (258) men. Six individuals were unknown. The mean age varied by payment group. The youngest group, with an average age of 39, was those who had no health insurance. Respondents who had more than one source of payment were the oldest group, with an average age of 55. Most of these individuals appear to be older Alaskans who supplement Medicare with private insurance or other payment sources.

Age of Survey Respondents



Health Services Used in the Past 12 Months: Respondents reported using a wide variety of health services. The type of care sought most often was cleaning and preventive dental care (49.2% of sample). The next most frequently used types of health care were family practice (48.2%), general dental services (34.3%), optometry and glasses (34.1%) and obstetrics/gynecology (22.5%).

Of those who listed a payment source, people with insurance through a job were the most frequent users of health services of almost every kind. People who paid for health care through private pay insurance and those who had no insurance were the least likely to have used health services. This is particularly true for dental services. Sixty-four percent (64%) of those insured through a job visited a dentist for cleaning or preventive care during the past year. Only 29% of those without insurance used the same service. Similarly, while 41.8% of those with insurance through a job received general dental care this year, only 24.1% of those without insurance and 22.2% of those with private pay insurance used these services.

People with insurance through a job also used a wider variety of health services than people in the other payment groups. They reported using an average of 3.2 different health services during the past year. Those with more than one payment source used an average 2.8 services, followed by people using federal sources (2.7 services) and those who pay for their own insurance (2.5 services). Respondents who do not have health insurance or another payment source used an average of 2.4 health services in the past twelve months.

Use of Health Services in Past 12 Months
Percentage of Respondents Reporting Visits to Health Care Providers

Health Service	All Respondents	Insurance (Job)	Insurance (Priv. Pay)	Federal Sources	No Insurance	More Than 1 Source
Medical Services:						
• Family Practice	48.5	53.3	36.1	44.4	43.1	51.5
• Obstetrics/Gynecology	22.5	27.1	13.9	19.0	19.7	14.1
• Other Specialty	10.4	9.5	5.6	11.1	11.7	13.1
Dental Services:						
• Cleaning/Preventive	49.2	64.0	44.4	38.1	29.2	40.4
• General Dental Services	34.3	41.8	22.2	31.7	24.1	32.3
• Orthodontics	4.6	3.5	5.6	4.8	5.8	7.1
Hospital Emergency Room	15.6	14.4	16.7	17.5	16.1	18.2
Alcohol/Drug Counseling	1.0	1.4	0	1.6	0	1.0
Optometry/Glasses	34.1	38.6	36.1	38.1	21.2	34.3
Mental Health Counseling	6.0	5.5	5.6	6.3	8.0	5.1
Chiropractic Services	19.8	25.1	5.6	19.0	13.1	18.2
Midwifery	2.4	1.4	5.6	0	4.4	4.0
Acupuncture/Acupressure	5.3	4.6	8.3	1.6	5.1	9.1
Naturopathic Medicine	6.7	7.2	11.1	4.8	6.6	6.1
Home Health Services	<1.0	<1.0	0	3.2	<1.0	1.0
Respite Services	<1.0	<1.0	0	0	<1.0	0
Hospice Services	<1.0	1.4	2.8	0	0	0
Fairbanks Health Center:						
• Well Child Clinic	3.6	2.9	2.8	3.2	5.1	5.1
• PHN Home Visits	<1.0	<1.0	2.8	3.2	0	0
• Family Planning	3.4	1.7	5.6	7.9	4.4	3.0
• Immunizations	7.8	6.6	8.3	6.3	8.0	14.1
• Other Center Services	4.4	2.3	8.3	4.8	8.8	4.0
Other	3.6	3.2	0	3.2	5.1	1.0

National studies report that women who do not have health insurance often delay prenatal care until late in their pregnancies. Although respondents were not directly asked about prenatal care, the data indicate that this may also be the case in this survey sample. The average ages of respondents who have health insurance through a job and those without any health insurance are nearly the same (40 and 39, respectively). Almost half of the women (45.9%) with insurance through a job sought out OB/GYN services during the last 12 months while only 27.8% of those without insurance received similar services. While it is not possible to directly relate this data to prenatal care, women without insurance are less likely to receive regular examinations and related prevention services.

Another women's health service respondents were asked about was mid-wife services. When considered together with OB/GYN services, the pattern of use remains the same.

For women between 16 and 40 years old, 55.1% of those with insurance through a job had received OB/GYN or mid-wife services in the past year while 36.2% of the women without insurance received similar services. Older women (41 and older) sought out service less often than younger women, with 35.7% of the women with insurance and 15.4% of the women without insurance seeking services in the past year.

Use of Women's Health Services by Age Group

Women's Health Services	Insurance (Job)			No Insurance		
	# of Women	16 - 40 Yrs Old	41 and Older	# of Women	16 - 40 Yrs Old	41 and Older
Women in Payment Groups	205	107	98	97	58	39
<i>Women's Health Services:</i>						
OB/GYN	92	54	38	26	16	10
Mid-Wife	3	3	0	5	4	1
Both	2	2	0	1	1	0
Services Total	97	59	38	32	21	11
% in Age Group Using Women's Health Services	47.3%	55.1%	35.7%	33.0%	36.2%	15.4%

How Do You Rate Your Health? Most survey respondents rated their health excellent or good. More than ninety percent (92.5%) of the people with insurance through their workplace reported that their health was excellent or good. The next most healthy group was those with private pay insurance (91.6%), followed by people whose health care is supported by federal sources (85.8%), those without insurance (82.5%), and those with more than one payment source (78.7%). It is not surprising that those with more than one source are the least healthy since they are significantly older than the other groups. However, it is interesting that the youngest payment group, those without insurance, report excellent or good health significantly less often than the payment group closest to them in age, respondents who have health insurance through a job.

How Do You Rate Health Care in Fairbanks? Most people responding to the survey (77.4%) rated health care in Fairbanks as excellent or good. Those with private pay insurance were the most satisfied, with 91.6% rating care as excellent or good. People with insurance through their job were the next most satisfied (81.8%), followed by those with more than one payment source (76.7%) and those with federal payment sources (71.5%). Individuals who do not have insurance were the least satisfied, with 69.3% rating health care in Fairbanks as excellent or good.

Have You Sought Health Care Outside the Fairbanks Community?

Almost a third (32.1%) of the survey respondents received health care from providers outside the Fairbanks community in the past five years. People who have more than one source of payment for health care were the most likely (43.4%) to seek care elsewhere. One third (33.3%) of those with federal payment sources received care outside the community, followed by 30.6% of the respondents with private pay insurance and 29.9% of those with no insurance. People with insurance through a job were the least likely (29.4%) to have sought care elsewhere.

Reasons for Seeking Care Outside Fairbanks

<i>Reasons for Seeking Health Care Outside Fairbanks</i>	All Respondents	Insurance (Job)	Insurance (Priv. Pay)	Federal Sources	No Insurance	More Than 1 Source
Specialized Care Not Available in Fairbanks	16.4	15.7	18.2	14.4	7.3	30.2
Better Quality Care Available Elsewhere	4.4	6.9	0	9.5	0	2.3
Health Care Costs Less Elsewhere	25.2	30.4	9.1	9.5	36.6	16.3
Wanted to Receive Care Closer to Family	5.3	3.9	18.2	4.8	7.3	2.3
Other or More Than One Reasons	45.2	40.3	54.6	57.1	46.3	46.5
No Response	3.5	2.9	0	4.8	2.4	2.3

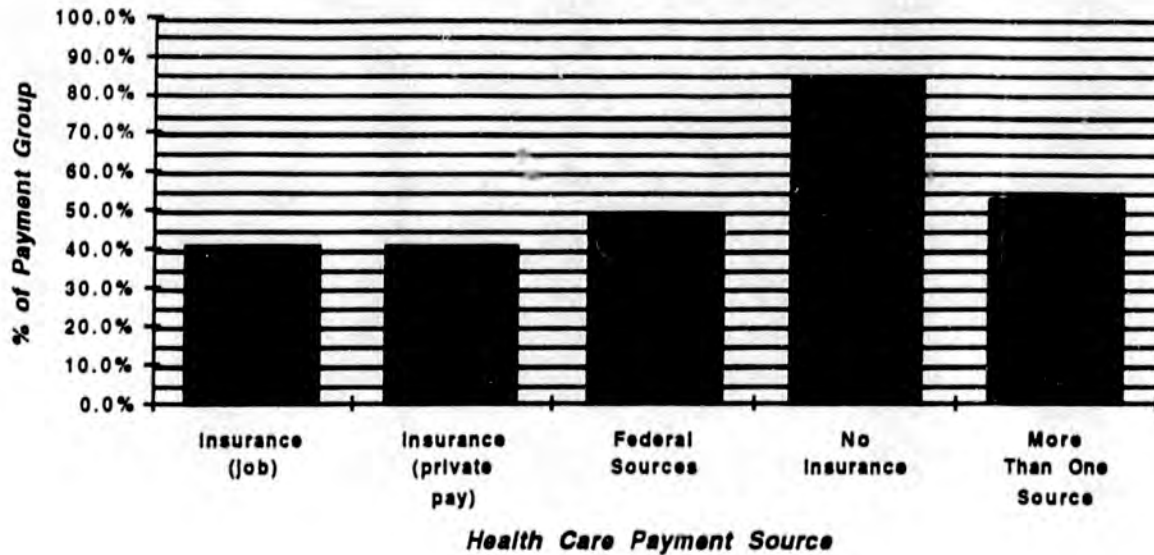
Have You Delayed Health Care Because of Cost? Survey respondents who had no health insurance were more than twice as likely to have delayed seeking health care because of the cost than people with insurance through their job or private pay insurance (84.7% compared to 40.6% and 40.5% respectively). Approximately half of those with federal payment sources (48.5%) and those with more than one source (52.5%) reported that they have delayed seeking care.

Conclusions: A number of conclusions can be drawn from data. The discussion of findings is accompanied by quotes from respondents' answers to the open-ended question, "What is the most serious problem you experience in getting health care?" Each quote is followed by the sex, age and location where the survey was completed.

"I married my husband for his health insurance. I could not go to a dentist or eye doctor (for glasses) prior to that and got other care either from the Fairbanks Health Center or if I thought I absolutely had to have medical care.

Woman, 42 - Health Forum

People Who Have Delayed Health Care Because of the Cost By Health Care Payment Source



"During my second pregnancy, I didn't seek prenatal care until my third trimester after an initial evaluation. We just couldn't afford to have care. When you don't have health insurance, it is so frustrating to know that there are health care professionals out there, but we can't get care because we don't have the money."

Woman, 38 - Fairbanks Health Center

The cost of health care is the most important barrier experienced by survey respondents. The effects of this barrier can be seen throughout the data. People who have no insurance and pay cash for care are the most significantly impacted. They use most health care services less often than other payment groups. The greatest disparity is in the use of preventive health care services, such as dental cleaning/preventive services and women's health services (OB/GYN, midwifery). People who do not have health insurance rate their health status lower than other groups. They also rate the quality of local health care lower, which is not surprising considering their lack of access to care. Respondents in this group were also twice as likely to have delayed seeking health care because of cost. The long-term implications of lower health status, lack of preventive care and delaying care will be felt in the need for more expensive acute care in the future.

"The cost of medical attention is astronomical. This cancels the opportunity for preventive medicine for my family, as well as many others. I am a single parent with two children."

Woman, 44 - Fairbanks Senior Center

The cost of health care is an issue for all payment groups. A number of respondents noted that paying insurance deductibles or co-payments is often a problem. While people who had no insurance were the most likely to have delayed care because of cost (84.7%), it is interesting to note that almost half of people with insurance, either through a job (40.6%) or private pay (40.5%), also delayed seeking care.

"Even with insurance, the cost of medical care is so high that I still measure whether or not I can do without the treatment."

Woman, 28 - Midwifery Clinic

"Health care is too expensive. I have insurance but I still can't afford what I need (considering the deductible and 20% I must pay and my insurance company's refusal to pay Alaskan rate for services). I need a couple of thousand dollars worth of dental care right now but my insurance will only pay 50%, so I can't do it. This lack of care now may result in serious problems later (like the loss of a bunch of teeth). Society winds up paying in situations like that, and the state and the feds pay more for serious problems later than they would for preventive care now."

Woman, 28 - Fairbanks Health Fair

Nearly a third of the people responding to the survey (32.1%) reported that they had sought health care outside the community in the past five years. The follow-up question on why they chose to look elsewhere for services was inconclusive. It is apparent that there are many reasons, including the need for specialized care and the cost of services in Fairbanks. This question merits further study to determine the reasons for and the solutions to this problem, and to gauge the economic impact on the Fairbanks health care service system.

FAIRBANKS COMMUNITY HEALTH PROJECT
Issues and Solutions
WORK GROUPS - November, 1991 - January, 1992

ISSUES	SOLUTIONS
A. COST OF SERVICES: The cost of care is the greatest barrier to access of health services. People who do not have insurance or qualify for Medicaid can not afford adequate care. This is an especially critical issue for people with chronic conditions or chronic mental health problems. B. MEDICAID: Medicaid is an all or nothing situation - people qualify for everything or nothing. Single people between the ages of 18 and 65 can not qualify unless they are pregnant or have a disability. The application for Public Assistance and Medicaid is cumbersome and, once a person is determined eligible, many of the care options are limited to treatment of acute conditions.	- Standardize insurance forms to reduce processing time - Encourage insurance companies and Medicaid to reimburse a wider variety of services including alternative health care, psychological services, and home health care - Tort reform to control malpractice costs - physicians might order fewer tests and procedures, lowering costs - Sliding fee scales developed and advertised (professional groups) - Increase the number of mental health providers that can be reimbursed by third party payors - Expand Salvation Army Medical/Dental Care Access Program to include similar pro bono efforts in medical specialty services, alternative health providers, and mental health services, i.e. targeted clinics - work through local professional organizations - Encourage networking between small businesses to form larger groups for health insurance coverage - Increase availability of health care services for people without insurance to reduce the use of the emergency room at the hospital for primary care - Greater prescription and use of generic drugs - Insurance companies should be required to provide an insurance pool for people who are "uninsurable" or have "pre-existing conditions" - Medicaid should be expanded to cover other services, i.e. prevention services, psychologist and counselors, alternative health care services, and home health care - Incentives for providers to accept Medicaid, i.e. reduce paperwork required, find other ways to simplify process - Advocate for adequate funding in state Medicaid budget - shortfalls mean some services are not available until the beginning of the next budget year - The state Medicaid program should allow a person to 'spend down' to meet Medicaid financial requirements - Medicaid application process should be streamlined - difficult to understand and lengthy - Find ways to increase Medicaid recipient compliance and/or responsibility for showing up for appointments, perhaps a token payment for services

ISSUES

- C. **PHYSICIAN-PATIENT RELATIONSHIPS:** Patients need more time to talk to physicians, to discuss tests, prescriptions and the patient's condition. Physicians rarely make referrals to alternative health services or to allied services, like home health or homemaker services. Patients believe that malpractice suits would be less likely if physician-patient relationships improved.
- D. **CASE MANAGEMENT:** There is little coordination of case management. Some people have more than one case manager, which is confusing for the patient and often puts providers in conflicting positions.
- E. **HEALTH EDUCATION:** Health education and disease prevention information is not easy to find. Information should be available throughout the borough and region, and include materials appropriate to people of other cultures and non-readers. Information should be available on all kinds of health services, including alternative care options.
- F. **FUNDING FOR SERVICES:** Funding for new and existing services is not adequate.
- G. **FAIRBANKS HEALTH CENTER:** Public health services are currently provided in sub-standard facilities scattered throughout town.

SOLUTIONS

- Provide professional organizations (physicians, dentists, nurses) with information on in-home, alternative and mental health services in community
- Patient education on how to take responsibility for health care and to better communicate individual needs to physicians
- Local "clearinghouse" for services to work with individual agency case managers and to provide information on pro bono services around the community
- Establish a centralized information and referral source
- Weekly column in the Fairbanks Daily News Miner
- Hire marketing expert to develop community education campaign
- Use local theater and dance groups to reach adults and children
- Involve UAF journalism and broadcasting department in developing community health education campaign
- Work with university to develop a Public Health Education degree - encourage existing programs (i.e. the Addictions School) to include prevention in their courses
- Include information on alternative health service options in public health education campaigns
- School health education should include information on alternative health care options
- Medical continuing education opportunities should be well publicized and open to the public
- FNSB should take on health and social services powers to administer borough-wide services
- Community fund raising or support for services should always be sought first - communities can make decisions about what they will support
- Look first to community associations, like civic organizations or churches, to solve community problems
- Consolidate state public health programs in offices that provide adequate space and equipment for services
- Need agreement on the new health center site

ISSUES

- H **INFORMATION RESOURCES:** Better coordination is needed between in-state research and information resources (ex., UAA - Alaska Health Sciences Library) and programs and policy makers.
- I **MEDICAL AND ALTERNATIVE HEALTH CARE :** Medical care providers have negative attitudes about alternative health care services and providers. This makes it difficult for patients to be referred to alternative health care services. Without a referral, a patient can not get insurance coverage for the care. There is a lack of networking between the medical and alternative health care communities. The doors to continuing education opportunities are often closed to providers outside the medical care system.
- J **RELATIONSHIP BETWEEN RESEARCHERS, PROGRAMS, AND POLICY MAKERS:** The funding of services is often based on what was funded in the past rather than on information on what works best. Policy makers, including boards and commissions, should be up to date on current research and trends in the field.
- K **SERVICES FOR PEOPLE WITH PERSONALITY DISORDERS:** In-patient and out-patient care for people falling between crisis and chronic is not available, especially for people without insurance.
- L **COMMUNITY HEALTH:** The community needs a greater focus on optimal health and wellness. People are generally not concerned about health until they are sick.
- M **PREVENTIVE HEALTH CARE:** Preventive health care services are usually not covered by insurance or Medicaid. Preventive care is especially lacking for women.
- N **TRANSPORTATION:** Transportation was cited as a problem by all service providers. Lack of transportation is a major access problem for many people, especially older Alaskans and people with disabilities.

SOLUTIONS

- Organize regular community resource information days
- Encourage insurance companies and Medicaid to reimburse alternative health care
- Alternative health providers should be certified or licensed
- Open medical continuing education classes to alternative health care providers as a way to begin a dialogue between the provider communities
- Alternative health care providers should organize to identify concerns, produce materials, and do public education
- Program funding should be done through zero-based budgeting to encourage thorough review of current research and trends
- Use community needs assessments to fund services people need rather than what programs want to provide
- Service agencies and groups must advocate for well informed board and commission members
- Expand services to people with mental health problems which are not chronic or expand definition of chronic mental illness
- Media campaign - "A healthy community is a more productive community"
- A healthy community will require free or low cost preventive and acute services for people who can't afford them
- Fairbanks is an aging community - we need to plan now for our future
- Need to plan for the long term needs alcohol and drug exposed children
- All women should be guaranteed prenatal services, either through Medicaid or state services
- Increase hours and capacity of Van Tran
- Coordinate the use of agency vans for picking up people around town when not in use by the individual programs